ACT Government
Health

DIRECTOR-GENERAL MINUTE

Purpose

To seek approval for the Cognitive Institute (CI) to provide the Executive of the Canberra Hospital and Health Services (CHHS) with a presentation of their 'Promoting Professional Accountability' (PPA) program, see **Attachment A**.

Background

Unprofessional behaviours, including bullying and sexual harassment, undermine ACT Health's ability to provide a safe working environment to employees and safe care to patients.

The PPA program developed by the CI is evidence based and draws on previous experience from the USA to engage staff in reporting unsafe and unprofessional behaviours by using a graduated intervention framework, based on the Vanderbilt principles. Such programs have been found to have a positive and sustained effect on behaviours such as hand hygiene, see **Attachment B**. The PPA program has been adapted to the local Australian market and has been tested with legal practitioners, human resources experts, and unions.

The Royal Australasian College of Surgeons (RACS) also signaled its intent to utilise principles in the Vanderbilt model to support their drive for culture change and leadership, see **Attachment C**.

The KPMG Review of the Clinical Training Culture, CHHS (September 2015) identified reluctance amongst staff to report bullying and sexual harassment, see **Attachment D**. Anecdotally, reluctance to report unprofessional behaviours is ongoing and not restricted to the medical profession at CHHS.

The ACT Health Clinical Culture Committee (CCC) has agreed that the cultural program should be extended to include other disciplines across ACT Health, see **Attachment E**.

CI recommends that implementation of the PPA program is supported by the Speaking Up for Safety program which aims to empower employees to raise issues with colleagues when they have a patient safety concern, see **Attachment F**.

Whilst not designed to solve all issues relating to bullying and sexual harassment within ACT Health, the program offered by the CI would provide a strategy to support cultural change and demonstrate that ACT Health does take action with respect to inappropriate behaviours. The program offers training to ensure staffs are equipped with the tools to drive the cultural change required.

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Issues

Prior to considering development and implementation of the PPA program at a particular site, the CI seeks commitment from the highest levels of leadership. Further information and discussion will be required to determine whether the program would be suitable for implementation across the whole of ACT Health, or CHHS. To obtain further information and gauge the level of support for the program, it is recommended that the CI is asked to provide a presentation to the CHHS Executive.

The CI's PPA program will compliment existing programs offered by ACT Health that educate staff in what constitutes bullying, harassment, and discrimination. These programs are:

Respect at Work - All Staff Workshops
Respect at Work - Manager Session
Respect at Work - Doctor Session
Senior Doctor Leadership Program

The Respect at Work - Doctor Session is a two hour session that educates doctors on what constitutes bullying, harassment, and discrimination (BHD); the responsibility for doctors in senior positions to address any allegations of inappropriate behaviour that comes to their attention; the consequences/implications of these behaviours not being addressed; and reaffirms our organisational expectation that senior doctors role model positive behaviour and challenge inappropriate behaviour when it is observed and/or comes to their attention.

The Senior Doctor Leadership Program is a 4 day program that covers the following:

Workshop 1 - Setting behavioural standards and coaching for optimal outcomes
Workshop 2 - Leading people to new places
Workshop 3 - Facilitating effective team work
Workshop 4 - Mediating conflict and negotiating effectively.

The Senior Doctor Leadership program does not just focus on BHD behaviours, but more broadly looks at how to get the best out of people; achieving goals; facilitating effective teamwork; and addressing conflict. Workshop 1 addresses BHD behaviours and does provide participants with tools to help manage inappropriate behaviours and performance concerns through a coaching model. The key message is that Senior Doctors in their leadership role have a responsibility/obligation to address inappropriate behaviours and minimise these behaviours. The program educates Senior Doctors on the negative impact that these inappropriate behaviours have on the workplace, individuals, and patient care.

Organisational Development, People and Culture have advised that the CI's PPA program, specifically the 'Readiness Workshop', will compliment existing programs. The 'Readiness Workshop' assesses the organisational infrastructure of CHHS to identify any gaps that will impact on our ability to support a culture of safety.

Organisational Development, People and Culture have also advised that CI's PPA program 'Accountability Leaders' Intervention Skills Workshop' will compliment the existing 'Respect at Work' program. The CI's workshop develops leaders' skills in addressing behaviours that undermine a culture of safety and quality.

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The CI's PPA program 'Peer Messengers' takes a different approach to addressing informal conversations about single reported incidents. Currently, allegations of inappropriate behaviour are managed by the *direct* manager at the local level. The CI's PPA program 'Peer Messengers' trains carefully selected peer messengers to address clinician behaviour that undermines a culture of safety and quality. Peer Messengers practice performing interventions through skill building exercises and simulations. Ongoing coaching and support is provided to executives, leaders, and peer messengers.

It is understood that the CI's PPA program will interact with the current RISKMAN system.

Benefits/Sensitivities

The CI have expertise in developing and supporting implementation of programs such as this, and the program is designed to ensure that those involved are trained and prepared to address unprofessional behavior.

If implemented, time for training of staff needs to be considered to ensure clinical activities are not disrupted.

Given the national scrutiny of culture within the medical profession, there is likely to be media interest if the program is implemented and could be used as a positive news story.

The program has been implemented in both public and private hospitals, such as the Royal Melbourne Hospital, and some staff will be familiar with the program, see **Attachment G.**

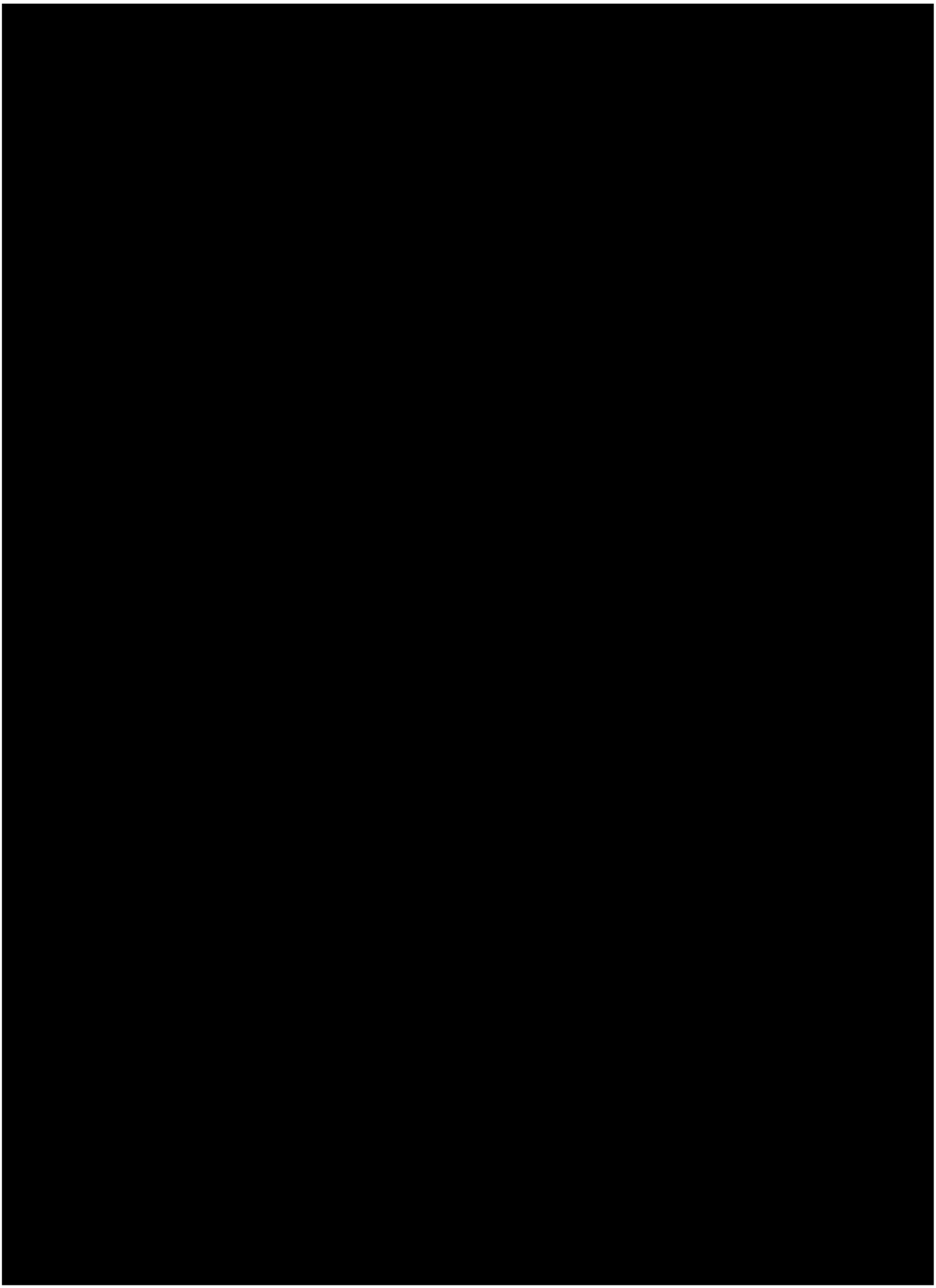
Financial

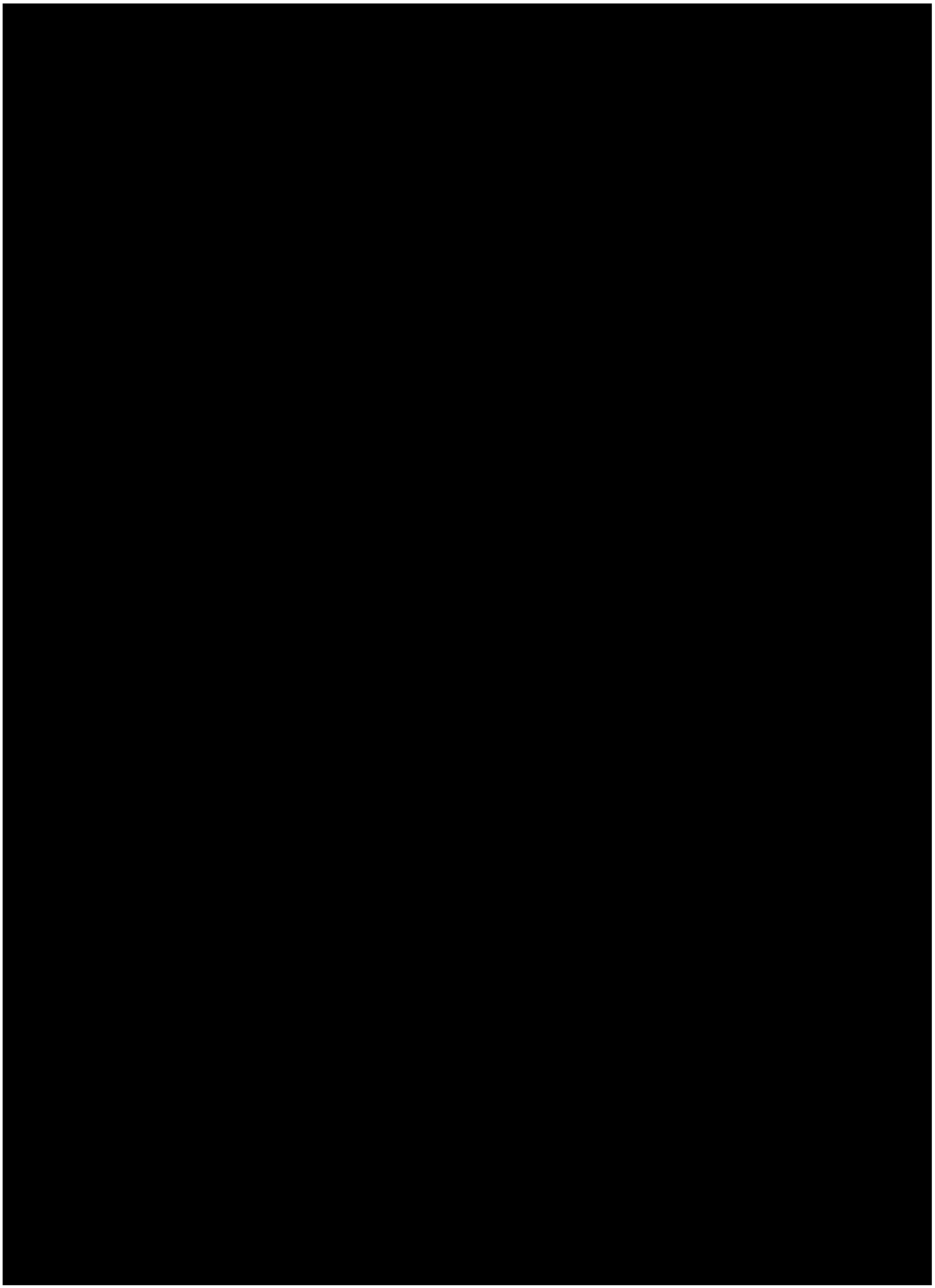
There are costs associated with development and implementation of the program. The CI has quoted $5,500 for a presentation of their program to the Executives of ACT Health.

