REFORM OF NSW HEALTH GOVERNANCE ARRANGEMENTS

AN OVERVIEW

Why are we restructuring?

The Minister for Health asked the Director-General to review the current governance structure of the NSW Health to ensure alignment with the Government's health policy. The changes now proposed build on those already undertaken with the establishment of Local Health Districts and are critical to ensure an effective patient focused health system, empowered local decision making, and strengthened clinical engagement.

These changes will also assist in creating a more resilient and adaptable health system which will be better placed to participate in the national reforms now underway.

The Governance Review Report can be found at www.health.nsw.gov.au

LOCAL HEALTH DISTRICTS

What are the key changes for Local Health Districts?

The key changes are in the area of governance and capacity. The Boards of Local Health Districts will become responsible for oversighting the performance of the Chief Executive. This will include developing an annual performance agreement with the Chief Executive, and reviewing the Chief Executive's performance against the KPIs in that agreement.

The Chairs of LHD Boards will come together on a regular basis as the Council of Board Chairs to confer with the Minister for Health and the Director-General, and become a key leadership group for NSW Health.

The majority of resources and staff from the HRTOs will in future be managed by LHDs, the only major exceptions being pathology and public health protection functions. Where it doesn't make sense to split functional units between LHDs, they will negotiate an aggregated service arrangement either through hosted or jointly managed arrangements. Local Health Districts will assume full responsibility for general recruitment functions, with Health Support Services only retaining responsibility for IT recruitment system technical development, maintenance and support, and major recruitment initiatives such as annual JMO recruitment where commissioned to do so.

LHDs will also have a greater say in the governance of shared public health system services with the introduction of a board with majority LHD representation for Health Support Services.

For building projects under $10M, it will be open to LHDs to manage these projects themselves subject to having the requisite capacity and skills, or alternatively, to engage Health Infrastructure on a cost recovery basis or a private sector project manager through open tender. To promote best practice project management, Health Infrastructure will be

tasked with developing standardised contracts, documents and templates together with systems for ensuring compliance with best practice and relevant Government policy to assist the LHDs.

How will Medicare Locals be linked?

The Commonwealth Government's commissioning of primary health care organisations – Medicare Locals – will complement the strategy of local governance for state health services and further encourage participation and ownership by local communities. The delivery of integrated patient care will increasingly require effective linkages of LHDs with Medicare Locals and other local healthcare providers. The LHDs will have primary responsibility for facilitating effective engagement with the Medicare Locals, in ways that suit local circumstances.

THE CLUSTERS AND TRANSITION ORGANISATIONS

What is happening to the Clinical Support Clusters/Health Reform Transition Organisations?

The three Clinical Support Clusters will be abolished, and the resources in the Health Reform Transition Organisations (HRTOs) will be fully deployed to other entities in the public health system, in particular the Local Health Districts. The staff working for the HRTOs will also be deployed and managed by other health entities, mainly Local Health Districts (LHDs). Where it is difficult to split smaller services across LHDs, the Review has specified arrangements for LHDs to host or jointly manage these key support functions.

How will the deployment of staff and resources from the HRTOs be managed?

Each of the HRTOs will have a transition management with District representation and some external change management assistance, to deploy resources and staff to LHDs, and co-ordinate the establishment or revision of any organisational structures necessary to receive those resources and associated staff. The team will ensure that where appropriate, hosting or joint management arrangements for services will be established by LHDs.

What is the timetable for this transition?

Transition teams, led by appropriate HRTO staff and including LHD representation, with access to external expertise, will take responsibility for ensuring that the current resources based in the HRTOs are distributed fairly.

A Framework to guide the transition of functions and services from the HRTOs to Districts and other health entities has been established as part of the Governance Review process. Substantial completion of the allocation of functions to LHDs is targeted for 31 October 2011. It is expected that the HRTOs and Clusters will be able to be formally dissolved by the end of 2011.

HEALTH SUPPORT SERVICES

Will there be changes to HSS?

With the exception of Information and Communication Technology (ICT), the public health system services provided by Health Support Services will be renamed *HealthShare NSW* and have a revised governance structure. The Chief Executive will now report to a governing Board which will have majority LHD representation and an independent Chair. *HealthShare NSW,* as it will now be called, will still be the principal provider of shared services for NSW Health.

However, it is recognised that the current arrangements can be improved, and *HealthShare NSW* will be tasked with developing a stronger customer focus and contestability of pricing. This will ensure *HealthShare NSW* is more responsive to the needs of the LHDs while still enabling us to reap the benefits of shared services across the public health system. Another change will be the transfer of general recruitment functions and associated resources back to the Local Health Districts/Networks. HSS will continue to support and maintain the IT recruitment system.

