Presbyterian Support East Coast

Review of Management and Leadership Functions and Structure at Cranford Hospice

Harper|Devine

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1.0 Executive Summary

Introduction

In July 2007 a review of the clinical, strategic and leadership functions within Cranford Hospice was carried out by Joanna Harper of Harper Devine Ltd. This report provides a summary of the findings and recommendations for changes to the management and leadership structure.

The aim of the review was to develop the most appropriate structure to support the following functions within the currently dynamic field of national and local palliative care service delivery:

- Service vision
- Strategy
- Internal service development leadership
- External strategic relationships
- Leadership of the medical and nursing clinical disciplines
- Participation in wider PSEC organizational planning and management e.g. the executive team
- Representation of Cranford at Board meetings
- Management, administration and compliance systems

The reviewer gathered information from 46 staff and other key stakeholders, identified a range of common themes and issues relevant to the purpose of the review and developed three management and leadership structure options for consideration.

Current contextual factors

Increasingly it is being recognised that palliative care is relevant for all those with life-limiting illness. Consequently the demand for palliative care services is rapidly expanding.

Cranford Hospice has been contracted by the HBDHB to implement the Palliative Care Plan for Hawke's Bay, based around the national strategy. The key objectives of the project can be summarised as:

- Development of positive, cooperative professional relationships between providers in primary, secondary and tertiary sectors
- Provision of ongoing education in basic palliative care
- Implementation of clinical care pathways in all sectors
- To define and develop service coordination cooperatively across sectors, identifying and addressing workforce issues
- Development of a clear process for service audit. (Palliative Care Implementation Plan)

Cranford hospice is no longer the sole provider of specialist palliative care service in the region with the recent establishment of the Hawke's Bay hospital service. This

development requires new ways of collaboration with the aim of creating a seamless service for patients across the continuum of care.

In addition there are a range of other health providers and organisations involved in palliative care and who have established a range of programmes with attached funding to support access and delivery of palliative care.

In summary, the key contextual themes are increasing demand, increased governmental planning, control and funding and increased stakeholder groups and service providers. There is a much greater need to work collaboratively using a specialist generalist partnership model with improved coordination between all the parties and an increased focus on education and skill development.

All of this needs to be considered within the dynamic tension between Cranford and PSEC, the aim being to maintain the strong regional Cranford brand and uniqueness while capitalising on the benefits of belonging to the larger PSEC.

Summary of key issues identified

While there is no doubt that Cranford Hospice provides an excellent service to patients and their families on a day to day basis, there are a range of leadership and management structure issues that have been identified through this review process which are impacting on service delivery. These need to be addressed if Cranford is to achieve the planned objectives and move forward positively in the next few years of delivering palliative care services in Hawke's Bay. In summary these are:

- A lack of visible and legitimate nursing leadership and nursing workforce development.
- Recruitment and retention issues for both nursing and medical staff with the immediate need to replace one medical officer who is about to resign.
- An unsustainable workload for the combined role of Medical Director and Medical Officer.
- A need to improve medical team development and support to medical staff.
- A lack of consistency in clinical practice.
- A need to develop a stronger collegial and equitable partnership between medical and nursing staff.
- A lack of collaboration and team work within the senior leadership team and poor processes to address differences/conflict.
- Role confusion, in particular between the Medical Director and the Manager roles and less so between the Manager and the Principal Nurse roles.
- Clinical staff reporting to a non clinical manager.

- Frustrations around the length of time taken to address issues and develop services.

- Ongoing disconnect between PSEC and Cranford.

- Lack of well informed information from Cranford to the PSEC executive team and the Board.

- A lack of clinical input and advice to the executive and the Board.

- A lack of an effective forum for clinical staff to discuss ideas related to service development and other innovations.

- A number of "missed opportunities" for service development and collaboration within the greater PSEC services.

- An ongoing feeling around loss of national reputation and innovation.

The Way Forward and Recommendations

Three models have been proposed along with the strengths and weaknesses of each. Refer pages 30 – 32 (Appendices) The reviewer believes that any one of the options would be an improvement on the current structure but would have a preference for Option One.

It is also recommended that:

- The service be supported to place a heavy emphasis on improving the culture, team work and communication skills over the next 6 – 12 months, regardless of the structure chosen.

- PSEC recognises the dynamic tension between Cranford and the rest of PSEC, valuing the individuality and uniqueness of the strong Cranford brand and what it offers PSEC while encouraging the development of collaborative innovative organisational wide synergies.

- The CEO and PSEC executive members who have organisational wide functions meet regularly with Cranford staff to ensure that PSEC understands how best to support Cranford staff to do their work and Cranford staff have a better understanding of what support is available at PSEC, i.e. CEO, HR, fundraising, financial.

2.0 Background

As a result of a number of internal and external factors (Refer Draft Review Terms of Reference, Appendix One) the PSEC CEO has decided it is timely to carry out a review of the clinical, strategic and leadership functions within Cranford Hospice. Joanna Harper of Harper Devine Ltd. was asked to carry out this review and did so in July 2007. This report provides a summary of the findings and recommendations for a number of changes.

Cranford Hospice is one of four services delivered by PSEC with the purpose of; "Ensuring that those with terminal illness, together with their loved ones and family/whanau, receive holistic support and control of pain and other symptoms." A leadership structure that will effectively deliver on this purpose within the currently dynamic national and regional context of the New Zealand Palliative Care and Cancer Control strategies and the PSEC strategic direction and leadership structure is required.

3.0 Scope and Purpose of the Review (Refer Terms of Reference, Appendix One for further details)

Scope

To examine the clinical leadership , management, strategic leadership structure to the level of Principal Nurse.

Purpose

To ensure that Cranford has the skills mix and appropriately aligned and sized senior roles to support its role in developing palliative care within the region including strategic and operational development.

This will include examining the appropriate structure and roles to support the following functions:

- Service vision
- Strategy
- Internal service development leadership
- External strategic relationships
- Leadership of the medical and nursing clinical disciplines
- Participation in wider PSEC organizational planning and management e.g. the executive team
- Representation of Cranford at Board meetings
- Management, administration and compliance systems

4.0 Process

The review project was organised into the following stages over the period from the 9th of July until the 10th of August:

- Review of background information and related documentation
- Data gathering through individual interviews with staff and other key stakeholders
- Analysis of information gathered into key themes and issues
- Feeding back to those in the key effected roles and other staff
- Development of recommended changes to the management and leadership functions and structure based on the findings
- Report writing and feedback to the CEO

Forty six people were interviewed during the course of the data gathering providing a wide range of perspectives from those in the key Cranford leadership roles themselves to those who report to these roles, those external service providers who link with the Cranford services, those who are involved in the planning and funding of palliative care service, those in leadership roles in other PSEC services and support role functions and those who work in other palliative care services outside of Hawke's Bay. For a full list of those spoken with refer to Appendix Two.

