THE BAMM CLINICAL DIRECTORS' SERIES

THE BRITISH ASSOCIATION OF MEDICAL MANAGERS

Clinical Director of PATHOLOGY

Tackling the Role

Edited by Michael Galloway

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Series Foreword

Managing the clinical service is a challenging occupation in which the role of the doctor has increased exponentially since the radical changes of the Thatcher government in the middle to late 1980s (is it really that long ago!). The involvement of clinicians in management was, of course, a fundamental tenet of the late Sir Roy Griffiths' advice in his response to the confidential enquiry into the NHS in 1983.

It is tempting to think that the challenges facing doctor managers have also increased dramatically but that would be to forget the context of the earlier times and the enormous culture change that has been achieved. Nevertheless, the complexity of the agenda that faces today's doctor managers, indeed all managers, has changed beyond all recognition.

Devolved management structures are the norm rather than an optional extra and the directorate model – in one form or another – is widely accepted as fundamental to effective trust management. It is here that the political and managerial is translated into practical action – no mean feat in this era of change mania and run-away demand inflation. The individuals who have taken the risk of leading directorates have seen a major change in their roles, from the early days of budget holders (or rather overspend blame-takers) to the current and developing roles as strategic clinical leaders, key to the future direction of their organisation. They have also experienced, however, the isolation of a 'different' career path, the status of clinical director and the unpopular management decision.

These individuals need help and a network of peers. They need a 'home' in which they can share their learning, share their successes, share their failures. BAMM does that – it is why the organisation exists and this series is a further building block in the framework of support for clinical directors. What is innovative about this series is its focus. The suggestion that specialty training in medicine is interchangeable would be met these days with some considerable scorn – registrars no longer hop across major specialty divides because it is too difficult. Focused training is the norm. Yet the clinician in management makes do with generic management texts which, excellent as they may be, do not recognise the enormous diversity of today's NHS. Managing a pathology service is just not the same as managing a cardiac surgery service.

This series is not about fostering differences but is about providing help with the context and practicalities of managing directorates – discrete and highly complex integral parts of the even more complex whole that is today's NHS hospital. It is the aim that along with standard texts clinician managers will have this, their directorate-specific text to help and thereby also achieve one of the fundamental aims of clinical governance – the sharing of learning, good ideas and best practice.

Peter Lees
Jenny Simpson
BAMM
April 1999

Foreword

Change, change and more change: the clinical director has a pivotal role which includes leading and developing strategic change for the directorate, but taking on the title does not come with a 'user manual'. Clinicians in disciplines such as pathology need to know about financial management, quality assurance, purchasing equipment, and 'health & safety' but we do not always get to grips with these until taking on a management role. Here is a 'shortcut' guide for clinical directors – the chapters on these important topics should be compulsory reading for anyone tackling the role.

The clinical director, essentially, learns 'on the job'. At times the role can seem a lonely one – 'on the one hand explaining and justifying management to clinical colleagues and on the other impressing on managerial colleagues the reality of clinical practice'. More than anything, the clinical director learns and benefits from networking and comparing notes with colleagues in similar positions. Many of the challenges and problems in pathology are not unique. What better than to learn from colleagues, either on a similar learning curve or those more experienced, who understand the problems and have 'been there, done that, got the T-shirt'.

At BAMM Pathology Network Group meetings the same issues were common to many, whether in a large teaching hospital or a small DGH. Some clinical directors had already dealt with complex change projects, such as changes to the 'on call' service or laboratory mergers. We realised there was much to learn from

their experiences. Sharing these and the different solutions arrived at, gave fresh insight and perspectives to important issues facing clinical directors of pathology and revitalised the approach to them. So this book, in a way, represents the metaphorical 'pooling of T-shirts'. It pulls together the threads of the topics discussed at BAMM Pathology Network Group meetings and condenses them into an excellent series of practical and valuable chapters, dealing with specific, relevant topics. These range from the 'Corporate role of pathology' and 'Clinical governance', through to 'Benchmarking laboratory performance' and 'Changing working patterns', making an apposite and readable guide for anyone with an interest in managing pathology services.

This book is also testimony to the enthusiasm and commitment of its editor, Michael Galloway, the first chairman of the BAMM Pathology Network Group and to all those who have contributed chapters. The group members too played a large part in shaping content of the meetings which formed a nucleus for this book.

