Beamans
Management Consultants

Isle of Man Dept. of Health: Review of Management Effectiveness Noble's Hospital

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EXECUTIVE SUMMARY

1. In the light of concerns expressed about the management of Noble's Hospital Beamans Management Consultants were invited by the Chief Minister and Chief Secretary to carry out a review to determine how effective existing management arrangements at the hospital are in managing and co-ordinating the provision of acute care.

2. For the purposes of this review we took the term 'management effectiveness' to refer to any aspect of planning, leadership, organisation or control of the delivery of acute health care including aspects of planning and control currently exercised by the Department of Health (the department). The review did not look at or consider aspects of clinical effectiveness which are subject to a separate range of reviews due to be undertaken by the West Midlands Quality Review Service.

3. The review identified a number of areas where improvements to existing arrangements could be made. These can be summarised as follows:

    - The need for a new management and governance framework which offers greater clarity as to who is responsible and accountable for the provision of acute health care.

    - The need for the department to adopt a more strategic, 'hands-off' role in relation to the hospital.

    - The need for senior hospital management to focus more on service developments and enhancing levels of quality as opposed to day-to-day management issues which should be the responsibility of Clinical Directors and Divisional Managers.

    - The need for more attention to be given to planning at both a strategic and operational level. In the absence of a detailed planning framework which sets out what the key objectives are, particularly in relation to quality, it is difficult to judge relative levels of performance.

    - The need to deal with long-standing issues in relation to ICT and data quality and most importantly, to use data to drive quality improvement.

4. Looking ahead, the key challenge for Noble's is to maintain public confidence. The review concludes that it is doubtful whether that confidence can be maintained simply by adapting existing hospital and departmental mechanisms of governance and management. In short, more radical change is required and a more modern, patient centred, accountable system of governance and accountability needs to be put in place.

5. The review proposes that a Governing Board should be established to build more transparent relationships and partnerships with patients and the public and most importantly, build trust and restore public confidence. The hospital also requires Executive leadership and to this end, proposes that a Hospital Managing Director be appointed who will be accountable to the Board for the performance of the hospital.

6. Although it should be left to the Hospital Managing Director to determine what consequential changes to the Noble's management structure might be appropriate (and what plans to put in place to address the issues identified in this report, plus other issues which may emerge from the series of quality reviews being undertaken by the West Midlands Quality Review Service) the review envisages that the Hospital Managing Director will be supported by a Director of Nursing, a Medical Director (which would be a full-time role without clinical commitments) and two new Director level roles: a Director with responsibility for financial governance and assurance including longer-term financial sustainability and obtaining value for money; a Director (initially for a fixed-term duration – 3 years) to lead what we broadly refer to as the performance and improvement agenda.

7. Other planned changes notwithstanding, the governance and management framework proposed for the hospital will require consequential changes to the departmental management framework. The Director of Healthcare Delivery and to a lesser extent the Deputy Chief Executive and Director of Finance will no longer have a part to play in the day-to-day management oversight of the hospital. However, the main challenge for the department will be adopt a more strategic, hands-off role and think strategically about the delivery of acute care in the context of developing more integrated health and social care provision.

8. Finally, we would like to finish our commentary by saying we were impressed by the dedication and professionalism of all the staff we met during the course of this review. And whilst reviews such as this naturally focus on what is not working well it is important to recognise and acknowledge the dedication of staff to providing a high-standard of service and care to the people of the Isle of Man.

1. Introduction

1.1 Beamans Management Consultants were invited by the Chief Minister and the Chief Secretary to carry out a review to determine how effective existing management arrangements are at Noble's hospital in managing and co-ordinating the provision of acute health care.

1.2 In commissioning the review the Chief Minister and Chief Secretary were conscious of the fact that concerns had been expressed about management effectiveness at the hospital and therefore felt that an independent review would be helpful in establishing whether there were any grounds for those concerns. The fundamental aim of the review was therefore to consider the existing management arrangements at the hospital and, if appropriate, to make recommendations as to how the effectiveness of those arrangements could be improved. However, it is important to remember that the review is not concerned with issues of clinical effectiveness. It considers how effective management arrangements are in supporting the provision of acute health care not how effective clinical interventions are in the provision of that care.

1.3 The full terms of reference for the review were:

To provide an assessment of the management demands accorded by the effective running of Noble's Hospital and as part of that assessment:

- *Review the role, functions and senior management structure of Noble's hospital.*
- *Identify changes or improvements which might be made to the way in which existing functions are delivered including any issues e.g. human resource, organisational etc., which may be adversely impacting on the efficiency or effectiveness of service delivery.*
- *Identify the most efficient and effective senior management structure to meet current and future operational requirements.*
- *Recommend changes, identifying costs and benefits, and an implementation plan.*

In undertaking the review the review team will have regard to models of good practice in the UK and other jurisdictions.

1.4 The work was carried out by Michael Bourke, Graham Martin and David Conroy and this brief report sets out the findings and conclusions of the review.

Our Approach

1.5 Interviews were held with a number of staff whose roles fell within the scope of the review (see Table 1 below) so that a complete picture of their role within the current management framework could be established. Separate discussions were also held with the Chief Minister, Minister for Health, Member for Health, Chief Secretary and Chief Executive to get a wider perspective on the issues relating to the current and future provision of acute health care.

Table 1: Roles Reviewed

Hospital Manager
Director of Nursing, Midwifery & Therapies
Medical Director
Director of Healthcare Delivery
Divisional Managers: Medical; Surgical; Operations; Women, Children and Outpatients; Diagnostics and Professional Services
Clinical Directors: Medical; Surgical; Women, Children and Outpatients; Diagnostics and Professional Services
Senior Nurse: Surgical; Women, Children and Outpatients; Diagnostics and Professional Services

1.6 We also spoke to a number of other staff whose roles link to or provide support to the work of the hospital.

Table 2: Additional Consultees

Deputy Chief Executive
Director of Finance
Director of Management Information & Technology
HR Business Partner for the Dept. of Health
Transformation Change Co-ordinator
Head of Organisational Learning & Development

Acknowledgements

1.7 We are grateful for the co-operation we received from all staff we spoke to during the course of the review. We would also like to acknowledge the helpful contributions and insights provided by individual members of staff on the issues and challenges facing the hospital. For these contributions we are grateful.

2. The Role of the Department of Health

Introduction

2.1 Noble's hospital forms an integral and fundamental part of the Island's health care system. It operates under the auspices of the Department of Health (the department) and is accountable through the department to the Minister for Health who in turn is accountable to Tynwald. The department is responsible for setting the policy – the parameters for acute health care in the Isle of Man – and for defining the management framework – the broad rules which the Hospital Manager must adhere to in managing and co-ordinating the work of the hospital.

2.2 In considering how effective existing management arrangements are at Noble's hospital we therefore need to firstly consider:

- The role of the department in setting the parameters for acute health care provision and in particular the strategic and operational planning framework within which acute health care is delivered.
- The role of the department in the day-to-day management of the hospital.

