Deakin/DHHS Alliance

(Barwon-South Western Region)

Health governance and workforce change in the Barwon South Western Region

This project was commissioned by the former Department of Health and completed under the auspice of the Barwon South West Alliance between Deakin University and the Departments of Health and Human Services.

Acknowledgments

We acknowledge the Wauthaurong and Wurundjeri people of the Kulin nation as the traditional owners of the land that we work on and we pay our respects to them, their culture and their elders, past, present and future.

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Executive Summary

The operation of Victorian public health services is overseen by the Victorian Department of Health and Human Services (DHHS), including planning, performance monitoring, policy development, funding and regulation. At a local level, health services are governed by Boards, who are responsible for corporate and clinical governance, and the executive management of the health service is responsible for overseeing strategic planning and operational management. The structures and functions of these roles have changed significantly over recent decades, with impacts for workforces, communities and service delivery. Ongoing challenges remain, including adapting to changes in clinical service delivery, health policy and funding and the need to focus on efficiency and productivity as the demand for services grows and alters in nature.

Typical of many such communities, health services in the Barwon South Western (BSW) region have been continually challenged and required to adapt to change. This project collected and reviewed information from written reports and interviews with key informants, including both current and former management and board members of Western District Health Services, Moyne Health Services, and Hesse Rural Health Services. The focus was on understanding the successful processes of governance and workforce change in the BSW Region over the past 20 years, given local experiences of change and adaptation.

The project sought to record the story of governance reconfiguration in these services, document the range of health service governance models and workforce changes in the BSW region, and analyse trends and changes to identify drivers for successful change. Key emergent themes were identified in relation to:

- Service Delivery Models
- Department interactions
- Boards of Management
- Organisational management
- Stakeholder engagement

Based on the findings, recommendations were made for the integrated activities of three key parties, being the Department, Boards and Management. For the Department, an important focus is providing strategic and flexible support to help regional services meet the needs of their communities. For Boards, the emphasis is on ensuring they have the right skills, clarity and community engagement to operate effectively and fulfil their governance role. For executive management, challenges lie around the need to balance strategic planning and implementation, strong leadership and management skills and the ability to collaborate effectively with the community and other services where relevant.

In the BSW region, as adaptation has continued to be required of regional and rural health services, they have developed an increasingly robust and mature change capability, with a more sophisticated approach to planning and implementing change, noting local community and stakeholder sensitivities. The report concludes that it is by maintaining an integrated focus on these processes that these services will be in the strongest position to face future changes due to factors such as population ageing, the changing profile of chronic disease, new technologies, policy change and unpredictable events.

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Introduction

Victorian public health services operate under the auspices of the Victorian Department of Health and Human Services (DHHS, formerly Department of Health (DOH), amalgamated in January 2015). The department is responsible for planning, performance monitoring, policy development, funding and the regulation of health service providers. Within this model, health services are governed by boards, established under the Health Services Act 1988. Boards are responsible for all aspects of corporate and clinical governance and must respond and adapt to challenges such as changing health care needs and demographics, as well as meeting expectations regarding regulatory and government policy requirements and standards.

The governance structure and function of health services, community health and other health entities has changed significantly over recent decades. The changes in health service delivery models and the range of services provided has had a profound effect on workforce practices and patterns during this time. There continues to be many challenges facing health services in the next decade. As an example, Commonwealth government changes to aged care provision may profoundly impact current entities. In addition, a focus on efficiency and productivity means that health services must continually examine their administrative and other structures to be accountable for their funding to government and their communities.

The reconfiguration of health services in the Barwon South Western Region over this period is an illustration of the need for continual adaptation in health care provision, a need which is often not well understood by local communities and some providers.

In this context the project aimed to collect and analyse qualitative health data (from both written and oral sources) to capture positive examples of governance and workforce change in the Barwon South Western Region over the past 20 years. The project was completed by a Deakin University team working under the auspice of the Barwon South West Alliance between Deakin University and the Victorian State Government Departments of Health and Human Services in the Barwon South West Region. The scope of the project covered local health services with three organisations selected by the Department as the focus for the report, given their experiences of reconfiguration and change. These organisations were Western District Health Services, Moyne Health Services, and Hesse Rural Health Services. Key informants from these organisations were identified by the Department and then invited by the Deakin University team to either attend an interview or complete an online survey about their experiences.

Project Aims

The defined aims of this project were as follows:

1. To record the story of governance reconfiguration in the region, including any recent reconfiguration which has responded to emerging health needs or governance trends and challenges.
2. To document the range of health service governance models in the BSW region over an agreed period, and include case studies of these models to tell the story of governance reconfiguration in the BSW.
3. To develop a broad picture of workforce change in the region, for example move from medical only models to the inclusion and development of new roles, such as specialist allied health and nursing roles.
4. To analyse the trends and changes and draw project-relevant conclusions about the drivers for change.

Qualitative data collection and analysis

Participants and method:

Five individuals were identified by the Department of Health as key informants, and invited to attend in-depth semi-structured interviews with a Deakin University project team member. These interviews elicited information about their roles and experiences with governance, including changes in approach, key learnings and challenges. A further six participants were asked to complete an online survey addressing similar questions. Participants included current and former organisational management and board members from Hesse Rural Health, Moyne Health Service, Western District Health Service, and the former Koroit Health (now amalgamated with Moyne Health Service). The online surveys and interview transcripts were analysed to identify themes and categories. Where relevant, quotes are provided in italics to illustrate the themes and categories. Due to the small number of respondents, individuals are not identified in this report.

Background

A review of annual reports, health services' own commissioned histories and other relevant written sources was completed by the Deakin team to identify key milestones and significant drivers of the changes, in order to provide context for this report. Summaries of the key changes that have occurred across the three health services are documented in the flow charts below, commencing from their establishment as entities.

Hesse Rural Health Services

1994: Hesse Rural Health was formed following the amalgamation of Beeac & District Hospital, Leigh Community Health Centre and the Winchelsea and District Hospital. Each of the three services had an independent Board of Management. A new Board was formed for Hesse Rural Health recognising the need for an integrated service.

1995: Beeac Hospital becomes a Community Health Centre.

1997: Construction of the Aged and Administration Redevelopment leads to the increase in provision of aged care beds.

1999: First formal strategic plan developed, the focus is on growing primary and aged care.

