

# STRATEGIC CONSULTANCY ASSIGNMENT

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WHAT STRATEGY SHOULD ROYAL UNITED HOSPITAL ADOPT TO ENSURE THAT THE MAXIMUM TIME PATIENTS WAIT FOR AN OPERATION IS 3 MONTHS BY 2008?

**ROYAL UNITED HOSPITAL**

**BATH**

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## ABSTRACT

In July 2000, the Government set out its vision for the reform of the National Health Service (NHS) in a document entitled ***The NHS Plan***. To ensure the best utility for the additional investment and funding, national objectives for patient care were introduced. One of the **key targets** was that the **maximum wait** for a **hospital operation** should reduce from 18 months in 2001, to **3 months by 2008**.

In the NHS Performance Ratings published in July 2002, the Royal United Hospital (RUH) in Bath was found to have the **worst track record** for patient waiting times in the UK. This was a major contributing factor to the RUH acquiring the status of a **‘zero star hospital’**.

## STRATEGIC QUESTION

**What strategy should RUH adopt to ensure that the maximum time patients wait for an operation is 3 months by 2008 ?**

### WHY ?

To meet the Government target for waiting times and to enhance its overall status.

### WHAT ?

An improvement in the speed of access for surgical care to patients.

### WHEN ?

By 2008.

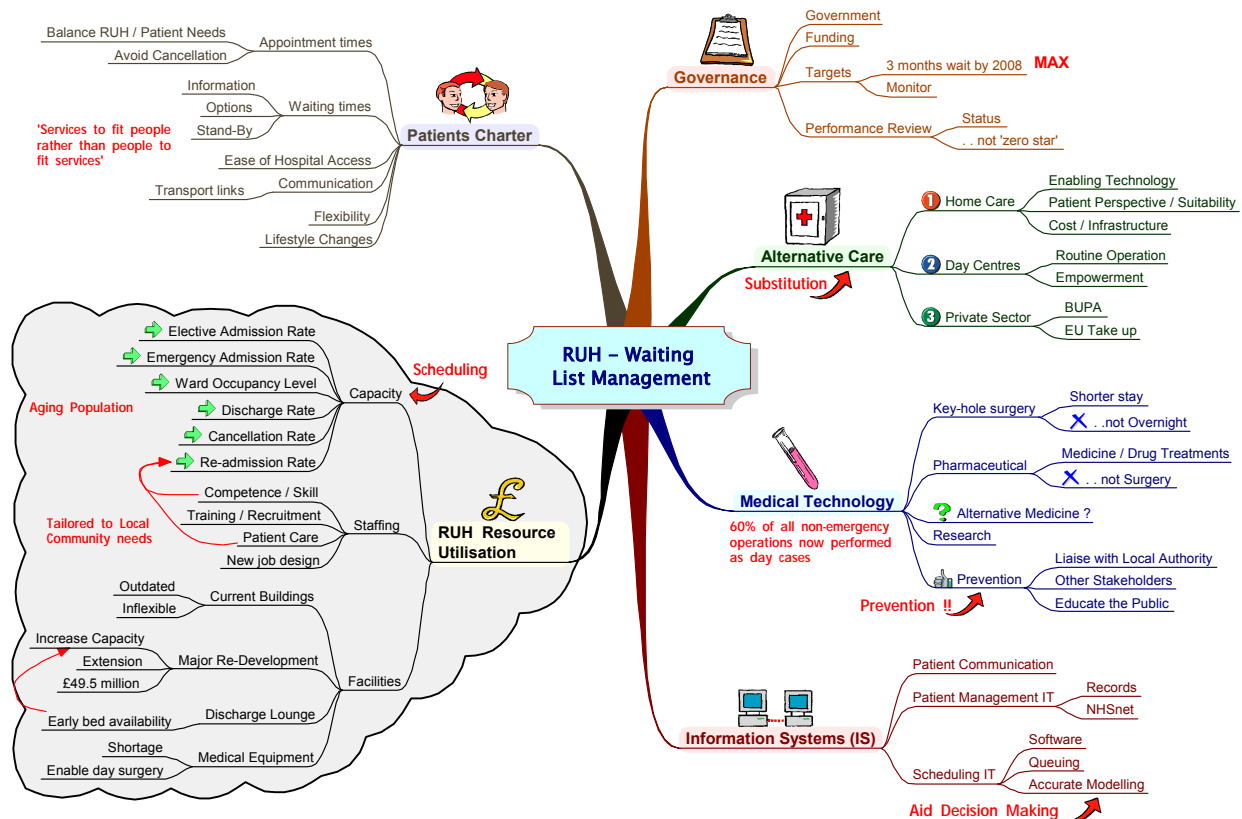
### HOW ?

