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NHS Confederation Chief Executive

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Time for a fresh debate

The NHS is one of the biggest organisations in the world. In many local communities, the NHS is the biggest employer. Significant additional resources are being invested to support the biggest ever reform of the way services are delivered.

Any commercial organisation on this scale, and with this change agenda, would be expected to recognise the value of high-quality management. Yet the contribution of NHS management is often overlooked, or even derided. At worst, NHS managers are dismissed as an army of bureaucrats. Some commentators seem caught in a disingenuous debate where on the one hand it is claimed there are too many managers, but on the other the NHS is exhorted to improve the way it is run.

The NHS Confederation believes there needs to be a better understanding of what managers actually do and their contribution to improving services for patients.

This report is part of a drive to challenge the myths surrounding NHS management, and to show the reality of committed, talented and hard-working individuals who make a real difference to the patient experience.

It is not just the Confederation that believes management matters in the NHS. The Commission for Healthcare Improvement and the Audit Commission have both recently reported that managers are making a direct contribution to improving patient care, and that the quality of management is generally high, though thinly spread and facing outstanding challenges.

The case studies in this report are further evidence of the crucial role that NHS managers play. From practice managers working to achieve same-day appointments, to chief executives leading multi-million pound projects that will modernise hospital care, all are tasked with the same mission – to ensure high quality services for patients and to improve public health.

Of course, there can be no room for complacency. NHS management needs to raise its game still further if we are to transform the service. Now is the time to move the debate forward to look at how we can more effectively support and develop NHS managers in delivering the biggest public service reforms in recent history.

We invite you to take a fresh look at why management matters.

Dr Gill Morgan
Chief Executive
NHS Confederation
Why does management matter?

A happy triumvirate once ran the NHS. In hospitals, the medical superintendent ruled supreme while matron regimented nurses and patients alike in starched, serried rows and the hospital secretary busied himself with tedious administrative chores. GPs, as ‘independent contractors’, went about their duties untouched by any managerial superstructure.

It is a picture of perfect order and harmony, in which grubby bureaucratic preoccupations were never allowed to impinge on the purity of clinical decision-making. Medicine, nursing and management each knew its place and unfussily combined to offer a service which acted unerringly in the patient’s best interests. It is, of course, almost total fantasy.

Under-managed

The truth is that throughout much of its history the NHS has been chronically under-managed, a factor that has acted against the long-term interests of its doctors, nurses and patients.

During the reign of the medical superintendent, individual consultants’ decisions dictated the shape of services. Clinical services were strictly off-limits and regarded as unsusceptible to ‘management’. Those making decisions had little interest in containing costs. Immune to external scrutiny, services were often inefficient, and lengthy waits to use them were meekly accepted as inevitable. Services were organised for the convenience of the professions not the patients using them.

Circumstances are different in the 21st century. Patients no longer deferentially accept what it suits professionals to provide; they want a say in how, where and when services are delivered. Political pressure for change demands responsive and flexible organisations.

Modern medicine is capable of things undreamed of a generation ago. In the medical superintendent’s world, patients undergoing hernia operations expected to stay in hospital for 10 days; today they may be discharged after six hours. Marshalling a system to enable that – and dozens of other similar advances – to happen without a hitch calls for managerial acumen more sophisticated than the old triumvirate could ever provide.

‘The Audit Commission has recently reported real improvement in some parts of the service and found a very strong link to the quality of management in place. It is wrong, as some do, to claim that the NHS is over-managed’

James Strachan
Audit Commission

One of the toughest management jobs in the world

- 1 million treatments every 36 hours
- 300 million primary care consultations a year
- 1.3 million staff
- £55 billion budget
- £2.3 billion IT investment
- Biggest hospital building programme in NHS history
The failure to take management seriously persisted through many years of NHS reform. Even in the 1980s, Sainsbury’s chief executive Roy Griffiths famously remarked in his health service management inquiry that ‘if Florence Nightingale were carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge’.

Making a difference

There has been a revolution in NHS management since then. The Commission for Healthcare Improvement (CHI) and the Audit Commission have both recently highlighted the difference good management is making to patient care. CHI commented on the number of strong, able leaders in the service, while the Audit Commission concluded that ‘the key to improvement has been the better management of resources’.

Far from the image of an army of bureaucrats, the reports show that NHS managers are tackling the things that matter to patients: from reducing the amount of time spent waiting to see a GP, to developing new services in the community that avoid unnecessary hospital stays.

Today, clinical care and management are increasingly integrated. Good management requires a sound understanding of clinical processes. In turn, many clinicians recognise they need to develop their own management and organisational skills to provide an efficient and effective service to patients.

We have come a long way from the world of the medical superintendent, but the debate on how we run our health service has yet to catch up. Without excellent management throughout the NHS, clinical staff will lack the support they need, with neither time nor space to reflect on their practice and nurture new thinking.

Management in the NHS must be recognised not as a force for oppressing the legitimate concerns of the healthcare professions, but as a means of enabling them to deliver first class care to patients.

‘Organisations which provide healthcare must be well-led and well-managed. Leadership is crucial. Management does matter.’

Sir Ian Kennedy
Commission for Healthcare Audit & Inspection
Who are today’s NHS managers?

Grey men in suits? Bean counters? Bureaucrats frustrating clinicians? This is the image that is often portrayed of NHS managers.

The reality is that NHS management consists of a wide range of roles that make a real contribution to improving patient care.

Diverse skills

One of the key myths of NHS management is that there are two very distinct tribes: managers and clinicians.

In fact, the senior management team in NHS organisations is made up of a combination of managers with non-clinical backgrounds, and those who have clinical qualifications.

