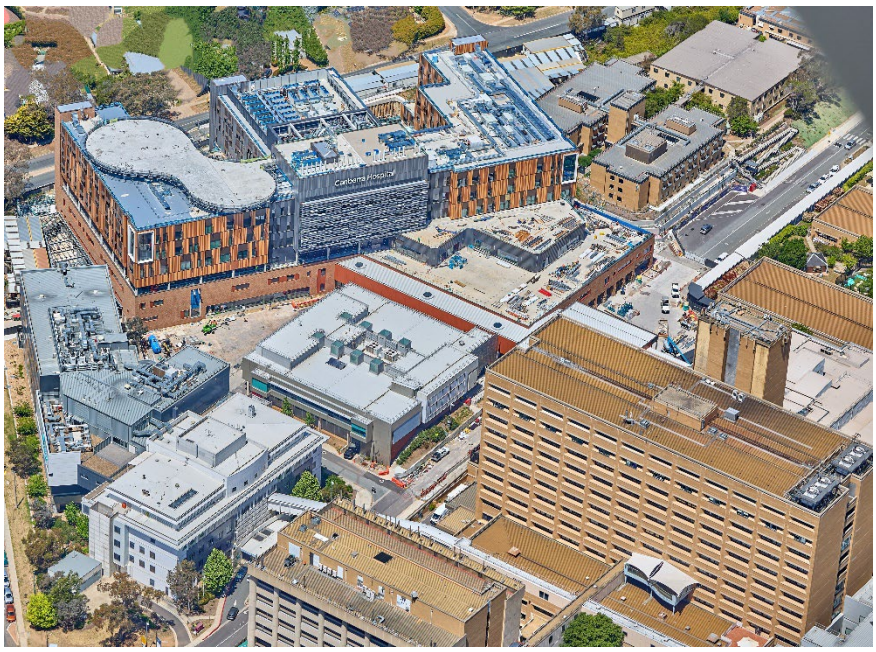
Canberra Health Services

ACT Government

Canberra Health Services Consultation Paper

Canberra Hospital Service Management Realignment

May 2024



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1. Introduction

Canberra Health Services (CHS) is focussed on the delivery of high quality, effective, person centred care.

In February 2024 CHS outlined its intent to refocus organisational will on accountability and service delivery in a proposal to establish a General Manager role dedicated to management of Canberra Hospital.

This proposal builds on that direction with respect to the organisation of medical and associated administrative functions at Canberra Hospital. It should be considered in the context of planning the future governance for ward-based nursing staff.

Prior to July 2023 CHS centred on one single large tertiary hospital, even though it has extensive investments in community-based services, run through a series of divisions centred on traditional medical identities (surgery, medicine and so forth).

This underlying structural arrangement coupled with a career reward value-proposition related to becoming an executive, has resulted in a proliferation in executive positions and a relative devaluing of roles directed at integrated service delivery.

In signalling a reversal of these priorities, from divisions and executives to integrated operations and service provision, CHS is now committed to implementing structures, functions and rewards that support a clear accountability for:

- Clinical performance
- System performance

1.1 Clinical performance

Clinical performance covers the two aspects of a clinician role:

- Role 1: The performance of a clinical task (a consult, a procedure, an act of caring).
- Role 2: The direction of elements of care delivered by others (admit, discharge, investigations, consults and referrals).

In healthcare the latter is almost entirely an attribute invested in doctor roles (although increasingly evident in advanced practice roles in nursing and allied health).

In considering clinical performance both things matter and can be measured. The second of these, the direction of elements of care have a direct effect on how the system is configured and works which is strongly linked to system design and performance.

1.2 System performance

As healthcare has become larger and more complex even relatively straightforward care has come to rely on the coordination of a number of interrelated departments and things. When people talk about the health system, whether they appreciate this or not, they are talking about how all these interrelated things work together for someone.

System management is a thing. It is not something that people who trained as clinicians can do as a result of their clinical training (medical, nursing, allied health or any kind). It is a thing that requires people to train in and to become expert in.