2003: Expansion of Hesse Lodge increases aged care beds.

2006: First mail out of annual report to 2,600 homes within the community to keep the community informed of key service initiatives.

2010: Website launched to increase translation of key service initiatives to the public.

2013: Extensive education undertaken by Board of Management to prepare for, and respond to changes in policy and regulation.

Moyne Health Services

2000: Moyne Health Services was formed following the amalgamation of the Port Fairy Hospital, Belfast House, Moyneyana House and their associated services.

2009: Completed a Community Needs Assessment (CNA) to form the basis of strategic service planning. This resulted in a Plan of Consolidation to improve the administrative management.

2010: Service Plan was completed based on CNA to form 'model of care'.

2012: Koroit hospital is now included in Moyne Health Services. All residents relocated to new facilities.

2011: Participated in the Australian Health Governance benchmarking project. This process provided feedback to further refine governance practices.

2011: Developed a Strategic Working Group to prepare for master planning.

2013: Moyne Health conducts a Community Forum to inform community of the proposed redevelopment plans.

2014: Moyne Health is granted a $3 million state funded redevelopment.

Western District Health Services

1997: Twelve public hospitals established the voluntary South West Alliance of Rural Hospitals.

1998: WDHS created following amalgamation of Hamilton Health services and other local services, and then in July 1998, was joined by Penshurst and District Health Service.

2000: Amalgamation to form **Coleraine District Health Service** (Homes for the Aged Care Committee; Hospital Board of Management; Coleraine and District Hospital; Coleraine and District Homes for the Aged Care; Merino Bush Nursing Centre), due to patient demand for broad range of health care services.

2005: Coleraine District Health Services merged with Western District Health Services.

2011: Merino Community Health Centre opened.

2011: Funding received ($26+ million) Coleraine campus redevelopment - to create a one stop health precinct for the Coleraine Community.

2013: Coleraine Health precinct opened.

Drivers of change

The sections that follow summarise the themes that emerged from the responses provided to the Deakin University team. Respondent details are masked to ensure confidentiality.

Changes in service delivery

The story of change over the past few decades has presented similar themes for all the health services reviewed in this study, and likely reflect themes that will have relevance in most regional and rural services. Historically, many smaller rural communities had a local health service, whilst larger towns would house a hospital providing a range of acute services, including midwifery, surgery and other inpatient care. Often staffed by local general practitioners, these services were generally under pressure by the 1980's, attributed to:

- Increased community and clinical expectations around the quality of health service delivery
- Increased complexity and range of medical procedures, with associated cost increases
- Demographic changes, with reduced call for acute services such as surgery and midwifery, as regional populations reduced in size and shifted towards an older demographic
- Decreased access to medical practitioners who were capable and willing to manage the range of services expected.

Whilst framed in the context of the NSW Health Service, the Garling Report (2008)[1] summarises many of these systemic issues comprehensively.

Some services made the decision to cease higher risk acute services including surgery and midwifery during the 1980s (eg. Penshurst Hospital ceased theatre operations in 1984 and midwifery in 1989). This move was largely triggered by the 'quality/volume' trade-off. This refers to the evidence-based contention that a minimum level of service provision in a specialist area is required for practitioners to develop and maintain the expertise necessary to provide high quality outcomes. For example Orthopaedic surgeons are required to perform a minimum number of hip replacement procedures each year to retain relevant skills. The requirement to actively maintain specialist skills has system implications. The Victorian State Trauma System (VSTS) provides a comprehensive example. A 1999 Victorian Government review[2] highlighted the need for state-wide trauma services to be centralised to ensure specialist skills were actively maintained enabling best practice outcomes to be achieved. The VSTS was gradually implemented from 2000, with associated improvements in patient outcomes including reduced fatalities and shortened inpatient durations[3][4].

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[1] Garling, P. (2008). Final report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals.

[2] State of Victoria, Department of Human Services (1999). *Review of Trauma and Emergency Services*. Report of the Ministerial taskforce on trauma and emergency services and the Department of Human Services working party on emerge and trauma services, Department of Human Services.

[3] State of Victoria, Department of Human Services (2009). Trauma towards 2014 - Review and future directions of the Victorian State Trauma System, Department of Human Services,

[4] State of Victoria, Department of Human Services (2015). Victorian Trauma System.

Developments in specialist practices and centralisation in acute service systems together with local demographic changes have had a combined influence in driving change in local health services:

> We needed to look at a different service mix because what you've got is financially unsustainable, there's … the demographic changes that were taking place, the service demand changes, service mix, the financial imperatives, the quality requirements, changes to clinical practice. (Participant 3)

For rural and regional services, there was a move to provision of sub-acute and community based service provision, such as post-acute care, medical and rehabilitation care, palliative and recuperative services, with more complex acute services referred to larger regional centres. Most services saw a shift towards increasing provision of low and high level aged care residential services, with some amalgamating with existing nursing homes and others increasing the number of aged care beds.

Explaining the rationale for change, and focusing on what the local service does well, has helped with adjusting to these changes.

> They did have to work out what services would be provided … (asking) is that a good service to be in or is that something the board should jettison, and it bailed out of obstetric … and surgical services. And people would … go to the larger centres…(They) went to those other services and said well when you discharge your people home you make sure you tell us because we want to provide the service in home, so we grew our in-home services which are highly visible to the community. (Participant 3)

Another major change was the closure of many former asylums for those with mental illness. During the 1980's-1990's, many states moved towards deinstitutionalisation and mainstreaming of psychiatric and disability services. Mental health asylums such as Aradale in Ararat and Brierly in Warrnambool, were decommissioned during the period 1993-1998, with advances in clinical care meaning community care arrangements could be successful for many patients and psychiatric services therefore became integrated into the public health care model.

Case mix funding

A crucial change for Victorian health services (previously referred to as Victorian hospitals and associated services) was the introduction of case mix funding in 1993. Previously, public hospital funding was based on historic budgets, and provided as a block funding payment regardless of activity, rather than being based on the actual services provided. During the mid-late 1980's, the Victorian Department of Health moved towards implementing a case mix funding model, which provided activity-based funding. This required changes to the reporting systems, including electronic reporting of patient episodes and costs.