At board level in NHS trusts a medical director and nursing director sit alongside the chief executive. In primary care trusts (PCTs) a GP is a key member of the board and also chairs the professional executive committee made up of a range of clinicians who oversee the day-to-day running of the organisation.

Below board level there is a similarly diverse group of staff with management responsibilities. Full time non-clinical managers – like commissioning managers or facilities managers – work alongside doctors and nurses who combine management responsibilities with their professional roles.

In hospitals, for example, nurse managers play a key role in ensuring the smooth running of the ward while still providing direct patient care.

Solihull Primary Care Trust

Solihull PCT directly employs 1,050 people, in addition to working with over 700 family health service staff. It has a total of 23 senior managers.

At board level there is a chief executive, seven executive directors, including the director of finance and the medical director, an associate director of nursing and a GP who chairs the professional executive committee. The board also includes a chair and 5 non-executive directors.

13 senior managers report to the board, including the head of occupational health, the pharmaceutical advisor and the head of family health services.

Over half of the senior management team have a clinical qualification.

Homerton University Hospital NHS Trust

Homerton University Hospital NHS Trust employs 1,700 staff, and has a total of 19 senior managers.

At board level there are 6 executive directors, 3 of whom have clinical backgrounds, a chair and 5 non-executive directors.

There are 13 managers who report directly to the board. This includes 4 general managers, 2 of whom have clinical backgrounds, 4 clinical directors and 5 senior nurses who all combine their management role with their clinical responsibilities.

++ 3% of NHS staff are managers or senior managers ++ 4p in every pound
Diverse roles

While there are many managers who have day to day involvement in the provision of patient care, there are also managers in core functions like finance, HR and IT that play an equally crucial role in improving our health service.

Every NHS board has a finance director, backed up by a finance team who are responsible for managing a budget of £134 million for an average trust, and £180 million for an average PCT.

The NHS is often the largest local employer. HR directors are overseeing one of the biggest recruitment drives in the health service’s history as well as the new Agenda for Change agreement which will modernise pay and conditions for over one million NHS staff.

At the same time, £2.3 billion is being invested to overhaul the NHS IT infrastructure. Ensuring these new systems really transform services will depend on the skills and expertise of IT managers and their teams.

And NHS project managers are now tasked with delivering one of the largest hospital building programmes in the world – not to mention refurbishing 3,000 general practice surgeries by 2004.

Who are tomorrow’s NHS managers?

The NHS runs a general management training scheme which brings young talented people into the NHS as well as offering a route into senior management for those with clinical and professional backgrounds in the service. The scheme has just been ranked number one for general management by the UK Graduate Careers Survey.

In 2003 there were 4,300 applications for 90 places. Over the past five years, women have made up three-quarters of the trainees and 6.7 per cent have been from minority ethnic groups.

There is also a major drive to bring in experienced managers from other sectors. The Leadership Centre – part of the Modernisation Agency – has recently launched a national Gateway to Leadership programme which provides a fast-track introduction to NHS management.

‘NHS managers deserve our backing for their contribution to the improvements already under way. And they deserve our support as they face the challenges ahead.’

Lord Hunt of Kings Heath

of NHS expenditure is spent on management costs ++
The role of NHS management is clear – to ensure health services are efficient and effective and responsive to patient needs.

This requires new ways of doing things, not just more of the same. New ways of organising services, to put patients’ needs first. New ways of working, to ensure the skills and abilities of NHS staff are put to best use. And new relationships across the NHS, with local government, and the voluntary and private sectors.

Managers at all levels in the service are squaring up to the challenge of delivering this change agenda at the same time as ensuring existing services are delivered to high standards.

The NHS Confederation believes there are five key areas where NHS management has a crucial role to play in delivering a modern health service. The case studies in the following pages illustrate how these five challenges are being met in practice.

Improving patient care and the patient experience

Good management has the potential to make a major contribution to how patients experience the NHS. Many of the things that patients complain about need management attention to put them right.

This means that managers must focus on effective systems that enable clinicians to provide high quality care. But it also means paying attention to the other things that affect how people feel about the service they receive – from the quality of hospital food to the standard of GP premises.

Re-organising services around the needs of patients requires managers who can challenge the traditional way in which care has been provided, to encourage innovation and new thinking. And it needs managers who can effectively measure how the service is performing to focus the organisation on how things can be improved.

Turn to page 10 for an example of how a hospital in Taunton has transformed its orthopaedic care by looking at the service from the patient’s perspective.

Creating an environment where staff can do their best

A key task of any manager is to lead, motivate and develop their staff. In the NHS, the diverse skills and professional backgrounds of staff make this a particularly challenging task.

Management expertise can add real value to the delivery of clinical services and deal with the problems of poorly designed processes that still make it difficult for doctors and nurses to do their jobs. This is perhaps the area where the biggest improvements for patients can be made.

Managers need to have real leadership skills to encourage and inspire frontline staff who are often working under real pressure to do their best for patients. And good management plays a crucial role in ensuring that staff are equipped with the skills they need to do their jobs well.

Turn to page 16 for an example of how training and support for staff has turned around an ambulance trust in Bedfordshire.
Ensuring the best use of resources

With record investment going into the health service, NHS managers more than ever are tasked with achieving maximum value from every pound. The drive for efficiency is important both in ensuring the service offers value for money, as well as maximizing the number of patients who receive NHS care.

In a service still suffering from shortages of doctors, nurses and beds, this means making tough decisions about how to make best use of clinicians scarce time, and tough choices about where to allocate resources in the face of competing priorities.

**Turn to page 18** for details of how South Birmingham PCT has chosen to invest in a community-based service for heart failure patients rather than concentrating funding on hospital care.