Strategic & Operational Planning

2.3 In 2011 the department published a strategic plan: *A Strategy for the Future of Health Services in the Isle of Man*. The purpose of the document was to set a strategic direction for the health services in the Isle of Man over the period 2010 to 2020. In June 2012 the Mersey Internal Audit Agency undertook a Management Information Review. Notwithstanding the fact that auditors noted that this area of activity was under resourced, the review also highlighted a number of fundamental or significant issues which, in the opinion of the auditors, prevented the department and divisions from clearly understanding whether, or the extent to which, the service was performing to an acceptable level in terms of core activity and/or value for money.

2.4 In response to this report the department acknowledged the importance of timely and insightful information and has embarked on a journey to improve current reporting arrangements to provide a greater focus on performance and delivery monitoring in relation to its core strategic objectives. The question of management information and reporting arrangements in a Noble's hospital context is complex and one on which we comment further in para 3.33 *et seq*. However, the key point in the context of this debate is that there is no operational plan for the delivery of acute health care. Put simply: how can you judge management effectiveness if there are no objectives to judge it against?

2.5 In our view, there are two significant gaps in the planning framework which impact on management effectiveness. First, there is no operational plan which translates strategic objectives into delivery objectives against which performance can be judged. In effect, you cannot judge the performance of the hospital – and by definition the performance of hospital management – in any meaningful way because there is nothing to judge performance against save historic levels of performance. Second, the absence of an effective operational planning process makes it impossible to make judgements on the allocation of resources between different aspects of acute health care (and more broadly between primary and acute health care). Again, it is open to question how far annual budget allocations to Noble's reflect deliberate and carefully weighted decisions by senior departmental managers (and Ministers) or simply the incremental outcome i.e. plus or minus a given percentage, of the budgeting round.

2.6 The importance of planning, and linked to this the requirement for accurate, timely and appropriate information upon which informed decisions can be taken, and performance monitored is well understood by the department. The Performance and Delivery Group which is chaired by the Member for Health and comprises representatives from Noble's management team and the department is, we understand, currently working to address these issues. We should also acknowledge that this is not a quick fix because of historic problems of data quality (see para 3.33). Nevertheless, although management information systems are improving, as evidenced by the development of ihub, they are still not strong enough to inform strategic decision making.

2.7 In summary, the Strategy for Health needs to be translated into an operational plan, which clearly identifies the core activities and priorities for acute healthcare provided by Noble's Hospital and further work needs to be undertaken to improve performance reporting (see also para 3.35).

The Department's Role in Relation to Hospital Management

2.8 Figure 1 on page 10 illustrates the current management framework within which management of Noble's hospital rests. The most significant point of note is the relationship between departmental management and the hospitals' management. The Hospital Manager is line-managed directly by the Director of Healthcare Delivery who in turn is line managed directly by the Deputy Chief Executive. In practice this means that responsibility and accountability flows directly through the management chain from the Hospital Manager, through departmental senior management to the Chief Executive. Although it is implicitly assumed that the Hospital Manager is responsible at no point in that chain is there anything which makes it explicitly clear who is responsible and who is accountable for the effective delivery of acute health care provision at Noble's hospital.

2.9 In any organisational context and perhaps more so in an acute health care setting, it is important to know who is responsible for various aspects of service provision and who they are accountable to for the effective delivery of those services. It could be argued that the Hospital Manager is responsible for the effective delivery of service provision at Noble's hospital but is accountable to the Director of Healthcare Delivery for the judgements that are taken in relation to how those services are delivered. However, this assumes that the Hospital Manager is able to take judgements as to how resources are planned, organised and deployed to meet service delivery requirements. Apart from judgements relating to the day-to-day running of the hospital the department has traditionally exercised a close scrutiny over the work of Noble's hospital and exercises responsibility for all key decisions relating to finance, staff and wider questions of resource allocation. We comment further on this issue in para 3.35 et seq.

2.10 In management terms the department has both a strategic and operational role. Clearly, the department's fundamental role is to think strategically. It also has an operational role in that those who are responsible for the leadership, management and co-ordination of health care provision must be accountable – and held to account – by the department and the Minister for the delivery of those services. However, accountability should **not** require the department (except *in extremis*) to intervene or interfere in the day-to-day management of the hospital. The department's priority should be to set clear objectives, provide advice, development and encouragement as necessary; not to second-guess operational decisions taken by hospital management. This is an important point.

