Middle Articles

HOSPITAL TOPICS

Oxford and McKinsey: Cogwheel and Beyond

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The problem of designing a rational hospital management structure essentially depends on answering one question: how can a mainly lay board or committee effectively run a business in which most of the day-to-day decisions are taken by an unco-ordinated autonomous group of professionals—the medical staff? To try to answer this the United Oxford Hospitals invited McKinsey and Company to examine the use and misuse of resources and to make suggestions for improving the management structure.

The Hospitals

The group consists of the Radcliffe Infirmary (600 beds), the Churchill Hospital (420 beds), the Cowley Road Hospital (205 beds), the Slade Hospital (79 beds), and the Osler and Sunny side Hospitals (91 beds). The last two used to be isolated units nursing patients with respiratory diseases as well as tuberculosis and tuberculous meningitis. The Slade Hospital has beds for patients with infectious diseases and dermatological and gynaecological conditions. On the other hand, the Cowley Road Hospital is concerned with geriatrics, the emphasis being on hospital treatment rather than custodial care. The Churchill Hospital is a semi-acute general hospital, admitting some obstetric as well as acute gynaecological, but few acute general medical or surgical, cases. Most of the acute medicine and surgery is done at the Radcliffe Infirmary, which also provides a busy accident service.

The functions of the group as a whole is unusual for a teaching hospital. In fact, the six hospitals fulfil the role of the only district general hospital—as well as having total responsibility for geriatric care—for the central area of the Oxford region. The Radcliffe Infirmary is an extremely busy hospital and has the rather dubious distinction of having the lowest cost per patient of all the provincial teaching hospitals, mainly because of the extremely short length of inpatient stay (7.2 days). The reason for this short length of stay is not an abnormal mixture of specialties, but merely the extreme pressure under which the beds are worked.

Administrative Background

In previous years many of the medical staff as well as the board had become frustrated by the difficulties of taking decisions in such a large body as the medical staff council, which is composed of all the 110 consultants in the group. Clearly the medical council and its subsidiary bodies, the standing committees of physicians and surgeons, had become ineffectual, and many members had stopped attending them. Because of this a sub-group of the medical staff council—a medical advisory committee—was formed. Again, this was quite a

sizeable body (19 members) and suffered the grave disadvantage—common to all purely medically constituted committees—of discussing projects without the benefit of nursing, financial, or administrative advice. The hospital found itself facing an ever-increasing clinical burden. Not only was this at a time of great financial stringency, but the poor management structure made it difficult to obtain clear guidance from the clinicians. For their part, the clinicians found any attempt to change the organization as futile as boxing cotton wool.

Many people with experience of serving on hospital boards are painfully aware of the chasm between the boardroom and the clinical areas, and of their different kinds of thinking. This gap is poorly bridged by the traditional machinery of the medical advisory committee. Advice framed in one context is duly proffered as a basis for decision-making in another. Because the professional staff affected by the decision so often feel that they have not been party to it, the decision somehow fails to get itself implemented. For this reason the board decided that this was a problem worth the attention of top management consultants, and in April 1968 McKinsey Co. Inc. was asked to study the problem in depth.

Paying for this expensive help, however, was another problem. The Department of Health's approach to management consultancy has, perhaps reasonably enough, been tentative, to say the least, and certainly in the field of full-blown consultancy management it was clear that boards must venture on their own. Despite the fact that the endowment funds of the United Oxford Hospitals were meagre, and the claims on them many, the board decided to invest a substantial sum in this enterprise.

The Study

Though many of the recommendations made by McKinsey refer to problems which any hospital might have been able to solve for itself, the employment of management consultants does have two very important advantages. Firstly, they put in a team which has time to study problems in depth, for as long as three or four months. Secondly, the medical and administrative staff are more likely to adopt a plan suggested by a disinterested outsider than one proposed from some internal group.

The McKinsey team sent to Oxford included three or four highly paid intelligent and sympathetic young men. They obtained information about the existing management structure by interviewing many members of the staff at all levels and asking them to quote any occasions when they had wanted a procedure changed; to outline whether this had been easy or difficult, and, if the latter, where the fault lay. As a result of these interviews, it was obvious that there was much overlapping of responsibility in the organization. Another method of inquiry used was to formulate a hypothetical problem and then ask a range of staff which person in the administration they would go to for help.

Yet another large part of the McKinsey brief was to relate the workload of the United Oxford Hospitals to its revenue, comparing this with that of other similar hospitals, both

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teaching and non-teaching. For this purpose, the Department of Health's own records were used and impressive evidence was prepared and then submitted to the Department to support our case for more revenue. Finally, the team examined ways in which the existing revenue could be spent more profitably. The study was completed within about six months and the proposals approved by the board of governors in November 1968.

