Newsletter: 41/2018
Date: 23 January 2019
Distribution: SNSWLHD members
Contact: Your HSU Organiser

SNSWLHD: Proposed Changes to Clinical Operations Directorate Structure

Dear Member,

Attached is correspondence the HSU has received from Southern NSW Local Health District regarding proposed changes to the Clinical Operations Directorate Structure.

Member feedback requested

The HSU industrial team is currently reviewing the potential impacts of the proposed restructure upon affected employees. We are now seeking feedback, views and comments from our members.

Please review the attached documentation and provide comment and feedback by 6 February 2019. You can submit it by email to julie.gordon@hsu.asn.au with subject line *SNSWLHD Clinical Operations.*

HSU organiser and sub-branch involvement

Your HSU organiser will be visiting your workplace shortly and convening a meeting to discuss the matter with affected employees. The HSU is also seeking expressions of interest from members to be part of the consultative process as a workplace delegate in any upcoming USCC meetings regarding this proposal. The most effective way to deal with these kinds of proposals is by taking into account the concerns of the group, agreeing on a way forward and presenting that united position to management.

Please distribute this newsletter to your work colleagues for their information and comments and encourage them to attend the meeting.

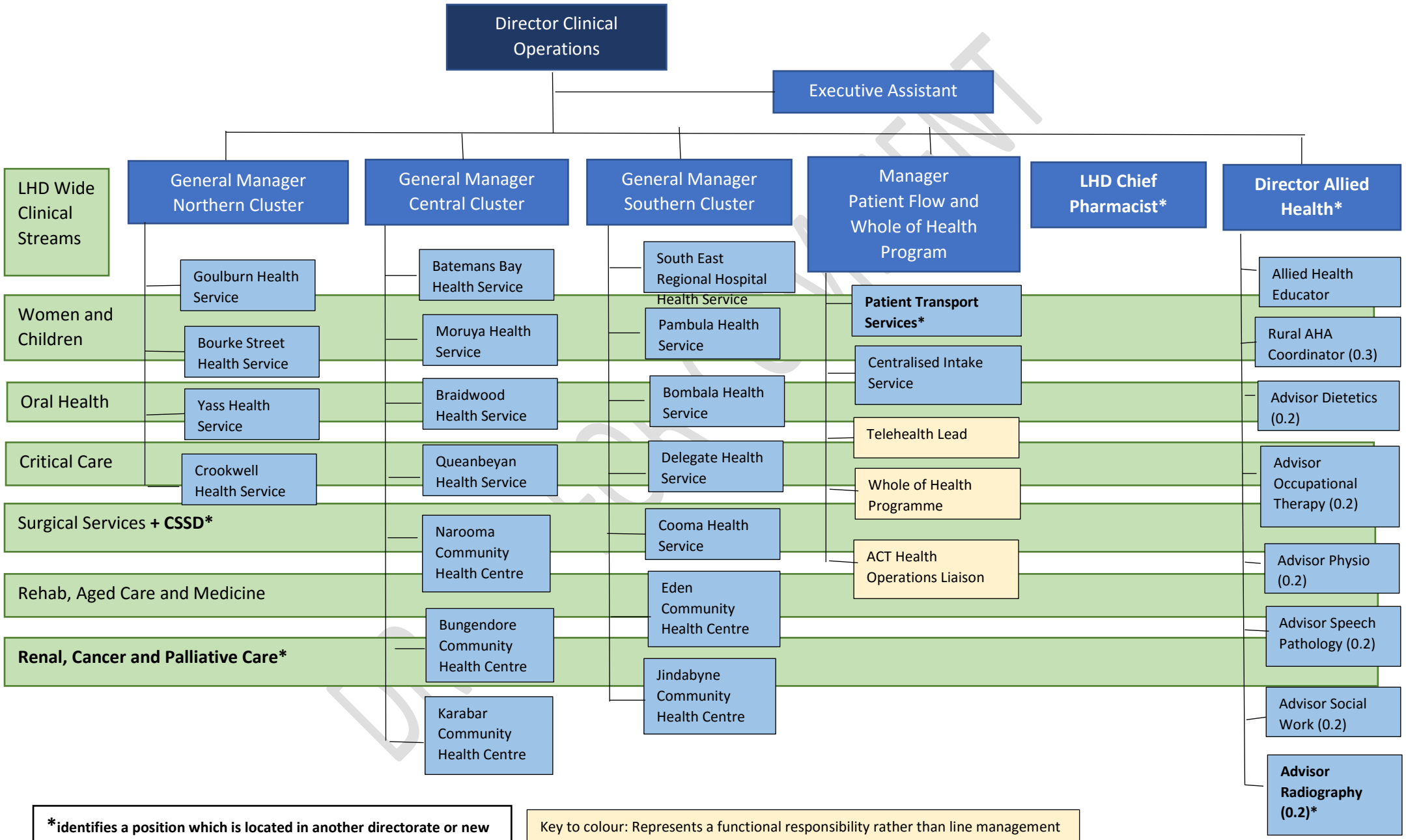
Not a member of the HSU? Now is time to join and have your say! You can join online at www.hsu.asn.au/join or call 1300 HSU NSW and join over the phone.

A union's effectiveness and negotiation power depends upon the strength and density of its membership base. Join your work colleagues today by becoming a member of the Health Services Union and help us continue to protect and improve your working life.

In unity,

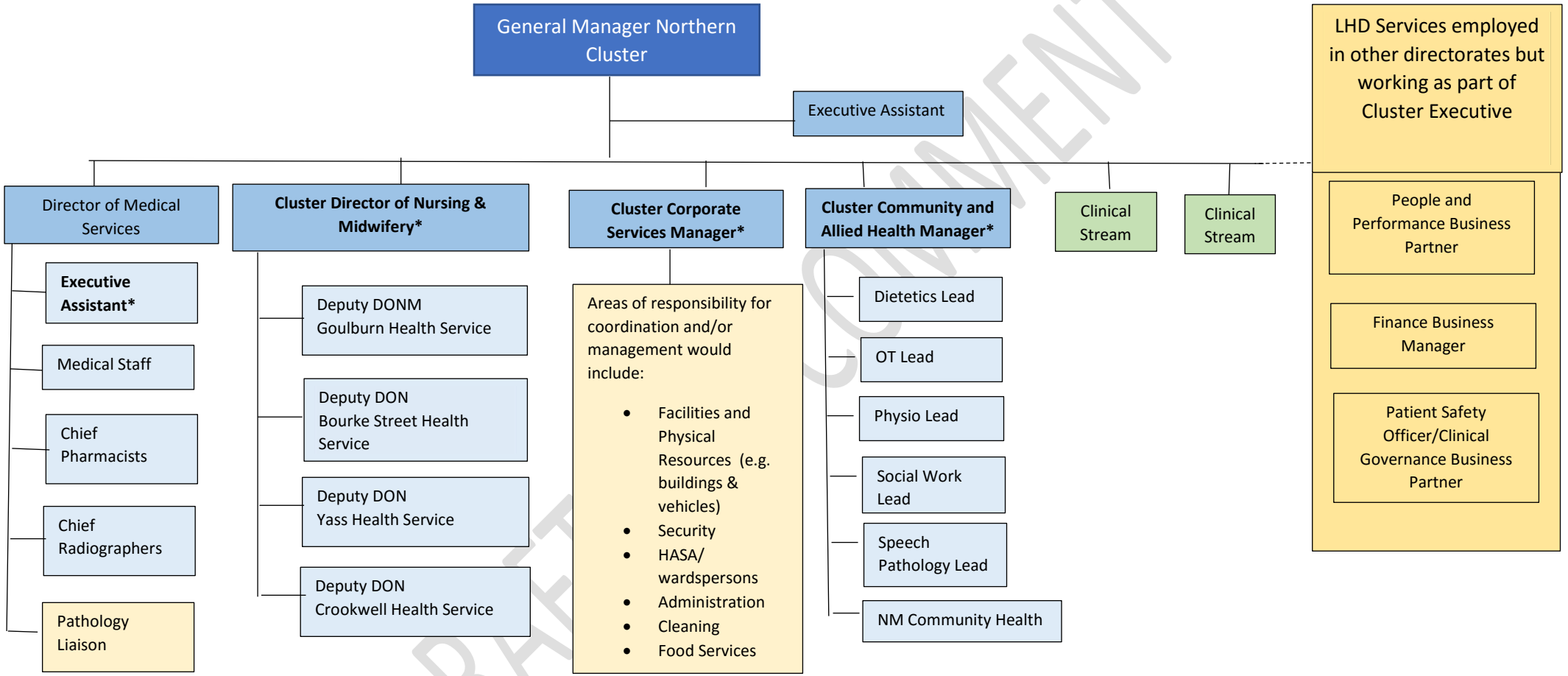
Gerard Hayes
Secretary, HSU NSW/ACT/QLD

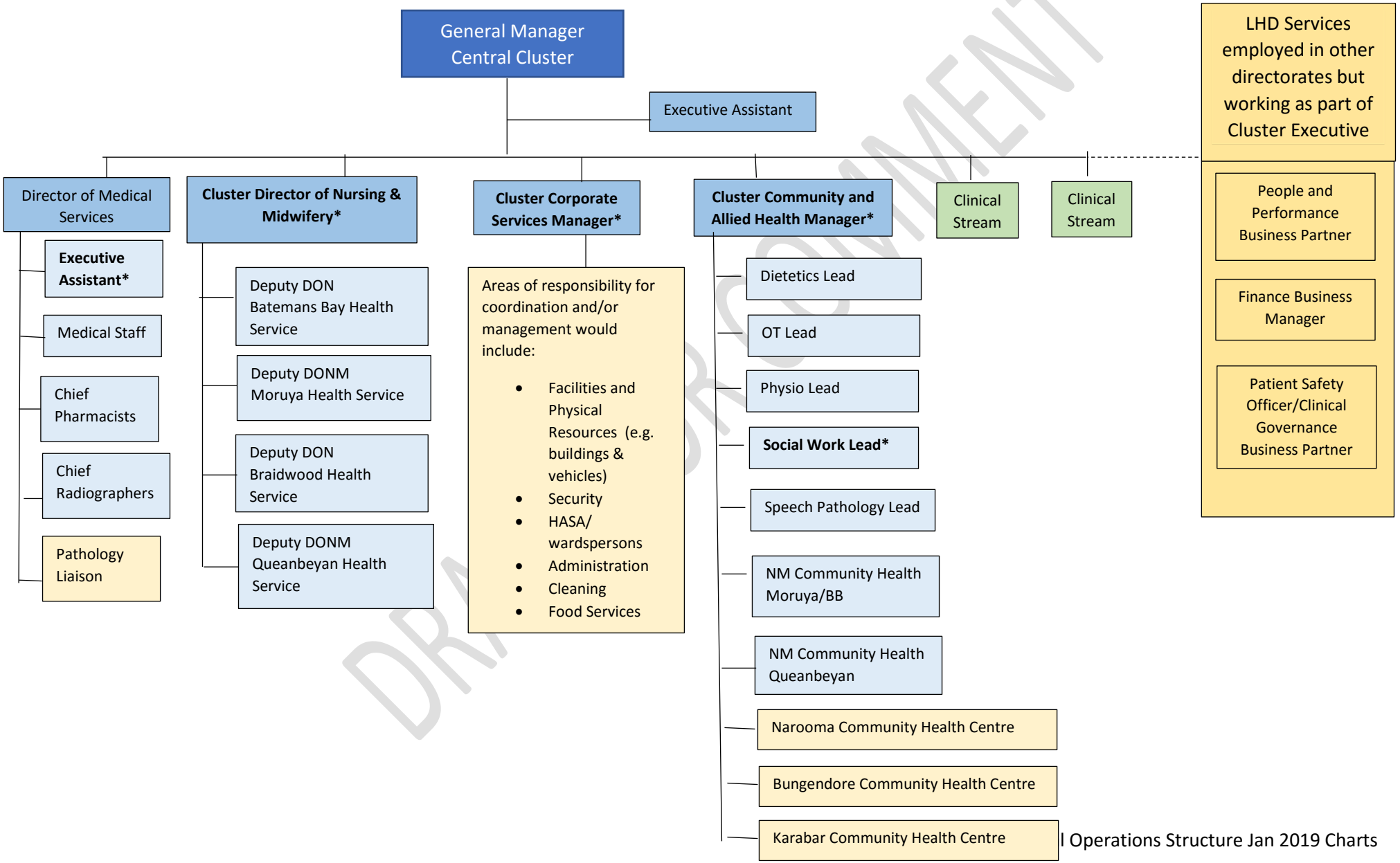
Proposed Structure Clinical Operations Directorate