From July 1993, a basic case mix funding model was introduced for acute care in Victorian health services[5]. This was gradually refined, with expansion to outpatient services in 1997 and sub-acute and rehabilitation services in 1999. Case mix funding had significant ramifications, particularly for smaller services where pressure on budgets required a review of the viability of a range of service offerings. To remain viable, many agencies and providers needed to adapt their service delivery models, as was noted by the Small Rural Hospitals Task Force reports at the time[67].

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5 State of Victoria, Department of Health (2015). Casemix Funding History.

[6] Small Rural Hospitals Task Force (1995). *Small Rural Hospitals Task Force Report*. Victorian Department of Health and Community Services.

[7] Tehan, M. & Knowles, R. (1995). *Small Rural Hospitals Task Force Report: Ministerial Responses*. Victorian Department of Health and Community Services.

Respondents in the present study felt that case-mix funding was limited in its success, and struggled to meet the needs of smaller rural settings. They also commented that it led to a sense of competition, rather than collaboration between services and a different perception of the services that could be offered.

> *Case mix funding was only ever designed for the large metropolitan ones … it was about high volume throughputs, you can't do high volume throughputs through small places and you have to have a whole range of services … so case mix was never going to work. So subsequently the government changed the way they'd fund, made it flexible funding as in a pool of funding and then you work out how you run your service once you can have guaranteed funding. But you couldn't necessarily have case mix funding if you didn't have a theatre of high level to bring people through the door, and you certainly couldn't compete with a Barwon Health or anything like that. (Participant 3)*

Amalgamations

Another significant change was the trend over the 1990's and 2000's for independent bush nursing and rural hospitals to be amalgamated to form larger health care networks. The historical journeys of amalgamation over the last twenty years for the services reviewed in this project are summarised in Figures 1-3. The trend for services to merge has continued into recent years, with Koroit Hospital becoming part of Moyne Health Services in 2012.

These mergers were largely driven by demographic changes, and specifically declining rural populations. However, other factors included the requirements to centralise technology and skills to improve the quality of acute services. Health services found benefits in partnering with other services to share resources and infrastructure, to enable access to more specialised and tertiary facilities. However, these changes presented a significant challenge to community identity and sense of ownership. Communities were challenged to recognise that smaller local campuses could not meet all their health needs.

> *Some rural hospitals … feel they've got to be all things to all people…We'd rather do a few things well. There's other people that … can do that better, let's outsource this function to someone else to manage for us because the compliance costs are too high so that we can focus on giving our local community great support in these particular areas. (Participant 4)*

The nature of amalgamations and collaborations has varied. Some were effectively imposed as a result of government policy, whereas more recent changes have been gradual and community-driven. Whether imposed or developed locally, it has taken time to embed change in both the organisational and community cultures.

> *Now the thing I'd say about that is yes we achieved amalgamation, new organisation, new structures in place [but] culturally it took … a long time. (Participant 1)*

Most amalgamations have been seen as successful, with respondents identifying benefits including broader services, increased staff networks and a sense of sustainability.

> *Positive outcomes included access to a greater range of services for the local community; back-up and a source of counsel/collegiality for otherwise isolated senior nursing, medical and executive staff; and in each case physical facilities were able to be upgraded within the revised budget of the larger entity. (Participant 6)*

Other experiences of amalgamation

Many of the health services in the region have commissioned histories of their services, and these, together with annual reports, form a rich source of material to consider change over a period of many years. Capturing all these experiences is beyond the scope of this project, but one which was

highlighted by current Chief Executives of health services was the successful creation of the multi-purpose service which is Otway Health.

A Community of Care, the history of Otway Health and its predecessor organisations, details many of the challenges which the predecessor organisations faced in the early 1990s. These included the introduction of casemix funding, detailed above, and limited access to capital. At this time:
> "there was an increasing recognition that health and community programs were complex and overlapping and that this had implications for rural communities. Each small rural service had its own committee of management and program grants that required separate management and accountability. The MPS emerged in this changing environment… in 1991."[8]

Five services were considered for the creation of the MPS at Apollo Bay; a hostel, the hospital, the community health centre, community centre and shire home and community care services. The MPS was declared on 1 January 1995 and a new facility was planned to bring together the services, which was opened in August 1996.

This is an example of opportunity meeting preparation, as much preparation for funding and other changes had already occurred, and with the advent of a new model, the Apollo Bay services were well placed to deliver the new model of service provision. The results however, were not without challenges, as the impact on local GPs became a factor which influenced implementation. Therefore, this example also highlights the importance of understanding all key stakeholders and the complexities of existing service relationships.[9]

The importance of communities understanding proposed changes is also highlighted in this example:
> "I think basically that the staff and clients lacked the understanding of the new concept of the Multi Purpose Service."**10**

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[8] Griffiths, P. (2002). *A Community of Care: A 50 Year History of the Otway Hospital*.
[9] Griffiths, P. (2002). *A Community of Care.* p118.
[10] Griffiths, P. (2002). *A Community of Care.* p119.

Many of the health workforce changes that have impacted the region were forecast in Duckett's (2000) review [11] of the Australian health care workforce including the trend for growth and specialisation in nursing, medical and other health professional roles. According to the ABS, in 2014 the health care and social assistance industries have grown to contribute 12% of total national employment, with over 1.4 million workers. Of these employees, hospitals made up over 25% and residential services (including aged care) a further 14%, with nurses around 50% and medical practitioners the next largest grouping[12]. Duckett's review highlighted a range of issues including impacts on the provision of services in regional and rural settings. National health workforce trends have been more recently examined through programs of the former Health Workforce Australia Agency [13] and the federal Department of Health[14].

What worked?

Respondents in the present study described a number of factors that contributed to managing change successfully. A number of respondents considered that a gradual approach was important, enabling a more considered planning approach and potentially a slower pace of change. More gradual change seems to have contributed to perceptions of better planning and communication, with local communities more able to adapt, accept the changes and develop ownership. A demonstrated commitment to genuine community engagement and consultation also provided opportunities to listen to concerns and explain the benefits.

> *It's about being honest with the community. Like we can be honest back in the early '90s and say you can't run your health service that way anymore, we've got a new funding dynamic, it's just the way it's got to be, all industries have to become more efficient, it doesn't matter whether it was us or it was a manufacturing plant we all had to get more efficient in the way we went about work… then you've got to allow community to understand that, I think, and adopt it. (Participant 3)*

Allowing time for affected parties to get used to the concept of change, such as mergers or other governance arrangements, and providing a gradual pathway towards these, helped in adjusting to these changes.

