



**Review of
South East Regional Hospital**

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Executive Summary

The Secretary, NSW Health, initiated this Review of the operation and management of the South East Regional Hospital (SERH) at Bega, which was opened in March 2016. In undertaking the Review, documentation was provided by the Ministry and District, a large number of people were interviewed and several submissions were received.

The Review examined the issues arising from the commissioning of the new hospital, the culture of SERH, clinical governance and leadership.

With respect to *commissioning*, there is little doubt that a range of issues important for smooth transition to the new site and role were poorly addressed. Some of these issues include inadequate attention to service planning, clinical workforce requirements, administrative support needs, models of care and community engagement.

The local staff at Bega worked exceedingly hard in ensuring that the transition to the new hospital was safe. However, they were considerably under resourced and poorly supported, particularly by the District office.

Whilst there was a great deal of investment in and attention paid to the capital requirements in building SERH, it appears that there was minimal investment in the people and the *culture* desired in the new hospital.

When analysed against the District values of collaboration, openness, respect and empowerment, it is clear that these values are not “lived values” at SERH, and a focus on improving the culture is now important. As a consequence of this poor culture, there appears to be an unacceptable level of bullying and harassment which requires rectification.

The Board, District CE and hospital GM are committed to improving the *clinical governance* at SERH and a number of commendable steps are in train. These steps are, however, somewhat dependent on the engagement and enthusiasm of the individuals concerned and a more systematic approach to reviewing and improving clinical outcome data is needed.

With respect to *leadership*, a fundamentally different approach is required which broadens the base of the leadership team beyond executive management to include senior doctors, nurses and allied health.

In summary, an enormous opportunity to effect hospital cultural change, improve service planning, implement more appropriate models of care and provide greater community cohesion was not achieved in the construction of the new SERH.

The attention focused on the non-capital related issues was sadly lacking.

Nevertheless, the reviewers found a willingness of staff and others to both acknowledge these failings and endeavor to rectify them. Some of this rectification is already well underway by both District and SERH personnel.

The reviewers have identified a ten-point plan, which, if fully embraced, would serve as a starting point for ongoing improvement. The ten points are as follows:

- 1. Create a cross disciplinary senior leadership group at SERH that role models the values of the District and demonstrates exemplary leadership behaviours, including their own leadership development.***
- 2. Create updated service and clinical workforce plans for SERH.***
- 3. Review and modernise the models of care at SERH, in a process lead by the clinical leaders prioritizing those models that remain contentious.***
- 4. Create within the clinical governance system, a process for the systematic dissemination, analysis and discussion of available benchmarking data and a process for collecting granular local clinical data to be reviewed in forums with external clinicians from peer hospitals.***
- 5. Implement a hospital wide program to address the apparently systemic and long standing bullying and harassment.***
- 6. Employ additional administrative support officers to adequately improve operational efficiency and customer service to patients and their families.***
- 7. Improve SERH's human resources capability, especially the recruitment and performance management functions, to adequately support hiring, developing and managing staff.***
- 8. Encourage the actions of the District CE to build the District budget for FY2018 using a transparent bottom up approach providing a more detailed assessment of the actual costs of operating and maintaining SERH compared to the former Bega Hospital.***
- 9. Create a detailed communication strategy, overseen by the General Manager that keeps staff/patients and, importantly, the community fully informed on the progress of implementing the recommended changes.***
- 10. Provide a period of stability in senior roles in the District and SERH to create a stable team that ideally will work together over multiple years to deliver the promise of SERH.***

It is proposed that a Project Manager be appointed to work with the local management team and the local health district to implement the recommendations and that external reviews are conducted in six and twelve month's time to assess progress.

Chapter 1: Terms of Reference

The Terms of Reference for the Review were to:

1. Analyse and assess the role of Hospital and District management in establishing the Hospital's processes and procedures in transitioning to the new Hospital
2. Identify any deficiencies, including the nature, extent and causes of any deficiencies, in the management of the Hospital
3. Assess mechanisms for clinician and staff engagement and communication and their potential impact on culture/morale at the Hospital and staff turnover
4. Assess system, process and capacity to detect, respond and to manage emerging critical issues within the Hospital
5. Provide a final report and recommendations in relation to any changes to accountabilities, policies and practices that may assist in defining the future directions for the management of the Hospital.

Chapter 2: Process of Review

Two mechanisms were put in place to interview people for the Review:

- any interested person could provide a confidential submission directly to the Ministry of Health and/or seek an interview with the reviewers.
- District/SERH personnel arranged interviews with all senior managers at both Bega and in Queanbeyan. The Review team arranged meetings with other relevant people in both the Ministry and with the Board.

A list of those interviewed is at **Appendix 1**. An additional 14 individuals have not provided approval for their names to be published and their names do not appear on the list.

A number of submissions were received and both the Ministry and District compiled other relevant documentation.

The assistance of people in the Ministry, the Southern NSW Local Health District and at SERH in arranging interviews and compiling material is acknowledged.

Chapter 3: Commissioning

The SERH opened in March 2016, replacing the Bega District Hospital and the emergency, operating and clinical bed capacity at Pambula Hospital.

The greenfield site selected for SERH enabled the construction of a bespoke facility which is physically about three times larger than the Bega District Hospital. The capital cost for the new build was \$187M.

