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Culture Reform Oversight Group Agenda

Monday, 13 December 2021
3.30pm-5.30pm
Meeting Room DG Conference Room, Level 5, Bowes St/ Via WebEx

		Sponsor	
Item 1	**Welcome and apologies**		
	1.1 Introductions	Chair	5 min
Item 2	**Decision and discussion items**		
	2.1 Second Annual Review- Priorities	Chair	20 mins
	2.2 Medical Engagement Strategy	CEO CHS	10 mins
	2.3 Organisation Culture Improvement Model Assessments a. ACTHD b. CHS c. CPHB	Chair	30 mins
	2.4 Employee Surveys (ACTHD, CHS and Calvary)	DG ACTHD, CEO CHS, CEO Calvary	10 mins
	2.5 System-wide Dashboard and Analysis	EBM PS&C ACTHD	10 mins
Item 3	**Updates**		
	3.1 Member Updates (Verbal)	All Members	10 min
Item 4	**Noting Items**	Chair	10 min
	4.1 Implementation of Recommendations and Project Plan		
	4.2 Culture Review Implementation Program Risk		
	4.3 Working Group Progress a. Transition student to clinician b. Early Consultation c. System-wide HR Matters		

	4.4 Minutes and actions arising from previous meetings, 9 August 2021 and 27 October 2021	
Item 5	**Other Business**	
	5.1 Oversight Group Communique	Chair

Next meetings:
February 2022

Culture Review Implementation
our journey of positive change

Culture Reform Oversight Group
Meeting Paper

OFFICIAL

Agenda Item:	2.1
Topic:	**Second Annual Review Priorities**
Meeting Date:	13 December 2021
Action Required:	**Discussion**
Cleared by:	**Director-General, ACT Health Directorate**
Presenter:	EBM People Strategy and Culture Branch

Purpose

1. To note the findings from the second Annual Review (Review) of the Culture Review Implementation; and
2. To discuss priorities for action for the remainder of the Culture Review Implementation.

Background

3. Recommendation 19 of the *Final Report: Independent Review into the Workplace Culture within ACT Public Health Services* (the Culture Review) states "That the 'Culture Review Oversight Group' auspice for the next three years, an annual, independent and external review of the extent of implementation of the recommendations of the Review and consequent impact on cultural changes within the ACT Public Health System".
4. Ms Renee Leon was contracted to conduct the second independent review in May 2021.
5. Ms Leon discussed her initial findings at the Oversight Group meeting on 29 June 2021 and her preliminary findings at the Oversight Group meeting on 9 August 2021.

Issues

6. The report completed by Ms Leon 'Culture in the ACT public health system: Second Annual Review' is at Attachment A.
7. The project plan outlining identified priorities developed by the Culture Review Team, and endorsed at the Culture Review Implementation Steering Group is at Attachment B.

Key Findings

a) Good foundational work has been done to establish strong frameworks for the reform of culture. This includes the Workplace Change Framework, the Organisation Culture Improvement Model, and the work the three health organisations have respectively undertaken to refresh and embed their organisational values.

b) Values need to be seen by staff to be lived at all levels. More needs to be done to establish expectations of positive workplace behaviour and to build leadership and management capability to uphold those expectations in practice. The rollout of Speaking Up For Safety in the two hospitals is a good start but will not be the only training and development that is required.

c) Formal changes have been implemented to ensure clinicians are involved in strategy and governance arrangements, and to increase the information and engagement opportunities for clinicians throughout the health system. Further development of clinical leadership capability and a willingness to listen and respond to front line clinical staff will be needed to ensure that clinician engagement improves at all levels.

d) The work that has been done to establish a research strategy is a positive start but needs more focus and momentum. The approach to research needs to be based in open and positive relationships between the health services and the universities, with genuine opportunity for clinicians to engage in research.

e) There is an opportunity and a need for improved collaboration and coordination across the health system, including between the Health Directorate and the health services, between the ACT and NSW health systems, and between health services and health consumers.

f) System-wide measures of performance, on both strategy and culture, should be developed and adopted for transparent reporting of progress.

8. A summary of key findings against each recommendation is at Attachment C.

Sustainability

9. The Review highlights the need for culture reform to transition from the implementation of the 20 recommendations of the Culture Review, to an embedded part of normal business by end of financial year.

10. The Review recommended that remaining work on Culture Review recommendations is consolidated and prioritised for action. Priorities for action were discussed at the Steering Group at the meeting of 6 October 2021 (Attachment C). This action plan forms the initial phase of transitioning culture reform into core business.