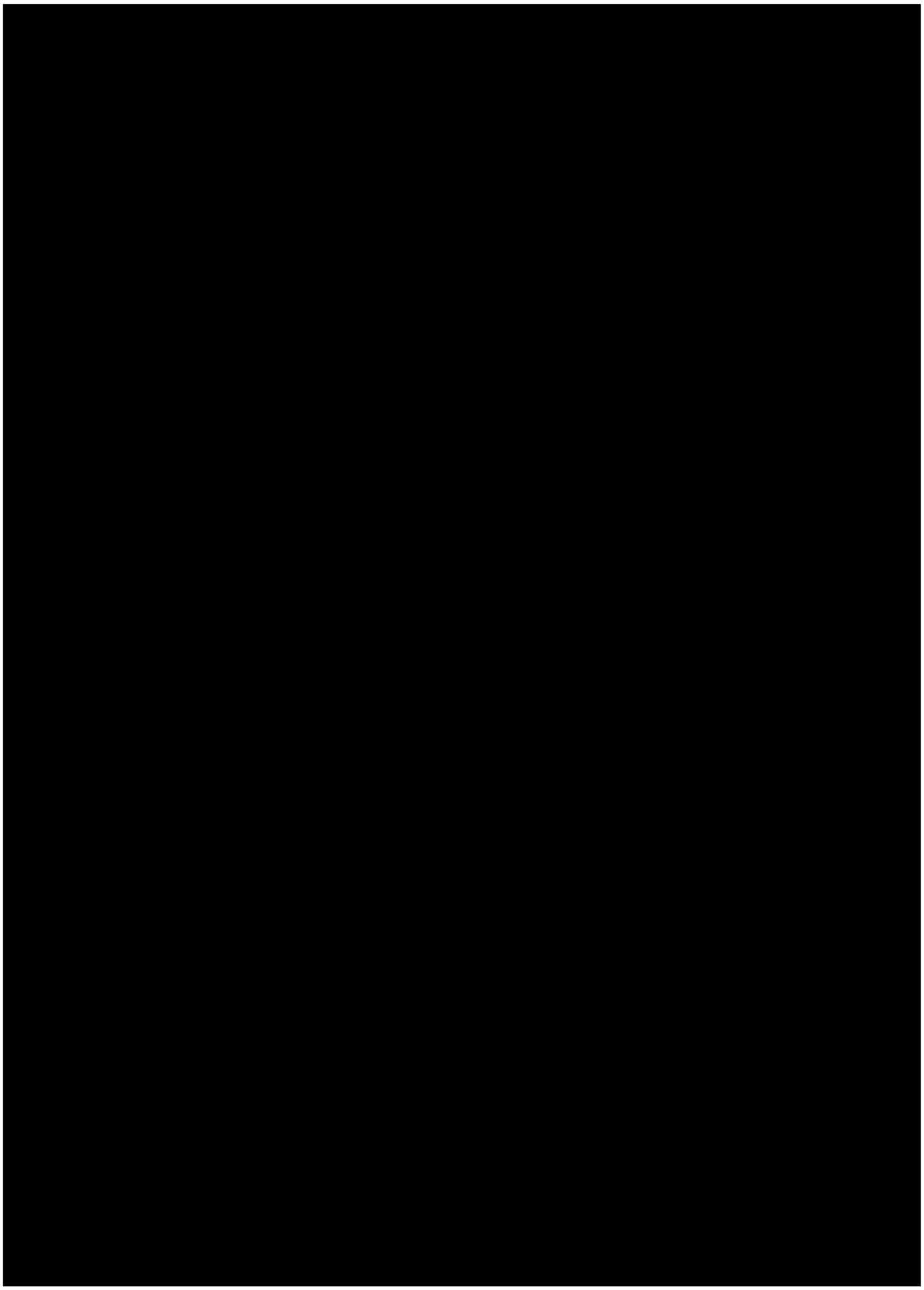
Signed off by:	Christina Wilkinson	Phone:	43596
Title:	Acting Chief Medical ~~Officer~~ Administrator		
Branch/Division	Canberra Hospital		
Date:	25 October 2016		

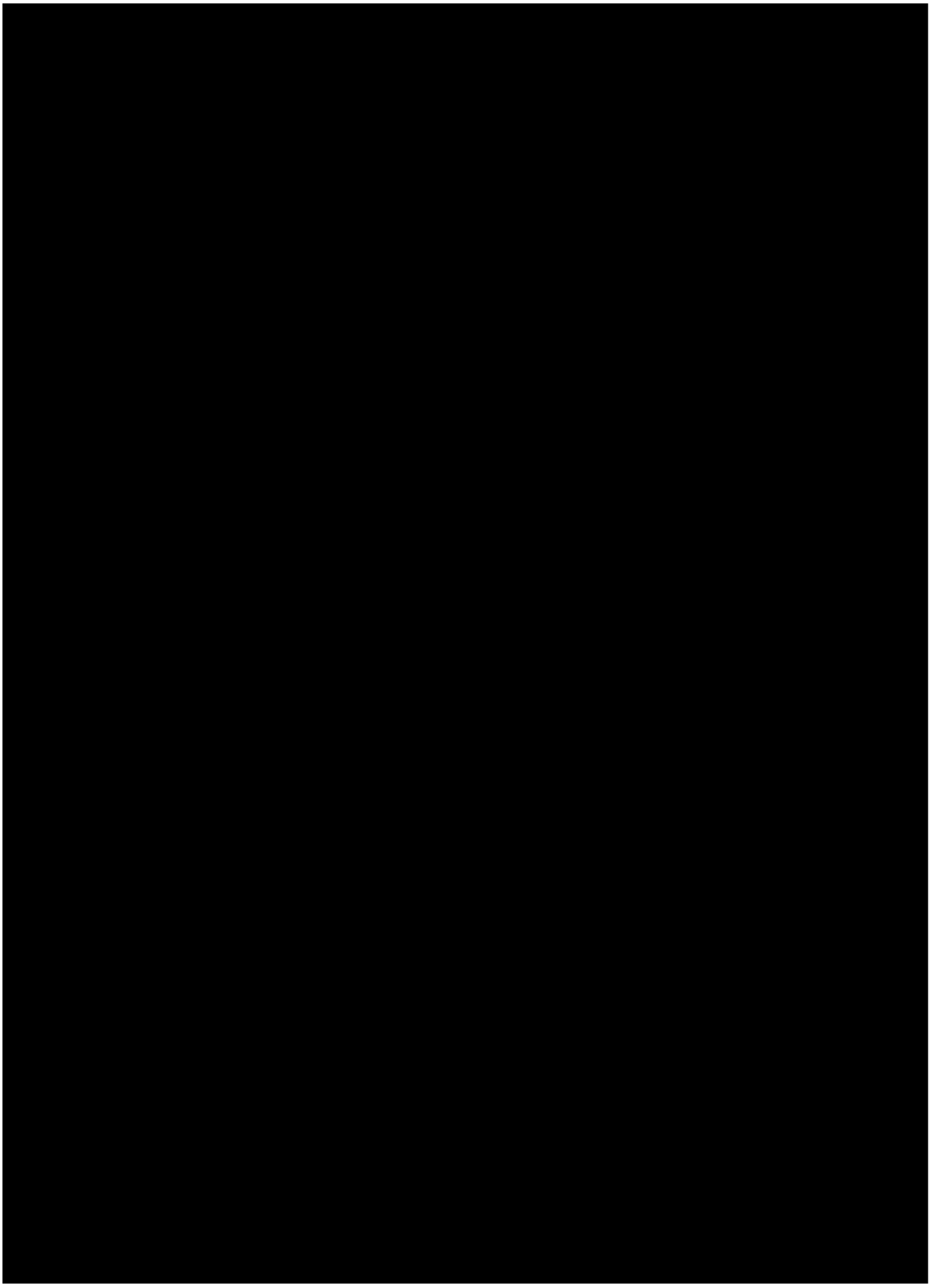
Action Officer:	Patricia O'Farrell	Phone:	51083
Title:	Executive Director		
Unit:	Organisational Development People and Culture		

