



FUTURE ARRANGEMENTS FOR GOVERNANCE OF NSW HEALTH

REPORT OF THE DIRECTOR-GENERAL



TRANSMITTAL LETTER

The Hon. Jillian Skinner MP
Minister for Health and Medical Research
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SYDNEY NSW 2000

Dear Minister Skinner

I am pleased to present my report on the Future Governance Arrangements for NSW Health in accordance with NSW Government health policies and the broader NSW Government agenda for good governance in the public sector.

Key themes of the Government's approach to public services include openness of government and accountability for performance, transparency, leadership, customer service and fiscal discipline. Your long-standing commitment to devolution and localism as a driver of improved patient care is a principle that was clearly shared by the many staff who generously provided their views and ideas to the Governance Review.

I believe that these principles have been central to the deliberations of the Governance Review Team and the actions proposed in this Report.

There is much to applaud about the people and processes which underpin our State's health system, but we must be vigilant to ensure that the governance framework that surrounds them serves them well and is resilient to emerging challenges to the way healthcare has traditionally been delivered.

I would like to acknowledge the hard work and wise advice of the Governance Review Team and all we spoke to during the course of this Review who spoke honestly and openly.

I also acknowledge the enthusiasm in the system to embrace the opportunity to build a NSW health system of the future.

A handwritten signature in black ink, appearing to read 'Mary Foley'.

Dr Mary Foley
Director-General

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EXECUTIVE SUMMARY

The Director-General's Governance Review was tasked with reviewing the functions, responsibilities, structure and relationships of each of the main components of NSW Health and their alignment with the Government's policy directions, particularly devolution to Local Health Districts, transparency and accountability, and strengthened clinical engagement. The deliberations of the Review were strongly guided by the principle that every decision and every person working within the NSW health system is focussed on achieving the best outcome for the patients in its care.

The organisations that form NSW Health covered by the Review include:

- the Department;
- Local Health Districts;
- statutory health corporations (the Pillars);
- the three Clinical Support Clusters within the Health Administration Corporation;
- the Health Reform Transition Organisations (HRTOs); and
- other entities within the Health Administration Corporation, namely Health Support Services and Health Infrastructure.

The key proposals of this review are:

- Local Health Districts (LHDs) and Specialty Networks will have responsibility and accountability for managing all aspects of hospital and health service delivery for their local district or specialty network under a Service Agreement between the Department of Health as purchaser and system manager/regulator and the LHD Boards as providers of health services. The LHD Boards will in turn determine and manage a Performance Agreement with their Chief Executives.
- The Department of Health will become the Ministry of Health, providing Westminster functions supporting the Minister and the Government, regulatory functions, public health functions (disease surveillance, control and prevention) and system manager functions in statewide planning, purchasing and performance monitoring of health services. It will be significantly reduced in size, consistent with its core functions, the devolved model of health service governance and more effective use of the four Pillars.
- The three Clusters will be removed as an intermediate level of health service management and the majority of functions and resources intended for the Clusters will be devolved to LHDs.
- The clinical and support services located in the Health Reform Transition Organisations will be fully redeployed from the old area structures with the large majority of the almost 12,000 staff distributed equitably to LHDs. Where it is difficult to split smaller services across LHDs, the Review has specified arrangements for LHDs to host or jointly manage these key support functions.
- The four Pillars will be strengthened to have a key role in their respective areas of health care design, standards, reporting, education and associated policy. Areas of overlap and split accountabilities between the Department and the Pillars will be removed with relevant

functions and staff transferring to the Pillars. The Report specifies new, more collaborative processes for the Ministry and Pillars to work together. The Pillars will also develop close working relationships in support of LHDs.

- Specific recommendations for the Pillars are:
 - The Clinical Excellence Commission (CEC) will take responsibility for quality and safety and providing leadership in clinical governance with LHDs.
 - A reformed Agency for Clinical Innovation (ACI) will be structured to take on a greatly strengthened role as the primary agency for engaging clinical service networks and designing and implementing new models of care. All of the previous Department's clinical services redesign and development functions will transfer to the ACI. The Policy and Technical Support Unit will also be incorporated into ACI providing economic and technical expertise.
 - The Bureau of Health Information (BHI) will be recognised as the primary source of quality information to the community, healthcare professionals and policymakers. Responsibilities for the Patient Survey will transfer from the Department to the BHI.
 - The Clinical Education and Training Institute (CETI) will be restructured to become the Health Education and Training Institute (HETI) with an expanded focus on clinical and non-clinical leadership development and undergraduate and vocational training in addition to CETI's existing focus on postgraduate services. Some Departmental and Cluster functions will transfer to HETI.
- Health Support Services (other than ICT) will become *HealthShare NSW* governed by a Board with majority LHD representation and an independent Chair. *HealthShare NSW* will enter into Service Level Agreements with LHDs and be tasked with developing a stronger customer focus and contestability of pricing.
- ICT statewide services will become *eHealth NSW*, a separate administrative unit within the Health Administration Corporation. The Chief Executive of *eHealth NSW* will join the Director-General's Executive Team. The Department's current eHealth responsibilities will move to *eHealth NSW*.
- Health Infrastructure (HI) will offer a support service to assist LHDs in their management of capital projects below \$10 million. LHDs will have the option to purchase these services from HI or elsewhere.
- A Business Case will be developed for the four pathology hubs currently located in the Clusters, the Division of Analytical Laboratories and Forensic Pathology to be linked as a statewide service – NSW Health Pathology.

The report details responsibilities, accountabilities and working relationships of the various entities that comprise NSW Health on the basis of clear delineation and non-duplication of roles and collaboration, such that all entities have a joint governance responsibility to ensure effective and responsive public healthcare services for the people of NSW.

1. INTRODUCTION

The health system's ... building blocks alone do not constitute a system, any more than a pile of bricks constitute a functioning building. It is the multiple relationships and interactions among the blocks – how one affects and influences the others, and it is in turn affected by them – that converts these blocks into a system.” (de Savigny et al. 2009)¹.

1.1 GLOBAL TRENDS

Reform of health systems and their governance is a global phenomenon. The shift in disease burden from acute to chronic conditions means that our current health systems, which were originally designed in the 1950s with a focus on acute care delivered through hospitals on an episodic basis, struggle to address the need to coordinate patient care across care settings inside and outside hospitals, involving a multidisciplinary range of health professionals and care services. This has led to health systems being designed around the institutions that deliver services rather than the populations they serve.