Financial Proposals

The study showed that in fact there were few areas in which large financial savings could be made. Perhaps the major and most controversial proposal was that the group should close down the small peripheral chest units at the Osler and Sunnyside Hospitals and instead use the existing beds in the Churchill Hospital. These two hospitals were due to close in about two years' time when construction of Phase 2 of the new teaching hospital in Oxford began. It was believed that this would result in a cash saving of £30,000 per annum for each of these two years and in an opportunity to redeploy nursing staff more economically (value £19,000 per annum). Moreover, a clinical advantage would result from the integration of these services within the Churchill Hospital, because of its better x-ray facilities, pathology laboratories, and junior staffing. It was hoped that the money for improving and altering wards in the Churchill Hospital could be found from a special allocation from the Department of Health. Because of national financial stringency, however, this sum was not forthcoming, and the cost (about £25,000) had to be underwritten from the group endowment funds. As might be expected from a project which involved many of the hospitals' departments—which had either to give up beds or move their wards—this decision was met with a storm of protest, some of which was quite justified and constructive. The bed-occupancy of the Churchill Hospital had been examined, and it was thought that with internal reorganization the patients with chest disease from the Osler and Sunnyside Hospitals could be housed there without any major new building. As a result, the Osler and Sunnyside Hospitals were closed within less than a year of the plan first being accepted. It remains to be seen through the coming winter whether this plan has been too ambitious. Nevertheless, we feel that the improvements in the facilities for these patients will justify any temporary strains on the Churchill Hospital. In addition, if, under our present management structure, such strains do become intolerable, we should be able to redeploy resources in the group to take account of this. For example, if an epidemic broke out in the children's wards, it would be necessary to stop some routine admissions and perhaps make an extra ward available to them.

Executive Committee and Divisions

The major change proposed by McKinsey was in the management structure of the group. Instead of medical committees, as recommended in the cogwheel report, McKinsey recommended the establishment of a small executive committee, consisting of four medical members (representing divisions), the chairman of the board of governors, the chairman of the finance committee, the director of nursing, a board member responsible for nursing, and the administrator. Such a committee structure had the very great advantage of being small yet including all branches of the hospital organization. Any decisions taken in this committee were unlikely to have ignored any information from a group which had not been consulted. Furthermore, these decisions would also have a realistic financial and administrative basis, and since the committee was small, there was no room for sleeping partners or for sectarian interest.

After consultation, however, it was decided to form only three divisions (each with an elected chairman), instead of the four. The division of medicine represented all the physicians, both specialist and general; the division of surgery also included gynaecology and anaesthetics; and the division of laboratories and radiology represented the x-ray and radiotherapy departments as well as all the various pathology laboratories. In retrospect, we think that such divisions were a very sensible choice, since clearly the appropriate chairman could not be accused of representing any narrow group. The alternative was a representative for every specialty or group in the United Oxford Hospitals, which would have meant a much larger committee.

Elections

The management consultants took great care with the election of the medical division chairmen. Each candidate proposed for election had to have six sponsors, and to be elected had to have more than half of the total votes available, including abstentions. Thus, in the event of a three-cornered election the two top candidates on the first poll might have to be considered in a second election. Furthermore, McKinsey recommended that each division should be encouraged to elect candidates who were fully occupied with hospital work rather than select candidates in posts where it was known they would have time to spare for the job. In addition to the chairmen of the three divisions on the executive committee, a fourth medical member would be elected by the medical staff council as a whole as a sort of ombudsman. (It should be pointed out that the Medical Staff Council representative was elected by *all* the consultant staff, whereas the divisional chairmen are elected by those members of their particular division only.) Thus, not only did those elected have the backing of more than half the electorate, but they were also busy in the mainstream of hospital work rather than "medical politicians." The idea of this was to try to get clinicians who might otherwise plead lack of time to take part in management processes. If these posts were held for a non-renewable period of two to three years, most of the hospital staff would at some time be actively involved.

Representatives

Each of the three divisions also included four junior members, two from the Radcliffe Infirmary and two from the Cowley Road and Churchill Hospitals combined. The junior medical staff were left free to choose a representative from whatever junior grade they wished. Similarly, each of the three divisions included a nursing administrator (Salmon grade 7) and a section administrator, with a secretary. The idea of these posts was that they should provide continuity in the divisional structure and administrative help to the chairman, and would mean that the central administration was kept informed of what is going on within the divisions.

The three sections—medical, nursing, and administrative—are therefore closely linked at the divisional as well as the executive level. This, together with the inclusion of junior staff in the deliberations of the medical divisions, has paid handsome dividends. For example, because the number of acute emergency cases admitted, particularly on the medical side, had reached up to 15 to 20 per day, it seemed that this was more than one "firm" could cope with under the old system, so we tried having two firms on duty at once. It proved very much more easy and diplomatic to discuss such problems within the individual divisions. The junior representatives were able to put their side of the case; a satisfactory compromise was reached and then transmitted to the junior staff by their own elected members.

At present the divisions meet about every six to eight weeks

to discuss problems which involve the whole division. For example, in the medical division we have recently debated the future of geriatrics within the group. As a result, it was agreed that the geriatricians should join in the emergency rota of the hospitals but still be responsible for their special area. A similar system already exists in this hospital; for example, the cardiologists or nephrologists are responsible, with the other physicians, for intake of general medical patients on a rotational basis.