By producing an action plan based on a strategic analysis of the options available to the RUH.

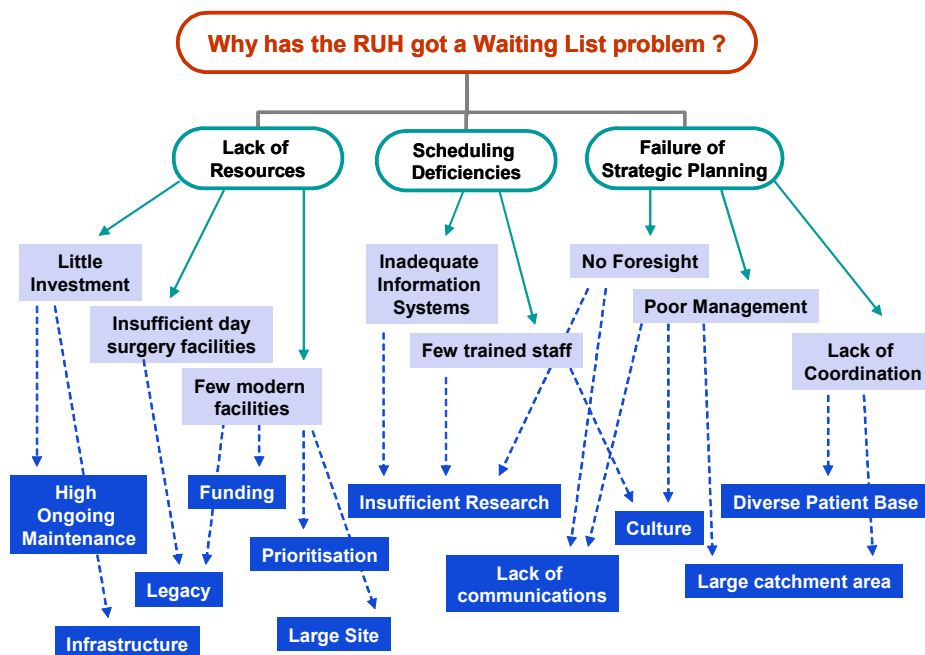
**FOR :** The Board of Directors, RUH NHS Trust.

## CONTEXT

To identify the factors of influence relating to waiting list management within the RUH, a MindMap has been used to capture and highlight the key problems (*overleaf*). It is an appropriate tool to unravel complexity at this level, since it is important to tease out the basic ideas and character of the problem, rather than getting too embroiled in the detailed interconnections and relationships.



While the MindMap is good at drawing out high level holistic issues, it would be useful to delve deeper and unearth the real reasons for RUH's waiting list problem. By using a **Why Diagram**, it is possible to investigate the root causes of the question:



## FUTURE SCENARIO

At this stage it is worth forecasting the drivers for change that are expected to impact on the environment in which the RUH will operate in 2008. The intention is not to generate robust end-state scenarios, but to produce a short 'story' or description of the transformations in key sectors over the next 5 years. Whilst recognising that this approach is simplistic and rather imprecise, is nevertheless a reasonable stance given :

- ✦ the time horizon of the strategic question,
- ✦ the likelihood that Health will remain a Government priority, and
- ✦ the rigorous and lengthy testing procedure for new medical techniques / drugs.

### Resources

The NHS capital budget is expected to increase and be supplemented by private capital through PFI schemes. The RUH has already secured future funding to the tune of £49.5M for re-development and modernisation. This should add extra capacity and hence reduce patient waiting times.

### Technology

Innovation, in both information and medical technology, is likely to produce changes in health care. Keyhole surgery will continue to ease time in hospital and newer drugs will reduce the need for some operations altogether. IS will improve patient scheduling and enhance access to patient records.

### Political

Patient waiting times retain their prominent status as a key Government target. The Government will expect to see a tangible return on their investment. RUH management staff will use IS systems to monitor and report metrics. The pressure for further improvements will continue.