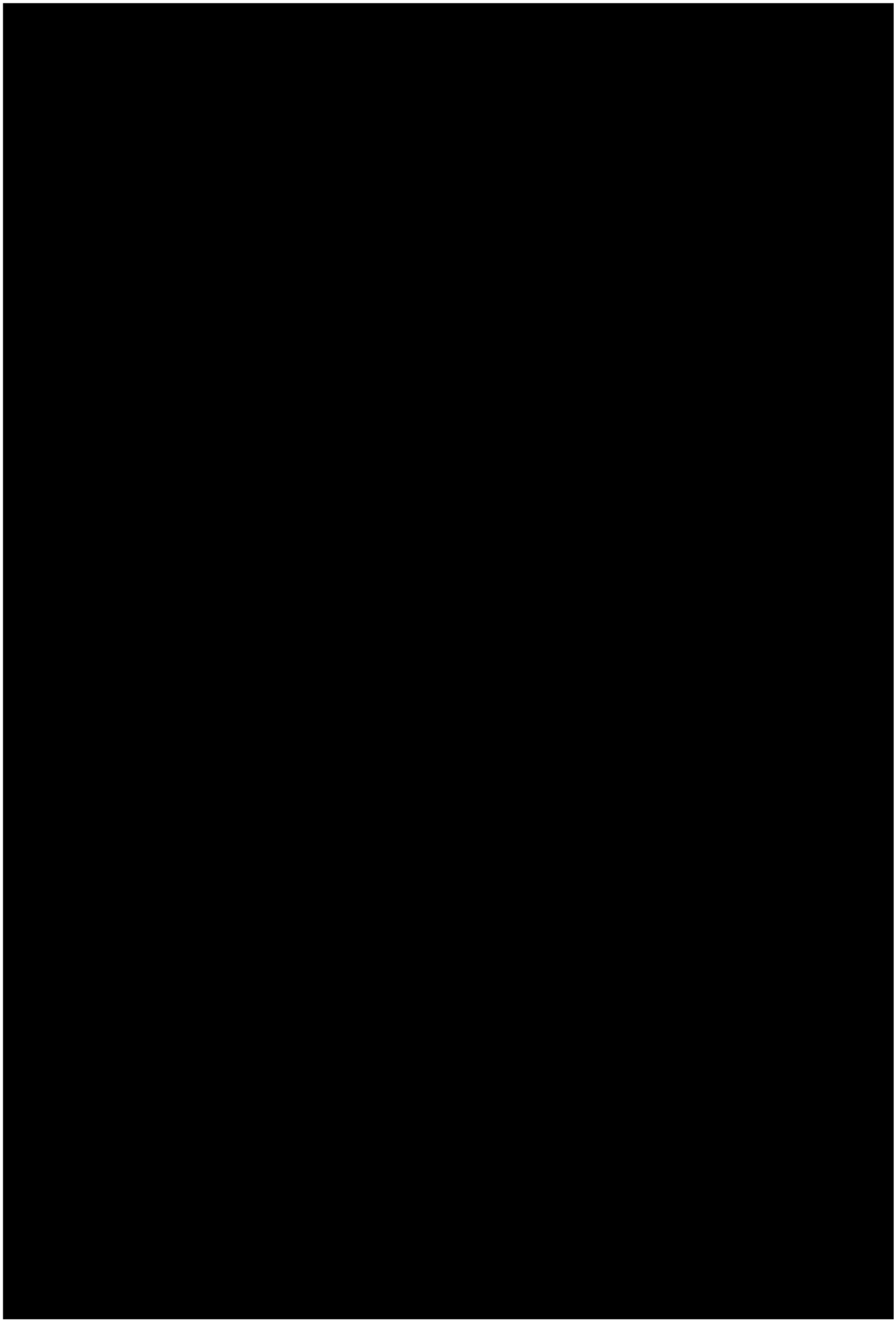
TRIM Reference No. _____

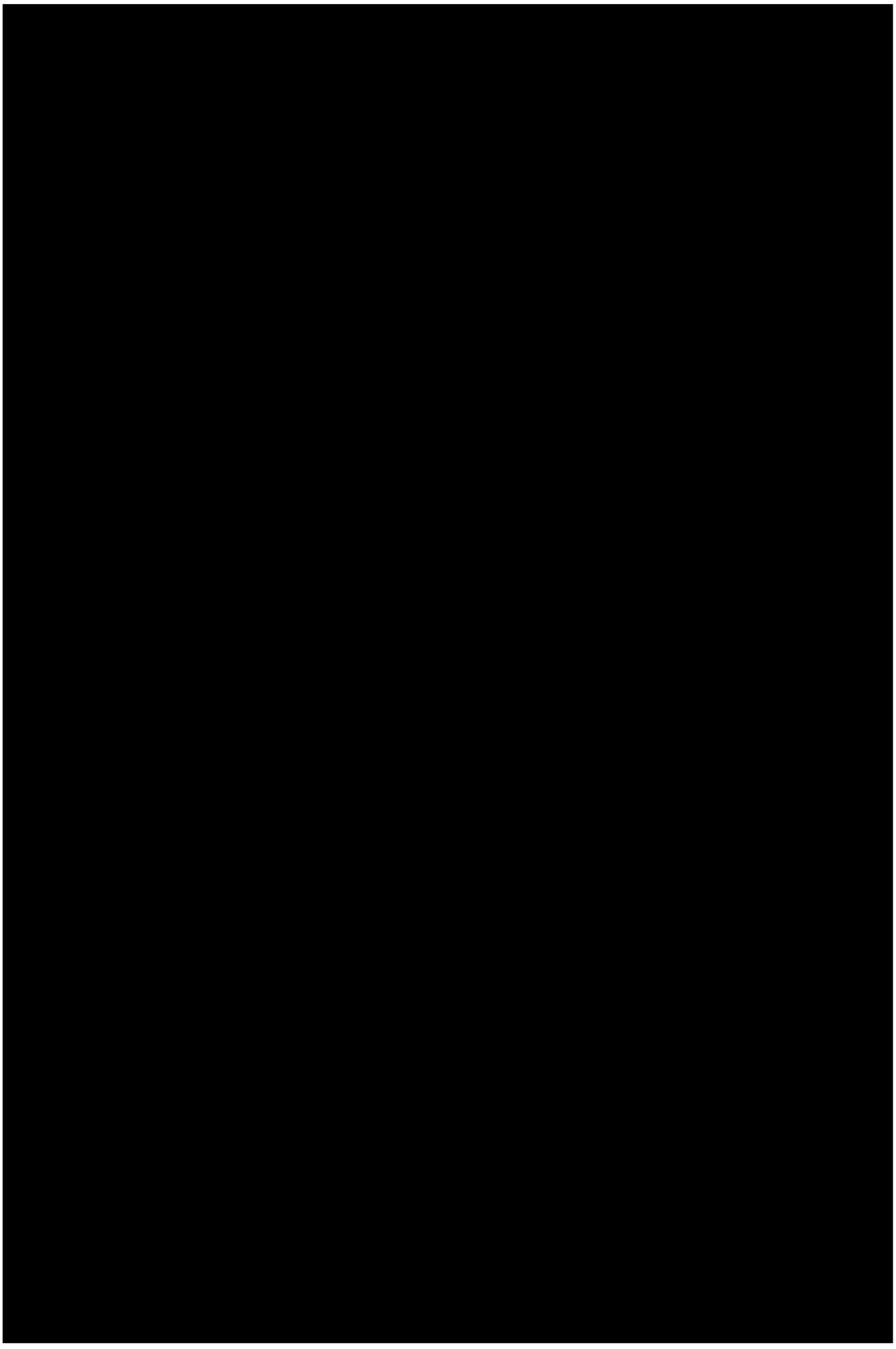


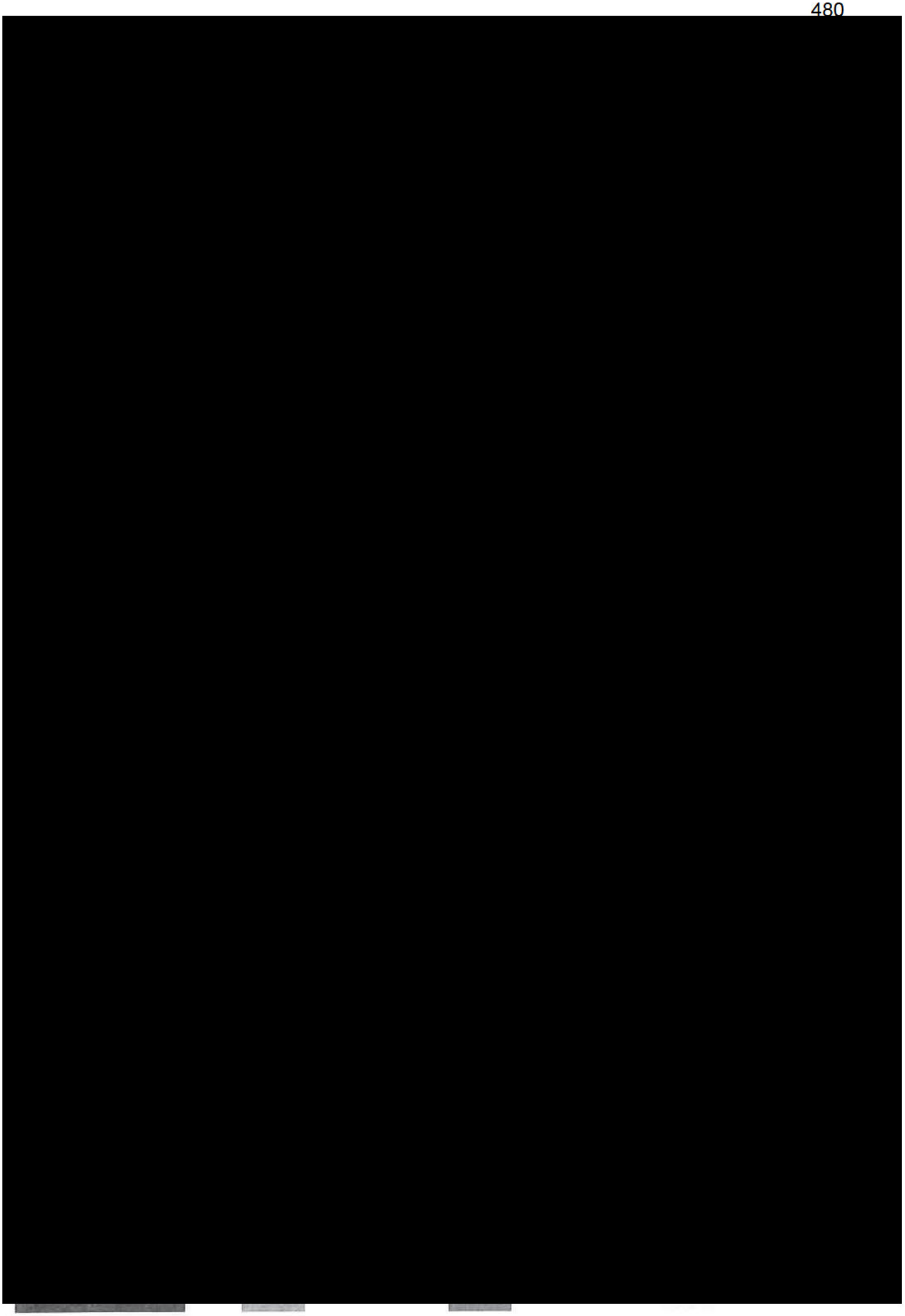


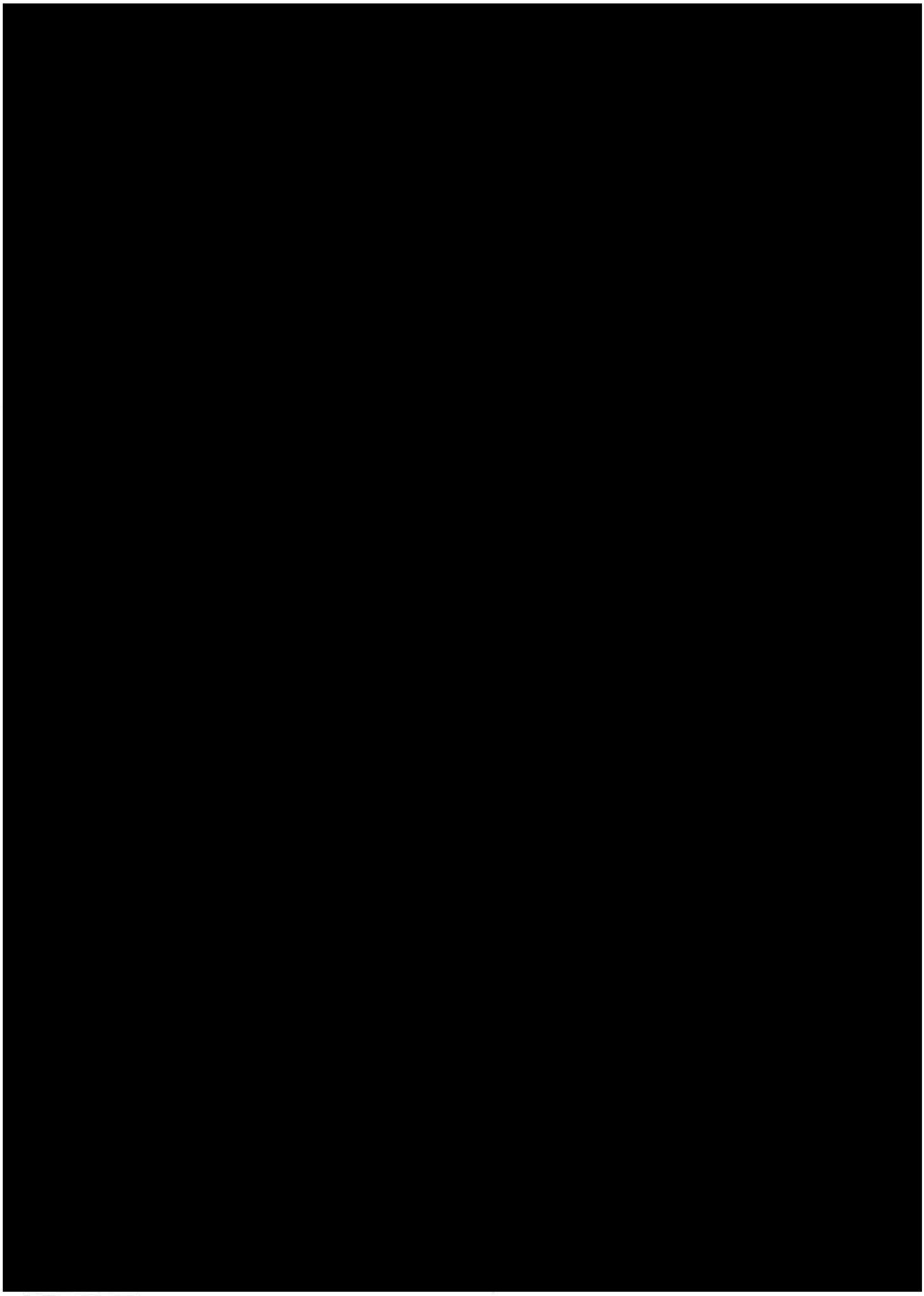












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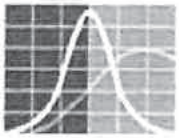

INFECTION CONTROL AND HOSPITAL EPIDEMIOLOGY NOVEMBER 2013, VOL. 34, NO. 11

ORIGINAL ARTICLE

Sustained Improvement in Hand Hygiene Adherence: Utilizing Shared Accountability and Financial Incentives

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OBJECTIVE. To evaluate the impact of an institutional hand hygiene accountability program on healthcare personnel hand hygiene adherence.

DESIGN. Time-series design with correlation analysis.

SETTING. Tertiary care academic medical center, including outpatient clinics and procedural areas.

PARTICIPANTS. Medical center healthcare personnel.

METHODS. A comprehensive hand hygiene initiative was implemented in 2 major phases starting in July 2009. Key facets of the initiative included extensive project planning, leadership buy-in and goal setting, financial incentives linked to performance, and use of a system-wide shared accountability model. Adherence was measured by designated hand hygiene observers. Adherence rates were compared between baseline and implementation phases, and monthly hand hygiene adherence rates were correlated with monthly rates of device-associated infection.

RESULTS. A total of 109,988 observations were completed during the study period, with a sustained increase in hand hygiene adherence throughout each implementation phase ($P < .0001$) as well as from one phase to the next ($P < .0001$), such that adherence greater than 85% has been achieved since January 2011. Medical center departments were able to reclaim some rebate dollars allocated through a self-insurance trust, but during the study period, departments did not achieve full reimbursement. Hand hygiene adherence rates were inversely correlated with device-associated standardized infection ratios ($R^2 = 0.70$).

CONCLUSIONS. Implementation of this multifaceted, observational hand hygiene program was associated with sustained improvement in hand hygiene adherence. The principles of this program could be applied to other medical centers pursuing improved hand hygiene adherence among healthcare personnel.

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Hand hygiene (HH) is essential in preventing healthcare-associated infections (HAIs),[1,2] yet HH adherence among healthcare personnel (HCP) remains suboptimal.[2,3] In 2009, Vanderbilt University Medical Center (VUMC) launched a system-wide initiative aimed at achieving and sustaining HH adherence using direct observation (including outpatient and procedural areas), an accountability structure and process, and financial incentives. This article details the VUMC HH program implementation and subsequent impact from July 2009 through August 2012.

METHODS

Setting

VUMC is a health system based in Nashville, Tennessee, that includes adult, pediatric, and psychiatric hospitals; on-

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campus outpatient clinics; and an extensive network of outpatient care sites throughout middle Tennessee. VUMC supports over 65,000 inpatient admissions, 160,000 emergency department visits, and 1.6 million ambulatory visits annually.[4]

Baseline Program

From 2004 to 2009, the VUMC HH program consisted of mandatory annual faculty and staff training, awareness events, and adherence monitoring via direct observation. These efforts produced limited improvement in measured HH adherence rates. In June 2009, VUMC leadership established the following 2 goals: (1) to improve HH adherence and (2) to prevent HAIs through efforts aligned with pursuit of a culture of safety.[5] Because these interventions were iterative quality improvement efforts involving no protected health information, Vanderbilt institutional review board approval was not required.

Launch of Expanded Program

Implementation of the HH initiative was performed in phases, with planning and readiness assessment followed by the program launch and a later active accountability phase. The following section describes key elements of the first phase.

Readiness assessment and planning. Before initiating the system-wide initiative and to increase the probability of success, the HH team used a project bundle to direct preparation, as described previously.[5] The bundle consists of 9 elements subdivided into 3 sections: learning system, people, and organizational readiness.[5] The project bundle focused planners on addressing the following: defining the problem, ensuring project alignment with the organization's mission, securing financial support, defining performance and measurement objectives, and establishing leadership commitment.

Leadership goal setting. After preplanning and securing leadership commitment, improved HH adherence was adopted as an institutional quality improvement goal. Performance related to the goal immediately became a factor in annual performance evaluations and incentive compensation for medical center leaders.