Whilst many of the cultural and governance problems outlined in this report pre-dated the new building, there is little doubt that, outside the capital construct, a range of issues important for smooth transition to the new site and role were poorly addressed. Significant opportunities for change were lost in commissioning the new hospital.

The detrimental impact of poor commissioning was compounded by the dissatisfaction caused by the Rural Doctors Association (RDA) contract change (which could have been managed more expertly) and the shift of SERH from block funding to activity based funding (ABF).

By all accounts, the local staff at Bega worked exceedingly hard in ensuring the transition to the new SERH was safe. However, they were considerably under resourced and poorly supported by the District office. As one example, the appointment of a designated transition manager did not occur until six weeks pre “go live” date. This appointment was substantially too late in the process.

Community Engagement

A major criticism of the commissioning was the poor quality of community engagement regarding the rationale, benefits, consequences and limitations of building SERH.

The submission from the Board provided to the Review states:

“There was inadequate information provided at an early stage about the benefits (or limitations) the new hospital would provide. When information was provided, it stressed the positives without explaining any negatives. In particular, the message was not sold about the diseconomies and clinical inefficiencies of trying to maintain two hospitals (Pambula and SERH) in the same area. This led to an upsurge of community demand to “keep our hospitals open” (ie Pambula), which has created an underlying local suspicion of the new hospital and preparedness to accept that any criticism of it is justified. Inadequate attention was given at an early stage to how the Pambula site could be re-used in ways which would be seen as benefiting the local community and gaining community support”.

A number of strategies are proposed in this report for rectification of some of the problems evident at SERH. Understanding these problems and then addressing them in a systematic and transparent way will require the full engagement of the community.

Models of Care

Any transition to a new hospital, encompassing changes such as altered ward configurations, changed theatre layout, a redesigned emergency department (ED) and new or more complex services requires the development and adoption of new models of care. These were not completed prior to the move, and much of the staff dissatisfaction and ongoing tensions could be attributed to this. Even the size of the new facilities such as the ED and high dependency unit (HDU) were reported to be discomforting to some staff.

One example of inadequate attention to models of care cited in interviews related to the use of birthing baths in maternity and the strongly differing opinions of the medical and midwifery personnel as to their clinical appropriateness.

Lack of attention to the new models of care was not limited to SERH. At Pambula, there was limited planning with staff and the community regarding the move to a proposed nurse led clinic. Consequently, the transition has been difficult and is still subject to ongoing discussions and refinements involving staff and the local community.

To the credit of the new management team, there is considerable “catch up” effort in place to address the appropriate models of care.

Administration workforce

The scope of this Review did not extend to a full appraisal of workforce related issues. However, one issue that arose consistently in consultations was the reported dearth of appropriate support staff.

There appears to have been inadequate, if any, comprehensive workforce planning as part of the commissioning of SERH.

One submission to the Review team provided by a staff member, highlighted disparities at SERH in comparison to another hospital in which that person had worked. The staff member cited, for example, a lack of on-site Clinical Support Officer, Ward Clerk, Storeperson and Human Resource Officer. She also pointed out to the lack of specialised nursing personnel with appropriate education and training; in particular nurse educators and specialised CNCs.

Others spoke about the allocation of a single ward clerk to cover physically adjacent wards in the old Bega Hospital with the same person being expected to cover the same wards now physically separated in the new SERH.

The lack of sufficient administrative personnel in areas such as security was also highlighted in other submissions/interviews.

It is unknown whether this apparent lack of administrative support personnel and more specialized nursing roles is a District wide issue or limited to SERH. Obviously, where nurses undertake roles such as stores ordering, packing, human resource functions etc.; there are not only cost consequences for the hospital but it is demoralizing for the staff involved and makes a focus on patient care more difficult.

The reviewers acknowledge that SERH has been undertaking an Administration Review, but believe an investigation of this issue by the District is appropriate.

Ongoing structural issues

There are several issues which either remain unresolved or are only now being addressed, which has further impacted on the full complement of clinical services at SERH.

These include:

- the Sub-Acute unit remains unopened pending appropriate nursing and medical appointments. As common elsewhere, no business rules or models of care have been developed, relationships with other wards remain unsolved and the required skills of new staff remain undocumented
- the Short Stay unit is unopened awaiting appointment of suitable medical and nursing personnel.

There are other building related issues which also require resolution.

- the hospital windows are cobweb ridden and dirty. Reportedly, there has been unresolved issues between the District and NSW Health Infrastructure (HI) regarding respective responsibilities. It is understood a contract is only now being let for cleaning
- a retail space at the front entrance remains unlet
- by all accounts, the lack of commissioning an appropriate and contemporary IT strategy, that had been developed and previously agreed, has also impacted on the functionality of SERH. Frequently cited was the opportunity lost in creating a better medical records system and operating theatre management system.