### Demographics

As the percentage of older people in the RUH catchment area continues to increase, this will result in a greater demand on resources. Also, the increasing life expectancy will place a greater demand on bed capacity.

### Private Sector

More affluent patients will chose private health care which will free up waiting times within the RUH. However, this could affect staff retention and recruitment as nurses and doctors are seduced into the private sector.

### Patient Expectations

The consumer culture will continue and patients will have greater access to information. This will increase their expectations about how care is delivered and its quality; the Patients Charter will reflect this.

## STRATEGIC OPTIONS

Against this backdrop, the next phase is to structure a more detailed analysis of the internal and external environmental factors in order to develop recommendations that the Board of Directors can consider. A TOWS matrix will be used as the mechanism to assess and exploit the interactions between the internal strengths and weaknesses of the RUH, and the wider opportunities and threats in the Health service. Then, the more credible and practical proposals can be grown into an actionable plan.

<p>What strategy should RUH adopt to ensure that the maximum time patients wait for an operation is 3 months by 2008 ?</p> 	<p><b>THREATS</b></p> <p>T1 – Competition for Staff T2 – Erosion of Public Confidence T3 – Growth in Ageing Population T4 – Litigation T5 – Private Health Care T6 – Funding Constraints T7 – Patient Expectations</p>	<p><b>OPPORTUNITIES</b></p> <p>O1 – Government Incentives O2 – Innovative Treatments O3 – New Technology (IS) O4 – Centralised NHSnet O5 – Greater Public Awareness</p>
<p><b>WEAKNESSES</b></p> <p>W1 – Current ‘zero-star’ Status W2 – Legacy / Dated Equipment W3 – Infrastructure W4 – Staff Recruitment / Retention W5 – Management Skills W6 – Establishment Size W7 – Large Catchment Area</p>	<ol style="list-style-type: none"> <li>1. Develop Information Systems to manage Scheduling and Patient Data (W2,W5,W7,T2,O1, O3,O4)</li> <li>2. Utilise New Buildings Programme to Expand Patient Capacity (S1,W3,T3,T7,O1)</li> <li>3. Invest in Infrastructure to Provide Modern Facilities and Minimise Long Term Maintenance Costs (S1, W1,W2,W3,W6,O3,T5,T6)</li> <li>4. Update Equipment and Utilise the Developments in Medical Technology to Reduce Patient Time in RUH (O2,O3, W1,T4,T7)</li> <li>5. Work in Partnership with Patients and Local Authorities to Achieve Joint Objectives and Enhance Local Decision Making (T2,T7,O5,W5,W7,S2,S3)</li> <li>6. Improve Information Flow and Communication Channels with Patients and Communities (T2,T3,T7,O3,O4,S2,W7)</li> <li>7. Expand Training &amp; Development for Staff to Improve the Quality of Treatment (O1,T1,T4,W4,S4)</li> <li>8. Increase Public Education and Target the Root Causes of Medical Treatment (T3,O3,W7)</li> <li>9. Regard Patients Needs when Scheduling Operations to Reduce Cancellations (T3,T7,O4,W7,S2)</li> <li>10. Motivate Staff by Providing an Attractive and Challenging Working Environment (T1,W4,S1,S4)</li> <li>11. Consider Recruiting from Abroad to meet any Staff Shortfalls (T1,O1,W4)</li> </ol>	
<p><b>STRENGTHS</b></p> <p>S1 – New Modern Building S2 – Local Perspective / Knowledge S3 – Active ‘League of Friends’ S4 – Committed Staff</p>		

