Independent Review Panel
Workplace Culture Review
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Independent Review into the workplace culture within ACT public health services

The Health Care Consumers' Association (HCCA) was incorporated in 1978. It and is both a health promotion charity and the peak consumer advocacy organisation in the Canberra region. HCCA provides a voice for consumers on health issues and provides opportunities for health care consumers to participate in all levels of health service planning, policy development and decision making.

HCCA involves consumers through:

- consumer representation, and consumer and community consultations,
- training in health rights and navigating the health system,
- community forums and information sessions about health services, and
- research into consumer experience of human services.

HCCA is a member-based organisation. For this submission we received some targeted input from consumers, as well as drawing upon research on these issues undertaken by HCCA and others. We are aware of recent changes to the structure and note that for this submission, 'ACT Health' refers to both policy and clinical arms.

Thank you for the opportunity to advocate for consumers and express consumer views on workplace culture within ACT public health services.

Yours sincerely

Dr Alan Thomas
President, HCCA

HCCA Submission to the

Independent Review into the workplace culture within ACT public health services

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Executive Summary

HCCA recognises that staff can only provide safe and high quality, consumer-centred care when they feel valued and supported in the workplace.

In 2018 HCCA undertook research with consumers that resulted in the publishing of a report "Spend Time to Save Time: What quality and safety means to health care consumers and carers in the ACT".[1] This report identified

- the characteristics of high quality and safe care experienced by consumers and carers in the ACT,
- characteristics of care that make consumers and carers feel unsafe,
- the nature of improvements that consumers believe would ensure that all care is safe, effective and of a high quality in the ACT, and
- the effectiveness of existing consumer feedback processes.

HCCA has taken a practical approach to this submission. First we outline the consequences of poor workplace culture and their impact on consumers. Secondly, we present examples of poor workplace culture including

- Limited time for care of consumers and carers
- Prolonged staffing uncertainties
- Agency staff and unplanned leave
- Communication delays
- Unbalanced focus on targets and accreditation
- Appropriate reporting processes for staff to address bullying.

We provide recommendations to address each of these problem areas. Finally, we assert that the implementation of consumer-centred care leads to

- better health outcomes,
- improved consumer, carer and family experience of care,
- better clinician and staff satisfaction, and
- wiser allocation of resources.

Ultimately, consumers want good care that is centred around their needs. A consumer-centred approach by health care providers has been shown to improve the quality and safety of care[2]. This is more likely to occur in a psychologically safe workplace, where consumers and health services staff are able to trust each other and communicate freely in relation to care and systems.

HCCA Recommendations

1. ACT Health must ***provide sufficient staffing to ensure both staff and consumer safety.*** This will improve care, the capacity for shared decision making, and improve the quality and safety of our health care system.
2. ACT Health work to ensure culture change that leads to health services ***focussing on consumer-centred care.***
3. ACT Health must ***urgently consider how to improve job certainty.*** Possible actions include minimising long-term 'acting' positions so that making permanent appointments are a high priority. This approach will remedy the impact of staffing uncertainties, their impact on individual staff and patients, and will improve the organisational culture, particularly morale.
4. ACT Health must ***undertake analysis on the use of agency staffing across its services.*** ACT Health could identify whether particular areas of public health services have higher use of agency staff and how this might be reduced (e.g. need to employ more permanent staff to meet needs and provide staff with certainty, for instance.) A reduction in unplanned leave could be considered as a measure of impact of any culture change initiatives introduced.
5. ACT Health must ***make available clear and transparent data on outcomes around communication*** across a range of areas, including delivery of discharge summaries and outpatient letters from specialists to GPs.
6. ACT Health ensure that ***communication around concerns or complaints are focussed on a better, more restorative process*** involving all affected people, both consumers and clinicians.
7. ACT Health ensure that systems are in place to ***look at data trends broadly across the organisation and patient care***. These should not be limited only to areas where the organisation will be required to be assessed – such as meeting accreditation or targets such as NEAT or NEST – but used to identify risks to safety and quality in the systems and processes in our healthcare system.
8. ACT Health ***use RiskMan as intended*** - ***a tool for supporting continuous quality improvement***, not as a threat to staff or as part of a culture of blame. As part of using effective incident reporting, ***patients and families should also be able to report incidents in real time***. Consumer and family complaints, concerns and compliments provide a rich source of information about where improvements may be needed and what patients appreciate. These provide an active opportunity for learning and action.
9. ACT Health should have ***clear reporting*** processes in place that ***allow, enable and support staff to speak up against bullying without experiencing negative repercussions.***
10. ACT Health should ***engage collaboratively with staff and the community in developing its cultural aspirations for the future.***
11. ACT Health should resource a ***centre for staff professionalism which takes a holistic, person-centred approach to addressing the support needs of staff*** in navigating professional challenges and maintain overall wellness.

