Building Consensus:
Involving Stakeholders in Structure Design

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Overview

- Background & context
- Consultative process leading to a new AH structure: from Jan 2006

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Background & context

- Melbourne Health
  - Major metro hospital / trauma centre, across 2 sites: 350 acute beds, + 90 subacute beds, extensive ambulatory services
  - ~6000 staff members
  - Clinical services primarily organised in Divisions
- Allied Health
  - ~230 EFT
  - AH Prof 90%, AHA's 10%
  - Predominantly female, & fulltime
  - ~15% of workforce enrolled in formal postgraduate study

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2003-4

- Divisional model proposed, with support of CEO & Executive
- Workshops to differentiate roles of AH Mgrs & Sr Clinicians in relation to disciplines & divisions, eg:
  - Geographical co-location of staff working within divisions
  - Mgrs became “Discipline Leaders”
  - Sr Clinicians to be supervised by AH Mgrs in their divisional roles, not by Discipline Leaders
  - Changes to Prof Development & Performance Appraisal processes
- External consultant report, commissioned pre-Christmas 2004
  - Met with some resistance
  - Union involvement

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2005

- Formal dialogue between unions and MH began in Jan
- Formation of an Allied Health Industrial Consultative Committee (AHICC)
  - Building on previous model
  - Staff & union reps, DAH & AH Mgr reps, & HR / IR
  - Staff wanted to return to discipline structures, and were not in favour of divisionalisation; didn't understand the rationale behind the change
- Formal communications from Union:
  - Not opposed in principle
  - Perceived lack of transparency & consultation
  - Queries: Org Change process / maintenance of discipline support / evidence base supporting the proposed changes / professional associations
  - Lack of AH representation at the Exec level

"…Compromising quality of patient care, professional discipline issues, annihilation of career path…. mgt attitude of forging ahead despite concerns of employees…"

Letter from HSUA to MH, Mar 05

2005

- Proposal re: a trial process
  - Cease divisionalisation, bring in independent external expert
  - Instigate a trial to xamine, evaluate & report on:
    - AH Mgt role – division vs discipline / pt outcomes / R&R / budgets / workload / supervision / career structure
- MH agreed to a trial
  - Option for external review if necessary after trial
  - Clin Epi commissioned to undertake a literature review & evaluation
- Trial was worked up by the AH Mgt team & AHICC
  - Staff Survey (October): views on access to supervision / mentoring / education & professional development / job security & teamwork issues
  - Commenced in November: appointed “Site Mgrs” in each of the larger disciplines

Organisational focus shifted: major financial crisis

Culminated in a change in CEO

2006

- Appointed in late 2005, commenced late Jan 2006
- AH Staff & Managers: experienced significant local unrest for almost 2 years
  - Compounded by significant degree of organisational difficulty
  - Two sites: 10 mins apart; difference in experience, perspective, and in collective corporate memory
  - Discontent amongst staff
- Organisational level: Acting CEO, range of systemic issues
  - Perception that the AH situation was problematic
  - Discontent amongst key stakeholders

"….The question is: 'why isn't this pt seeing their physio today?', and the answer is 'because we are all busy having a meeting about our structure'…"

"It's time to put it to bed & move on – whatever that looks like…."

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Ascertaining Status Quo

- Overwhelming
- Trial structure in place
    - Context was grounded in the history of the dispute
    - End date, but no clear exit strategy
- Consultative process was happening
    - No comprehensive audit trail
    - Plethora of different opinions
- Clear inferences that significant effort would be required
- Clear benefit in being new to the organization
    - A logical time for reflection
    - Fresh eyes and **ears**
    - Validation that recent experience had been very challenging for staff & mgrs

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Reinvigorating the Consultation

Purpose of AHICC:

- To provide a forum for communication between key stakeholders, promoting industrial harmony
- To provide clarity in relation to process
- To influence a positive outcome for all concerned

Intended Outcome:

- To determine a structure meeting the needs of key stakeholders, and to make formal recommendations to MH Exec in relation to that structure