> *First step was to actually support and build up relationships, interact with the board, lead them through what the differences were…Departments sitting out, as a third party supporting it, both parties talking together … gradually stepping through it in terms of saying here is the benefits, here's your area of risk, in order to avoid this risk here's the amalgamation options… The original board members who are still members of the community many years after are happy with their decision which then reinforces through the community, we made the right decision. (Participant 2)*

The opportunity for all impacted parties, including communities, staff and residents where applicable, to have a voice, was also considered important by respondents.

> *(In) transition planning for changes, (you want) residents and families informed about changes and given time to find alternative options, staff informed about changes and support provided to find alternative work, and staffing and service provision phased down in a planned and timely manner (Participant 5)*

A further contributing factor for successful amalgamation was also described to involve establishing strong working relationships with other services or leveraging from existing relationships:

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[11] Duckett, S. (2000). The Australian health workforce: facts and futures. *Australian Health Review, 23* (4)
[12] ABS (2015) Labour Force Quarterly, May 2015
[13] Health Workforce Australia (2015). Health Workforce Australia
[14] Australian Government Department of Health (2015). Health Workforce

The reason the amalgamations worked so well was the way the senior staff… built up strong working relationships with the key staff of the other services, long before there was any suggestion of amalgamation, by providing back-up and resources to assist them to achieve their goals, strategic planning etc. The …board already included people who were key players in each of those areas of activity/district communities and were in a position to see the difference…When the time came for the formal discussions to take place, there was already a high degree of confidence and trust. (Participant 6)

Ongoing demonstrations of respect for the communities and networks that were coming together helped to build a sense of shared ownership in the new service structure. One strategy described by respondents was to maintain service identity during reform transitions.

So this community never lost its hospital, it grew an aged care service but it kept its hospital… Has it really got a hospital, no I don't think so. It's got a fantastic aged care service and a brilliant community health centre… but leave the word hospital on the door for a while because that was important. (Participant 3)

However, local service change can still entail loss for some health service users, especially where the replacement services are less readily accessible.

Some of the campuses have gone from strength to strength and admin has being stream lined, but in reality most of the people in the Health service catchment have to travel further and wait longer for basic health needs (Participant 7)

How was change well-managed?

Respondents described government engagement and communication to have been important features of successful change. Respondents felt that some changes were mandated by government, with policy and funding changes resulting in interventions imposed on communities. Where this did not include genuine community engagement, it contributed to a sense of unsustainability.

It was quite apparent to me that it wouldn't be sustainable, that people, the culture of the organisation would revert back to what was comfortable…They're (the board) totally in reactive mode, we haven't got time to sit down … we need to get on with it. The problem with that approach is there is a question mark over the sustainability… that's not going to achieve lasting change in the organisation especially if you've got board members that think it's all rubbish as well. (Participant 4)

However, where the pressing need for change was understood by the community, a "circuit breaker" approach might be considered necessary. As a last resort, this could involve Government using powers under the Health Services Act 1988 to removing existing structures and appoint an Administrator.

The single best strategy was not fiddling around with trying to modify but to say we want one person appointed to do the role, cuts out all the delay of politics and everything and we were able to in a very short period of time put in place a strategic plan, a structure in place, significant strategies, plans… achieve so much because the delay in the consultative process and the committee structure were taken away for an interim period to repair the organisation… There was about a two year period of angst and everything that goes with losing a large portion of your staff and everything else. But out the other end we then had a board re-established… (and told) here is your strategic plan, here is your key platforms of that, here is where we're going, here is all the components …. (Participant 2)

Alternatively, government could appoint delegates to the board.

What they did was to appoint or include on the board Ministerial governance. So effectively maintain the board as governance body for the health service but put in Ministerial delegates as members of the board

to lead the discussion and provide feedback to the Minister. … issues with how you actually move forward, constant change in direction, because you've got too many moving parts. (Participant 2)

Features of previous well managed changes included: careful community and organisational planning and communication, as well as communication with communities about the context of change, including when government intervention occurs. Demonstrating respect for local history was an important part of successfully managing change.

What lessons can we learn?

The experiences of respondents in this study suggest key lessons in relation to the following areas:

- Relationships with the Department of Health (now Department of Health and Human Services)
- The membership and function of Boards of Management
- Strategic and operational management
- Stakeholder engagement

Department of Health and Human Services

Importance of strong Department relationships

The importance of good relationships with government departments is critical for all health agencies, as they provide support and funding and manage the performance of health services. By building and maintaining these relationships and actively collaborating with other local entities, individual agencies can be better prepared and supported to meet their local challenges.

One of the key things for an agency is its relationship with the Department of Health, it's absolutely integral to its success…If you're looking to change something you have to mount a very persuasive case, put together a very well researched submission and then argue your case with the Department and then be prepared to take that as far as you need. (Participant 4)

Positive support for local networks

The support provided from the state departments include better governance and support for boards and management, and more flexible funding models were acknowledged as positive changes.

Some good things that have come out of the department that weren't there twenty years ago, governance structures, support for boards, that kind of stuff has grown … particularly in the last decade, that's actually very good. Setting up chair regional areas… all the chairs of the different health services get together and understand from a governance perspective what they need to be across …It certainly wasn't there twenty years ago. (Participant 3)

Challenges of state-wide policy implementation

An important theme emerging from respondents was the view that state-wide standards such as governance models may not cater for the unique needs of smaller regional health services, and there is a need for local customisation.

What we should be doing is not adopting models of governance that are generic. At a BHP governance… should be different (to) this level of the public system…It's important to have local governance but let's be real about the expectations (Participant 2).

Whilst acknowledged as a necessity, compliance pressures are perceived as a significant drain on governance and resources which limits opportunities for other activities.

I put about five times the amount of resources into compliance now than I used to even ten years ago… because we've got all these accreditation standard requirements … and they keep growing in their needs and we keep putting money into that instead of putting it into client care. …With the department we see more and more compliance orientated things as well because they're moving down certain paths…that's where they're driven, but it makes it more complex for health services. (Participant 3)

Respondents would like to be able to customise or tailor some requirements to their settings.