Impacts of workplace culture on safety and quality in healthcare

The issue of poor workplace culture in health care has received increased public attention in recent years, following the 2016 Senate Inquiry into medical complaints process in Australia[3]. The Senate Inquiry found that bullying, discrimination and harassment levels remain disconcertingly high, despite the apparent 'zero tolerance' approach reported by medical administrators and colleges. Workplace culture in health care has also been the focus of many newspaper and journal articles. Westbrook[4] describes unprofessional behaviour as 'sufficiently widespread in the Australian health care system that it could be considered endemic'. Impacts include

- poor staff psychological wellbeing, including stress, reduced teamwork and communication, and loss of concentration,
- negative impacts on staff satisfaction, staff absenteeism and retention, leading to costly staff turnover, and
- patients with increased medico-legal risks, increased cost and higher rates of dissatisfaction.

Another widely documented inquiry into bullying and harassment was that of the Royal Australasian College of Surgeons[5]. The revelations from this and other college studies has seen the issues become part of the revised Australian Medical Council's Standards for Medical Colleges[6], as well as in the pre-vocational medical education standards[7].

The Australian Health Reform Association has called for reform to address this bullying culture to 'ensure a safe environment for healthcare professionals so all can contribute efficiently to a high standard of patient care'[8].

Westbrook[9] states that

> *health professionals consistently recognise the link between unprofessional behaviour and threats to patient safety and wellbeing… [with] emerging evidence that even low level unprofessionalism is a significant risk to patient safety.*

And while there is a limited and undeveloped evidence base for achieving fundamental change in the culture of the healthcare system, the risks to patient care mean action must be taken.

Examples of poor workplace culture

Limited time for care of consumers and carers

In 2017 HCCA conducted an ACT-wide survey on consumer experiences of quality and safety in health care. Feedback from this survey ultimately informed ACT Health's Quality Strategy 2018-2028[10]. The survey responses highlighted areas in the ACT health care system where workplace culture was noted to have an effect on consumer safety. The final report identified

- the characteristics of high quality and safe care experienced by consumers and carers in the ACT,
- characteristics of care that make consumers and carers feel unsafe,
- the nature of improvements that consumers believe would ensure that all care is safe, effective and of a high quality in the ACT,
- the effectiveness of existing consumer feedback processes.

Overwhelmingly, consumers observed that health professionals seemed rushed, or were often too busy to talk or listen to a consumers' concerns. Some consumers had witnessed bullying and harassment of staff, including disrespectful behaviour between colleagues in the presence of patients. Tension between doctors and nurses in particular, was mentioned as an area requiring better cooperation and respect.

The survey revealed that the most common observation of consumers was the extreme busyness of health staff. For example:

> *[It] can feel like staff are really busy (which they are) so if [my question] is not really important I don't ask and just use Google or ask nursing friends.*

> *Everyone seems frantically busy in the hospital. It's ridiculous.*

Consumers felt there was not enough time allowed in appointments for thinking about what they had just been told and discussing concerns with the health professional. They mentioned that health professionals appeared not to have enough time to listen to a consumer's questions. Mostly, they felt rushed during appointments.

> *I felt like I was interrupting or holding them up from seeing other patients.*

Consumers believe that if the staff appeared less busy they would feel able to ask questions during their appointment or during their time in hospital.

> *It didn't always happen, but sometimes we felt rushed and like we were wasting people's time. Sometimes I felt like practitioners wouldn't hear me complete my questions and kept assuming what I was asking, which got very frustrating.*

Consumers noticed that ACT Health in general seemed to be under pressure and understood that this pressure was often a symptom of understaffing.