Change continues and there is no 'arrival point'. The clinical director travels on a voyage of discovery and adaptation: now we see the introduction of clinical governance as a framework embracing the quality and efficiency of a service, tomorrow, no doubt, there will be other changes, other challenges. Yet the same skills, awareness and background knowledge will be needed to tackle the role. A wealth of essential and practical information for clinical directors in pathology can be found here – topical and forward looking. It is reassuring to have such a useful guidebook for the journey!

Suzanne Chapman
Consultant Medical Microbiologist
Clinical Director, Rapid Diagnosis & Assessment
April 1999

In conclusion it is hoped that this book will help clinical directors achieve organisational development with the aim of improving the quality of their pathology service. The practical lessons that have been learnt from the BAMM Pathology Network Group deserve a wider audience. From a personal point of view it has been an exciting four years in which to be involved with such an enthusiastic group of medical managers who have participated in the BAMM Pathology Network Group meetings. Finally I would like to acknowledge the contribution of Tim Scott, who first suggested the idea of the book, and to thank Susan Nicholson who skilfully helped to prepare the manuscript.

Michael Galloway
April 1999

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Introduction

DENISE POTTER
MICHAEL GALLOWAY

This book has been written at a time of considerable organisational change both within the NHS and within pathology. The introduction of the concept of clinical governance has focused attention on the quality of healthcare and not just the costs. Unfortunately there have been a number of well-publicised failings in pathology laboratories in which a poor-quality service has adversely affected patient care. As a result it will become increasingly important for clinical directors of pathology to be aware not only of the cost-effectiveness but also the quality of their service.

Clinical director of pathology – a pathologist's view

A number of factors which are important to the success of any quality improvement initiative have been identified.[1] The major components include clarifying roles and responsibilities; the development of appropriate data, including performance indicators that can be used to monitor and improve the quality of the service; appropriate incentives; and the development of teamwork. There is evidence that working in teams can have a beneficial effect on

financial performance, quality of care and staff motivation.[2] Within pathology, teamwork is becoming increasingly complex as a result of initiatives such as multidisciplinary working and revised management structures, usually as a result of incorporating pathology into a larger directorate. It is therefore essential that the clinical director of pathology takes a lead in developing teamwork within the laboratory so that the concepts of clinical governance can be implemented. It is equally important that the managerial role of the consultant in each speciality is clearly defined and that they are supported in developing the role of a multidisciplinary team within the laboratory. These changes require leadership, a skill clinical directors of pathology will need to acquire.[1]

At trust level, pathologists will be key individuals in implementing clinical governance. This is a result of the wide remit pathologists have, not only within the clinical areas of a trust but also, particularly for microbiologists, in the non-clinical areas in relation to infection control. There is potential risk associated with this wide role of pathologists. This risk is best described as pathologists having the benefit of hindsight. For example, histopathologists performing postmortems may identify the reasons why things have gone wrong. Lessons and new ways of working should be learnt from this rather than using clinical governance as part of a disciplinary process or a way of settling old scores!

Clinical director of pathology – a general manager's view

In all but very rare cases, clinical directors are themselves clinicians. The dichotomy which may be neatly packaged within terms of an allocated number of sessions for clinical work and a further number for managerial work ignores the inherent difficulty in being a part-time worker and a part-time leader. In reality this dichotomy is generally played out in the modification of the clinical director (leader) role. The temporary nature of the clinical director role creates a longer-term vision of 'colleagues' not employees. The significance of the influence of longer-term team working amongst consultants should not be ignored, particularly as it is likely that some 30 years of working life may be spent at the

same place with the same colleagues. Being an equal but temporarily in charge modifies the actions of even the most gung-ho clinical director, at least within their own speciality.

The appointment of clinical directors is also usually subject to approval by their consultant colleagues. This process in itself is likely to produce the appointment of the 'most accepted'. This further reinforces the team working element of the role. It is unlikely that the 'most accepted' would be the consultant whom the others felt would initiate wholesale reorganisation of departments or indeed challenge their individual performance. Whilst this reflects the reality of the job, i.e. autonomous professional interests versus the corporate management agenda, the difficulties of incorporating these interests cannot be underestimated. This skill of a clinical director has been described as being able to 'hunt with the service providers', as well as being able to 'run with the unit managers'.[3]

Clinical directorships for the future look rather more prescriptive. The role of clinical governance in trusts, performance frameworks and national service frameworks all serve to reinforce the more prescriptive nature of healthcare in the future. Clinical directors will be charged with the delivery of this 'prescription'. It will be interesting to review how comfortable a profession that arguably wants to 'play a bigger part in managing the health service, to protect their clinical freedom'[4] is when it finds itself leading the delivery of services which will reduce the opportunities for clinical freedom. A new agenda, more prescriptive, more limiting and explicitly tackling priorities and rationing from both national and local perspectives is outlined in *A First Class Service: quality in the new NHS*.[5] This time the government's aim is to review performance, individual and corporate, in a way that is clinically meaningful to the staff.