Planning for the future and leading change

If the NHS is to meet rising public expectations and changing patient needs, NHS managers need to be ahead of the game. It is their job to set a compelling vision for the future, and to provide clear leadership, enabling staff to focus not just on the here and now but on the changes that will deliver better services over the longer-term.

**Turn to page 22** to see how PCTs in Greater Manchester are collaborating on a project to develop one-stop health and social care centres which will transform future health services.

The case studies in the following pages show how NHS managers are responding to this challenging agenda.

The managers featured are not just one-off examples. They are a reminder of the committed and talented NHS managers who are working with their teams to make a real difference to patient care.
Improving patient care and the patient

Sally Oliver
General Manager, Taunton & Somerset NHS Trust

Patients undergoing hip replacement operations in Taunton now enjoy a streamlined passage through the system where once they were beset with unnecessary administrative obstacles. A project to clear away the clutter that had accumulated around the admissions and in-patient process has brought shorter hospital stays, fewer cancelled operations and fewer readmissions.

“It was surprising how difficult it was for patients to get into hospital,” says Sally Oliver, general manager for trauma and orthopaedics at the town’s Musgrove Park Hospital, describing the typical patient journey the project team discovered when they traced it.

“We mapped the process on a piece of wallpaper, pinned it up and left it for a few weeks,” says Jenny Pickhaver, lead physiotherapist and the project’s manager. “It opened a lot of people’s eyes. Everybody in the team admitted nobody knew the whole story.

“It had no doubt once been a fair system. But it had just evolved. If you set out to design it you’d never do it like that,” says Sally. The results were inefficient procedures which led ultimately to operating slots being missed and the service struggling to meet targets.

Now, quick simple solutions combined with long-term change have enabled the orthopaedic service to reduce length of stay by two days, halve cancelled admissions and discharge 21 per cent of patients within seven days compared with nine per cent previously.

Solutions

Relatively straightforward changes like relocating an admissions clerk within the department brought immediate gains. Revamping the pre-operative assessment clinic – after asking patients why they didn’t turn up – raised attendance to 100 per cent: more congenial surroundings and a convenient time were the secret. “They sound like relatively small details, but it’s often those that cause the most frustration and hassle,” says Jenny.

Better preparing patients for what to expect has made a real difference. They are now given a range of leaflets and a timetable explaining each stage of their seven-day stay. “You’ll hear a patient say, come on – I should be up today,” says Sally, “and that’s brilliant.”

Dynamic management underlies the project’s achievements. As part of the South West regional specialty partnership programme, it was able to fund protected time for Jenny to act as project manager and create space for the eight multidisciplinary team members involved to brainstorm ideas.

“‘All organisations, whether public or private, are hugely reliant upon first class management skills. We must not denigrate the important contribution that excellent management can make in providing the right environment for professionals and staff.’

Digby Jones
Confederation of British Industry

++ Additional investment will allow an extra
Managers making a difference

They consulted widely and visited other trusts for ideas they could 'Taunton-ise.' Building effective communication networks has been crucial.

“We very much felt all sorts of people, whether clerical workers or clinicians, knew what needed to be done,” says Jenny. “But there had been no forum for them to express their ideas. Early gains, such as providing a new blood pressure monitor for a clinic, helped win colleagues’ confidence.

“That sends the message that if you come up with a sensible idea the managers will try to do whatever they can to sort it out,” says Sally.

Team members are now in demand throughout the trust for help with change management. “It’s known that we do deliver,” says Sally with pride. "And the whole thing has been great fun to do."

Medical director Peter Cavanagh adds: “The team has set an example to the trust on how redesign work can improve the patient experience and enhance staff’s working lives."

41,000 hip replacement patients to be seen each year ++
In the London Borough of Newham, 61 per cent of the population are from ethnic minorities.

Newham Healthcare NHS Trust’s bilingual health advocacy service is a key part of ensuring that health services cater to the needs of this diverse community. Farida Malik runs the advocacy service.

“Our aim is to overcome language and cultural barriers and to support communities to make better use of health services. We deal with people who speak very little or no English. My team has 37,000 face-to-face contacts with patients, in 40 different languages, every year.

Access

“Health workers cannot carry out any intervention if they cannot talk to the patient. Without us, a large number of our community would not have appropriate access to secondary care. Doctors would not be able to diagnose what is wrong with patients, and we could not do any surgery without informed consent.”

Farida’s team regularly attends consultations between health care workers and patients. It has also developed services for hearing impaired patients by providing sign language interpreters.

Breaking through the language barrier: Farida Malik

“We work in partnership with clinicians and are accepted as part of the team. Health advocates ensure that clinicians can respond to patients’ needs. Patients benefit as they are reassured their problems are being explained clearly and correctly.”

Mike Gill, the trust’s medical director, comments: “The advocacy service is invaluable. It provides an interpretation service, but it also supports patients in negotiating their way around health services and helps reduce cultural barriers.

“From the clinical perspective that means we are more likely to make the right decisions about diagnosis and treatment and those decisions are more likely to be both accepted and understood by our patients.”

‘Health advocates ensure that clinicians can respond to patient’s needs.’
Carole Brown
Practice Manager, Doncaster

Practice manager, Carole Brown, has been working with her team in Doncaster to dramatically cut waiting times.

Following a process of staff consultation and careful planning the team analysed data on patient demand and took time out from running the surgery to look at how they could reorganise services to meet it.

As a result, the practice has overhauled its booking system. Established clinics remain bookable in advance but for most patients a routine appointment can now only be booked 48 hours in advance. Nearly a year on from implementation, the benefits have been profound.

“We have done away with the situation where patients have to wait up to three weeks for an appointment. Now we aim to see patients the same day,” says Carole.

