

Proposal to Improve the Governance, Management and Delivery of our Digital Healthcare Functions

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Background

Our CCIO has recently stepped down and our Clinical Systems Manager has resigned and will leave the organisation in July. New arrangements are needed to deliver the engagement, system optimisation and benefits realisation issues raised in the ATOS report.

Vision

We want to become the best integrated cardiothoracic healthcare provider. This cannot occur without strong delivery from our digital infrastructure. This fact has been recognised at a macro level in the creation of health economy wide “local digital roadmaps” that will compliment delivery of regional sustainability and transformation plans. The national ambition is to achieve a fully interoperable health and care system by 2020 that is paper-free at the point of care.

We have invested upwards of £7.5m in our EPR. Whilst it has delivered well in terms of replacing clinical records, additional benefits realisation has been sub-optimal.

Change No. 1 - Form follows Function

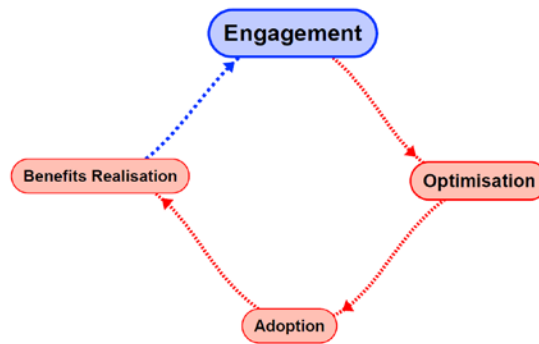
The principal problems with delivery thus far is summarised below:

1. Engagement – the organisational model we have deployed thus far has failed to deliver the levels of engagement we need to realise on-going benefits from our digital systems
2. Optimisation – the Trust does not have a clear plan for developing the EPR and other digital systems to support staff to become increasingly safe, effective or efficient
3. Adoption – a long history of not getting what staff need from EPR optimisation (principally) and other digital systems has led to entrenched levels of poor adoption
4. Benefits Realisation – this has rarely been formally captured but is felt to be extremely limited.

We therefore need to introduce a structure that:

- Is constantly seeking opportunities to enhance the capability of our digital estate (Engagement)
- Has the will and capacity to develop plans (appropriately prioritised) for how the EPR and other digital systems need to evolve to deliver benefit through better processes and outcomes of care (Optimisation)
- Encourages staff to use existing and new functionality from our digital systems (Adoption)
- Formally tracks the planned benefits to ensure they are delivered (Benefits Realisation)

This focus on these four key priorities should become self-fulfilling as the new structures begin to deliver.



Change No. 2 – Immediate Changes to the Management Structure

Non-Clinical

At the Executive meeting in December we proposed a number of changes. Now that the CCIO is no longer in place, it is suggested that these are now implemented at pace. They are:

A single executive becomes the accountable officer for the three principal functions; Clinical Systems, IT and Informatics (Business Intelligence). He/She becomes the Chief Information Officer.

The IT and Clinical Systems teams are merged under the leadership of the current Head of IT. He assumes responsibility to the entire digital estate. This is seen as a developmental opportunity and performance will be periodically evaluated.

The Head of IT job title is changed to Head of Digital Systems. The term “Clinical Systems” is too narrow – other IT systems contribute to making the hospital work. The scope of the job remains primarily systems, so this term is retained. The digital part of the job title better reflects the new national nomenclature around digital maturity and digital roadmaps.

The Clinical Systems Manager job title is changed to the EPR Systems Manager as this better reflects the breadth of duties. A like for like replacement is made urgently to reduce the risk of staff leaving to join alternative Allscript installations in the North West. Our EPR is a clinical system, and strong leadership is required to translate the senior clinical direction that comes from this management model into system changes. This person would need to evidence a strong track record of delivery. Day to day working relationships will be principally with the Associate CCIO’s and CNIO’s / Heads of Nursing. The relationship with the Head of Digital Systems will be primarily managerial.

The informatics restructure is allowed to complete uninterrupted.

These two functions would operate semi-independently, but the lead executive would begin to pave the way for a merger of these two functions over the following 12 months.

The organisation begins recruitment of a new post, the Head of Digital Healthcare who would likely be a non-clinician with significant track record of:

1. Bringing teams together to function effectively as a single unit
2. Robust planning and the delivery to time
3. Developing excellent working relationships with senior clinicians
4. Understanding of opportunities to enhance healthcare delivery from working digitally
5. The delivery of measured and significant benefit (both clinical and financial) from digital systems

This process will take a minimum of six months. Present incumbents in our IT and Informatics structures will be eligible to apply.

Principal Benefits - Added internal resilience and proper planning.