The pressures of an ageing population, continuing advances in medical technologies and treatments (which have substantially increased life spans and reduced disability), the complex combination of health and social factors to be addressed in managing chronic illness and ever increasing community expectations means that most health systems are growing in expenditure at a rate greater than GDP. Yet despite the rate of growth in expenditure, all modern health systems continue to have wide variations in treatment patterns and patient outcomes, and patients and their carers find it increasingly difficult to navigate and secure the range of services they need.

In response to these challenges, health system governance needs to incorporate a number of critical design factors to support clinicians and patients to achieve effective healthcare:

- Local flexibility and responsiveness so that health services can engage with patients and the community in the design of services to meet individual patient needs and to build the local linkages between hospitals and other health and social services which are required to support healthy communities;
- Clinician engagement in the design of models of care and decision making for local and system wide policies to ensure quality, safety and effectiveness of care;
- Rigorous evidence based policy and effective information systems to support best practice in clinical care and system management and performance;
- Transparency of funding and decision making about the allocation of resources;
- Clear accountability at all levels of the system for performance against validated standards and benchmarks;

¹ de Savigny D, Taghreed A, eds. 'Systems thinking for health systems strengthening'. *Alliance for Health Policy and Systems Research*. Geneva, World Health Organization, 2009.

- Capable and adaptive workforce focussed on teamwork and cooperation; and
- Adoption of effective information and communication technologies which will pervade all aspects of health system governance, supporting effective, accountable service delivery, coordination of care and empowerment of patients.

These design features require both clearly delineated system wide governance combined with local governance flexibility and accountability. Lord Ara Darzi, former UK Parliamentary Under-Secretary of State at the Department of Health described this approach when visiting Australia recently as: “localise where possible, centralise where necessary”.

1.2 POLICY CONTEXT OF THE GOVERNANCE REVIEW

NSW Government health policy sets the direction for this Review, with the following policy particularly relevant to system governance design²:

- Equitable access to timely quality healthcare regardless of financial status, background or place of residence;
- The right of the individual to make choices based on realistic expectations of the health system;
- Efficient and appropriate allocation of resources where they can do the most good on the basis of models of best practice which deliver best health outcomes;
- Openness of governance and accountability for performance;
- Greater patient involvement in decision-making about their healthcare to improve health outcomes and devolving decision making to improve patient care closer to the patient; and
- Greater community and clinician involvement in planning and delivery of efficient, world-class health services supported by world-class facilities, equipment and technology.

These policies are underpinned by the NSW Health CORE values of Collaboration, Openness, Respect and Empowerment that will shape the health system for the future.

A key element of the Government’s health policy is the devolution of the management and governance of the State’s public healthcare services to Local Health Districts (LHDs) governed by Local Health District Boards. The legislation to establish Districts and their Boards came into force on 1 July 2011.

The Government’s policy for the establishment of LHDs predates, but is consistent with, the COAG national health reform model of a National Health and Hospital Network, under which NSW recently reorganised its eight large Area Health Services into seventeen Local Health Networks from 1 January 2011. The Government’s policies support moving more quickly, and definitively, to a devolved governance model for LHDs.

Under the previous Government’s model, three Clinical Support “Clusters” within a Division of the Health Administration Corporation were to act as a management and service level between the Department and the Local Health Networks within a defined geographic region. The Minister for

² NSW Liberals & Nationals (2011), ‘Plan to Provide Timely, Quality Health Care’

Health, in her address to Chairpersons of Governing Councils of Local Health Networks on 8 April 2011, noted the importance of the Cluster functions and signalled that these functions need to be redeployed so as to avoid an unnecessary additional layer of health administration. The Minister noted that the Cluster functions could be assigned across a range of options including the Department, Districts, Health Support Services or the “Garling Pillars”.

At the time of this Review the Clusters had only progressed to the stage of establishing senior executive teams. As a consequence they contain some of the more senior and experienced health service management capability which had previously been working at the Area Health Service level. The Clusters also include the Health Reform Transition Organisations (HRTOs) which are largely comprised of services and functions that had previously been organised at an Area Health Service level and were not straightforward to devolve to local management.

To ensure the Districts are sufficiently resourced to take on their responsibilities, it is important that the Cluster services and functions be devolved as far as possible.

The Government’s health policies build on the recommendations of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals³ - the Garling Review - particularly in relation to the promotion of an open and responsive culture, transparency of budgetary and performance information and clinical engagement. These principles are reflected in the so-called “four Pillars” recommended by the Garling Review, namely the Bureau of Health Information (BHI), the Clinical Excellence Commission (CEC), the Agency for Clinical Innovation (ACI) and the Clinical Education and Training Institute (CETI). These four organisations are leading edge developments in health system design nationally.

This Review looks at how to further develop these organisations, including more effective working relationships between them and the Department of Health, based on clear role delineation, and greater connectivity of these organisations and the LHDs.

At the time of writing, the national health reforms are in the process of negotiation between the Commonwealth and State and Territory Governments (COAG). Subject to agreement being reached, there will be significant changes in how hospitals are funded and managed which need to be reflected in the NSW Health governance arrangements. This involves implementing Activity Based Funding (ABF) on the basis of nationally determined efficient prices, agreed block funding for small hospitals and some designated services, national governance structures for health system performance and the use of Service Agreements between state health authorities and Local Hospital Networks (Local Health Districts in NSW) will be important considerations for the operation of the NSW Health governance arrangements.

The Commonwealth Government’s commissioning of primary health care organisations – Medicare Locals – will complement the strategy of local governance for state health services and further

³ Garling Peter (2008) *Final Report of the Special Commission of Inquiry - Acute Care Services in NSW Public Hospitals*.
[http://www.lawlink.nsw.gov.au/Lawlink/Corporate/ll_corporate.nsf/vwFiles/E_Overview.pdf/\\$file/E_Overview.pdf](http://www.lawlink.nsw.gov.au/Lawlink/Corporate/ll_corporate.nsf/vwFiles/E_Overview.pdf/$file/E_Overview.pdf). Accessed 26 June 2011

encourage participation and ownership by local communities. The delivery of integrated patient care will increasingly require effective linkages of LHDs with Medicare Locals and other local healthcare providers.

1.3 THE GOVERNANCE REVIEW

The Director-General announced her process for the review of governance of NSW Health on 5 May 2011 with the intention of specifying and implementing new governance architecture early in the new financial year.

