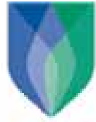

Bermuda Hospitals Board
CARING FOR OUR COMMUNITY

Putting patient care at the heart of our hospitals

CONSULTATION PAPER ON REORGANISING CLINICAL STRUCTURES AT BERMUDA HOSPITALS BOARD

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Introduction

In 2007/8, BHB initiated a review of its vision, mission and values to provide a foundation on which to build a three year strategy from 2008-2011, which was approved by the Board in May 2008. While BHB's legislated mandate to care for the Bermuda community remains a constant, the changing local and international healthcare market meant BHB needed to update its strategy in order to evolve into a higher quality healthcare organisation that meets or exceeds the constantly evolving international standards of care.

Our new vision, mission and values, which can be found in Appendix 1, were agreed following extensive feedback from staff across the organisation. They established a bold new vision and, as our clinical staff members are key for us to achieve our vision, one of our stated goals for this fiscal year is to establish a clinical structure that empowers staff to improve the patient experience and clinical quality at BHB.

The Senior Management Team had already been restructured in January 2007. New positions such as the Director of Nursing & Allied Health and Director of Physician Relations were established to focus and improve leadership for our clinical staff. While physician leadership has been strengthened and improved, the logical next step is to review our nursing structure.

This strategic planning process has illuminated and reinforced that the current Programme Management structure is no longer suitable to provide the management, clinical oversight, coordination and communication required to support the highest level of quality patient care that the BHB is capable of delivering. Programme Management needs to be restructured to put patient care at the heart of our hospitals.

This paper offers a plan to reorganise the clinical management and reporting structure at KEMH and MWI to meet the BHB Mission statement of "Ensuring the highest quality of healthcare through services, education and leadership" and achieve our long term vision of becoming the "first choice for health and wellness".

Background

For the past twenty years, hospitals internationally have been through cycles of recommendations on how to improve operational performance. During the early 1990's, one such recommendation called for grouping like patient populations and decentralising many support and ancillary services (such as Dieticians, Physical Therapy, and Social Work) to report directly to a common director. Called *Patient-Focused Care (or Programme Management* at the Bermuda Hospitals Board), it was thought that structuring clinical services around different patient groups promoted interdisciplinary collaboration. It was also anticipated that productivity and flexibility could be increased through cross-training staff to various clinical functions.

While theoretically attractive, once implemented organisations found that *Patient-Focused Care*, like all such schemes, had practical flaws and execution failures. Most importantly, accountability for defining, implementing, and monitoring professional practice standards and other work standards became diluted under the decentralised structure. A well-documented consequence of this organisational structure is that a director does not necessarily have the content expertise to manage the competency of diverse clinical and non-clinical personnel and to ensure the quality of the auxiliary functions within the organisation.

Not unlike many of its U.S. and U.K. counterparts, the Bermuda Hospitals Board adopted a variation of *Patient-Focused Care.* In 1998, the BHB reorganised to the Programme Management Structure which was characterised by:

- Grouping patients with similar diagnoses and care needs into a common "programme" under one Programme Manager
- Decentralising the professional departments of physical therapy, occupational therapy, and social work and reassigning staff to a Programme with reporting lines to the Programme Manager
- Creating the position of Team Leader intended to oversee professional standards for professional groups dispersed across programmes
- Eliminating the position of the Assistant Unit Coordinator (AUC) in nursing, the role which provided frontline clinical supervision and oversight for nurses

- Creating the position of Clinical Coordinator, a role intended to carry out frontline management functions in departments of varying sizes

Rationale: Why are we doing this?

Since the incorporation of Programme Management at BHB, the deficiencies of the structure and its ultimate impact on the care provided to our patients has been a point of contention. Even with the dedication and hard work provided by the care team, the objectives have not been fully realised at KEMH as voiced by physicians, union leadership, clinical staff, and hospital leadership.

At MWI, however, Programme Management has been more successful and has provided a solid structure from which we can now evolve.