Roles and responsibilities

At the time of the construct of SERH, the respective roles of HI, the District and the hospital administration was not clear. Some of these issues have subsequently been rectified in other capital works projects in NSW, whilst others remain unresolved. Some general comments frequently raised include:

- there was both a physical and psychological distance between Bega and Queanbeyan District Office. Reportedly at that time, few people from the District visited Bega, and there was a perception of “them” and “us”. It is apparent to the reviewers that, with some notable individual exceptions, there was insufficient project oversight and support by the District. The extent to which the Board was aware at that time of the severity of the problems is unknown
- the skills base in Bega (and in Queanbeyan) was, in retrospect, quite inadequate for such a major capital project
- there were insufficient “alarms” at the lack of commissioning/change management to accompany the capital construction. It is understood the reforms to “Gateway” in HI now provide early alerts of weaknesses in the various elements of a building project
- the hospital was built, but stood empty for some months prior to “go live”. This discontinuity did not aid a smooth transition
- there is a view that HI should have a much stronger “hands on” role, particularly in capital builds in smaller Districts. For example, HI having responsibility in going to market for retail space across several sites by portfolio offering would gain a better return
- for some projects, HI undertakes post occupancy evaluation. It is proposed that such an evaluation is undertaken at SERH.

Service Planning / Medical Workforce

It appears that the service planning providing a guide to the eventual size and service mix of the SERH was inadequately enacted.

Whilst there were some service planning underpinning bed requirements, there appeared to be no medical workforce planning to guide future service enhancement.

The nature of the medical workforce at SERH is shifting quite rapidly as would be expected in the move from a District to Regional hospital. From a predominantly GP/VMO led service, there is and will continue to be, increasing appointments of partial/full time staff specialists (such as the new colorectal surgeon), FACEM led emergency department and substantially increasing rotation of junior doctors.

The reviewers believe it is now timely to develop both a new service plan and a comprehensive medical workforce plan. The latter should more comprehensively address appropriate linkages to other hospitals in both NSW and Victoria.

The workforce plan should also put strategies in place to diminish the SERH dependency on agency personnel – both medical and nursing which are both costly and indicative of a less than optimal culture.

Chapter 4: Culture

This chapter specifically focuses on the current culture of SERH because it is a weakness that is limiting the ability of the Hospital to deliver on optimal health care.

As described in the previous chapter, while there has been a great deal of investment in and attention paid to the new building, it appears that there has been minimal investment in the people and culture of the hospital and scant effective attention paid to the human team that deliver the services in the physical build. This needs rectification.

The reviewers suggest that the best way to analyse the culture that we observed and felt is in terms of the most important culture statement of the District - its Values. These Values comprise Collaboration, Openness, Respect and Empowerment.

Collaboration

The aspiration of the District is to be a team that works collaboratively to achieve the best outcomes for consumers.

The characteristic that stood out during the review process was the lack of a “we”. It is hard to recall a conversation or example where the notion of team, collaboration and working together for a common goal was first and foremost.

The SERH displays almost tribal behaviour both within clinical and administrative teams and across the hospital. By all accounts, this has been a feature of the hospital for many years, The physical environment of the SERH has contributed to this isolation being a much larger space than the previous Bega Hospital, with separate dining areas and no common area for staff.

The executive team at the hospital is new and, by all accounts, is working in a much more collaborative fashion. Historically however, the team has been perceived as elitist and not engaged in role-modelling collaboration. It is the responsibility of senior management to role model joint problem solving, identify and address system impediments to success and create an environment where the skills of staff are used effectively in achieving a collective outcome and negative behaviours are out of place and addressed.

Doctors, nurses and allied health leaders are also not collaborating effectively to create high quality services for patients. An example is the process by which the service profile of the High Dependency Unit (HDU) was developed.

While models of care can be contentious, there is rarely a “right answer” that can be proposed by one party. The best care for patients always requires people to be working together professionally for the true best interests of the patients.

The reviewers heard frequent accounts of clinical teams that are not working effectively which appears to be in part due to the lack of commitment to the value of collaboration across the Hospital.

Openness

The aspiration of the District is to encourage feedback creating a learning culture of continual improvement. Most interviewed argued this is lacking at SERH.

There appears to be a lack of mature conversation between parties with perceived differences, and a preference for dealing with disagreement through formal processes that do not allow continual improvement. The lack of a performance culture, with frequent conversations resulting in a development plan for all staff, is notable.

The culture appears more one of fear of retribution. This does not exist in hospitals where the systems and processes are open and transparent.

Respect

The aspiration of the District in the values statement regarding respect needs to be questioned and reconsidered. It does not call for staff to respect *each other*.

The reviewers heard stories from staff that reported a lack of mutual respect and covered a wide range of interactions including:

- inappropriate personal language
- exaggerated responses to perceived or actual actions of others
- lack of acknowledgement of communication and engagement
- providing false feedback presumably to avoid difficult conversations
- lack of honest explanation of why certain decisions and actions have been taken
- lack of acknowledgement of current issues and difficulties and a plan to fix them e.g. the dirty outside of the building, restricted access to verandahs from clinical areas and the broken glass in the stairs at level 3
- inadequate training
- inadequate authentic feedback for unsuccessful internal applicants for positions and a perception of favouritism
- perceived lack of transparency and response to the findings of internal and external reviews including clinical governance, human resources and the administrative officer service
- inadequate consultation with front-line staff regarding new policies and procedures.

Again, it is emphasised that many of these issues are historical and have been acknowledged by the new executive team. Nevertheless, respect is at the heart of a culture of continuous improvement and this is a culture that the hospital should aspire to.

Empowerment

The District aspires to create an environment where consumers are empowered and staff are encouraged to innovate with new clinical and business models.

Rather than finding empowered staff who are making a positive difference to the best of their ability, many staff expressed the view that they were disheartened and disempowered.