It remains to be seen whether clinical directors seize this opportunity for management or whether the more prescriptive and 'managed' nature of healthcare and subsequently the professionals within it reduces the added value to trusts of clinicians participating. The balance of attempting to incorporate professionals into the management agenda appears theoretically easier now as the management agenda has actually become a management agenda for clinical change and excellence. Whether in fact a

service benchmarked as acceptable will be pushed the extra mile by clinical directors who are used to incorporating colleagues' autonomous styles must be in doubt.

It seems in pulling together the clinical director model for management the trust must look at the way in which clinical directors are appointed, the expectations of the postholder, their tenure in post and the time commitment required to address the agenda. Perhaps for the first time managers within directorates supporting clinical directors will be working to deliver the same priorities as their clinical colleagues. It may be the end of the clinical director model of management being used as a management vehicle of control, 'the incorporation of professionals themselves into managerial roles, subject to managerial parameters'.[6]

Pulling it all together within an organisation relies heavily on development of strategies jointly with relevant services. Activity within pathology has a knock-on effect for the financial control of the laboratory services. The development of budgets to support service level agreements is beneficial in identifying increased activity and its associated cost. However, clinical directors must be cautious of the supposed wisdom that service level agreements bring costs under control. This may be true within elective specialities where demand can be controlled, however, the devolvement of a budget to an emergency speciality with no capacity to stem demand may only be shifting the overspend around the organisation. This has been particularly true in terms of acute medicine over recent years, which nationally has seen huge increases in workload. Whilst financial support has been available this has largely been to address specific projects in terms of managing winter pressures – the principle that emergency beds must always be available.

Once again the new NHS agenda will require areas such as pathology to develop services, not in consultation with other specialities but rather at a subspeciality or even disease-based level. Examples of this have already been evidenced with pathology departments responding to the Calman–Hine initiatives for cancer service development.[7] Agreements for reporting frameworks and turnaround times for tests should have been reached for each cancer type. This requires the pathology department to be both flexible in its approach to activity management and to adapt to the prescriptive nature of other specialities' clinical service reviews.

Perhaps, therefore, service level agreements are to become a misnomer being replaced with service delivery agreements.

Finally, whilst recognising all the limitations of vested interests, professional autonomy and demand-led service delivery, some model of clinical management must pull it all together. Of course the new NHS agenda is precisely about pulling it all together from a patient's perspective. The boundaries of departments, trusts, primary and secondary care are nonsensical when from a patient's perspective it is just stages and management of the same disease. From a clinical director's position the challenges are all about creating a desire amongst staff to change as a result of benchmarking and to balance the ideology of an improved clinical service for patients which may actually not improve the lot of those providing the service. The bridge to fill the implementation gap between 'what should be' and 'what is' is now a centrally controlled requirement.

Conclusion

There have been many centrally led initiatives over the years which it was anticipated would offer the golden goal in terms of clinical management of services. Programmes such as the resource management initiative, GP fundholding and contracting were designed to improve information to clinicians, offering hope for improved management of resources and better clinical quality. Of course, in some areas, some of these aims were met. Clinical governance does give the clinician the opportunity to be directly involved in defining the quality of a service by development of guidelines, setting standards of care, etc.[8]

Decisions about service priorities and standards will inevitably become more transparent and offer the greatest opportunity for the clinical director to strengthen both the management and leadership elements of the job. However, there is no panacea for each individual project or management task. A series of plans must be in place – selling an ideal to staff without a supporting process achieves only frustration with one's existing lot, whereas implementing a process without selling the rationale becomes bureaucracy.

In order to both achieve and to monitor change in pathology the clinical director must first ensure that processes are in place. Such

processes include human resource management, formal and informal communication networks. Information on activity, effectiveness and service delivery must dovetail with financial control processes. Furthermore the clinical director must be an experienced influencer of opinion – understanding that different messages will be required to sell the same package to all the varied professionals in the directorate who of course will maintain their own clinical and intellectual preferences even within a managed multidisciplinary service.

References

1 Koeck C (1998) Time for organisational development in healthcare organisations. *BMJ.* **317**: 1267–8.

2 Firth-Cozens J (1998) Celebrating teamwork. *Qual Health Care.* **7**: S3–7.

3 Packwood T, Keen J and Buxton M (1992) Process and structure: resource management and the development of sub-unit organisational structure. *Health Services Management Research.* **5**: 66–76.