Financial incentives via a self-insurance trust allocation rebate program. VUMC is self-insured for malpractice claims. Funding for the trust occurs through annual facility and physician allocations (premiums). Because of favorable claims experience, instead of reducing premiums, a trust rebate program was created in fiscal year (FY) 2008. The program permitted academic departments and facilities to reclaim a portion of their annual allocation by achieving leadership-endorsed safety and risk-prevention goals (with associated metrics). Rebate dollars accrued to each department or facility annually in a weighted fashion on the basis of contributions to the trust and attainment of threshold, target, or reach performance targets for up to 4 goals. In June 2009, improved HH adherence was included as 1 of 4 patient safety metrics in the rebate program. The HH component of the allocation rebate was worth up to 25% of the total rebate dollars (2.5% of yearly premiums) distributed to departments and units on the basis of the entire medical system's performance. Modest HH adherence goals were set in the first year of the program (VUMC-wide adherence of 65% as a threshold goal, 75% as a target goal, and 85% as a reach goal) with the intent of increasing performance requirements each year. Rebate dollars were paid as a lump sum at the close of the fiscal year and could be used at the discretion of department leadership. Anecdotally, most dollars served to support quality and safety initiatives and provide salary support for patient safety officers. The magnitude of this financial incentive was modest. Rebates could reach as high as 2.5% of the malpractice premiums for attainment of the targeted HH goals. For example, for a physician whose yearly premium was $10,000.00, the rebate amounted to $250.00.

Expanded HH direct observation program. From July through October 2009, the observation program was expanded to include all inpatient and outpatient locations, including procedural areas and off-site clinics. To foster shared accountability, all location managers contributed observers to the observer pool. To limit bias, observers were required to conduct observations in a location over which they had no supervisory or employment role. Each observer was tasked with conducting an assigned number of observations on the basis of the location's clinical volume and size (20 observations per month for most areas). Each observation included HH adherence, the observed moment (eg, before room entry), job description of the person observed, and location. All VUMC faculty and staff were eligible for observation.

Observers attended required training on a standardized observation methodology. Although the education program emphasized the need to perform HH for each of the World Health Organization's 5 moments for HH,[6] to create a sustainable and less obtrusive process for observations, we adopted a simplified measurement strategy incorporating observation of adherence before entry and upon exit of the patient environment. Initially, observers were instructed to simply observe and record HH adherence in an unobtrusive fashion; however, the observer role expanded as accountability interventions were added in the program's second phase (see below).

System-wide marketing campaign. In May 2010, VUMC launched a system-wide marketing campaign consisting of poster messaging and targeted talks aimed to increase HH awareness and its importance in preventing HAIs. A follow-up campaign was launched in July 2011 as a part of the program's active accountability phase.

Active Accountability Phase

Since November 2010, the program has also focused on active performance awareness and accountability based on the fol-

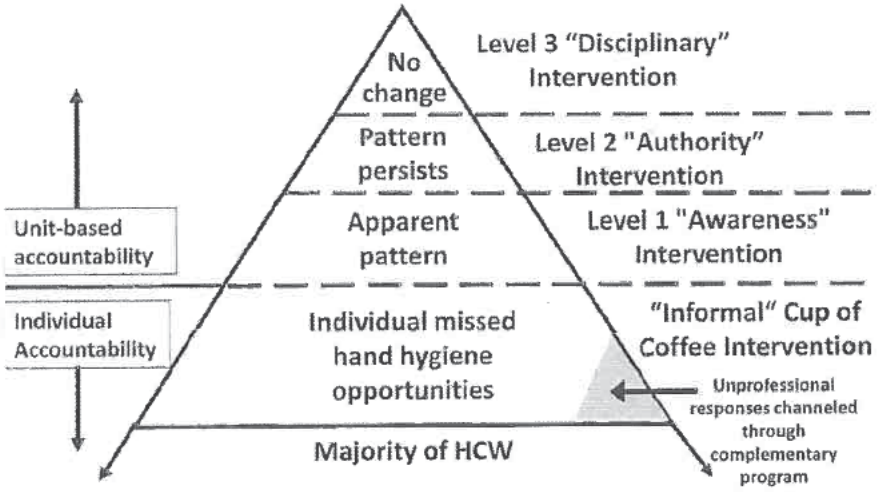

FIGURE 1. Depiction of tiered hand hygiene accountability interventions, based upon the model developed by Hickson et al.[7] HCW, healthcare workers.

lowing steps: formation of an executive committee, location-specific accountability interventions supported by scorecards, structured individual accountability interventions, and a continued marketing campaign. The following are descriptions of these components.

HH executive committee (HHEC). Consisting of key physician and nursing leaders, the HHEC was established to review location performance monthly and direct interventions. The HHEC meetings served to ensure HH remained a leadership priority and to promote transparency in accountability interventions.

Location-specific accountability interventions. At the monthly HHEC meeting, units with low adherence were identified for interventions on the basis of a system-wide HH intervention pyramid (Figure 1).[7] The pyramid was adapted from Hickson et al,[8,9] who used the associated process and method to intervene with physicians with high medical malpractice risk. As data revealed underperformance of a unit, a level 1 "awareness" intervention was initiated by the HHEC. Unit leaders (medical and nursing leader and the local quality and patient safety director) received a confidential correspondence stating that, although HHEC members knew that unit leadership shared the health system's goal of preventing HAIs, their current level of HH adherence was inconsistent with that goal.[5] Recipients were provided a scorecard illustrating their unit's monthly and year-to-date HH adherence, adherence by job description (eg, physician and nurse), and a transparent comparison with other units. The letter affirmed that recipients were trusted to take actions that they thought best to address performance and that follow-up data would be provided. Following receipt of the letter, an informal meeting was held between the unit's leadership team and representatives of the HHEC to declare confidence that the unit could reach the system's goal, to encourage dialogue regarding the unit's performance, and to address any barriers to HH specific to that unit. Level 2 "authority" interventions (Figure 1) were conducted when unit leaders were unable or unwilling to affect change. Differences between the level 1 and level 2 interventions were that associated department chairs or hospital directors were notified and a formal meeting among all parties was conducted to address barriers and improve performance.[8] A level 3 "disciplinary" intervention (Figure 1), designed to address recalcitrant locations, required a formal corrective action plan with defined expectations, responsible parties, timeline, and consequences for failure to achieve the intended outcome.[5]

Structured individual accountability interventions. Initially, observers were instructed to provide no direct feedback. However, to promote culture change, direct peer-to-peer accountability was felt to be both necessary and synergistic. In November 2010, observers were trained to provide direct feedback when a HH opportunity was missed. Feedback occurred through what is termed a "cup of coffee" conversation (Figure 1).[7] The conversation is designed as a nonjudgmental, respectful sharing of a single observation or event and is consistent with a culture of safety. The conversation could occur between any 2 parties regardless of organizational "rank."[5,7] Observers were also trained to respond to unprofessional behavior by documenting such behavior through the organization's event reporting system or using their chain of command. System leadership monitored event reporting and acted as necessary, consistent with organizational policies concerning behaviors that undermine a culture of safety.

TABLE 1. Hand Hygiene Adherence and Observations, Stratified by Location

Variable	Total no. of observations	Mean no. of observations per month	Mean hand hygiene adherence, %
Baseline period (January 2007–May 2009)			
Overall	3,032	105	52
Inpatient	3,032	105	52
Adult	2,449	84	50
Pediatric	583	20	62
Outpatient	...	...	...
Adult	...	...	...
Pediatric	...	...	...
Launch of expanded program (June 2009–October 2010)			
Overall	29,351	1,727	75
Inpatient	17,652	1,038	67
Adult	8,615	507	68
Pediatric	9,037	532	70
Outpatient	11,699	688	81
Adult	10,224	601	76
Pediatric	1,475	87	73
Active accountability phase (November 2010–August 2012)			
Overall	80,637	3,665	89
Inpatient	52,461	2,385	87
Adult	21,035	956	85
Pediatric	31,426	1,428	88
Outpatient	28,176	1,281	93
Adult	21,544	979	94
Pediatric	6,632	301	93

Outcome Measures

HH adherence was tracked using numerator and denominator data from individually recorded observations recorded through a web-based interface (REDCap Software, Nashville). Adherence was calculated as the number of adherent HH opportunities divided by the total opportunities observed. To examine an association between improved HH adherence and HAI reduction, existing institutional HAI surveillance data were used. HAI surveillance was performed prospectively by independent infection preventionists using standardized definitions for HAIs.[10]

Statistical Analysis

HH adherence data were compared using segmented regression analysis for the following phases, defined a priori: baseline period (January 2007–May 2009), program launch (June 2009–October 2010), and active accountability phase (November 2010–August 2012). *F* statistics were then calculated using R, version 2.15.1 to evaluate differences between time periods ($P < .05$ was considered to be statistically significant).[11,12] A correlation analysis between improved HH adherence and HAI infection reduction was also performed using a cubic spline interpolation to calculate an R^2 coefficient.[13] For this comparison, an aggregate metric of device-associated infections (which included all inpatient central line–associated bloodstream infections, catheter-associated urinary tract infections, and all intensive care unit–attributed ventilator-associated pneumonias) was used, because these infections were felt a priori to be impacted by HH adherence. Benchmark rates for each infection type were used to calculate an expected number of device-associated infections by unit type.[14] A monthly composite device-associated standardized infection ratio (SIR) was calculated by dividing the total number of observed device-associated infections by the total number of expected infections. Similar to previously published work,[15] surgical site infection data were excluded from the analysis, because these infections were expected to be inherently less sensitive to HH adherence. Because of migration to a nucleic acid amplification test for *Clostridium difficile* midway through the study period, this outcome was not included in the analysis, given that introduction of higher-sensitivity tests has been associated with increased infection rates.[16]

RESULTS

From July 2009 through August 2012, a total of 109,988 observations were completed, spanning 36 inpatient and 112 outpatient locations. Table 1 illustrates observations, mean number of observations, and mean HH adherence stratified by location for each program phase. Total numbers of observations obtained and HH adherence increased with each program phase. Overall adherence above 85% has been sustained since January 2011. Figure 2 illustrates the segmented regression analysis, showing differences in HH adherence over

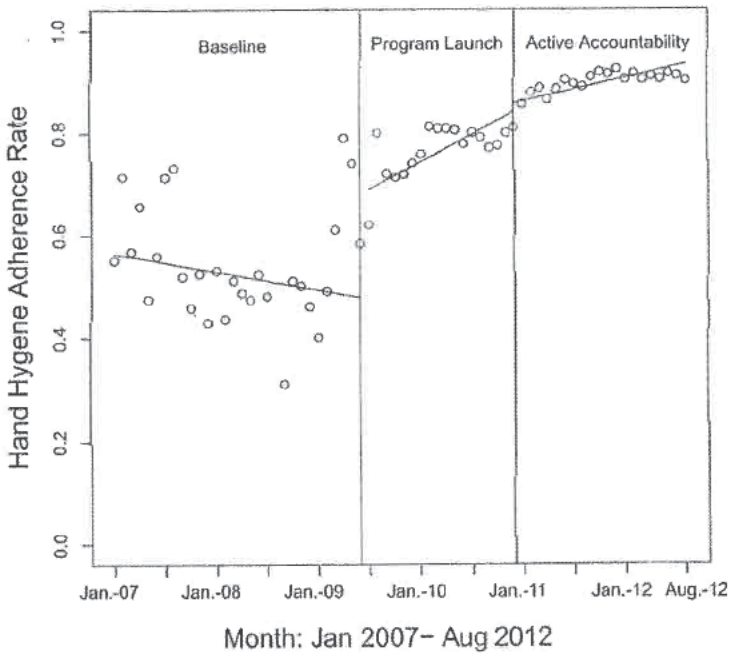

FIGURE 2. Segmented regression analysis evaluating monthly hand hygiene adherence rate (percentage adherent) over the 3 time periods included for study analysis: baseline, program launch, and active accountability. Each circle corresponds with the monthly institutional hand hygiene adherence rate. Each line corresponds with the calculated regression line for each time period.

time ($P < .0001$), increases in adherence with each intervention phase ($P < .0001$), and changes in the slope of the HH curves associated with each time period ($P < .032$).

Table 2 illustrates the HH adherence by year, system performance, and percentage of available rebate dollars claimed. Leadership expected improvement and steadily "raised the bar." The target goal was achieved in FY 2010, permitting all units to reclaim 75% of rebate dollars. To date, a reach level of performance has not been achieved.

Figure 3 illustrates the relationship between monthly HH adherence and device-associated HAIs. HH adherence rates were inversely correlated with device-associated SIRs ($R^2 = 0.70$). Both HH adherence and device-associated SIR showed significant improvement over time.

DISCUSSION

HH adherence improved with development and launch of an expanded direct observation program combined with goals and incentives promoting individual and group accountability. Improvements were supported by a process and method for sharing individual and unit data with interventions based on a HH accountability pyramid.[7] High HH adherence has been sustained for 18 months. In addition, an impact on HAI rates is suggested, because HH adherence was inversely correlated with device-associated SIR. Specifically, in months in which institutional HH adherence rates were high, institution-wide device-associated SIRs were low. Interestingly, the shape of the correlation curve between HH adherence and infection rates suggests that only marginal improvement is achieved until a certain point is reached (75% in our study). Because other HAI prevention initiatives were occurring, we cannot attribute causality to the decrease in device-associated infections during the study period. It is reasonable, however, to consider that improved HH rates had an impact. Most evidence-based bundles for reducing HAIs include HH as a component. It is also possible that HH marketing and accountability efforts reminded personnel of best practices in protecting patients from HAIs. Success of this multifaceted HH program is attributable to many factors, and several deserve review: obtaining leadership commitment, use of a tiered accountability model supporting a culture of safety, financial incentives, and the inclusion of outpatient and procedural areas.