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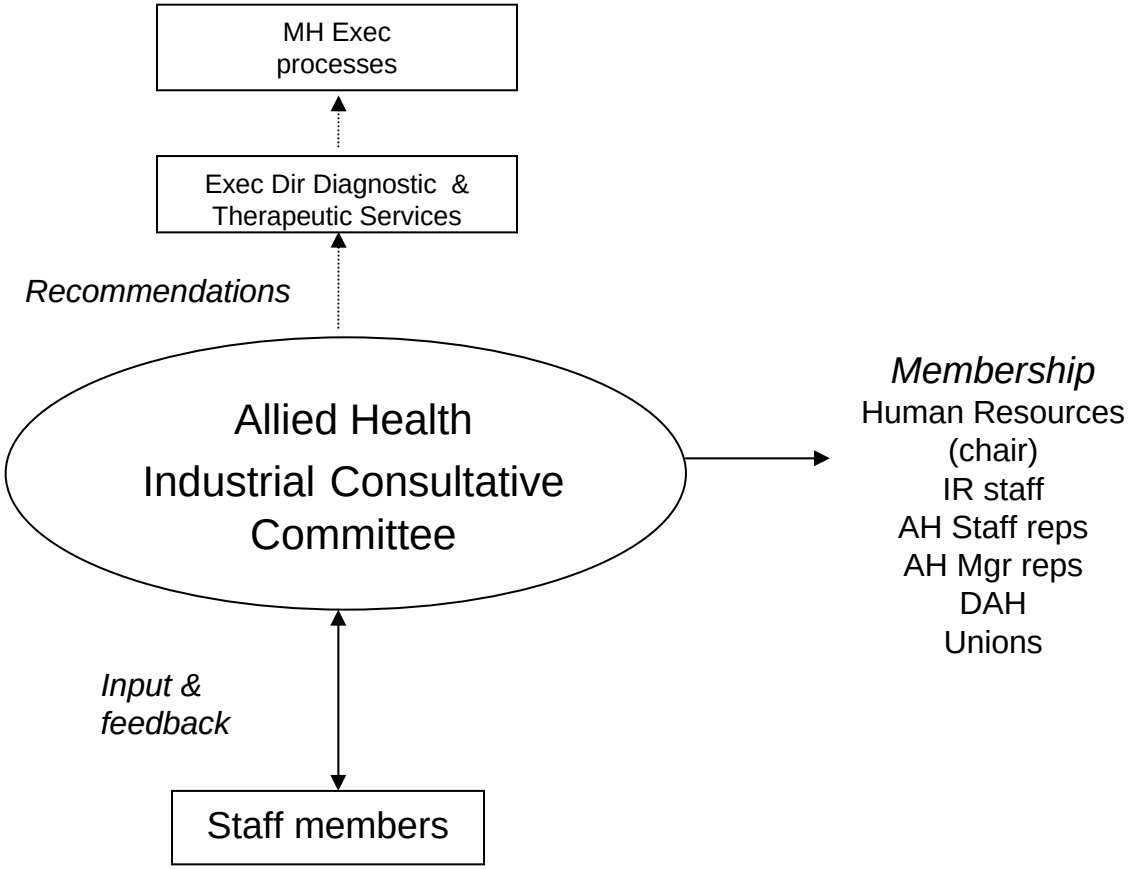
Reinvigorating the Consultation

Commence Feb 05

Key focus = structure; life of committee time-limited

Likely end-date: July 06
**once structure determined*



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Articulating process

- DAH became Chair of the AHICC
- Clarity:
  - Statement of Purpose
  - Rules of engagement: actions well-articulated, minutes accurate & timely, follow-up would be prompt
  - Determine & clarify “message” for other staff
- Confirm group’s expectations of process

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Key Phases & Process Points		Timelines	
1. Trial in progress	Eval: Baseline survey	Oct 05	
	Trial commenced	Nov 05	
	Eval: Interviews with AH Mgrs	Feb – Mar 06	
	Eval: Interviews with non-AH sr staff / Exec	Mar – Apr 06	
	Eval: Re-survey of AH staff	Mar – Apr 06	
2. Completion of trial	Trial period end	Apr 06	*
3. Evaluation	Clin Epi eval completed	Jun 06	
4. Analysis Multi-factorial: evaluation, organisational & policy context, financial impact eg:	Baseline survey results Gr 3&4 interview results Comparison of roles & resp with Award / EBA Detailed costings, aligned with budget-setting process Informal feedback	Apr – Jun 06	* * *
5. Determination & ratification of structure	Definitive recommendations from AHICC to Exec	Jun 06	
6. Implementation of structure	Recruitment	ASAP post-above	