5.0 The Current Structure

Refer Appendix Three

6.0 The current context

Delivery of palliative care service in New Zealand and Hawke's Bay have changed significantly over the past decade. Palliative care arose from within local communities and was supported by volunteers, to provide holistic care for adults dying of cancer. Cranford Hospice is one of the oldest hospice's in New Zealand and has just celebrated 25 years of service to the Hawke's Bay community.

Increasingly it is being recognised that palliative care is relevant for all those with terminal illness and in fact Cranford now provides services to an increasing number of non cancer patients. Consequently the demand for palliative care services is rapidly expanding.

With a growing recognition of palliative care as a unique specialty, an expert workforce of health professionals from a wide range of professional groups is developing as they complete advanced training in palliative care practice. This growing expert workforce is now available to teach and support primary and secondary care generalist health providers and provide specialised support to manage patients and families with complex needs.

Inequalities in the provision of palliative care services across New Zealand, has been recognised as an issue by the government and currently there is a drive to provide comprehensive and coordinated palliative care services throughout the country. This has been articulated through the 2001 Palliative Care Strategy and the 2005 Cancer Control Strategy which provide a framework to progress developments.

Cranford Hospice has been contracted by the HBDHB to implement the Palliative Care Plan for Hawke's Bay, based around the national strategy. This project is currently being project managed by Dianne Keip, who reports to the Cranford medical director. The key objectives of the project can be summarised as:

- Development of positive, cooperative professional relationships between providers in primary, secondary and tertiary sectors
- Provision of ongoing education in basic palliative care
- Implementation of clinical care pathways in all sectors
- To define and develop service coordination cooperatively across sectors, identifying and addressing workforce issues
- Development of a clear process for service audit. (Palliative Care Implementation Plan)

The project is due for completion by January 2008.

Up until very recently, Cranford Hospice was the sole provider of specialist palliative care services in Hawk's Bay. Recently the Hawke's Bay hospital has also established a palliative care specialist service. This development requires new ways of collaboration with the aim of creating a seamless service for patients across the continuum of care. Cranford shares the newly appointed Palliative Care Specialist Physician with the hospital palliative care service. She works 10 hours per week at Cranford and provides a valuable link between the two services.

In addition there are a range of other health providers and organisations involved in palliative care and who have established a range of programmes with attached funding to support access and delivery of palliative care. E.g. Bay Home Support - Chronic Medically Ill funding, the HBHPO Palliative Care Initiative with "packages of care" funding.

There are a range of other developments that have been identified as part of the implementation plan e.g. establishment of partnership and service development with rural services, Maori Providers and PHOs. Work in these areas is progressing.

Other relevant internal contextual factors relate to the relationship of Cranford to PSEC and the identity of Cranford within the Hawke's Bay community. Cranford is a strong community "brand" and it is important that this brand and uniqueness is maintained. The rest of PSEC services function under a restorative and social service model. It has been argued that this model is not applicable to Cranford and the palliative care model and that palliative care is not part of PSEC's core business. This tension needs to be acknowledged and the PSEC management structure be flexible enough to accommodate this dynamic with the aim of both maintaining the uniqueness of Cranford and it's specific needs and utilising the benefits for both parties of economies of scale and service synergies.

In summary, the key contextural themes are increasing demand, increased governmental planning, control and funding, and increased stakeholder groups and service providers. There is a much greater need to work collaboratively using a generalist specialist partnership model with improved coordination between all the parties and a focus on education and skill development. All of this needs to be considered within the dynamic tension between Cranford and PSEC, the aim being to maintain the strong regional Cranford brand and uniqueness while capitalising on the benefits of belonging to the larger PSEC.

These factors need to be kept in mind when considering what might be the best possible leadership and management structure for Cranford.

7.0 Key Findings and issues

7.1 Nursing Issues

Almost without exception clinical and other staff identified a range of leadership and management issues that need addressing in relation to the nursing service. These can be summarised as follows:

- An absence of strategic direction, leadership and vision.
- A feeling of invisibility and lack of voice/leadership at both an operational, senior management and strategic level. As a result the nursing workforce is feeling disenfranchised and disempowered.
- Workloads are unsustainable particularly for the community based patient care coordinator roles.
- A lack of succession planning and development of staff into more senior roles. The Cranford nursing work force is aging with a number of nursing staff close to retirement. The average age of nursing staff at Cranford is 47 (compared with the national average of 43) Palliative care nursing requires a skilled and mature workforce and specific strategies need to be developed to recruit and educate staff who are able to take on senior roles.
- Staff expressed frustrations around a lack of action and/or resolution of ongoing issues they believe directly impact on their ability to provide the best possible care e.g. enrolled nurse competencies, workload issues, spiritual services for patients.
- Role confusion between the manager and the principal nurse. Staff indicated that on occasions they were unclear about who to go to, to address which issues and that the role of the Principal Nurse lacked any legitimate power to make decisions.

Currently the role of Principal Nurse reports to the Cranford Manager. Both parties expressed frustrations around this arrangement and there is a sense of inertia in being able to progress issues.

In the opinion of the reviewer, the current functions of the Principal Nurse as outlined in the job description lack any sense of vision, strategic direction, and leadership "teeth". The role is defined as a purely operational role. In addition, there is also an obvious lack of visibility within the Cranford Manager's job description related to nursing in general and development of the nursing service. Given that nurses are the largest part of the workforce and the key group providing direct patient contact it is vital that this group is well managed and supported on both a day to day basis by someone who knows and understands the nursing role and function and who has legitimate power to make the necessary decisions.

It is also essential that given the strategic issues and direction of delivery of palliative care services both regionally and nationally that the Cranford nursing service is in a position to address the issues identified above and take up the challenge to be a key player in service delivery and development. It was the opinion of nearly all those spoken with that the current positioning and role functions of the Principal Nurse is not appropriate to provide the necessary leadership required to develop the service to meet future requirements.

7.2 Medical Issues

Currently Cranford is medically staffed by a full time Medical Director and a team of part time medical officers with a range of skill and experience. There has been a recent joint appointment of a specialist palliative care physician who works 10 hours a week at Cranford and 20 hours a week at the newly established hospital palliative care service. The Medical Director does not hold a specialist registration however she does have many years of palliative care experience and has played a significant role in the development of the Hawke's Bay service over the years. She is well respected among the Cranford staff who spoke highly of her commitment and dedication to the role over many years. The role of the Medical Director (according to the current job description, which is under review) is to:

- Provide clinical leadership for the medical team including rosters and appraisals.
- Support quality improvement activities, clinical audit, and policy development.
- Provide leadership and input into education programmes both internally and externally.
- Negotiate and maintain service contracts with the DHB, in collaboration with the CEO and Cranford Manager.
- Maintain professional relationships and linkages with hospital medical staff, GPs and other community providers.
- Contribute a clinical and service delivery perspective for PSEC.
- Work as a member of the medical team as a Medical Officer in direct patient care.