A major improvement has been the reduction in patients who do not attend which has fallen by about 60 to 70 per cent.

“We now have more time to implement changes which we wanted to implement but never had time to think through,” says practice nurse Pamela Parsons.

As a result, nurses have now trained to do cytology, which has taken away some of the work from doctors. The practice plans to train reception staff as health care assistants. And the nurses’ schedule is being changed to include minor illness clinics, making better use of their time.

Teamwork

Dr Shabbir Ahmad, senior partner at the surgery, notes that he spends less time dealing with frustrated patients. And staff uniformly agree that the surgery is now a better place to work.

Reflecting on the changes, Carole says: “The biggest sense of achievement is that this has been a team effort. I initially sowed the seeds and have worked hard to motivate the team but change has been achieved by everyone working together.”

Shorter waits: Carole Brown

‘… now we aim to see patients the same day’
Creating an environment where staff

can work

Trudie Davies
Service Improvement Facilitator,
Leeds Teaching Hospitals NHS Trust

Ward 26 at Leeds General Infirmary is proving to be a popular place to work in the NHS. Once a tenth of its nursing posts were vacant. Now there are no vacancies, staff are queuing to work there and sickness absence has plummeted.

"People used to dread coming to work on the stroke unit because it’s such hard work," says Trudie Davies, a service improvement facilitator within the Trust’s performance improvement team who has been instrumental in this transformation. But since the unit reorganised gains for staff – as well as for patients – have raised morale beyond any expectation.

Tailored care

As a sister on the unit, Trudie realised on her first day that it lacked a system. She proposed that instead of all nurses being involved in the ward round, she made that her role, “to give everybody a break and to keep the consultant and ward staff happy”.

“We started to tailor care around what was needed, and changed the way we worked. It started off so that we could make our lives easier. As our lives got easier it gave us space to get our heads above the water and think about what we really wanted to do,” says Trudie.

Meanwhile, enthused by this early managerial success, she undertook the Royal College of Nursing’s leadership course. “I started to look at the service from a different point of view – not just a nursing perspective but a strategic one.”

‘One 68-year-old man who was cared for on Ward 26 describes his treatment as “absolutely wonderful”.’
Managers making a difference

Soon more opportunities appeared. “The trust invested a lot of faith in me and I was given a lot of autonomy in running the ward.”

New skills

Matron Sue Jones says Trudie became adept at using her leadership skills to win resources which enabled her nurses to develop their skills. For example, staff nurses trained to carry out swallow tests on stroke patients, then trained other nurses to do this too. Previously, hard-pressed junior doctors had had to do the tests, and some patients were overlooked. Switching the responsibility meant patients benefited, and nurses had the satisfaction of acquiring a new skill.

Sisters now manage the ward beds and have increased turnover by 30 per cent. Central to this are the ‘bed meetings’ instigated by Sue, which have become forums for exchanging ideas and discussing problems.

“Sometime you’re quite isolated on a ward as a G-grade,” says Trudie. “You don’t know what’s going on above you.” The bed meetings help combat that, as do weekly meetings with medical staff to brief them on any changes.

Leading lights

As the staff nurses took on new roles, the unit needed cover for them. It turned to its healthcare assistants. An F-grade nurse spent two days a week focusing on developing their role. All have passed NVQ level 2, and some are now aiming at level 3, “…which is fantastic from our perspective because they are very much leading lights among the hospital’s healthcare assistants,” says Sue.

The unit has saved money since adopting the changes. “Healthcare assistants at level 3 are far better budget managers than a ward sister,” says Trudie. “So we’ve saved a lot on stores and continence care.”

Empowering people and valuing them as a team have been important lessons, she says, as she has shifted from nursing to management. And the patients’ verdict? One 68-year-old man who was cared for on Ward 26 after he suffered a stroke describes his treatment as “absolutely wonderful.”

“We need to facilitate team working between nurses, doctors, managers and everyone in the health care team in order to transform services for patients.”

Dr Beverly Malone
Royal College of Nursing

++ 73% of hospitals now have specialist stroke units, up from 45% in 1999 ++
Anne Walker
Chief Executive, Beds & Herts Ambulance & Paramedic Service NHS Trust

Complaints about the three-star Bedfordshire and Hertfordshire ambulance service now come almost as a shock to Anne Walker. In her three years as its chief executive she has seen them fall by two-thirds. But in her early days there she found they gave her great insight into what she had to do.

“There was rarely a complaint that didn’t tell you an awful lot about what needed to change,” she says.

Anne quickly realised it was a dysfunctional organisation with a hierarchical command-and-control structure that failed to develop its staff. “People were very used to being told what to do. The amount of independent thought, action and decision-making was quite limited.”

Though the organisation had already undergone a lot of change, it had not been implemented properly. Local healthcare partners regarded the trust as closed and secretive. And it was failing the people it was meant to serve, managing to reach only 45 per cent of category A calls within eight minutes when the target was 75 per cent.

Streamlined

Today, response times exceed that target. The trust has secured extra resources for new vehicles and 25 per cent more staff. Patient surveys reveal high levels of satisfaction, and six community health councils sit around the board table.

“We have moved from being a pretty dysfunctional set-up to one that is streamlined, very keen to be good and with a much more flexible, supportive approach to staff,” says Anne, who joined the NHS 23 years ago as a graduate trainee.

It has meant enormous change for staff, but it has all been achieved without anyone invoking the grievance procedure, let alone industrial action. “It’s good management that’s brought about this change. It isn’t a fairy wand or anything else. It’s lots of good, sensible management,” says Anne.