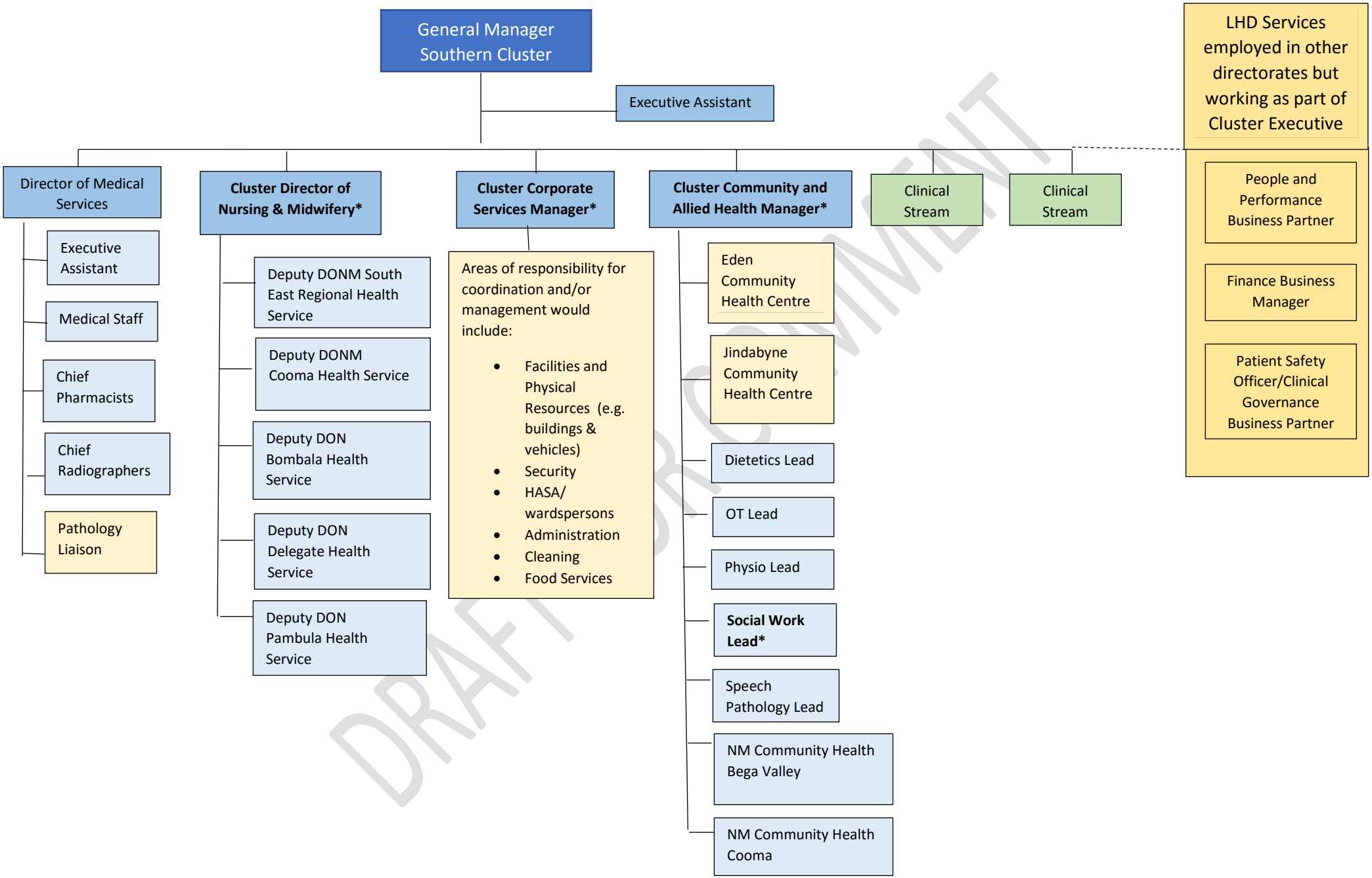
*identifies a position which is located in another directorate or new

Key to colour: Represents a functional responsibility rather than line management





l Operations Structure Jan 2019 Charts



Proposed Clinical Operations Structure Jan 2019 Charts

Clinical Stream (A)

Womens and Children Clinical Stream
(4 *direct reports to GM*)

Maternity Services

CMC Cooma (Report to Cluster DONM)

CMC QBN (Report to Cluster DONM)

LHD Director Obs & Gyn*

Paediatric Services

LHD Director Paediatrics*

CNC Paediatrics (Report to DONM cluster)

Womens Health / Child Youth and Family Services

Manager - 1.0

- ✓ CIFTS Manager – 1.0
- ✓ SWISH/STEPS Coordinator – 1.0
- ✓ Child and Family CNC – 0.6

Integrated Violence and Neglect Services

Manager – 1.0

- ✓ Staff Specialist Forensic Medicine
- ✓ Clinical Lead CPCS – 0.5
- ✓ Clinical Lead SAS – 0.5
- ✓ JIRT Senior Clinician – 1.0
- ✓ Child Wellbeing Coordinator – 1.0
- ✓ Out of Home Care Coordinator – 0.6
- ✓ After hours Crisis Coordinator – 1.0
- ✓ Clinical Project Officer -1.0

Oral Health Clinical Stream

Manager 1.0FTE
(1 direct report to GM)