In addition, the Medical Director carries out an important public relations/speaking role, although this role has been reduced since the appointment of the Cranford Manager. There was general acknowledgment of the expertise of the Medical Director in carrying out this role and the importance of providing a credible clinical face to the public through this function.

The Medical Director also currently plays an important role as a representative on various local, regional and national groups, although due to other work demands is not able to focus on this aspect as much as she would like.

In addition to the above the Medical Director is involved in post graduate education, completing a Masters in Clinical Teaching.

The medical staff report to the Medical Director as does the Chief Pharmacist, Executive PA, Project Leader for the HBDHB Palliative Care Implementation Plan, and the Clinical Nurse Specialist (CNS) who is seconded to Healthcare services(HBDHB). The Family Support Team of three and the Education Coordinator also state that they report to the Medical Director on a professional level but not for line management.

From discussions with staff both internally and externally it is evident that this role has provided a strong clinical leadership focus in developing the service, providing vital clinical linkages with the DHB and other clinicians and GPs and is an important clinical face (along with the Principal Nurse) to the public relations work of the organisation.

With the addition of the Cranford Manager role two years ago and more recently the PA role, the Medical Director has been able to provide a greater focus on the Medical Director functions in addition to her Medical Officer role. However staff indicated that the reality of being able to combine these two demanding roles effectively remains a problem.

The key issues identified in relation to the Medical Director role and for Cranford medical staff generally are:

- Confusion between the Manager role and the Medical Director role and reporting lines. (Refer also below – Leadership Team Issues)

- A number of the medical staff indicated that they do not feel as well supported clinically by the Medical Director as they require. They believe the current demands of the two roles is unsustainable.

- Medical and nursing staff indicate that within the medical team there is a lack of team work and inconsistency of clinical practice sometimes leading to medical treatments being changed as different doctors are rostered on and off.

- Recruitment and retention of medical staff, particularly with palliative care experience and expertise. This is not unique to Cranford being a national and international issue, however currently this is of particular relevance given that one of the medial officers who works 4 days per week and is part of the on call weekend roster has resigned. (Ongoing recruitment issues should not effect the way the Medical Director role is structured as such, but rather the structure

needs to ensure that there is enough flexibility to accommodate changing needs in this area)

- A need to define the most efficient and effective use of the newly appointed clinical specialist role. Staff spoken with indicated that this role is already improving relationships between the two specialist services and providing valuable additional support and advice for medical and nursing staff.

- A need to establish strong linkages, a collaborative approach and clinical pathways across the continuum of care and in particular between the hospital palliative care service and the Cranford service. (This has also been identified as a key area for development within the palliative care strategic and operational plan).

- Some medical staff also spoke of a need to change the way medical staff see their role in the future. They believe that there is a need to "work along side" other practitioners, including GPs, practice nurses and other community based nurses to empower them to play a greater role in providing the care of patients, as opposed to "taking ownership" of patients. There is acknowledgment that this is beginning to happen but that greater emphasis in this area is required.

- While the nurses spoken with indicated that there was a good relationship between the nursing and medical teams, they indicated that the service is "medically driven" and that they would like to see a stronger professional partnership model. It is the experience of the reviewer that increasingly in New Zealand, nursing is playing a greater role in both the care delivery aspects and service development decision making.

The resignation of one of the medical officers along with the recent appointment of the specialist palliative care physician role provides an opportunity to review medical workloads and functions.

It is clear that the following medical functions are essential:

- Clinical leadership for the medical team including appropriate and timely support and advice, peer review and professional development.

- Supporting quality improvement including clinical audit, clinical practice guideline development, research and service development opportunities.

- Further development and maintenance of collegial medical relationships e.g. hospital staff, GPs and other medical staff regionally and nationally.

- Medical input and advice to the PSEC executive and Board in relation to strategic planning.

- Education of generalist providers and Cranford staff.

- Strategic and operational advice related to service development and contracts, operational plans, human resource and educational plans, information management plans, including decisions around appropriate resourcing.

- Medical Officer cover as part of the roster.

There are also a number of other clinical functions that need to occur which could be carried out by one or more medical, nursing or other clinical staff, e.g. pharmacists, with relevant input form each of the clinical disciplines.

- Development of strategic relationships and ongoing networking with key stakeholders e.g. PHOs, Maori providers, community based NGOs, the hospital palliative care services, DHB planning and funding.

- Ongoing input into regional and local cancer and palliative care services development and plans.

- Development and maintenance of a quality improvement culture among all clinical staff.

- Education of GPs, practice nurses and other generalist palliative care providers.

- Leadership and line management of all other clinical roles. In the opinion of the reviewer it is not appropriate to have clinical staff reporting to non clinical staff. Staff expressed frustration around this.

- Public relations and public speaking providing a credible clinical face.

There is no doubt that a medical leadership role is required with the key functions being to support and develop the medical team, lead quality improvement activities including audit, maintain collegial relationship and linkages, and provide medical input and advice to strategic service development and contracts. This person also needs to be a functioning part of the rostered medical team providing direct patient care.

7.3 Management Issues

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The manager role was created about two years ago. Initially reporting to the Medial Director this role now reports directly to the CEO (along with the Medical Director). In summary, the manager role has the following key functions:

- The general day to day operational management of the facility, including maintenance, health and safety requirements, HR functions, financial management.

- The key link/liaison person with the PSEC including executive team representation.

- Fundraising, communication and marketing activities through liaison with the equivalent PSEC manager/team.

- Monthly reporting functions.

- Overall coordination and oversight of the quality improvement programme, risk management and compliance with legislative, audit and contractual requirements.

- Building of networks externally with key stakeholders, representing the Hospice service at meetings.

- Management of complaints, conflict resolution and disciplinary procedures

The manager has line accountability for the:

- Principal Nurse
- Administration coordinator
- Education coordinator
- Pharmacists
- Family support team
- Household team leader (who is also the volunteer coordinator)

Without exception staff identified a number of benefits that have come about as a result of this role being in place. These include:

- Improved systems and process approach reducing risks related to compliance requirements.

- A greater interface/improved relationships and communication with the PSEC team and executive and in particular in relation to fundraising.

- Improved management of donors.

- Development of a range of administrative policies and procedures.

- Improved linkages with stakeholders and benefactors.

- Reduction of the Medical Director's time spent on administrative and other management functions allowing greater input into her medical roles.

Issues identified in relation to the Manager role are as follows:

- Confusion between the Manager role and the Medical Director role and reporting lines. A number of clinical staff indicated that they were unsure of which person to go to for which issues and that they are often referred on to the "other party". On occasions staff have been given different information, advice and or a decision from both parties. This was seen as de-motivating to staff as they decided that trying to progress ideas and new developments in this environment was "all just too hard" in addition to doing their normal work.