The District should aim for a culture where staff are empowered and trusted to deliver continuous improvement, where performance management is a safety net of last resort and good behaviour flows from a culture of transparency, responsibility, accountability and leadership.

Bullying and Harassment

Many interviewed claimed that certain staff have long exhibited behaviours that are at best robust, and at worst, evidence of bullying and harassment. These behaviours have reportedly been evident for many years in the former Bega Hospital.

There will always be disaffected individuals who engage in a review such as this. However, the reviewers heard many stories from a wide variety of departments. Issues raised included:

- cliques forming in teams
- behaviours left unaddressed, sometimes in senior personnel to whom others look for guidance
- minimal public and private discussion from the hospitals senior employees about acceptable standards of behaviour
- a preference for written communication and reporting where context, intent and non-written cues are hard, if not impossible, to receive.

In summary, the culture of the SERH is not healthy and the cause can reasonably be ascribed to a lack of the organisation living its values. Harassment is a symptom of such a culture that needs to be addressed at both an individual, hospital and possibly, District level.

Suggestions

Four suggestions are made to improve the culture of SERH.

Firstly, SERH would benefit from undertaking a cultural improvement program under the responsibility of the senior leadership that:

- defines the senior leaders of the hospital
- has those leaders take responsibility for the culture of the hospital
- has those leaders define, communicate and role-model the new culture.

The responsibility of leadership does not reside solely with senior management, but should occur across all disciplines and in all geographical areas. Senior clinicians, experienced line managers, experienced team leaders and members of the executive all need to form a team that lives the values of the District.

The values of the District are a reasonable basis for the culture going forward, accepting our comments that the respect value should include respect for each other. What is required is the practical application of those values in actions, behaviours and responses that staff can understand, see and replicate.

The reviewers note that this is the same theme that was reported back to the Board at its meeting of 10 March 2017 following a site visit to Middlemore Hospital, New Zealand, in January.

Secondly, the implementation of a specific program across SERH targeting the behaviours of harassment and bullying is recommended.

Many jurisdictions and organisations have developed programs that should be able to be implemented with little modification. An example of one such program that might be available and easily modified is “Let’s Operate with Respect”, developed the Royal Australasian College of Surgeons. They have been through a very public examination of bullying and harassment within the surgical profession in recent years. As a result it has developed a program based around respect to address the underlying behaviours and assumptions that lead to this scenario.

If this program is selected, discussions should take place with the College on modifying the program for a non-surgical audience. Or, the modification already completed by St. Vincent’s Health should be examined.

Thirdly, SERH would benefit from an experiential learning program with other hospitals that have an enviable culture

It would be useful for SERH to develop a partnership program with a select number of hospitals with whom they can collaborate on the cultural change program. This can include visits to the other places by SERH staff, visits in by the staff of the other institutions and the development of individual mentoring / support / guidance relationships by those tasked to lead the program.

Finally, it is proposed SERH implement a program to define “above the line and below the line” behaviours in every team in the hospital. It is proposed that this simple exercise is rolled out across the hospital, lead initially by senior staff in a train the trainer approach, to all teams. The aim is to provide an organisation wide conversation and a language for calling “below the line behaviours” simultaneously with the leadership providing pragmatic examples of the desired culture and behaviours.

Chapter 5: Clinical Governance

On the basis of the evidence before the reviewers, it would appear that SERH is presently delivering a service of acceptable safety and quality. However, this safety and quality would be at risk if the matters regarding culture, leadership and governance that are raised in this report are not effectively addressed in a timely manner.

There have been a number of recent positive developments in relation to clinical governance at both SERH and across the District, including:

- the external review of clinical governance across the District that was commissioned by the CE and received in January this year
- the actions of the recently appointed Director of Medical Services for SERH to implement improvements to the system of clinical governance in SERH
- the recent appointment of a new General Manager for SERH who has expressed a commitment to better systems, processes and engagement in clinical governance
- organizational reforms of the District to strengthen professional stream oversight and governance
- engagement by the Medical Staff Council including an action plan submission.

In addition to these excellent developments, some further suggestions are made with respect to:

- process
- culture
- leadership.

Process

The processes of clinical governance appear haphazard and somewhat dependent on the engagement and enthusiasm of the individuals concerned. It is proposed that the hospital creates and embraces a system of clinical governance that is consistent across departments.

The Bureau of Health information provides a rich source of benchmarking data regarding access, appropriateness, effectiveness, efficiency, equity and sustainability. There appears to be an opportunity for improvement in how this data is discussed and analysed within SERH and used for change.

The system level data found in BHI reports is important, but not sufficient to drive the cultural change required within the clinical ranks of the hospital. Data at a more granular clinical level regarding outcomes of care should be collected locally, analysed and compared with peer facilities. External engagement in audit, models of care and improvement ideas would be of benefit.

The reviewers understand that the District has rescinded its membership of the Health Roundtable, the peak benchmarking and clinical information-sharing body in Australia and New Zealand. Membership of, and active engagement in, the Health Roundtable could be very beneficial to the hospital at the moment because of the granularity and peer review outside New South Wales of clinical data and the opportunity to share in roundtable discussion.