Clinical Director

Oral Health Intake

System and Support Officer

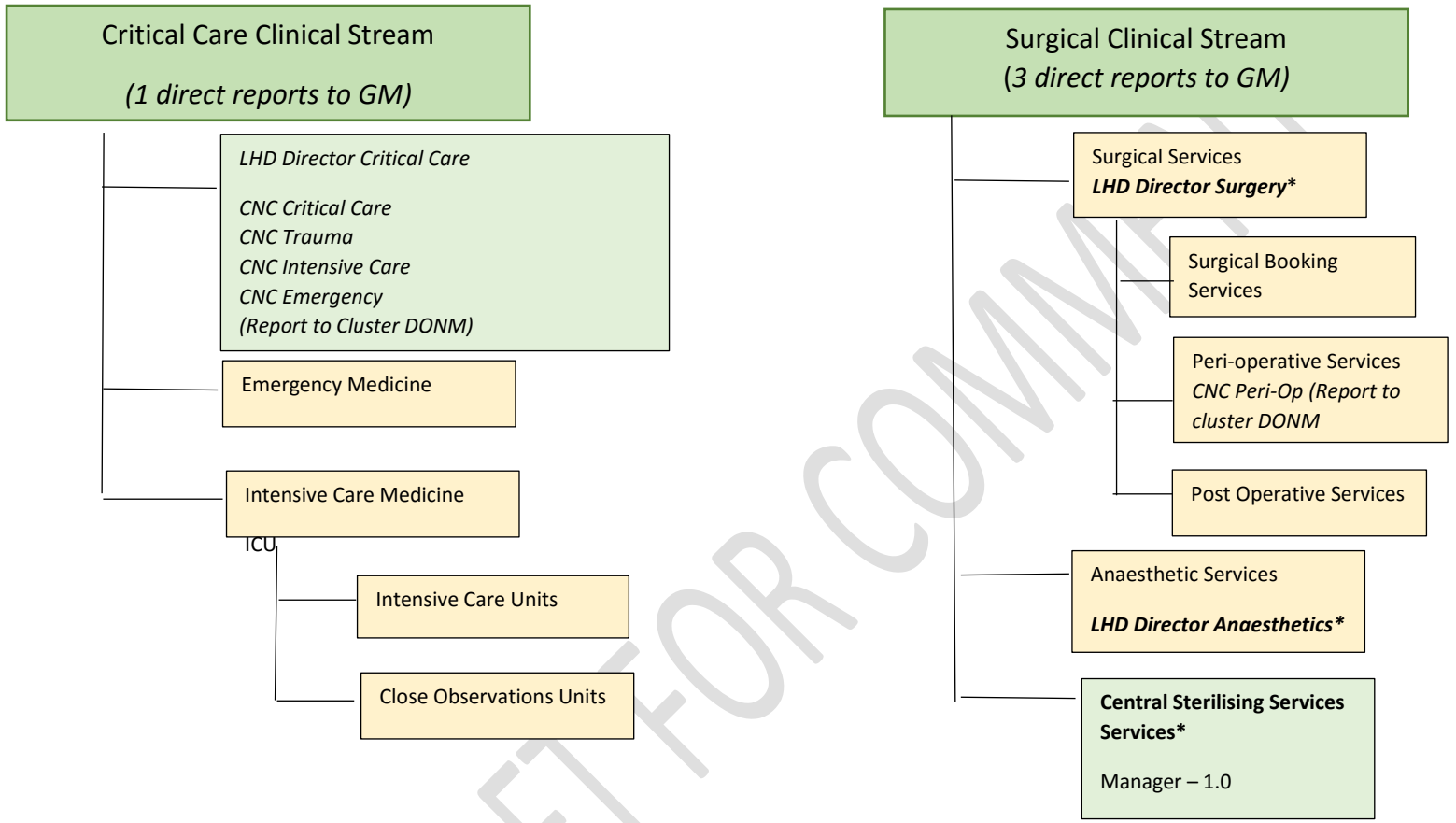
Program Coordinator

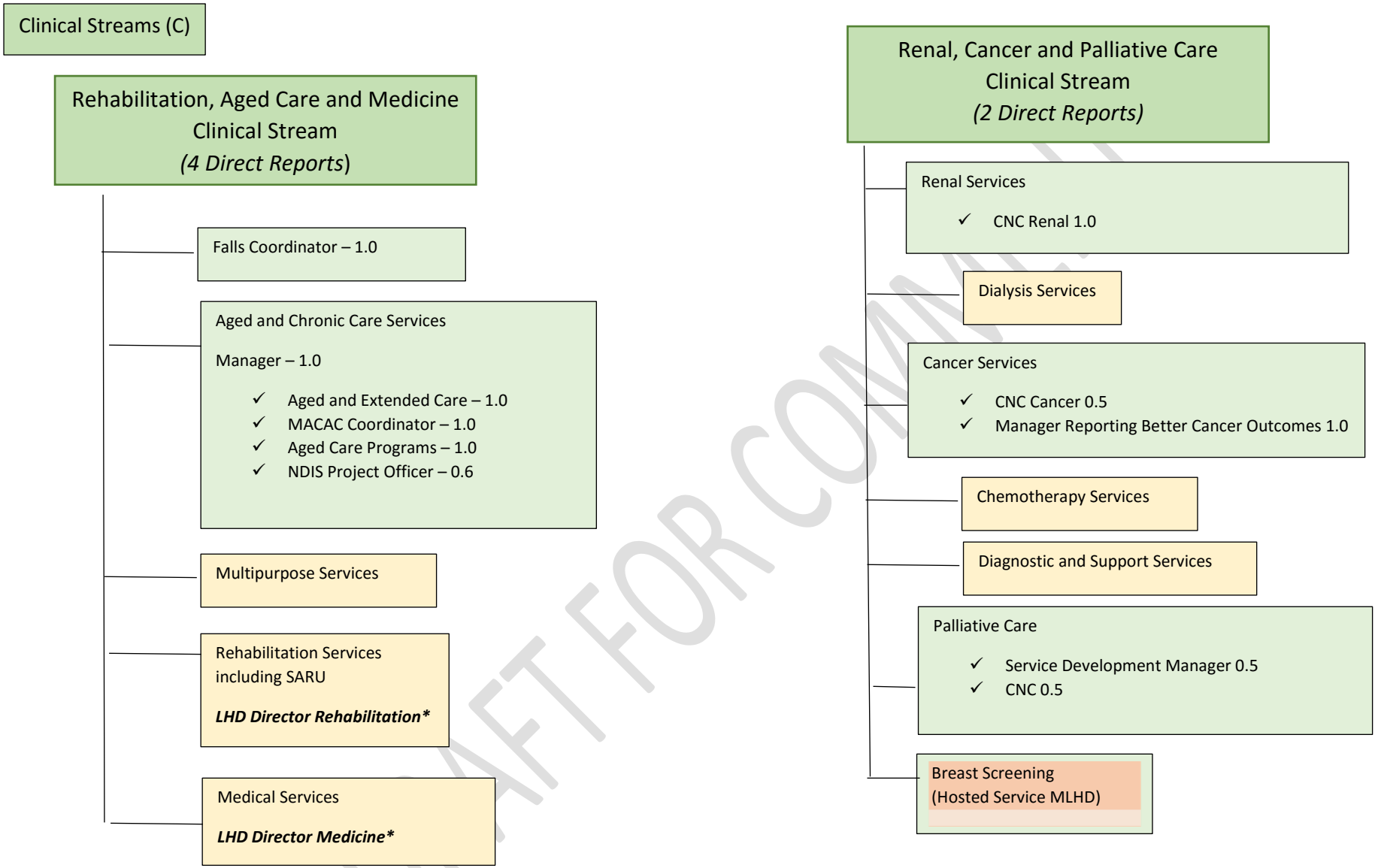
Wailing List Officer

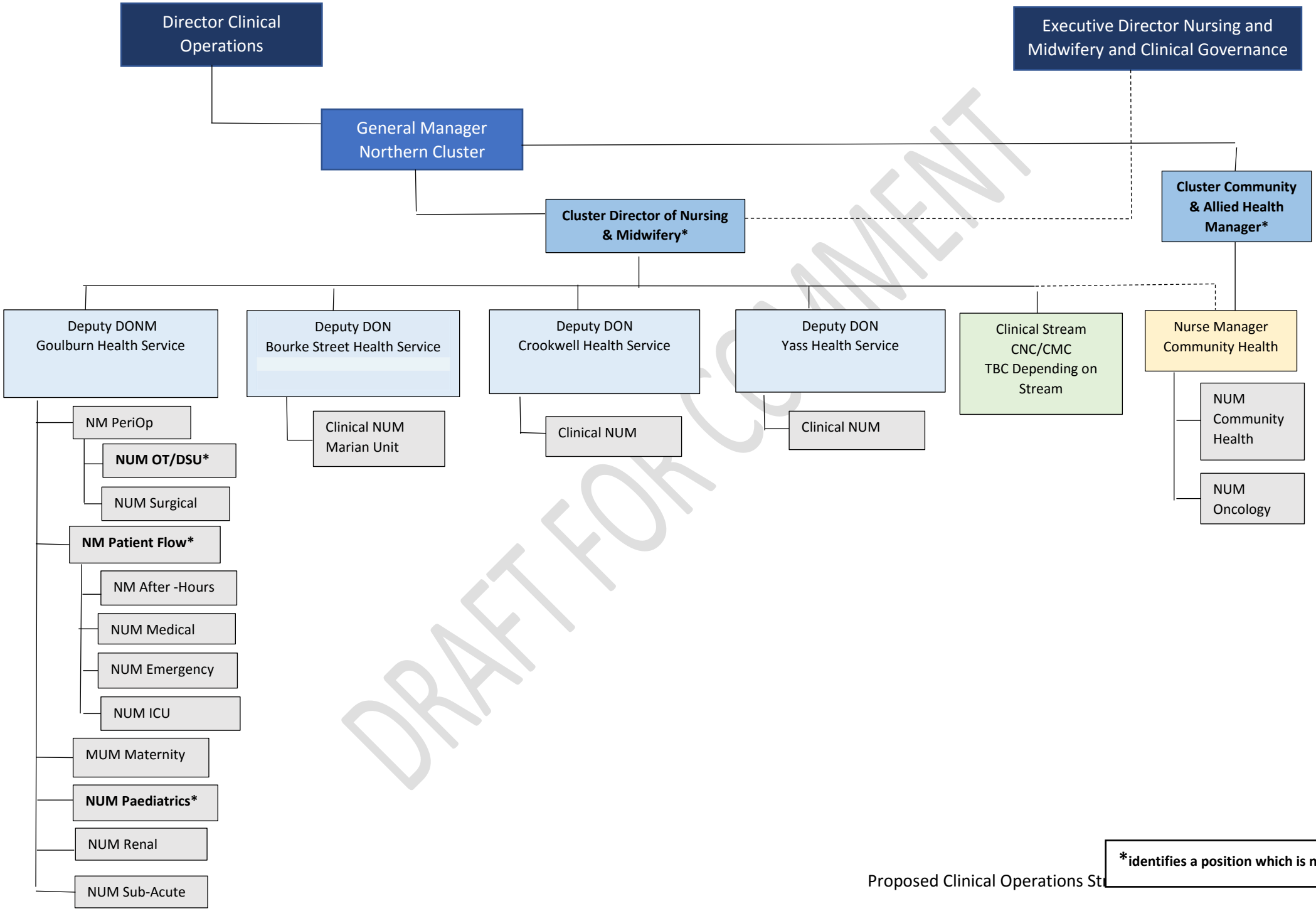
- Hub 1 - Bega/Pambula/Moruya clinics
  - ✓ Dental Officer – 1.0
  - ✓ Oral Health Therapist – 1.0

- Hub 2 - Queanbeyan/Yass/Cooma/Goulburn clinics
  - ✓ Dental Officer – 1.0
  - ✓ Oral Health Therapist – 1.0

Clinical Stream (B)







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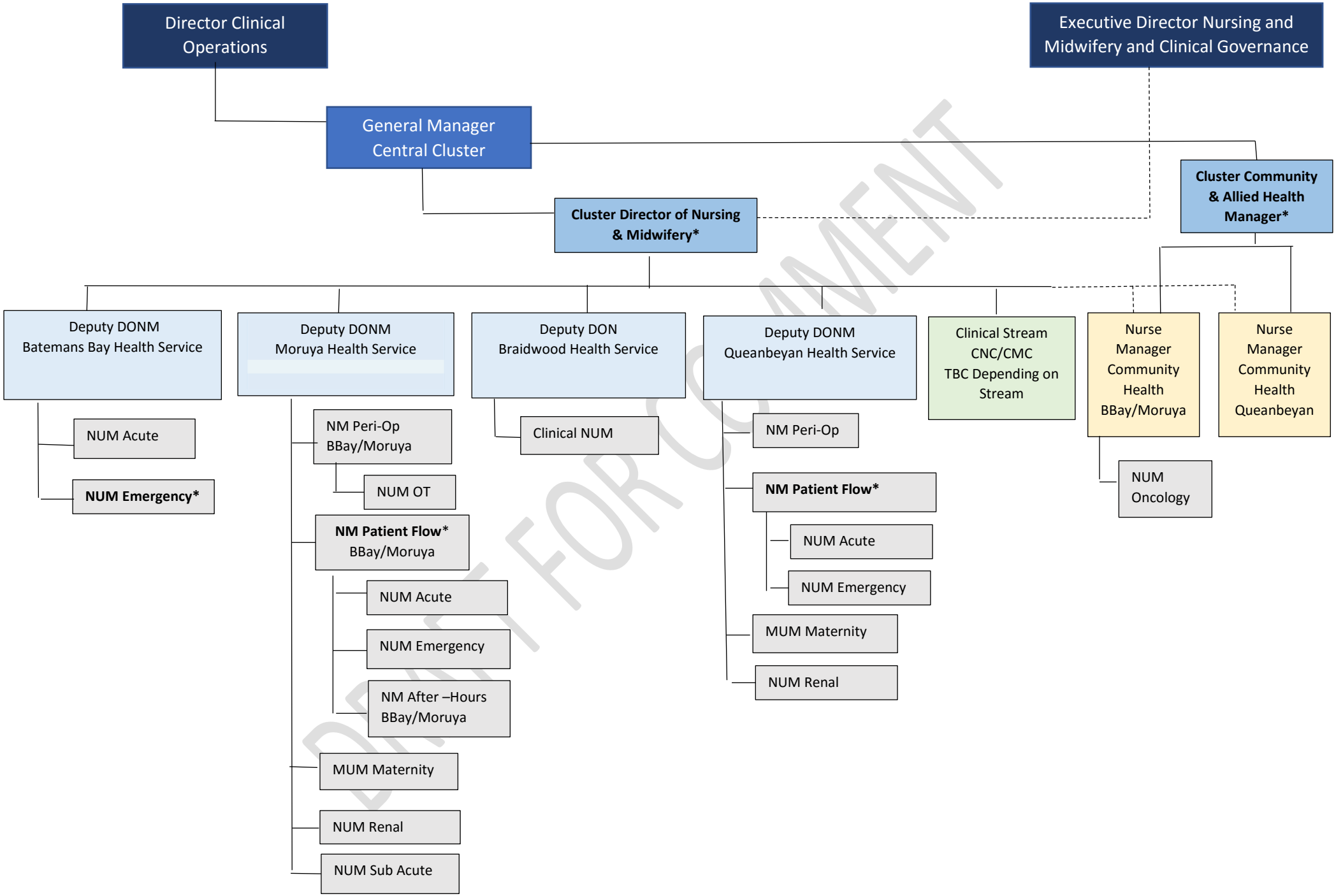

