Trust Board Paper N

To:	**Trust Board**
From:	**John Adler, Chief Executive**
Date:	**29 August 2013**
CQC regulation:	**All applicable**

Title:	Simplification of the Clinical Management Structure incorporating Revised Executive Portfolios

Author/Responsible Director: John Adler, Chief Executive/Richard Mitchell, Chief Operating Officer/Kate Bradley, Director of Human Resources

Purpose of the Report:

- Introduces the proposal and rational for change
- Outlines the benefits of the change and the associated timelines
- Requests the Board's endorsement of the proposal and associated timelines
- Introduces changes to the Executive portfolios

The Report is provided to the Board for:

Decision		Discussion	
Assurance		Endorsement	X

Summary / Key Points:

- UHL's current structure is one of the most vertical and highly concentrated of any very large trust in the English NHS.
- Despite the many talented, committed and hardworking leaders at UHL, the Trust also has significant performance issues.
- It is felt the current management structure does not support effective working.
- It is proposed that the three Divisions and 12 Clinical Business Units are disestablished and are replaced with seven Clinical Management Groups (CMGs).
- The change will have three key benefits and ultimately, will support our senior clinical and non-clinical leaders in focusing on delivering fewer actions more effectively.
- A management of change process has begun including timely communication to all staff and a risk assessment and project plan will be circulated shortly.
- In parallel, executive portfolio allocations are being reviewed and Board members are invited to comment on the proposed allocations.

Recommendations:

The Trust Board is asked to **note** the report and to **endorse** the proposals and associated timelines

Previously considered at another corporate UHL Committee? No

Board Assurance Framework: No	**Performance KPIs year to date:** No

Resource Implications (eg Financial, HR): Costs in the new structure will be contained at the same level as the current structure.

Assurance Implications: Yes
Patient and Public Involvement (PPI) Implications: No
Stakeholder Engagement Implications: Yes
Equality Impact: Yes
Information exempt from Disclosure: None
Requirement for further review? Yes

University Hospitals of Leicester NHS Trust

Report to: **Trust Board**

Date: **29 August 2013**

Report from: **Chief Executive with Chief Operating Officer, Acting Chief Nurse, Medical Director, Director of Human Resources and Director of Finance and Business Services**

Subject: **Simplification of the Clinical Management Structure**

1. Introduction

1.1 Executive Directors have recently discussed the benefits of reviewing the current Clinical Management Divisional Structure. The two main drivers to the proposed change are:

- **Multi-tiered layers of management**- UHL has four layers in its management structure from Executive Team to service provision, whilst most other NHS Trusts of a similar size, (e.g. Guy's and St Thomas FT, Sheffield FT, Newcastle FT), only have three. At UHL, there have been examples of delays in information being communicated in either direction, decisions being delayed due to unnecessary escalation or confused accountabilities. It is also felt that the Executive Team are too far removed from service provision.
- **Size and complexity of Divisions**- Planned Care and Acute Care are each equivalent in terms of income, expenditure and staffing to average sized DGHs, but they do not have the infrastructure to manage the complexity. UHL's current structure is one of the most vertical and highly concentrated of any very large trust in the English NHS.

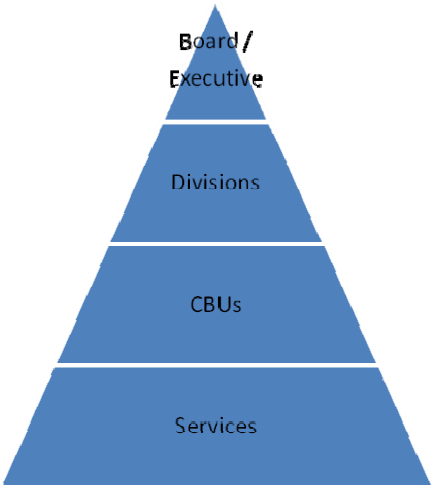
1.2 In addition to the two main drivers, the Executive Directors reviewed the rationale for the previous changes. In April 2010, the Trust implemented revised management arrangements involving the disbandment of 12 Clinical Directorates and the establishment of four Clinical Divisions. The new structure mirrored the structure in place at Guys' and St Thomas' FT. GSTT disbanded their structure in 2011 and moved back to a Clinical Directorate structure. The number of Divisions at UHL was reduced to three earlier in 2013, with the disbandment of the Clinical Support Division and the redistribution of its responsibilities across the three remaining Clinical Divisions, effective from 1 April 2013 (Minute 6/13/2 – 31 January and Minute 34/13 – 28 February 2013 refer).