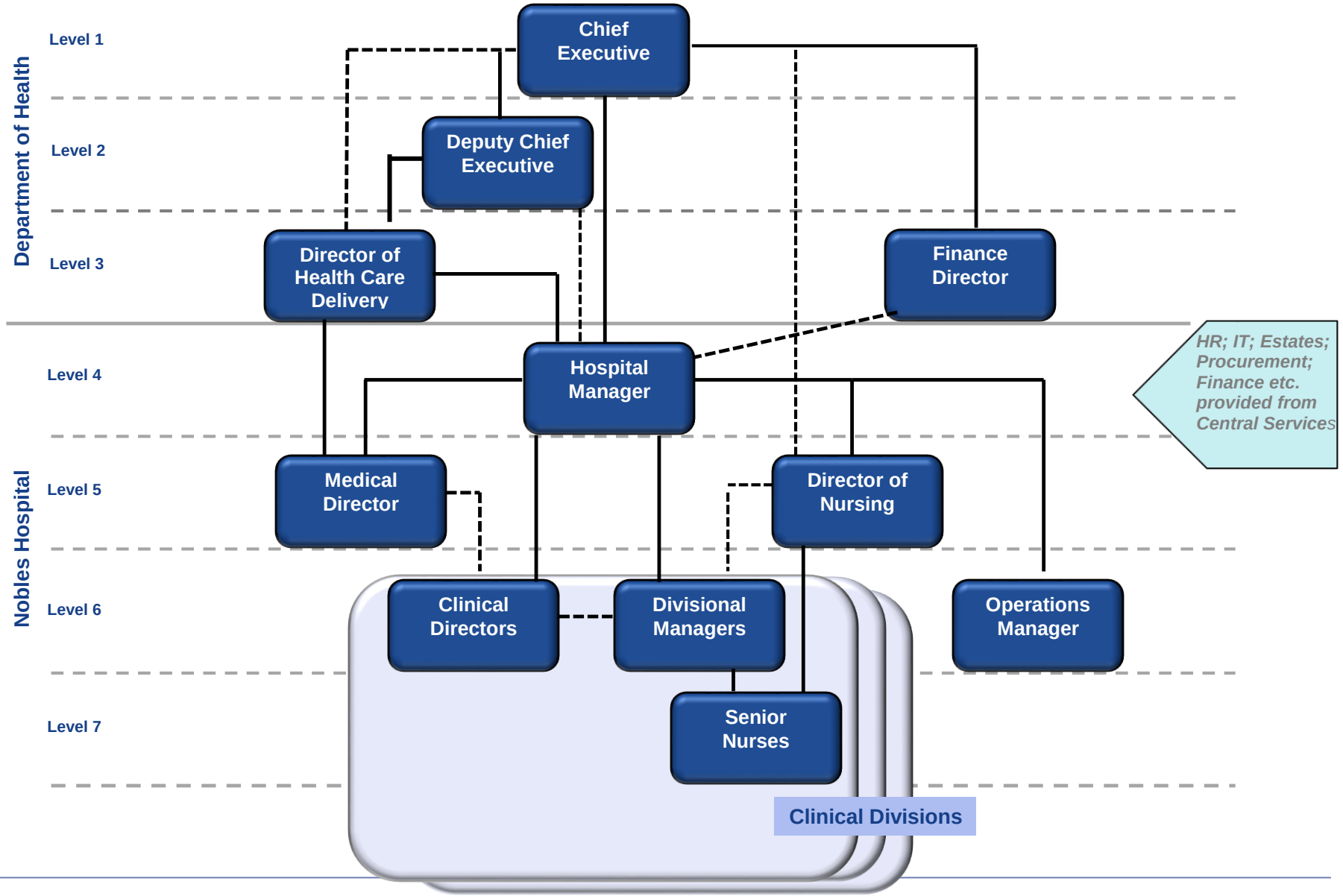
Conclusions

2.11 There is a need for the department to distinguish between responsibility and accountability within a governance framework which offers greater clarity about who is responsible for what. The department needs to adopt a more strategic, even 'hands off', role in its relationship with the hospital. In short, the department needs to be less concerned with the detail and more concerned with how the outcomes contribute to meeting core strategic objectives as set out in the health strategy.

2.12 However, more delegation needs to be accompanied by better management. For such a delegated system to work properly both the department and hospital need to be clear about what outcomes it is expected to achieve. There also needs to be a robust planning and governance framework in place within which hospital management have the freedom to manage but by the same token are accountable to the department and the Minister for the achievement of service delivery objectives.

2.13 In section 5 we look at what that system of planning and governance might look like within a framework which offers greater clarity about who is responsible for what.

Figure 1: Current Structure – Accountability Levels & Reporting Relationships



3. Management at Noble's Hospital

Introduction

3.1 The management framework at Noble's hospital is illustrated in Figure 2 on page 12. The hospital is organised into 'divisions'. These cover all clinical areas of activity plus one non-medical area of activity - operations. Each clinical division is managed by a team - usually a consultant (Clinical Director), a senior nurse and a Divisional Manager. Every division has its own allocated budget and reports to the hospital's management team.

3.2 This model is common in the UK NHS and has been adopted by Noble's – and where necessary adapted – to fit within the department's wider management and governance framework. The issue we need to consider is how effective this model is in supporting the provision of a full range of acute services - plus 24-hour accident and emergency care. In judging management effectiveness we have looked at and considered the management and organisational structure (including the management of people) and the management and operational processes in place to support management decision making.

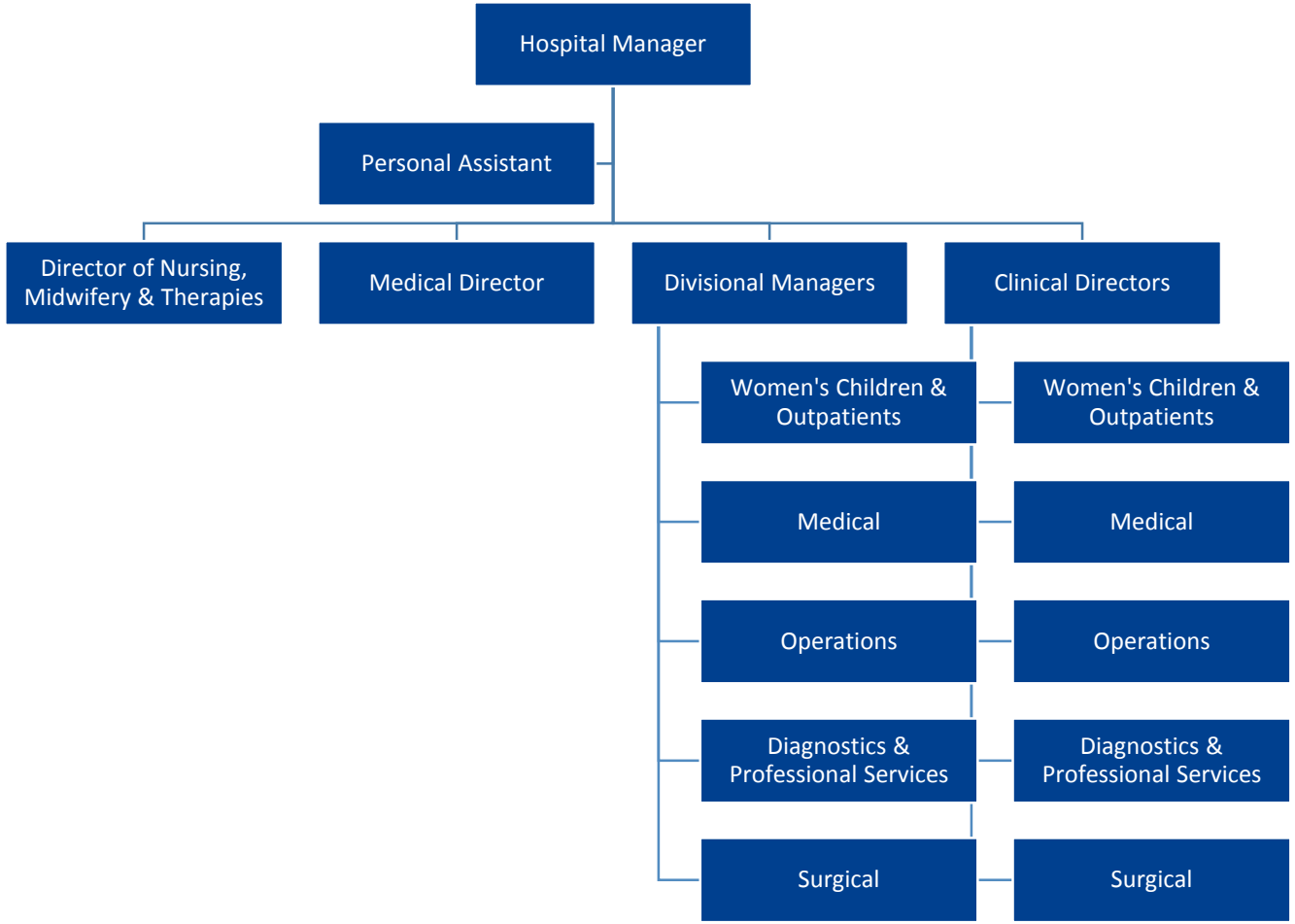
Management Structure

3.3 Figure 2 overleaf also depicts the reporting lines within that structure. In considering issues relating to the structure it is also necessary to consider the nature of roles and their responsibilities and how they link together. For the sake of clarity we have therefore combined our commentary on the strengths and weaknesses of the present organisational arrangements with those relating to individual roles.