> *Nurses are frantically trying to get all their tasks done and I know it's supposed to be 'patient centred care' but the reality is they are spread dangerously thin. I saw them making errors because they had to do double shifts or the area would be left minus a nurse.*

> *[We need to ensure that] registrars… have not been working 40 hours straight without sleep. That 'culture' absolutely MUST be changed as it impairs effective clinical decision making.*

Even in cases where consumers had a positive experience with the health care system they noticed that staff were rushed or working under difficult circumstances.

> *Most of the staff that I have encountered are friendly and efficient yet they always seem rushed.*
>
> *Hospital staff are very good at their job even though they are over worked and under paid.*

Most medical staff are doing their best under difficult circumstances, such as staff and funding shortages. Overall, time appears to be a scarce resource in ACT Health. Reducing unnecessary duplication, testing or paperwork may free up time. This would then enable staff to better meet the care needs of patients and families.

In 2017-18 HCCA conducted research on care coordination for people with chronic and complex conditions. This research emphasised issues in the workplace culture of hospitals in the ACT that impacted negatively on coordinating care, finding that:

- The pressures of clinical work and managing acute medical problems meant that health professionals did not have enough time to provide a comprehensive, holistic assessment of patients, including everyone involved in their care, before they are discharged.
- The roles and responsibilities of health professionals are not always clearly defined and this contributes to confusion and tension between staff with overlapping or similar roles.
- Some clinical processes are not standardised leading to stress and anxiety for new staff.
- Inadequate or incompatible patient records systems contribute to health professionals' frustration and fraught interdisciplinary relations.

The Australian Commission for Safety and Quality in Health Care supports and promotes shared decision making[11]. The evidence shows this takes time but improves outcomes. Shared decision making involves three things.

1. The integration of a patient's values, goals and concerns with the best available evidence about benefits, risks and uncertainties of treatment, in order to achieve appropriate health care decisions
2. Clinicians and patients making decisions about the patient's management together
3. In partnership with their clinician, patients are encouraged to consider
    - available screening, treatment, or management options and the likely benefits and harms of each,
    - to communicate their preferences, and
    - to help select the course of action that best fits these.

Shared decision making takes time and requires respect between staff and patients. It is an important part of consumer-centred care and forms part of the strategic priorities of the ACT Health Quality Strategy 2018-2028[12].

We note that the Royal Australian College of Surgeons (RACS) has done some excellent work in the areas of respect. We commend their work for improving culture in the medical workforce through their "Operating with Respect" program. https://www.surgeons.org/about-respect/ However, while this is a great program, it doesn't address local issues.

Recommendation 1: ACT Health must provide sufficient staffing to ensure both staff and consumer safety. This will improve care, the capacity for shared decision making, and improve the quality and safety of our health care system.

Recommendation 2: ACT Health work to ensure culture change that leads to health services focussing on consumer-centred care.

Prolonged staffing uncertainties

We believe that continued restructuring across ACT Health in recent years also contributes to staff uncertainty. This has affected

- the provision of consumer-centred care/patient outcomes,
- ACT public health care service staff, and
- HCCA as an organisation.

HCCA holds concerns about staff uncertainty and the resulting impacts on patient care. Staffing uncertainties can impact upon individual staff and their teams, as well as on the outcomes for patients in the delivery of care. The critical problems in radiology at The Canberra Hospital are a prime example. *The Canberra Times* reported[13] that the radiology department has been understaffed for some time, spending months without a clinical director and sending scans off-site for reporting. It has transpired that the offsite provider does not always refer to patients' previous scans, unless they prepared the previous report for that patient. The quality of these external scanning processes needs to be included in local quality assurance processes[14]. These processes also need to look at the time taken to get a report and the quality of the findings, given the importance of prompt, high quality radiography for patient care and safety. An audit of the department's teaching credentials by the Royal Australian and New Zealand College of Radiologists raised concerns that registrars were not receiving adequate training and were at times forced to treat patients without the supervision of a trained radiologist. There is no doubt that these kinds of issues are impacting on both staff practice and patient care.

Staff who are uncertain about their role and position within an organisation will find it difficult to give their complete focus to patient care and can impact on how valued they feel within that organisation. This situation can result in a 'trickle-through' effect to other staff and more generally result in negative impacts on the organisational culture. Additionally, once the poor culture of an organisation becomes know, it may have difficulty attracting and retaining staff. This results in more frequent efforts spent on recruitment or more dollars spent on agency staff to cover the shortfall.