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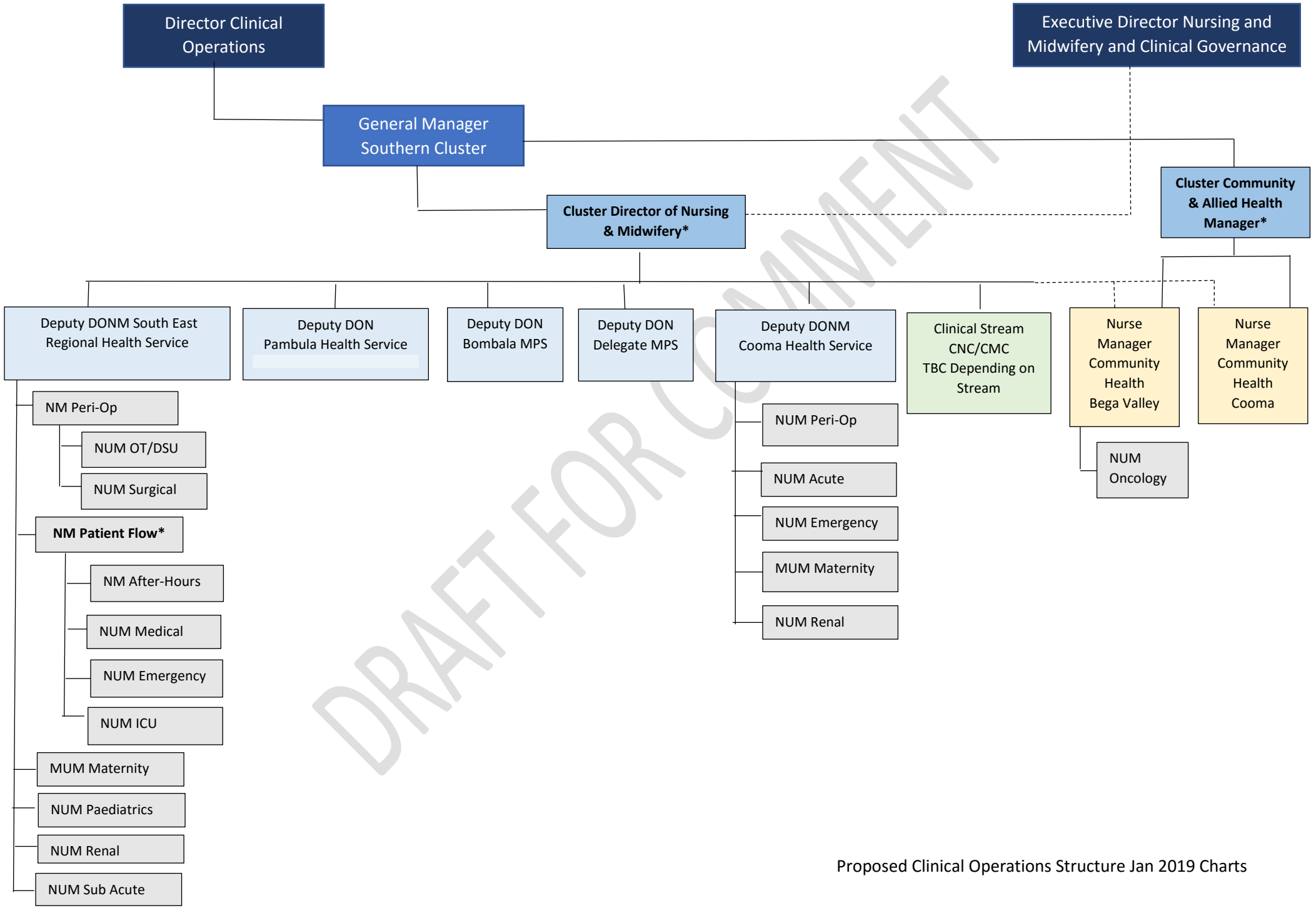

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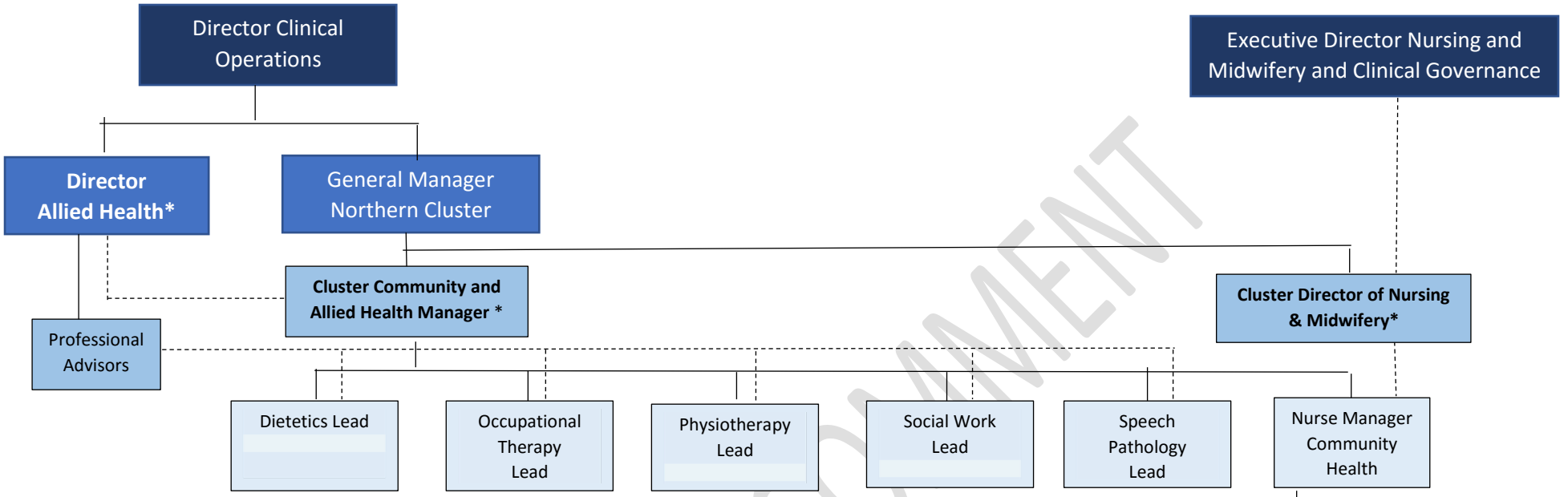
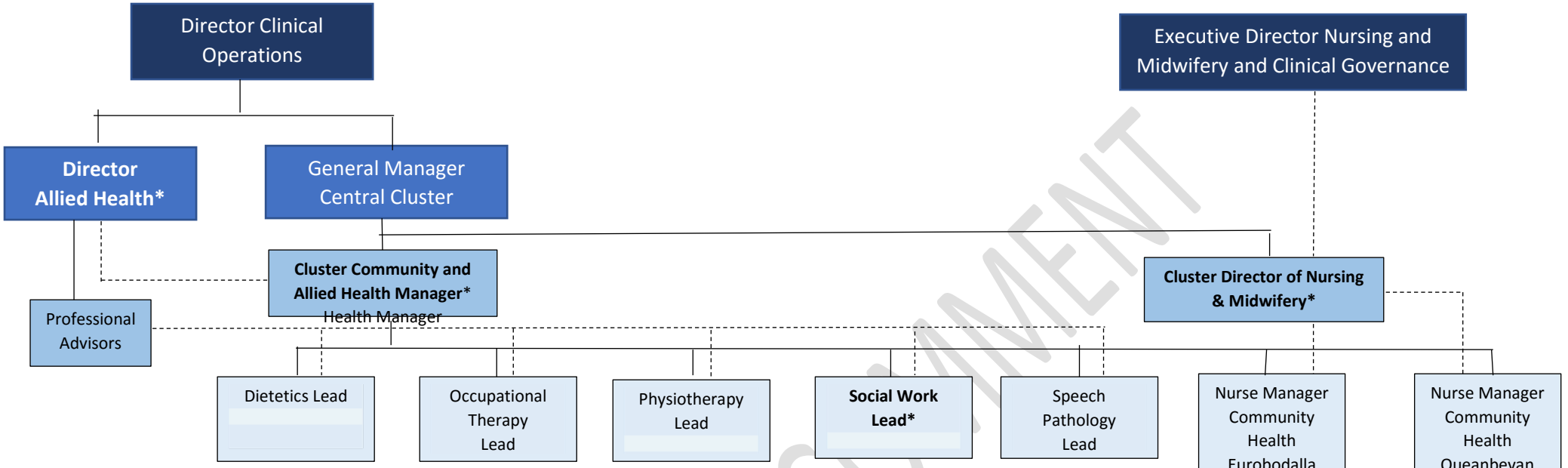


Clinical Programs may include:

- Brain Injury Service
- Care Navigation
- Child and Family Health Nursing
- Child Protection Counselling
- Community Allied Health
- Community/Primary Health Care
- Community Nursing
- Counselling
- Diabetes services
- Hospital in the Home
- Hydrotherapy
- Inpatient Allied Health
- Oncology
- Palliative Care
- Podiatry
- Rehabilitation
- Renal Outreach
- Sexual Assault Services
- Sexual Health Services
- Specialist Geriatric Outreach
- Transitional Aged Care Services
- Tuberculosis Services
- Womens Health



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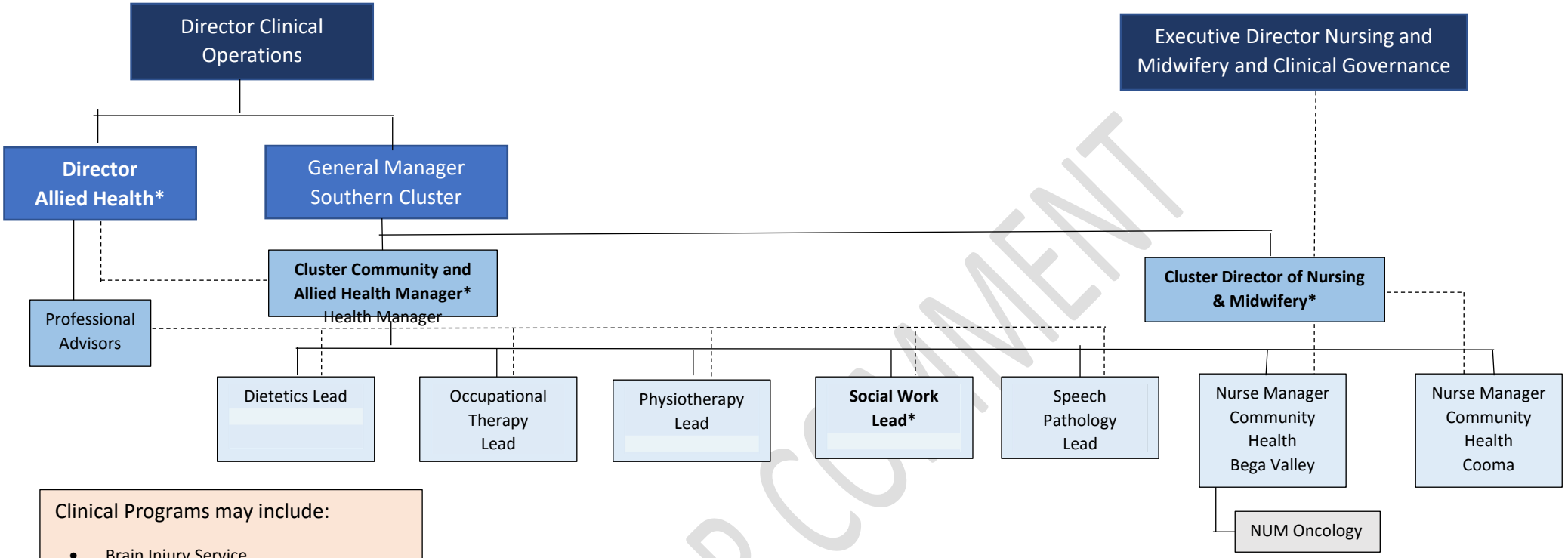