A number of external stakeholders spoken with also identified that they were confused as to who best to go to for what decisions, e.g. hospital, and planning and funding managers.

- Clinical staff having to report to both a non clinical person for line management issues and a clinical person for professional issues. Staff stated that this can be confusing and frustrating. In addition it was quite clear that some roles e.g. education coordinator and family support team felt that they are not able to develop their roles and services as they would like.

- The manager's job description strongly identifies the need for the manager to work collaboratively and co-operatively with the medical director. A number of staff stated that this was not the case. (See leadership team issues below)

- Some staff expressed frustrations in relation to both day to day issues being progressed and the ongoing development of services. e.g. volunteer services, family support, education coordinator service.

7.4 Leadership Team Issues

Feedback from all levels of staff indicated that communication between the Medical Director and the Manager was not effective and collaboration between the two roles is lacking. Many staff believe that, rather than a strong cohesive senior team working collaboratively pursuing a common agenda, the Medical Director and the Manager, in particular, are pursuing different agendas and on occasions are in direct conflict. In addition, staff also believe that the role of the senior nurse is either "sidelined" or ineffectual in the leadership team.

There is a lack of clarity around the roles of the Medical Director and the Manager. This has not been helped by the fact that there have been three changes to their role functions in the past two years. This can on occasions lead to conflict which some staff indicate is not always well managed with a 'flow on" effect to other teams, e.g. nursing, family support. Staff sometimes receive contradictory answers from both the Medical Director and Manager and they were able to give examples of where this was not only frustrating but was effecting the development of their service.

A cohesive management and leadership team all working to achieve the same goal is important for any work environment, however in the palliative care work environment this is particularly important as staff need to feel well supported by their managers and able to openly address issues as they arise.

In the reviewers experience those hospices where there is strong collegial partnership between nursing and medical lead roles which is well supported by a manager (a triumvirate model) have the most positive and innovative environments which suit the current and foreseeable future palliative care environment. e.g. Arohanui in Palmerston North aims for this approach.

It is essential that these team issues are addressed.

7.5 Disconnect between PSEC and Cranford

Almost without exception staff spoke of there being a disconnect between the rest of PSEC services, the executive team and the Cranford service. Having said this most staff felt that there had been improvements in this area over recent time and had found the recent increased contact from the CEO and HR manager, while the Cranford Manager was away, valuable. Staff had also appreciated the increased contact from the Funding Manager.

The Cranford Manager is part of the PSEC executive group and has found this beneficial in improving communication between Cranford and the rest of the organisation. The Medical Director no longer sits on the executive group and sees the lack of clinical input and clinical leadership at this level of concern.

Some clinical staff saw little or no value in the relationship with PSEC, while others(clinical and support) either had limited awareness or were unaware of the services provided at Hillsbrook, even though following discussion, they could see that they may benefit from their input. e.g. educational services, volunteer communication. Some Cranford staff could see opportunities where their services could benefit the wider organisation and were keen to explore these but felt there was not a suitable forum to progress these ideas.

A number of clinical staff felt that the PSEC senior managers had little understanding of the nature of the acute clinical environment and other emotional demands placed on staff constantly work in the palliative care field. Generally there was a strong sense of loyalty to Cranford with limited or in some cases no loyalty to PSEC.

PSEC staff based at Hillsbrook expressed frustration at the "isolationist" approach of many Cranford staff and felt that there were a number of opportunities and "synergies" between the parties that were not being realised, e.g. education of staff, pharmacist input, Enliven services for palliative care patients. The support of partnerships with other PSEC services has been identified as an objective of the Cranford and Palliative Care plan for 2007/2008.

Fundraising and public relations is a key aspect of the running of the Hospice service and according to the fundraising manager about 70% of fundraising activities is for Cranford. Despite this the fundraising/PR manager is based at the Hillsbrook site. The Cranford team were both positive and appreciative of the increased visibility of the fundraising manager over recent ~~times~~ but still believe that given their dependence on this source of income and on the good will of the public there is an opportunity to further develop this relationship and some suggested that this role be sited on the Cranford site and/or there be a dedicated fundraising/PR person for Cranford.

Another area of concern referred to relates to the application of consistent and robust systems, processes and policies across the whole organisation, e.g. HR practices, contractual requirements. PSEC needs to be assured that staff at the Cranford site are aware of and applying organisational wide policies and systems etc. at all levels within the organisation. Although senior staff spoken with felt that this had greatly improved since the appointment of the Cranford manager they could not be assured that this was always the case.

In summary, despite improvements over the past year or so there remains a significant disconnect between Cranford and PSEC resulting in:

- Missed opportunities for service development and efficient use of available resources, for both parties.
- A risk to both parties around the potential of inconsistent application of robust processes, systems, policies and procedures.
- Negativity, dissatisfaction and frustration for both parties related to a "them and us" attitude.

This is a key leadership issue which needs to be addressed through strong leadership and excellent communication, requiring a leader who understands health service delivery issues which are broader than palliative service delivery.

7.6 Clinical input and advice to the CEO, PSEC Executive Team and Board

Currently the hospice manager provides the key link with the CEO, PSEC executive and Board. Clinical advice and input is sought on the request of the CEO to the Medical Director. Given the apparent lack of team work and collaboration between the Medical Director, Manager and Principal Nurse the quality of that input is unlikely to reflect a consistent, unified and/or balanced view. The CEO has expressed ongoing frustrations in this regard.

Given the high profile of Cranford in the community and the need to be progressing the development of the service in line with DHB requirements and the regional palliative care strategy it is imperative that the CEO, executive team and board are well informed of both operational and strategic issues that are reflective of both current and future requirements and trends.

7.7 Loss of Reputation

Many staff spoke of a feeling that, for some time now, Cranford has not been seen as a national leader within the palliative care field. Cranford is one of the oldest hospices in New Zealand and staff indicated that for many years was seen as an innovator in the field. There is a feeling that, with a few exceptions, there is little innovation, research and development taking place and that staff are just struggling to get through the day to day work. It is apparent to staff that many other hospices around the country are well ahead in the area of service development and innovation. Staff believe that an amazing service continues to be provided to the patients and families in Hawke's Bay but there is a sense of loss around national reputation. As one person put it "they have lost their mojo."

In fact, the reviewer was informed of the PhD research project being carried out by the charge pharmacist in relation to use of high dose steroids. This work is being both nationally and internationally recognised as significant and PSEC needs to ensure that this sort of work is actively encouraged and supported and utilised to rebuild the reputation of the service as one that is leading edge and innovative. The Medical Director is also pursuing a post graduate masters in clinical education.