HCCA has worked, and continues to work closely, with many areas across ACT public health care services. As such we have been aware of many changes to staffing and organisational structures over recent years. In the mix of this uncertainty, we have also been aware of many staff 'acting' in various roles and positions without these positions being filled for some time. Keeping up to date with constant changes to organisational structure and ongoing staffing changes has been challenging for HCCA and our work with ACT public health care services. At times it has made it difficult to know who to contact with regard to particular issues or contracts. It is also difficult to establish and maintain good stakeholder relationships when staff continually change roles and positions. Good stakeholder relationships are important to HCCA's role providing a voice for consumers and providing input to service planning, policy development and decision making.

An example of where uncertainty has negatively affected HCCA is our contract for Advanced Care Planning. Ongoing delays of many months in ACT Health signing the contract meant that the person we had ready to do the work found employment elsewhere. This has resulted in a delay of the delivery of this project to the ACT community.

Recommendation 3: ACT Health must urgently consider how to improve job certainty. Possible actions include minimising long-term 'acting' positions so that making permanent appointments are a high priority. This approach will remedy the impact of staffing uncertainties, their impact on individual staff and patients, and will improve the organisational culture, particularly morale.

Agency staff and unplanned leave

HCCA is aware of the significant numbers of agency staff being used across ACT public health services as a result of increased, unplanned leave. While we recognise that there is always some need for agency staff, HCCA suggests that cultural issues have led to increased unplanned leave. This can have a negative impact on patient safety. It should always be the aim to minimise the need for agency staff. Staff who are unfamiliar with the work environment and processes, and do not have a sense of investment in and ownership of the workplace, may be less able to ensure the quality and safety of patient care. Absenteeism is also a common sign of an unhappy workplace, where staff do not feel value or engaged[15].

Building a stronger internal capacity for ACT public health services also better respects the contribution of the ongoing knowledge and experience of staff, and helps to ensure that staff are integrally committed to the values and work of the organisation.

Twigg[16] and others have undertaken significant research in this area. The evidence confirms that both

- the number of registered nurses caring for patient is critically important to prevent adverse patient outcomes, and
- improvements in nurse staffing is a cost-effective investment for the health system.

Related research also suggests individual assessment of each ward to determine staffing requirements is preferable to a "one-size-fits-all" approach. 'Nursing hours per patient day (NHPPD)' is demonstrated to improve patient safety[17]. This method classifies each hospital ward using characteristics such as patient complexity, intervention levels, the presence of high dependency beds, the emergency/elective patient mix and patient turnover. NHPPD can then be allocated for each ward, based on its classification.

***Recommendation 4*: ** ACT Health must undertake analysis on the use of agency staffing across its services. ACT Health could identify whether particular areas of public health services have higher use of agency staff and how this might be reduced (e.g. need to employ more permanent staff to meet needs and provide staff with certainty, for instance.) A reduction in unplanned leave could be considered as a measure of impact of any culture change initiatives introduced.

Communication delays

HCCA is aware of a number of delays in communication processes that result in poorer health care for consumers. We believe this reflects a poor culture in timely communication in ACT public health services. Examples include:

- ***Delays in discharge summaries going out to GPs and community health services***. We have recently been made aware that data and benchmarking in this area is focussed on internal processes only. The desired outcomes is the timely receipt of information in the community to ensure continuity of care. This is a significant "duty of care" issue for doctors and the hospital, and prompt completion at the time of discharge must be given a high priority. We need data on how long it takes information to reach the appropriate person within the community.

- ***Delays in letters from medical specialists being sent out to GPs and community health services***. Lots of good work has been done to improve efficiency and support timely processes in this space. Yet performance remains poor because the practice of doctors in timely communication has not changed. We have heard of some doctors dictating the communication to a service on the phone when the patient is present. This provides an opportunity for the patient to correct any information that is not correct and to know what is being included.

