

DHHS directions 2009

Frequently asked questions

1 Why have these changes been made?

We are not interested in change for the sake of change. Statistically Tasmanians have a higher health risk than the rest of Australia and this is resulting in a growing demand for DHHS services. The organisation has been reshaped to put us all in a better position to deliver improved, more integrated services for patients and clients into the future. Health and human services are expensive, and we need to ensure we spend taxpayer dollars effectively – we have to avoid service silos which can result in duplication and service gaps.

The major theme of the structural changes is integration – so that we avoid overlaps and can close off gaps in service provision, and improve communication between service providers and our patients. They will allow:

- Greater autonomy and accountability for the parts of the DHHS that are delivering services
- Better coordination and integration of the core policy, planning and performance roles
- Better support for the more effective and efficient delivery of health and human services (including finance, HR and IT support).

Above all, we want to reduce the bureaucracy for patients and clients who need care.

2 When are the changes taking affect?

The new organisational structure is effective immediately. Some changes have already taken place, such as the new model for planning, development and management of health services in the North West led by CEO Jane Holden. Other changes are more complex and will take place over a transition period – commencing today, but extending through until the end of 2009. Examples include the integration of primary and acute health services in the South of Tasmania.

3 How will they improve patient and client services?

The changes place renewed emphasis on our core business of delivering health and human services. They reflect and support the integrated service delivery approach that is a key theme of Tasmania's Health Plan and the human services reforms. A more integrated system means a smoother patient/client journey through the system, and a better overall experience of – and outcome from – the system.

The restructure will also contribute to more efficient and effective systems, which will have a positive effect on service delivery.

4 How will the changes affect me?

These changes will affect some staff more than others. Some staff will be moving to a different Group, in line with the reorganisation of functions between the eight Departmental Groups. If you are one of these people, your manager will be talking to you about your individual situation (if they haven't already). Note that arrangements are being put in place to ensure a smooth transition from a pay and personnel point of view.

For the majority of staff, roles and physical location – as well as direct reporting lines – won't change. **It's in the area of 'professional reporting lines' that we're all going to notice some changes.**

This means that while your line manager will be responsible for your work on a day-to-day basis, staff and operational units will have professional leadership from and accountability to one of the eight Departmental Groups at differing points in time. For example, a hospital seeking to introduce a change to nursing workforce will need to discuss such changes through the Chief Nurse and Allied Health Group. This Group – part of 'the Department' - is responsible for developing policy in this area which the hospitals, as operational units, implement. An operational unit preparing a budget bid or document including financial information will need to seek clearance through the Finance and Business Performance Group prior to final approval or forwarding to the Secretary or Minister's Office. Some of these professional reporting lines already exist through Departmental Executive clearance matrixes. The difference is that there is now not a single Deputy Secretary through which all information for an operational unit is cleared. The relevant clearance now depends on the issues addressed.

5 How does this restructure relate to the recent Human Services Group restructure?

The changes to the Human Services Group are part of the overall reshaping of the DHHS. Better integration of services is a key focus of both Tasmania's Health Plan and the current human services reform agenda, and a better integrated DHHS will make it easier to deliver integrated services.

6 Is this the end of the DHHS restructure?

This is the final major phase of the restructure – a process that began in March 2008. There may be some refinements to some of the detail, especially with some new additions to the Executive team. However the overarching framework is unlikely to change.

7 Who is responsible for policy and planning?

The Strategy, Planning and Performance Group, led by Catherine Katz, will have overall responsibility for high-level policy, planning and performance across the DHHS. See the [Fact Sheet](#) for this Group.

Development of program or service-specific policy will generally still be undertaken by the relevant Departmental Group or Unit (e.g. the Human Services Group or Chief Nursing and Allied Health). Health services policy will be developed by the Strategy, Planning and Performance Group.

8 Who is responsible for the hospitals and primary health services?

The CEOs of the hospitals, ambulance service and primary health services are responsible for the day-to-day management of their own services. These services no longer sit under a single Deputy Secretary.

The CEOs are accountable for delivering services against Departmental policies, plans and standards. They now report through the eight Group Executives for various elements of their operations (e.g. to the Chief Financial Officer on budget issues and the Deputy Secretary, Care Reform on safety and quality issues).

Management of our major hospitals and primary health services is going through a transition period. Because these changes will take time and are very complex, this transition period will occur throughout 2009 to accommodate the various elements being pulled into place – however all will be complete by the end of the 2009 calendar year.

A shift to geographical area integration of primary and acute health services is seeing these services brought together under a single management team in each area.

These changes mean Tasmania has had a North West Area Health Service since October 2008 (led by Jane Holden) and will have a Northern Area Health Service from early 2009 (led by John Kirwan) and a Southern Area Health Service towards late 2009. Bringing together primary and acute health services under area management does not mean we're looking to create regional health boards as has occurred in the past, and the primary health agenda will not be overshadowed by the acute hospitals. In fact, in keeping with Tasmania's Health Plan, the objective is to strengthen primary health services and care in the community.

9 What is the new Care Reform Group?

This Group, headed by new Deputy Secretary Alice Burchill, will have overall responsibility for human resources, workforce planning and development, safety and quality, and system reform. See the [Fact Sheet](#) for this Group.

10 Mental Health and Statewide Services – what does this include?

Mental Health and Statewide Services has been created under the leadership of Dr John Crawshaw and now incorporates statewide Mental Health Services, Health and Wellbeing Services (i.e. Oral Health Services and BreastScreen Tasmania) as well as the Alcohol and Drug Service, Forensic Mental Health Service, and Correctional Primary Health Service. These services will remain as statewide services.

11 What is the role of the new Chief Health Officer?

This Office has overall responsibility for population health, statewide forensic medical services and issues such as medical training, coordinating the health sector response to major emergencies, and clinical networks. The Chief Health Officer is supported by the Chief Medical Officer, Director of Population Health and Director of Statewide Forensic Medical Services. See the [Fact Sheet](#) for this Group.

12 What is the difference between 'the Department', 'the Agency' and an 'operational unit'?

'The Agency' refers to the entire Department of Health and Human Services, made up of:

- 'The Department' – responsible for policy, planning and performance; interface with government. Often referred to as 'above the line'. E.g. Safety and Quality; Aged Care and Rehabilitation; Audit and Assurance.
- The 'operational units' – delivering services against policies, plans and standards set by the Department. Often referred to as 'below the line'. E.g. Hospitals; Primary Health Services; Disability, Child, Youth and Family Services.

It's worth emphasising that the Department, not the operational units, provide the interface with government. There are strict [protocols](#) governing communication between the DHHS and the Ministers' offices (which is almost always through the Office of the Secretary), and these protocols should be adhered to at all times.

13 What are the 'DE' and 'SME' committees?

The Departmental Executive (DE) replaces the Agency Executive Committee (AEC). It comprises the Secretary, the head of each of the eight Departmental Groups and the Director of Public Health. The Executive, which focuses on high-level policy and performance issues, meets weekly.

The System Management Executive (SME) replaces the Systems Oversight Committee (SOC). This is a decision-making group which comprises the Departmental Executive and CEOs of the operational units. It meets monthly.