For many of the same reasons we will outline in this document, Programme Management has been phased out or removed from most hospital organisations in the US and UK. With our focus on the patient and achieving the highest quality of care for Bermuda per our mission, vision, and values, we have determined that the well-intentioned Programme Management structure has failed to meet its expectations and needs to be removed.

One of the main reasons that Programme Management needs changing at KEMH is that the scope and complexity of the Programme Managers' responsibilities have become too large to effectively manage. Theoretically, grouping these departments should have enhanced communication and coordination of care. However, with the ever increasing complexity of delivering high quality international level patient care, the Programme Managers are pulled in too many and often diverse directions. The scope does not allow them to successfully and thoroughly attend to all of the different aspects of their respective programmes. Without a clearly-defined, supporting frontline management structure, the Programme Manager's scope is further increased as functions that would normally be carried out by frontline managers are assumed by the Programme Managers. They become entrenched in fighting fires and not able to strategically plan, develop, or continuously focus on improving the quality of care and operational effectiveness.

As with many other organisations, the adoption of the Programme Management structure contributed to a "silo" or "stovepipe" mentality. In this environment, standardising specific protocols and patient care delivery practices and communicating across programmes is very difficult. In addition to its operational challenges, the Programme Management structure depends on the Programme Managers for crucial business planning functions as well as development of their specific service lines, for which the inherent scope issue allows little time.

The following are some additional reasons why Programme Management now needs changing, particularly at KEMH:

- Insufficient clinical leadership to support the bedside nurse
- Loss of the Assistant Unit Manager position in the main wards which removed much of the front line clinical oversight, training, and care focus
- Lack of consistent clinical synergy throughout the hospital and continuum of care
- Lack of role clarity and accountability at some levels of management within the programmes
- Variation in standards and practices
- Insufficient leadership in non-nursing specialties such as physical therapy

The planned replacement of Programme Management addresses or corrects many of the issues highlighted in this document and greatly improves our ability to provide consistent high quality patient care.

Proposal

The proposed structure for KEMH is similar to the BHB organisation prior to Programme Management, but has been updated to be in line with the current proven best practices in successful acute care hospitals in both the US and UK. The KEMH organisational charts of the current and proposed structures are located in Appendix II and Appendix III. The same philosophy, principles, process, and rationale have been applied to MWI. The current MWI organisational structure and the proposed structure can be found in Appendix IV and V.

A major element of the restructure at KEMH is to reduce the scope of three clinical programmes and to realign similar departments into new service-focused areas. Instead of 'Programmes' we will call these areas 'Directorates', which will be led by 'Directors' instead of 'Programme Managers'. Specifically, the new Surgical Services Directorate will now be responsible for just the perioperative aspects of care, without the management responsibility of the two surgical inpatient wards. The new Medical Surgical Directorate will manage the four main wards, while the diverse outpatient service departments (currently included in the Medical Programme) will function in a new Outpatient Services Directorate. A few Directorates will remain substantially the same, including Critical Care and Maternal/Child. The number of directorates will increase from five to six, which reduces the scope of these directorates.

The new scope, reduced complexity, and improved alignment of these directorates and departments at KEMH will allow management to focus on the quality of care delivered in their respective areas in the patient care continuum. Also, this new structure will better align itself with the Medical Staff leadership hierarchy and consequently enhance communication between nursing and physicians.

Essential clinical leadership functions include:

- monitoring changes and updates in professional practice standards
- ensuring that hospital and department policies procedures, and standards reflect best practices
- making sure that all staff are aware of and comply with these requirements
- ensure development and succession planning

This new structure and scope will allow the clinical management to perform these critical functions. This strong organisational structure strengthens BHB's clinical leadership enabling them to better meet and exceed the goals and expectations of the BHB Mission, Vision, and Values. As a result of this significant investment, we will put patient care back at the heart of our hospitals, and bring quality clinical care and leadership closer to the bedside.