Over compliance and over complicating things, it's one size fits all…Have a look at our annual report… the finance section. Why are we wasting money looking at foreign currency translation? … that is irrelevant… (but) we do that because we're required to … (and) that's an enormous burden. (Participant 2)

Respondents could be frustrated by their perceptions that governments are not responsive to their ideas or suggestions for innovation.

We've got good initiatives. But often … government needs to seed those initiatives… once they put up a seeded initiative often you can go out to community and you can triple or quadruple that amount of money because community will come forward with other funds. We have probably stopped doing that over the last ten years or so. (Participant 3)

Governance Boards

Respondents commented on the importance of the role of Governance Boards, both in their formal accountabilities and as a key link to the communities they represent.

Board responsibilities and roles

There have been significant changes in the nature and role of Health Service Boards over the past twenty to thirty years. Previously referred to as Boards of Management, Health Service Board members were now more involved in day-to-day operations, with representation including staff and local health providers. This role has now evolved, with a significant focus on corporate and clinical governance.

The Bristol inquiry and other inquiries … turned the focus on the CEOs and boards, you're responsible for clinical governance, you're not just responsible for the financial operations and the clinical people are responsible for the clinical practices and governance etc., this is your responsibility. (Participant 1)

Clarity around the Board's role in strategic planning and decision making has increased with a greater sense of professionalism.

(Boards) make changes and decisions based on clear evidence and data and expert advice including from Management, Department of Health, and External Consultants, Politicians. (They need to) look at best evidence and review all options … identify challenges and risks and pending changes and make tough decisions early to plan for changes and transition… (and then) develop clear goals and objectives e.g. orderly wind down of services & transition to other service options, retention of excess funds for community (Participant 5)

However, some considered the increased focus on compliance and risk management to be onerous and impacting on the attraction of the role.

Risk management has certainly grown and that's probably one of these compliance issues that we have. We've got to be really careful because if we want to bring community members in on a board and at the same time all we do is poke … issues of risk and compliance then some of them will sit there and think this is not for me … Risk is important, there's no doubt about it, but so is innovation. (Participant 3)

Influencing Power

The ability of the Board to influence externally, especially in their community groups, was considered important by respondents.

> *All of the people on the Board … just because they have an association to it… whether they be connected to a bowls club, the CFA [Country Fire Authority], the Lions Club, church groups…they're connected to multiple people. And so long as they're briefed up with good information to pass out on issues it works well… The role of the CEO is to make sure that you're using those board members as a vector of good information. (Participant 3)*

Their ability to help communities to accept change was an advantage during amalgamation processes, with the option to retain previous board members in advisory roles.

> *One of the things that we did was retain a Community Advisory Board…who look at just the specific issues…They are appointed by [the Service], they don't have any real governance role or responsibility but they are the conduit between the … community, the CEO… and the Board … Every two months they have … meetings … they'll get a report from their manager, they'll get a report from the CEO … We also have a Board rep on each of those that attends and they'll focus on the issues that relate to [that catchment]. They'll be involved in fundraising… It also retains some community ownership which is important. (Participant 1)*

Relationship with Management

Maintaining an effective relationship between the Board and organisational management roles was considered critical, given the importance of this interface with the CEO and other senior managers.

> *The CEO and the board have to be … in step. And if there's a mismatch that's where you've got problems… The board and the CEO having … a really good and respectful relationship…a mutual respect that allows people to share their ideas and be up front about concerns… that's really, really important … The board sets the tone for the organisation, the board and the CEO. (Participant 4)*

Respondents also noted the delineation between the Board's role in governance and Operational management and unique challenges in the healthcare sector.

> *We try to get in some staff that can operationally manage well and understand the system really well and we'll just stick to doing governance (Participant 3)*

> *Governance roles are peculiar to health care, you can't mimic exactly what takes place … for private companies. We've got to take parts of their learnings … and their knowledge … and then work out how public health sector boards are different. (Participant 3)*

Recruitment and composition

Board recruitment has changed over the period reviewed. Historically, Board members might be those with specific ties to the health service, including local medical practitioners who might also be staff. Alternatively, Board roles could be seen as associated with other leadership roles in the community, or a reward for community service.

> *Because they'd achieved certain things for their community, it was kind of like a payback to be appointed on a board sometimes. (Participant 3)*

With the move to a more explicit corporate governance approach, there is now more emphasis on seeking specific or desired skills and achieving diverse community representation. This has presented challenges in recruiting Board members.

It's becoming more and more difficult… We're having a generational shift… I'm not going to necessarily spend my life actively becoming part of a Board director role because I've got other things to do in my life… that is a problem. (Participant 3)

The only difficulty we've had is getting the right gender balance …There's capable, very capable women out there, it's trying to get them interested in putting an application in. (Participant 4)

Expectations and the recruitment process are more complex and may act as a disincentive.

The focus on governance, the level of compliance and expectation of the governance body, bearing in mind they're representatives of the community and are unpaid, … Once upon a time you filled out a simple application, you maybe had an interview, you then went through a selection process and were appointed ultimately by the governor and council … If you have ever looked at the application process now to apply for the board … it's harder to get people. (Participant 2)

Other organisations such as local banks are also competing for the same talent pool, which is a challenge especially in smaller communities.

People that actually want to participate on a Board they're now looking at other Boards… it's competitive … those Board members are working out do I want to be on a hospital Board, do I want to be on a Bendigo Bank Board… Hospital Boards had a big standing in the community and I think they still do but a bank Board represents potentially something that maybe is a bit different.(Participant 3)

The size of boards has been generally reduced, but representation is still important.

Seven to eight's about right… six is a bit too light on … you've got all these subcommittees … Twelve is just too many and what you've got is … seat warmers. (Participant 1)

There's eleven places on the board here and it seems to work well… representing (the) original three geographic points. (Participant 3)

Governance skills take time to develop, hence some respondents felt multiple terms were advantageous.

Having board members that stay on your board for a long period of time, they understand and they see cycles of change the way through, they can then make really good value decisions as opposed to quick spontaneous decisions. (Participant 3)

The mixture of skills is also important. Strategic thinking is valued, and there is recognition that specialist skills can be brought in as advisors, but that professionals with too narrow a skill set may not add value in a board role.