This Report outlines the outcomes of the review and the proposed actions to empower local health services, build a sense of joint ownership across all parts of the system, and improve transparency, accountability and responsiveness across all entities comprising NSW Health.

The contribution of the Governance Review Team and NSW Health staff to the development of this Report is gratefully acknowledged.

2. THE GOVERNANCE REVIEW

2.1.SCOPE

The Governance Review assessed the functions, responsibilities, structure and relationships of each of the main component parts of NSW Health including the Department, Local Health Districts (LHDs), statutory health corporations (the Pillars), the Clinical Support Division (the Clusters) and Health Reform Transition Organisations (HRTOs) and shared services operated by the Health Administration Corporation (Health Support Services and Health Infrastructure).

The Review had regard to the following design imperatives:

- LHDs are to be resourced and supported to take on their new roles and enable effective decision making as close as possible to the patient with local engagement of staff and communities;
- The HRTO functions are to be devolved to Districts as far as possible, unless the function is one where there are clear and compelling reasons for delivery on a statewide or other basis;
- The Department of Health is to be reorganised to focus on the funding and performance of a more devolved health system;
- Functional duplication and omissions between the Department, the Pillars and statewide support services must be addressed;
- Any system redesign should promote the most efficient use of limited resources and maximise the opportunity to develop and expand best practice models for the advancement of the system as a whole in its capacity to deliver a better experience for patients;
- The CORE values of Collaboration, Openness, Respect and Empowerment are respected throughout the review process and are embedded in the proposed frameworks;
- Organisational structures take account of the portfolio requirements of the two Ministers, Minister Skinner - as Minister for Health and Minister for Medical Research - and Minister Humphries - as Minister for Mental Health and Minister for Healthy Lifestyles - and note that the Mental Health Task Force will be reporting by end August 2011 on the design for a Mental Health Commission;
- The governance framework provides for clear allocation of responsibilities, transparency in accountability and logical linkages and processes between all NSW Health entities;
- There is adequate access to robust information for all NSW Health entities, their staff and communities about system funding and performance;
- Consideration is given to the role of, and requirement for, linkages with Medicare Locals; and
- Recommendations are consistent with principles of cost neutrality and meet the COAG requirements of no additional bureaucracy.

2.2.MEMBERSHIP

A small Governance Review Team was assembled to provide expert advice and support to the Director-General in the conduct of this Review:

- Mr Shane Solomon, former Under Secretary for Health and Executive Director of Metropolitan Health Services in Victoria, and former CEO of the Hong Kong Hospital Authority;
- Dr Nigel Lyons, Chief Operating Officer (Northern) and Chief Executive Health Reform Transition Organisation (Northern); and
- Ms Karen Crawshaw, Deputy Director-General, Health System Support.

Dr Denis King, Chairman of Illawarra Health District and member of the Transition Task Force was an adviser to the team and Ms Joanna Holt, Director of Policy and Co-ordination, Office of the Director-General provided secretariat functions for the Governance Review.

3. CONSULTATION

The Governance Review Team met regularly during May and June 2011 and had regard for governance arrangements in other states and territories as well as 'best of breed' models internationally.

To inform the Review, a number of meetings were held with the major entities comprising NSW Health as well as a number of other key stakeholders.

3.1.KEY ENTITIES CONSULTED

The following entities were invited to meet with the Governance Review Team:

- Agency for Clinical Innovation (ACI)
- Clinical Excellence Commission (CEC)
- Clinical Education and Training Institute (CETI)
- Local Health District Chief Executives
- Local Health District Board Chairs
- Health Infrastructure (HI)
- Health Support Services (HSS)
- Health Service Association (HSA) on behalf of Affiliated Health Organisations (AHOs)
- Clinical Service Divisions (or Clusters)
- Health Care Advisory Council (HCAC)
- Deputy Directors-General

The Governance Review Team is grateful to all those individuals and organisations who put the time aside to share their views including by way of written submission. The thoughts and suggestions received were invaluable in shaping the thinking and decisions contained within this Report.

4. KEY THEMES FOR REFORM

The Governance Review Team undertook an intensive period of consultation to ascertain the views of key stakeholders which were thoughtfully given. In addition, a simple web-based questionnaire was deployed to seek the input of the staff throughout NSW Health. Over 1730 staff generously contributed their thoughts and ideas about what was working and what could be improved in terms of health systems governance. The analysis of these responses provided an invaluable source of information and is available separately.

Through this process of iterative consultation and assimilation, seven key themes emerged around which the proposed actions have been grouped. These are:

- 4.1 Devolution of authority and responsibility to Local Health Districts (LHDs);**
- 4.2 Changed role and structure for the Department of Health;**
- 4.3 Increased clinical leadership, engagement and support;**
- 4.4 Investment in our people;**
- 4.5 Greater transparency and utility of health information;**
- 4.6 Realising the potential of statewide services; and**
- 4.7 Recognising ehealth as the way of the future.**

Each of the proposed actions is explained in greater detail below.

4.1. DEVOLUTION OF AUTHORITY & RESPONSIBILITY TO LOCAL HEALTH DISTRICTS (LHDs)

In keeping with NSW Government policy to devolve the management and governance of the State's public hospitals and healthcare delivery services to Local Health Districts and Specialty Health Networks (LHDs⁴), the Governance Review assessed the capacity to further devolve responsibility and empower local services.

The Department of Health and LHDs will move to a purchaser – provider relationship

Each LHD will negotiate an annual Service Agreement with the Department of Health which will become the Ministry of Health (see section 2.2 below). The relationship between LHDs and the Ministry will be more at arm's length than the current arrangements where the Department tends to micro-manage. The Service Agreement will specify which services will be purchased or funded, the

⁴ References throughout the document to Local Health Districts also include Specialty Health Networks.

volume and price for Activity Based Funded (ABF) services, and/or block funding as appropriate for some services. The Agreement will articulate which health strategies, targets and goals are to be pursued to achieve local and statewide initiatives as well as what measures will be used to monitor performance at both State and National level. While funding for LHDs will continue to be capped, the Service Agreement will ensure transparency and consistency of funding, service levels and required performance and will be determined on the basis of negotiation - similar to the Victorian model. If agreement cannot be reached by the commencement of the financial year then the Minister will have final authority to determine the Agreement.