An important aspect of the reorganisation across BHB will be redefined job descriptions and titles for the leadership positions. The new job descriptions will appropriately outline the management positions responsibilities, authority, and delineate specific accountability. The new titles will correlate directly to their span of control, job complexity, and daily responsibilities.

Across BHB, eleven Director Positions will replace the ten current Programme Managers, which aligns with similar management responsibilities in the US and UK. The Clinical Coordinators will convert to a Manager title for their specific area. In addition, the ill-defined and often confusing positions called Team Leader at MWI or Clinical Leaders/Professional Practice Leaders at KEMH, or similar will become Supervisor and their true responsibilities accurately outlined in their job description. Please refer to the summary chart of the changes in the management positions below.

Table I: Summary of Management Position Changes

Current Post	New Post / Renamed	Scope redefined	Comments
Programme Manager	Director	Yes	Managing Directorate of multiple departments and / or service. Major change in scope and job description to include strategic responsibility for achieving Board goals
Clinical Coordinator	Manager or Appropriate Leadership Title	Yes	Operational manager of defined department. Current position mapping over to new title and responsibilities clarified.
Team Leader, Clinical Leader, Professional Practice Leader, or Similar Title	Supervisor or Appropriate Leadership Title	Yes	New job description defining and clarifying responsibilities.
	Assistant Unit Manager	Yes	A newly-budgeted position that will be a clinical supervisor on the four Medical – Surgical Wards

This focused span of control supports more timely completion of managerial responsibilities in the areas of employee education, development, and performance appraisals. The new structure will provide additional leadership and growth opportunities for talented and desiring staff; assist with succession planning; and foster Bermudianisation. Another benefit is to reduce the impact of leadership taking vacations and managers covering two areas or departments at one time on the nursing and surgical wards.

The KEMH Reorganisation:

The five existing Programmes within KEMH will be regrouped into the following six directorates: Medical-Surgical Services, Surgical Services, Outpatient Services, Critical Care Services, Maternal Child Services, and Allied Health Services.

Medical-Surgical Directorate

Adult acute care is provided on the two surgical and two medical inpatient wards at KEMH. Bed availability often dictates that a medical admission be placed on a surgical ward. The new Medical-Surgical Directorate will combine the four wards and related nursing support services. This consolidation of adult inpatient departments will facilitate a common standard of care for patients in whichever ward they stay. It will also help streamline communication, standardise and consolidate policy and procedures and ensure more consistent documentation of inpatient records. For staff, combining the wards also provides greater opportunity to standardise and integrate continuing education, training, and orientation.

In addition to the consolidation of the four main medical-surgical wards, this reorganisation will re-establish the Assistant Unit Manager position. The focus of this position is to bring clinical leadership closer to the bedside and improve oversight of the entire ward on a daily basis.

Clinical Coordinators' current responsibilities include addressing human resource problems, scheduling staff, and participating in hospital-wide initiatives. This means their ability to oversee patient care management on a day to day basis is often limited. While this position will continue to have oversight for clinical quality on the wards, the Assistant Unit Manager position will take on the day to day duties. The position will define and clarify clinical accountability for daily clinical oversight, coordination, and communication for both patients and care providers. By bringing clinical leadership closer to the bedside, the Assistant Unit Manager will be better able to manage the variability in education, training, experience and previous work environments naturally accompany the diverse nursing workforce at KEMH (29 different countries) to ensure a consistent clinical quality. Strong clinical oversight and development are essential to ensure that

patient care is aligned with KEMH standards, policies, and procedures. The Assistant Unit Manager role also provides a structure for consistent frontline support when implementing ongoing improvements in nursing practice at the bedside, organisational changes (such as the hospitalist programme) and information system changes and upgrades.

Surgical Services Directorate

The scope of the Surgical Programme will be streamlined to focus solely on the perioperative functions encompassed by the operating rooms, post anesthesia care unit, surgical ambulatory unit, pre-admission testing, colposcopy, and central sterilisation. This tighter focus, absent the inpatient surgical wards, allows perioperative management to devote their attention singularly to managing, executing and improving processes to support the entire perioperative care team. Also, the reorganisation provides more time to enhance professional development of the nursing team.