Countless quality and safety initiatives are launched with good intent but wither on the vine because of a lack of effective leadership.[5] Project leaders must continuously evaluate health system leadership support. Leadership commitment can be evaluated by asking a few questions. Is the project consistent with the system's quality and safety priorities? Does financial support exist, including support for key personnel? Are system leaders willing to publicly affirm commitment to the goal and its associated metrics? Are leaders willing to

TABLE 2. Hand Hygiene Adherence and Self-Insurance Trust Rebate Performance

Fiscal year[a]	Performance goal, %			System hand hygiene adherence, %	Rebate, % of available potential rebate dollars claimed[b]
	Threshold	Target	Reach		
2010	65	75[c]	85	77	75
2011	85[c]	90	95	85	50
2012	88[c]	92	95	91	50

[a] Fiscal year is defined as ending in June of the year listed (eg, fiscal year 2010 *represents* July 2009 through June 2010).
[b] Total *potential* rebate was 2.5% of yearly malpractice premiums (eg, if a department's premiums totaled $10,000, the potential rebate for that department would be $250).
[c] Correlates actual performance with the performance goal achieved.

address noncompliant individuals? Too often, system leadership support is signaled initially but then disappears once difficult decisions arise, undercutting the authority of the project team. Before initiating the VUMC HH program, leadership commitment was secured. When individuals resisted elements of the HH plan, VUMC leadership was prepared and responded in a measured and effective way.

Framing HH practices as a measure of professionalism supported accountability and feedback conversations associated with the HH program. Several physicians and nurses received accountability interventions on the basis of the HH accountability pyramid and the health system's professional conduct policy, and in each instance, leadership was fully supportive.

Shared accountability was present in the day-to-day function of the HH program at the location level. Each clinical area donated an observer to the observer pool who was responsible for observing practice in another area, creating shared reliance upon one another. Also, location-specific accountability interventions provided opportunities for hospital and clinic leadership to be invited in to partner with units to address underperformance. Additionally, the response of underperforming units' improvement plans provided leaders with insight into the safety culture in each poorly performing clinical area (eg, exhibiting a collegial mindset and desire to work as a team or, alternatively, dysfunction and a lack of leadership).

VUMC leadership also reasoned that financial incentives should align with achievement of important safety goals. Within the HH program, the potential rebate by departments and facilities amounted to 2.5% of yearly malpractice premiums, a small amount when distributed throughout the system. On the other hand, even small financial incentives impact medical practice behavior.[17] Another aspect central to program success was the decision to have all departments and facilities share the same HH goals and therefore the same rebate percentage. Leaders were invested not only in the performance of their own areas but in the performance of other areas as well. This aspect of the program helped reduce a "silo" mentality. Sharing of unit-specific data also created collective accountability, because underperforming units were known by all whose rebate might be affected by their performance.

In addition to the traditional focus on inpatient wards, VUMC expanded the program focus to include outpatient and procedural areas using the same methodology throughout the system. Many HH programs either exclude outpatient clinics or use different metrics to assess their adherence. Although outpatient clinics outperformed inpatient units in overall HH adherence, a number of outpatient clinics and procedural areas required the tiered accountability approach. Procedural locations were also included. Although the workflow of the procedural locations provided challenges to leadership (eg, determining accessible locations for alcohol-based hand gel dispensers), these challenges also encouraged routine dialog about HH and its importance. In such circumstances, leadership went to great lengths to work through any barriers to HH adherence.

The VUMC program has limitations common to any observational HH surveillance program. First, direct observational programs are unable to observe most HH opportunities.[18,19] Second, although each observer received the same training, an assessment of observer variability was not undertaken.[20] Third, this study is limited by its nonrandomized, quasi-experimental design,[21] and we have no way to evaluate the impact of individual aspects of the program. In addition, observer bias likely influenced the results, and actual adherence may have been lower. By having the observers correct behavior, they clearly identified themselves, further increasing the risk of bias.[22] Although such bias may influence an observational HH program, institutional leaders believed that the benefits of direct individual accountability outweighed the risk of artificially improved adherence. Although a direct observation HH program has well-described limitations, a hands-on direct feedback approach brings accountability benefits that are not possible with an entirely automated HH surveillance program. A final limitation is that many providers are not covered under self-insurance pools, a key component of our program's financial incentive; however, with changes in provider reimbursement, physicians are increasingly being employed by hospitals and, in most cases, being incorporated into their self-insurance programs.[23] Thus, the applicability of the financial incentive used in the VUMC program may increase in the future.

CONCLUSIONS

We successfully implemented a multifaceted observational HH program based upon the principles of extensive project planning, leadership buy-in and goal setting, financial incentives linked to performance, and use of a system-wide shared

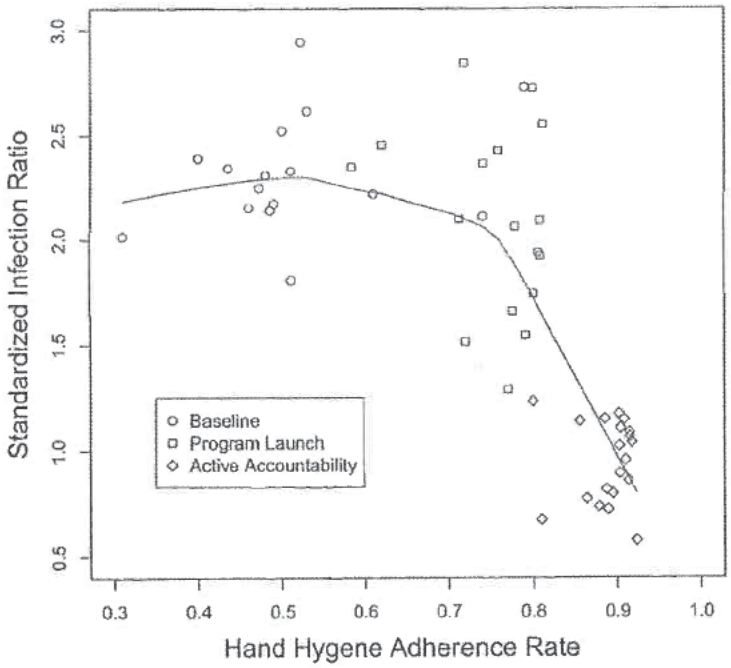

FIGURE 3. Correlation of monthly institutional hand hygiene rate (percentage adherent) with the corresponding institutional device-associated standardized infection ratio (SIR) is shown. Each point shown (circle, square, or diamond) corresponds to the hand hygiene adherence rate and device-associated SIR for the same month. Differing symbols denote each phase of the hand hygiene intervention. The fitted cubic spline interpolation line is shown.

accountability model. Improvements in HH have been sustained across the entire health system. Leadership engagement through a formal accountability structure coupled with institutional financial incentives have encouraged both nursing and physician leadership to pursue a culture of consistent, sustained HH adherence.

ACKNOWLEDGMENTS

We are indebted to all Vanderbilt University Medical Center (VUMC) faculty and staff for their participation in the hand hygiene program, especially for their enthusiasm and professionalism. We are indebted to all of the hand hygiene observers who make the VUMC hand hygiene program possible and to the hand hygiene executive committee members who guide the program. We would like to specifically acknowledge Ilene Moore, Brian Nelson, Jim Pichert, Brian Rothman, Deede Wang, and the perioperative informatics team for their significant contributions to the VUMC hand hygiene program.

Potential conflicts of interest. All authors report no conflicts of interest relevant to this article. All authors submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest, and the conflicts that the editors consider relevant to this article are disclosed here.

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ACT Government
Health

Clinical Culture Committee

Out of Session
Agenda Item 3.4: Statement of ACT Health Culture

Recommendation:

It is recommended that the Committee:

- *Approve* the proposed process for organisational-wide consultation to develop the Statement of ACT Health Culture.

1. Background

At the 19 July 2016 Clinical Culture Committee (CCC) meeting, members decided that the development of the Statement of Desired Culture (one of the recommendations from the KPMG Review), now referred to as the Statement of ACT Health Culture, is to be extended beyond doctors to include application to and consultation with all ACT Health staff.

The focus groups for doctors commenced on 4 July 2016 and sessions are being held until mid-August. Promotion of the work was provided by clinical leaders, announcements at Grand Rounds and a flyer aimed specifically at Junior Medical Officers publicising eight meetings. The consultation has engaged with senior and junior medical officers and timelines have been met. Feedback was given to all participants who attended focus sessions.

Further work with doctors was scheduled as follows:
August 2016: on-line dissemination of a draft Statement to all medical staff
September 2016: finalisation and endorsement of the Statement and then publication.

Given the consultation process is now to be widened, the above activities will not proceed as originally planned.

2. Recommended process for wider consultation

A recommended process for wider consultation with staff across ACT Health is as follows:

Phase 1: September – November 2016

- Early September 2016: Organisational Development staff attend DDG/Executive Director meetings to brief executives and professional leads on the purpose of this work and seek assistance in coordinating divisional representation at focus groups and promoting consultation.

- Early September 2016: Organisational Development and Government and Communications collaborate on a marketing campaign to support the work.

- Mid-September to end November 2016: Divisional/Branch focus groups are conducted by Organisational Development staff, with approximately 10% of the ACT Health workforce having an opportunity to attend in person. This means approximately 30 focus groups (1 hour each with 25 staff) will be conducted – the number of focus groups per division/branch will be based on proportional headcount.
    - Executive Directors and their staff along with the relevant professional leads will be responsible for coordinating a representative mix of staff from their various professional groups and from junior to senior levels within their division/branch.
    - Two "open" focus groups will be made available to staff not selected to attend the division/branch focus groups – this provides further opportunity for staff consultation and sends a message of inclusivity.

Phase 2: December 2016

- Organisational Development collate material from all focus groups and draft a Statement.

- Clinical Culture Committee meeting to discuss, revise and endorse a draft Statement to be used to obtain staff feedback.

Phase 3: January – February 2017

- Organisational Development make the final draft of the Statement available to all staff for online feedback.

Phase 3: March 2017

- Organisational Development collate online feedback and recommend changes (if any) to the Clinical Culture Committee for final endorsement.

Phase 4: March 2017

- Organisational Development and Government and Communications collaborate on a launch of the Statement and associated materials (such as posters, intranet, within employment documents).

Advantages

The process outlined above provides for meaningful, representative consultation. This is crucial given the nature of this Statement and its importance as an engagement/culture improvement tool. The consultation process will also serve to refresh staff engagement with ACT Health's Values (as they are a key starting point for the focus group discussions) and further raise awareness of appropriate and inappropriate workplace behaviours.

Disadvantages

This will require a redirection of resources from within Organisational Development and from Government and Communications. It also means a longer timeline for completion than when it was originally conceived as medical-only work.

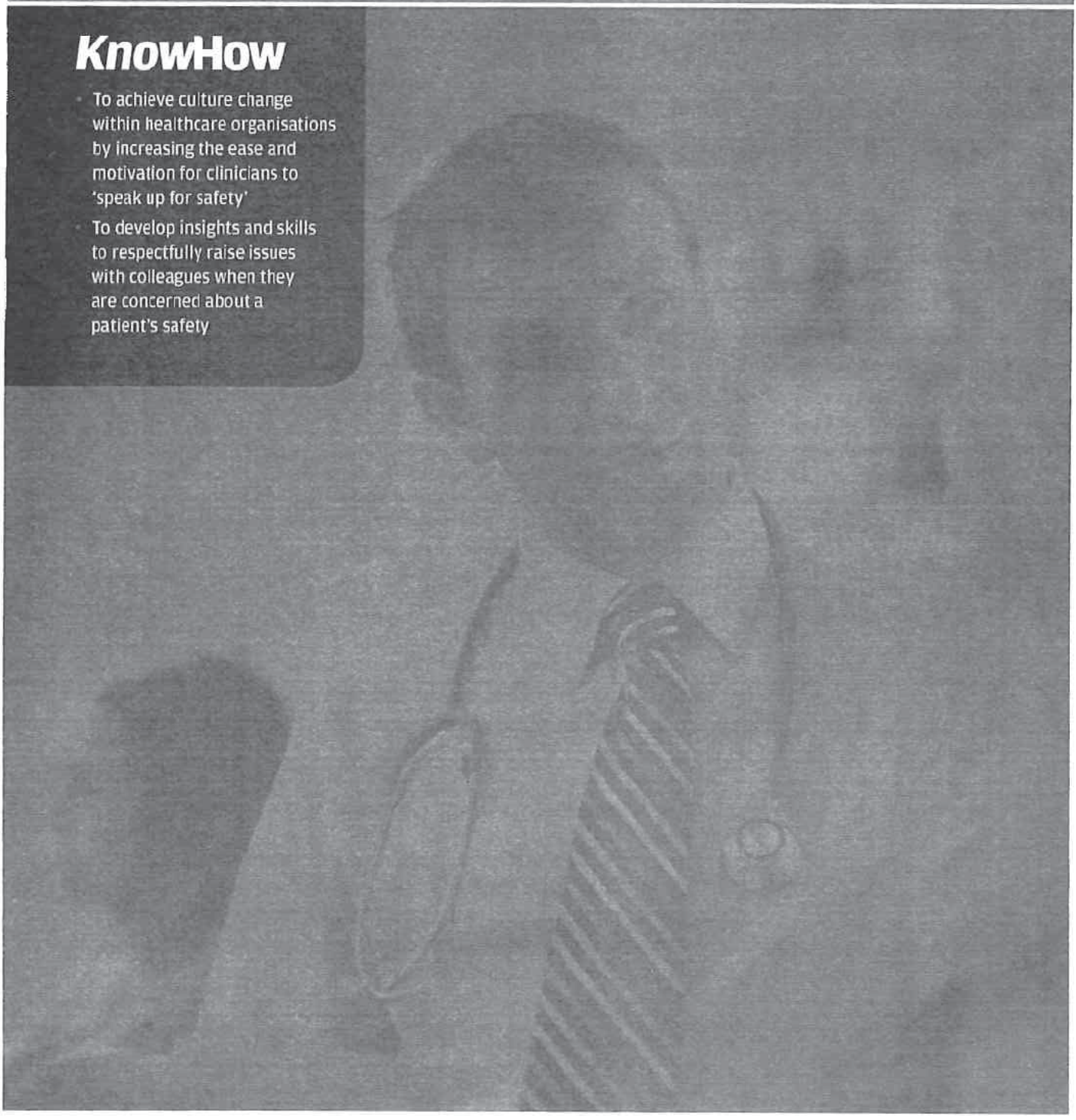
COGNITIVE INSTITUTE
KnowHow

Speaking Up for Safety

Part of the Cognitive Institute Safety and Reliability Improvement Series

KnowHow

- To achieve culture change within healthcare organisations by increasing the ease and motivation for clinicians to 'speak up for safety'
- To develop insights and skills to respectfully raise issues with colleagues when they are concerned about a patient's safety



COGNITIVE INSTITUTE
KnowHow

PRESENTATION OVERVIEW

SPEAKING UP FOR SAFETY

Increasing the ease and motivation for clinicians to raise patient safety concerns with colleagues through graded assertiveness communication skills training.