Hospital Manager

3.4 The most senior role at Noble's is the Hospital Manager. The first notable point that stands out about the role is its title – Hospital Manager. The title is historic and reflects the fact that the role is part of the department's management framework. It also reflects the fact that the hospital is effectively managed as a division of the department with the Hospital Manager directly line-managed by the Director of Healthcare Delivery. Operating as a division of the department also means that all corporate service activity has to be transacted through the department or other government departments. For example, all HR matters are managed, co-ordinated and delivered through the Office of Human Resources; all Finance matters are managed, co-ordinated and delivered by the

Figure 2: Noble's Hospital Management Structure



department's Finance directorate (and government's shared-service centre); and all IT matters are managed, co-ordinated and delivered by the department's Management Information & Technology (MI&T) directorate, in collaboration with the Department of Economic Development's (DED) Information Systems Division (ISD). We comment further on the effectiveness of these arrangements in para 3.35. However, in the context of the Hospital Manager's role the fact that these key elements of corporate service provision have to be negotiated and transacted through the department or other parts of government undoubtedly inhibits and adds to the complexity of the role.

3.5 Looking at the role in more detail the main focus of attention is on providing support to the day-to-day management and co-ordination of service provision. The role holder works in tandem with the Director of Nursing and the Medical Director to ensure that the hospital functions effectively on a day-to-day basis. The role holder also provides support to the Divisional Managers and deals directly with a range of corporate issues particularly those relating to HR, IT and Finance.

3.6 The role holder also interacts with the Minister, Member for Health and senior departmental managers on wider health service issues both formally – through attendance at meetings, and various committees – and informally – through regular discussions and dialogue on issues that naturally arise or which may be giving cause for concern. The role holder also takes responsibility for responding to hospital related Tynwald questions which can take up a substantial amount of time.

3.7 In terms of the volume of work activity there is no doubt that the demands on the role holder's time internally and externally are substantial. In our view, these demands are exacerbated by the relative weakness of how the management structure at divisional management level really operates (see para 3.20 *et seq*) which effectively forces the role (in management terms) to look down and not up, and deal with short term operational issues and not longer term strategic challenges.

3.8 Yet, the fundamental question here is whether the role, its remit and in particular its relative level of responsibility and accountability, has been properly defined in terms of it being the most senior executive role within the hospital. In terms of its remit you would naturally expect the role to focus on:

- Working closely with the department to clarify and organise how best the hospital can play its full part in implementing the 2011 Strategy for Health.

- Organising the planning and development of services including re-designing/transforming services and implementing new models of care to meet the current and future healthcare needs of the population.

- Working closely with other parts of the health and social care system (community, primary care, social care etc.) to ensure that fit for purpose services are provided in a seamless way for the local population.

- Ensuring that specific strategies, objectives, standards and timetables are established within each service area and all aspects of service delivery are enhanced.

3.9 In short, you would expect to see more emphasis on the development of services and enhancing levels of quality as opposed to the day-to-day management of services which should be the responsibility of Divisional Managers.

3.10 There is one final point in relation to this post that we would draw attention to. The role forms part of the Isle of Man Civil Service Senior Leadership Group which means the role is graded and paid according to Isle of Man Civil Service pay-scales. Other senior management and administrative posts at the hospital are graded and paid in relation to terms and conditions for staff directly employed by the Isle of Man Department of Health and Department of Social Care (DH & DSC) which are based on the UK NHS Agenda for Change pay and grading framework. The fact that the Hospital Manager is graded and paid according to Civil Service terms and conditions creates a pay anomaly which means the role holder's pay relative to more junior management and administrative staff is inequitable.

Director of Nursing, Midwifery & Therapies

3.11 This role holder has a dual role. As well as fulfilling a senior leadership role at Noble's, the role holder is also the head of the Nursing and Midwifery professions, and responsible for the professional leadership, performance and development of these professions in the Isle of Man. The role holder also provides visible leadership for nurses and midwives across all sectors – primary, acute, social and community, ensuring that the professional values, ethos and principles of the professions are maintained.

3.12 As the department's most senior advisor on nursing and midwifery issues, the role holder is also responsible for providing expert professional advice and support to the Minister and senior departmental administrative and professional colleagues, on all aspects of policy which impact on nursing, and midwifery.

3.13 In a Noble's context the role holder works in tandem with the Hospital Manager and the Medical Director to ensure that the hospital functions effectively on a day-to-day basis. Again, a key part of the role involves working with and supporting Divisional Managers in ensuring that services are properly resourced. More widely, the role holder is also directly responsible for Patient Safety & Governance including Infection Prevention and Control.

3.14 Over the years the role holder has done much to monitor, review and improve systems and practices to deliver safe high quality patient care. The role holder has also sought to drive performance, practice and services to patients through better training and development, audit, appraisal and peer review.

Medical Director

3.15 In broad terms the Medical Director provides professional medical advice to the Hospital Manager and medical leadership to the medical and clinical workforce which should include the development of processes which ensure the full engagement and commitment of all clinicians to deliver improvements to patient care and clinical outcomes. A key role therefore for the Medical Director is to establish clear lines of accountability and ensure that all relevant clinical staff are managed, supervised and trained appropriately with regard to clinical services, and managing through a strong governance framework. Linked to this is the requirement to work with the Hospital Manager to ensure effective clinical and managerial structures are in place to achieve financial and corporate objectives and to ensure the effective, efficient and economical use of resources in achieving planned activity and delivery of all required performance targets.

3.16 More widely, the Medical Director is responsible for providing advice on medical staffing issues having regard to statutory requirements. The role holder also contributes to strategic service developments, particularly relating to the Hospital's response to international changes in clinical practice and trends, pathway changes and issues of clinical standards, accreditation and clinical governance.

3.17 However, whilst the Medical Director is responsible for medical and professional leadership, accountability for the work of the Clinical Directors in relation to how their divisions are performing falls to the Hospital Manager. In our view, accountability for the performance of the Clinical Directors both professionally and managerially should fall to the Medical Director. This role should also be responsible for taking action if poor performance issues arise with the medical workforce. However, if this role does assume these responsibilities this will impact on the role's clinical commitments.

Clinical Directors

3.18 In broad terms the role of the Clinical Director is to provide clinical leadership within each clinical division and ensure effective management and support for all clinical staff within their area. The Clinical Director is also responsible for effective clinical governance arrangements in the division and for providing advice to the Hospital Manager, Medical Director and Director of Nursing on matters of clinical policy and practice, staffing, education and training.

3.19 The expectation is that each Clinical Director will work in partnership with their respective Divisional Manager to provide joint accountability for the quality and performance of the division and development of divisional strategy. However, opinions as to who was accountable for the quality and performance of the division were mixed. This was not helped by the absence of any agreed operational plans, objectives or performance targets for any of the divisions.