TOWS Deductions	Themes
<ol style="list-style-type: none"> <li>1. Develop Information Systems to manage Scheduling and Patient Data</li> <li>9. Regard Patients Needs when Scheduling Operations to Reduce Cancellations</li> </ol>	<p>Upgrade and develop Information Systems to enhance Waiting List Management and support Clinical Processes</p>
<ol style="list-style-type: none"> <li>2. Utilise New Buildings Programme to Expand Patient Capacity</li> <li>3. Invest in Infrastructure to Provide Modern Facilities and Minimise Long Term Maintenance Costs</li> </ol>	<p>Deliver an Infrastructure Modernisation Programme to Improve the Facilities and Augment Capacity</p>
<ol style="list-style-type: none"> <li>4. Update Equipment and Utilise the Developments in Medical Technology to Reduce Patient Time in RUH</li> </ol>	<p>Invest in Leading Edge Clinical Services and Grow the R&amp;D Capability</p>
<ol style="list-style-type: none"> <li>5. Work in Partnership with Patients and Local Authorities to Achieve Joint Objectives and Enhance Local Decision Making</li> <li>8. Increase Public Education and Target the Root Causes of Medical Treatment</li> </ol>	<p>Improve and enhance Relationships with key Internal and External Stakeholders</p>
<ol style="list-style-type: none"> <li>6. Improve Information Flow and Communication Channels with Patients and Communities</li> <li>8. Increase Public Education and Target the Root Causes of Medical Treatment</li> </ol>	<p>Introduce a Communications Plan which Facilitates the Effective 2-Way Flow of Information</p>
<ol style="list-style-type: none"> <li>7. Expand Training &amp; Development for Staff to Improve the Quality of Treatment</li> <li>10. Motivate Staff by Providing an Attractive and Challenging Working Environment</li> </ol>	<p>Provide Development Opportunities and a Stimulating Working Environment for All Staff</p>

## VIABILITY MATRIX

From the TOWS analysis, 11 deductions were drawn and these have been grouped into a number of strategy areas or 'themes'. It is important to explore the viability of the RUH in implementing these strategies and to do so, a Viable Hospital Matrix (VHM) has been developed:

Information Systems	Modern Facilities	Medical Technology	Relationships	Communications	Human Resources
S	M	E	R	C	H
<b>S1</b> Integrated & aligned with clinical processes	<b>M1</b> Prestigious & optimal utilisation	<b>E1</b> Cutting edge equipment. Advanced R&D.	<b>R1</b> Active involvement from all parties.	<b>C1</b> Professional information network established and utilised.	<b>H1</b> Highly motivated & stimulated
<b>S2</b> Efficient but not exploited fully	<b>M2</b> Modern & reliable with some spare capacity	<b>E2</b> Current technology with an active research facility.	<b>R2</b> Effective participation. Greater need to educate public.	<b>C2</b> Broadly successful but large catchment area still problematic.	<b>H2</b> Fully involved. Easy to recruit
<b>S3</b> Adequate use technology but not networked.	<b>M3</b> Satisfactory with functional utility. At capacity.	<b>E3</b> Mixed level of equipment; mostly up-to-date. Reactive research policy.	<b>R3</b> Enthusiastic. Can be overwhelmed by scope and scale of issues.	<b>C3</b> Targeted information policy with some deficiencies.	<b>H3</b> Contented & informed
<b>S4</b> Reliance on stand-alone and dated technology.	<b>M4</b> Out of date and straining to meet load.	<b>E4</b> Mixed level of equipment; mostly out-of-date.	<b>R4</b> Limited interaction.	<b>C4</b> Ad-hoc and unconvincing.	<b>H4</b> Functional. Retention a problem.
<b>S5</b> Few Systems. Not integrated. Reliance on legacy.	<b>M5</b> Crumbling Infrastructure. Overborne.	<b>E5</b> Outmoded clinical equipment. Little research.	<b>R5</b> Autonomous & isolated.	<b>C5</b> No coherent communications plan. Reactive.	<b>H5</b> Disgruntled & apathetic.

From this viability matrix, the transition in configuration can be seen :



This analysis indicates that although 'excellence' in all configurations is not a prerequisite for success, the areas of greatest improvement need to be made in:

- ⊕ updating existing Information Systems,
- ⊕ focussing on improving the Hospital infrastructure and Facilities, and
- ⊕ enhancing the working environment.

## RESOURCE EVALUATION

A Congruence Analysis was conducted to ascertain the likely perceptions of different stakeholders, including Hospital Management, Staff, the Local Community, Patients and the Government. The attractiveness of the proposals arising from the VHM by the stakeholders was universally positive; this was not an unexpected result. The greatest threat to a successful implementation is likely to be the availability of suitable and sustainable resources. In order to identify the areas requiring greatest backing, a Resource Analysis was carried out:

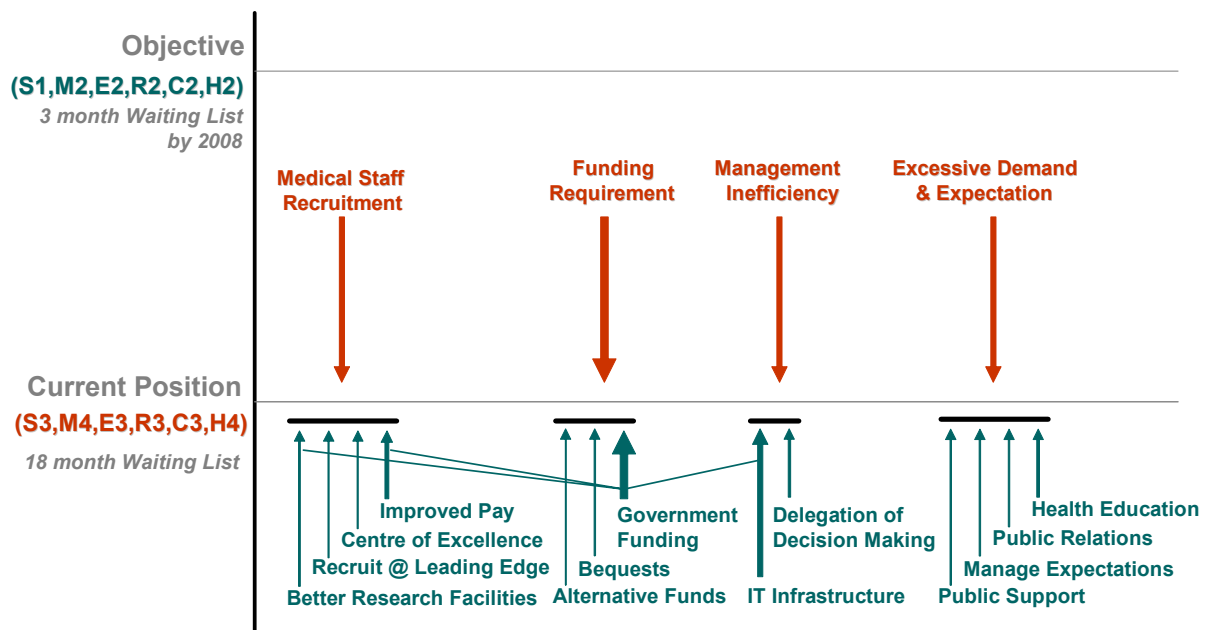
SubCategory	From:	To:	Resource Gaps
<b>S : Information Systems</b>	<b>S3</b> Adequate use of technology but not networked.	<b>S1</b> Integrated & aligned with clinical processes	
Upgrade IT Infrastructure	2	4	2
Enhance Indigenous Decision Making	2	3	1
User Training	2	4	2
<b>M : Modern Facilities</b>	<b>M4</b> Out of date and straining to meet load.	<b>M2</b> Modern & reliable with some spare capacity	
Develop Project Mgt Capability	1	3	2
Building Modernisation Programme	1	4	3
Local Council / Government Support	2	3	1
<b>E : Medical Technology</b>	<b>E3</b> Mixed level of equipment; mostly up-to-date. Reactive research policy.	<b>E2</b> Current technology with an active research facility.	
Recruitment of High Calibre Staff	2	4	2
Provision of Medical Facilities	2	4	2
Enhance National Image	1	3	2
<b>R : Relationships</b>	<b>R3</b> Enthusiastic. Can be overwhelmed by scope and scale of issues.	<b>R2</b> Effective participation. Greater need to educate public.	
Conduct Relationship Audit	2	3	1
Establish Knowledge Mgt System	2	3	1
Increase Local Health Education	1	3	2
<b>C : Communications</b>	<b>C3</b> Targeted information policy with some deficiencies.	<b>C2</b> Broadly successful but large catchment area still problematic.	
Develop PR / Comms Strategy	2	4	2
Utilise Local Government Channels	2	4	2
Identify Key Opinion Formers	1	4	3
<b>H : Human Resources</b>	<b>H4</b> Functional. Retention a problem.	<b>H2</b> Fully involved. Easy to recruit	
Enhance Salaries / Package	2	3	1
Improve Research Facilities	2	4	2
Improve Working Conditions	2	4	2
Improve Personnel Management	2	3	1

*note : the highlighted rows indicated prominent expenditure*



## OBSTACLES

The Resource Analysis identified several actions that would require considerable funding to enable a successful implementation programme. However, this may not be the only obstacle to achieving the objective of a maximum 3 month wait for an operation by 2008. To flush out any other factors, a Force Field Analysis (FFA) was carried out:



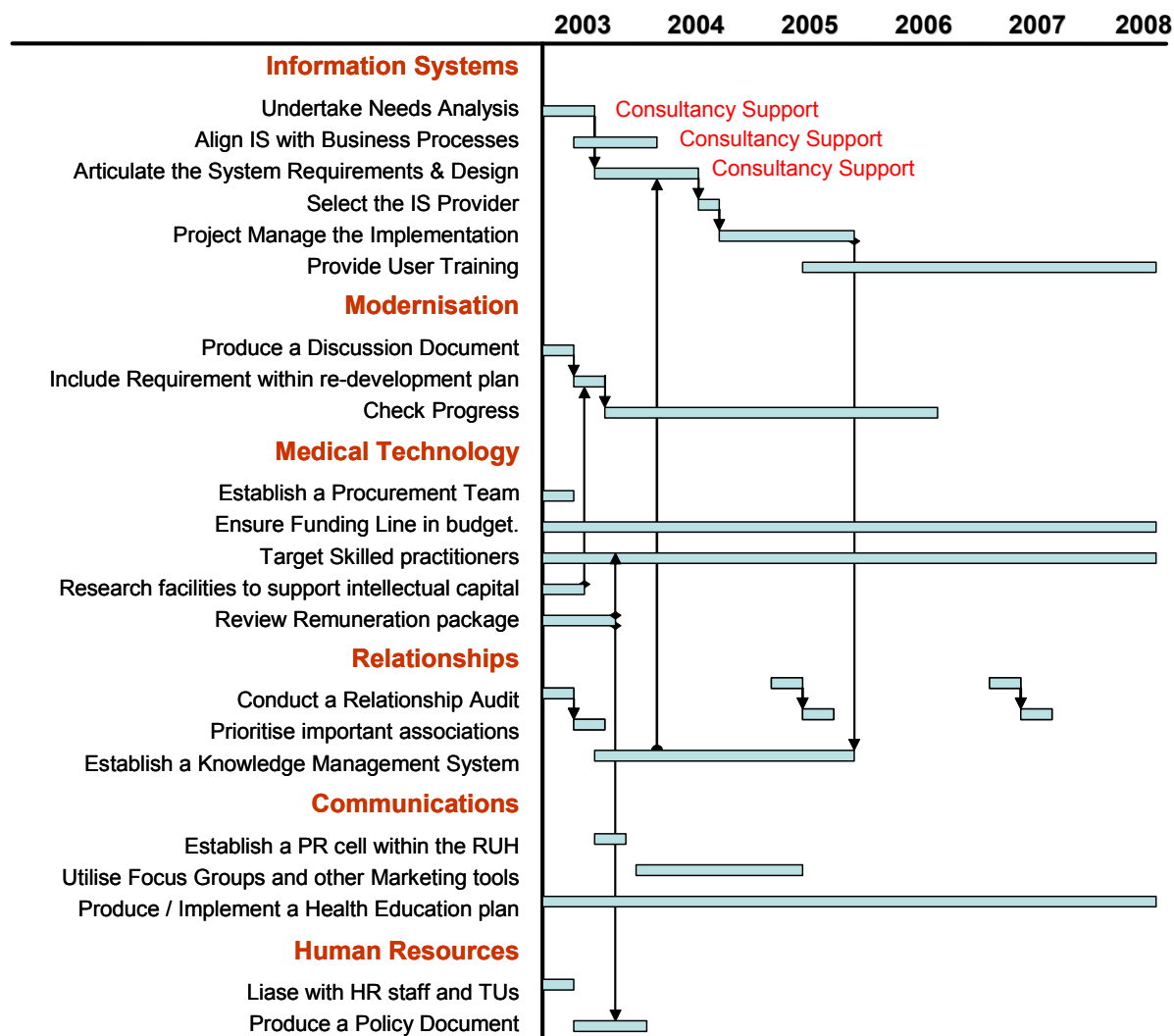
The dominant restraining force is the Funding Requirement, as expected. Perhaps more importantly, the FFA shows us that securing adequate Government funding is crucial to overcome this constraint. In addition, since this action supports several others, a loss or reduction of Government funding will jeopardise the whole implementation programme.

