

Response to Consultation Paper on THS Structure (Draft 1)

This is a brief critique of the first draft proposal of an organisational structure for the Tasmanian Health Service (referred to hereafter as ‘the structure’) that comes into being on July 1st 2015.¹

Firstly, the underlying ‘philosophical’ assumptions and basic principles will be considered, then specific points will be addressed, and lastly an alternative approach will be outlined.

PHILOSOPHICAL ASSUMPTIONS

1. The underlying leadership/management ‘philosophy’ is unclear.
2. The structure appears to reflect a direction towards a centralized managed system directed from a substantial Tasmanian Health Service (THS) corporate executive based in Launceston.
3. The role of the three regions and their hospitals and associated services are downplayed to a point that may be counter-productive. The notion that the only way to bring about an end to parochialism is to downgrade local governance structure is potentially flawed.
4. The focus on hospitals, and acute care, has the potential to impede or reverse integration that has been achieved since the formation of three regional health services.
5. Community care is marginalized despite the rhetoric about seamless services.
6. Clinical engagement does not appear to be progressed by this structure. Despite years of attempts to engage clinicians by the

¹ Building the Tasmanian Health Service. Consultation Paper: Proposed THS structure, 20th April 2015.

creation of clinical networks and lead clinicians groups, the ‘parallel universe’ of clinical ‘advice’ still persists. The structure fails to integrate clinicians into its strategic planning, governance and business practices. This is very much a manager’s management system with strong centralization around the THS secretariat in Launceston.

7. Sovereignty/top down v association/bottom up wrong way round: a ‘flatter’ structure is needed to bring about the cooperation and clinical process reform that the government seeks.
8. The concept of the DHHS as ‘system manager’ needs clarification. DHHS needs to be a ‘ministry’ and to set policy, standards and purchasing mechanisms, and be the purchaser and monitor policy implementation and standards. The future DHHS structure needs to be known and there should not be duplication of similar senior positions in DHHS and the THS. Surely the THS is the system ‘manager’ with the parameters being set by the government via the DHHS.
9. There is no mention of public health or preventive programs.
10. Academic, research, education, training and development, innovation, and the UTAS relationship: none of these pressing issues are articulated in the structure.

SPECIFIC POINTS

1. The THS base in Launceston is too big and some of the roles are unnecessary. It is top-heavy, and appears to insert another layer of centralized bureaucracy.
2. The Governing Council needs an efficient secretariat for GC not an executive-level position of Director of Corporate Governance.

3. Operations cannot be centralized: the need for a THS Clinical Operations Officer is questionable.
4. Communications and ‘engagement’ cannot be effectively driven from the THS secretariat.
5. Statewide Executive medical and nursing directorships are superfluous if clinical governance remains at the local level. The DHHS has always had Chief Nurse and Medical officers, and it will be important to establish which DHHS/THS ‘side of the line’ these posts reside in.
6. Credentialing for medical and other health professionals needs to be centralized.
7. It is inappropriate for a Clinical Redesign directorship to have line management reporting from clinical services.
8. The proposed statewide clinical groupings are traditional medical ‘craft group’ based and do not appear to offer much scope for clinical innovation, and should be based more on the patient journey.
9. Statewide clinical service groupings are an old-fashioned response to an unclear problem, in some cases back to the future for unarticulated reasons. It is here that the sovereignty-association balance is most critically the wrong way round. ‘Ground up’ association of senior clinicians, within clear policy settings, is a better way to address deployment and equity of service distribution and clinical ‘redesign’.
10. The relationship between CAG (Clinical Advisory) groupings and the proposed statewide clinical groupings needs clarification and development.

11. The CAGs at present provide uneven coverage of the health system and are limited to an advisory capacity without a clear afferent/efferent action ‘circuit’.

ALTERNATIVE APPROACH

- A ‘minimalist’ THS secretariat and office should be established on July 1st as a first step that does not embed such a top-heavy bureaucracy in Launceston. This should consist of:
 - CEO
 - Deputy CEO/Clinical Governance/S and Q/Clinical Redesign director
 - CFO
 - Director of Credentialing, Safety and Quality
 - GC secretariat

Functions:

- Planning
 - Strategy
 - Compliance
 - Government and DHHS relations
 - Oversight of safety and quality
 - Statewide bodies that exist already (eg SCDC for drug and pharmaceuticals), or should be (eg Clinical Ethics Committee), should be included in the central THS structure.
- Clinical services should be encouraged to think statewide in their planning and development, but specialist service delivery will often need to be in a northern (current THO North and North West)

and southern (current THO-South) ‘hub’ grouping for geographical reasons.

- The following should remain at a regional level:
 - Day to day operations
 - Safety and Quality monitoring and reporting
 - Clinical governance
 - Facilities management
 - Financial accountability

- The downgrading of the present THO CEO posts to ‘Manager’ posts sends a message that the real authority and leadership resides in THS HQ. This is not healthy, and a title of Executive Director seems more appropriate.

- Each region (or north/south ‘hub’) should have a local management group that consists of:
 - Executive and operations director (one post)
 - Medical, nursing and allied health leads
 - Business Manager
 - Human Resources Manager
 - Facilities Manager
 - S and Q coordinator

- Rather than create statewide clinical ‘directorates’, consideration should be given to encouraging the major CAG groupings to develop into new statewide ‘Clinical Programs’ that groups services around the main patient journeys. CAGs could then align with statewide program groupings that mirror or merge/evolve into

clinical programs. Where statewide services already exist and are working well, or if a program believes it would be better as a formal statewide service, this possibility should exist.

- Such clinical programs would have the following statewide responsibilities:
 - Clinical leadership and redesign
 - Cooperation, service configuration and clinical service allocation
 - Clinical governance advice
 - Standards and policies
 - Training
 - Education
 - Research and development

- Cancer needs its own statewide group. Sub-acute services, community and general practice liaison should not be broken up into separate directorates. Suggested Clinical Program groupings (each headed by a convenor or clinical lead):
 - Emergency, trauma and retrieval
 - Critical care
 - Surgery and perioperative care
 - Women and Children, Child and Adolescent Mental Health
 - Heart and Chest
 - Brain and Stroke (including neurosurgery)
 - Cancer and Blood
 - Sub-acute (aged care, aged care psychiatry, rehabilitation, palliative care, pain medicine, general practice liaison, community services)

- General Medicine, Medical Specialties, Pathology and Diagnostic Imaging
 - Adult Mental Health, Drug and Alcohol
 - Public Health, Prevention, Epidemiology, Data, IT, Clinical Redesign (joint DHHS/THS/UTAS group to unite and lead all public health, data and health IT activity in the state)
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- Clinical Program leads report to the THS executive, and operate within the policy, purchasing and funding envelop agreed by government, DHHS and THS.
 - Clinicians have a direct say in strategy and budget allocation, as well as ‘clinical’ advice.
 - Program leads and other senior clinicians should all have academic titles at an appropriate level, that they then hold ‘seamlessly’ (not necessarily old conjoint structure, or with financial ‘splitting’ unless the academic component exceeds what would normally be expected of a unit head or senior clinician), and the clinical professors/senior lecturers should have a clearly articulated stake in the strategy and operations of the UTAS school of medicine.

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