1.3 Quality of care

In simple terms quality of care is an outcome of both clinical performance and system performance. If both are done well then quality of care will be good.

1.4 Designing a healthcare organisation to deliver clinical and system performance

In designing a healthcare organisation to deliver high quality, even exceptional care, both clinical performance and system performance must be understood and allocated to parts of the organisation able to be accountable for their parts.

Handing control of the system to clinical staff results in, paradoxically, frustrated clinical staff as each clinician tries to create locally optimised solutions to what becomes a poorly functioning system.

Handing clinical control to managers not expert in that clinical pursuit, well that's a bad idea nobody needs to explain further. Allowing each to do their own thing isn't a great idea either and gives rise to the need to invent clinical engagement strategies.

2. Purpose

This proposal outlines the intended management and leadership arrangements for managing clinical performance delivered through medical staff, and system performance delivered through operational management, and a mechanism for purposeful design of the interface between these.

This paper specifically provides the opportunity for consultation and feedback on:

1. The principles outlined in this proposal.
2. Rationalisation of senior divisional management roles and revised leadership structure.
3. Implementation of a Co-Directors Agreement.

Disclaimer: This proposal identifies or infers a number of possible changes to other management structures and roles, however this proposal does not include consultation on these matters. Where a change is envisaged outside of medical and system management, this will be consulted upon in alternate form.

This consultation process specifically does not cover North Canberra Hospital, Nursing Midwifery and Patient Support Services, Medical Imaging, Pathology, Healthcare Technology Management, Pharmacy, traditional nursing and allied health professional roles including Executive Director Allied Health, Executive Director Medical Services (EDMS), Executive Director Nursing and Midwifery and Patient Support Services.

3. Current Model

The current model of management hierarchy for Canberra Hospital has had a well-recognised traditional form (Figure 1).

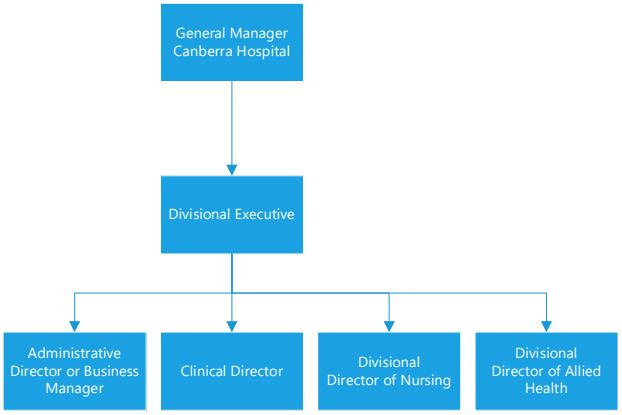


Figure 1: Current Model of Management Hierarchy

In this arrangement each body of professionals has their own reporting line.

In this arrangement, at every level, representatives from different line managers have to cooperate to get something done and the only person with a span of control that approximates the system is the General Manager. In this arrangement:

- Divisional identity is based on medical personality (e.g. Division of Surgery, Division of Medicine).
- System management is not evident.

When fully represented, the organisation functions as a hierarchy or beauracracy (Figure 2).

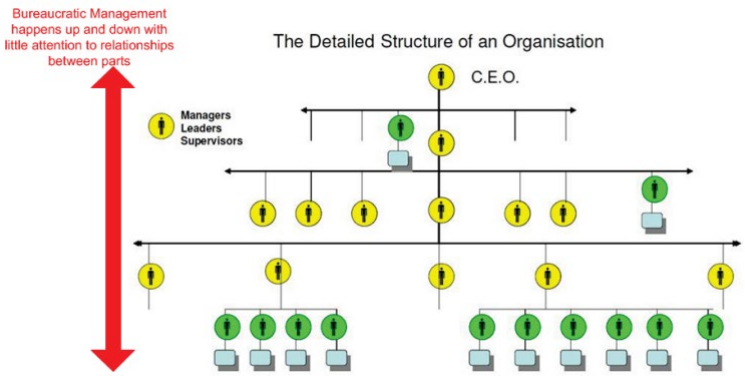


Figure 2: Organisation Functions as a Hierarchy

4. Rationale for change

The rationale for change is set out in the prior sections. In summary:

- To implement an organisation that recognises and is purposefully designed to accommodate clinical performance and system performance.
- To explicitly allocate clinical and system management to appropriate parties.
- To explicitly clarify the interface between system and clinical performance and introduce the appropriate mechanisms for this interface to be optimised.

5. Proposed future model

5.1 Principles

5.1.1. Introduction of system management

Canberra Hospital is proposing to implement a management model involving the introduction of operations management (Figure 3). Operations management is the name given to purposeful management of the moving parts of the system. This is important because this activity is what aligns with a significant aspect of the patient experience.

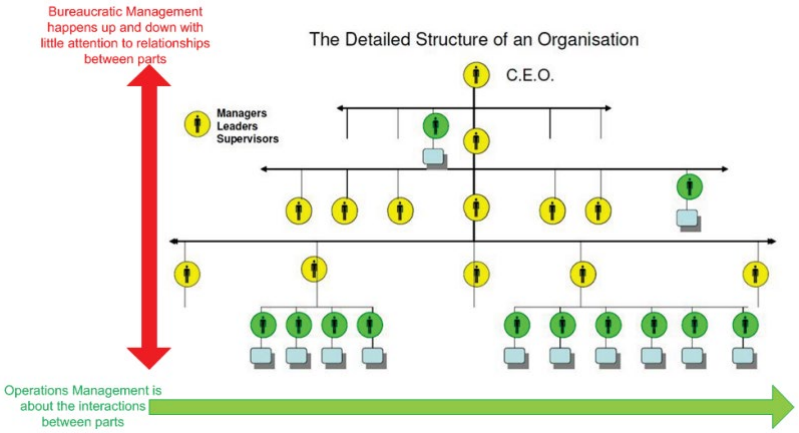


Figure 3: Bureaucratic Management and Operations Management

The means to do this is largely coordinated through an operations centre.

5.1.2. Operations Management and Co-Director Interface

As the operations management function (and centre) is developed the relationship between service delivery and system management will work as follows (Figure 4).