Embarking

- Initial recommendation to extend the trial until June 30th
- Started to articulate the decision-making process, & to formulate a reference framework
- Analyse the results of the Baseline Staff Survey

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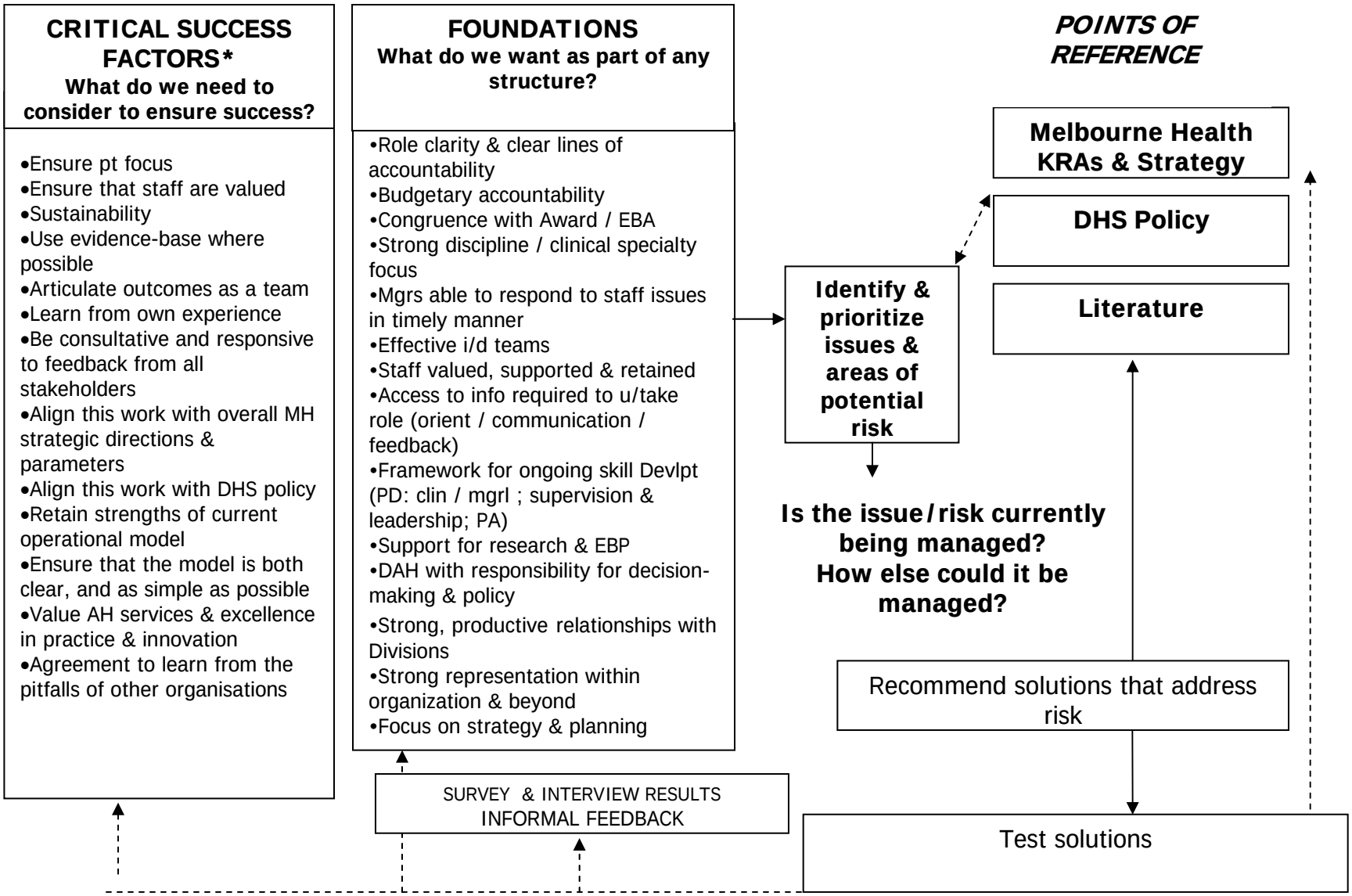