Coupled with the funding issue, the FFA has highlighted the significance of the IT / IS infrastructure in playing a key role to buttress and offset Management Inefficiency. Also, the issue of Medical Staff Recruitment needs to be addressed on several fronts.



## ACTION PLAN

The Action Plan draws on the output from the TOWS, Resource Analysis and FFA. An overall high-level plan for the RUH Board of Directors is shown below :



## RECOMMENDATIONS

- ✚ Develop and strengthen the use of Information Systems to support Clinical Processes and enhance Waiting List Management.
- ✚ Ensure Systems Integration both internally and with other Health Service providers in the community.
- ✚ Incorporate a suitable Surgical Facility within the planned buildings modernisation programme to increase capacity for the conduct of Operations.

- ✚ Monitor developments in the Medical field to prioritise the procurement of new technology that can reduce the time a patient spends in the RUH.
- ✚ Recruit and retain leading edge practitioners in the specific area relating to elective care and make sure these resources are aligned with local needs.
- ✚ Forge Meaningful and Effective Relationships with Internal and External Stakeholders to coordinate the demand on the hospital system.
- ✚ Develop and implement a robust Public Relations Strategy to rally the image of the RUH within the wider NHS and locally.
- ✚ Improve the range and scope of Health Education within the community by exploiting existing Local Government and other communication channels.

## CONCLUSION

Although Government Funding to the tune of £49.5M has already been secured, further funding will be required if the objective of reduced waiting times is to be achieved. While some undertakings within the Action Plan can be compromised without adversely affecting the overall outcome, the risk of failure will be significantly increased if:

- ✚ the Information System is not upgraded,
- ✚ the Surgical Facility is omitted from the modernisation programme, and
- ✚ steps are not taken to motivate, recruit and retain key staff.

**The Action Plan is feasible but resolving funding issues is seen as a critical success factor.**

### Reference:

RG Coyle "Practical Strategy: Structured Tools and Techniques", forthcoming Pearson Education, 2003.

## BRIEF ON THE NATURE, PURPOSE AND POTENTIAL USE OF VIABLE FIRM MATRICES (VFM).

**Purpose:** A Viable Firm Matrix is a technique that can be used to help **visualise** the way a firm needs to **evolve** if it is to meet its **strategic goals**. But it is far more than a simple roadmap. The technique allows an organisation to conduct an **objective examination** of its **characteristics and design** against a proposed **strategy**.

**Nature:** The VFM is constructed around key **attributes** or themes that are fundamental to the prosecution of the strategy and associated action plan:

Information Systems	Modern Facilities	Medical Technology	Relationships	Communications	Human Resources
S	M	E	R	C	H
S1 Integrated & aligned with clinical processes	M1 Prestigious & optimal utilisation	E1 Cutting edge equipment. Advanced R&D.	R1 Active involvement from all parties.	C1 Professional information network established and utilised.	H1 Highly motivated & stimulated
S2 Efficient but not exploited fully	M2 Modern & reliable with some spare capacity	E2 Current technology with an active research facility.	R2 Effective participation. Greater need to educate public.	C2 Broadly successful but large catchment area still problematic.	H2 Fully involved. Easy to recruit
S3 Adequate use technology but not networked.	M3 Satisfactory with functional utility. At capacity.	E3 Mixed level of equipment; mostly up-to-date. Reactive research policy.	R3 Enthusiastic. Can be overwhelmed by scope and scale of issues.	C3 Targeted information policy with some deficiencies.	H3 Contented & informed
S4 Reliance on stand-alone and dated technology.	M4 Out of date and straining to meet load.	E4 Mixed level of equipment; mostly out-of-date.	R4 Limited interaction.	C4 Ad-hoc and unconvincing.	H4 Functional. Retention a problem.
S5 Few Systems. Not integrated. Reliance on legacy.	M5 Crumbling Infrastructure. Overborne.	E5 Outmoded clinical equipment. Little research.	R5 Autonomous & isolated.	C5 No coherent communications plan. Reactive.	H5 Disgruntled & apathetic.

Selection of the attributes is critical to the process & requires perception and creativity  
( No more than seven to preserve an overview of the organisation )

To illuminate the attributes, a discrete yet distinct acronym is formed from a letter within each heading.