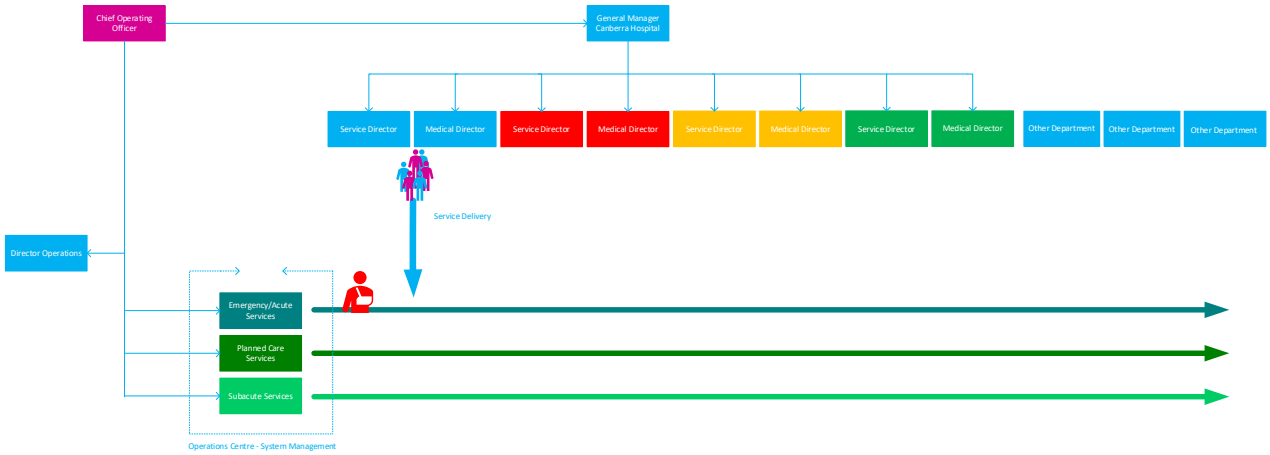


Figure 4: Service Delivery and System Management Relationship

To deliver services in a way that is consistent with good clinical and system performance there will have to be significant investment in clinical service planning as the means for specifying how the system works in a coherent way with clinical imperatives.

At times there may well be conflicts of interest that become evident and should be treated as opportunities for improvement in quality of care rather than traditional battle lines being drawn between clinicians and management.

This proposal accepts the operations centre concept, noting that development of operations centre capability is subject to a separate proposal, and considers how the remainder of the organisation responds and fosters good clinical performance.

To align with the principles noted above the future proposed leadership and management structure is provided (Attachment A).

5.2 Rationalisation of Senior Divisional Roles and revised leadership structure

5.2.1 Introduction of a Co-Director model for clinical performance

In relation to medical leadership and management, and aspects of allied health, it is proposed to create a co-director model. The co-director model recognises that medical staff do not conform to management models associated with other clinical groups i.e.:

- Medical staff do not generally pursue full time management roles.
- Medical leadership is often provided by a practicing clinician, where recognition by the group as a competent clinician is a prerequisite.

Both of these mean that medical staff are not inclined to manage others. Nonetheless the ability of medical practitioners to determine more than just their own input means their input into system design and operation is vital if both system and clinical performance are to be optimised.

The co-director model creates a relationship between manager and clinician to optimise clinical performance and system performance. This relationship has to be explicitly arranged so that each can be accountable.

5.2.1.1 Clinical/Unit Directors roles

No material change to existing Clinical/Unit Director roles is envisaged beyond a change in reporting line through to the Medical Director. Professional reporting lines remain through to the EDMS.

There will be a requirement for individuals who occupy a newly created Medical Director role to enter into an agreement with the relevant Service/Divisional Co-Director on respective accountabilities.

5.2.1.2 Executive Directors and Operations Directors

In the current model divisions are headed by an executive and contain either an operations director, a business director, or an equivalent role.

This proposal refocuses the role of divisional management leadership on service delivery and signals an amalgamation of the executive role and operations director or equivalent role into a single Service Director role.

There are five Executive Director roles in scope for this consultation:

- Division of Medicine
- Division of Surgery
- Cancer and Ambulatory Services
- Women, Youth and Children
- Rehabilitation, Aged and Community Services

In recognition of this change it is proposed that the Executive Director role will be ceased in its current form, and new roles established as Senior Officer Grade A (SOG A) positions with an individual ***Attraction and Retention Incentive*** (ARIn), or a commensurate employment arrangement. This proposed change in employment type provides individuals in these roles with secure permanent employment, rather than 3-5-year contracts.

There are three SOGA Operational Director positions also affected in Divisions of Surgery, Medicine, and Rehabilitation, Aged and Community Services. The potential impacts of this proposal have been discussed directly with affected individuals. Should these SOGA positions cease due to the proposed changes, any direct reports of the SOGA's will then report to the Service Director position.

Other positions not outlined above that directly report to an Executive Director are proposed to report to the Service Director. The change proposed is a change in the name/title of position that these positions report to. Should any reporting line changes be identified following this decision they will be consulted on separately.

While the proposed changes may result in some positions/roles being ceased, and employees currently in temporary/acting roles may be returned to their substantive positions, it is not intended that the proposed changes will result in any redundancies, or any employee being identified as an actual excess officer.

5.3 Implementation of Co-Director Agreement – Co-operative Governance

It is proposed that this relationship between Co-Directors is captured explicitly in an agreement to enable individual and collective accountability. When, and as formed, co-directors will enter into formal agreement on what each will contribute to the co-director accountabilities. The proposed draft Co-Director Agreement is provided (Attachment B).