The reorganisation will allow the Surgical Services Director more time to devote to clinical planning of service growth or expansion according to the perioperative services requested by the surgeons and the strategic direction of the organisation. For example, rapid advances in technology in the perioperative area need to be scrutinised for efficacy and carefully planned so that their implementation ensures quality and safe outcomes for patients.

The proposed reorganisation of surgical services represents a common structure found to be successful in both US and UK hospitals.

Allied Health Services Directorate

A dedicated directorate for allied health services was recently established to focus management and allow for planning and expanding services to meet the care and access needs of our patients. This is an international best practice and had also been advocated by BHB staff in allied health disciplines. The directorate includes the physiotherapy, occupational therapy, speech therapy, dieticians, the day hospital, and other rehabilitative team members. This re-institutes dedicated clinical departments for these specialties and allows for the focused daily management of patient care and oversight of the staff that comprise these departments. This focused management will now coordinate coverage for staff vacations, sick time, and other extended leaves. Recently a new program manager for this area was hired to allow management of these specialists by an expert rehabilitation professional. As mentioned above, by returning the management of this directorate to a rehabilitation professional, the organizational commitment to quality standards throughout the managerial functions of hiring, ensuring competency, and conducting performance evaluation will be reestablished.

Outpatient Services Directorate

Over the next three years at KEMH, the number of visits to the departments providing care in the ambulatory setting is projected to increase. The proposed reorganisation groups the diabetes, asthma, cardiac, infusion therapy, dialysis, home care, ortho/limb and brace, HIV, oncology, and cardiac diagnostics clinics into one Outpatient Services Directorate. This change will facilitate a common approach to operational processes that are shared across clinics (such as billing) as well as clinical processes that are required for accreditation (such as the patient safety goals). Since outpatient services often have operating needs and challenges that differ from inpatient services, a designated directorate will better enable advocacy for outpatient issues within our organisation such as increasing accessibility and awareness of these important services.

Critical Care Directorate

The current configuration of critical care services is appropriate in scope to meet the Mission, Vision, & Values of the organisation. Clarifying and redefining job descriptions will assist this area to meet our patient care goals. The Surgical Services and Medical-Surgical reorganisation will enhance communication and coordination of care between the Critical Care Directorate and the inpatient wards. A direct result will be better coordination and more timely patient transfers and placements.

Maternal-Child Directorate

As with Critical Care, the current configuration of Maternal-Child services is appropriate in scope to meet the Mission, Vision, & Values of the organisation. As with other directorates, job descriptions will be clarified so that accountabilities, responsibilities and roles are clearly defined.

The MWI Reorganisation:

The same philosophy, principles, process, and rationale have been applied to MWI. Due to the unique patient population and their care needs at MWI, the associated organisational structure differs from the new acute care organisational model being proposed for KEMH.

Programme Management at MWI had been introduced with much greater success as it promoted an interdisciplinary approach to very different, specialised client groups and eliminated a duplication of service that existed before, where one patient had multiple files in different areas. For these reasons MWI physicians were highly supportive of the approach for their client groups.

As such, the organisational structure for MWI's requires fine tuning only and the major emphasis will be clarification of job descriptions and expectations. In addition, the titles of the leadership positions will be aligned with KEMH.

Process: How will we do this?

A key objective of the new structures at KEMH and MWI is to ensure there is role clarity, appropriate scope, and an appropriate grade. Each position is being carefully evaluated to ensure it is at the appropriate level.

Communication

The process of transitioning from the current Programme Management structure to the proposed reorganised structure will occur in partnership with union colleagues, the medical staff, and hospital personnel. It is intended that two-way communication assist in making this an open and transparent process to ensure that employees, physicians, and other stakeholders are both informed and have the opportunity to provide input.