I've got a board with people that are movers and shakers in their own field, there's a diverse mix of skills and experience. The information that's put up by management is interrogated and questioned in a non-confrontational way, the assumptions behind that are looked at … The board also has a long term view, the board's prepared to take calculated risks… to advance the service … So by calculated I mean they go in with their eyes wide open, they can rationally justify we've made this decision because of x, y and z and we acknowledge and accept the risks that come with doing that. (Participant 4)

If we want specialised accounting skills we'll go out and get that. If we've got a…legal issue then we'll go out and seek information from someone who's purist in that area. (Participant 3)

Remuneration and Acknowledgement

Respondents noted that whilst rural health service board members are not remunerated, acknowledgement of their contributions would be appropriate.

> *I don't subscribe to the view that they should be paid necessarily. …Just because they're volunteers and they're not paid doesn't diminish the value that they bring. … I think it would be really good if government somehow conveyed a deep appreciation for what a lot of these people do … They're totally responsible under the Act, they've got board meetings … there's fundraising … they're using their networks and contacts, they're the public face... [it's] a lot of commitment. (Participant 4)*

> *They don't want to be paid. But … you can pay their education … perhaps a company directors course … it might run for a week … in Melbourne so how about we pay for the board members to get up there and do it (Participant 3)*

Operational Management

The role and function of organisational management has necessarily adapted with the change in function and the emphasis on strategic planning and governance, as well as newer leadership practices. The CEO's role in both operational management and advising the Board is critical to good governance.

> *A lot of places get governance wrong… they think that the board becomes accountable to the CEO or the executive group… it doesn't work that way. The CEO must be administering to the committee, to the management, to the board of directors, and if they get that balance right then it'll work. (Participant 3)*

Changing governance practices

There is an increasing emphasis on adopting best practice management strategies to improve internal communication and understand culture.

> *We have a communications forum … every three months and all the senior exec will turn up. …Some people will give us questions on notice and we stand up and I'll talk about the redevelopment plan or whatever or answer a written question. (Participant 4)*

The challenge of recruiting skilled staff in the regional context has led some managers to adopt practices that maximise information sharing and opportunities for skill development across executive teams. Services are also looking to work collaboratively across the region and share resources, especially in areas such as Information Technology (IT) where economies of scale apply.

> *We started what is known as the SWARH, the South West Alliance of Rural Health…We all had our own individual patient systems and finance systems… IT departments…that's a huge cost … The only way we would give any money is for a group of hospitals to work together in … a cluster, so we embraced that. What that involved was adopting common patient systems… a common finance system …That's now a crucial part of our business because all of our IT, all of our communications, all of our infrastructure … is intimately linked … That then locks us into working as a group for some pretty key information and working together. So that at the same time created interaction between health services. (Participant 2)*

Boards and managers are open to engaging external consultants or liaising with other organisations to exchange learnings.

> *We engaged … independent consultants … to do external service plans…in terms of… demographic changes … service demand changes, service mix, the financial imperatives, the quality requirements, changes to clinical practice. (Participant 1)*

> *We can't get all of our information… (and) knowledge from the public sector, go out to the NGOs and … the private sector… find out how they run. (Participant 3)*

One current project which reflects this approach to learning from others is the Barwon South Western Region Business of Aged Care project, conducted over 2014-2015 and currently being evaluated. Drawing on learnings from private sector providers, this project worked in partnership with local Public Sector Residential Aged Care Service (PSRACS) providers, reviewing their service delivery and leadership approaches around PSRACS, and developing a more business-oriented approach to service delivery, including tailored tools to respond to changes arising from local community needs and Commonwealth Aged care reforms.

Strategic planning

The critical function of future planning was emphasised by respondents, including the need to predict challenges, mitigate risks and maximise flexibility.

> *I don't have a crystal ball to know what the world looks like in fifteen years … Our data tells us that there's a real growth area in community aged care services, there'll be a slightly shrinking demand for residential aged care, our hospital occupancy levels are declining …. However in fifteen years' time… there might be a change, So … we've built into the master plan … flexible design principles that allow you to … adapt because that's absolutely key. (Participant 4)*

Staffing

Expectations of staff commitment, both in terms of hours and duties, have changed significantly over the past few decades, especially for nurses and medical practitioners. In Balmoral, 90 years ago when the service was established, a lone bush nurse managed 447 visits, 81 days in residence caring for the ill and 10 all-night maternity cases in a year[15]. These days, services are provided by a range of staff including remote area nurses, visiting doctors and allied health specialists, telehealth facilities and partnerships with other agencies.

> *Staffing's very challenging… The expectation is that you're available there twenty four hours a day. That was fine … in '82 because you had doctors who … had terms like honorary, they would actually do on call for nothing seven days a week…The new generation… actually wants probably a life, there are things like safe hours … (they say) I don't mind working four days a week or thirty eight hours a week but when you want me to cover on call for seven days or three weeks straight, not interested… We have an ED department that may have as few as five attendances a day … (or) may have fifteen or twenty in the space of a couple of hours. You can't afford to say sorry we're not staffing it in the unsociable hours; what happens if there's an incident? (Participant 2)*

Broader health sector workforce challenges were identified nationally in the Health Workforce 2025 Report[16]. This report identifies significant shortfalls in the supply of medical and nursing graduates for rural and regional services, with an ageing workforce and lack of sufficient trainees to fill post-graduate placements contributing to this. New roles are emerging, in both residential and community health settings, in response to these challenges. In acute care settings, Nurse Unit Managers and Directors of Nursing are increasingly part of the strategic leadership team and have greater involvement in planning activities. In hospitals and in community health services, a broader range of providers includes roles such as Nurse Practitioners, Occupational Therapists, Dieticians, Leisure and Activities Coordinators and Nurse Educators. This reflects both challenges in the workforce and a change in the service delivery mix.

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[15] Department of Health Victoria, 2015, Bush Bash, Health Victoria, Vol 7, No 7
[16] Health Workforce Australia (2012): Heath Workforce 2025 Report: Doctors, Nurses and Midwives.

More locally, specific staffing issues for rural and regional settings including an ageing workforce, scarce resources within the region and inflexibility in workplace relations arrangements.