Clinical

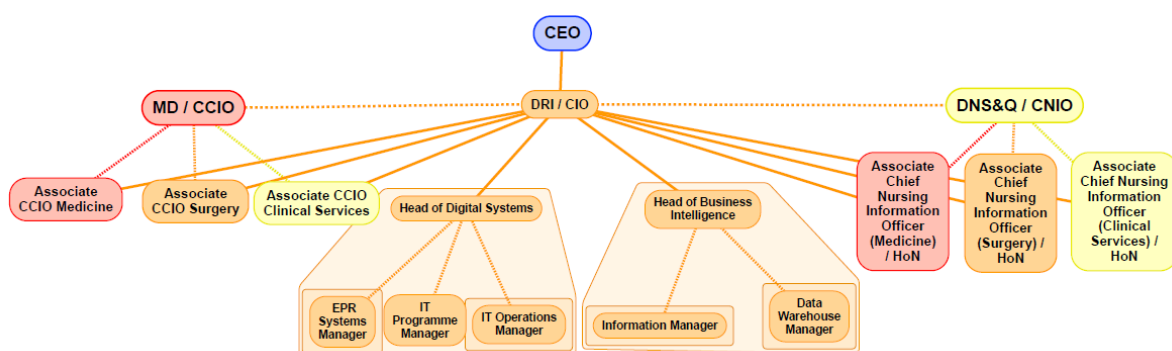
The Medical Director assumes the role of CCIO.

All CCIO duties are designated to three new Associate CCIOs', one per Division (not the AMD's).

The Associate CCIO's become accountable to the CIO for the delivery of the engagement, optimisation, adoption and benefits realisation objectives. They remain professionally accountable to the MD.

The Nursing Director assumes the role of the Chief Nursing Information Officer (and represents AHP's as well).

All CNIO duties are designated to the existing three Heads of Nursing. The Heads of Nursing assume Associate Chief Nursing Information Officer responsibilities and become accountable to the CIO for the delivery of the engagement, optimisation, adoption and benefits realisation objectives. They remain professionally accountable to the DNS.

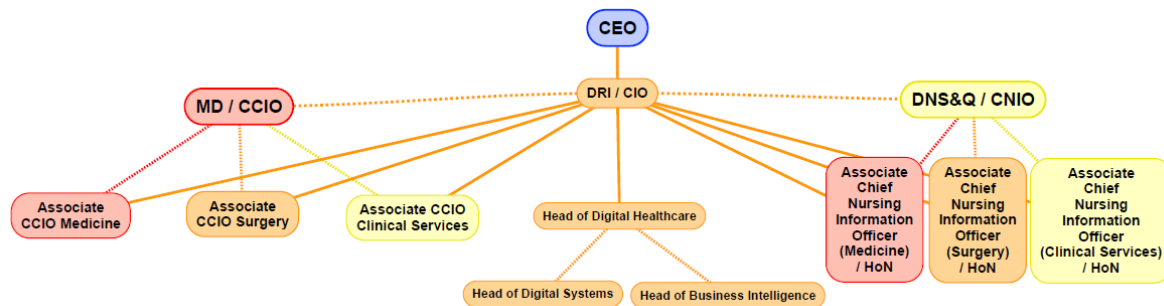


Principal Benefits – accountability, and the distribution of leadership within the Divisions.

Change No. 3 – Medium Term Changes to the Management Structure

The Head of Digital Healthcare is appointed. The job title has been chosen for some of the reasons above together with the widening scope which now includes information reporting, coding, scanning, data quality etc. This appointment would be subject to panel, but likely 8c / 8d. The

organisation could then consider whether the Head of Digital Systems and Head of Business Intelligence posts continue to be required.



Principal Benefit – single line of accountability for all IM&T related function (ATOS recommendation)

Change No. 4 – Governance

The exiting route for IM&T reporting is through the Risk Management Committee. If we are serious about realising our ambitions for digital healthcare, then the profile of its activity needs to be raised, reporting directly into the Operational Board.

There has been a serial problem with attendance to the two strands of IM&T governance presently in existence. It is suggested these two groups are disbanded, and a new single overall governance group is created – the Digital Healthcare Committee - to deal with a new agenda. The new agenda would include:

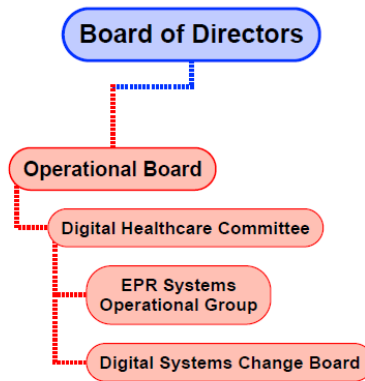
- Monitoring of engagement, optimisation, adoption and benefits realisation (described in the digital healthcare strategy)
- Delivery of our part of the local digital roadmap (iLINKS programme, CQUINS etc.)
- Governing the selection of new digital systems to ensure interoperability
- Good governance of enabling functions such as record keeping, information governance, data quality etc.

This group would meet every other month.

Attendees: CCIO and associates (one as chair), CNIO and associates (one as deputy chair), CIO, Head of Digital Healthcare, Head of Digital Systems, Head of Business Intelligence

The existing Clinical Systems Operational Group is renamed as the EPR Systems Operational Group to better describe its scope of responsibilities which are specific to EPR and associated systems.

The existing Clinical Systems Change Board is renamed as the Digital Systems Change Board to better describe its scope of responsibilities which encompass a wider scope of IT systems.



The CIO hosts a monthly 1:1 meeting with each of:

The MD / CCIO and Associate CCIO's

The DNS / CNIO and Associate CNIO's / Heads of Nursing

The purpose of these meetings would be to ensure that plans are developing and being delivered to the satisfaction of all.

Principal Benefits of Changes

1. A single governance group so people only have to worry about attending one digitally related meeting every other month.
2. A significantly beefed up clinical representation on the main governance group.
3. The Divisions being seen to lead the initiative (chair and deputy chairmanship)
4. Agenda includes external (local health economy) perspective