Re-engineering

Meeting response-time targets meant re-engineering the entire system. Anne hired consultants to help, and reviewing the trust’s human resources department was an early priority.

“There got to the heart of a lot of things. It was all about how the trust treated staff.”

Where previously ambulance headquarters had made plans and imposed them regardless of local circumstance, Anne devolved responsibility – for £34 million is being invested
devising rotas, for example – to local stations. Managers had no experience of staff involvement like this. “They had been on courses but come back and thought, ‘how do I make that happen in this organisation?’ We wanted training tailored to the issues here.” They got it.

There was less resistance to change than scepticism that it would last. “They feared I’d leave and they’d be left in a mess,” says Anne. “But now we’ve passed the point of no return. We’ll never go back to where we were because everything has changed.”

Reflecting on the transformation, she says: “I didn’t come in and write a consultation document putting everybody’s job at risk then expect performance to improve.

‘It was all about how the trust treated staff’

“I did work out where there were problems and I sorted them out – putting some people in posts where they got more development and training. You have to care a lot about the people who work for you. By that I don’t mean being soft, I mean being tough.”

She knew it had worked when a staff member told her recently: “Anne, I bet nobody has told you, but it’s different now – and it’s much better.”
Ensuring the best use of resources

Keith Poyntz
Deputy Director of Commissioning,
South Birmingham PCT

In many ways the two halves of Keith Poyntz’s 25-years in the NHS are worlds apart. The first half he spent in a hands-on clinical role as an operating theatre practitioner.

The second, after successfully completing the NHS Management Training Scheme, saw him hang up his scrubs and turn to commissioning as a new career.

But for Keith – now deputy director of commissioning at South Birmingham PCT – the change of direction doesn’t feel too severe. In fact, he says, understanding the way services are viewed and prioritised within hospitals has been a positive benefit in one of his recent projects to totally change the shape of treatment for thousands of heart failure patients across south Birmingham.

Up until 18 months ago, heart failure patients in this area faced a wait of six to 12 weeks on an outpatient waiting list to see a cardiologist. During this time, their condition could deteriorate fast with breathlessness and lack of mobility adding to the anxiety of waiting for diagnosis and a proper treatment plan.

But back in 2001, the picture for these patients began to change. As coronary heart disease (CHD) commissioning lead for primary care groups in the south of the city, Keith was focusing on the then newly-published CHD National Service Framework.

“A lot of the emphasis in these early discussions was on investing the resources in secondary care procedures, not on longer-term treatment for heart failure or rehabilitation,” explained Keith. “Yet in south Birmingham alone, there are around 8,000 patients with heart failure – a disease which can be significantly improved with the right medication, patient education and treatment plan.”

Blueprint

Heading a working group, including cardiologists and GPs, Keith knew he wanted to think seriously about investing £350,000 in a community-based service which would not only benefit these patients, but would, in essence, pay for itself through reducing emergency hospital admissions.
“The evidence base was there from other centres, albeit not from such a community-based setting. By maximising patients’ care through medication and education, they were improving health outcomes and keeping people out of hospital.”

Eighteen months on, and following a successful pilot of the service in 2002, a Birmingham-wide blueprint for heart failure has been implemented in the PCT.

Already covering half of the GP practices in the area, the service currently runs from a hub in the acute trust and two centres in the community. Using GPs with a special interest and specialist nurses the clinics are already making a quantifiable difference to patients:

• 100 per cent of patients are being seen by the clinic within two weeks of GP referral, compared with the six to 12 week wait for an outpatient appointment
• The new clinic takes as little as one hour to diagnose patients and set up treatment and follow-up plans
• Patients can arrange appointments which are convenient to them and closer to home
• Patients can discuss their treatment in detail with the specialist nurse.

‘This is a bureaucracy-free, friendly and personal service for patients’

‘Any well-run health system will need managers whose role is to make the best use of clinicians’ scarce time.’

Dr David Green
Civitas

Bureaucracy-free

Dr Naresh Chauhan, a GP in South Birmingham’s Riverbrook Medical Centre who worked with Keith to set up the service, said: “This is a bureaucracy-free, friendly and personal service for patients. Patients appreciate being given the time to discuss their treatment with the GP and specialist nurse.”

A strong advocate for rapid intervention in the community, Dr Chauhan added: “One of my patients was becoming progressively breathless and was even having trouble walking into the surgery. Within two weeks of his assessment at one of the heart failure clinics, he was mowing his lawn. That speaks for itself.”

rose by a third to 16.5 million last year ++
Planning for the future and leading change

Bill Stevenson
Organisational Development Director,
Peterborough Hospitals NHS Trust

Working smarter, not harder, was Peterborough Hospitals Trust’s approach to cutting waiting times for cataract surgery. In the process it united optometrists, GPs, nurses and surgeons to devise an innovative, award-winning service of national renown.

It also succeeded in shrinking waiting times from 12 months to between six and eight weeks.

Peterborough’s one-stop service for people needing routine cataract operations enables optometrists to refer them direct for surgery: “Someone taking their mother to the high street optometrist with an eye problem can come out with a date and time for surgery in hospital,” explains Bill Stevenson, the trust’s organisational development director, who was a driving force behind the scheme. “They can’t believe it.”

Formerly, a visit to the optometrist would have been followed by one to the GP, at least another to outpatients, a third to a pre-op clinic before admission for surgery, then finally another trip for a follow up. Now patients complete a health check questionnaire which is discussed over the phone with an ophthalmology nurse before the operation. After surgery they are discharged within an hour. “Patients love it,” says Bill.

Enhanced service

The surgeons are able to treat virtually all cataracts as day cases, while the optometrists – benefiting from extra training and accreditation by the consultants – feel part of the team and have the satisfaction of being able to offer an enhanced service. Nurses too are using their skills to the full.