Divisional Managers

3.20 Divisional Managers should typically be responsible for the strategic direction, service development, resource allocation, overall performance and operational management of the division for which they are responsible. Whilst maintaining a close focus on the operational detail they should work in close partnership with the Clinical Directors to ensure clinical activity is effectively managed and services are developed appropriately. In collaboration with their Clinical Directors, Divisional Managers should be:

- Developing, agreeing and implementing service strategies for their areas of service provision including operational plans which accord with and support the hospital operational plan and the achievement of strategic health care objectives.

- Monitoring and evaluating achievement against operational plans and service strategies and making adjustments to budgets, targets and delivery goals as necessary.

- Supporting the Clinical Director with regard particularly to clinical governance, the management of risk, and the achievement of excellent clinical outcomes, patient satisfaction, the achievement of mandatory waiting times and the teaching, training and retention of staff.

3.21 The Divisional Managers we spoke to only seemed to fulfil part of this remit. As far as we could ascertain there was little emphasis on service planning and linked development activity. There were no operational plans in place or objectives set against which the performance of the division could be evaluated. In short, the focus of these roles was on the operational detail and monitoring day-to-day service activity (and budgets) not the pro-active management of services.

Senior Nurses

3.22 Senior Nurses in each division have responsibility for supporting the Clinical Director in providing effective clinical leadership and for supporting the Divisional Manager in ensuring resources are utilised efficiently and effectively in the clinical environment. The focus of these roles is on the day-to-day delivery of quality care provision and providing visible professional leadership and line management for a team of nursing and support staff. As expert practitioners Senior Nurses have played, and continue to play, an important role in supporting the Director of Nursing, Midwifery & Therapies in leading, developing and maintaining effective patient centred care.

Management & Operational Processes

Noble's Executive Team

3.23 The Noble's Executive Team meets every four weeks and comprises managers and clinicians from across the hospital plus HR and Finance representatives. Total membership of the Executive Team is approximately 22. The sheer size of the team means that it cannot possibly function as an effective executive management team responsible for planning and directing the work of the hospital. In real terms the Executive Management Team is a management forum which is used to disseminate information and seek views on key issues.

3.24 In practice the de facto position is that the Hospital Manager, the Medical Director and the Director of Nursing effectively act as the hospital's Executive Management Team and, will, subject to securing any necessary departmental approvals, take decisions relating to service provision in a hospital context. We should add that this is not a criticism: the de facto position simply recognises that there are different levels of management decision making required at different levels in any management hierarchy – and different mechanisms for taking those decisions. The issue here is to ensure that the most appropriate mechanisms are in place to facilitate that decision making

Performance & Delivery Group

3.25 This group was set up by the department and is the key mechanism for reviewing the overall performance of the hospital. The group meets monthly and is chaired by the department Member for Health, Mr D Butt, MLC. The group comprises the three senior members of the hospital Executive Team and senior departmental managers including representatives from other parts of the health system. Whilst from an external perspective, this body may appear to be the de-facto 'Health Board for the Isle of Man', its purpose is unclear to some members of the group and is not uniformly seen as a decision making body.

Operational Planning

3.26 In section 2 we highlighted the fact that there is a lack of attention given to planning within the hospital both at a strategic and operational level. The direction set by the department in its Strategy for Health is not connected or translated into an operational plan. In short, there is no clear set of priorities for the delivery of acute services that link to the Strategy for Health and more importantly, link to the delivery of performance targets for the hospital. Again, we would reiterate the point that without a clear understanding of the hospital's agreed priorities and the lack of a focused operational plan it was difficult for us to evaluate or assess how the current structure, as set up, underpins and supports the hospital's delivery of services.

3.27 Further to this, there is a lack of robust clinical, management and financial information systems to support the performance management of service provision by hospital management against recognised best practice guidance, clinical resource utilisation and budgetary controls. In this regard, it is important to draw a distinction between the volume of data and quality of data. Each month the Noble's Executive Team considers an operational data digest of some 70 to 100 pages. Yet, whilst issues relating to the underlying data quality and thus the validity of interpretations relating to that data remain, it is difficult to see how the existing management information framework and system can support effective management decision making.

Quality Improvement

3.28 In an acute health care context a key element of management focus has to be on quality improvement. Again, in the absence of a detailed planning framework which set outs what the key objectives are in relation to quality it is difficult to judge relative levels of performance. We are aware from the Francis Working Group report that there is a proposal to set-up a Quality Surveillance Group the need for which was agreed by the Performance & Delivery Group. This will be helpful in driving quality improvement.

However, in driving that improvement there does need to be a better articulation of the strategy for improving quality and more evidence to demonstrate that clinical leaders are effectively driving it.

3.29 There is no doubt that there is currently a disconnect between what hospital's management said were the key issues and challenges and what some believe is actually happening in wards and departments around the hospital. This is compounded by the fact that there are weaknesses in the performance data and as a consequence weaknesses in the assurance that hospital management can provide. Put simply: where is the evidence to provide reassurance about the quality of care? Again, there is a need to review quality performance reporting to ensure it is measuring the right things and is triangulated effectively to identify risk areas and is tested through systematic assurance programmes. In this latter respect, we should acknowledge that the Chief Executive of the department has commissioned the West Midlands Quality Review Service to carry out a series of reviews aimed specifically at identifying areas where action may need to be taken to improve quality.

3.30 Finally, there is a need to ensure that there is an effective feedback loop to staff who report quality issues i.e. if a member of staff reports an issue they are aware of and, most importantly, what action had been taken as a result of that report.

Committees

3.31 Figure 3 on page 20 highlights the committee and meeting structure relating to the work of the hospital. It might be prudent, given the number of committees and meeting fora, to review their terms of reference, membership and reporting mechanisms to determine whether they all add value and do not duplicate responsibilities or other mechanisms used to share and distribute information.

Figure 3: Committee & Meeting Structure

ICT & MIS Systems

3.32 It is not the purpose of this review to drill-down into individual issues which may be giving cause for concern but to consider how effective existing management arrangements are in being able to deal with those issues. The reason we comment on this particular issue is because of the importance of management information in the management decision making process both at an operational and strategic level. As we highlighted in para 2.6 without robust clinical, management and financial information it is impossible to make judgements on the allocation of resources between different aspects of acute health care.

3.33 This is a long-standing issue which the Performance & Delivery Group are currently seeking to address. The background, issues and problems linked to what is typically referred to as Health Informatics were summed-up in a background paper entitled *Information for Patient Safety – IOM & the Francis Reports & Keogh Reviews August 2013,* compiled as part of the Francis Working Group report and included as Appendix 20.3 to that report.

3.34 This paper also makes the point that deficiencies in underlying data quality and data extraction notwithstanding, there have been problems with the provision of ICT. We would commend this paper and its conclusions which aptly sum up the challenges in relation to the management information framework and system which, in our view, needs to be tackled as a matter of urgency. In this latter respect, it is worth nothing that Trusts in the UK need to review their quality performance reporting to ensure it is measuring the right things, triangulated effectively to identify risk areas, and most importantly, includes independent sources of assurance from staff, patients and stakeholders.