11. In transitioning to core business, the Review recommends that the following issues are considered:

    a. Unless the three organisations commit ongoing resourcing, Culture Review Implementation (CRI) Team monitoring and support for specific programs of work will need to be reduced, and work will need to be absorbed by the three organisations as business as usual. The Review notes that it would be highly desirable to maintain at least a small level of central oversight and support following the end of the project funding.

    b. Key outcomes of the Culture Review that remain to be fulfilled or are ongoing should be anchored in strategic plans and business plans, ensuring clear accountability for achieving expected outcomes.

    c. All three organisations must ensure the strategies they adopt and actions they commit to are being effectively communicated and implemented to the front line.

    d. Achieving an effective and well-coordinated health system will require greater collaboration between the three health organisations, both on matters identified by the Culture Review such as system-wide measures of success and clinical co-ordination, and more broadly on health system performance.

    e. The Review would encourage consideration of whether future governance models could fold culture into broader collaboration on health system performance and coordination.

<u>Governance</u>

12. The Review highlighted the following key issues relating to governance for the culture reform program:

    a. There has been tension between the roles of Oversight Group members as representatives of a particular sector or group, and their roles as contributors to a collegiate process of change.

    b. Structural issues, such as the funding arrangements for Calvary PHB and the divide of responsibilities between the Health Directorate and Canberra Health Services, have sometimes impacted the necessary spirit of collegiality.

    c. The recent establishment of Working Groups under the Oversight Group to progress particular issues is a positive step, but there needs to be ongoing willingness of Oversight Group members and their organisations to put in time and effort to make these Working Groups effective.

13. The Review recommends the following changes to governance to ensure continued progress and sustainability of culture reform across the health system:

    a. The Review encourages the Oversight Group to review its operations and agenda to ensure that it is focussed on the key drivers of workplace culture change.

    b. The roles and responsibilities of the Oversight Group and the Steering Group, and the communication lines between them, should be further clarified.

    c. The Oversight Group should operate in a similar mode to a Board, with responsibility for strategic guidance.

d. The Implementation Steering Group should, as a minimum, have responsibility to work together to progress action and outcomes on particular issues that the Oversight Group identifies as needing action or resolution between the three health organisations.

e. The Steering Group should share information and learning between the three health organisations on what is working well or not and identify opportunities for more strategic partnership work.

f. There needs to be greater clarity and agreement between the three health organisations as to the matters that require a system-wide approach, such as the identification and monitoring of health system data and overall commitments to the key aspects of workplace culture improvement, and the matters on which details can vary to reflect the different functions and nature of the three organisations.

Benefits/Sensitivities

14. The Review is of interest to the health sector and the ACT and surrounding community more broadly.

Recommendation

That the Oversight Group:

- *Note the findings of the second annual review of the implementation of the Culture Review.*
- *Discuss priorities for action for the remaining months of the Culture Review Implementation.*

Culture in the ACT public health system: Second Annual Review

November
2021

Renée Leon, Leon Advisory

Contents

Executive summary

A positive workplace culture is a key driver of organisational success and performance. Over many years, there have been concerns that the public health system in the ACT suffers from a poor workplace culture, including high levels of bullying and other inappropriate workplace behaviour and concerns that the resulting climate posed risks to workforce capability and clinical care. Although these problems are not unique to the ACT health system, the ACT experiences additional pressures that arise from its small size and relative isolation from a broader range of peers and clinical settings, compared to most State health systems.

In 2019, based on an independent review into workplace culture, the leaders of the ACT public health system committed to wide-ranging action to address the culture problems in the system. Despite the significant impacts of the COVID-19 public health crisis, they have continued to engage with that commitment and to deliver programs and initiatives aimed at culture reform.

Good foundational work has been done to address the recommendations of the 2019 review. All three health system organisations have given greater focus and meaning to their organisational values and have embedded these values into strategic documents and staff training. Training programs have been rolled out that encourage staff to speak up about issues of concern. Procedures for handling complaints and addressing poor behaviour have been reviewed and some improvements have been made. Structures and processes have been established that provide greater opportunity and expectation for clinicians to be actively involved in management and governance decisions in the health services.

These are all very worthwhile steps that have taken considerable effort and resources to achieve across a busy health system and in especially challenging times. The three health organisations are to be commended for sustaining the effort to develop and implement these initiatives.

While these initiatives have had some positive effects on the experience of staff in the health system, there needs to be much greater effort on the aspects that will have the most impact. In particular, there needs to be greater investment in setting expectations of positive workplace behaviour, building the capability of leaders and managers at all levels to exemplify and facilitate that behaviour in their teams, and ensuring that positive behaviour is rewarded while poor behaviour is firmly addressed. Providing staff with clear and consistent communication about the importance of a positive workplace culture and the work underway to embed that culture will also be important.