Excellence brings diverse rewards. Peterborough was able to access capital to build a self-contained theatre, reception and garden for day-case eye surgery patients. “None of that was on the agenda when we started, but managerially we have been able to take advantage of the opportunities.”

Much painstaking preparation laid the groundwork for the service. Bill spent nine months visiting GP practices and chairing meetings between the optometrists, GPs and surgeons. “I said we’re setting up this joint project to work smarter, not harder, in the interests of our patients and staff.”

Culture change

It was hard work and at times felt as if it was going nowhere, Bill admits. “Getting the ideas isn’t difficult. Making them happen is. Change is the hardest thing I’ve come across in the NHS.”

But one by one he won converts. “Then it got progressively easier. Once you start the dialogue, opportunities begin to appear. All projects have different difficulties, but most are around asking people to do something they’ve never done before.

‘Someone taking their mother to the high street optometrist can come out with a date and time for surgery. They can’t believe it.’

++ Fast-track surgery centres could provide 30,000 cataract operations by
“It’s about handling people and gradually changing the culture of the organisation. It takes time.” The key to doing it successfully is trust. “You’ve got to be in the organisation and be known so that people listen to you,” says Bill, who has been at Peterborough for 12 years. “We have a team here that has the trust of surgeons, GPs and optometrists. You have to demonstrate that it’s helping you all to work and develop each other’s skills.”

For the future, the hospital is examining the feasibility of offering a similar service to glaucoma patients and extending post-operative assessment by telephone. After 30 years in the NHS, Bill declares: “I’m enjoying myself more now than I’ve ever done.”

‘Managers and clinicians should not find it difficult to work together in their common aim: the care and safety of patients.’
Professor Carol Black
Royal College of Physicians

Smart work: Bill Stevenson talks to Liz Hawkes, assistant general manager for surgery at Peterborough
As project director of the Manchester, Salford and Trafford Local Improvement Finance Trust (LIFT), Trevor Purt has been responsible for bringing together six PCTs, three local authorities, an ambulance trust and the private sector.

His project, the largest of the first six LIFT pilots in England, puts private firms in partnership with primary health services to develop a new generation of one-stop shop health and social care centres in Greater Manchester. Life expectancy in this area is the shortest in England, with 27 of the 33 Manchester wards in the top ten per cent most deprived in the country.

“This project has been likened to knitting fog. But from being behind time when I joined in January last year, we have now achieved or bettered our target milestones, procuring our private partner earlier than we first anticipated. The biggest difficulty was engaging ten different organisations with different cultures and management. It was exceptionally challenging to get everybody to work to agreed deadlines but we achieved it.”

Around £60 million is to be spent on the initial set of schemes with an expected £200 million to be spent over the first five to seven years of the 25-year project.

‘Professional, effective management in healthcare is as much a public duty as in any other critical service.’

Maurice Cheng
Institute of Healthcare Management
“The aim is to integrate differing services under one roof, and not just from within the NHS – taking us away from the old view of the GP surgery. With local authority involvement we can include housing and benefit offices, social services and even libraries. Third parties could provide services such as crèches, coffee shops, internet cafes and supermarkets.

“We are looking at how we can integrate community services to provide a new way of delivering care in cutting-edge buildings. It will blur the boundaries of primary, secondary and community care and enable us to plan services, take a step back and look at exactly what facilities patients need and where.

Trevor has worked hard on consultation with local people who have been able to influence not only the services going in to these buildings, but their locations as well.

“It has given us a completely new view of the relationship between the community and service providers and enabled us to promote social entrepreneurship and local ownership. Shares in the LIFT company are now devolved to trusts for the local community.”

Edna Robinson, chief executive of Salford PCT said:

“We looked to Trevor to provide really strong coordination of what was a complex range of stakeholders with a diverse range of needs. He needed to find common ground, draw out the key social and healthcare challenges and then market those to the private sector to attract a high-grade partner.

“He had to keep us on time, on track and on target. He made it simple, professional and possible, while ensuring it never lost its emotional core of regenerating a complex inner-city health service.”

Common ground

“LIFT is such a necessity because nationally less than 40 per cent of primary care premises are purpose-built, half are either converted houses or shops, 80 per cent are too small and 70 per cent need repair. If services are put under one roof in good-quality premises, people can work together more effectively in a much better environment.”

centres were established between April 2000 and December 2002 ++
Working with others to achieve more

Steve Phoenix
Chief Executive, Adur, Arun & Worthing Primary Care Trust

Working with others for the benefit of all has been the abiding principle for Steve Phoenix.

In addition to meeting the health needs of almost 250,000 people on the West Sussex coast, the Primary Care Trust manages specialist commissioning for all 15 Surrey and Sussex PCTs, administering an annual budget close to £350 million.

Steve, who first joined the NHS in 1980 as an HR specialist and has held director-level posts for more than ten years, began his partnership working soon after his appointment by linking with the chief executive of the local acute trust.

Integration

"I believed patients would be best served if we aligned the energies of the two organisations. We created a degree of vertical integration with the acute trust, for example, by creating three joint directors of estates and facilities, HR and information systems and technology. We developed a strategy about partnership and integrated working that was designed to focus on delivery of what was needed for the population."

Steve also chairs a joint management body which brings together the PCT, the acute trust, social services and the specialist mental health and social care trust.

"Organisational boundaries are irrelevant as far as the public is concerned. The views and aspirations of different organisations should not, under any circumstances, get in the way of providing what is right for patients. We must live, breathe and mean this approach, not just say it."