AHICC Reference Framework

** nb: adapted from Law,D & Boyce, R (2003): Beyond Organisational Design: Moving from structure to service enhancement. Australian Health Review, V26 (1)*

Logistics

- AHICC meeting weekly: 90 mins
- Several clinicians, 2 AH Mgrs, HR, HSUA 3 rep, DAH for each meeting
- Feedback sessions from reps to staff
- Usual monthly Forum at each site, supplemented by additional formal feedback sessions

= Labour intensive ++, major commitment of time & effort

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Initial interview findings

Trial Gr 4's	AH Mgrs	Exec / Sr Staff
Difficulties maintaining split clinical and managerial roles	Split roles for Gr 4's < ideal	Lack of transparency
Gr 4 roles not being used in a clinical capacity	Mgr had 'lost touch' with the other site	Lack of understanding of AH business
Issues of being based on one site	Role expectations were not clear	Not clear about reporting lines
Role confusion with Discipline Mgrs	Potential for service integration & "whole-of-org" approach to suffer	Aware of issues, but didn't really appreciate the nature of concerns
Short trial period		Supportive+ of AH Mgr roles on Divisional Execs

Staff Surveys 1 & 2

2nd staff survey (April), with comparative report (May)

- Differences were in a +ve direction: more agreement, & less disagreement
- Items relating to divisional roles were still unclear
- No material change in issues such as succession planning & skill mix; service development; consumer input; equipment; links with divisions; research

Evaluation itself could not provide a definitive answer, partly because the evaluation question was not “is this the best structure for you?”

Moving on

In AHICC meetings, and in an all-day workshop, we systematically worked through “Foundations”:

- Assigning relative priority
- Identifying issues
- Utilising the reference points
- Coming up with strategies
- Assessing potential impacts eg how clinicians AND mgrs would benefit if “x” happened?

FOUNDATIONS **What do we want as part of any structure?**
•Role clarity & clear lines of accountability •Budgetary accountability •Congruence with Award / EBA •Strong discipline / clinical specialty focus **•Mgrs able to respond to staff issues in timely manner** •Effective i/d teams •Staff valued, supported & retained •Access to info required to u/take role (orient / communication / feedback) •Framework for ongoing skill Devlpt (PD: clin / mgrl ; supervision & leadership; PA) •Support for research & EBP •DAH with responsibility for decision-making & policy •Strong, productive relationships with Divisions •Strong representation within organization & beyond •Focus on strategy & planning

What did that mean?

- High priority
- What is “appropriate access” and from whose perspective?
- What are the specific impacts?
- Are mgrs supported in their own roles ie do they feel able to respond?
- Is there a different way & what might the risks be?