> *Change in the workforce is really hard work…it is challenging, and particularly with an average age of about 48 to 50 then … having to adjust to rapid changing technology is a problem, and getting a newer workforce in who want modern technology is a problem too 'cause you've got to supply it. (Participant 3)*

Particularly in nursing and personal assistance roles, the workforce is largely part-time in rural areas, and sector-wide pressures such as increased risk of injury and adopting newer technology and equipment is an issue.

For specialist staff, whether clinical or administrative, sourcing those with the relevant skills and experience can be difficult and present a challenge financially

> *We are struggling in terms of maintaining specialist staff within the budget, so one of our key initiatives is working with the local group to establish sub-regional corporate services… We have a virtual pool of services, one corporate services group supporting five agencies… [It's] really about economies of scale and complexity. Just haven't got the skills, haven't got the ability budget wise to get sufficient volume and we need to make that delivery efficient. (Participant 2)*

As noted previously, there was an awareness that retention of services which were reliant on a specialist workforce was not possible when the quality/volume trade-off was considered, emphasising the need to maintain a sufficient volume of cases to retain practitioner competency.

Stakeholder engagement

All respondents emphasised the importance of engaging with a wide range of stakeholders, particularly the local community.

Community and consumers

The local community are the main clients of health services and have a strong sense of ownership and investment in services provided in their communities. Historically, local health services were part of a community's identity and communities are active fundraisers to keep services vibrant and functioning. With the closure of other local businesses, the retention of health services has also been seen as a symbol of survival.

Community identity

Respondents noted the historical sense of attachment to a local health service as part of a community's identity, which was difficult when mergers or closures were proposed.

> *They'd seen their bank close, they'd seen local businesses close down, all that was left was the hospital and the local school. (Participant 4)*

Community engagement

Boards are seen as vital mechanisms to maintain connection with the local community.

> *In small towns because you're so connected to the community and people are asking you what's going on… these guys worked that out well…they're just gonna talk about how we're sustaining a vibrant health service. (Participant 3)*

Several participants noted the importance of ongoing two-way community dialogue.

> *We go out and try to engage the other community and talk to them about their needs… how we're meeting them, all that kind of stuff, and from that at the same time we also say would anybody like to think about being a board member. (Participant 3)*

Other important stakeholders include medical practitioners, who may not necessarily be employed by the health service but have significant local community impact and influence.

> *Medical staff generally are a very powerful group …. …the community … says we can't lose our docs, we need to have them supported, clearly there is a problem, how do you then tackle it. So it's that relationship, it's the working together. (Participant 2)*

Influencing for change

The importance of engaging with the community using multiple communication modes throughout planning processes was emphasised. In some cases, it was considered that management or boards may have understood the need for change well, but it was vitally important to communicate those drivers and rationale to all parties, particularly local community members and service consumers who were immediately impacted.

> *(You need to) identify, engage and inform key stakeholders (about the) changes and reasons for decisions e.g. residents & families, staff, community, business….Transparency and open ongoing discussions with community & key stakeholders (are vital). (Consider) public announcements and public meetings to discuss and explain the reasons for closure of service and alternative arrangements. This provides a forum for concerned community members to voice concerns (Participant 5)*

Respondents reported that dialogue has helped with communicating the rationale for changes within the community.

> *There's key stakeholder groups within each community and it's about identifying them and talking with them. And it's about making sure that people understand… why do you need change, why is this going to be better. (Participant 1)*

> *A series of very well attended and spirited public meetings were held, first protesting about the sackings and as the process evolved, keeping the community in touch … Press statements began providing factual information about the changes … these became more positive. (Participant 6)*

By maintaining the sense of identity through change, acceptance could be facilitated.

> *We still had the identity of ….Health Service or the one at …and kept their names attached … we didn't … force that part (Participant 3)*

This also involved looking at arrangements for protecting local donations and funding.

> *Making sure that there was … some ring fencing around their funding … and… around donations… that was important from the community's perspective. We still want to support our health service. (Participant 1)*

A visible commitment to the local service has helped to alleviate community anxiety.

> *The community here saw a change in development, they saw a lot of growth, they saw a lot of buildings take place… that tells them we're actually here long term. (Participant 3)*

Where change was perceived as harsh or sudden, rebuilding trust has been a priority.

The community initially twenty years ago had an issue with trust … governments were coming in if you like or bureaucracy were coming in and saying we don't want to have that anymore, it doesn't work… … every now and then you have to have a major change point … I'd actually say that worked and then it was just about how we managed it (Participant 3)

Discussion

Participants reflected on multiple experiences of change over the past few decades. Most health services in Victoria were historically set up as independent entities by local communities, but with demographic changes and shrinking populations, particularly in smaller communities, they have needed to adapt in order to survive. In the 1980's, state government departments, as funding agencies, required state-wide implementation of systems such as Case Mix funding and service reconfiguration, such as the emergence of community-based mental health services. Amongst respondents, there was a perception of a "one-size-fits-all" approach, which did not recognise some of the local challenges. However, services were generally able to adapt to these changes over time.

The challenges of the quality volume trade-off were also becoming increasingly important, with the growing evidence of a minimum level of service provision required for providers to maintain competencies and appropriately manage complex risks. As community expectations increased around service quality, changes in the way services were delivered were necessary to respond to this.

Another impetus for change came from identified short-comings in existing service models. Where the evidence for change was strong, as in deinstitutionalisation and the closure of large disability and psychiatric residential settings, this supported a move to care appropriately for those with a mental illness or a disability in the community. The awareness of the dignity and human right of consumers to be cared for within their communities was also increased, although some residents, families, staff and communities found this traumatic. In other cases where significant clinical or governance failures were identified, government powers under the Health Services Act 1988 were used to disband existing management structures and appoint an administrator. Whilst this might have been difficult and felt abrupt at the time, respondents felt that in such situations, a circuit breaker approach was the most effective way to bring about change.

Respondents felt that more recent changes have been better handled, with greater sensitivity to the needs or fears of the community, and more emphasis on consultation. Time has been allowed for genuine engagement, with a range of communication tools used, including public forums, mail-outs and newspaper articles. Demonstrating a commitment to provide some local services has helped, as has using existing physical locations which provide a sense of continuity, even where buildings were renovated or completely replaced.

Respondents recognised the importance of leveraging existing relationships with clients or patients, staff and other local community members. With other health services, such relationships might be a pre-cursor to amalgamations, or just a way to share resources and expertise. Overall, there seems to have been a move from more competitive relationships to a greater sense of regional collaboration, whether formalised or not.