Clear and transparent data on processes and outcomes around communication needs to be made available across a range of areas, including delivery of discharge summaries and letters from specialists to GPs. At the very least this data needs to be available to staff and relevant standards committees to inform quality improvement activities. This could also form part of public reporting and accountability. The impact of timely communication on the continuity of care, as well as the safety and quality of healthcare for consumers, must make the case for supporting the clear need for improvement.

Recommendation 5: ACT Health must make available clear and transparent data on outcomes around communication across a range of areas, including delivery of discharge summaries and outpatient letters from specialists to GPs.

Recommendation 6: ACT Health ensure that communication around concerns or complaints are focussed on a better, more restorative process involving all affected people, both consumers and clinicians.

Unbalanced focus on targets and accreditation

HCCA holds concerns that important issues for patient care are overlooked because of ACT public health services focus on certain targets (or accreditation measure, as occurred earlier in 2018).

Both the National Emergency Access Target (NEAT) and National Elective Surgery Targets (NEST) are targets that have been put in place to help ensure that patients are treated within their recommended clinical priority time frame. However, research has demonstrated potential limitations on patient outcomes. Constant pursuit of stringent time-based targets may actually compromise quality of care and endanger patient safety[18]. Despite the potentially major impact of the NEAT upon patient care, research has shown that there was no prospective standardised framework for monitoring outcomes for patients admitted to hospital from emergency departments. This means that while the meeting of targets may be pursued by hospitals as a means to improve performance, the end result may not necessarily be improved patient care and outcomes.

Whilst HCCA supports the need for standards and targets, such as those provided through the NSQHS standards[19], or targets such as NEAT and NEST, it is important that broader data analysis is undertaken within ACT public health services to ensure that other key areas for improvement are identified and resources are made available to improve care.

We are also aware that RiskMan offers another rich source of data for quality improvement, but that there are issues around the culture of using this tool in ACT public health services. We know there are situations where RiskMan is being used in a negative way against staff, as in 'I RiskMan'd them' to shame or single-out staff. This creates a culture of blame and fear which is not consistent with either open disclosure or processes of continuous quality improvement. Culture such as this does not encourage reporting or learning from mistakes. Instead, ACT public health services needs to be using tools such as Riskman to enable staff to do their best and to ensure that systems are set up in ways that help support patient safety. Much more timely action is also required on complaints or concerns raised in relation to treatment and outcomes, as well as a double-loop learning approach. When HCCA was attending one of the Quality Forums last year, staff noted that there wasn't even really a single-loop learning system, as most data on performance did not automatically connect back to the work area. The continuing failure to accept patient notifications of incidents also limits the reality of a partnership approach to high quality health care.

Recommendation 7: ACT Health ensure that systems are in place to look at data trends broadly across the organisation and patient care. These should not be limited only to areas where the organisation will be required to be assessed – such as meeting accreditation or targets such as NEAT or NEST – but used to identify risks to safety and quality in the systems and processes in our healthcare system.

Recommendation 8: ACT Health use RiskMan as intended - a tool for supporting continuous quality improvement, not as a threat to staff or as part of a culture of blame. As part of using effective incident reporting, patients and families should also be able to report incidents in real time. Consumer and family complaints, concerns and compliments provide a rich source of information about where improvements may be needed and what patients appreciate. These provide an active opportunity for learning and action.

Appropriate reporting processes for staff to address bullying

A recent article in the *Medical Journal of Australia* reported that patients all over Australia are being put at risk due to the impacts of staff bullying[20]. Westbrook suggests that bullying and other unprofessional behaviour is now considered to be endemic in the Australian healthcare workforce. It is clear that behaviour, teamwork and culture need to be addressed. Poor culture threatens workplace sustainability through creating a psychologically unsafe workplace for all staff. This, in turn, is a danger to safe, quality healthcare for consumers.

Poor workplace culture that encourages shame can actually compound fear and create an environment prone to further error. This elevated stress in staff can slow progress in reducing patient harm, but also compromise long-term psychological well-being and resilience of health care staff. Tito Wheatland[21] states that

> 'this serves neither patients nor doctors well…it results in high on-going personal and economic costs to users and providers of services in the health system, as well as the broader community'.

Mannion and Smith[22] propose that the elements of a healthy culture should be adopted by managers and leaders. These include (but are not limited to)

- fostering a learning environment,
- offering sustained and visible senior management support to clinical team and services, and
- ensuring that staff across the organisation feel 'psychologically safe' and able to speak up when things are felt to be going wrong.