What is happening to ICT?

Given the critical nature of ICT as an enabler of health systems, state wide ICT services will be administratively distinct from the other services within Health Support Services and known as *eHealth NSW*. In the immediate term, it will be co-managed with *HealthShare NSW* pending a more thorough review of the best way to govern it in the future.
The Chief Executive of *eHealth NSW* will join my Executive Leadership Team. The Department's current strategic eHealth responsibilities will move to and be consolidated in *eHealth NSW*. An early objective of *eHealth NSW* will be the re-setting of strategy based on extensive consultation with clinicians and other users and the redesign of ICT governance to ensure clear statewide plans and an appropriate balance with local initiatives.

PATHOLOGY SERVICES

What is going to happen to the four public pathology hubs and their associated clinical networks?

It is proposed that the state wide model of four hubs be retained and built upon. A business case will be developed for a state wide governance structure for the four hubs, that ensures effective clinical linkages with Local Health Districts and transparent, consistent and competitive pricing models. Also in contemplation in *NSW Health Pathology* is the inclusion of the forensic pathology services and the Division of Analytical Laboratories.
Once the state wide structure is established pathology staff, currently managed within the HRTOs, will be under the governance of NSW Health Pathology. Their day to day duties and work locations will not be affected. Appropriate business models to support the operation of the hubs will be developed.

THE DEPARTMENT OF HEALTH

How is the Department of Health going to change?

The Department will become the Ministry of Health providing Westminster type functions supporting Ministers and the Government, regulatory functions, public health functions (disease surveillance, control and prevention) and system manager functions in state-wide planning, purchasing and performance monitoring of health services.

The Ministry will focus on its core roles as a purchaser, planner and performance monitor for the health system as a whole. The Ministry will consist of four divisions covering core functions:

- Strategy and Resourcing;
- Service Purchasing and Performance;
- Population and Public Health; and
- Governance, Workforce and Corporate Services.

The Department will reduce in size by around 25% through a combination of function and staff transfers to other health entities and position deletions.

How will the reduction in the size of the Department be achieved?

The Ministry will have a much more focused role and set of responsibilities. The Ministry will have a key role in facilitation and coordination across the system (note: where intervention is required the Ministry will get involved operationally)

Specific functions and associated staff will be transferred to various public health system entities:

- clinical safety and quality, and the credentialing project will be transferred to the Clinical Excellence Commission
- clinical redesign and development of models of care, including out of hospital care, and clinician engagement mechanisms will be transferred to the Agency for Clinical Innovation
- Department corporate support services (ICT, payroll, purchasing, facility management, library and records) will be transferred to Health Support Services
- employment screening services to Health Support Services
- eHealth strategy will transfer to eHealth NSW as part of a more general review of eHealth governance currently within Health Support Services
- nursing and other workforce training related functions will be transferred to the Health Education and Training Institute once established
- management of the patient survey will transfer to the BHI.

In restructuring the four Divisions, positions will be reviewed to identify opportunities for efficiencies such as in administrative support, and for more generic policy development roles across a broad subject range rather than basing positions on specific subject areas.

Will the Ministry still be responsible for vetting and coordination of information, or will LHDs and other health entities communicate directly with the Minister's Office?

A key function of the Ministry is to provide support to the Government and the Ministers in the Health Portfolio. The Ministry will maintain responsibility for the preparation and coordination of key government documents, including cabinet minutes, responses to parliamentary questions and ministerial correspondence, and briefings. As part of this process the Ministry will seek input from the LHDs and other health entities, with the expectation that they will provide timely, accurate and current information.

How will the Ministry be able to access expert advice on clinical initiatives in the future?

The Ministry will be able to call on the expertise of LHDs and other health entities such as the Clinical Excellence Commission and Agency for Clinical Innovation. The ACI will be expected to have well-established, expert clinician networks and linkages across the health system to support not only the Ministry when required, but the other Pillars as necessary. The Ministry and the Minister will also have access to advice through advisory bodies and taskforces as required.

How will the Ministry effectively oversight the performance of LHDs?

There will be a new Performance Management Framework with clear expectations for all LHDs. The Performance Management Framework is intended to allow LHDs autonomy and will only specify the most important performance parameters expected by the Government. It will specify the key minimum performance standards and thresholds, and specify what level of performance would prompt closer Ministry support and scrutiny

Each LHD will negotiate an annual Service Agreement with the Ministry of Health. The relationship between LHDs and the Ministry will be more structured and transparent than the current arrangements with clear delineation of roles and responsibilities. The Local Health District or Network is responsible for determining how it will deliver healthcare services within the framework of the Service Agreement and state wide policies.