Vision

Steve has also taken a leading role in the creation of Vision 2010 – a multi-agency strategy in which senior frontline staff and the relevant agencies ask themselves ‘What do we want health care locally to look like in 2010?’

“There are lots of initiatives and funding around, so we must harness them to serve people best. Governments, organisational boundaries and chief executives all come and go, but people still need care and treatment.

‘Organisational boundaries are irrelevant as far as the public is concerned.’

++ Primary Care Trusts are now
“We are working to get all the organisations excited about new ways of doing things, re-shaping the hospital, a new future for primary care in the light of the new GP contract and getting social and community care to support people in their own homes more effectively.”

Steve adds, “People are very enthused by the picture they are helping to paint. That would not have been possible two years ago without this much greater level of trust and commitment which has grown out of the determination of local leaders to make a real difference. For the PCT that means sound management, shaped by local clinical priorities and a focus on the needs of people.”

Open process

The PCT has also resolved a long-running problem over what to do with two community hospitals in Rustington and Littlehampton, which, in spite of their committed staff, were inadequate and out-dated.

“Efforts to do something have been going on for about 20 years, says Steve. “Everyone agreed there should be a new hospital but half wanted it on one site and the rest on the other. We have devised a combination of beds and community services integrated around an intermediate care model.

“The plan has gone down very well, partly because of the open process we committed to. We established a reference group including any interested party that thought it should be involved. We had monthly meetings, they saw all the working papers and we spent a lot of time talking about the options.

“We try to adopt that approach to everything we do. It is about the responsibility of leaders to set the values of the organisation. People must see that you have integrity, that you say what you mean and you mean what you say. If you make a commitment, you honour it. That is what I have been trying to do and I want people in the organisation to do.

“We are seeing the rewards of that approach. People trust us; they don’t always like the decisions we have made, but they trust us to do the right thing. Part of our responsibility is for people to see our values, not written down on some glossy card, but through what we say and do and how we behave every day.”

‘People with long term conditions want and need different sections of the health service to work together as one. Without high quality management this rarely happens.’

Paul Streets
Diabetes UK

responsible for spending 75% of the NHS budget ++
Working with others to achieve more

**Sarah Hooper**  
**RADIATE Team Manager, Hounslow PCT**

Sarah Hooper is responsible for leading a multi-disciplinary team working with older people to reduce unnecessary hospital stays and smooth the transition from hospital to home.

Based at West Middlesex University Hospital, RADIATE (Rapid Assessment and Diagnosis and Treatment for the Elderly) works with patients aged over 65 to ensure they can maintain their independence for as long as possible.

The team is made up of 23 health professionals including nurses, occupational therapists, physiotherapists, speech and language therapists, psychologists, social workers and some consultant medical time.

**Diverse**

Sarah, RADIATE’s operational manager, is responsible for bringing together this diverse group employed by the hospital, the local primary care trust, as well as social services.

"Managing a team of people with skills ranging from nursing to psychology can be complex," says Sarah.

Sarah works closely with the professional leads who are responsible for the clinical supervision of the team. “We meet on a regular basis so I can gain their valuable professional input.”

RADIATE takes between 80 and 90 referrals a month from GPs, district nurses and social workers, and from patients discharged from A&E. Sarah is working with colleagues to develop a single point of access for all intermediate care referrals. This will ensure patients receive the right services as well as freeing up GPs’ time.

Pilots are also under way for a single assessment process to eliminate the duplication of patient information and ensure that each service has access to accurate, up-to-date records.

Sarah is justifiably proud of the team’s achievements: “Our ultimate goal is to catch everyone in the community before they need emergency care. However, right now our aim is to work across the PCT and with West Middlesex University Hospital to ensure that as many older people as possible can be successfully rehabilitated into their own home and, with our help, maintain their independence.”

‘Our ultimate goal is to catch everyone in the community before they need emergency care’
A key part of Hari Sewell’s job is ensuring that service users have a real say in how the trust is run – so it genuinely meets their needs.

“There has been a long tradition of service users playing an active role within the organisation. Over time that role has developed from being on the periphery of things to something more robust where there are clear expectations from staff about user involvement.

“The Government’s approach to mental health already provides a framework for involvement in treatment and care, so we are focusing on involvement in the business of the organisation, which is less well-defined at national level.”

Hari feels that service users have warmed to the opportunity to influence how services are provided on an ongoing basis, rather than relying on one-off consultations.

“We co-opt service users on to committees and we also have a user advisory group which provides ongoing input into the whole life of the care trust. We have a programme where users interview other users about their experiences and we find we get a different response to what a professional might get.”

The trust is now looking at how it can more effectively involve users in monitoring service standards, and in decisions about service configuration.

“More than 100 people have been involved since the trust was established of which a core of between 30 and 40 are significantly involved. Their diagnoses cover the full range of conditions such as schizophrenia or depression.

“Having service users involved in absolutely everything keeps us focused all the time on why we do what we do. For me that is fundamentally important.”

‘Rethink’s vision is for a health service that gives people with severe mental illness a real say in their care, with high quality services which help them recover a fulfilling life. This vision can’t be realised without first-class management.’

Cliff Prior
Rethink
Dr Sue Allan
PEC Chair, Ealing Primary Care Trust

Dr Sue Allan is a GP in a five-partner practice in West London. But she is also chair of Ealing Primary Care Trust’s Professional Executive Committee (PEC), responsible for overseeing the day to day running of the PCT.

Sue works closely with the trust chair and chief executive to ensure that local primary care services meet the needs of the 350,000 people served by the PCT.

“GPs can bring a fresh approach to management by suggesting different ways of doing things because they come at it from a different angle,” says Sue.