4 Smith R, Grabham A and Chantler C (1989) Doctors becoming managers. *BMJ.* **298**: 311.

5 Secretary of State for Health (1998) *A First Class Service: quality in the new NHS.* Department of Health, London.

6 Harrison S and Pollitt C (1994) *Controlling Health Professionals.* Open University Press, Birmingham.

7 Calman K and Hine D (1995) *A Policy Framework for Commissioning Cancer Services.* Department of Health, London.

8 Donaldson LJ and Gray JAM (1998) Clinical governance: a quality duty for health organisations. *Qual Health Care.* **7**: S37–44.

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Clinical directorates: background

TIM SCOTT

Since the 1960s, a variety of commentators have been concerned about roles of doctors, nurses and other clinical professionals within the management of hospitals and, more generally, the NHS. Academics and others pointed to what they saw as a gulf between doctors and managers and a variety of initiatives over the years have had this as one focus of their concerns.

The elaborate arrangements within the Grey book (the 1974 re-organisation) for the Area Medical Advisory Committee (AMAC) as well as the cogwheel structure at hospital level are manifestations of this. But what these achieved was no more than advisory mechanisms for tapping into the clinical voice rather than any joint management mechanism. The experience of many managers and indeed of clinicians was that doctors and others had no involvement in the implementation of their advice but could 'shroud wave' and block change without taking responsibility for resolving financial and other pressures.

Functional management

At this point in time, management arrangements, and therefore budgets, bore little resemblance to the pattern we see in the late 1990s. Many budgets were still held at district level, for example physiotherapy and occupational therapy, and those budgets that were held at hospital level were held on a functional basis. That is, there was a nursing budget broken down perhaps into out-patients, accident and emergency (A&E), and wards. There would be a medical staff budget, often held by the personnel department, since most medical staff, at least in non-teaching hospitals, were paid at a regional level and had contracts with the regional health authority. The pharmacist would hold the hospital or even district-wide drugs budget and there would be budgets for portering, medical records, catering, training and medical secretaries. The vast majority of these budgets would be held by administrators, who were accountable through an administrative hierarchy.

Griffiths's review

Sir Roy Griffiths's fundamental review of the management of the NHS (the first as he reminded us since the Bradbeer Report in 1954) saw this as a primary concern. In this report, framed as a letter to the Secretary of State, Griffiths suggested experiments in what he called 'management budgeting'. This was to be a form of responsibility accounting with budgets framed around doctors, or groups of doctors, who, in financial terms, he saw as the prime drivers of expenditure. 'It is the actions of doctors, working as leaders of clinical teams, that lead to expenditure of funds and budgets will provide a means by which they can accept responsibility' was his view.

The management budgeting experiments were driven at regional and local level, rather than having any national focus or leadership. In all number of hospitals they were seen as an attempt to control doctors and resulted in confrontation between the finance function and the medical profession. In fact they became increasingly unpopular and were seen as a source of friction by such bodies as the British Medical Association (BMA).

When Ian Mills, a senior partner from management consultants Price Waterhouse, was appointed to the NHS Executive as the NHS's first director of financial management, he saw the management budgeting programme as one of his key tasks. In late 1986, in Health Notice number 34, he launched the re-engineered and re-visioned programme to be known as resource management, which was to spring phoenix-like from the ashes of management budgeting.

Resource management

There is always an iteration between central policy and what goes on in the NHS. The NHS prefers to invent things itself and to draw from other health services and other health systems and always 'interprets' central policy within its own framework. Increasingly we have also seen central policy makers recognising this effect and outlining ends whilst being less specific about the means. Such was to be the case with the management arrangements and particularly management structures which were associated with the resource management programme. There was already interest in the NHS in one or two places in changing the local management arrangements to involve doctors and nurses more fully. Some of those locations saw the resource management programme as providing validation that they sought, as well as an opportunity to tap into, central funds. Guy's Hospital, in particular, had visited Johns Hopkins in the USA and determined that there were aspects of their way of working which they wished to try. For them, resource management offered an ideal opportunity. Other hospitals, including Southampton University Teaching Hospital, were also engaged with the Hopkins model but did not feature in the early parts of the resource management programme. The Griffiths legacy of individual general managers had meant that every hospital could determine its own local management arrangements within the broad principle of general management and some had borrowed, or even invented, ways of involving clinical staff more fully.