6. Implementation

Should the proposed changes proceed following consultation, the move towards a fit-for-purpose management model based on a co-directorship model will be implemented as follows:

1. Consultation on the principles outlined in this proposal.

2. Rationalisation of senior divisional management roles and leadership reporting lines.
3. Implementation of a Co-director Agreement contract.
4. Development of Operations Centre capability.

Note: Point 4 is dependent on a significant increase in CHS to plan, build and run services integrated across divisions and in time across campuses. This programme has a timeline of 6-9 months and commenced in March 2024.

6.1 Implementation Timeline

Table 1: Proposed Structure implementation timeline

Step	Action	Date
1	Consultation with General Manager Canberra Hospital and Chief Operating Officer Canberra Health Services	6 May 2024 - completed
2	Meet with directly affected staff (Executive Directors, Clinical Directors and Directors of Operations)	8-10 May 2024 - completed
3	Consultation Paper tabled at Clinical Operations Executive (for noting and discussion)	21 May 2024
3	Consultation period begins with all stakeholders (formal consultation)	28 May 2024
4	Consultation period ends	11 June 2024
5	Decision and communication of decision	25 June 2024
6	Implement Change	Dependent on the above

7. Consultation and Feedback

During consultation, we are seeking responses to the following questions:

- Do you have any concerns about the proposal? If so, what are they?
- Do you have any other feedback you would like to be considered in relation to the proposed changes?

Feedback on this paper should be provided via email to the Office of the General Manager, Canberra Hospital Canberra Health Service chs.tchgm@act.gov.au by COB 11 June 2024.

Information about the directorate can be found on the website:
www.canberrahealthservices.act.gov.au

Acknowledgement of Country

Canberra Health Services acknowledges the Ngunnawal people as traditional custodians of the ACT and any other people or families with connection to the lands of the ACT and region. We acknowledge and respect their continuing culture and contribution to the life of this region.