Managers are able to respond to staff issues in a timely manner

Gradually built the model that would meet our needs

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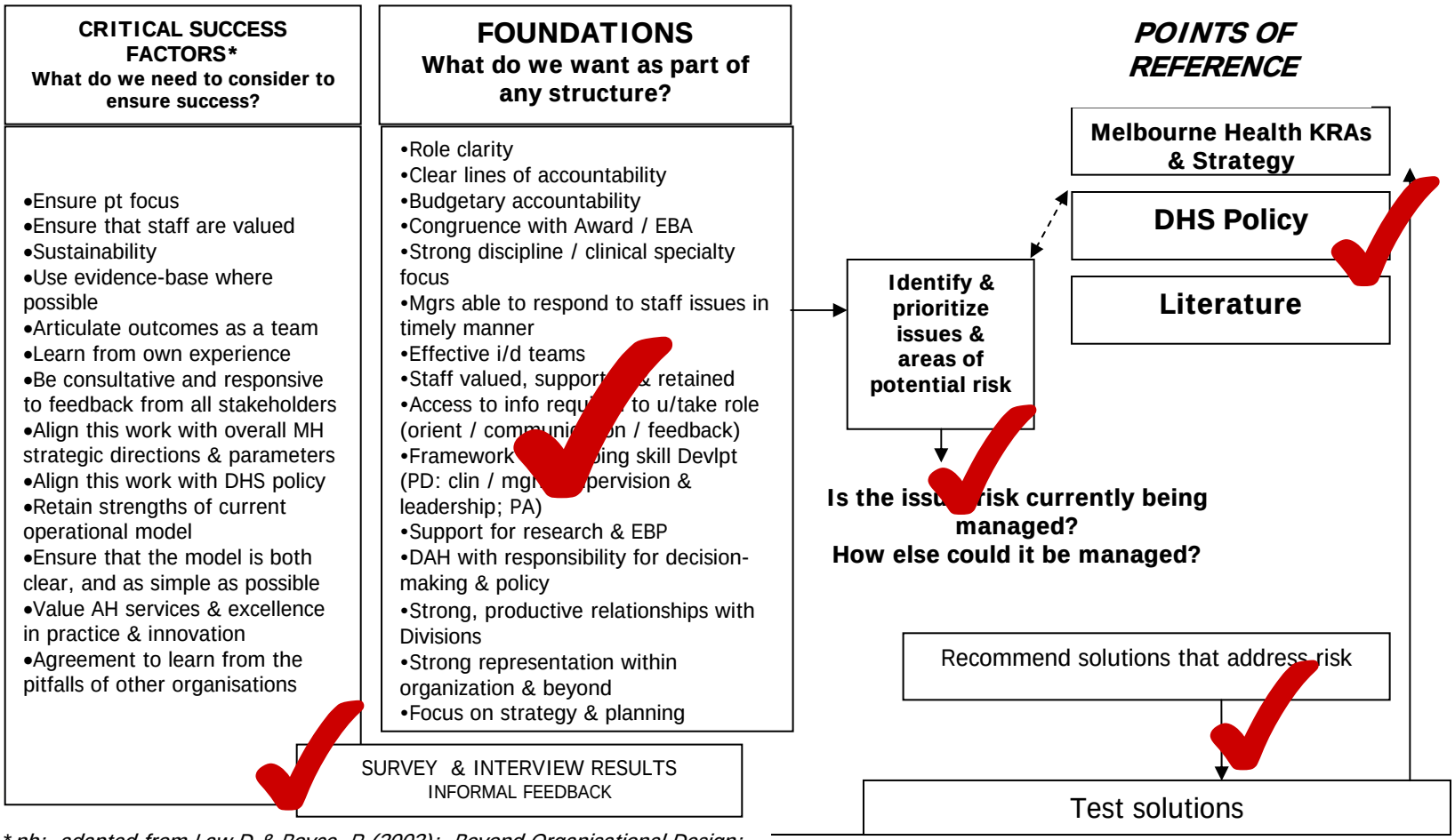

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Check & re-check

Refining

- Refined the focus
- Made draft recommendations
- Developed PDs for the new roles
- Worked up Budget Analysis & impacts
- Presented to the staff
- Made definitive recommendations