This Board-approved Consultation Paper is being shared with the BIU and BPSU leadership, affected staff and other stakeholders listed at the end of this document to give them the opportunity to provide official feedback on our new structure.

BHB looks forward to any comments or questions which must be returned in writing to Mr. David Hill, CEO, not later than September 10, 2008 via email (david.hill@bermudahospitals.bm) or mail (PO Box HM1023, Hamilton HM DX, Bermuda). Any feedback will be shared with and reviewed by the BHB Board.

Proposed Position Changes at KEMH and MWI

The Director, Manager, Supervisor, and Assistant Unit Manager positions will be clearly defined under the new structure.

The current Clinical Coordinators will transition directly to the respective managers position within KEMH. They will function within the newly defined job description and appropriate training and support will be provided to ensure their successful transition.

The new Assistant Unit Manager positions at KEMH will be filled based upon the BHB's existing personnel hiring and selection processes. Appropriate training and support will be provided to ensure their successful transition.

The team leader positions are not currently at the supervisory level and will be mapped to the supervisory management level. Appropriate training and support will be provided to ensure their successful transition.

BHB's existing ten Programme Manager posts are the only positions that are significantly changing. Although Programme Managers have provided an integral service to BHB and our patients, the current scope, complexity, and detailed job responsibilities do not directly map to the new Director positions within the new organisational structure. The new Director positions will be aligned with and based upon similar positions in US and UK, where the focus is more strategic for this type of leadership position, versus day to day operations.

The Director placement process consists of five steps, which will help identify where best to place existing Programme Managers and also how best to support them with development in their new roles:

Step 1: The current Programme Managers will list their top three preferences. As there is one additional position in the new structure at this level, once all Programme Managers have been through the process, any remaining positions will be opened to internal candidates. If an internal candidate cannot be identified, an external process will be initiated, in line with our commitment to Bermudianisation and required Immigration Policies.

Step 2: All Programme Managers will participate in an assessment of their leadership strengths and development opportunities. The assessment will be conducted by Development Dimension International (DDI). This process will provide information on core strengths that can be leveraged as well as targeted opportunities for development, and multiple approaches that research has shown to be effective in developing specific leadership skills.

Step 3: All Programme Managers will have a standardised 360° evaluation conducted by an external company. This evaluation gathers feedback from peers, direct reports, and the person to whom they report.

Step 4: All Programme Managers will participate in a behaviourally-based interview consisting of the same interview questions and scenarios. The interview panel will be:

- Two union-designated leaders
- BHB leadership: CEO, Deputy CEO, COO, Chief of Staff, Chief of Surgery or Chief of Psychiatry, Director of Nursing, Director of Human Resources
- One board member

- Senior nurse executive from one of BHB's clinical partners

Step 5: A four person selection panel including the CEO, Deputy CEO, COO and Director of Human Resources, will review gathered information and make a final decision on placements.

Appropriate training and support will be provided to ensure the successful transition and development of those selected for the new roles.

Timeline

Activity	Date
Consultation Paper approved by BHB Board	July 22, 2008
Consultation Paper released to : • BIU and BPSU leadership • BHB Staff whose positions are included in the new structure • Minister of Health • Chief Nursing Officer • Medical Staff Committee • Bermuda Hospitals Charitable Trust • Hospitals Auxiliary of Bermuda • Bermuda Health Council	August 8, 2008
Consultation Paper Comments received by BHB	September 19, 2008
Reorganisation final approval by BHB Board	September 23, 2008
Individuals will be aligned with new roles where appropriate • Finalise details of the Clinical Coordinator conversion to Manager • Implement the conversion of Team Leader to Supervisor • Interview and select Assistant Unit Managers • Conduct application process for Directors	October 2008
Implement Manager and Assistant Unit Manager positions where appropriate	November 2008
Complete Director selection process	January 2009
Implement Director positions	February 2009
Managers, Supervisors, Assistant Unit Managers participate in BHB succession planning assessment and development	February 2009 and ongoing