LHDs will be responsible for planning services for their local populations

The Local Health District or Network is responsible for determining how it will deliver healthcare services within the framework of the Service Agreement and the District's Annual and longer term Strategic Plan in order to maximise the health of its local population (or defined patient population for Specialty Networks) as well as collaborate on broader health initiatives. A critical responsibility of Districts and Networks, and one strongly supported by LHD Chairs and clinicians, will be the delineation of roles of hospitals and other health facilities in their Clinical Services Plans within Statewide planning frameworks. Districts will also develop relationships and service networks with Medicare Locals and primary health care services.

LHDs will have the flexibility to purchase some services

LHDs will be empowered to, in turn, purchase services from Affiliated Health Organisations⁵ and other non-government organisations including in relation to developing service networks in the community setting, from private hospitals such as in relation to the management of planned surgery, or other kinds of services where local circumstances make this appropriate.

A New Performance Management Framework

There will be a new Performance Management Framework which will clearly layout expectations for all LHDs. The Performance Management Framework is intended to allow LHDs maximum autonomy to determine how the expected performance is achieved, and will only specify the most important performance parameters expected by the Government to avoid micro-management of service operations by the Ministry. It will specify the key minimum performance standards and thresholds, and specify what level of performance would prompt closer Ministry support and scrutiny. The new Performance Management Framework is intended to create transparency of expectations, but also leave LHDs free to identify other areas of performance important for local communities and clinicians.

In the case of Affiliated Health Organisations, which operate recognised public health services under the *Health Services Act*, the Ministry will develop a framework which provides for a consistent approach. A draft Performance Management Framework is available as a separate document.

⁵ Affiliated Health Organisations (AHOs) are non-government religious organisations or charitable institutions whose establishment or services are recognised by the State of NSW as a public health service (ss13 & 62 of the *Health Services Act 1997* (NSW)). Historically these religious organisations or charitable institutions became public health service providers in order to meet specific health needs of the NSW community.

The Chairs of LHD Boards will come together on a regular basis as the Council of Board Chairs to confer with the Minister for Health and the Director-General.

Building Board capability to govern

The increased responsibilities and accountabilities to be borne by LHD Boards will require a broad range and depth of skills and expertise around the boardroom table. The Minister has announced some new appointments to help equip Boards for the task ahead, especially in relation to financial and governance capability. In addition, governance training will be offered to Board Members early in the first term of their appointment. This training will include the particular requirements for governance in relation to Health and Government. Governance guidelines for LHD Boards will include provisions for Board Chairs to conduct performance reviews of individual Board members as well as whole-of-Board evaluations, in accordance with established best practice processes for governing boards.

Chief Executive appointments will be determined by Local Health District Boards

The District or Network Board will be responsible for the selection of the Chief Executive (CE) and will recommend formal appointment under the *Health Services Act*. The Board will negotiate a Performance Agreement with the appointed CE and will monitor CE performance against agreed key performance indicators. The Board will have the role of annual performance review of the Chief Executive. Whether to discharge a CE, or renew or not renew a CE's contract will rest with the Board in consultation with the Director-General, and will be based on performance against the District's Service Agreement and the CE's own Performance Agreement with the Board.

Empowering Chief Executives to manage services

Chief Executives, with the guidance of their Board, will be given the appropriate delegations to manage the resources required to deliver the services specified in their Service Agreements with the Ministry. LHD Chief Executives will have the delegation to employ staff and manage staffing levels within the context of CORE values and the Industrial Relations and Public Sector Employment frameworks and policies applicable to the NSW Health Service.

Removal of a Layer of Management within NSW Health

The Northern, Southern and Western Clusters were established under the previous government to manage an array of services provided across LHD boundaries and provide a range of technical and expert services through clustered arrangements rather than vest these in the LHDs directly. This layer of management between the Department and the LHDs will be removed to flatten the organisational structure and bring decision-making closer to the patient. It is recognised that the Clusters contain some of the most experienced leaders within NSW Health, and efforts will be made to identify opportunities for their continued contribution in other roles.

Redeployment of Health Reform Transition Organisations

Across the three HRTOs there is currently just under 12,000 Full Time Equivalent (FTE) staff. Almost 70% of these staff are directly involved in delivering clinical services which will be devolved directly

back to the LHDs. The exception will be Pathology Services which will deliver services on a contracted basis to the LHDs through the four pathology hubs and related networks. Other, non-clinical functions located with the Clusters, include staff with expertise in areas such as services planning, financial management, and medical administration. These resources will be an important part of building the capacity of LHDs.

Most staff will remain in their current location either directly working for a District, or continuing to provide an aggregated service to a number of LHDs under hosted or jointly managed arrangements between those LHDs. Detailed schedules of distribution of functions and staff to LHDs will form part of the implementation framework for the new structures. The devolution of these functions to LHDs will significantly bolster the capacity of LHDs to undertake their responsibilities and result in some savings in management positions and resources.

Provision for some functions to be 'hosted' by one LHD on behalf of others or joint management arrangements

Where arrangements for joint management of services are already in place or there was insufficient staff / breadth of expertise to distribute equitably to LHDs a joint management or hosted model is proposed for consideration by LHDs. Details of these functions are available along with a proposed template for Inter-District Agreements. The process of transferring staff and resources will be managed to ensure the least disruption to staff and to maximise fairness of resource allocation to each LHD. Where LHDs can reach mutual agreements to share resources, these arrangements will be supported.

Provision for statewide coordination of Public Health services

HRTOs are currently providing Public Health services (involving just over 500 FTE) which support a number of LHDs. While these services will continue to reside locally, on a hosted basis, provision has been made for these resources to be centrally coordinated and directed by the Chief Health Officer as these services require mobilisation across District boundaries.

4.2 CHANGED ROLE & STRUCTURE FOR THE DEPARTMENT OF HEALTH

A new role for the Department

Devolving greater authority to the LHDs and to clinician-led Pillar agencies in NSW demands a change in role for the Department of Health. While the Department has an important part to play, it needs to step back from day-to-day operations and focus on its core roles, which are:

- Advising the Minister on policy, legislation, and governance arrangements;
- Planning for future capacity (such as beds, technology, specialised services) and workforce needs of the whole state of NSW in accordance with state and national health priorities;
- Securing the resources the system needs to deliver on the Government's policy, through its proposals to both the NSW Government and the Commonwealth Government;

- Distributing resources fairly to promote equity, quality and efficiency;
- As system manager, negotiating Service Agreements with LHDs ('purchasing' services), monitoring progress against the agreements, and intervening only where performance does not meet specific standards;
- Stimulating system-wide initiatives that improve quality and efficiency based on the need for a critical mass of expertise or economies of scale, such as purchasing and shared electronic medical records;
- Ensuring clinicians are actively engaged in service planning, management and formulating budget priorities; and
- Performing its regulatory duties, such as protecting public health and licensing private service providers.