As part of this, we believe that staff in ACT public health services need assurance around reporting processes. Specifically they need to know that they will not experience negative repercussions if they speak up. Westbrook[23] suggests that professional accountability programs are a relatively new approach to managing unprofessional behaviour by removing the barrier of having to report this type of behaviour to superiors, who hold the power. Staff can use an online system to report negative or positive behaviour anonymously. This helps organisations to put together a more accurate picture of patterns of problem behaviour. Improving the organisational culture becomes 'everybody's business'.

We note that the recently opened University of Canberra Hospital have produced an excellent 'Culture Charter'[24]. The charter was based on the ideas and feedback from over 250 UCH staff and leaders. This is a great example of good culture in health care. The initial feedback from staff patients and families about their experiences of UCH suggest that the joint creation of the charter has resulted in a commitment to its contents and their translation into a positive workplace culture should be formally recognised, resourced and supported to mentor others.

Similarly, interns and registrars at Canberra Hospital have developed two charts on *Creating a Positive Workplace Culture*, for interns and registrars[25]. Part of creating a trust-based health system, where staff are engaged and feel valued is to have them help design these kinds of cultural commitments. Consumers should also be involved in these conversations. A collaboration to do this, as was done at the University of Canberra could be an important first step. At the University of Canberra, there was strong involvement through yarning circles of Aboriginal and Torres Strait Islander consumers, which was also a useful model for collaboration in a culturally sensitive manner.

Health services such as the Brigham and Women's Hospital in Massachusetts US have embedded a person-centred approach to workplace culture in their *Center for Professionalism and Peer Support*[26]. This centre provides support for staff in tackling communication challenges and resolving interpersonal difficulties which does not rely on top-down measures. It provides a 'lateral scaffolding' which includes professionalism training, peer support, disclosure and apology processes, and staff wellness initiatives. These give staff the skills, confidence and processes to address interpersonal issues and resole them quickly, thereby helping avoid escalation and the need for a more heavy handed approach. It embeds a supportive culture where everyone owns the responsibility for a positive workplace culture.

A health service cannot expect its staff to demonstrate kindness, compassion and person centre care to patients and families if its own processes do not model those qualities to staff. It is all one systems. A mature service, in addition to not accepting poor behaviour and requiring staff to take responsibility for their actions, will include transparent processes, appropriate training and supports for resolving issues, and support for the overall mental and physical wellbeing of staff members.

Recommendation 9: ACT Health should have clear reporting processes in place that allow, enable and support staff to speak up against bullying without experiencing negative repercussions.

Recommendation 10: ACT Health should engage collaboratively with staff and the community in developing its cultural aspirations for the future.

Recommendation 11: ACT Health should resource a centre for staff professionalism which takes a holistic, person-centred approach to addressing the support needs of staff in navigating professional challenges and maintain overall wellness.

Improving workplace culture and patient care

Health services that are consumer-centred are more likely to provide high quality and safe care. In recognition of the high value consumers place on consumer-centred care, HCCA developed a position statement[27]. In essence, consumer-centred care meets the physical, emotional and psychological needs of consumers, and is responsive to someone's unique circumstances and goals. Some examples of what consumer-centred care might look like in practice include:

- providing consumers with good quality, unbiased information about options for their health,
- providing information to a consumer's family and carers about these options so they can support the consumer and know what is happening,
- allowing consumers, carers and families to have time to discuss the options and ask questions, and
- empowering consumers to choose the best option for them.

Good workplace culture helps underpins and supports the delivery of consumer-centred care. The implementation of consumer-centred care leads to

- better health outcomes,
- improved consumer and family experience of care,
- better clinician and staff satisfaction, and
- wiser allocation of resources.

Earlier this year HCCA published a report "Spend Time to Save Time: What quality and safety means to health care consumers and carers in the ACT"[28]. We believe that the recommendations made in this report (attached at Appendix A) relate well to the Independent Review into Workplace Culture within ACT public health services. This research highlighted the following key elements of care that consumers look for in a good experience in the health care system:

- Staff who listen and communicate well, who take the time
- Friendliness, respect and genuine care
- Coordination and support for self-management, including timely discharge summaries and well-thought out continuity of care

Developing a good workplace culture in ACT public health services will support and value staff to deliver safety and high quality consumer-centred care and achieve better health outcomes.