KnowHow

- To achieve culture change within healthcare organisations by increasing the ease and motivation for clinicians to 'speak up for safety'
- To develop insights and skills to respectfully raise issues with colleagues when they are concerned about a patient's safety

Overview

The Speaking Up for Safety presentation includes:

- consideration of the role of respectful questioning of colleagues in patient safety
- reflection on the ethical considerations of speaking up for patient safety
- examination of video scenarios exploring the barriers to effectively raising a voice for safety
- demonstration of techniques that are effective in overcoming these barriers
- explanation of the theory of graded assertiveness
- examples of communicating graduated concern, including helpful words and phrases
- rehearsal exercises to assist participants find the 'right' words to use
- reflection on being 'spoken up' to.

Background

All clinicians will on occasion observe decisions or behaviours that cause them to consider whether the safest possible care is about to be delivered to a patient; whether observing the most junior or the most senior and respected clinician.

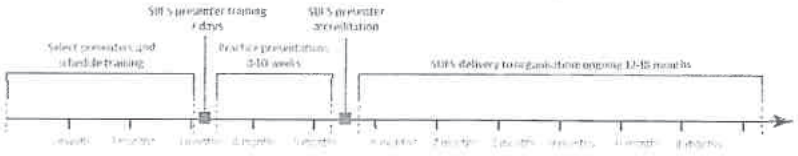
How a clinician responds to this dilemma is a reflection of:

- their training
- their personal belief systems
- their self confidence
- the culture of their own professional group
- the way their professional group interacts with other professional groups
- the culture of the organisation they work in.

The barriers to a proactive response in such a situation are well known - fear of overstepping authority, expectations of negative consequences, or simply a lack of understanding of the framework and words to use when communicating concern.

Other industries have learnt that the ability to speak up for safety is one of the most valuable resources they have to prevent errors of commission or omission.

This workshop examines the ethical considerations that impact on clinicians as they consider the decision to speak up for safety. It then provides the words and skills that will support and facilitate an individual clinician's decision to speak up.

Train the Trainer Programme	Cognitive Institute offers a licensed Train the Trainer Programme to allow accredited in-house presenters to deliver the Speaking Up for Safety presentation on an ongoing basis in your organisation. Cognitive Institute will conduct a Train the Trainer Programme in Speaking Up for Safety to your selected presenters, providing educational material and KnowHow which will enable the accredited presenters to deliver a one hour training workshop for all employees. Cognitive Institute will provide this under a licence agreement for a three (3) year period.
Duration	The Train the Trainer Programme training will take two days, delivery to be negotiated. Part 1 - Train the Trainer - Two (2) days Part 2 - Accreditation - Four (4) hours per group of six (6)
Audience	Selected trainee presenters (refer Selecting Trainees for Speaking Up for Safety). Groups of six (6) with maximum of 18 per session.
Proposed plan for training	• **Selection** - your organisation determines the number of trainee presenters required in groups of six. • **Training** - Cognitive Institute conducts a two day training programme. • **Practice** - trainees practice presenting the one hour Speaking Up for Safety presentation. • **Evaluation and Accreditation** - each trainee is assessed and accredited to present the one hour Speaking Up for Safety presentation.
Programme Timeline	**Speaking Up For Safety (SUFS) Train the Trainer Programme** 
Cognitive Institute Evaluation and Accreditation of Presenters	• The purpose of this evaluation process is to determine the quality of the trained presenters after they have had the opportunity to present two to three workshops in their organisation. • The evaluation will be conducted by a Cognitive Institute accreditor who will sit in on a 'live' presentation with participants observed co-presenting the one hour presentation. • The accreditor will provide constructive feedback to the presenter(s) and a brief written assessment of the competence and potential effectiveness of each trained presenter. • Following successful accreditation, presenters will be able to deliver the one hour Speaking Up for Safety workshop to all staff in the organisation. It is recommended to maintain skills they present approximately two (2) workshops per month. • Presenters are encouraged to spend time in private rehearsals and present two to three 'tame' events to groups of participants prior to accreditation.

COGNITIVE INSTITUTE

Licence	The Speaking Up for Safety Train the Trainer Programme is provided under a three (3) year licence agreement, commencing from the date of the Speaking Up for Safety Train the Trainer Programme. Only accredited presenters will be licensed to undertake the continuing training programme. The licence agreement ensures that the quality of the training programme is continually maintained. If the number of accredited trainers required by your organisation to maintain its ongoing training programme falls due to trainer attrition, it may become necessary to contract Cognitive Institute to train and accredit additional trainers.
	For information on the Cognitive Institute, presenters and courses visit www.cognitiveinstitute.org **To book a course call Head Office on +61 7 3511 5000 or email enquiries@cognitiveinstitute.org**

COGNITIVE INSTITUTE

THE AGE

Victoria

Royal Melbourne Hospital targets bullying with new Cognitive Institute program

May 28 2016

Julia Medew
Health Editor
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Forty per cent of staff said they had seen bullying at the Royal Melbourne Hospital. *Photo: Pat Scala*

Hospital workers who raise their voices aggressively, ignore patients or belittle colleagues are being reported to management at the Royal Melbourne Hospital under a radical new system to eliminate bullying – a problem thought to be rife there.

Chief executive Gareth Goodier said his 8800 staff were being trained to anonymously report unprofessional behaviour through a new online " we care" system in the hope it will gradually improve the hospital's culture.

The commitment comes after 40 per cent of 1763 staff surveyed at the hospital last year said they had witnessed bullying on the job, and one in five said they had experienced it themselves. Many said they were too scared to report it and felt that even if they did speak up, nothing would be done.

The hospital, which employs some of Australia's leading doctors, has been rumoured to house some senior bullies and last year a coroner began investigating the suicide of nurse Desmond Ponting who had allegedly been assaulted and bullied there by medical staff.

The "we care" system encourages staff to anonymously report any behaviour that undermines an open harmonious atmosphere where people can fearlessly remind a colleague to wash their hands or clarify a clinical instruction – important requirements for safe healthcare.

Dr Goodier said after various staff surveys showed "pretty poor and unacceptable" results, the hospital invested in the evidenced-based program through the Cognitive Institute in Australia, which aims to slowly break down damaging aspects of the hierarchical culture in hospitals.

The Royal Melbourne is believed to be the first Australian hospital using the system. After coming under fire for bullying, harassment and discrimination, The Royal Australasian College of Surgeons has also shown interest in it.

Under the program, pioneered by Vanderbilt University in the US, a small number of trusted "triage" staff regularly assess the anonymous reports coming in, and then "care messengers" – senior doctors, nurses and other workers – tell the reported person what has been alleged and ask them to reflect on it.

Executive director of People and Culture at the Royal Melbourne, Bridgid Connors, said the messengers were trained not to accuse the person of wrongdoing, but to say in a brief conversation: "It's been observed, it's been reported, We'd like you to reflect on that whether that did or did not occur."

Ms Connors said while most staff will never get reported, evidence from US hospitals showed 80 per cent of people who are reported once never get reported again because they change their behaviour. Another 13 per cent will get reported repeatedly, prompting a more serious discussion with their manager, and a small cohort of recalcitrant staff will end up in formal counselling or disciplinary proceedings which may involve them being dismissed.

Ms Connors said staff *had been* warned not to make vexatious complaints because they, too, could lead to disciplinary action, and she said in US hospitals very few people fraudulently reported colleagues. She said one of the unique things about the system was its focus on staff getting used to receiving feedback *and taking it on* board professionally.

Dr Goodier said staff clearly felt scared to speak up about disruptive behaviour because the hospital's HR department had only received about 12 to 15 reports of serious misconduct a year, of which about 10 to 12 were proven. He said the Melbourne Health board, which is chaired by Melbourne's Lord Mayor Robert Doyle, had agreed to back the program even if it ends up weeding out high profile or prestigious staff.

Executive Director, Clinical Governance and Medical Services, Cate Kelly said the board's commitment to not shy away from disciplining such people was crucial to the program's success.

"Basically if you *blink* in that process the whole cultural transformation process falls over because it just reinforces that message that it's not fair and transparent and consistent," she said.

ACT HEALTH
ASSEMBLY BRIEF

Minister:	Health
Cleared as correct and accurate as at:	22/07/2016
By Executive Director:	Yu-Lan Chan
Telephone:	x51086
Action Officer	Flavia D'Ambrosio
Telephone:	x55320

ISSUE: ACT Health - Review of culture and management training programs at Canberra Hospital (KPMG Report)

Context

The Clinical Culture Committee (CCC) was established by the you as Minister for Health, as a governance body in response to the findings of the KPMG Review of the Clinical Training Culture at Canberra Hospital and Health Services (CHHS) (the Review) and the findings of the Royal Australasian College of Surgeons (RACS) report on discrimination, bullying and sexual harassment, both conducted in September 2015.

Key Talking Points

- The Clinical Culture Committee met for the first time in October 2015 and continues to meet on a monthly basis. The Committee is chaired by Ms Nicole Feely, Director-General, ACT Health. Membership includes senior medical staff from ACT Health, Calvary Hospital and ANU Medical School as well as two junior medical staff representatives (13 members in total).
- A comprehensive action plan to address the recommendations from the Review was endorsed by the Committee at its 31 May 2016 meeting. Key components of the action plan currently being addressed are:
  - Extensive consultation with doctors on the development of a Statement of Desired Culture.
  - Extensive review of current complaints management processes and related policies.
  - Development of the broader Medical Culture Communications Strategy which will communicate and promote across ACT Health all the work of the Clinical Culture Committee.
  - Conducting the *Respect at Work* training program specifically for doctors. To date 135 Divisional and medical executives have participated in this program. The most recent session conducted on 14 June 2016 was attended by approximately 40 Junior Medical Officers.
  - 62 Clinical and Unit Directors have been identified and formally invited to participate in the Senior Doctor Leadership Program. This cohort has been split into two groups, with cohort one commencing the program on 30 August 2016 and cohort two commencing the program on 19 September 2016. The program will provide medical leaders with practical skills and strategies for influencing behaviour change, diagnosing team dynamic, setting expectations and encouraging a culture of innovation.

Background

The Review recommendations were:

1. Work with Executives and Clinical Directors to conduct further detailed analysis of those areas noted in the Review as having a culture that accepts or condones bullying, discrimination and/or harassment.
2. Engage senior leaders and staff across Canberra Hospital and Health Services in developing a statement of desired culture for success.
3. Using the statement of desired culture as the basis, develop, implement and embed a 'saturation' communications campaign.
4. Adjust reward and performance measure for leaders to reflect desired leadership behaviours and capabilities
5. Develop and institute mandatory leadership and management training for all clinicians who hold a leadership or management position
6. Review governance structures in relation to the accountabilities and reporting requirements associated with bullying and harassment.
7. Strengthen policy statements to clarify and commit to consequences for unacceptable behaviour.