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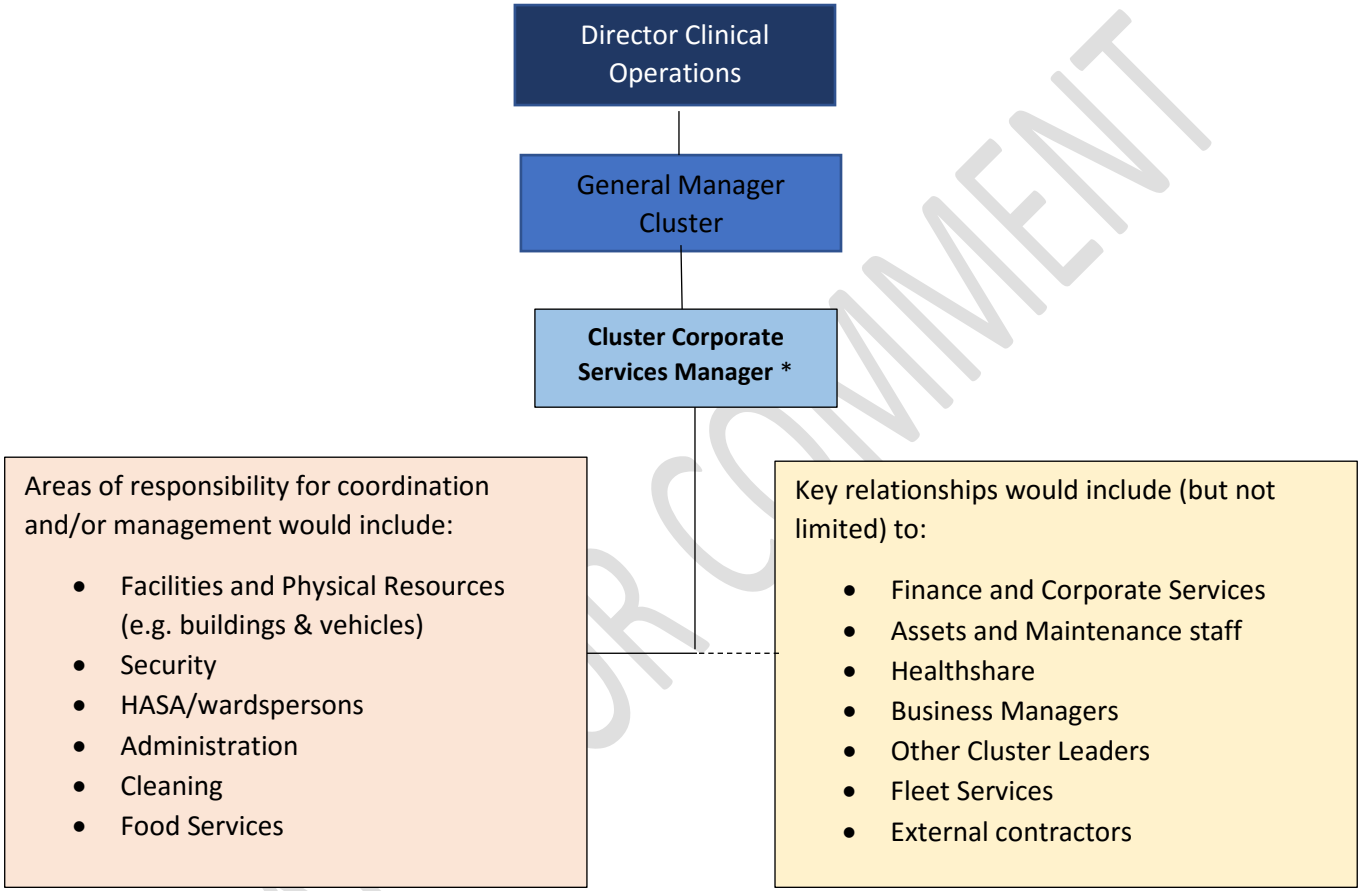


Southern NSW Local Health District

Clinical Operations Directorate Proposed Structure

January 2019

Introduction

The development of this proposal included a review of previous proposals for the structure of the Clinical Operations Directorate, and the feedback which had been received about those proposals.

A 'green fields' perspective was also used. This means that if we were establishing the services as they exist and as we anticipate they will develop (based on the strategic plan for the LHD and the current capital works projects underway and in planning) what sort of management and leadership structure would we put in place to provide a consistent and robust approach to support service delivery at each site and service. This enables us to not be bound by how services may have evolved over time in response to specific initiatives or issues but instead take a fresh look at what do we need now and into the future.

This proposal is intended to support the clinical operations directorate to meet its service obligations in an effective and efficient manner whilst ensuring there are manageable and supported leadership and management functions.

It is expected that through the process of consultation and feedback this proposal can be refined and improved and therefore your thoughts about what will work and what may not and any alternative suggestions is greatly welcomed and appreciated.

Thank you
Jude Constable
Director Clinical Operations

Factors considered in determining this structure

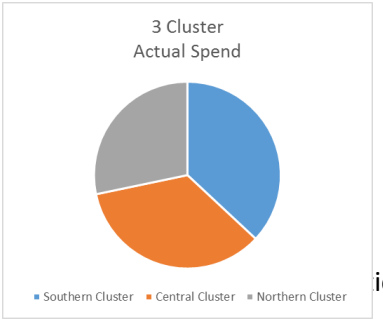
1. Size and Complexity

Each part of the directorate should have an equitable workload for managers. This can be considered in a number of ways but the intention is to create roles which are comparable in size and complexity to ensure that they can be graded appropriately and all roles can attract and retain qualified, capable and effective leaders/managers.

Staffing numbers and budget are most commonly used indicators of size.

Complexity may be considered in the range of services provided in each cluster and how this relates to overall LHD functions. The number of accountable key performance indicators and/or capital developments planned or possible can also impact on the size of the role.

Each General Manager also needs a team of business support staff who form part of a cluster executive in either a direct reporting or business partnering relationship.



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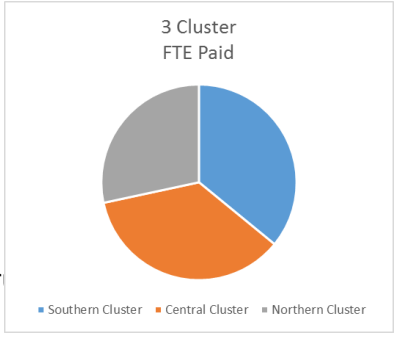


2. **Service Flows and Relationships**

The patient /population health needs and flows across the LHD have also been considered so that in a future state each part of the organisation has a larger Level 4 facility supporting a number of smaller facilities.

This is intended to enable sharing of skilled resources in a way that makes sense for patient needs and for staff movements and management. For example it should also support training and development opportunities.

This is currently the case for the proposed Northern and Southern clusters and is planned in the Clinical Service Plan for the Eurobadalla within the proposed Central Cluster.

3. **Standardisation of Care**

It is recognised that there is a need for enhanced leadership across similar services being delivered in a number of sites across the LHD. This is specifically to ensure that the standard of services for patients is consistent, safe and high quality across the LHD, that access is equitable , that planning and service development occur from a population perspective not just in isolated communities.

4. **Award Requirements**

Award requirements in relation to management and leadership roles must be adhered to.

Proposed Structure

1. **Geographical Clusters**

It is proposed that the service clusters are re-aligned to three geographical areas instead of the current four. The Ambulatory and Integrated Care Cluster will not exist and services will be relocated within other components of the structure. The three geographical clusters will include:

- Northern Cluster which would include health services provided in: Goulburn, Bourke Street, Yass, and Crookwell facilities;
- Central Cluster which would include health services provided in Queanbeyan, Braidwood, Batemans Bay, Moruya, Narooma, Karabar and Bungendore; and
- Southern Cluster which would include health services provided in Cooma, South East Regional Hospital, Delegate, Bombala, Pambula, Eden and Jindabyne.

Each Cluster will be managed by a General Manager (GM) who has a leadership team including the following roles:

- Cluster Director of Nursing and Midwifery (DONM)
- Cluster Director of Medical Services (DMS)
- Cluster Community and Allied Health Manager
- Cluster Corporate Services Manager

Each cluster leadership team will be supported by the following:

- Business manager
- People and performance business partner
- Patient safety/clinical governance business partner.

These roles will report directly through their respective Directorate structures but have a strong relationship and role within the Cluster leadership team.

Each facility will have an identified senior on-site manager at each hospital who has sufficient delegation to manage day-to-day patient care and hospital operations, and is the primary contact for the relationship between the local community and that hospital. This role has been reflected in the nursing structure below as Deputy Director of Nursing and Midwifery within the cluster nursing structure and is further described in appendix 1.

a) Nursing Structure

- Each cluster will be led by a Director of Nursing and Midwifery (DONM) for the Cluster. This will be the most senior position for all nursing care delivery and professional matters arising in all services and facilities within the cluster. This role reports directly to the GM and professionally to the Executive Director of Nursing and Midwifery and Clinical Governance (DNMCG).
- The Cluster DONM will be supported at each facility by a Deputy DONM or DON (reporting to the Cluster DONM) who is the senior position for the facility to lead the delivery of nursing care and act as the primary contact for matters related to patient care delivery in the site.
- These Deputy DONM/DON roles will not manage non-nursing staff or responsibilities which instead would be managed by other cluster leadership positions like the community and allied health manager or corporate service manager.
- A detailed description of the proposed changes and rationale for the nursing structures within each cluster is provided as appendix 1.

b) Community and Allied Health Structure

- Each Cluster will have a Community and Allied Health Manager who oversees the delivery of community and allied health services across the cluster sites. This role will form part of the cluster leadership team and report directly to the GM.
- A detailed description of the proposed changes and rationale for the community and allied health structures within each cluster is provided as appendix 2.

c) Corporate Service Structure

- Corporate services will be managed through a central coordination point as a Corporate Services Manager reporting to the GM.
- Their role will include oversight of a range of corporate functions for the cluster. Some of these will be through liaison with other LHD staff who manage those services directly and some will be to directly manage the service for the cluster.
- The role will act as a central resource for all managers in the cluster and as part of the cluster leadership team in relation to these matters.
- The functions include:
    - Facility and physical resource issues (e.g. buildings and vehicles)
    - Security
    - Orderlies/wardspersons
    - Administration staff
    - Cleaning
    - Food services

2. Clinical Streams

It is proposed that six clinical streams are established and that each GM has accountability for overseeing the work of two of six clinical streams for the LHD.

Each clinical stream will have one or more LHD Directors who are medical staff who will report to the GM with professional support provided through the Cluster DMS.

These roles will provide clinical direction across the LHD in relation to the roles and functions of the clinical streams and may be created as Clinical Academic roles in partnership with University partners.

It is intended once clinical streams have been established an additional process will be undertaken to ensure there is medical leadership structures that are consistent across the LHD for similar facilities. This will include departmental leadership roles.

It is anticipated that medical staff (including specialist medical staff and GPs) will be connected with and supported through both clinical streams and facility structures.

Other clinical leadership roles working within the specialty from an LHD perspective including senior allied health and or clinical nurse/midwifery consultants will also be located within the clinical stream and report through the Allied Health Manager or DONM for the Cluster as appropriate.