Prevention

Until recently, Ealing’s doctors lacked a screening service to detect signs of osteoporosis. Sue worked to secure the support of clinicians and managers to establish two local centres. “Now we can scan patients in at-risk groups and prevent its onset with treatment. It has the potential to make a significant difference to people’s lives.”

Sue is also working to create a permanent pool of locum doctors. “With 180 GPs there is always someone wanting cover. Not only does it give us a dedicated reserve familiar with the patch but we can use it to encourage GPs to get more involved with either clinical or managerial work in the trust. It can free up a doctor with special interests to run clinics, or allow a GP to lead a project.”

Despite the difficulty of juggling her responsibilities as a GP and as a PEC chair, Sue finds the role a rewarding one. “There are frustrations, but mixing clinical practice with management can also be the best job in the world.”

‘A real strength of PCTs is that they put GPs at the heart of the management team. Supporting doctors in management positions and encouraging close collaboration between managers and frontline staff is the key to delivering better patient care.’

Professor David Haslam
Royal College of GPs
The Royal College of Nursing welcomes and supports the NHS Confederation’s ‘Management Matters’ campaign. Leadership and effective management are key to quality patient care.

Dr Beverly Malone
Royal College of Nursing

All organisations, whether public or private, are hugely reliant upon first class management skills. We must not denigrate the important contribution that excellent management can make in providing the right environment for professionals and staff.

Digby Jones
Confederation of British Industry

Organisations which provide healthcare must be well-led and well-managed. Leadership is crucial. Management does matter.

Sir Ian Kennedy
Commission for Healthcare Audit & Inspection

What is the future for NHS management? See overleaf
The modernisation of the NHS requires increases in the number of doctors, nurses and beds, but as the NHS plan recognised, this will not be enough on its own. There is a need to streamline and change the way services are provided, new staff roles need to be developed and a huge programme of investment in information, buildings, and equipment is needed. All of this requires high quality management.

This report has highlighted twelve examples of how good management can make a difference. They are just a tiny sample of the many managers who are helping clinical staff to deliver services more effectively and directly improving the patient experience.

There is good evidence from recent studies that senior NHS management is comparable in quality to managers in the commercial sector. But there is no room for complacency. The NHS Confederation believes we must do more to effectively support NHS managers and develop the skills needed to meet the challenges ahead.

**Developing the people**

**Promoting new skills**

Properly applied management expertise can add real value to the delivery of clinical services but this requires new skills in how to create well managed systems. Managers need to understand clinical work – not so they can interfere or dictate to clinicians, but so they can help nurses and doctors to do their job. Training and education is a part of this but managers also need on the job learning and support from their peers.

This needs to be accompanied by a focus on developing other key skills that are essential to transforming services, including strategic planning and more effective use of increasingly complex information systems.

**Attracting clinicians into leadership roles**

Because so many of the changes the NHS needs require an understanding of clinical processes we need to find more ways to attract clinicians into management positions.

Clinical managers know that their management role can have just as much of an impact on patient care as their clinical work, and this is an important motivating factor for taking on these roles. But we still need to find more ways to make these positions attractive, and to provide clinician managers with appropriate training and ongoing support.

**Supporting middle managers**

There is a growing recognition that we need to invest in top quality senior management. But the NHS also needs high quality leaders and managers at other levels of the organisation.

The NHS has tended to undervalue its middle and junior managers. In fact, these staff often have some of the most crucial but stressful jobs because they have to balance the requirements of senior managers with those of their clinical colleagues. This can be made more difficult because of the difference in status and career stage between some middle managers and consultants.

We need to look at what could be done nationally, regionally and locally to better support middle managers. This should include tailored development programmes and networking and peer learning opportunities across the public, private and voluntary sector.

Where next for NHS management?

- Attracting clinicians into leadership roles
- Supporting middle managers
- Developing the people
- Promoting new skills
Developing the job

Promoting effectiveness
The jobs we ask NHS managers to do must be realistic. There is still a tendency to set people huge, if not impossible, tasks and then become impatient when there is not a very rapid change.

There is no point in developing leadership and management skills and capacity if the environment in which leaders practice undermines their effectiveness. Unless this is addressed many of the resources put into management development could be wasted.

If individuals are not delivering then this needs to be tackled, but the process needs to be fairer, ensuring that individuals are not blamed where the wider system is the problem. It will be harder to create a culture of putting the patient first if we are unable to look after our own staff.

Setting better targets
Management without the engagement of clinicians will fail to deliver change. But managers will find it hard to engage their frontline clinical staff if the performance management regime does not connect to the realities of their everyday life.

Tough targets for delivery are important. But the number of targets needs to be reasonable and many more of them must be developed locally so they relate more closely to the patient experience and front line staff views of service quality. The Department of Health has made progress in this area but there is further to go.

Unleashing innovation
Finding the time to develop new ideas and working practices is essential in a rapidly changing NHS. Managers need to have access to funds that allow staff to look beyond the here and now to develop the innovations that will deliver better services over the longer-term. This requires a culture where experimentation and risk taking are actively encouraged.

Clinicians and managers also need the opportunity to learn from best practice in other parts of the NHS, and elsewhere, to ensure that successful innovations can spread across the service.

Taking the agenda forward
The Confederation believes that action in these areas would help NHS management to fully realise its contribution to transforming the NHS.

We need to focus on developing both the people and the jobs as two sides of the same coin. And we need to do this as part of a fresh debate about the difference good management can make to improving patient care.
The Confederation brings together the organisations that make up the modern NHS across the UK. Working with our members, we are an independent driving force to transform health services and health by:

• influencing policy and the wider public debate
• connecting health leaders through networking and information sharing.

For further information on the Confederation’s Management Matters work, contact the Public Affairs team on 020 7959 7240.

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