ACT HEALTH
ASSEMBLY BRIEF

Minister:	Health
Cleared as correct and accurate as at:	16/3/2017
By DDG / Executive Director:	Patricia O'Farrell
Telephone:	6205 1086
Action Officer	Flavia D'Ambrosio
Telephone:	6205 5320

ISSUE: Review of culture and management training programs at Canberra Hospital

Key Talking Points

1. ACT Health continues to implement the seven recommendations made by the Review. Progess and key achievements against the recommendations have occurred to date.
2. The Clinical Culture Committee (the CCC) continues to meet on a monthly basis. The CCC is chaired by the ACT Health Director-General. Membership includes senior medical staff from ACT Health, Calvary Hospital and ANU Medical School as well as two junior medical staff representatives (13 members in total).
3. ACT Health continues to work to improve the workplace culture within our hospitals to ensure a safe and productive workplace.
4. Progress against the recommendations includes:
    - **Recommendation 1:** Further analysis of the 2015 ACT Health Workplace Culture Survey for medical staff was completed along with discussions with relevant executives. The CCC is considering a pulse survey in 2017 to track progress.
    - **Recommendation 2:** Focus groups were held in July – August 2016 to develop the statement of desired culture, with 153 doctors attending. The CCC decided to widen this work to the whole organisation and over 30 focus groups were held in September – November 2016, with 474 staff attending from across ACT Health. The statement is being drafted using the focus group information, with union consultation to occur in February 2017, followed by an online staff consultation process in March 2017 before it is finalised.
    - **Recommendation 3:** Communication using the statement will roll out following its finalisation and a broader strategy is nearing completion. ACT Health is also building a new intranet site with self-help resources and tools on workplace culture for managers and staff.
    - **Recommendation 4:** Work has commenced to review performance management arrangements for medical staff including performance planning and feedback processes. It is also intended to explore opportunities for enhanced links with entities such as the ANU to minimise duplication.
    - **Recommendation 5:** The Senior Doctor Leadership Program for Clinical and Unit Directors commenced delivery in August 2016 (and will conclude in June 2017) and is being facilitated by the Advisory Board Company, a leading healthcare research and leadership development organisation based in USA and working internationally. The program's focus is on practical skills and strategies for influencing behaviour change, diagnosing team dynamics, setting expectations and encouraging a culture of innovation. Feedback from participants has been very positive. In addition, the Respect at Work workshop continues to be rolled out across the medical workforce, specifically addressing inappropriate behaviours.

- **Recommendation 6:** Feedback is currently being sought from other health jurisdictions in Australia to inform potential improvements in this area. ACT Health is also exploring the programs offered by the Cognitive Institute for further embedding a culture of "speaking up".
- **Recommendation 7:** The Respect at Work Policy has been reviewed and will be considered by the Policy Advisory Committee early in 2017. The policy applies to all staff and focuses on promoting a positive workplace. It provides information on how unacceptable behaviours can be addressed. Significant consultation has occurred across the organisation as well as with unions.

Background

- In May 2016 a comprehensive Medical Culture Action Plan was endorsed by the Committee with a range of initiatives designed to address the recommendations from the Review. Key components of the action plan currently being addressed are:
  - Extensive consultation with doctors on the development of a Statement of Desired Culture.
  - Extensive review of current complaints management processes and related policies.
  - Development of the broader Medical Culture Communications Strategy which will communicate and promote across ACT Health all the work of the Clinical Culture Committee.
  - Conducting the *Respect at Work* training program specifically for doctors. To date 135 Divisional and medical executives have participated in this program. The most recent session conducted on 14 June 2016 was attended by approximately 40 Junior Medical Officers.
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- The seven Review recommendations were:
  - Work with Executives and Clinical Directors to conduct further detailed analysis of those areas noted in the Review as having a culture that accepts or condones bullying, discrimination and/or harassment.
  - Engage senior leaders and staff across Canberra Hospital and Health Services in developing a statement of desired culture for success.
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  - Develop and institute mandatory leadership and management training for all clinicians who hold a leadership or management position.
  - Review governance structures in relation to the accountabilities and reporting requirements associated with bullying and harassment.
  - Strengthen policy statements to clarify and commit to consequences for unacceptable behaviour.

ACT Government
Health

RECEIVED
by
17 MAR 2017
Office of the Director-General
ACT Health

DIRECTOR-GENERAL MINUTE

TRIM Reference No. DGC17/496

SUBJECT:	Clinical Culture Committee New Membership

From:	Shaun Strachan, A/g Deputy Director- General Corporate
Through:	Patricia O'Farrell, Executive Director, People & Culture Corporate

Critical Date:	Friday, 17 March 2017
Reason:	To ensure new members can attend the next Clinical Culture Committee, scheduled on Tuesday, 21 March 2017

Recommendations

That you:

Approve to the new members for the Clinical Culture Committee	*AGREED* *NOT AGREED* *PLEASE DISCUSS*

Please discuss.

Nicole Feely
Director-General
ACT Health

18 *March 2017*

ACT Government
Health

DIRECTOR-GENERAL MINUTE

Purpose

To seek your approval for Ms Jane Murkin, Deputy Director-General, Quality, Governance and Risk, and Mr Ric Taylor, Director, Organisational Development, People & Culture, to be new members of the Clinical Culture Committee (CCC).

Background

The CCC was established by the former Minister for Health, Simon Corbell MLA, as a governance body in response to the findings of the *Review of the Clinical Training Culture at Canberra Hospital and Health Services* conducted by KPMG in 2015 and the findings of the Royal Australasian College of Surgeons' report on discrimination, bullying and sexual harassment.

The purpose of the CCC is to develop, oversee and monitor initiatives to deliver appropriate behaviours and remove inappropriate behaviours within medical programs and across ACT Health. You are the Chair of the Committee and the Committee meets every six weeks.

Several members have resigned from the Committee: Dr David Blythe, Ms Yu-Lan, Dr Tom Lea-Henry, Dr Denise Riordan, Mr Ian Thompson and Dr Christina Wilkinson. Dr David Blythe and Dr Christina Wilkinson have been replaced by Dr Jeffery Fletcher, A/g Chief Medical Officer.

Issues

The current CCC membership is attached at Attachment A.

During the CCC February meeting (Tuesday 7 February 2017) members agreed to recommend to you, the Chair, for Ms Jane Murkin and Mr Ric Taylor to be new members of the CCC.

Ms Murkin attended the February meeting as a guest and presented on leadership for cultures of high quality and safe healthcare and continuous quality improvement. Members agreed that Ms Murkin would be a valuable asset to the Committee due her knowledge and understanding of culture improvement and its links with quality improvement.

As Director of Organisational Development, Mr Taylor would be valuable as a permanent member. Mr Taylor has extensive experience in culture improvement initiatives and due to his vast corporate knowledge understands the challenges of culture improvement in ACT Health. Mr Taylor would replace Ms Yu-Lan Chan's previous membership.

ACT Government
Health

DIRECTOR-GENERAL MINUTE

Benefits/Sensitivities

The addition of the new members will ensure the continuing work of the CCC.

Media

Have relevant communications material to support this brief been attached (communications plan, draft media release, talking points etc)? ☐ Yes ☐ No ☑ N/A

Has the Communications Branch been consulted? ☐ Yes ☐ No ☑ N/A

Signed off by:	Patricia O'Farrell	Phone:	620 51086
Title:	Executive Director		
Branch/Division	People & Culture		
Date:	02 March 2017		

Action Officer:	Flavia D'Ambrosio	Phone:	620 74835
Unit:	Organisational Development		

ACT Government
Health

Attachment A

Clinical Culture Committee

ACT Health Clinical Culture Committee Membership at February 2017

Name	Position
Ms Nicole Feely	Director-General, ACT Health (Chair)
Prof Walter Abhayaratna	Member, Clinical Director, Medicine, ACT Health
Dr Bryan Ashman	Member, Clinical Director, Surgery, ACT Health
Dr Eleni Baird-Gunning	Member, Surgical Registrar, ACT Health
Ms Veronica Croome	Member, Chief Nurse, ACT Health
Dr Jeffery Fletcher	Member, A/g Chief Medical Officer, ACT Health
[redacted]	Member, [redacted], ANU Medical School
Dr Klaus-Martin Schulte	Member, Professor of Surgery, ACT Health
[redacted]	Member, [redacted], Calvary Hospital
Ms Patricia O'Farrell	Observer, Executive Director, People & Culture (P&C), ACT Health
Ms Bronwen Overton-Clarke	Observer, Public Sector Standards Commissioner and Deputy Director-General, Workforce Capability and Governance, Chief Minister, Treasury and Economic Development Directorate

ACT HEALTH
ASSEMBLY BRIEF

Minister:	Health
Cleared as correct and accurate as at:	18/4/2017
By DDG / Executive Director:	Patricia O'Farrell
Telephone:	6205 1086
Action Officer	Flavia D'Ambrosio
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ISSUE: Review of culture and management training programs at Canberra Hospital

Key Talking Points

1. ACT Health continues to implement the seven recommendations made by the Review. Progess and key achievements against the recommendations have occurred to date.
2. The Clinical Culture Committee (the CCC) continues to meet on a six-weekly basis. The CCC is chaired by the ACT Health Director-General. Membership includes senior medical staff from ACT Health, Calvary Hospital and ANU Medical School as well as two junior medical staff representatives (9 members in total). Membership is currently being reviewed.
3. ACT Health continues to work to improve the workplace culture within our hospitals to ensure a safe and productive workplace.
4. Progress against the recommendations includes:
   - **Recommendation 1:** Further analysis of the 2015 ACT Health Workplace Culture Survey for medical staff was completed along with discussions with relevant executives. The CCC is considering a pulse survey in 2017 to track progress.
   - **Recommendation 2:** Focus groups were held in July – August 2016 to develop the statement of desired culture, with 153 doctors attending. The CCC decided to widen this work to the whole organisation and over 30 focus groups were held in September – November 2016, with 474 staff attending from across ACT Health. The statement has been drafted using the focus group information. Union consultation and an online staff consultation process will occur in May 2017.
   - **Recommendation 3:** Communication using the statement will roll out following its finalisation and a broader strategy is nearing completion. ACT Health is also building a new intranet site with self-help resources and tools on workplace culture for managers and staff.
   - **Recommendation 4:** Work has commenced to review performance management arrangements for medical staff including performance planning and feedback processes. It is also intended to explore opportunities for enhanced links with entities such as the ANU to minimise duplication.
   - **Recommendation 5:** The Senior Doctor Leadership Program for Clinical and Unit Directors commenced delivery in August 2016 (and will conclude in June 2017) and is being facilitated by the Advisory Board Company, a leading healthcare research and leadership development organisation based in USA and working internationally. The program's focus is on practical skills and strategies for influencing behaviour change, diagnosing team dynamics, setting expectations and encouraging a culture of innovation. Feedback from participants has been very positive. In addition, the Respect at Work workshop continues to be rolled out across the medical workforce, specifically addressing inappropriate behaviours.

- **Recommendation 6:** Feedback is currently being sought from other health jurisdictions in Australia to inform potential improvements in this area. ACT Health is also exploring the programs offered by the Cognitive Institute for further embedding a culture of "speaking up".
- **Recommendation 7:** The Respect at Work Policy has been reviewed and officially endorsed by Policy Advisory Committee in March 2017. The policy applies to all staff and focuses on promoting a positive workplace. It provides information on how unacceptable behaviours can be addressed. Significant consultation has occurred across the organisation as well as with unions.

5. All Divisions and Branches across ACT Health have developed Workplace Culture Actions Plans to address results from the 2015 Workplace Culture Survey. A new SharePoint online site has been developed to enable reporting by all Executives against their Workplace Culture Action Plans. Reporting commenced in March 2017 and then quarterly through to the Director-General.

Background

- In May 2016 a comprehensive Medical Culture Action Plan was endorsed by the Committee with a range of initiatives designed to address the recommendations from the Review. The seven Review recommendations were:

1. Work with Executives and Clinical Directors to conduct further detailed analysis of those areas noted in the Review as having a culture that accepts or condones bullying, discrimination and/or harassment.
2. Engage senior leaders and staff across Canberra Hospital and Health Services in developing a statement of desired culture for success.
3. Using the statement of desired culture as the basis, develop, implement and embed a 'saturation' communications campaign.
4. Adjust reward and performance measure for leaders to reflect desired leadership behaviours and capabilities.
5. Develop and institute mandatory leadership and management training for all clinicians who hold a leadership or management position.
6. Review governance structures in relation to the accountabilities and reporting requirements associated with bullying and harassment.
7. Strengthen policy statements to clarify and commit to consequences for unacceptable behaviour.

ACT HEALTH
ASSEMBLY BRIEF

Minister:	Health / Mental Health
Cleared as correct and accurate as at:	/ /
By DDG / Executive Director:	Jane Murkin/Patricia O'Farrell
Telephone:	6207 7780
Action Officer	Ric Taylor
Telephone:	6205 5320

ISSUE: Status of the Clinical Culture Committee (CCC)

Key Talking Points

1. The Clinical Culture Committee (the CCC) was established in October 2015 and now meets on a six-weekly basis. The CCC is chaired by the Director-General. Membership includes senior medical staff from ACT Health, Calvary Hospital and ANU Medical School, junior medical staff representatives, as well as the Deputy Director General Quality, Governance and Risk and the Executive Director of People and Culture.