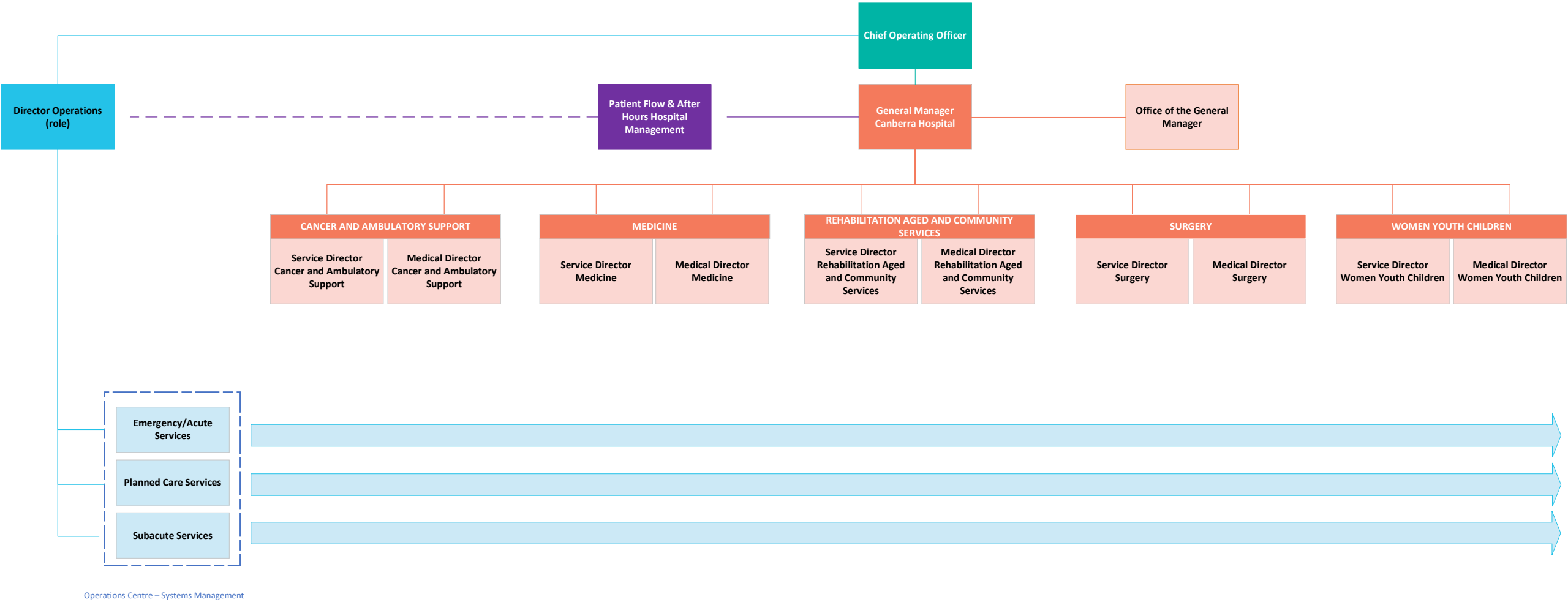
Accessibility call (02) 5124 0000

Interpreter call 131 450

canberrahealthservices.act.gov.au/accessibility

Attachment A

CONSULTATION
CANBERRA HOSPITAL SERVICE MANAGEMENT RE-ALIGNMENT



Operations Centre – Systems Management

Co-director Agreement – Co-operative Governance

Canberra Hospital

Canberra Health Services (CHS)

Co-director Agreement – Divisional Co-Directors, CHS

Date

Parties

Service Director, Division, Canberra Hospital, Canberra Health Service

Medical Director, Division, Canberra Hospital, Canberra Health Service

Co-director Agreement – Divisional Co-Directors, CHS

1. Background

A. Doctors and Managers must work together in large and complex organisations in the best interests of patients, staff, and the community.

B. As health services get bigger and more complex the role and functions related to running a part of it becomes the domain of staff trained to do so – professional management.

C. Traditional governance arrangements in simpler times were able to be covered by a senior doctor, a senior nurse, a senior allied health person, and an administrator.

D. This is no longer feasible. The coordination of staff, facilities and patients arriving at the right place at the right time is non-trivial.

E. We rely in these circumstances on trained managers to run or operate departments and systems effectively and efficiently. No one else is trained to do so to the same extent.

F. This creates a tension in some circumstances between traditional medical models based on semi-autonomous medical practice (clinical management) and managers trying to manage in a setting of increasing complexity (system management).

G. Patient safety is reliant on the best parts of both things. Either one, when taken without consideration to the other is unhelpful.

H. In considering how to promote arrangements that apportion to each participant the things that person should be accountable for, and not things that they are not, it is appropriate to consider specifically that:

   a. It is not appropriate to appoint a doctor or nurse, or anyone else as the single point of accountability as a symbolic appointment. That person must be able to be accountable for the whole department and every and all aspect of that department.

   b. It is not appropriate to ask a person trained in management to make uninformed decisions on medical or clinical matters (even if they have some clinical background).

   c. It is not appropriate to make someone other than the person “in charge” responsible for pivotal considerations such as “the budget”.

I. One of the reasons for appointing a doctor as Medical Director is to preserve influence and control of a clinical perspective.

J. The perception of loss of control when a clinician foregoes the director role is based on a learned lack of trust in the system and the absence of a mechanism for accountability and responsibility to be enacted.

K. The basis of resolving this tension lies in the application underpinning the principles of negotiating and contracting: Risk must be allocated where it can best be borne.

L. The purpose of this instrument is to allocate accountability to the appropriate person or role.

2. Definitions and interpretation

2.1 Definitions

Responsible means the party in question is able to undertake the task or matter personally.

Accountable means the party in question will face some or other consequence of some matter or task succeeding or failing, irrespective of their ability to undertake the matter personally or through resources under their control.