The reviewer believes that while this loss of reputation may not be directly attributable to the structural changes over the past couple of years, the current structure and lack of effective leadership and team work is probably playing a significant part in the stifling of innovation and preventing the service from achieving the vision. Leaders at both the PSEC level and Cranford level need to be identifying and actively encouraging research, post graduate opportunities, study trips etc. from within all disciplines, and seeking ways to financially support these ventures.

To summarise,

While there is no doubt that Cranford Hospice provides an excellent service to patients and their families on a day to day basis, there are a range of leadership and management structure issues that have been identified through this review process and which are impacting on service delivery. These need to be addressed if Cranford is to achieve the planned objectives and move forward positively in the next important few years of delivering palliative care services in Hawke's Bay. In summary these are:

- A lack of visible and legitimate nursing leadership and nursing workforce development.
- Recruitment and retention issues for both nursing and medical staff with the immediate need to replace one medical officer who is about to resign.
- An unsustainable workload for the combined role of Medical Director and Medical Officer.
- A need to improve medical team development and support to medical staff.
- A lack of consistency in clinical practice.
- A need to develop a stronger collegial and equitable partnership between medical and nursing staff.
- A lack of collaboration and team work within the senior leadership team and poor processes to address differences/conflict.
- Role confusion, in particular between the Medical Director and Manager roles and less so between the Manager and Principal Nurse roles.
- Clinical staff reporting to a non clinical manager.
- Frustrations around the length of time taken to address issues and develop services.
- Ongoing disconnect between PSEC and Cranford.
- Lack of well informed information from Cranford to the PSEC executive team and board.
- A lack of clinical input and advice to the executive and board.

- A lack of an effective forum for clinical staff to discuss ideas related to service development and other innovations.

- A number of "missed opportunities" for service development and collaboration within the greater PSEC services.

- An ongoing feeling around loss of national reputation and innovation

8.0 The Way Forward - Structure Options

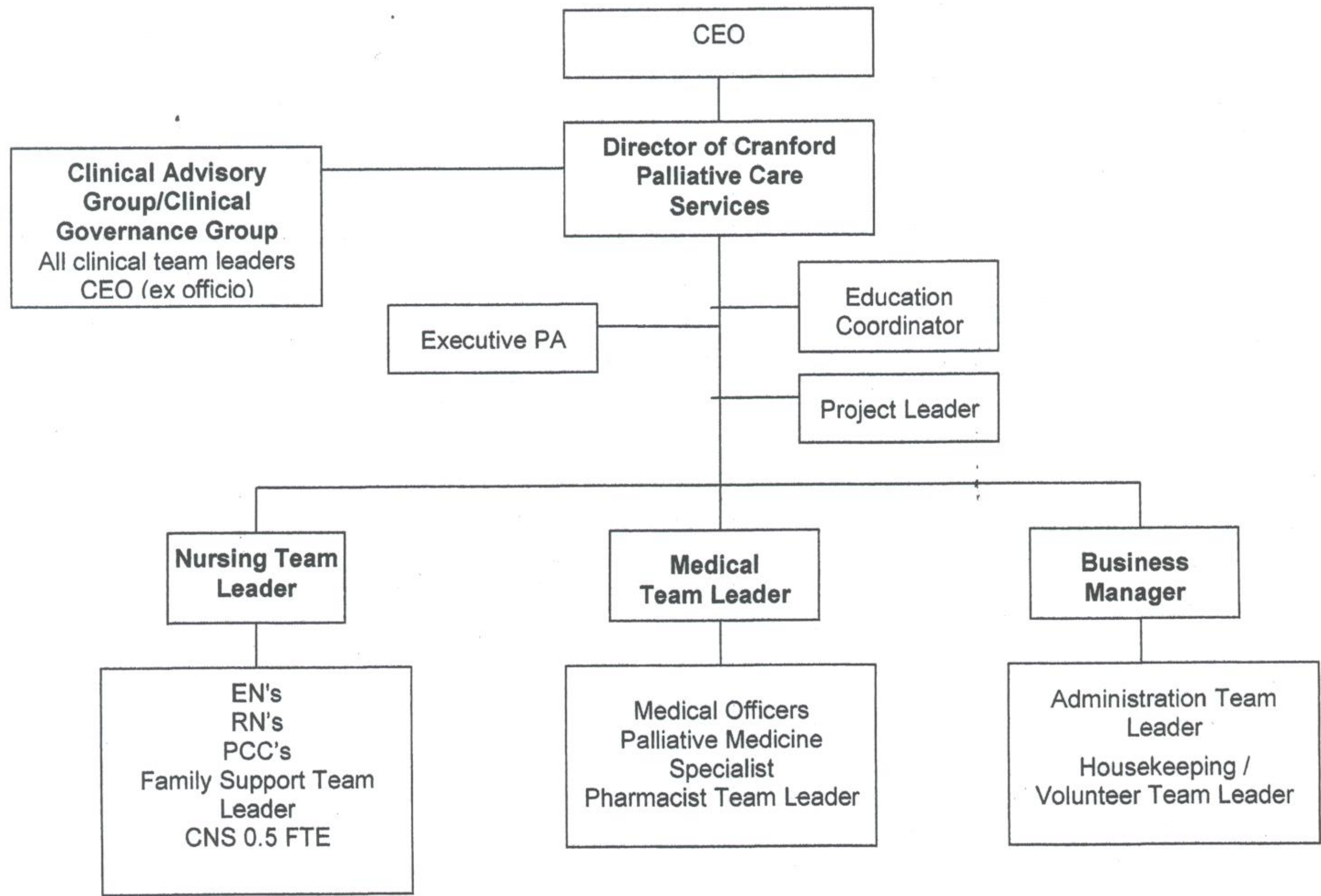
No organisational structure is perfect, each having strengths and weaknesses. The aim of any structure is to facilitate communication and connections between roles in order that teams and individuals are supported in the best possible way to do their work. A good structure has:

- Clear lines of accountability
- Simple communication pathways that encourage communication flow easily "up and down" and "side ways" between those teams with functional relationships
- The ability to support a team approach
- Effective span of management control (a manageable number of direct reports to one person)

Regardless of the structure good leadership, communication and team work are the essential ingredients.

In considering the above issues and larger contextural issues the following structure options are put forward:

8.1 Structure Option One: Triumvirate reporting to Director of Palliative Care Services



Option One: Triumvirate reporting to Director of Palliative Care Services

Functions of the various roles in Option One

Director of Cranford Palliative Care Services

This role would require some one with excellent communication and conflict management skills who is clinically well respected in the field of Palliative care and/or related clinical services, who understands the bigger health industry context and who has an ability to establish local, regional and national links.