Each attribute is expanded into a range of practical possibilities

( Although the resultant matrix describes every possible permutation of the firm, not all the patterns will be viable )

The attributes necessary to **enact** the strategy, along with an assessment of the firm's current status, are **highlighted** in the matrix. A **gap analysis** can then be carried out to examine **alignment** and associations so that:

- the extent of modifications,
- the level of resources necessary to execute the changes, and
- the feasibility of the firm to implement the strategy . . . . can all be determined.

**Potential Use:** So far, this brief has concentrated on the viability of a 'firm' in the conduct of a full strategic analysis (eg ACTIFELD). However, this technique can be applied to a range of organisations or issues ie VHM (hospital) or VPM (policy). Additionally, the methodology can be deployed :

- to evaluate and down-select possible suppliers and contractors, or
- as a 'quick look' tool to explore strategic options.

Not only can the VFM form a baseline for **action**, but it can act as a source for **communicating** the strategy; even the generation of the VFM can be a powerful tool for debate since it focuses attention on the key issues and exposes any difference in opinion or perception between the **stakeholders**. However, successful application depends on **involvement**, **creativity** and **honest appraisal** from all participants.

## **LIMITATIONS AND BENEFITS OF THE TECHNIQUES FOR STRATEGIC CONSULTANCY IN THE ANALYSIS OF THE REAL WORLD.**

The real world is complex. By its very nature, a strategic question or issue must be forward looking and it is not easy to predict the future horizon with any degree of certainty. Change is a natural bi-product of strategic decisions and brings with it additional complications which can exaggerate ambiguity. Human involvement in the decision making process can result not only in irrationality through foibles, culture and politics, but different stakeholders will have different needs and perspectives which must be managed. Above all, strategic development is a dynamic process which necessitates a proactive approach, rather than the linear, reactive response so typical in most operational and tactical situations.

However, complexity can be reduced through the use of appropriate assumption and modelling techniques, but the trick is to find a balance between simplicity and the level of detail necessary to validate an outcome. This is unavoidably a matter of subjectivity, but perhaps the main advantage of applying the techniques for Strategic Consultancy is that they provide a practical framework and methodology that also enables a degree of objectivity; this robust audit trail is important since the results of a strategic analysis are often subtle and intuitive. But the tools are not prescriptive nor do they need to be applied in all situations. Rather, their selection should be tailored so that their utility enhances the understanding or scrutiny of a specific problem.

Also, a key benefit of the technique is the process itself. There is perhaps, an innate tendency for strategic decisions to take place in the higher echelons of an organisation. While the process undoubtedly requires senior management commitment, it also requires representative input from all levels to capture the requisite knowledge and experience. This broader involvement is essential to gaining 'buy-in' and ownership through a wider understanding of the strategic process. This leads to an additional benefit, namely the ability of the techniques to surface tensions, expose misconceptions and draw politics away from the real issues.

Even this open approach may not negate the inherent problem of rationality. The selection of participants is crucial if the techniques are not to be limited by internal bias or functional preconceptions. The pool of participants may need to be drawn from outside the company to combat this limitation. However, with the right members, the process can act as a forum that allows rational, informed debate to take place, thus creating an agenda for discussion at a strategic level.

While the techniques are sensible and encourage flexibility, there is the danger, even temptation, that they could be applied religiously as a 'check list'; a belief that if we do everything by rote, then we will end up with the right answer. Whilst this tack was certainly not advocated on the course, it must be remembered that time is a valuable commodity for today's manager. They can be overwhelmed by tactical problems and can focus on operational issues at the expense of taking a gestalt view. In fact, some may even argue that the high 'clock-speed' of their industry would consign any action plan as instantly out-of-date since any conclusions derived from such a method would be obsolete.

There is no doubt that any successful application of these techniques depends on allocating time and resources. But if their premise is that taking a 'snap-shot' in time to understand a strategic problem is of limited value, then they are right. In fact, dealing with dynamics and shocks remains a major limitation of many existing approaches.

However, the benefit of adopting these techniques is that the prosecution of a strategic issue will always be somewhere on a perpetual loop. The nature of the industry may well dictate the scope and frequency of that loop, but regardless of the environment, the central tenet is that the methodology is not linear. Rather, the techniques are iterative since there is no other feasible way to react and respond to changes that will occur naturally.

Indeed, we should be very wary of someone, when tasked with prosecuting a strategic question, utters the words: ***"Phew, it's finished !!"***