Consent means a matter or task cannot be approved or undertaken without agreement from the party granted right of consent in that matter or task[1].

Informed means that the matter or task can only proceed when the party in question has been informed as to the nature and extent of the matter or task. The right to be informed does not infer the right to give or withhold consent but does allow the party in question to appeal to a third party or referee.

2.2 **Interpretation**

The conditions for accountability for one party to be upheld are as follows:

- The person must know what they are accountable for.
- The person must know who is accountable to them.
- The person must have control over the systems and processes for which they are accountable.
- The person must receive regular reports on their performance.

The allocation of RACI attributes is based on application of this understanding.

3. Allocation of Accountability, Responsibility and Related Matters

The following roles, tasks and matters will be applied to the relationship between the Co-Directors according to the RACI framework (see definitions).

Task or Matter	Service Director	Medical Director
Formulation of policies and procedures relating to clinical practice.	Informed	Accountable
Provision of "clinical" advice and triage of clinical tasks.	Informed	Responsible
Allocation of available resource to clinical priorities	Accountable	Consent
Organisation of workforce: "troops to task"	Responsible	Informed
Recruitment, human resource management and related matters.	Accountable	Informed

[1] Note, some RACI matrix references use consult as the "C". This instrument does not.

Financial management	Accountable	Informed
Amendments to this Co-Director Agreement ”Agreement”	Consent	Consent
Programme Health Outcomes	Accountable according to individual tasks and matters above	Accountable according to individual tasks and matters above

Dispute Resolution:

- Where an individual is allocated a control such as “consent”, and the other party proceeds without consent, notification to the accountable executive will require the matter or task is discontinued as a default setting pending remediation.

- Where an individual is allocated control such as “informed” that party is required to notify the accountable executive where a task or matter proceeds without the party having been informed in a timely or full manner. In this instance the task or matter will proceed as a default until such time as the accountable executive has considered the matter. This is generally the case where business as usual is required to continue.

4. Statement of intention

4.1 No legally binding effect

the parties agree that this document:

(a) is merely a statement of the current intention of the parties and may change;

(b) is not intended to be legally binding on the parties or to give rise to legal rights or Obligations; and

(c) does constitute co-governance in good faith. Where one party acts in such a way as to demonstrate bad faith and this matter cannot be remediated by the accountable executive by addressing that behaviour or by amending the Co-Director agreement to the satisfaction of both parties, then the accountabilities outlined in this document will be considered null and void.

4.2 Binding Obligations

(a) The conditions for accountability cannot be rendered `null and void’. Neither party can be held accountable for something they did not know about (not informed), did not consent to, where they did not have control over the systems and process required to deliver their accountability, or where one party acted in bad faith.

(b) This agreement does not replace statutory or regulatory responsibilities of any particular party.

(c) The accountable executive will be bound by the agreement and the accountabilities therein, for example dispute resolution where this is mandated by the respective party RACI allocations.

5. Miscellaneous

5.1 **Renewal**

(a) Both Directors will sign the agreement for it to be valid.

(b) The renewal of the agreement will be no less than annual, overseen by the accountable executive (General Manager).

(c) The rights of both directors with respect to agreement changes are as described in section 3.

(d) Where no agreement can be derived with respect to renewal, the accountable executive will be required to construct a new agreement, dissolve any agreement or address themselves to the overall governance and changes thereto.

Co-director Agreement – Divisional Co-Directors, CHS

Signing page

Signed by Service Director, Division, Canberra Hospital, Canberra Health Services

Signature of Witness	Signature of authorised delegate
Print full name of Witness	Print full name of Authorised Delegate

Signed by Medical Director, Division, Canberra Hospital, Canberra Health Services

Signature of Witness	Signature of authorised delegate
Print full name of Witness	Print full name of Authorised Delegate

Executed by (line manager to above parties)

Signature of Witness	Signature of authorised delegate
Print full name of Witness	Print full name of Authorised Delegate