They would be responsible for:

- Service vision
- Strategic direction of the service
- Providing the key link with the CEO, PSEC Executive and Board ensuring they have all necessary information of both a clinical and management nature to allow the Executive group and Board to make sound decisions and develop robust organisation plans
- Representation of Cranford at Board meetings
- Encouraging the development of closer linkages between Cranford and the rest of PSEC establishing areas for synergistic service development and effective communication
- Oversight of the organisation wide quality improvement programme
- Developing and leading a strong and unified triumvirate senior leadership team
- Encouraging and leading innovation, research, best practice service developments based around strategic goals in collaboration with senior team
- Writing of business case and other funding proposals accordingly
- Public relations
- Management of complaints
- Service contract negotiations
- Monthly reporting to the CEO, board and against contract requirements
- Development of strong strategic and operational relationships locally, regionally and nationally

Nursing Team Leader/Director of Nursing

- Leadership of the nursing service
- Nursing strategic planning and development based on Cranford strategic plan which is developed collaboratively between the senior team and staff
- Fostering an environment of innovation, research and best practice development
- Work collaboratively with the Medical Team Leader and Business Manager
- Recruitment, selection and management of credentialling processes for nursing staff
- Workforce professional development, appraisal and education – career pathway development
- Assurance of appropriate range of support systems and processes for nurses
- Day to day management of the nursing services, rostering oversight, problem solving, nursing clinical advice and support

- Development and ongoing review of consistently applied best practice nursing standards, protocols and guidelines
- Quality audit and development oversight for nursing service, including relevant legislative compliance
- Liaison and linkages with appropriate local, regional and national groups and other professional relationships
- Public relations activities in consultation with the Director
- Monthly reporting to the Director
- Maintenance of clinical skills

Medical Team Leader/Director of medical services

- Leadership of the medical service
- Medical strategic planning and development based on Cranford strategic plan which is developed collaboratively between the senior team and staff
- Fostering an environment of innovation, research and best practice development
- Work collaboratively with the Nursing Team Leader and Business Manager
- Recruitment, selection and management of credentialling processes for medical staff
- Workforce professional development, appraisal and education – career pathway development
- Assurance of appropriate range of support systems and processes for medical staff
- Day to day management of the medical services, rostering oversight, problem solving, medical clinical advice and support
- Development and ongoing review of consistently applied best practice medical standards, protocols and guidelines
- Clinical audit and quality development oversight for medical service, including relevant legislative compliance
- Liaison and linkages with appropriate local, regional and national groups and other professional relationship
- Public relations activities in consultation with the Director
- Involved with education of medical students generalist providers and others
- Monthly reporting to the director
- Practicing Medical Officer

Business Manager

- Leadership of the non clinical team, including volunteers through a volunteers coordinator
- Key link person with PSEC for funding, marketing and communication
- Collaborative involvement in the strategic planning process for Cranford
- Work collaboratively with the nursing and medical team leaders
- Recruitment, selection and management of non clinical staff
- Appraisal, development and support of non clinical staff, including appropriate debriefing etc.
- Day to day management and maintenance of the facility and equipment
- Maintenance of appropriate administration and management standards and practices and compliance systems

- Oversight of the health and safety programme and ensuring appropriate systems are in place
- Oversight of budgets and financial reporting
- Public relations activities in consultation with the Director
- Monthly reporting to the director

Clinical Advisory Group/Clinical Board/Clinical Governance Group

I addition to the above roles it seems to the reviewer that a clinical governance/advisory group would be of real value in ensuring that clinical staff work together as a team and innovations are encouraged in a collaborative way. It would provide an opportunity for allied health and other clinical staff to fully be part of the clinical decision making process and develop innovations. The CEO would be an ex-officio member of the group and as such the forum would ensure that the CEO was well informed of clinical issues and that clinical staff feel heard and are able to raise issues of concern.

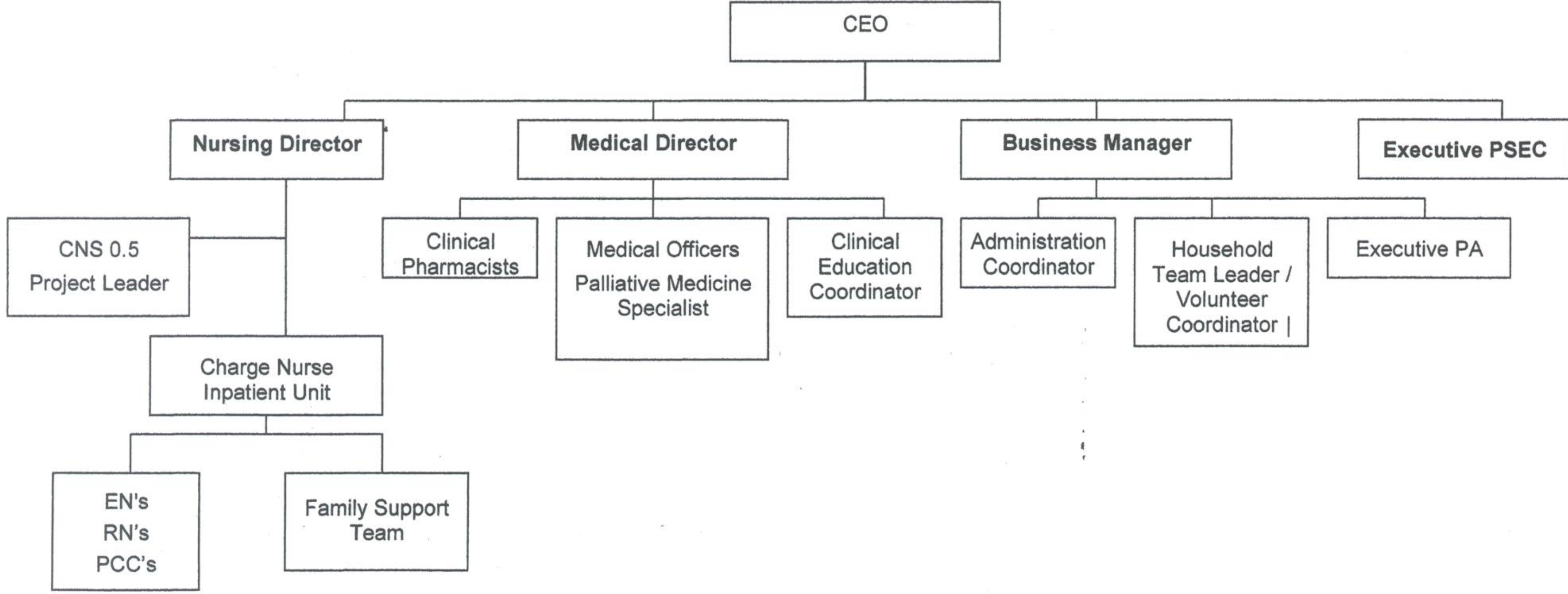
Strengths of this model

- A single clearly identifiable leadership role. Single point of accountability.
- One dedicated leader (with clinical credibility) who has the time, focus and legitimate power to advocate and progress the palliative care vision/plan.
- Focus of the leadership role is strategic and operational development of the service as a whole.
- Focus of the senior team is development of each team/service based around strategic plan for service.
- One point of contact with CEO and PSEC executive who has well informed advice from the senior team.
- Encouragement of stronger team approach between the nursing and medical service with support from a business manager.
- Increased nursing leadership role.
- Reduced number of reports to medical team leader/director.
- Clinical people reporting to clinical team leaders.
- Medical team leader has an increased focus on leading the medical team and carrying out medical work.
- The Business Manager will be able to devote more time to development of the volunteer service and other support services.
- The Project leader is more appropriately linked with service development role of Director.
- Establishment of a clinical advisory group to encourage interdisciplinary work and clinical innovation and ensure a stronger understanding of clinical issues by the PSEC CEO and team.