It is proposed that:

- a system is created for the regular distribution of BHI data throughout the hospital, its analysis and formal discussion
- more granular local data regarding clinical outcomes is collected and used in review with external peer hospital clinicians

To achieve, this the District should consider re-engaging with the Health Roundtable participating in benchmarking and domain specific roundtable activities and also consider taking a leadership role by seeking a Board position.

The morbidity and mortality process needs to become more formal and multidisciplinary. Stronger requirements are needed that all units undertake regular rigorous review of clinical activity, outcomes, deaths and near misses.

The processes surrounding no-blame investigation of actual avoidable incidents or near misses seems to be missing the opportunity for learning and system improvement. Communication that is broadly disseminated is a critical element of Root Cause Analysis and other near miss reviews, and the General Manager and DMS should lead a communication action in this regard.

There was anecdotal evidence that responses to concerns raised through the Incident Information Management System (IIMS) are slow and on occasions little or no feedback is provided. It is proposed that regular reporting back to the whole organisation regarding the matters raised through IIMS, and their resolution (including timeliness), would be a positive step forward.

Improvements are proposed in performance assessment, management and development of clinical staff, whereby the District develops a more robust process of clinical performance conversation and goal setting.

Culture

Chapter 4 is dedicated to consideration of the overall culture of SERH, and therefore this section relates only to those elements of culture that relate directly to clinical governance.

Many of those interviewed spoke of poor culture of reporting clinical incidents at SERH leading to significant under reporting. The reviewers were unable to determine the severity of this issue, but suggest it should be assessed by the District.

There appears to be a strong compliance culture and less in the way of a learning culture. Learning cultures require a healthy ability for self-reflection in a no-blame environment and a desire for continuous improvement. Many of the improvements required for good clinical governance require teamwork and collaboration, qualities which have room for improvement at SERH.

The system of clinical governance provides an opportunity to assess improvement in culture in a pragmatic and observable system. The proposals made are interlinked, for example a learning culture cannot be developed through process (such as effective communication of findings and responses) alone if staff remain disengaged or fear retribution. This is an ideal place for the Board to set expectations and ensure that those expectations are met by management.

Leadership

Chapter 6 is dedicated to the practice of leadership broadly across the hospital. As with culture, many of the findings in that chapter have application for clinical governance. The critical need for senior clinicians to demonstrate effective leadership in the constant review of clinical performance, improvement in care, modernisation of models of service delivery and multidisciplinary teamwork focused on patients is emphasised.

This is an area that is ideal for engagement of external parties to open-up the clinical governance system and provide support and assistance to clinicians and managers of the system. It is proposed that a small number of external clinicians and non-clinicians (including community members) are engaged to play a role in providing leadership to the clinical governance system, at least until this is internally self-sustaining.

Chapter 6: Leadership, Management and Communication

General Observations

This chapter refers to the *actions* of leadership and managing not the *people* who are often generically referred to as “management”. Leadership is a set of actions that can be taken by staff at all levels of the organisation structure. Managing is the act of planning, organizing and operating the business smoothly and efficiently.

Leadership and positional power have historically been confused at SERH. Reportedly, there has been a strong sense of the use of command and control by the senior management as a tool for setting direction, tone and culture, rather than using leadership through others. Collaboration and negotiation have been used too infrequently by senior clinicians, both doctors and nurses, to produce better clinical outcomes.

The historical void in leadership has allowed unhelpful behaviours and harassment to emerge while encouraging staff to turn to formal processes such as an IIMS report, a letter or an email.

The void in leadership has hindered the resolution of complex and important matters that affect patient care. For example:

- concerns from the security team as to the capability of all clinicians to be the leader in a Mental Health physical take-down
- the models of care for pregnant women, their babies and families
- the use and development of the High Dependency Unit / Intensive Care Unit
- reported lack of adherence to the chest pain pathway

Leadership actions are beginning to emerge in recent months. Examples include:

- the CE of the LHD has articulated a vision for the District which was acknowledged in many interviews
- the CE of the LHD is noted to be more visible at SERH than previous people in the role
- newsletters and direct communication are beginning to flow from the CE and the General Manager
- certain senior clinicians acknowledge that they could have responded to recent major events in a more constructive manner
- the Medical Staff Council has produced a helpful contribution to the design of the clinical governance system
- identifiable actions of the new GM in personally dealing with customer concerns and complaints at the front desk of the hospital.

The reviewers note however that despite a perception of significant investment in leadership development at the hospital, this is not translating into pragmatic action at the front-line. For example, the 2016 People Management Skills Program of the Health Education and Training Institute (HETI) of NSW Health at SERH was created for around 40 participants with only 8 completions and a restricted resource for ongoing support.

Developing a multidisciplinary leadership group

SERH would benefit from forming a group of senior leaders, led by the General Manager, from across the locations and professions of the hospital, who are aligned in vision and purpose and pulling together to create a great hospital. Clinical leaders do not see themselves on the same team as “management” and vice versa.

It is suggested that the General Manager defines a leadership group of between 15 and 20 people drawn from across the organisation who will be the core group to cultivate and grow the practice of leadership and be the clear leaders in the hospital. This group is not a new committee in the organisation structure but in many ways acts as a community of practice in leadership. The first action of this group might be the identification and participation in a leadership development program and thereby role model a 360 degree feedback process.