The role of Boards of Management has also changed over the past few decades. With better articulation of their strategic and corporate governance role, there is an emphasis on the range of skills required on a Board, rather than it being an assumed entitlement. This has given rise to challenges around recruitment. In relatively small communities, finding those with the requisite skills and willingness to take on Board roles can be difficult, especially when facing competition. Looking broadly at the range of available candidates, including options for virtual attendance to broaden the

skill base through appointing some out-of-catchment candidates, and finding innovative ways to provide support, training and acknowledgement may help to address these challenges.

Several respondents identified the importance of effective working relationships between the Board, the CEO and operational management. An emphasis on role clarity is seen as key to success, where Board members are there to provide oversight and governance, and CEO's and their teams are responsible for operational management. By ensuring that new Board members and staff are clear about their roles, this will help to promote better working relationships and minimise assumptions, misunderstandings or potential conflict.

Over the past few decades, strategic planning functions have increasingly become a significant part of the CEO role, under guidance from Boards. Using the best available information, health services are seeking to provide for current needs whilst retaining flexibility for potential future changes, sometimes looking towards a 20-25 year timeframe. This need to balance immediate needs with future adaptions requires access to the best possible data and projections of population trends, demographics and health service usage, available at a departmental level as well as more local sources. Additionally, having the courage to set longer-term plans, but adapt as required to emergent trends, is a complex issue for boards and management, requiring strong influencing and leadership skills.

Internal and operational challenges are a concern to both Boards and management, particularly in relation to workforce issues, with an ageing workforce, scarce resources particularly at the specialist level and funding challenges. There is also a sense that the increasing burden of compliance with departmental obligations is onerous. Focusing on forward planning and managing expectations is helping, but these remain significant challenges for health service management teams.

Overall, respondents reflected some key challenges in the immediate to medium-term, particularly around adapting to federal policy and funding changes and demographic movement, but a sense of an increased capacity and capability to meet those challenges through better skills of board members, partnerships and shared resources.

Over this period, whilst there have been multiple waves of change, there has not been a single dominant approach to implementing change. More recently, consistent with models such as that of Kotter[17], the importance of deliberate planning, communicating and working with affected individuals (whether staff, clients or the community) seems to have had greater emphasis. Whilst there is no one dominant language or model reflected in the responses to the present project, the processes of change appear to be as important as the outcomes, with an emphasis on maintaining engagement with a range of stakeholders through change processes and helping to build sustainability.

Recommendations

Considering their different levels of responsibility with respect to change, the Department of Health and Human Services (DHHS), local Boards and Executive Management in these services have opportunities to continue to improve their implementation of changes, whilst sharing accountability for the outcomes of health services.

DHHS

The department provides services including planning, performance monitoring, policy development, funding and regulation for local health service providers. Opportunities for the department include:

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[17] Kotter, John (2012). Leading Change, 2nd edition, Harvard Business Review Press, Boston

- Supporting local services to implement effective strategic planning based on the best information available but including flexibility to meet future needs so far as possible.
- Providing coherent, clear policies that provide frameworks for local health services, whilst allowing some customisation to meet local needs or reflect local issues.
- Continuing to create and support local and regional networks, which enable individual services to share their learnings, resources and work collaboratively.
- Providing a consistent model of monitoring and regulation, which engages with providers to help build their own accountability
- Continuing to support talent identification and development for potential leaders and board members, including access to training and development. Current examples of this include the "Building Board Capability [18] and LINK in Health [19] programs.
- Supporting initiatives to increase Board diversity, e.g. the Victorian Women's Register, and finding ways to increase the potential candidate pool, including technology-based solutions. This is also strengthened by the current government's commitment to increased diversity, as indicated in the Victorian public sector guidelines for Board appointments[20], which notes Government policy to better reflect the Victorian community with representation including gender, age, cultural, indigenous, regional and disability diversity.

Boards

For boards, the emphasis is on providing a governance model for health services to develop strategies, oversee performance, respond to challenges and meet regulatory and policy requirements. As such, opportunities for boards include:

- Conscious and innovative approaches to succession planning, recruitment, induction and training for board members to build the necessary skills for effective Directorship
- Continuing work on role clarity that maintains the role of governance and oversight without stepping into operational matters.
- Finding multiple means to engage effectively with local communities and bringing a sense of representation to their Board roles.
- Striking a balance between finding opportunities to innovate and managing risk
- Continuing to develop effective working relationships with CEO's and executive management, which allow for healthy discourse and robust challenge, whilst providing support and guidance.

Executive

The role of executive management includes requirements for competence with the strategic cycle and planning, strong leadership and management skills and the ability to collaborate effectively with other services where relevant, especially for smaller rural services that rely on larger providers for more complex health needs. The opportunities for Executive management include:

- Continuing to balance the requirements of leadership and operational management, by providing clear strategic direction and guidance for the organisation, whilst also being available and present to support staff in delivering the strategy.

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[18] Department of Health (2013). Building Board Capacity
[19] Department of Health (2015). LINK in Health
[20] Victorian Government (2015), Appointment and remuneration Guidelines for Victorian Government Boards, Statutory Bodies and Advisory Committees.

- Retaining the emphasis on broad and genuine engagement with all relevant stakeholders, including DHHS, staff, clients, community members and other related or local services.
- Maintaining a focus on succession planning and talent identification, to support the next generation of leadership with opportunities for skill development and broadening.
- Retaining an emphasis on working effectively with the Board, with a focus on role clarity and strong communication. Providing this opportunity to the full executive team, rather than just the CEO, will increase information sharing and provide opportunities for skill development and exposure.
- Finding opportunities to work collaboratively with other health services, including tertiary services, other regional centres, aged care and local medical and allied health clinics, to build effective networks and increase service options for clients.

Conclusion

In the Barwon South West health region of the DHHS, over the past few decades, several waves of change have impacted health services. Whilst the nature of change and its triggers may vary, local services appear to be developing an increasingly robust and mature approach to change, including a sensitivity for the process as well as the outcomes of change. Whilst challenges remain, the skills and processes currently evident and a continued focus on maintaining a coordinated approach will hold local health services in the strongest position to face future changes that will occur due to factors such as population ageing, the changing profile of chronic disease, new health technologies and unpredictable events.

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