Health Care Consumers' Association Inc
100 Maitland Street, Hackett ACT 2602
Phone: 02 6230 7800
Fax: 02 6230 7833
Email: adminofficer@hcca.org.au
ABN: 59698548902

HCCA Submission on the Review of Community Health Administrative Structure Draft Report

16 August 2013

Contact: Darlene Cox
Executive Director
darlenecox@hcca.org.au
02 6230 7800

Author: Heather McGowan
HIP Project Officer

Karen Faichney
ACT Health
Karen.Faichney@act.gov.au

Dear Ms Faichney

The **Health Care Consumers' Association (HCCA) of the ACT** was formed over 30 years ago to provide a voice for consumers on local health issues and now provides opportunities for health care consumers in the ACT to participate in all levels of health service planning, policy development and decision making.

HCCA involves consumers through:

- Consumer representation
- Consultations
- Training in health rights and navigating the health system
- Community forums
- Information sessions about health services
- Advocating for issues of concern to consumers

HCCA welcomes the opportunity to respond to the *Review of Community Health Administrative Structure Draft Report.* Our comments are informed by consultation with our consumer membership.

We have identified a number of areas which require clarification and development. We would be more than happy to discuss any issues further, if you would feel that is of use.

Yours sincerely,

Darlene Cox
Executive Director

General comments

We noted that there are a number of spelling mistakes, grammatical errors and poorly constructed phrases which obscure the intention of the sentence. Instances of "etc" should be reduced and lists expanded to include relevant information.

In addition, abbreviations and capitalisations should be employed consistently throughout the document, year designations should be applied to all dates and the attachments should include page numbers. There are also several uses of political, marketing and HR "buzz words" which would benefit from simplification or explanation to clarify their meaning.

The report should include the name of the author.

Furthermore, HCCA would like to see a more logical link between the feedback collected, and subsequently provided in the attachments, and the output generated as a result: the recommendations, change management plan and proposed structure diagrams.

HCCA would be happy to provide specific comments in track changes, if required.

Methodology – page 4

We would like to see the methodology include all background documents consulted that are of relevance to this review. In addition, key informants, from other services like Canberra Connect, should be listed. Likewise, the names (or position titles) of the "Directors" mentioned in the report should be listed in full. This provides transparency and a record of engagement.

Stakeholder consultation and feedback – page 5

In this section, HCCA feels that it would be appropriate to list the groups to which the briefing on the Administration Services Review was provided and on which date/s this occurred.

In addition, the listing of the consultation with consumer representatives should indicate that these consumers are affiliated with HCCA.

Staff – page 6

In this, and other sections of the report, points raised are often presented as simple phrases. It is important to elaborate on these. For instance, one of the barriers listed in the *Staff* section is simply "standardisation practices". Does this mean that

standardisation practices will need to be developed, are currently ineffective, or are too difficult for staff to adhere to?

Consumers – page 7

It would be more appropriate to note that a "one stop shop" for reception *could* address consumer issues, rather than *would.*

Clinicians – page 7

The section on clinicians would benefit from some case studies or examples obtained from interviews with key informants.

While the report goes on to identify that many staff are not capable of or willing to lead change, we see that there is an opportunity to engage those staff who want to and are able to take leadership roles in the change management process.

Community Health Intake (CHI) Line – page 8

The report requires more information about the role and composition of CHI. CHI and Community Health Centres are intrinsically connected. As such, it is simplistic to attempt to view these two services in isolation. It would be appropriate to include more background information about CHI, such as an explanation of its operation and a breakdown in staffing (nurses/administration) and task allocation.

While HCCA supports the measures aimed to tackle overflow from CHI, we would like to see more attention paid to building the capacity of CHI to be able to handle its workload more efficiently and effectively.

The report notes that 75% of phone calls are terminated by the CHI administration team, but it is unclear what this means. Are callers being routinely hung up on? Or is this an expression signifying that their information needs were met in that exchange? Is CHI functioning as more of an information line than a booking service? Are staff unable to make an appropriate phone referral for consumers? Background on this is required in order to make it a meaningful and relevant statistic.

SWOT analysis – page 12

The *Strengths* section should include explicit mention of an increased responsiveness to consumer needs, as well as "service demands".