New relationships are proposed with front-line services and with clinician leaders across NSW who have committed their time and expertise through organisations such as the Clinical Excellence Commission and the Agency for Clinical Innovation. The Department needs to attend to its core policy, strategic and government responsibilities and be less involved in day-to-day health service operations. This requires that the Department adopt a different relationship with LHDs based on clear funding and performance specifications and statewide policy and planning frameworks which support LHDs to deliver safe and effective clinical services. The Department will look to the Pillars as the focal points for clinical engagement and will transfer some clinical planning, design and review functions to the Pillars rather than split responsibility or duplicate these functions. The Department will develop closer working relationships to engage the Pillars in policy and planning processes.

A change in the name and structure of the Department is proposed to reflect this new policy/strategy and system manager role: it will become a *Ministry of Health* and will be significantly reduced in size to reflect this more devolved approach.

The Ministry will contain four Divisions that reflect its core functions.

Table 1: Ministry Divisions and Functions

Division	Core Ministry Functions
Strategy and Resources	<ol style="list-style-type: none"> 1. Setting policy and strategy for the overall NSW health system 2. Statewide services, capital and strategic planning 3. Putting the case for the resources needed to achieve high performance, both with the NSW Government and maximising Commonwealth funding 4. Supporting the development of rural health services 5. Co-ordinating the budget process across NSW Health 6. Design of the system for distributing funds to LHDs through Activity Based Funding (ABF) 7. Managing the budget for NSW Health 8. Mental Health, Drug and Alcohol Office (pending outcome of Mental Health Taskforce)
Service Purchasing and Performance	<ol style="list-style-type: none"> 1. Development and negotiation of Service Agreements with LHDs 2. Allocating funds under the new ABF funding system, and incorporating these in Service Agreements with LHDs 3. Monitoring performance of LHDs and other health service providers 4. Advising on actions to be taken when performance is below acceptable standards, including providing support to LHDs and assessment of management and governance
Population and Public Health	<ol style="list-style-type: none"> 1. The statutory responsibilities of the Chief Health Officer 2. Protecting the health of the public, including disease surveillance and control 3. Improving the health of the population through health promotion and illness prevention strategies 4. Population health strategies for Aboriginal people 5. Maternal, children and young people's health (pending review of the organisation of children's health services in NSW) 6. Oral health 7. Support to the Director-General in relation to the Office of Medical Research which will report to the Director-General
Governance, Workforce, and Corporate Services	<ol style="list-style-type: none"> 1. Preparing and overseeing implementation of legislation and regulations; Parliamentary, Cabinet and Ministerial Services 2. Regulating health services and products, such as private hospital licensing, regulating the use of dangerous drugs and poisons, prosecutions 3. Industrial relations strategy and Award negotiation 4. Workforce policy and planning required statewide 5. Provision of corporate and legal services to Ministry

The senior executive positions which are substantially changed will be filled through a merit appointment process.

Any functions that do not tie directly to the Ministry's core roles mentioned above will be devolved to the key clinical organisations (such as the CEC and ACI) or to the LHDs.

After careful consideration of each part of the current Department, the following devolution of responsibilities is proposed, reflecting a change in role and the working relationships between the various entities which comprise NSW Health.

Table 2: Change in role and responsibilities of the Department of Health

Function	Change proposed	Rationale
Safety and quality of clinical services	The majority of the current Department's resources to be transferred to the Clinical Excellence Commission (CEC).	<p>The CEC has proven its capacity to set statewide standards and develop programs to improve patient safety and quality. The Ministry will seek the necessary endorsement of policy and resources to implement the quality improvements proposed and will incorporate quality standards and guidelines into system performance frameworks.</p> <p>The Ministry will rely totally on the CEC for policy advice and development, review of, and response to, clinical incidents, and to represent NSW Health in national safety and quality forums.</p>
Clinical program development, innovation and new models of care	The current Department resources dedicated to clinical innovation and changes in models of care to be transferred to the Agency for Clinical Innovation (ACI) in its strengthened form. This will include Department units responsible for: clinical redesign; out of hospital care; chronic disease management programs; acute care services.	<p>The ACI is established to promote innovation in health service delivery and it has established an extensive network of clinicians working in this area.</p> <p>It will need to strengthen its capacity to translate these innovations into system-wide change proposals that can be put forward for funding support. It will need to ensure equitable distribution of funding in its service recommendations and support LHDs to implement these changes to clinical service delivery.</p> <p>The Ministry will identify system-wide priorities and negotiate with ACI to deliver these, such as emergency and elective surgery access and managing chronic disease to reduce avoidable hospital admissions.</p>

Function	Change proposed	Rationale
Workforce leadership and development	Various medical and nursing workforce development functions performed by the current Department will be transferred to a transformed Clinical Education and Training Institute, with its role expanding beyond post-graduate clinical training.	The vision of CETI has been restricted by limiting its scope and responsibilities to postgraduate clinical training. It will be re-established as the Health Education and Training Institute (HETI), with an expanded scope to cover broader management development and leadership programs for the system as well as vocational training. Significant changes will be required for the new organisation if it is to fulfil its potential as national leader in people development within the health sector.
Maternity, Children and Young People's Health (including child protection)	Transfer policy and program functions and the Keeping Them Safe Program in accordance with the findings of the review of the organisation of children's health services in NSW which will consider implementation of Commissioner Garling's proposed ' <i>NSW KIDS</i> '	Further review and consultation is needed to assess progress and determine the final governance structure for children's health following revisiting Commissioner Garling's report. It is noted that child protection functions are tied to the work of hospitals and health services in identifying children at risk.
eHealth	Transfer eHealth Strategy to a new entity - <i>eHealth NSW</i> - that will plan and coordinate the overall eHealth program for NSW. ICT governance will require further review including greater clinical engagement.	Currently eHealth strategy is split between the Department and Health Support Services. This dilutes the 'whole of NSW Health' ICT approach. A strong ehealth focus will be critical to achieving safe, efficient and innovative models of patient-centred care.
Transparent information on system performance	Transfer wider responsibilities for public reporting of accountability to the Bureau for Health Information (BHI), including conduct of the patient experience survey.	Since its recent formation, the BHI has demonstrated its value as an independent organisation reporting on system performance. Expanding its role will give it more scope to assess more system performance measures.
Departmental business support functions	Transfer administrative functions supporting the Department to the Health Support Services Agency, including payroll, employment screening and IT technical support and purchasing. Rationalisation of some administrative functions in keeping with the narrower remit of the Department.	These operational functions are 'core business' for Health Support Services and will help achieve economies of scale. With the streamlining of the new Ministry, the overall number of administrative support staff required will be reduced.