2. The CCC continues to oversee the implementation of actions to address the seven recommendations made by the *KPMG Review into Clinical Training Culture* which was conducted in June 2015. Progress against the recommendations include:

   - **Recommendation 1:** Further analysis of the 2015 ACT Health Workplace Culture Survey for medical staff was completed along with discussions with relevant executives. Quarterly pulse surveys are being considered to monitor and track progress.
   - **Recommendation 2:** Focus groups were held in July – August 2016 to develop the statement of desired culture, with 153 doctors attending. The CCC decided to widen this work to the whole organisation and over 30 focus groups were held in September – November 2016, with 474 staff attending from across ACT Health. The statement has been drafted using the focus group information and is being considered by the Deputy Directors General prior to union consultation and final staff consultation.
   - **Recommendation 3:** Communication using the statement will roll out following its finalisation and a broader strategy is in development. ACT Health is also building a new intranet site with self-help resources and tools on workplace culture for managers and staff.
   - **Recommendation 4:** Work has commenced to review performance management arrangements for medical staff including performance planning and feedback processes. It is also intended to explore opportunities for enhanced links with entities such as the ANU to minimise duplication.
   - **Recommendation 5:** The Senior Doctor Leadership Program for Clinical and Unit Directors commenced delivery in August 2016 and concluded in June 2017. The program's focus was on practical skills and strategies for influencing behaviour change, diagnosing team dynamics, setting expectations and encouraging a culture of innovation. Feedback from participants has been very positive. In addition, the Respect at Work workshop continues to be rolled out across the medical workforce, specifically addressing inappropriate behaviours. Options for future programs are now being considered.
   - **Recommendation 6:** New training has been developed for clinical and non-clinical managers who need to manage complaints of inappropriate behavior. This training provides

clarity and skills for the preliminary assessment process, strengthening accountabilities and building more trust into the reporting of such behaviours.

- **Recommendation 7:** The Respect at Work Policy has been reviewed and officially endorsed by Policy Advisory Committee in March 2017. The policy applies to all staff and focuses on promoting a positive workplace. It provides information on how unacceptable behaviours can be addressed. Significant consultation has occurred across the organisation as well as with unions.

Background

- In May 2016 a comprehensive Medical Culture Action Plan was endorsed by the CCC with a range of initiatives designed to address the recommendations from the Review. The seven Review recommendations were:

1. Work with Executives and Clinical Directors to conduct further detailed analysis of those areas noted in the Review as having a culture that accepts or condones bullying, discrimination and/or harassment.
2. Engage senior leaders and staff across Canberra Hospital and Health Services in developing a statement of desired culture for success.
3. Using the statement of desired culture as the basis, develop, implement and embed a 'saturation' communications campaign.
4. Adjust reward and performance measure for leaders to reflect desired leadership behaviours and capabilities.
5. Develop and institute mandatory leadership and management training for all clinicians who hold a leadership or management position.
6. Review governance structures in relation to the accountabilities and reporting requirements associated with bullying and harassment.
7. Strengthen policy statements to clarify and commit to consequences for unacceptable behaviour.

ACT HEALTH
ASSEMBLY BRIEF

Minister:	Health / Mental Health
Cleared as correct and accurate as at:	14/11/17
By DDG / Executive Director:	Jane Murkin/Janine Hammat
Telephone:	6207 7780
Action Officer	Ric Taylor
Telephone:	6205 5320

ISSUE: Status on the implementation of the recommendations from the Health Staff Culture Survey 2015

Key Talking Points

1. A wide range of actions have been implemented to address the findings of the 2015 Workplace Culture Survey and assist ACT Health to further improve its culture.
2. The 2015 Review made seven key recommendations which are being addressed through the Medical Culture Action Plan, endorsed in May 2016 by the Clinical Culture Committee (CCC). The Medical Culture Action Plan includes a number of initiatives identified to address each of the seven recommendations. Progress on the Medical Culture Action Plan includes:
   - The Senior Doctor Leadership Program for Clinical and Unit Directors commenced delivery in August 2016 and concluded in June 2017.
   - The Organisational Development Unit within People and Culture continues to provide an internal culture consultancy service which directly assists teams across the organisation to achieve positive results.
   - The Respect at Work Policy has been reviewed and officially endorsed by the Policy Advisory Committee. The policy applies to all staff and focuses on promoting a positive workplace.
   - The ACT Health Statement of Culture has been drafted and further consultation will be progressed prior to it being finalised.
   - The Medical Culture Communications Strategy is being developed to promote the work of the CCC.
   - Performance planning processes are being refined to focus on desired leadership behaviours for doctors. Performance Plans for staff are now being developed and recorded through an online module within the Leanring Management System Capabiliti. This enables more robust oversight of performance planning and development, and the Plan includes a section on conduct and behaviours which support constructive workplace culture.
   - 360 degree tools have been developed and utilised to broaden sources for feedback. Consumer feedback will be utilised for feedback on performance where available.
   - Policies for managing unacceptable behaviour inclusive of rights and responsibilities have been reviewed.
3. The Emerging Managers Program for early career managers has added to the suite of leadership and management programs within ACT Health, all of which have a focus on culture.
4. A new training program on Preliminary Assessments was developed. It is now being delivered to staff with people management responsibilities to ensure they follow correct and effective

procedures to resolve workplace issues (such as complaints about staff behaviour) in line with the preliminary assessment clauses in ACT Health's enterprise agreements.

5. ACT Health has an active Staff Health and Wellbeing Program with dedicated funding which provides a range of services designed to support both mental and physical health for individuals and teams, underpinning effective behaviours and workplace culture.
6. A new intranet site is being developed with self-help resources and tools on workplace culture for managers and staff. It is expected to be operational by March 2018.
7. ACT Health is currently developing a Quality Strategy and has taken a codesign and consultation phase to shape and inform its developement through dedictaed activities to engage as many staff as possible in the process.

Background

- ACT Health has conducted organisation-wide workplace culture surveys in 2005, 2007, 2009, 2012 and 2015. These surveys have provided a rich source of information for executives, managers and staff, and have been used to drive a wide range of culture improvement initiatives.
- The detailed results from these surveys are not made public for a number of reasons: assurances made to staff about the confidentiality of their responses and the risk of undermining staff confidence and participation in future surveys; the commercial value and intellectual property of Best Practice Australia as the survey provider which could be compromised; the nature of the reports which are designed for use as working documents by executives and managers within the organisation.

ACT HEALTH
ASSEMBLY BRIEF

Minister:	Health and Wellbeing
Cleared as correct and accurate as at:	14/11/17
By DDG / Executive Director:	Jane Murkin/Janine Hammat
Telephone:	6207 7780
Action Officer	Ric Taylor
Telephone:	6205 5320

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ACT Government

MINISTERIAL BRIEF

Health Directorate

UNCLASSIFIED

To:	Minister for Mental Health	Tracking No.: MIN18/
From:	Michael De'Ath, Interim Director General	
Subject:	Organisational culture – focus areas for next 12 months	
Critical Date:	Not applicable	
Critical Reason:	Not applicable	

- DG .../.../...

Purpose

To outline the approach to rebuilding organisational workplace culture at ACT Health over the next 12 months

Recommendation

That you note the information contained in this brief.

Noted / Please Discuss

Shane Rattenbury MLA 1/8/18

Minister's Office Feedback

Background

1. Since joining ACT Health, the Director General has received feedback from staff about the current state of our culture and the challenges of working in ACT Health over the last three years. There was acknowledgement that the culture had deteriorated over that time.

2. Over the last three months, the ACT Health leadership team has worked hard to rebuild the organisational culture, particularly through the reaccreditation process. The commitment from the leadership team is starting to show signs of a significant shift in the positivity of the workforce culture across the organisation. This is evident in the comments provided by the ACHS surveyors in their Final Draft Advanced Completion report and through unsolicited feedback provided to the Director General.

3. Developing a high performing culture where people feel valued, are able to contribute and build effective partnerships is a high priority for the Executive.

Issues

4. The importance of continuing to rebuild the organisational culture is vital during this period of reform and transition, and is a specific focus for the Transition Team. The Director General is confident that the Directorate leadership team is capable of continuing to drive the positive change that is required over the next three, six and twelve months.

5. The proposed culture development work over the next 12 months will involve interrelated focus areas of leadership, values, engagement and communication.

Leadership and Values

i. *Build a cohesive, values-based executive team.* This has been a major focus following the implementation of the form and function review and has centred on supporting staff during transition. It involves the Director General, Deputy Directors General and all Executive Directors.

ii. *Build an environment where collaboration can thrive.* Collaborative leadership events will be held to bring many leaders together from across the organisation. Events will concentrate on engaging directly with the DG and senior executive, with dialogue and support to focus on the future in a constructive and inspiring way, break silos and provide opportunities to consult on key issues. The first Collaborative Leadership event is scheduled to be held on 14 August 2018 and will provide an opportunity to contribute to the future state of the organisation.

iii. *Training on change leadership.* Training will be delivered to Directorate Leaders to support staff through key organisational changes, build resilience and improve change communications.

iv. *Ensure the Employee Assistance Providers are briefed on organisational issues.* This will enable the counsellors to better support staff by having greater awareness of the context in which staff may be seeking assistance.

v. *The Clinical Culture Committee in its current form will be concluded.* A final meeting will be held to acknowledge the achievements of the committee (such as the Senior Doctors Leadership Program and Respect at Work seminars for doctors and all staff), inform members about key elements of the refocused culture development work, and to start considering the governance of culture required for the two new organisations.
External stakeholders including the Australian Medical Association, the ACT Visiting Medical Officers Association and the various medical colleges can be valuable partners in promoting and reinforcing respectful values-based behaviour and collaborative cultures among doctors. To that end, Canberra Hospitals and Health Services (as the new clinically focused organisation post-1 October 2018) will seek to explore how those partnerships could be strengthened.

vi. *Embed cohesive senior leadership teams in the two organisations.* A leadership development program will be procured and customised for each organisation to accelerate the effectiveness of the leadership team working across the two organisations, and ensure that positive relationships can be maintained.

vii. *Revise and refresh Vision and Values for the two organisations*. A process will be developed based on the recent work done within ACT Health for the University of Canberra Hospital and successful work undertaken in the Community Services Directorate. This work emphasised a wide-ranging consultative approach and the direct use of staff wording of values-based behaviours. The launch of two organisations is an opportune moment to commence this work.

viii. *Assess culture six months after the two organisations are formed.* In the normal course of business, ACT Health would be due to have a culture survey in November 2018 (three years since the previous survey). That timing is not advisable given the move to two organisations and the need to allow the foundations of those organisations time to settle. A process for undertaking a survey across the two organisations will be considered once the organisations are formed and staff are settled.

Engagement and Communication

ix. *Develop and implement a consultation framework*. It is proposed to develop a practical guide for Executives and Managers to ensure ongoing compliance with the industrial framework and to genuinely ensure staff voices can be heard.

x. *Conduct bi-monthly staff forums and utilise cascading communication*. Recent forums have been well received and ensuring continuity of these is important. In addition, ensuring effective face-to-face cascading of key messages is critical given the time-poor nature of much of the workforce and the limited reach of electronic modes. Executives will be supported to ensure that critical messages can be relayed to all staff. This process has commenced and the transition program is trialling this approach to ensure staff awareness and engagement.

xi. *Increase the focus on genuine "good news"*. A process is being developed to enable the identification and promotion of the many instances of great care and service which happen across ACT Health every day. Values-based rewards and recognition practices will also be considered.

Workforce Strategy

6. The Workforce Strategy Development Project commenced in 2017, with the aim of providing a future-fit approach to ensure ACT Health has the right people, in the right place, at the right time delivering patient and family centred, safe and high quality care.

7. KPMG was contracted to assist in the development of the Strategy. The project has provided some important insights into elements of culture within the Organisation.

8. As a first step the consultancy undertook a current state observation which identified a number of system wide issues and their implications for ACT Health and the Workforce Strategy. Consultants have subsequently provided a comprehensive document on change management going forward.

9. A full briefing will be provided to you shortly on the development of the Workforce Strategy for 2018 – 2027.

Financial Implications

10. Continuing to invest in culture development is important for ACT Health, particularly through the transition process. While the overarching development and coordination can be managed through existing resources within ACT Health, there will need to be expenditure to achieve a number of these recommendations. Costings will be considered as initiatives are further developed.

Consultation

Internal

11. Key elements of this proposal have been presented at Director-General staff forums on 14 June 2018.

12. Executive Workshops have been conducted to establish the framework for this program of work and commence building a collaborative and transparent culture.

Cross Directorate

13. ACT Health People and Culture staff have met with counterparts in CSD to discuss values development, as well as being aware of work done in CMTEDD on culture which may be applicable.

External

14. Not applicable.

Benefits/Sensitivities

15. The benefits in improving culture are wide ranging given the significant direct and ongoing impacts on:

- Staffing (wellbeing, turnover, rates of unscheduled absence, willingness to recommend ACT Health as an employer)
- Patient care (quality, avoidable errors, efficiency, patient experience)
- Service delivery
- Capability and capacity to cope with change, challenges and adversity.

16. There are considerable risks if we do not pursue this work. They include reputational risks that can undermine staff and public confidence in the ACT Health system. If culture is not addressed effectively it will compromise the various reforms and higher standards required to ensure public healthcare in the ACT meets current and future expectations. At an operational level there will be a reduced ability to attract high quality, professional staff.

17. Investing in efforts to improve culture will build a solid foundation for ongoing change and will help to develop a resilient, adaptable workforce.

Media Implications

18. Not applicable.

Signatory Name: Sean McDonnell Phone: 62051086

ACT Government

MINISTERIAL BRIEF

Health Directorate

UNCLASSIFIED

To:	Minister for Health and Wellbeing	Tracking No.: MIN18/861 31 JUL 2018
From:	Michael De'Ath, Interim Director General	
Subject:	Organisational culture – focus areas for next 12 months	
Critical Date:	Not applicable	
Critical Reason:	Not applicable	

- DG .../.../...

Purpose
To outline the approach to rebuilding organisational workplace culture at ACT Health over the next 12 months

Recommendation
That you note the information contained in this brief.

Noted / Please Discuss

Meegan Fitzharris MLA 3/8/18

Minister's Office Feedback

Please discuss Clinical Culture Committee.

Discussed at Health Briefing 6/8/18.