1. Sought & gained agreement of CEO
2. Completed Org Change process
3. Implemented the structure

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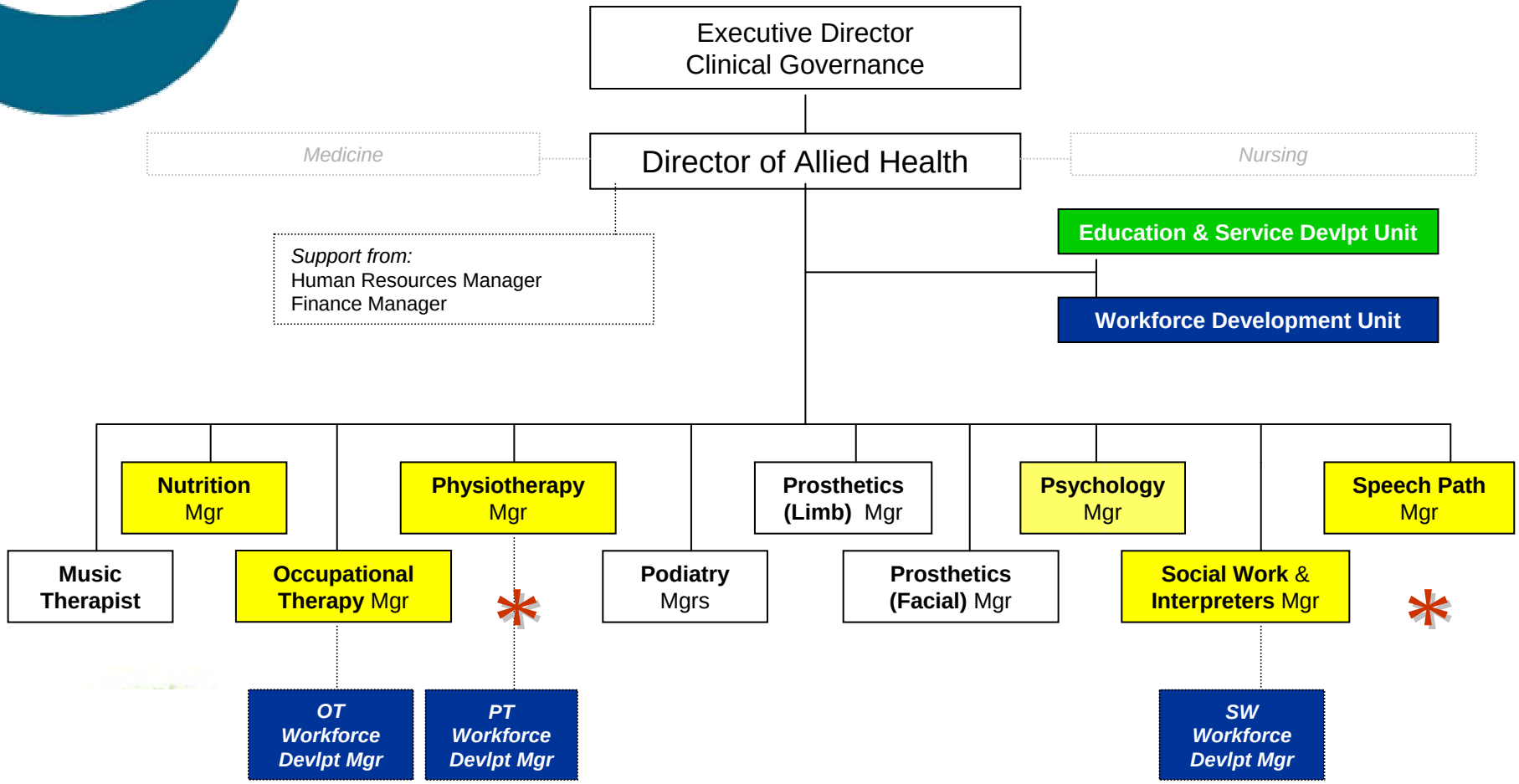

- *Changes to Divisional roles*
- *Communication systems*
- *Addressing clinical service gaps*

* Clinical Gr 4's

Achievements

- **Clinical discipline base** as the platform for effective team intervention and best practice patient care
- **Supported by CEO & Exec,** & complements the **MH Clin Gov Framework**
- **DAH on MH Exec**
- **Budget** remains within Allied Health
- **Consistent with contemporary literature**
- Built on **staff feedback, evaluation outcomes**, and **common sense**
- Built on **effective collaboration with key stakeholders**
- Focus on **practical outcomes for workforce & education**
- Focus on **strategic planning** for **sustainable** workforce & education outcomes
- **Defined path to Grade 4's**
- Knowledge base from which to review **communication structures, & address clinical service gaps**

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‘Essence of AHICC’

- **Rigorous debate**, interspersed with some careful **listening**
- Through the process, opinions were becoming grounded in the **literature** that was available, **in practice wisdom**, in **common sense**, and in a comprehensive understanding of what **staff & mgrs wanted**
- **Union participation** integral to process; compliance with award & sound understanding of practice in lead-up to EBA
- **Communication++++**
- Moved towards a **vision of what could be**, rather than a salvage operation

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THANK-YOU to AHICC

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