Provision of Corporate Services: ICT, HR & Finance

3.35 In the previous section we highlighted the need to tackle issues relating to Health Informatics. However, taking Health Informatics as an example, it is not within the Hospital Manager's gift to simply put in place an action plan to address this issue. Responsibility for the provision of IT rests with ISD; and responsibility for the provision of management information rests with the department's Management Information & Technology (MI & T) directorate. Add to the equation that the Performance and Delivery Group has cross-departmental responsibility for management information (and thus responsibility for tackling the issues outlined in the previous section) it is difficult to see what practical steps the Hospital Manager can take to remedy the problem. Put simply: the Hospital Manager cannot take action or make decisions in relation to an issue (in this case Health Informatics) that has a fundamental effect on the efficient management of the hospital. All the Hospital Manager can (and does do) is to seek to influence those decisions.

3.36 The situation with ICT is largely replicated in respect of HR and Finance functions. HR provision is the responsibility of the Office of Human Resources and even though elements of that provision might be exclusively utilised by the hospital the role holder cannot determine priorities or even have hospital based access to that resource: the resource has to remain based with the Office of Human Resources to preserve its identity as a corporate rather than an organisation (or in this case hospital) specific resource.

3.37 Moreover, in HR terms the Hospital Manager cannot determine the numbers and grades of staff required to support delivery of service objectives or make quick changes to the staffing profile to meet urgent or unforeseen priorities. The government freeze on public sector recruitment notwithstanding, the Hospital Manager could not, for example, decide to employ more clinical coders or say, a clinical informatics specialist without first seeking departmental approval. Equally, the Hospital Manager cannot recruit an additional technician instead of a similarly paying administrative role without first securing departmental approval.

3.38 Finance services are also provided by the department or in the case of transactional financial services e.g. payment of invoices etc., Isle of Man government's shared-services facility. The hospital has no Finance Director or Finance Manager: all financial planning and budgeting is managed and co-ordinated through departmental finance officers. In effect, whilst the Hospital Manager can influence the construction of the hospital budget the actual budget itself is compiled and agreed by the department and subsequently, negotiated and agreed by the department with the Treasury.

3.39 Moreover, having constructed and agreed the budget the department also monitors and approves all key items of expenditure within that budget. So, if, for example, the Hospital Manager wished to purchase an additional piece of equipment for a ward or spend monies to deal with an unexpected contingency this would be subject to departmental approval.

3.40 In setting out these examples we recognise the argument that this simply reflects Isle of Man Government's financial and governance arrangements which apply to all departments. However, our argument here is not about complying with Isle of Man Government's financial governance arrangements it is about the autonomy of the Hospital Manager to take management decisions within the wider parameters of those arrangements. In the illustrated examples it is the department that is effectively the decision maker not the Hospital Manager. And whilst the Hospital Manager should be accountable to the department for the decisions that are taken it should be left to the Hospital Manager's discretion to take those decisions.

Management Communications

3.41 Communications have an importance which goes beyond the transmission and receipt of information. The form which a communication takes (or, of course, whether communication takes place at all) can profoundly affect the attitudes of staff and the degree to which they understand and support hospital policies. It should also be remembered that many disputes and issues originate in a failure of communications – a misunderstanding by staff of the intentions of management (or vice-versa), or a misinterpretation of policy.

3.42 We have not, during the course of this review, sought to determine how effective management communications are within the hospital but would simply highlight the importance of management communication and engagement with clinical and non-clinical staff.

Conclusions

3.43 In considering how effective existing management arrangements are at Noble's, it is important to remember that management effectiveness in a hospital setting can only be judged in relation to the quality of care and treatment it provides and the context in which that care and treatment is provided. In the context of this review we have not sought to make judgements or draw conclusions in relation to the quality of care and treatment in each core area of service provision. In short, to reach a verdict on the effectiveness of care would require a more fundamental review process similar to the inspection model adopted by the UK CQC (see para 4.2 *et seq*).

3.44 Instead we have focused on how effective the existing management structure, systems and processes are in supporting the management of that care and treatment. In this regard, we would draw attention to the following:

- First, the lack of focus on longer-term service and operational planning which is exacerbated by the absence of any operational plans.
- Second, the lack of clarity in terms of the responsibility and accountability between the department and the hospital and within the hospital between the responsibilities and accountabilities of the Clinical Divisions and the Hospital's Executive Leadership Team particularly in relation to developing services. If it is not clear who has lead responsibility there is a serious risk that no-one will take responsibility.
- Third, the current departmental management structure means the Hospital Manager lacks autonomy.

- Fourth, the problems with the provision of ICT and the deficiencies in underlying data quality.
- Fifth, the need for more focus on quality improvement.

4. The UK Context

Introduction

4.1 Before looking at how things might be done differently it is perhaps worth pausing to reflect on recent developments in a UK context.

The UK Context

4.2 In judging relative levels of hospital performance Sir Bruce Keogh in his recent review of 14 UK NHS Trusts focused on the following key themes:

- Patient experience
- Safety
- Workforce
- Clinical and operational effectiveness
- Leadership and governance

4.3 In conducting his reviews Keogh developed a methodology which involved a detailed analysis of a vast array of hard data and soft intelligence to help identify key lines of enquiry for the review teams. These review teams which were around 15-20 strong, were composed of patient and lay representatives, senior clinicians, junior doctors, student nurses and senior managers. The diverse make-up of these teams was seen as key to getting under the skin of the organisations.

4.4 The methodology developed by Keogh now forms the basis of the Inspection model adopted by the UK Care Quality Commission (CQC) who are charged with inspecting every NHS acute Trust in England using this new approach by March 2015. The CQC model seeks to address the following questions:

- Are services safe?
- Are services effective?
- Are services caring?
- Are services responsive to people's needs?
- Are services well-led?

4.5 We highlight these approaches for two reasons. First, to highlight the fact that judgements on management effectiveness in a hospital context cannot be made in isolation. Management effectiveness has to be judged in relation to the safety, effectiveness, responsiveness, leadership and patient centred approaches to the delivery of services in relation to each core area of service provision. In short, to reach a verdict on the effectiveness of care would require a more fundamental review process similar to the inspection model adopted by the UK CQC.

4.6 The second reason for highlighting these approaches is to draw attention to some of the common challenges facing the wider UK NHS identified by Keogh as a result of his reviews. These included the following:

- The capability of hospital boards and leadership to use data to drive quality improvement. This is compounded by how difficult it is to access data which is held in a fragmented way across the system.

- The fact that some hospital trusts are operating in geographical, professional or academic isolation. This can lead to difficulties in recruiting enough high quality staff, and an over-reliance on locums and agency staff.