1.3 UHL has many talented, committed and hardworking leaders, but the Trust also has significant performance issues; A&E and emergency performance, referral to treatment waits (RTT), cancer performance and financial performance. It is felt the current management structure does not support effective working nor the level of operational grip required to manage a complex, multi-site, tertiary teaching Trust.

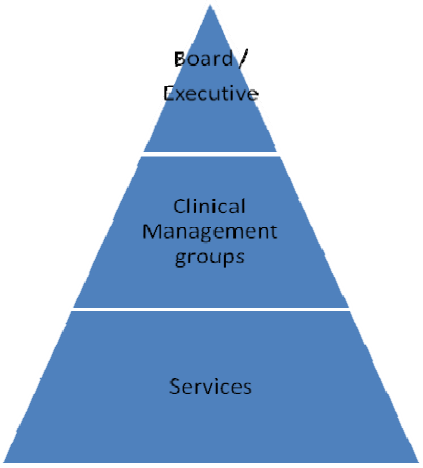
2. Proposal

2.1 In order to introduce a structure which addresses the issues described above, it is proposed that the three Divisions and 12 Clinical Business Units are disestablished and are replaced with seven Clinical Management Groups (CMGs), as detailed on the next page.

2.2 Costs in the new structure will be contained at the same level as the current structure.



Current



Future

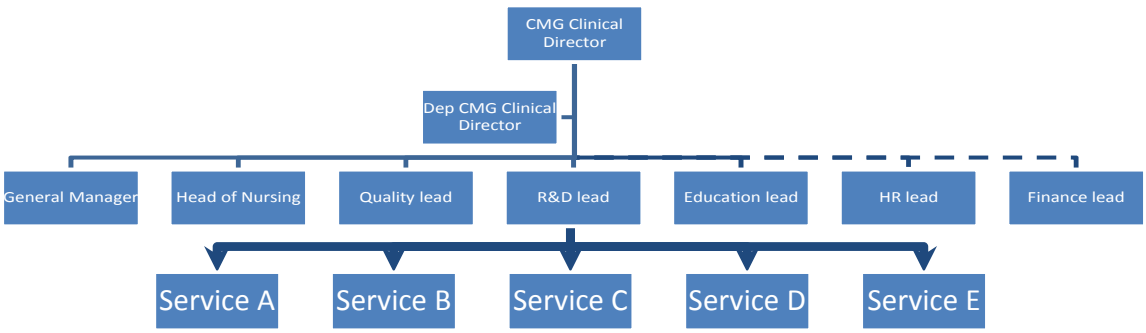
2.3 The seven proposed CMGs are:

- Cancer, Haematology, GI Medicine and Surgery
- Emergency and Specialist Medicine
- Musculoskeletal and Specialist Surgery
- Professional Services, Imaging, Medical Physics and Empath
- Cardiac, Renal and Respiratory
- Theatres, Anaesthesia, Pain and Sleep, (ITAPS)
- Women's and Children's

2.4 The table below details the proposed structure in finance and staff (wte) terms:

Clinical Management Group	Total Income	Total Expenditure	WTE
	£'000	£'000	
Cancer, Haematology, GI medicine and GI surgery	121,042	80,605	1059
Cardiac, Renal and Respiratory	129,310	98,473	1,430
Emergency Care and Specialty Medicine	105,434	90,334	1,397
ITAPS	27,846	68,963	1,089
Musculo Skeletal and Specialist Surgery	95,778	60,858	978
Professional Services, Imaging and Pathology	31,070	68,962	1,696
Women's and Children's	139,860	101,791	1681

2.5 The senior structure for each CMG will be:



2.6 It is expected that the proposal will provide three key benefits:

1. A simpler structure with fewer layers will support improved working between the Executive Team and service provision. Management visibility will improve with increased clinical engagement and quicker and more effective decision making.
2. Smaller management units, in terms of income, expenditure and staff numbers which will support improved operational 'grip' and clearer management accountability.
3. Improved parity between the comparative size of the units. Currently Women's and Children's is 40% the size of the Acute Care Division. In the proposal, the smallest CMG is 60% the size of the largest CMG.

2.7 Ultimately, we want our senior clinical and non-clinical leaders in the CMGs to focus on delivering fewer actions more effectively.

3. Management of change

3.1 John Adler met with Divisional and CBU colleagues on Thursday 15 August to inform them of the proposed change to CMGs. Ahead of the meeting, individual discussions had taken place with Divisional colleagues and these have continued. Discussions have also commenced with individuals who currently hold a CBU role.