The six clinical streams are proposed:

- Women and Children including maternity, gynaecology, paediatrics, child youth and family, integrated violence and neglect service
- Oral Health
- Critical Care including Emergency Medicine, Intensive Care Medicine including intensive care and close observation units
- Surgical - it is proposed that Central Sterilising Services are transferred from Finance and Corporate Services Directorate to align with the clinical services as a key support service enabling efficient and safe delivery of surgical services.
- Rehabilitation, Aged Care and Medicine including Aged and Chronic Care and Falls Coordinator. There would be a link with multipurpose services providing residential aged care. The rehabilitation services and in particular the SARU's would also be aligned.
- Renal, Cancer and Palliative Care – it is proposed these services are relocated from Director MHDA Directorate back to Clinical Operations. This is so that relationship management across clinical services both locally and with ACT Health can be maximised.

The programs within the current Ambulatory and Integrated Care cluster have been reviewed in relation to clinical streams and as identified above the following changes are proposed:

- Integrated Violence Abuse and Neglect will relocate to sit within the Womens and Children clinical stream. Whilst it is recognised that these services are not provided exclusively to women and children there is a significant alliance in the protection and support for vulnerable populations.
- Womens Health, Child Youth and Family will also relocate to the Womens and Children Clinical Stream.
- Integrated Care will relocate to sit as a specific portfolio within the responsibilities of the tier two Director for MHDA. The role title for this position will change to reflect this.The health pathways project will also sit within this portfolio. Centralised intake will be relocated within the portfolio of the Manager Patient Flow and Whole of Health

Program who reports to the Director Clinical Operations. This is an initiative of the integrated care model and close relationships and engagement are fundamental to continued success and support however it is a significant patient flow initiative for the LHD.

- Population health, public health and health promotion will also be relocated with the Director of MHDA with integrated care.
- Aged and Chronic Care will relocate to sit within the Rehabilitation, Aged Care and Medicine clinical stream. The Falls Coordinator will also be relocated to this stream. The rehab services including SARU will be aligned with the stream but remain managed as part of their local facilities.
- Oral Health will be identified as a clinical stream.
- The vacant Manager for Allied Health position will change to a LHD Director for Allied Health and report to the Director Clinical Operations. The role would be open to all the professional advisors for allied health within the LHD and be identified as 0.5FTE. All the senior allied health advisors and educators would report to this role for their professional responsibilities. Clinical components of positions will report through the local identified manager for the facility/health service. It is proposed an additional professional advisor be established at 0.2 FTE for Radiography and will also report through to the Director for Allied Health. This will be a position open to appropriately qualified and experienced radiography staff within the LHD.

Clinical streams would not be responsible for direct line management or budget holding for their services which would remain within the local sites, (noting that this may be different for some program funded services). They would provide leadership and direction across the LHD for the speciality population through a specific work plan in regard to:

- Policies and procedures,
- Standardisation of clinical care delivery through models of care development
- Quality and safety initiatives
- Service planning and development
- Workforce capability, education and development
- Research
- Links with ACT Health and other NSW Health services as appropriate

3. Other Clinical Operations Management Roles

There are two other senior roles currently reporting to Director Clinical Operations:

a) <u>Manager Patient Flow and Whole of Health (WOH) Program.</u>

- This position is currently temporary based on allocated funding from the Ministry in relation to the WOH Program.
- It is proposed that the position is made permanent following a review of the grading given changes to the allocated responsibilities.
- It is proposed that Patient Transport Services be relocated from Finance and Corporate Services Directorate to this position to recognise their role in providing patient support services that are integral to patient flow and clinical service delivery across the LHD.

- It is proposed that this position continue as the identified leadership role for telehealth due to the relationship between telehealth service provision and patient flow.
- It is proposed that this role take on two additional portfolios – management of the central intake service established as part of integrated care, and ACT Health operational relationship manager.

b) Manager Diagnostic Services.

- This position has existed for around 18 months and has been vacant since early August 2018.
- It had a role in overseeing the review of invoices for services and in contract relationship management with both radiology providers including Strickland and pathology providers including NSW Pathology and Capital Pathology.
- It also provides professional support for radiology staff and has been involved in service development across the services including consideration of needs for a pending tender process for radiology.
- This position will be deleted from the structure. Instead these services will be allocated within the accountability for the Cluster DMS's and through the GMs.
- The other functions including the professional leadership role for radiology and contact point for the LHD for these services will be developed as a designated part of an existing senior facility radiology role and be aligned with the other allied health professional roles reporting to the Director of Allied Health.

c) Other Considerations

1. Aboriginal Health

- Currently services are coordinated through an Aboriginal Health Manager within the Ambulatory and Integrated Care Cluster.
- As this Cluster is not proposed to continue in its existing format and given the importance of recognising and supporting service responsiveness for the local Aboriginal and Torres Strait Islander communities there is an opportunity to elevate the place of this service within a revised structure.
- This is unlikely to require re-grading of any positions but by reporting directly to a Tier 2 position and subsequently having an opportunity to participate with other General Manager/Tier 3 roles in strategic service improvement and decision making a positive impact may be acknowledged by the local community.
- This will be located as a specialised role reporting to the Director MHDA.

2. Senior Nursing Role for Community Health

- Community nursing is viewed by staff who undertake this function as requiring specialist leadership support and advice which is integrated with but also different that other nursing settings. Expertise and advice on professional matters in a community context and areas like workload management is identified as a gap for the LHD.
- A professional advisor function for community health nursing will be established at 0.2FTE and be open to community nurse managers within the LHD and will report to the EDNM&CG.

3. **Pharmacy Services**

- Currently the LHD Chief Pharmacist reports to the Executive Director of Medicine and is 0.4 FTE.
- It is proposed that the reporting line for this position will change to align under the Clinical Operations Directorate. This is related to the delegations associated with the budget and spending on pharmaceuticals which rest with the Director Clinical Operations.
- The Chief Pharmacist will therefore report directly to the Director Clinical Operations.
- It is also proposed that the FTE is increased to 0.8FTE and applications will be sought from the Chief Pharmacists working within the LHD.
- Site Chief Pharmacists will report through the Cluster Director of Medical Services instead of the General Manager.

Summary

A structure has been proposed which can be described as a matrix structure.

It includes a Cluster Leadership Team providing direct management and accountability for services provided in each location and facility grouped into three clusters linking one or more larger facilities supporting smaller facilities, all serving a geographical population.

This is supported by the development of clinical streams which will drive quality and consistency of care throughout the local health district through clinical leadership, research, education and service development.

These two elements have been brought together through the critical roles of the General Managers who will have oversight of both a geographical cluster and two clinical streams. To do this the Cluster Leadership Teams have been redesigned to provide clear accountability for all aspects of service delivery from a diverse range of perspectives and capabilities.

The grading for each position in the structure has not been included in the attached draft organisational charts as the process of finalising position descriptions and ensuring the appropriate grading is assigned according to Award provisions will occur after consultation and a final structure is approved by the Chief Executive.

Appendix 1. Nursing Structures by Cluster

The nursing structures for each facility have been revised to support consistency in similar facilities across the LHD. This has included consideration for the volume and range of services provided in each site and growth in activity over time. It is also based on the inter-relationships between facilities within a cluster and this is intended to strengthen support for smaller facilities and facilitate collaboration around patient flow through the cluster and across the LHD.

The key changes are also related to the creation of cluster management roles for directors of medical services, corporate services, community and allied health. These roles will be responsible for managing a number of functions across all sites and services within the clusters that were previously the responsibility of the Nurse Manager/Health Service Manager at a facility level. This change means that Nurse Managers at facilities will be the primary contact and an important community face for the facility but will be released from directly managing non-nursing and non-patient care functions at the site. Instead they will be supported by the accountable cluster management role who will undertake these responsibilities. For example the Nurse Manager would be the decision maker regarding staffing allocations across the facility and opening beds when demand requires it but if there was a maintenance issue that was not being resolved they could refer this to the Corporate Service Manager to resolve.

The grading for each position will finalised through the consultation process once the structure is approved.

As noted earlier it is intended that a professional lead (0.2FTE) for community health nursing will be established as part of the role for one of the NM Community Health and will report to the EDNM&CG.

The key changes are summarised below:

a) Northern Cluster

A cluster DONM is created

Goulburn

- Hospital DONM changes to become Deputy DONM, reporting to Cluster DONM
- Deputy DONM for Hospital is deleted.
- Nurse Manager (NM) Patient Flow is created to support the flow and nursing care delivery within the hospital and from other cluster and LHD sites. This reports to the Deputy DONM.
- After Hours NM report to NM Patient Flow.
- NUMs for Medical, Emergency and ICU report to NM Patient Flow.
- NM for Peri-Op and Day Surgery Unit (DSU) becomes NM Peri-Op and reports to Deputy DONM.

- NUM for Operating Theatre (OT) and DSU is created and will report to NM Peri-Op
- NUM for Surgical reports to NM Peri-Op
- NUM for Maternity and Paediatrics changes to be two separate positions – MUM for maternity and NUM for Paediatrics. Both positions will report to Deputy DONM.
- NUMs for Renal and Sub-Acute will report to Deputy DONM.
- NM Community Health will report to cluster Community and Allied Health Manager with professional reporting through the Cluster DONM to EDNMCG.
- NUM Community Health will report to NM Community Health and through cluster Community and Allied Health Manager with professional reporting through the Cluster DONM to EDNMCG.

Bourke Street

- The NM Bourke Street becomes Deputy DON reporting to the Cluster DONM.
- NUM for Oncology is relocated to report to the NM Community Health for consistency across the LHD. This means it reports through the cluster Community and Allied Health Manager with professional reporting through the Cluster DONM to EDNMCG.
- NUM for Marian Unit will be 0.5 Clinical and report to the Deputy DON.
- Responsibility for Brain Injury Service and TRACS will relocate from the NM Bourke Street to the cluster Community and Allied Health Manager.

Crookwell

- The NM Crookwell becomes Deputy DON reporting to the Cluster DONM.
- Deputy NM becomes Clinical NUM and is 0.5 clinical.

Yass

- The NM Yass becomes Deputy DON reporting to the Cluster DONM
- Deputy NM becomes Clinical NUM and is 0.5 clinical.

Braidwood

- Braidwood is relocated from Northern to Central Cluster
- NM becomes Deputy DON reporting to the Central Cluster DONM.
- Deputy NM becomes Clinical NUM and is 0.5 clinical.

b) Central Cluster

A cluster DONM is created.

DONM for Moruya and Batemans Bay is deleted.

The current structure has Moruya leading oversight of the majority of services for both Moruya and Batemans Bay from that location. This is supportive of directions for combined service model development for the future as part of the Clinical Services Plan and commitment to a new single facility for the Eurobodalla, announced in late 2018.

Due to the geographical distance between the Eurobodalla and Queanbeyan and the different patient flow patterns for patients presenting to these facilities this cluster has two Nurse Manager Patient Flow positions identified in the structure which is different from the other clusters.

Batemans Bay

- Deputy NM becomes Deputy DON reporting to Cluster DONM
- NUM Emergency created to support activity changes in both BB and Moruya and will report to Deputy DON
- NUM Acute is reviewed and reports to Deputy DON.