Function	Change proposed	Rationale
Inter Government Relations	Increase strategic resourcing capacity to negotiate for a greater NSW share of Commonwealth funds.	The anticipated COAG health reforms increase the criticality of strong strategic resourcing capability.
Planning	<p>Tighter focus on statewide planning, particularly whole of system capacity and the distribution of statewide specialist and quaternary services.</p> <p>Work with the CEC and ACI to ensure the service models being developed are incorporated in wider service and equipment planning.</p>	Planning is a core function of the Ministry to inform purchasing of services from LHDs. The Ministry needs to focus on statewide systems and service issues, safe-guarding equity of access, resource distribution and avoidance of duplication or service gaps.
Policy Development	Provide greater agility of policy development capacity across the broad range of subject areas.	There is a significant number of staff involved in policy development in specific speciality areas. It is proposed to move away from this “silo” approach and develop a policy development capacity and structure that is more flexible, wide ranging and responsive to changing priorities.

The result of these changes and a wider reduction across the Ministry will be a smaller NSW head office, with an estimated reduction of 25% in the overall positions. However, some functions have not been affected at this stage, namely the Mental Health Drug and Alcohol Office (given an upcoming review), as well as the regulatory functions of: health protection, licensing, inspection, statutory compliance and prosecution. When these services are excluded, the reduction in the core Ministry positions is estimated at around a third. This will make it the smallest state health authority in Australia when adjusted for the size of the system it regulates.

The details of staff transfers, matching and redundancies will be discussed with those affected. Following the appointment of key positions, there will be an assessment of positions within their scope of responsibility to refine roles, assess skills and capability and review grades to maximise efficiencies and system capacity.

4.3 INCREASED CLINICAL LEADERSHIP, ENGAGEMENT AND SUPPORT

While the future role of the Ministry will require it to be an informed purchaser and planner of health services, it should not duplicate functions better placed with ACI or CEC. Greater role clarity and frameworks which encourage partnering, combined with a mutual sense of cooperation and respect will allow each entity to collaborate while focussing on what they do best.

Clarify the roles and responsibilities of CEC

The CEC will play the lead role in policy and strategy related to the system-wide improvement of clinical quality and safety. It will take on most quality and safety functions currently managed by the Department including clinical incident reviews and responses, system clinical governance, representing NSW Health in appropriate state and national forums and providing advice, briefings and associated support to the Minister and Director-General.

Clarify the role and responsibilities of a strengthened ACI

The new ACI will have the central role in designing and implementing new models of care and improved patient pathways for adoption across NSW. Its focus will broaden to include the development of programs that can prevent hospitalisation, such as chronic disease management and an increased focus on developing appropriate models of care for rural health services. ACI will be restructured and resourced to undertake a significantly enlarged portfolio of responsibilities, all of which relate to the goal of driving clinical innovation and improved patient outcomes across the system.

Governance of CEC and ACI

The ACI and CEC will continue to share the same Board Members (although there is a separate Board for each entity) to maximise potential synergies.

It is proposed that the two entities collaborate to prepare Strategic and Annual Work plans to ensure complementary effort on priority issues. This could involve an annual meeting of CEC, ACI and the Ministry. At this time they will also undertake a 'stock take' of clinical committees (including those advising the Ministry) to avoid duplication and an excessive burden of involvement amongst key clinicians making substantial system-wide contributions.

Given the planned increase in responsibilities for ACI it is proposed that the Policy and Technical Support Unit, currently shared between ACI and CEC be incorporated into the new ACI. The CEC can avail itself of the technical, economic and policy expertise of the Unit, as and when required.

The leadership, structure and staffing of the new ACI will require review to ensure it has the capability to translate innovative ideas into actionable, resourced programs and to support its expanded set of responsibilities.

Establish Service Compacts between the Director-General and ACI and CEC

Rolling **3 year Strategic Plans and Annual work plans** will be prepared by CEC and the new ACI in consultation with each other, the Ministry and the LHDs. Close collaboration with the Ministry will ensure alignment of their priorities with forward planning and budget development. These will be

discussed, and ultimately agreed, with the Director-General. A **Service Compact** will be prepared, reflecting this interaction and agreeing to a specified body of work and the funding to support this. The Compact will build-in the agility for these agencies to deal with emerging issues encountered by the Ministry or LHDs whilst ensuring that matters of system-wide concern are considered and incorporated into the planned work of both ACI and CEC.

4.4 INVESTMENT IN OUR PEOPLE

Our staff, both clinical and non-clinical, are fundamental to our success in delivering patient-centred care. The way we work together is complex and requires skilful and empathetic leadership at all levels. The people we employ comprise over 60% of the cost of providing health services to the people of NSW; their education and training is critical to the effectiveness of our health system.

Establish the Health Education and Training Institute (HETI)

A new structure and capability mix will be required to undertake an expanded set of responsibilities proposed for HETI, which will include:

- undergraduate clinical placements;
- vocational education and training;
- management and leadership development; and
- the existing post-graduate clinical education functions of CETI.

The organisation will continue to be a Chief Executive governed Statutory Health Corporation. This will preserve the successful elements of CETI and its predecessor organisation, the Institute of Medical Education and Training, and continue the now mature programs and networks for post-graduate and specialist medical training. It must be responsive to local needs and develop innovative and high quality training and education that is cost-effective, accessible and capable of meeting both individual LHD needs and whole of system needs.

Transfer appropriate training and development resources and responsibility for associated staff currently with the HRTOs to HETI

A number of HRTO staff involved in training and development will be transferred to HETI. This transfer will not include functions which are appropriately localised, such as Clinical Nurse Educators (CNE) working within public hospitals and other health care settings. Major training institutes currently located at a District/previous Area level will also be incorporated into a statewide training and development framework.