Weaknesses

- Senior medical, nursing and management roles not directly represented on PSEC executive.
- An extra "layer" between the senior team and the CEO.
- Loss of power/status of Medical Director role.
- Risk that the Director of the Service may not represent the parties fairly or well.

8.2 Structure Option Two: Triumvirate reporting to CEO



8.2 Option Two: Triumvirate reporting to CEO

Strengths

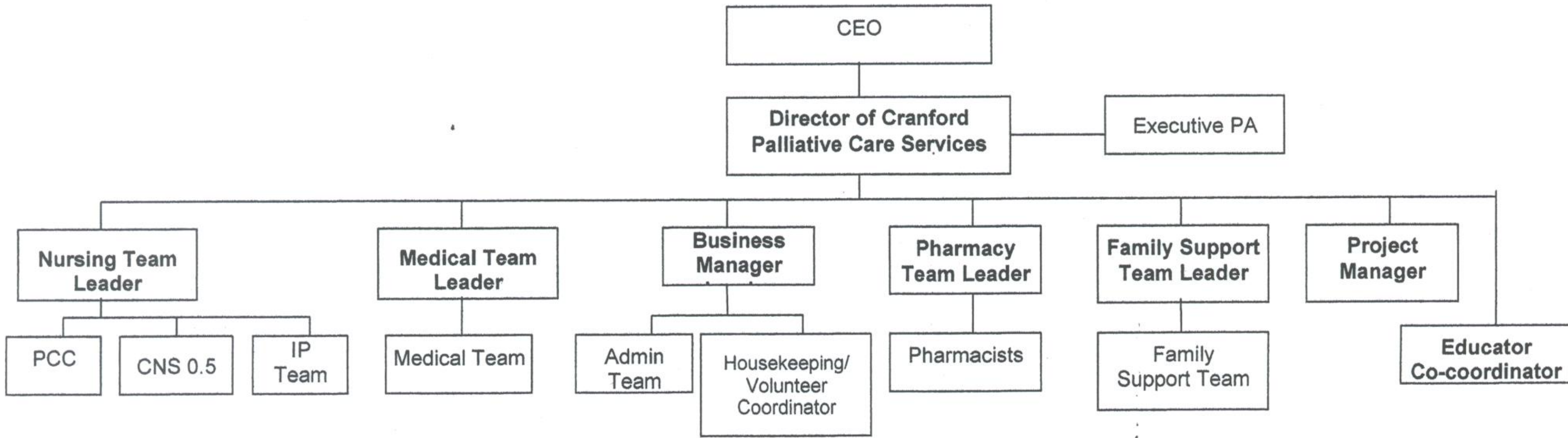
- Strong representation of senior clinical roles and the Cranford service on PSEC executive
- Increased nursing leadership role
- Clinical people reporting to Clinical Directors
- Extra layer for nursing allowing both strong operational and strong strategic leadership
- Encouragement of stronger team approach between the nursing and medical service with support from a business manager.
- Clinical people reporting to clinical team leaders.
- The Business Manager will be able to devote more time to development of the volunteer service and other support services.
- The Nursing Director would take some of the Medical Director's previous workload

Weaknesses

- 3 direct reports to the CEO from 1 service
- There would need to be a charge nurse/clinical nurse leader in addition to the role of Nursing Director in order to manage both the strategic functions and the day to day operational management functions
- Less reduction in Medical Director management/strategic functions

Note: This model would require good team work between the 3 senior roles

8.3 Structure Option Three: All teams reporting to Director of Palliative Care Services



8.3 Option Three:

Strengths

As for model one. In addition:

- Strong interdisciplinary team model – would act as the Clinical Advisory Group defined in Option One

Weaknesses

As for model one. In addition:

- Increased numbers of reports to the Director (in comparison to Option One)
- A number of hospices who have used this model are moving away from this approach citing this has not lead to an improved team approach.

9.0 Recommendations

It is recommended that:

1. One of the above models be implemented. The reviewer believes that any of the three options would improve the current structure, but has a preference for Option One.

2. The service be supported to place a heavy emphasis on improving the culture, team work and communication skills within the service over the next 6 – 12 months, regardless of the structure chosen.

3. The CEO and PSEC executive members who have organisational wide functions meet regularly with Cranford staff to ensure that PSEC understands how best to support Cranford staff to do their work and Cranford staff have a better understanding of what support is available at PSEC, i.e. CEO, HR, fundraising, financial.

4. PSEC recognises the dynamic tension between Cranford and the rest of PSEC, valuing the individuality and uniqueness of the strong Cranford brand and what it offers PSEC while encouraging the development of collaborative innovative organisational wide synergies.

During the course of the interviews with staff, a number of points were raised, that while not directly related to the scope of this review are worthy of note and need to be addressed in some way.

- A number of staff spoke of a lack of spiritual and social work services available to patients and their families. It was suggested that a chaplain and social worker roles become part of the service delivery team.

- Many staff feel that the volunteer service is undeveloped and requires a stronger and/or dedicated coordinator role to manage and further develop this service.

- The education coordinator role and service needs further development to ensure a clearly established purpose, objectives and planned approach which fits with the organisation strategic and operational plans.

- As increasing demands are made on the family support team they are lacking a clear sense of strategic direction and a related operational plan and resourcing to develop their service in the most appropriate way.

- Some staff indicated that research and advanced education already in progress is not as well recognised nor supported by the larger PSEC organisation as it should be. Leaders at both the PSEC level and Cranford level need to identify and actively encourage research, post graduate opportunities, study tours from within all disciplines and related funding opportunities.

- Staff in a number of non-clinical support roles did not feel like they were considered as a valuable part of the team and were not offered emotional and

other support as part of their roles despite the fact that they are often directly involved with patients and families during stressful situations.

- There needs to be a career pathway for nurses which is equitable in both title and pay scale to equivalent roles in the region and nationally e.g. Are the patient care coordinator role functioning at the equivalent level of Clinical Nurse Specialist (CNS) roles in Healthcare services? This work should be developed with input from the DHB Director of Nursing to ensure a consistent application of roles and titles.