Medical Leadership

Members of the senior medical group have taken a “hands off” approach to the hospital and moved into a “come in, do my work and go home” style. Whilst this is understandable in some respects, it cannot continue if the hospital is to flourish and serve its community. There needs to be meaningful engagement from all senior members of the hospital community to collaboratively address the issues facing SERH as outlined in this report.

The reviewers were encouraged by recent actions of the Medical Staff Council and its President. They have developed an Action Plan which provides a good foundation for future collaboration and development with the executive. The SERH need senior doctors to build bridges with the new CE / GM / DMS, resolve misunderstanding and provide the leadership that is critical to high quality patient care.

The senior doctors at SERH should accept the challenge to become a group who lead excellence in patient care, guide the development of new services, embody professionalism and provide a positive and active influence in the life of the hospital.

Nursing Leadership

At the level of the hospital, nursing has historically filled the void in medical leadership. Nursing appears to have thus become the dominant influence in setting the tone and culture in the various hospital departments. While well intentioned, this imbalance is at odds with high performing hospitals where doctors, nurses and managers work together in collaboration and partnership.

The reviewers heard that the senior nursing leadership at SERH has been disconnected from the clinical workplace, a situation which, if correct, is disturbing at an institution as small as SERH.

It was suggested by some nursing personnel that the senior nursing managers do not regularly perform rounds, visit the wards frequently or have an intimate knowledge of the key issues facing the clinical units.

It was not possible for the reviewers to objectively assess these criticisms of senior nurse management. However, some evidence would suggest that the limited capacity of senior nurse managers to have a greater clinical presence in the hospital was partially attributable to their high administrative load. As one small example, the Director of Nursing (DoN) does not have a dedicated Executive Assistant.

It is probable that the senior nursing management are not being well served by Human Resources. Human resources processes including recruitment, performance and talent development, addressing bad behaviour and the formulation and notification of HR related Policy have significant room for improvement.

The recent multiple changes in Nurse Unit Managers and the inability to recruit consistently at this level are a cause for concern and a call for greater analysis of the culture within nursing. There are questions as to whether this group are receiving adequate support, mentoring, coaching and resources to effectively discharge their critical role. The reviewers acknowledge that the leadership and behaviour of some of these NUMs has been questioned in interviews, and that this adds to the complexity of leading and managing this group.

It is proposed:

- that the whole executive team at SERH adopts a leadership style that takes them into the hospital and results in actions such as management rounds of the wards and meetings being scheduled to occur in the workplace of the staff
- that the nursing leadership of the LHD reassess the workload requirements they request of hospitals and that they actively engage a process to free up time for the Nursing Directors to be more inwardly engaged

- that, as part of the proposed review of HR, particular consideration is given to providing nursing with appropriately qualified resources
- that, at the very least, the DoN is provided with a dedicated Executive Assistant.

Administrative Leadership

Assessment of the Administrative Support Officers Service, gathered from interviews and observation, is that this service also is suffering from the absence of high quality leadership. An executive level appointment to lead this service does not appear to have provided the vision, strategy and direction to develop this into the valuable support service that it can be.

Executive Leadership

Historically, the executive team have been left carrying responsibility for leadership when others in the clinical professions should have been doing more of the “heavy lifting”. The proposals articulated earlier in this review are designed to better share the load.

The frequent changes in General Manager at Bega and the leadership / management style of some previous GMs and senior executives has contributed to the current problems. The recently appointed General Manager appears to have a good understanding of the problems she faces and the effort that will be required to achieve the desired turnaround. She will require the full support of other senior people.

Management

The practice of management at SERH has substantial room for improvement even allowing for the regional nature of the hospital. In this section, some management issues are highlighted. They are by no means comprehensive, but are indicative of needed changes.

In relation to the operational elements of human resources, three key areas were highlighted:

- grievance management
- formal notification processes leading to dismissal
- recruitment.

Formal grievance procedures seem to be instituted too readily and on occasions for matters that are best resolved outside of a formal process. This is partly a reflection of frustration, mistrust and the culture described in Chapter 4, all of which would be addressed with high quality strategic human resources.

In addition, there seems to be little governance over the grievance process such that system lessons are learned, and grievances are dealt with in a timely manner.

In relation to the formal notification processes, the reviewers were provided with multiple anecdotes where due process was not followed or where the process had not been successful in altering the behaviour or the dismissal of the person in question. It was not possible to fully analyse whether the root cause is a lack of knowledge of process, lack of senior human resources advice or a lack of will to follow due process. In any event, it appears that these processes, which should be used sparingly, are not being used properly.

The principal concern expressed in relation to operational human resources related to the recruitment function. The following issues were highlighted:

- lack of forward planning of recruitment needs
- very slow turnaround times for paperwork
- lack of understanding of the local environment and needs
- slow contract development
- lack of a sense of partnership to work together to capture good people who express an interest in working at SERH.

Recruitment of high quality staff in a timely manner is critical for a hospital like SERH and the current practice is poor. This requires remediation.

Other general observations

The reviewers are concerned with reports in relation to models of care, that may have a staffing basis, but that are matters of leadership. For example, the ability of the wards to manage more complex care after hours, such as epidural management / blood transfusions / certain infusions, is limited and this care is transferred to the HDU / ICU. Similarly, patients are reportedly occasionally brought to the operating theatre from the surgical ward without a nurse escort and handover is not effective.