Moruya

- Deputy DONM will report to Cluster DONM
- NM OT becomes NM Peri-Op Moruya and Batemans Bay (BB) to ensure consistency of titles across the LHD for and reports to Deputy DONM
- NUM OT continues reporting to NM Peri-Op who then reports to Deputy DONM
- NM Patient Flow created for Moruya and BB to support the flow and nursing care delivery within both hospitals and from other cluster and LHD sites reporting to Deputy DONM.
- NUM Acute is reviewed to take on close observation unit from NUM ED/HDU for consistency with other sites across LHD. This role will report to NM Patient Flow
- NUM ED/HDU is reviewed to be NUM Emergency only and will report to NM Patient Flow. This is to reflect changes in activity in ED presentations at this site and across the Eurobodalla.
- NM After-Hours (Moruya/BB) report to NM Patient Flow
- MUM Maternity will report to Deputy DONM
- NUM Renal will report to Deputy DONM
- NUM Sub acute will report to Deputy DONM
- NM Community Health BB & Moruya will report to cluster Community and Allied Health Manager with professional reporting through the Cluster DONM to EDNMCG.
- NUM for Oncology reports to NM Community Health through cluster Community and Allied Health Manager with professional reporting through the Cluster DONM to EDNMCG.

Braidwood

- Braidwood is relocated from Northern to Central Cluster
- NM becomes Deputy DON reporting to the Central Cluster DONM.
- Deputy NM becomes Clinical NUM and is 0.5 clinical.

Queanbeyan

- NM becomes Deputy DONM reporting to Cluster DONM
- Deputy NM is deleted.
- NM Patient Flow is created to support the flow and nursing care delivery within the hospital and from other cluster and LHD sites reporting to Deputy DONM
- NUM Peri-Op reports to Deputy DONM.
- NUM Acute is reviewed and reports to NM Patient Flow
- NUM Emergency is reviewed and reports to NM Patient Flow
- NUM Maternity is reviewed and reports to Deputy DONM.
- NUM Renal reports to Deputy DONM.
- NM Community Health will report to cluster Community and Allied Health Manager with professional reporting through the Cluster DONM to EDNMCG.

c) Southern Cluster

A cluster DONM is created.

South East Regional Hospital

- Hospital DONM changes to become Deputy DONM, reporting to Cluster DONM
- Deputy DONM for Hospital is deleted.
- NM Patient Flow is created to support the flow and nursing care delivery within the hospital and from other cluster and LHD sites. This reports to the Deputy DONM.
- After Hours NM report to NM Patient Flow.
- NUMs for Medical, Emergency and ICU report to NM Patient Flow.
- NM for Peri-Op reports to Deputy DONM.
- NUM for OT/DSU continues to report to NM Peri-Op
- NUM for Surgical title adjusted for consistency across the LHD to Surgical instead of Surgical/Preadmission and continues to report to NM Peri-Op
- NUM for Maternity will change reporting to Deputy DONM
- NUM for Paediatrics will continue to report to Deputy DONM.
- NUMs for Renal and Sub-Acute will continue to report to Deputy DONM.
- NM Community Health will report to cluster Community and Allied Health Manager with professional reporting through the Cluster DONM to EDNMCG.
- NUM Oncology will report to NM Community Health and through cluster Community and Allied Health Manager with professional reporting through the Cluster DONM to EDNMCG.
- NM Integrated Service Manager will be deleted.

Pambula

- NM changes to become Deputy DON reporting to Cluster DONM
- NUM acute/ED is deleted.

Bombala

- NM Bombala and Delegate MPS is deleted
- Deputy NM Bombala becomes Deputy DON reporting to Cluster DONM

Delegate

- NM Bombala and Delegate MPS is deleted
- Deputy NM Delegate becomes Deputy DON reporting to Cluster DONM

Cooma

- NM becomes Deputy DONM reporting to Cluster DONM
- Deputy NM is deleted
- NUM OT is reviewed to become NUM Peri-Op for consistency of titles across the LHD and reports to Deputy DONM

- NUM Ward is reviewed to become NUM Acute for consistency of titles across the LHD and reports to Deputy DONM
- NUM Emergency is reviewed and reports to Deputy DONM
- NUM Maternity reports to Deputy DONM
- NUM Renal reports to Deputy DONM
- NUM Community Health will report to cluster Community and Allied Health Manager with professional reporting through the Cluster DONM to EDNMCG.

Appendix 2: Community and Allied Health Structure by Cluster

Allied and community health organisational structures are often impacted significantly by the allocation of specific program funding targeting a specific care intervention or a patient population need or at times specific professional resources. This can lead to services evolving into fragmented structures with small allocations of FTE working across multiple clinical areas.

Whilst we need to retain a clear accountability and reporting of how such project/program specific funding is used we also need to have a structure which is meaningful for staff and makes sense in how we organise our work and respond to our communities.

The proposed structure is focussed on ensuing that there are appropriate leadership roles in place reporting to a Community and Allied Health Manager who has responsibility across all facilities and services provided within the cluster in the community and by allied health professionals. This is intended to provide flexibility in how staff are utilised to respond to areas of priority and to enable management of leave or vacancies whilst maintaining continuity of services. It is also intended to resolve the current confusion which arises at times for members of the community and staff in regards to community services which operate out of a facility but are managed by a different general manager.

It would be expected that each clinical program would have a lead within the community and allied health structure for the cluster who could coordinate the program outcomes across all disciplines to reduce the risk of fragmentation. This lead would also collaborate with other cluster leads for programs which operate across the LHD to support consistency and sharing of expertise. Sometimes this coordination of programs would be led through a key role in one of the clinical streams which are to be established, for example Oral Health. The detail of where each program might fit best would be developed through consultation as part of the implementation process once the final structure is approved.

The professional reporting lines for discipline leads will be reflected through a dotted line through the respective professional advisor to the Director of Allied Health position to be established and the Community and Allied Health Managers will also have a dotted line to this position.

As discipline leads are cluster based rather than site based it will be important to ensure that there is a senior presence distributed across facilities within the cluster.

The grading for each position will finalised through the consultation process once the structure is approved.

The key changes are summarised below:

a) <u>Northern Cluster</u>

- Cluster Community and Allied Health Manager (C&AHM) is created

- NM Community Health reports to C&AHM and has direct reports of NUM Community Health and NUM Oncology as per nursing structure.
- Discipline leads continue for Occupational Therapy, Speech Pathology, Dietetics, Physiotherapy and Social Work and will report directly to C&AHM and professionally through their discipline advisor to the Director of Allied Health.
- TRACS and the Brain Injury Service will relocate from the NM Bourke Street to report through the C&AHM.

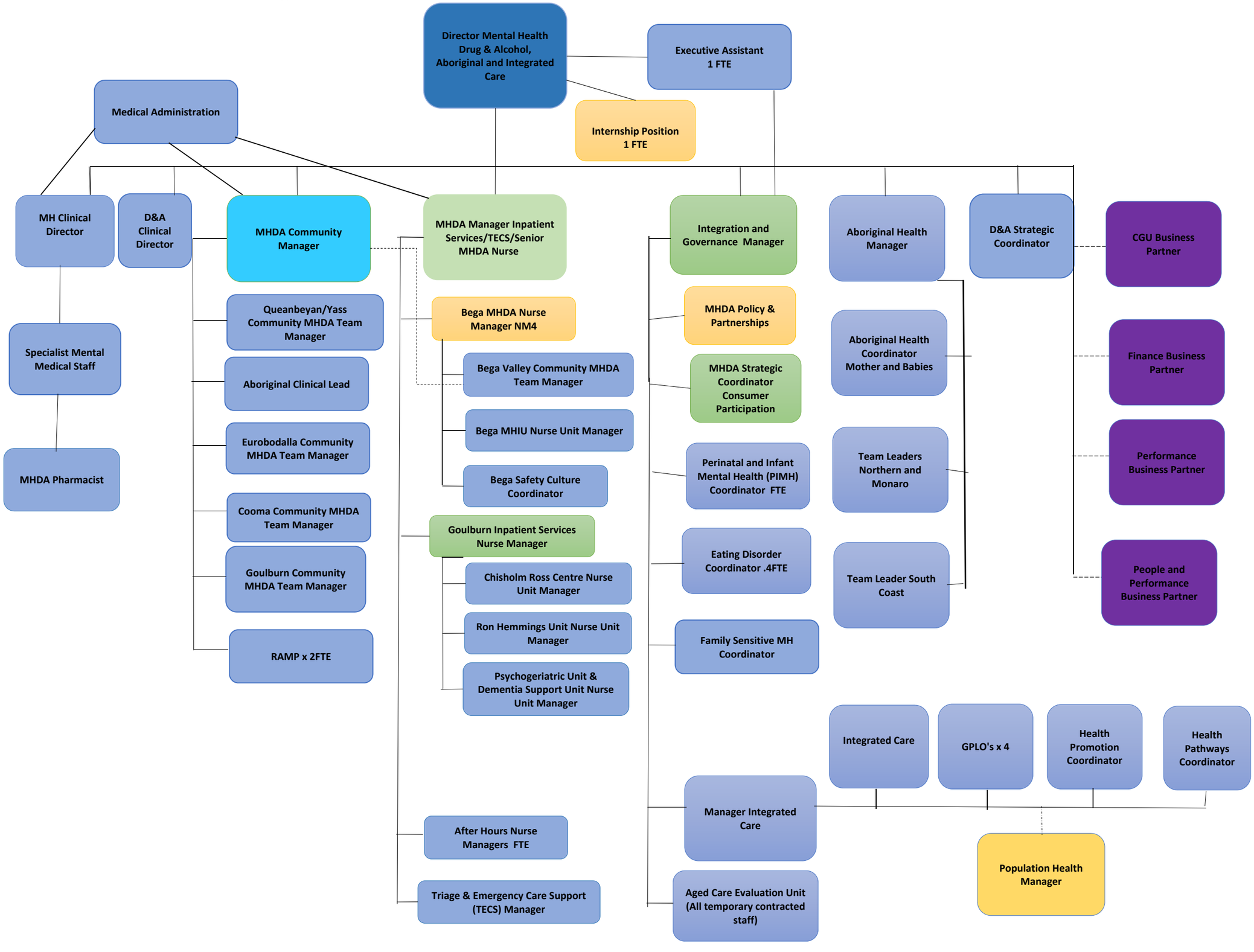
b) <u>Central Cluster</u>

- Cluster Community and Allied Health Manager (C&AHM) is created
- NM Community Health for Eurobodalla reports to C&AHM and has direct reports of NUM Community Health and NUM Oncology as per nursing structure.
- NM Community health for Queanbeyan reports to C&AHM as per nursing structure.
- Discipline leads continue for Occupational Therapy, Speech Pathology, Dietetics, Physiotherapy and will report directly to C&AHM and professionally through their discipline advisor to the Director of Allied Health.
- Discipline lead for Social Work to be created.