The *Opportunities* section notes that a shared reception model (SRM) can "[i]mprove customer experience" – more appropriate language in this context would be "consumer" or "client" experience.

In the *Weaknesses* section, it is unclear why "system integration" is designated as a weakness. This selection requires explanation in order for it to be meaningful.

The *Threats* section suggests that "[a]cceptance by consumers may be slow" despite evidence that consumers are in favour of an SRM. It seems more appropriate to include "acceptance by staff" as a threat in this section.

The strengths, opportunities, weaknesses and threats do not appear to be addressed within the report's recommendations.

Proposed structure – pages 13-17

The proposed structure layout requires clarification. In particular, the recommendations should match up more directly with the proposed organisational chart.

In the proposed structure diagram on page 15, the Senior Administration Manager is required to oversee six teams, which appears to be a huge workload and is a potential concern.

The organisational charts should compare the current and proposed structures, so that the key points of difference can easily be visually identified and the implications of removing the ASO6 position and maintaining the SOGC position can be clearly demonstrated.

There appears to be no explanation why two different models are being proposed, and why certain Community Health Centres have been allocated to one model or another.

Recommendations – page 19

The recommendations do not appear to address the barriers and concerns raised during the consultation process.

Out of scope observations – page 19

Needle exchange

As the consultant correctly notes, this information is anecdotal and has little, if any, connection to the scope of the review. It is unclear why this is information has been

included in this report, and would be more appropriately reported in a separate communication to ACT Health, either formally or informally. If this has been identified as an issue for staff, we would encourage you to undertake further research to scope the extent of the problem.

IT systems

It is surprising that IT systems have been identified as "out of scope" for the review. The integration of different systems surely represents one of the most significant barriers, and potential positives, in transitioning to a new administration model. This is of particular importance at Belconnen in the Enhanced Community Health Centre setting, in regard to the range of services provided, and clinical information systems that potentially are accessed, including the Consumer Portal.

Attachments

It is concerning that the issues raised during the consultation with Directors have only been briefly flagged in the main document, while the emphasis was placed on the benefits of moving to the shared model. This does not appear to be an objective analysis of the feedback and information collected during the review. If an effective SRM is to be implemented, there needs to be an emphasis on identifying risks and mitigation strategies. There is a table provided in the appendix, but the issues are simply listed as phrases. There needs to be a clearer explanation of what the concerns are and how likely they are to represent a substantial threat to the success of the new model. Two particular examples are as follows:

- The risk table identifies "[l]oss of ongoing/long term relationships" as a risk in adopting a new model of administration. It is not clear what relationships are being referred to, how they would be impacted by change, and what relevance this has to the broader review. Such explanation should be included for clarity.
- The risk table identifies "[c]linicians undertaking admin roles due to lack of staff confidence in reception/admin" as a risk. This point also requires clarification regarding the reasoning behind this statement.

While the write up of the consumer feedback session organised with HCCA is included in the attachments, the mental health consumers session feedback, which is referenced earlier in the report, is not included.

It would also be more appropriate to include John Kotter's 8 Step Change Model as an attachment, rather than in the body of the review. Kotter's Model is a very general model. The report could state that the change model developed for the Community Health Centres is based on the principles of Kotter's general change model.

Loss of specialised knowledge – throughout the report

Loss of specialised knowledge has been cited as a concern throughout the document, for both clinicians and consumers. Clinicians were concerned about a loss of support in more specialised tasks while consumers demonstrated concerns that a loss of specialised knowledge would mean that administrative staff would not be able to assist them with their specific needs.

As such, it may be worthwhile exploring the possibility of having a few administrative staff with specialised knowledge of particular health services working within the shared reception model. These staff members could support clinicians in those specialised tasks and also play an advisory role for educating generalist administrative staff.

Training should also be provided to new administrative staff to support them to develop specialised knowledge across the range of services provided at the Community Health Centres. There is little point to developing a one-stop-shop for health information and appointments if nobody has the answers. An emphasis on up-skilling staff will not only ensure quality service delivery but may act as an incentive for new staff who would otherwise be deterred by the “lack of identity” associated with generalist positions.