- The lack of value and support being given to frontline clinicians, particularly junior nurses and doctors. Their constant interaction with patients and their natural innovative tendencies means they are likely to be the best champions for patients and their energy must be tapped not sapped; and

- The imbalance that exists around the use of transparency for the purpose of accountability and blame rather than support and improvement. Unless there is a change in mind set then the transparency agenda will fail to fulfil its full potential. Some Boards use data simply for reassurance, rather than the forensic, sometimes uncomfortable, pursuit of improvement.

4.7 In a Noble's context, issues relating to data, use of locums, clinical management and quality management have all been raised by this and other recent reviews most notably the Mersey Internal Audit Agency Management Information Review and the Francis Working Group Review. In an acute health care context these issues and challenges are not unique. What is unique is the individual action plans required to tackle these issues and in the context of this review, ensuring that the right management framework is in place to tackle them.

5. Proposed Changes

Introduction

5.1 In this section we outline a number of proposals for change which we believe will put in place a more modern, patient-centred, accountable system of governance and accountability which will provide better support to the effective delivery of acute health care.

5.2 In setting out these proposals we should start our commentary by stating that we do not believe that an acute hospital the size of Noble's can continue to be managed as an operating division of the Department of Health. Leading, managing and co-ordinating a hospital facility providing 365 day, 24/7 acute health care presents a substantially different set of management challenges to those associated with the management of an administrative or policy arm of government. It also requires substantially different skill-sets. In this latter respect, a hospital which employs approximately 1,800 staff with gross running costs in the region of £80 million requires executive leadership.

Executive Leadership – Chief Executive or Hospital Managing Director

5.3 The highest ranking executive role in an organisation is typically given the title of Chief Executive. In a UK hospital the highest ranking executive usually has the title of Chief Executive. However, in the Isle of Man Civil Service the title of Chief Executive is usually reserved to the Head of an Isle of Man Civil Service Department. Therefore to avoid confusion – and for reporting purposes – we have given the highest ranking role at Noble's the title of Hospital Managing Director.

5.4 However, the significance here is not the title but what the title represents. The title should represent what the role is responsible for and in the context of the governance and management framework outlined below we believe our working title of Hospital Managing Director (there may well be a more appropriate title) is more apt than that of Hospital Manager. In this latter respect, we envisage this to be a substantially different role from that of the existing Hospital Manager.

A Governing Board

5.5 In our view, establishing a Governing Board as illustrated in Figure 3 on page 30 will help tighten accountabilities, improve governance and perhaps, most importantly help build more transparent relationships and partnerships with patients and the public. In this latter respect, the establishment of a Governing Board affords the opportunity to build trust and restore public confidence. In setting out this governance framework we would make a number of specific points:

- The purpose of a Board in a hospital context is to govern effectively and in so doing build patient, public and stakeholder confidence that their health and healthcare is in safe hands.
- A Board structure will provide greater clarity about who is responsible for the leadership, management and co-ordination of service provision – the Hospital Managing Director; and who that Hospital Managing Director is accountable to for the delivery of that provision.
- The constitution of the Board in terms of the balance between executive members, non-executive members (political and non-political) is a matter for debate. However, we would expect this to be a unitary board on which members of the hospital executive are represented.
- Clarity of role and an effective working relationship between the Chair and the Hospital Managing Director will be crucial to the effectiveness of the board. In essence the Chair will lead the board and non-executive directors, and the Hospital Managing Director will lead the executive and the organisation.

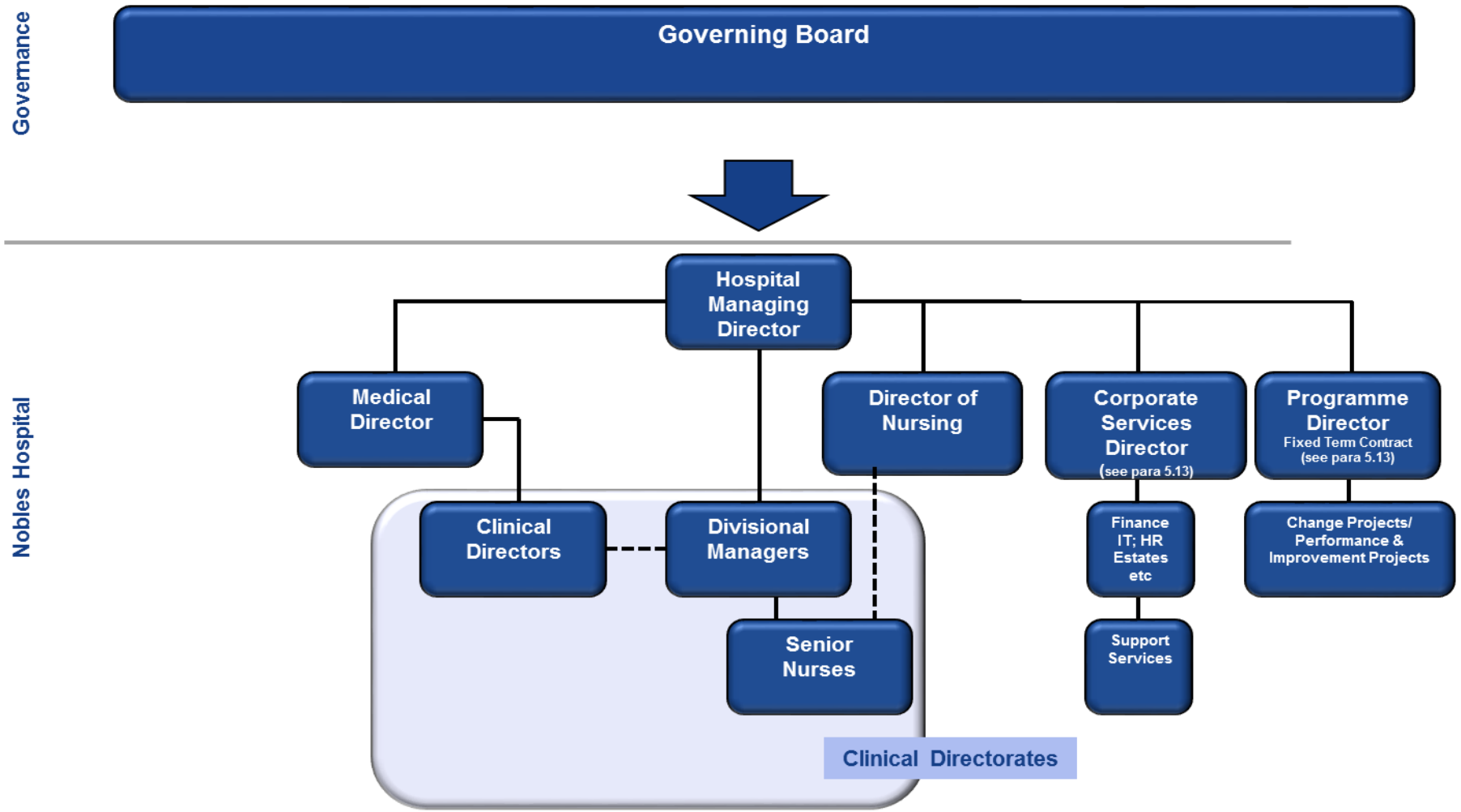
5.6 We would expect the Board to be accountable to the department which in turn will be accountable, through the Minister for Health, to Tynwald for the manner in which the duty of the Board is performed. In addition, we would expect the department to produce a Framework Document setting out:

- The main priorities and objectives of the Board in carrying out its functions and the process by which it is to determine further priorities and objectives.
- The matters for which the Board is responsible.
- The manner in which the Board is to discharge its functions and conduct its working relationship with the department and with any other relevant parts of government.