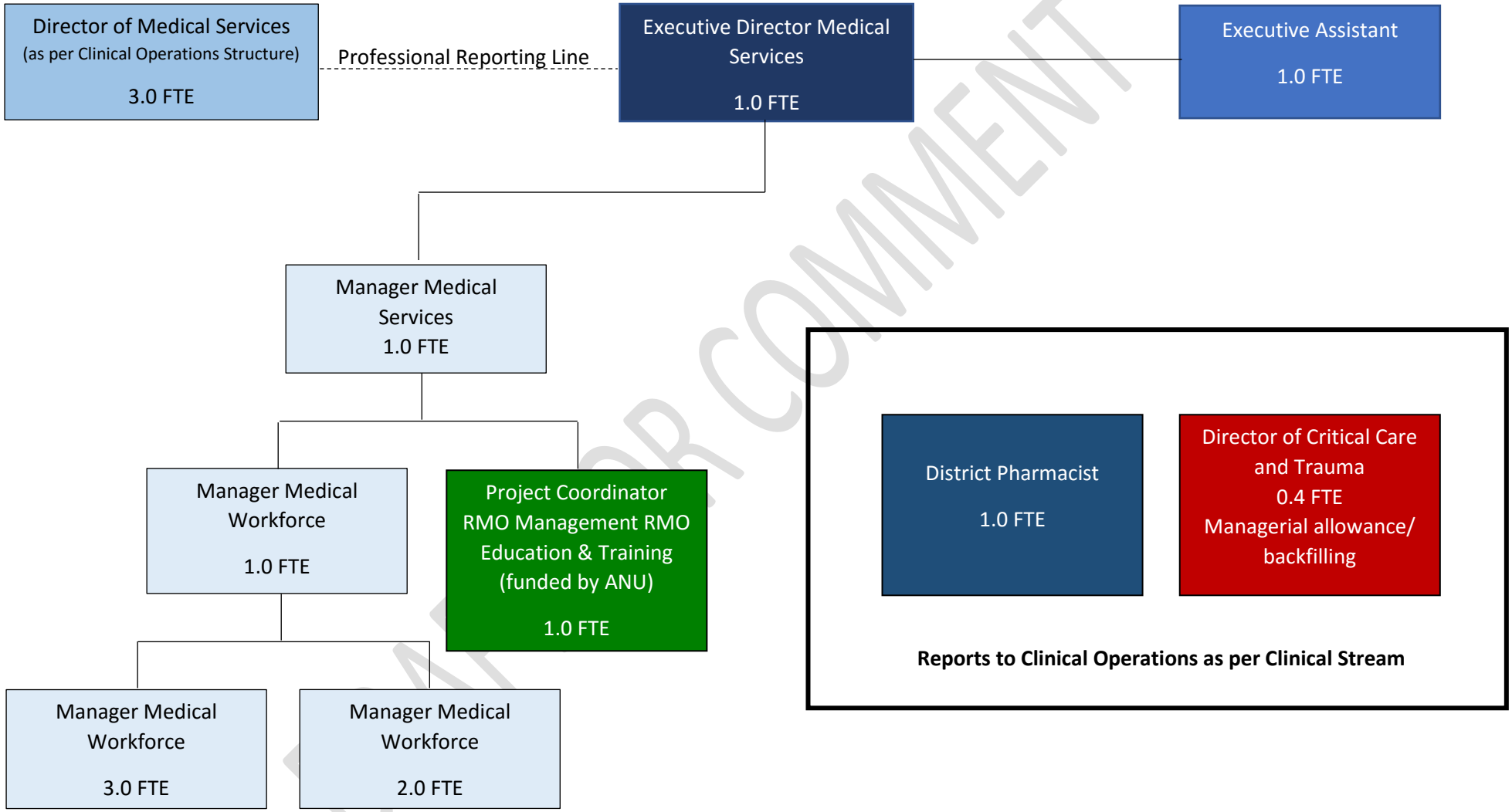
c) <u>Southern Cluster</u>

- Cluster Community and Allied Health Manager (C&AHM) is created
- Allied Health Manager is deleted.
- NM Community health for Bega Valley reports to C&AHM and has direct report of NUM Oncology as per nursing structure.
- NM Community health for Cooma reports to C&AHM as per nursing structure.
- Discipline leads continue for Occupational Therapy, Speech Pathology, Dietetics, Physiotherapy and will report directly to C&AHM and professionally through their discipline advisor to the Director of Allied Health.
- Discipline lead for Social Work to be created.

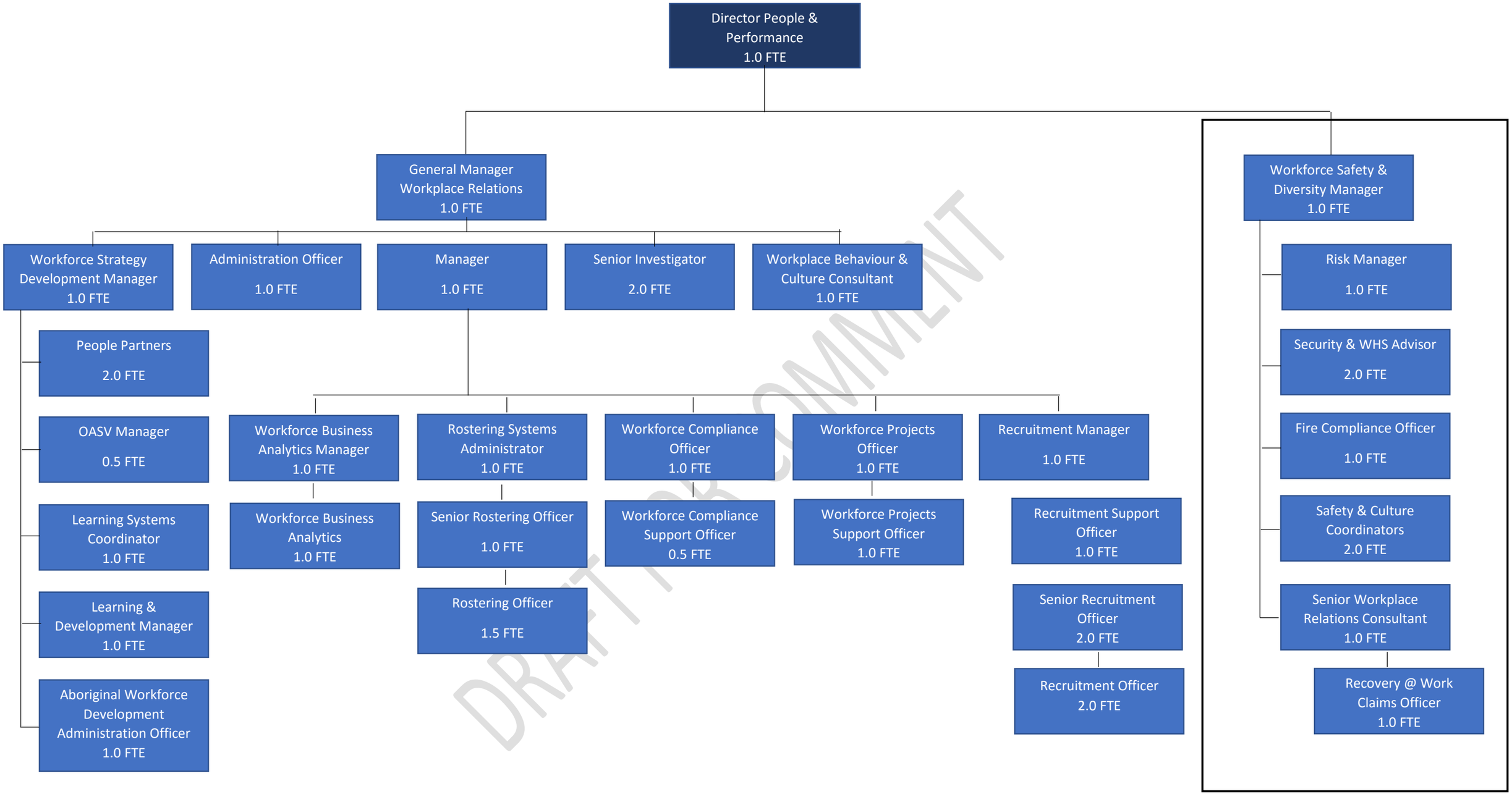
Proposed Structure Mental Health Drug & Alcohol Directorate



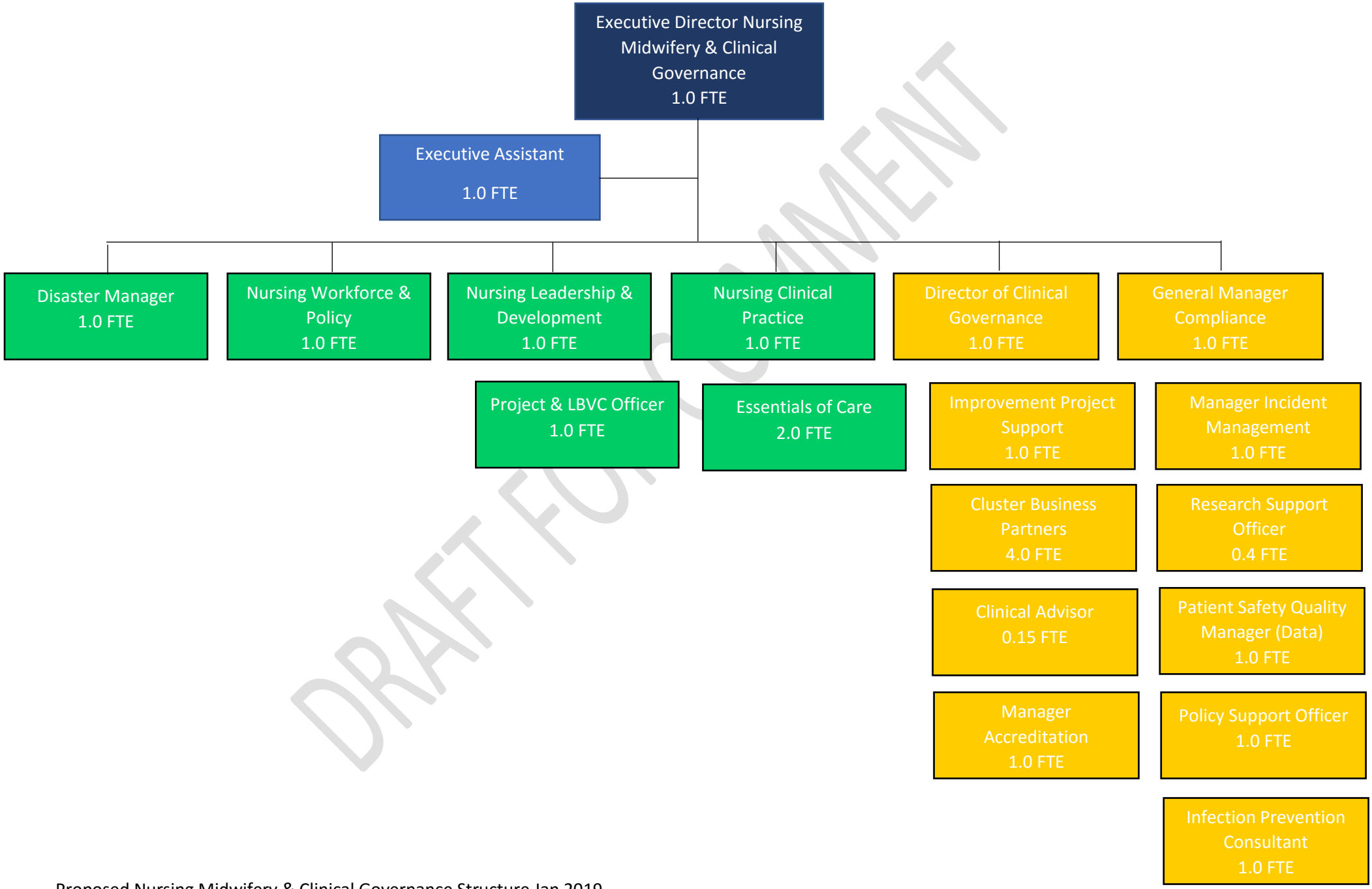
Proposed Structure Medical Services Directorate



Proposed Structure People & Performance Directorate



Proposed Structure Nursing Midwifery & Clinical Governance Directorate



Proposed Nursing Midwifery & Clinical Governance Structure Jan 2019

Proposed Structure Media & Corporate Communications Directorate