The model of Allied Health that is used within the appears to be a legacy of history that was not adequately addressed in service planning, workforce planning and commissioning. The Allied Health profession sits within Community Services and acute services are provided to the hospital as an addition to the substantive role of allied health practitioners in the community. The allied health leader sits in a co-leadership model with the nursing leader in community and they both report through the nursing stream. Therefore, the General Manager does not appear to receive direct advice regarding clinical care from the allied health profession.

The inadequate service planning and model of care design described in Chapter 3 appears to surface in allied health, particularly the issue of provision of a modified barium swallow service. A hospital with the service capability of SERH should provide this service and it is understood that the equipment has been installed, but the service is not operating.

The General Manager might reconsider the structure of allied health to create a more direct line of advice in relation to allied health clinical matters to triangulate the opinions of the medical and nursing professions.

Communication

The importance of effective communication and the opportunity to use this tool to assist in addressing some of the perceptions within the hospital and the culture change proposed for the hospital is enormous.

Some actions are proposed for consideration as starting points for more transparent communication:

- provide name badges, not security passes for staff as used in other hospitals
- senior personnel to personally send emails, especially those of a sensitive nature
- create a coordinated communication plan for the LHD CE, General Manager, professional stream heads and team leaders
- use email groups more effectively to distribute information to the right people and cut down internal spam
- create a process whereby staff can publicly ask appropriate questions regarding happenings in the hospital and receive public answers
- create social gatherings eg. staff BBQ's
- managers to create white time in their diaries to walk around
- senior doctors to meet to discuss contentious issues rather than writing emails or letters

Chapter 7: Other issues

ACT Patient Flows

There are considerable flow of patients, who live in the SERH catchment population to Canberra Hospital – recent calculations indicated \$28m p.a was reimbursed to ACT Health for these patients.

The District believes that one mechanism to better utilize SERH and attract a greater array of medical specialties to Bega will be to reverse some of these flows where clinically appropriate. The reviewers strongly endorse this strategy. Clearly, a large component of the \$28m would be for services that should only be provided in a tertiary hospital such as Canberra Hospital. However, it is inevitable that many other patient flows are for services that are or could be provided locally.

To this end, the District is exploring options such as the expansion of outpatient services at SERH and possibly attracting a private hospital operator to open private beds within SERH.

If these propositions prove viable, they would certainly encourage greater clinical presence in Bega, contribute to improving culture and gain better community support.

Earlier in this report, the need for better service planning and the development of a medical workforce plan was proposed. This is one important element of appropriate flow reversal. Equally important however, is the engagement of local General Practitioners, the Primary Health Network and the community.

Budget

Historically, the budget of the District has been of concern and much attention, particularly under the previous District CE was focused on rectification. The adequacy of the District budget by comparison to other Districts in NSW is beyond the scope of this Review.

What is concerning however, is the lack of transparency of the distribution of the budget across the District. This lack of transparency understandably fuels suspicion at SERH that it is not favourably treated. This is partly due to the budget formulation for all ABF hospitals in the District being predominately calculated on an historical basis and then “translated” into NWAUs. Such a process is neither satisfactory nor transparent. Funds have historically been maintained at District level to support budget “blow outs”.

New builds that replace existing builds are generally more expensive to run as they usually have a greater floor area, more glass, large volume of air to condition, changed ward configurations, larger workforce and different models of care providing better patient care and experience. This is difficult to reconcile in ABF budgeting where a new hospital is reasonably more expensive to run even though the output, in terms of NWAUs has not changed. The reviewers believe that appropriate financial modelling in this regard was not completed prior to the budget year of opening.

The ambitions of the District CE to rapidly move to a more transparent budget calculation for the District is applauded.

Medical Clusters

In an endeavor to break down the medical silos within the District, the CE is moving to the establishment of District clinical leads for the four major centres in each of the following disciplines:

- Womens/Children
- Anaesthetics/ED/Critical Care
- Medicine
- Surgery
- Mental Health
- GP Liaison.

It is proposed that in each discipline, the clinical leads across the four centres meet collectively to discuss issues and advise District Executive.

This initiative is welcomed and the clinicians spoken to in the Review strongly supported its establishment.

Chapter 8: Going Forward

This report was designed to undertake a pulse check on SERH. A number of issues have been raised by staff and others during the Review, the extent of which was concerning to the reviewers.

An enormous opportunity to effect hospital cultural change, improve service planning, implement more appropriate models of care and provide greater community cohesion was not achieved in the construction of the new SERH. The attention focused on the non-capital related issues was sadly lacking.

Nevertheless, the reviewers found a willingness of staff and others to both acknowledge these failings and endeavor to now rectify them. Some of this rectification is already well underway by both District and SERH personnel.

The reviewers have identified a ten-point plan, which, if fully embraced, would serve as a starting point for future improvement. The ten points are as follows:

1. Create a cross disciplinary senior leadership group at SERH that role models the values of the District and demonstrates exemplary leadership behaviours, including their own leadership development.
2. Create updated service and clinical workforce plans for SERH.
3. Review and modernise the models of care at SERH, in a process lead by the clinical leaders prioritizing those models that remain contentious.
4. Create within the clinical governance system, a process for the systematic dissemination, analysis and discussion of available benchmarking data and a process for collecting granular local clinical data to be reviewed in forums with external clinicians from peer hospitals.
5. Implement a hospital wide program to address the apparently systemic and long standing bullying and harassment.
6. Employ additional administrative support officers to adequately improve operational efficiency and customer service to patients and their families.
7. Improve SERH's human resources capability, especially the recruitment and performance management functions, to adequately support hiring, developing and managing staff.