3.2 Role descriptions have been produced for the CMG roles detailed in the structure and these will be evaluated on 4 September 2013. We have stated that the process of appointing to the CMG roles will involve slotting in individuals where possible, taking into account organisation requirements, individual preferences, experience and skills and continuity where appropriate. As appropriate we will hold selection processes where the opportunity for promotion exists.

3.3 We are aware of the level of uncertainty that the change is causing and we are working to provide individuals with appropriate support from external coaches where this is felt to be valuable. Clearly colleagues in some corporate functions are also affected by the change and we are working to align corporate roles with the CMGs and make changes to improve the effectiveness of the change.

3.4 In September we will hold LIA workshops to ensure colleagues have the opportunity to share their thoughts on what has worked well in the current structure so we can build on the strengthens going forward.

3.5 The proposal is to secure the CMG Management senior posts by the beginning of October and then to work with these teams to ensure their structures are effective to meet the CMG's needs. Any structural changes beneath the CMG management level would follow the UHL Management of Change Policy and consultation would take place with staff and Staff Side. Timescales are subject to review in the light of consultation requirements.

3.6 Communication material being disseminated to share includes:

- All staff messages at all key stages of the process
- FAQs
- New 'who's who' for each of the 'Clinical Management Groups' (including biographies)
- New INsite (internal web) pages reflecting new structure.
- New external web pages
- New posters at receptions / entrances
- Stakeholder and Media Briefings prepared
- Together Magazine Feature (with pull out)

4. Risk assessment and project plan

4.1 A risk assessment and detailed project plan is nearing completion and will be circulated over the next week.

Recommendation

The Trust Board is asked to note this report and to endorse the proposal and associated timelines.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

TRUST BOARD

29th AUGUST 2013

REVISED EXECUTIVE PORTFOLIOS

1. Introduction

As Board members will be aware, I put in place a series of interim arrangements in April to cover for the vacancies in the Chief Nurse and Strategy Director roles. With the arrival of our new Chief Operating Officer, imminent arrival of our new Chief Nurse and the appointment of our new Strategy Director, I am now in a position to plan more permanent arrangements. As you would expect, I have had extensive discussions about this with individual Directors (including Rachel Overfield and Kate Caston, who are not yet in post).

2. Principles

Essentially these plans are based on three basic principles:

- Portfolio allocations should have a sound rationale
- Allocations should play to the strengths of individuals and their areas of interest
- There should be a reasonable sharing of workload between Directors

It is also worth noting that the creation of the Business and Strategy Support Team will provide a more seamless interface between portfolios in certain areas (e.g. marketing and strategy).

3. Portfolio allocations

The table on page three shows the planned allocations, the basic rationale and the effective date. Any areas not mentioned can be assumed to be unchanged.

4. Recommendation

Board members are invited to comment on the proposed portfolio allocations.

John Adler
17th August 2013

AREA	CURRENT ALLOCATION	PLANNED ALLOCATION	EFFECTIVE DATE	RATIONALE
Estates and Facilities (Operational – Lot 1)	DFBS (I)	CN	9/9/13	Major interface is with Nursing and current operational issues impact on nursing most significantly. Line management of Horizons MD will be by CN in conjunction with Horizons Board Chair.
Estates (Strategic – Lot 2)	DFBS (I)	DS	When DS in post	Impacts most significantly on strategic agenda and reconfiguration
Site and Service Reconfiguration	DFBS (I)	DS	When DS in post	Core part of Trust Strategy
Information	COO	DS	When DS in post	Information should not be managed by operations in order to maintain Chinese Wall. Good alignment with Strategy role and balances workload. Performance Improvement role remains with COO
IM&T	DFBS (I)	DFBS	Immediate	Maintains current arrangements, plays to strengths/interests and balances workload
Senior Information Risk Officer (SIRO)	DFBS (I)	DFBS	Immediate	Links to IM&T
Chief Medical Information Officers	DFBS through CIO (I)	MD	Immediate	Provides a stronger linkage with MD team
Data Quality	Unclear	DS	When DS in post	Links to Information
Planning (operational and strategic)	DFBS (I)	DS	When DS in post	Core part of Strategy role
Contracting	DFBS	DFBS	Immediate	Link to Finance is key and balances workload
Improvement & Innovation Framework	CE (I)	DS	When DS in post	Core part of Strategy role
Foundation Trust application	CE (I)	DS	When DS in post	Core part of Strategy role
Marketing	DMC (I)	DMC	Immediate	Plays to strengths and balances workload
EMPATH	None	Part of new diagnostic and therapy Clinical Management Group	1/10/13	Embedding EMPATH as a large part of a CMG give sit an organisational home which was lost when the Clinical Support Division was abolished

(I) = Interim arrangement