For matters which need less general discussion but prompt action the divisional chairman is approached direct, and the matter brought to the executive committee if necessary. Sometimes a lot of preliminary work has to be done by the divisional chairmen in bringing together interested parties to discuss a particular project and get a consensus of opinion before approaching the executive committee for approval or comments.

Communication Problems

In a tight organization such as McKinsey outlined good communication at all levels is essential. We therefore began by issuing a news bulletin jointly from all the medical chairmen to the medical staff, including junior staff. Cyclostyled and sent out every three or four weeks, this gives details of all the decisions and actions of the executive committee taken during this period—for example, on what money has been spent and where and how next year's revenue allocation is to be spent. There have proved to be extremely few instances in which information has been regarded as too confidential to disseminate generally. This bulletin, which has been enthusiastically received, does, however, have the disadvantage of only detailing actions which have been taken and gives no idea of what action is proposed or under discussion. For this reason, the headings of the agenda for the future meetings of the executive committee are posted on the consultants' notice board, and anyone who has a point to make on any of these items is asked to contact his respective divisional chairman. Thus, the people concerned in any particular problem should already have been consulted before any matter of major importance is discussed in committee.

Pros and Cons of an Executive Committee

Two very great advantages of our executive committee are the speed and authority with which decisions can be taken. In some instances, difficult decisions are taken which would have been virtually impossible under the previous medical staff council structure.

During the last year two consultantships in specialties have fallen vacant in the group. Instead of simply replacing the consultant with another specialist of the same discipline, the executive committee took the opportunity of looking at the whole specialty structure of the group and of deciding whether such a specialist should be automatically replaced. Originally, there were three consultants in each of these two specialties, whereas in some there is only one. After discussion with the groups concerned about the consequences of not replacing a retiring consultant, the executive committee recommended to the board that for the time being these two vacancies should not be refilled.

Members

Inevitably the existence of the executive committee deprives the ordinary board member who does not serve on the committee of being directly involved in the running of the hospitals' affairs. In the conventional management structure, any board member with the necessary enthusiasm will find himself serving on one or more sub-committees of the hospitals' main authority and therefore be involved in some area of

hospital activity. Once all the sub-committees (except for the statutory finance committee) are abolished and all important decisions taken in the executive committee, the board member outside that "cabinet" will be able to function solely as a member of the larger body—the division—with its now restricted sphere of decision-making. The board of governors remains, of course, the statutory authority and retains the right to take—if only formally—decisions on all major matters of policy.

Fully alive to these difficulties, McKinsey made careful proposals regarding a constructive role for the board in three main areas of responsibility; firstly, to safeguard the interests of the patient; secondly, to create and maintain in the hospital a centre of excellence in which staff can care for the sick, teach, and conduct research; and, thirdly, to keep the level of expenditure from the Exchequer funds within the prescribed allocation. In addition, it was proposed that board members should be invited to volunteer, either singly or in pairs, to take a special interest in a particular sphere of the hospitals' work. In this way, two members would make it their business to keep in touch with what was happening, for example, on the nursing side, while others would be concerned with other departments, such as outpatients, etc. Though this is no novel device, it does seem—from relatively brief experience—not only to retain the ordinary member's interest but also to help the hospital staff feel that someone from the managing body and the outside world is concerned about their interests.

From the point of view of the medical members of the executive committee, the obvious snag is the demand made on their time. In theory, some relief could be given if the board of governors voted money to relieve each of the chairmen from three sessions of their work. In practice, however, it is obviously extremely difficult to get help for three sessions a week, particularly in a specialty; for this reason, no appointments of this kind have been made. So far we do not have enough experience to know how helpful divisional administrators are going to be to the medical chairmen of divisions, though in the future they should be particularly useful when each division is responsible for its own budgeting.

Financial Control

The decentralization of the financial control of the hospital was one of the main recommendations of the McKinsey report. The aim was that each division should be able to decide within limits what it wishes to spend its money on in a given year or quinquennium. Any money saved should then be reallocated to some other purpose within that particular division. Because of the considerable amount of background work required by the Treasurer's department to do this—for example, many supplies and services have had to be recoded on the computer to allow for divisional allocation of costs—the scheme has not yet been introduced. In an organization as large as this—with a budget of about £5 million per annum—the medical staff should be involved at a financial level. Thus, responsibility budgeting by means of enlightened self-interest should lead to thoughtful participation.

Finally, another advantage of employing outside consultants is that if they value their reputation they take great pains to make sure that their recommendations are implemented and once implemented continue to be acted on. Though the McKinsey study was officially finished in January 1969 their representatives continued to come to our committee meetings for many months after to make sure that our discussions were taking the right course, that the changes they had recommended were being carried out, and that the administrative structure was running smoothly once the decisions had been taken. They have done a difficult job intelligently and sympathetically. We hope this honeymoon period gives rise to a stable marriage.