8. Encourage the actions of the District CE to build the District budget for FY2018 using a transparent bottom up approach providing a more detailed assessment of the actual costs of operating and maintaining SERH compared to the former Bega Hospital.
9. Create a detailed communication strategy, overseen by the General Manager that keeps staff/patients and, importantly, the community fully informed on the progress of implementing the recommended changes.
10. Provide a period of stability in senior roles in the District and SERH to create a stable team that ideally will work together over multiple years to deliver the promise of SERH.

Writing reports such as this are comparatively easy. The difficulty lies in adopting the suggestions and maintaining the momentum for continuous change. Clearly there is a major role for the GM, aided by her executive and the clinical leadership group in embracing the necessary change. Equally important will be the support provided by the District and Ministry.

To help maintain the momentum for change, two suggestions are made.

- Firstly, a Project Manager should be appointed to work with the local management team and the local health district to implement the recommendations and that external reviews are conducted in six and twelve month's time to assess progress.
- Secondly, it is proposed that external follow up reviews are conducted in six and twelve months to assess progress.

Finally, one of the first actions of the incoming GM was to hold a cake cutting in the foyer of SERH to celebrate one year of opening. All staff were invited. Reportedly, no more than ten staff attended. On a lighter note, but with serious intention, the reviewers suggest that a clear KPI of a willingness by many more staff to attend for a year two celebration would be a strong indicator that positive changes are occurring.

Appendix 1: Interviews undertaken

Interviews were conducted with 54 individuals and 2 groups. This table records the names of the people and groups who have provided approval to publish their name either directly or indirectly by agreeing to interviews arranged by SERH /District. A further 14 people were interviewed whose names do not appear on this list. Two others chose to submit written documents alone.

Name	Position
Board of the Southern Local Health District	
Medical Staff Council	
Kerry Abramowski	Asset Manager
Amanda Adrian	Amanda Adrian and Associates
Michelle Arrowsmith	District Director Clinical Operations
Wendy Atkins	Manager Workplace Relations
Grant Bryant	Senior CT Radiographer
Fiona Burns	Nurse Manager
Julie Caldeira	Administrative Officer
Virginia Cater	Director People and Culture
Don Cave	Director of Medical Services
Paul Clements	Hospital and Security Assistant
AJ Collins	General Surgeon
Andrew Constance	Member for Bega, Minister for Transport and Infrastructure
Glenn Cooper	Finance Manager
Ruth Craze	iPM Support
Janet Crompton	District CE
Glen Davies	Director of Obstetrics and Gynaecology
Belinda Doherty	Director of Medical Services, Eurobodalla
David Dumbrell	A/Executive Director Medical Services
Giles Ellingworth	VMO Anaesthetist
Andrew Elliott	Chief Information Officer
Peter Gibbons	Senior Registered Nurse Theatres, Anaesthetic and Recovery
Graeme Gibson	Director of Critical Care
Wendy Grealy	Integrated Services Manager
Steven Holzhauser	Pharmacy
Wendy Hubbard	Cluster General Manager
Duane Kelly	Allied Health Manager

Name	Position
Jenni King	Business Manager
Matthew Knott	Orthopaedic Surgeon
Ashley Lynch	Registered Nurse, Theatre
Duncan McKinnon	GP Anaesthetist
Julie Mooney	Executive Director Nursing and Midwifery
Juan Prinsloo	RN Theatre
Cherie Puckett	Nurse Manager Leadership and Development
Krishnan Rajesh	Orthopaedic Surgeon
Sam Sangster	Health Infrastructure NSW
Nola Scilinato	NSW Nurses and Midwives Association
Graeme Sloane	Executive Director Clinical Governance and Organisational Effectiveness
Jenny Symons	Chair, SNSWLHD Board
Nicole Tate	Director of Nursing
Greg Thompson	Senior Dietician
Colin Weeks	Executive Director Finance and Corporate Services
Jane Yacopetti	Consultant

Appendix 2: Glossary of Terms

ABF	Activity Based Funding
ACT Health	Australian Capital Territory Department of Health
BHI	Bureau of Health Information
CE	Chief Executive of the Southern Local Health District
CNC	Clinical Nurse Consultant
District	Southern NSW Local Health District
DMS	Director of Medical Services
DoN	Director of Nursing
ED	Emergency Department
FACEM	Fellow of the Australian College of Emergency Medicine
GM	General Manager of the Southeastern Regional Hospital
GP/VMO	General Practitioner / Visiting Medical Officer
HDU/ICU	Combined High Dependency Unit and Intensive Care Unit at SERH
HETI	Health Education and Training Institute of NSW Health
HI	NSW Health Infrastructure
IIMS	Incident Information Management System
IT	Information and Communication Technology
LHD	Local Health District
Ministry	New South Wales Ministry of Health
NSW Health	New South Wales Ministry of Health
NWAU	National Weighted Activity Unit of activity based funding
Pambula	Pambula District Hospital
RDA	Rural Doctors Association
SERH	South East Regional Hospital