- The arrangements for providing the department with information to enable it to carry out its functions in relation to the monitoring and holding to account the hospital for the achievement of objectives.

5.7 We would also expect the Framework Document to include or reference a management statement/financial memorandum to the Chair and Hospital Managing Director setting out their responsibilities. In the case of the Hospital Managing Director we would expect this to include Accounting Officer responsibilities. In this regard, whilst we would expect the department's Chief Executive to remain as Principal Accounting Officer for the department we would expect to see the Hospital Managing Director appointed as an Additional Accounting Officer for the hospital.

Figure 3: Alternative Governance Model – A Governing Board



The Role of the Board

5.8 In broad terms we would expect the Board to:

- Set priorities for delivery of all services within the hospital in the coming year taking into account governmental priorities.
- Agree the objectives, priorities and corporate plans for the hospital and ensure that the Board's decisions are implemented.
- Monitor and review the hospital's performance in meeting its objectives and holding the Hospital Managing Director to account for that performance and for the proper running of the hospital.

5.9 We would also expect the Chair of the Board in collaboration with the department's Chief Executive to set objectives for the Hospital Managing Director which should be the subject of overall agreement and regular review between the role holder and the Chair.

The Role of the Hospital Managing Director

5.10 As well as being a member of the unitary Board we would expect the Hospital Managing Director's responsibilities to include:

- Leading the Noble's Executive Team.
- Leading, managing and co-ordinating the planning process setting out how the hospital intends to meet the priorities set by the Board.
- Playing a leading role in organisation development ensuring clinicians and other staff are fully engaged in the development and success of the organisation.
- Providing visible leadership with a focus on high standards of patient safety, experience and quality and the efficient and effective use of resources.
- Building effective working relationships with the department and other key stakeholders.
- As the Accounting Officer for the hospital ensuring that it meets its statutory obligations and is fully compliant with external regulatory standards.
- In conjunction with the Chair, ensuring that hospital business is conducted efficiently and that effective governance processes are in place.

The Role of the Department

5.11 In this model the department will be responsible for setting the strategic context. In short, there should be less concern with the details and more focus on setting clear objectives, maintaining quality and managing priorities. In our view, the department must adopt a more strategic, hands-off role and think strategically about the delivery of acute care in the context of developing more integrated health and social care provision.

Staffing Consequences

5.12 Once appointed it will be for the Hospital Managing Director to determine what consequential changes to the Noble's management structure might be appropriate and what plans to put in place to address the issues identified in this report, plus other issues which may emerge from the series of quality reviews being undertaken by the West Midlands Quality Review Service.

5.13 As part of this review process we have not sought to determine what the management structure should look like or how many staff at different levels are required to meet current and future service requirements. However, we would envisage that the Hospital Managing Director will be supported by a Director of Nursing, a Medical Director (which we would envisage as a full-time role without clinical commitments) and two new Director level roles as outlined below:

- The establishment of a Governing Board will require the appointment of a Director with responsibility for financial governance and assurance including longer-term financial sustainability and obtaining value for money. A key element of this role will be establishing and embedding the new management and governance framework including working with the newly constituted Board and the department to establish coherent Board reporting processes. Whether this forms part of a wider corporate service role, a Chief Operating Officer role, a Deputy Hospital Managing Director role or performance and strategy role will be for the Hospital Managing Director to decide.

- We would also envisage a role at Director level, initially for a fixed term duration, to lead what we would broadly refer to as the performance and improvement agenda. We are thinking here specifically of driving the quality improvement agenda; taking forward the Health Informatics agenda; and providing additional senior management capacity to lead or lend support to development activity. Again, it will be for the Hospital Managing Director to decide the precise remit and constitution of this role.

5.14 More widely, there will be a need for consequential changes to the department's management framework. Clearly, the Director of Healthcare Delivery and to a lesser extent the Deputy Chief Executive and Director of Finance will no longer have a part to play in the day-to-day management oversight of the hospital. The department will also need to consider how departmental services i.e. finance and management information services, which are purely hospital related are established within the hospital management framework.

5.15 However, the main challenge for the department will be to consider how it fulfils what in broad terms is a strategic planning and commissioning role across the whole health and social care spectrum. In particular consideration will need to be given to how best to obtain the right level of clinical input to future policy development. In this regard, we are conscious of the fact that this review has focused on the provision of acute health care whereas the department's remit relates to the whole spectrum of health care including its strategic development, operational oversight and regulation.

5.16 It is not within the remit of this review to make proposals on the type and quantum of changes which may be required to the departmental management framework arising either as a consequence of this review process, or broader changes envisaged for the future management and co-ordination of health and social care services. However, other planned changes notwithstanding, the governance and management framework proposed for the hospital will require consequential changes to the departmental management framework.

Conclusions

5.17 In putting forward these proposals we recognise there is an argument which says that all this can and should be handled within existing departmental frameworks. For example, the Performance & Delivery Group could be re-constituted to act as a Governing Board in tandem with the Health Services Consultative Committee (HSCC); a role of Hospital Managing Director could be established and greater autonomy afforded to the role; and a new Framework Document produced to make clear relative levels of accountability and responsibility.

5.18 However, this is to miss the key point of a Board structure. Looking ahead one of the key challenges for Noble's is to maintain public confidence. To do this there is a need to ensure that the organisation operates with openness, transparency and candour. The Governing Board will have an overarching responsibility, through its leadership and oversight, to ensure – and to be assured – that the hospital operates with transparency, openness and candour. A Governing Board which is inclusive in its representation and independent in its action can provide that oversight and

assurance and be seen to hold the Executive to account in a way that the department cannot.

5.19 Most importantly, the Board will have a key role in creating the culture which supports open dialogue which should include ensuring that complaints, concerns and suggestions from patients and staff are listening to and acted on fairly. In this regard, there is no doubt that recent events have shaken public confidence in Noble's. And in this regard the question here is not so much how effective the existing management and governance arrangements are but what needs to be done to restore that confidence. In our view, it is doubtful whether that confidence can be restored simply by adapting existing hospital and departmental mechanisms of governance and management. In short, more radical change is required.

5.20 We believe that a new framework of governance and management centred on the role of a new Governing Board will help to restore that trust and above all give confidence that acute health care at Noble's hospital is being delivered in an open and transparent way.