Transfer of functions, resources and associated staff from the Ministry to HETI

The Director-General's current functions in relation to the NSW Health Registered Training Organisation will be transferred to HETI, as well as:

- College of Nursing contract;
- Allied Health, radiation therapist and nursing scholarships;
- Radiation Oncology Medical Physicists & Radiation Therapists training programs;

- COAG Productivity Places Program and other VET programs;
- the Hospitalist Program and clinical coders framework;
- Aboriginal workforce programs including scholarships, Cultural Respect Training Framework and e-learning; and
- Implementation of financial and people management training packages.

Training and education activities currently undertaken by CEC and ACI will also be reviewed in relation to the role of HETI.

4.5 GREATER TRANSPARENCY AND UTILITY OF HEALTH INFORMATION

The Bureau of Health information has been successful in its efforts to produce health performance information to both assist patient choice and contribute to public debate. NSW is unique amongst states and territories in having an independent entity for this purpose. Building on this model can only serve to improve patient outcomes and benefit the system as a whole.

Clearly delineate the role of the Bureau as the System 'expert' in analysis and reporting of patient outcome information to the public and to clinicians

The role of the Ministry as system manager is to monitor and analyse the performance of hospitals and health services to ensure that the system is achieving the level of service specified in Service Agreements. Both roles will often require sharing of information sources and collaboration on information systems design and Key Performance Indicators. A cooperative relationship will be essential if each is to fulfil its separate obligations to the people of NSW. A ***Service Compact*** will be agreed between BHI and the Ministry based on BHI's ***Strategic and Annual Work plans***.

The Bureau will have a future role in commissioning the NSW Health Patient Survey and for analysis and presentation of results

The NSW Health Patient Survey Program contract held by the Department with commercial vendors comes to an end in 2012. It is proposed that the BHI be contracted to manage the design, collection, analysis and reporting of patient experience surveys on behalf of NSW Health.

4.6 REALISING THE POTENTIAL OF STATEWIDE SERVICES

➤ ***Health Support Services***

Health Support Services (HSS) provides linen, food, payroll, warehousing, procurement, recruitment and other shared services to public hospitals and health services, following consolidation of services from the former eight Area Health Services. Service consolidation is consistent with the whole of government Corporate and Shared Services Reform Program. While the formation of HSS has achieved benefits of scale, local health service staff have

expressed dissatisfaction with service delivery and price. A review of HSS currently underway will propose a series of measures for HSS to improve its services and customer responsiveness.

Health Support Services, excluding ICT-related functions, will become 'HealthShare NSW' under a governing board with majority membership from LHDs

HealthShare NSW will have strong District ownership and guidance through a governing board with majority membership from LHDs, metropolitan and rural, at a senior level (preferably a number of District/Network CEs). The Board will also have an independent Chair, external expertise and a Ministry representative. *HealthShare NSW* should be regarded as an operational support arm of LHDs.

HealthShare NSW will be set clear performance targets to achieve customer responsiveness, transparency and contestability of services and pricing

The new governing board will be responsible for ensuring there is a consistent and consolidated set of business rules for the entity, that a culture of customer service is inculcated, and that there is transparency in price setting to reflect true cost recovery, efficiency improvements, future reinvestment needs and contestability by means of benchmarking against comparable services. It should be noted that this will need to occur within, and be consistent with, assessment and benchmarking under the whole of Government Corporate and Shared Services Reform Program.

General Recruitment Services currently undertaken by HSS will be devolved back to Districts and Networks

Responsibility for recruitment has been split between HSS and LHDs which has blurred accountability for these services. Concern about delays in the recruitment process was a recurring theme heard during the course of the Governance Review. Under the new governance arrangements, it is important to reintroduce localism and role clarity in the area of recruitment services. This proposed devolution recognises that scale benefits have not been proven to outweigh the flexibility and responsiveness that comes from locally managed services.

➤ ***Health Infrastructure***

Health Infrastructure (HI) was established in 2007 with the purpose of strengthening capacity in major capital works project planning and delivery within NSW Health.

A recent post-implementation review of HI concluded that HI has been successful in addressing the on time, high quality and good practice elements of its role. The review also identified improvements that need to be made in stakeholder relationships and management, and in transparency around cost allocation and contingency setting, and where efficiencies are being achieved as a consequence of the HI business model.

Vest responsibility for planning and management of building projects under \$10M in Districts

It will be open to Districts to manage these projects themselves subject to having the requisite capacity and skills, or alternatively, to engage HI on a cost recovery basis or a private sector project manager through open tender.

A Service Compact with Health Infrastructure

A Service Compact will be negotiated between the Ministry's Strategy & Resources Division and HI to ensure its activities are aligned with the Ministry's priorities and strategic directions and that its services are cost effective and responsive.

Require the HI Board to review and instigate changes to Health Infrastructure's practices

An immediate priority for HI is to address concerns about stakeholder management, particularly clinical engagement, responsiveness and cost and budget transparency. The Board and management will be asked to develop a strategy to address these issues including designing some performance indicators to measure improvement.

Establish a system risk manager role for Health Infrastructure in relation to capital works project delivery

Another priority for HI will be to establish standardised contracts, templates and other documentation and develop systems for ensuring compliance with best practice and relevant Government policy.

➤ ***Pathology Services***

Pathology services in both the public and private sectors have moved to statewide integrated hub and spoke models, based on large automated central laboratories, in order to achieve the scale and logistics necessary for both quality outcomes and efficient pricing. NSW Health has already consolidated services into four public hospital pathology hubs. It also operates forensic pathology, working closely with Coronial services, and the Division of Analytical Laboratories. Queensland, Western Australia and South Australia have already established fully integrated statewide public hospital pathology services.

Develop a Business Case to consider the cost-benefit of establishing a state wide entity to comprise the four public hospital pathology hubs and networks, forensic pathology services across the State, and the Division of Analytical Laboratories

The governance structure and business model for such an entity will be determined in consultation with the Peak Pathology Council following consideration of the outcomes of the current consultancy investigating this initiative. The business model will also consider other options, particularly for rural LHDs, to purchase services from private providers in specified circumstances.