Concluding remarks

We recognise that staff can only provide safe and high quality consumer centred care when they feel valued and supported in a workplace.

We are therefore pleased that HCCA has the opportunity to put a submission to the Independent Review into the Workplace Culture within ACT public health services.

The Independent Review is an opportunity for the Review Panel to make recommendations that are clear and actionable, leading to real change and cultural improvement across ACT public health services.

Ms Darlene Cox, Executive Director HCCA, is the contact person for HCCA's submission. Please do not hesitate to contact her if you wish to discuss our submission further. HCCA would be happy to clarify any aspect of our response.

Endnotes

[1] https://www.hcca.org.au/wp-content/uploads/2018/10/HCCA-report_WEB-003.pdf

[2] https://www.hcca.org.au/wp-content/uploads/2018/09/Consumer-Centred-Care-Position-Statement-FINAL-.pdf

[3] Senate Standing Committee on Community Affairs. Medical complaints process in Australia. Canberra: Parliament of Australia; 2016. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MedicalComplaints45/Report [accessed 20/11/2018]

[4] Westbrook, J. et.al. Endemic unprofessional behaviour in health care: the mandate for a change in approach. Med J Aust 2018; 209 (9): 380-381. https://www.mja.com.au/journal/2018/209/9/endemic-unprofessional-behaviour-health-care-mandate-change-approach

[5] RACS EAG Report. Expert Advisory Group on Discrimination, Bullying and Sexual Harassment advising the Royal Australasian College of Surgeons (RACS). Report to the Royal Australasian College of Surgeons. 28 September 2015 RACS, Melbourne. Available at http://www.surgeons.org/about/expert-advisorygroup/reporting/ : see especially "Unhealthy work practices and training arrangements", page 12; and page 2, where it is stated the "Long established traditions that have been inherited and have normalized unprofessional and, and sometimes illegal, behaviours must be relinquished."

[6] Australian Medical Council. *Standards for the Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs by the Australian Medical Council 2015.* See especially Standard 7.4.1.

[7] Australian Medical Council and Medical Board of Australia. *Intern training – National standards for programs*. Standard 7.2.3.

[8] Pun, A. Bullying in the public health system. 6 Nov 2018. https://johnmenadue.com/anthony-pun-bullying-in-the-public-health-system/

[9] Westbrook, J. et.al. Endemic unprofessional behaviour in health care: the mandate for a change in approach. Med J Aust 2018; 209 (9): 380-381. https://www.mja.com.au/journal/2018/209/9/endemic-unprofessional-behaviour-health-care-mandate-change-approach

[10] ACT Health Quality Strategy 2018-2028: Person-centred, safe and effective care. ACT Health: Canberra 2018. https://www.health.act.gov.au/sites/default/files/2018-10/Quality%20Strategy%20Booklet.pdf

[11] https://www.safetyandquality.gov.au/our-work/shared-decision-making/

[12] ACT Health Quality Strategy 2018-2028: Person-centred, safe and effective care. ACT Health: Canberra 2018. https://www.health.act.gov.au/sites/default/files/2018-10/Quality%20Strategy%20Booklet.pdf

[13] White, D. Staff shortages mean radiology patient history could be ignored. The Canberra Times 2018; 26 September.

[14] Questions arise about whether all of this work is being done by Radiologists qualified to practice in and regulated in Australia. If this is not the case, how are we ensuring that patient safety is assured?

[15] ACHSM Webinar conducted by Dr Stephen Webster, Associate Medical Director of the Cognitive Institute on 4 November 2018, noted this in his presentation entitled: "Normalising speaking up in healthcare – the role of leaders."

[16] Twigg, D. et.al. The impact of nurses on patient morbidity and mortality – the need for a policy change in response to the nursing shortage. Australian Health Review 2010; 34:312-316.
[17] Twigg, D. et.al. The impact of the nursing hours per patient day (NHPPD) staffing method on patient outcomes: A retrospective analysis of patient and staffing data. International Journal of Nursing Studies 2011; 48:540-548.
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[19] https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/nsqhs-standards-second-edition/
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