Chief Executives, with the guidance of their Board, will have the authority to manage the resources required to deliver the services specified in their Service Agreements with the Ministry.

Will there be further restructure once the Office of Preventive Health and the Mental Health Commission are established?

A Ministerial Taskforce on Preventative Health is being established, chaired by Prof Stephen Leeder. The Taskforce will develop strategies to enhance personal and community health with an emphasis on keeping people healthy and out of hospital. This Taskforce is due to report to Minister by 30 November 2011.

A Mental Health Taskforce has been established, to develop recommendations on the establishment of the Mental Health Commission. To inform the Taskforce, public consultation and across government consultation has commenced. The Commission is to be operational by 1 July 2012.

The need for any further restructure will be assessed once the government has considered the reports of these Taskforces.

What is happening to NSW Kids?

The Minister has requested that an Expert Group be convened to give advice on a governance model and other advice pertinent to the oversight and delivery of Children's Health Services in NSW.

The Expert Group will consult and provide advice to the Minister and Director-General on the recommendations, a preferred governance structure and other elements required for the effective delivery of a strategy for children's health and services throughout the State. It is anticipated that the Working Group will report by the end of December 2011.

Pending the outcome of this process, the Ministry will be accountable for state wide policy and planning for maternal and child health services, and for co-ordinating implementation of the recommendations of *"Keeping Them Safe".*

CLINICAL EXCELLENCE COMMISSION, AGENCY FOR CLINICAL INNOVATION, CLINICAL EDUCATION AND TRAINING INSTITUTE AND BUREAU OF HEALTH INFORMATION (THE PILLARS)

What is happening to the Pillars?

A number of functions will be transferred from the Department to the 'Four Pillars'. Where there is a significant change of functions the organisation of the relevant health entity will need to be restructured to accommodate the major change in role.

The Clinical Excellence Commission (CEC) will take full responsibility for system quality and safety and providing leadership in clinical governance with LHDs. The related functions in the Department, including critical response management for adverse clinical incidents and clinical risk management, will transfer to CEC, as will the state wide credentialing project.

A reformed Agency for Clinical Innovation (ACI) will be restructured to take on a strengthened role as the primary agency for state wide clinician engagement and for designing and implementing models of care to make the public health system more efficient, better performing and sustainable over the longer term. The Department's clinical redesign, clinician advisory structures and models of care development functions will transfer to the ACI. The Policy and Technical Support Unit will also be incorporated into ACI providing economic and technical expertise which will be available to the CEC on request.
The Bureau of Health Information (BHI) will be recognised as the primary source of quality information to the community, healthcare professionals and policymakers. Responsibilities for the Patient Survey will transfer from the Department to the BHI.

The Clinical Education and Training Institute (CETI) will be replaced by the Health Education and Training Institute (HETI) with an expanded focus to include non-clinical leadership and

management development, and undergraduate and vocational training. Some Department and Cluster functions will transfer to HETI.

What will be the governance arrangements between the Ministry and the Four Pillars?

The Four Pillars will be an important source of expertise for the health system. Rolling 3 year Strategic Plans and Annual work plans will be prepared in consultation with each other, the Ministry and the LHDs. Close collaboration with the Ministry will ensure alignment of their priorities with forward planning and budget development. These will be discussed, and ultimately agreed, with the Director-General. Service Compacts between the Ministry and the Pillars will be prepared, reflecting this interaction and agreeing to a specified body of work and the funding to support this. The Compact will build-in the agility for these agencies to deal with emerging issues encountered by the Ministry or LHDs whilst ensuring that matters of system-wide concern are considered and incorporated into the planned work of the agencies.

RESTRUCTURING PROCESS

What will be the Governance arrangements for the restructure?

A Governance Transformation Group will be immediately established to oversight the implementation of all the changes proposed by the Governance Review. The Director-General will chair this Group and will be engaging external support in the form of an experienced Project Manager and access to organisational design and change management expertise as and when required.

In addition for each part of NSW Health requiring detailed restructure there will be specific Transition Implementation Teams.

What is the timeframe for restructure?

By the end of 2011 the aim is to:

1. Complete the establishment of, and appointment to:
    - the senior executive management structures of the *Ministry* ,
    - the senior executive management structures of new or revised health entities,
2. Be well progressed in realigning divisional structures of Ministry and developing or amending organisational structures for new or revised health entities.
3. Complete the deployment of resources from the *Health Reform Transition Organisations* and formally dissolve the *Clusters* and *HRTOs*.
4. Transition *Health Suppport Services* to the new board governance arrangements as *HealthShare NSW.*
5. Establish *eHealth NSW* and develop a strong governance framework for ICT.
6. Develop the appropriate future governance structure and commence work on the appropriate business models for *NSW Health Pathology*.