4.7 RECOGNISING eHEALTH AS THE WAY OF THE FUTURE IN HEALTH CARE

In NSW, the current ICT governance model can be regarded as a “half-way house” with staff and functions spread between the Department which has a strategic role, Health Support Services, which is responsible for rolling out major corporate and clinical systems, and Area Health Service-based ICT services which are currently located in the Clusters. The statewide roll out of major systems needs to be supplemented with pervasive clinical engagement at the local level involving multiple testing and iterations of new systems before they are implemented. ehealth has enormous potential to transform the delivery of health care, whether by improving efficiency (e.g. digital radiology, finance and HR systems), reducing errors (e.g. e-prescribing), or increased patient empowerment and convenience (e.g. personally controlled electronic health record, telehealth and home monitoring).

Affirm NSW Health commitment to lead Australia in the development of ehealth

Successful ehealth implementations on the scale of NSW Health require whole-of-system commitment and strong leadership at the highest levels. To assist realisation of this objective, it is proposed that there is a consolidation of ICT strategic and planning functions and inclusion of a lead executive member on the Ministry Executive Leadership Team.

Establish the ICT functions currently within HSS as ‘eHealth NSW’ and transfer the remaining ehealth functions in the Ministry to eHealth NSW

eHealth NSW will become the system leader for the NSW Health information strategy, forward planning and delivery. It will be governed from within the Health Administration Corporation and, in the immediate term, co-managed with *HealthShare NSW*. In the light of the findings of the Audit Taskforce on ICT Planning and Investment, it is critical that an early objective of *eHealth NSW* is a re-setting of strategy based on extensive consultation with clinicians and other users and the redesign of ICT governance to ensure clear statewide plans and an appropriate balance with local initiatives.

Set the direction of further development of ICT resources under an integrated governance structure which connects between statewide and local services

A fully integrated Information Systems Strategic Plan must be developed, with clear and deliverable milestones and realistic timelines that allow proper clinical engagement and testing of systems before implementation is commenced. This master plan will need to focus always on patient outcomes, supporting enhanced clinical intelligence and recognition of the specific requirements of individual LHDs.

Include the Chief Executive eHealth NSW as a member of the Director-General’s Executive Leadership Team

This will facilitate system-wide planning, prioritisation of investment and engagement in ehealth processes.

5. IMPLEMENTATION

A Governance Transformation Group will immediately be established to coordinate the implementation of the actions contained within this Report. This Group will be chaired by the Director-General and coordinated by a Project Manager along with a small but expert change management team. Members of the Governance Transformation Project Management Team will participate in, or lead, specific teams in each of the entities undergoing major governance change. Given the degree of change proposed, it is intended that the transition process is expedited to reduce confusion and uncertainty but provides for staff to be strongly supported through the change process to assist their adaptation to new roles, relationships and/or working environments.

5.1 CLUSTER DISAGGREGATION AND DISSOLUTION OF HRTOS

Transition teams, comprising Clinical Support Division executives and LHD nominees and a member of the Governance Transition project management team, will take responsibility for ensuring that the current resources based in the HRTOS are distributed fairly to LHDs. A Framework to guide the transition of functions and services from the HRTOS to Districts and other health entities has been established as part of the Governance Review process. Substantial completion of the allocation of functions to LHDs is targeted for **31 October 2011**. It is expected that the HRTOS and Clusters will be able to be formally dissolved well before the end of 2011.

5.2 TRANSFORMING DEPARTMENT TO MINISTRY OF HEALTH

The restructure of the Department into a Ministry will commence immediately with any necessary revision, deletion and creation of senior executive roles. The restructure will be supported by the Workplace Relations and Management Branch. This will include the amendment, development and evaluation of position descriptions, redeployment and recruitment, unattachment and displacement, liaison with the Department of Premier and Cabinet and SOORT as required, and relevant industrial consultation.

5.3 ABOLITION, CREATION AND REVISION OF HEALTH ENTITIES

This process will commence immediately with any necessary legal establishment and deletion of entities, and consequential revision, deletion and creation of senior executive roles. This work will be supported by the Department's Legal Branch, Financial Management Branch and Workplace Relations and Management Branch. It will include the preparation or amendment of any statutory instruments, fulfilment of associated financial and tax requirements, development and evaluation of position descriptions, redeployment and recruitment, unattachment and contract termination, liaison with SOORT, as required.

The Governance Transformation Group and Project Team will work with CEC, ACI and HETI to achieve the changes contained within the Governance Report. In addition, assistance will be provided by the Ministry to support the HR and Financial tasks required to give effect to the proposed organisational redevelopment.

5.4 TIMELINE

By the end of 2011 the aim is to:

1. Complete the establishment of, and appointment to:
 - the executive management structures of the Ministry; and
 - the executive management structures of new or revised health entities.
2. Complete the transfer of functions and associated staff from the Ministry or internally realigning units and staff within the Ministry.
3. Formally dissolve the Clusters and Health Reform Transition Organisations.
4. Rename Health Support Services, *HealthShare NSW* and appoint a governing Board.
5. Establish *eHealth NSW* and develop a strong governance framework for ICT.
6. Prepare a business case detailing the appropriate future business model and governance structure for the *NSW Health Pathology*.

5.5 RESTRUCTURING FRAMEWORK

The Principles governing the 'Restructuring of Staff' are set out below and will involve consultation with all relevant industrial associations at an early stage. A detailed framework will be issued shortly.

Principles:

- Redeployment opportunities are to be maximised. Wherever possible, staff should be directly redeployed to appropriate positions in the new structures.
- Where practical and appropriate, staff who are not able to be directly redeployed, are afforded priority consideration for positions in the new structures.
- Where practical, reasonable efforts should be made by HRTOs to coordinate the times for conduct of priority placement processes for positions in similar functional or service lines.
- Where practicable, staff whose substantial duties involve the undertaking of functions which are to be transferred from one NSW Health entity to another will transfer with those functions.

Order of restructure:

- i. Following the Governance Review, consultation with unions will occur on implementation of new structures.
- ii. Redeployment and priority recruitment of award staff for functions transferring from HRTOs will be immediately progressed with the aim of substantial completion by 31 October 2011.
- iii. Senior executive positions in the Department of Health (Ministry) and Chief Executive positions in new or substantially changed health entities will be appointed.
- iv. Senior Ministry and Chief Executives of new or substantially changed health entities will then finalise and recruit to their respective executive structures.
- v. Transfer of Department of Health award staff between Department of Health (Ministry) Divisions, or to health entities as part of a transfer of functions, will be progressed at the same time as (iii) and (iv) where appropriate.