Appendices

Appendix One:

Terms of Reference:

Review of Clinical, Strategic and Management Leadership functions within Cranford Hospice

Background.

Internal Changes Since 2005

The leadership functions at Cranford have been restructured over the past two years with the creation of the Manager position, ending of the Director of Palliative Care position and inclusion of Strategic leadership within the role of Medical Director (formerly combined with the Director role). In addition, nursing roles have changed with the evolution of car nurses into Palliative Care Co-coordinators and the corresponding change of the Patient Care Co-coordinator role to that of Principle Nurse.

In these processes lines of accountability have altered and the weighting of which roles participate in functions such as external relationships, strategic leadership, participation in PSEC Executive and Board meetings have all altered.

In addition Cranford has had the HB DHB contract to implement the regional Palliative Care strategy over 2006 and 2007.This has also changed the nature of roles in strategic development.

External Factors

The nature of palliative care and the role of Cranford Hospice has changed and is continuing to change as the principles of the NZ Palliative Care and Cancer Control strategies are implemented in the HB region. There is a greater emphasis on inter-agency collaboration and relationships in patient care e.g. with the Hospital Palliative Care team and GP practices. Skills in palliative care and a palliative approach are being actively developed in other services. This is changing the nature of the role and relationships of Cranford and of various disciplines within the multidisciplinary team, particularly nurses.

This trend of a wider range of providers and stakeholders is reflected nationally with the emergence of Palliative Care NZ in addition to Hospice NZ.

Locally the HB DHB has announced its intention to review all palliative care services with a view to creating a more integrated service across providers.

Workforce Issues

In addition to the above external factors, workforce issues continue to shape leadership and clinical practice. There is an international shortage of palliative care health professionals particularly doctors. Some international and national practice indicates a growing emphasis on nursing in this context.

At Cranford the Doctor shortage has affected management and leadership functions as we have historically tried to combine medical management and leadership functions in one role. This has proved unworkable as the demands to fill the medical roster have increased with shortages.
With the resignation of Dr Suze Helman this issue has arisen again and the Medical Director Dr Kerryn Lym has suggested that her role might need to relinquish most of its strategic functions in order to dedicate time to clinical duties.

Conclusion

Workforce issues require that some reorganization of leadership functions is considered. Given the wider environment it is logical to take this opportunity to review the overall clinical management and strategic leadership to ensure that Cranford is well placed to make a valuable contribution to the changing nature of palliative care. For that reason this review is to be undertaken.

Review

Scope: Examine the clinical leadership, management, strategic leadership structure to the level of Principle Nurse.

Purpose: ensure that Cranford has the skills mix and appropriately aligned and sized senior roles to support its role in developing palliative care within the region including strategic and operational development.

This will include (but not be confined to) examining the appropriate structure and roles to support the following functions:

- Service Vision
- Strategy
- Leadership of internal service development
- External strategic relationships
- Leadership of the medical and nursing clinical disciplines
- Participation in wider PSEC organizational planning and management e.g. the Executive Management Team
- Representation of Cranford at Board meetings
- Management, Administration and Compliance Systems

Process: The review is sponsored by the CEO and will be managed by external consultant Joanna Harper of "Harper Devine". All staff at Cranford will be given the opportunity to have input along with other stakeholders approved by the CEO.

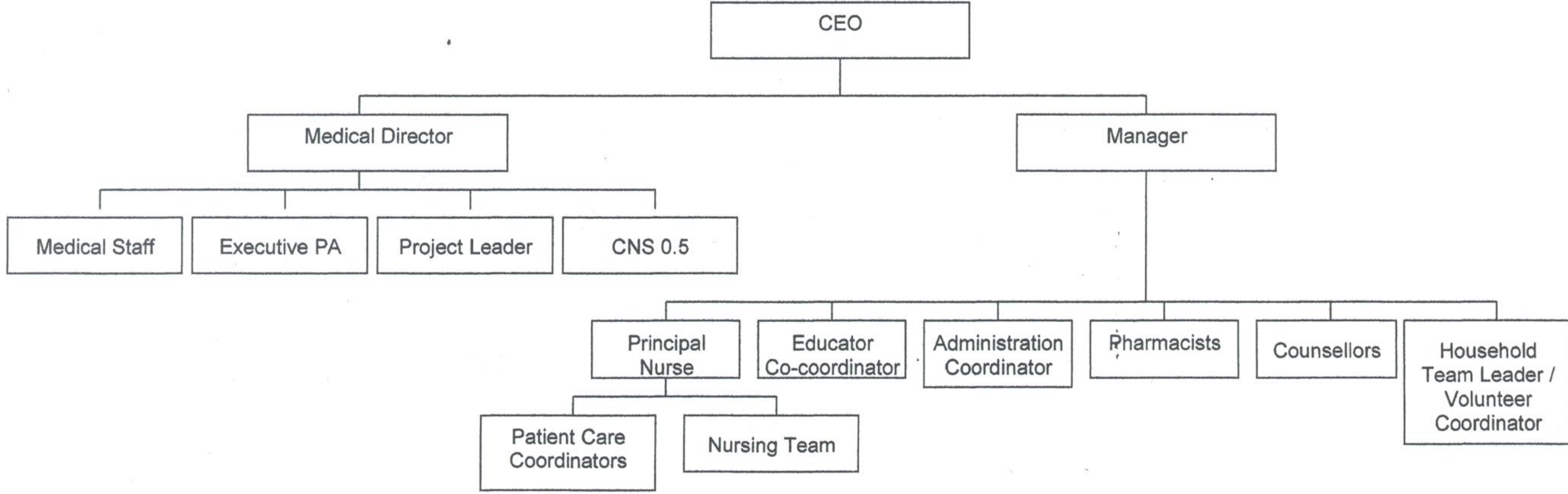
The review will report to the CEO and a summary of the findings will be made available to all participants.

The CEO will make final decisions as to the leadership and management structure.

Shaun Robinson

Appendix Three

Current Structure



References

The New Zealand Palliative Care Strategy, 2001

The HBDHB Cancer Services Plan: A Plan to promote improvements to cancer service delivery. Dianne Keip, August 2006

Specialist Palliative Care Tier Two Service Specification. Consultation Draft 3.12. 2006

Palliative care Advisory Committee Scoping Report. Palliative Care New Zealand: Speaking with one clear voice: a national organisation for palliative care. September 2006

Project Plan. Palliative Car Implementation Plan. HBDHB, Prepared for Cranford Hospice . November 2005.

Annual Plan – Cranford/Palliative Care

PSEC Strategic Direction 2006 – 2011 (Summary document August 2006)

PSEC Human Resources – 3 year strategic plan 06 – 09