The ACT is a small jurisdiction, with a limited range of public hospitals and health services. To attract and retain the experienced and talented clinical staff needed to deliver high quality health services, the ACT must have a public health system with a strong reputation for professional opportunity, evidence-based care, and a positive culture. Initial efforts have been made to establish a closer relationship with academia in order to foster opportunities for professional growth and to build a culture that values clinical research and innovation. However, these steps have been limited to date and more needs to be done.

There is the need and the opportunity for greater collaboration and coordination across the public health system, including with health consumers and their representative organisations.

Structures such as the NGO leadership group have been established that provide a good platform for a more engaged relationship with health consumers; that relationship should be fostered in practice at all levels.

The forums and engagement that have been established between the three health system organisations to respond to the issues of culture provide an opportunity for ongoing engagement between them on health system performance, of which culture is an important but not the only element.

Finally, the ACT health system needs to have clear goals and metrics of success. These need to be established on a system-wide basis, to measure and report transparently on the progress towards a successful health service, reflecting key elements of both strategy and culture.

Key findings

1. Good foundational work has been done to establish strong frameworks for the reform of culture. This includes the Workplace Culture Framework, the Organisation Culture Improvement Model, and the work the three health organisations have respectively undertaken to refresh and embed their organisational values.

2. Values need to be seen by staff to be lived at all levels. More needs to be done to establish expectations of positive workplace behaviour and to build leadership and management capability to uphold those expectations in practice. The rollout of Speaking Up For Safety in the two hospitals is a good start but will not be the only training and development that is required.

3. Formal changes have been implemented to ensure clinicians are involved in strategy and governance arrangements, and to increase the information and engagement opportunities for clinicians throughout the health system. Further development of clinical leadership capability and a willingness to listen and respond to front line clinical staff will be needed to ensure that clinician engagement improves at all levels.

4. The work that has been done to establish a research strategy is a positive start but needs more focus and momentum. The approach to research needs to be based in open and positive relationships between the health services and the universities, with genuine opportunity for clinicians to engage in research.

5. There is an opportunity and a need for improved collaboration and coordination across the health system, including between the Health Directorate and the health services, between the ACT and NSW health systems, and between health services and health consumers.

6. System-wide measures of performance, on both strategy and culture, should be developed and adopted for transparent reporting of progress.

Introduction

In March 2019, the *Independent Review into the Workplace Culture within ACT Public Health Services*, commissioned by the ACT Minister for Health in September 2018, provided its final report ('the Culture Review'). The Culture Review found a 'worrying and pervasive poor culture across the ACT Public Health system' and made a series of recommendations directed at creating a happier and healthier health service. One of those recommendations was that there be an annual independent and external review of the extent of implementation of the recommendations and the consequent impact on cultural changes with the ACT Public Health system. This Review is the second such annual review, and commenced in May 2021.

Terms of reference

The scope and focus of this annual review was to examine and make findings and recommendations in relation to the following:

a) Changes or amendments to the recommendations of the Culture Review of a not insubstantial nature and the reasons for making such changes or amendments
b) The extent of the progress made with the culture review implementation process against the original plans outlined in the Report
c) The impact on the workforce culture from the changes introduced to date
d) The effectiveness of the initiation and planning phase of the culture review implementation process, given that the focus is now in implementation phase, including:
    i. What has worked well and why, and has there been any early impact?
    ii. What has not worked well and why, and has there been any impact?
    iii. What may therefore need to change or be improved?
e) What has been learned so far and how can these insights and experiences be leveraged to improve the process and outcomes/impact of the culture review implementation process?

Methodology

The Review considered a wide range of data and information provided by the ACT Health Directorate ('the Health Directorate'), Canberra Health Services ('CHS'), and Calvary Public Hospital Bruce ('Calvary PHB'). These will be referred to collectively in this report as 'the three health organisations'. The Review interviewed staff and stakeholders across the public health system, including senior management, heads of people and culture units, representatives of clinical and administrative workforces, stakeholders in the broader clinical and academic community, health consumer and other non-government organisations, and staff from all three health system organisations. A list of those interviewed is at Appendix A.

The Review is grateful to the three health organisations for their extensive engagement with the Review and to the many staff and stakeholders who gave the Review their valuable time and insights. The Review was ably supported by secretariat staff seconded from the Health Directorate, who worked tirelessly to distil key information from the substantial quantity of documents provided to the Review.

Context

As the Culture Review noted, poor culture has been a problem across the ACT public health system for many years, and has been the subject of earlier reports and reviews. The Culture Review, and the high level commitments made to implement its findings that were made by Ministers, the three health organisations and key stakeholders, have been seen as a significant opportunity to change this history and move the health system to a positive workplace culture that supports high quality care.

Implementation was launched in mid 2019. The first Annual Review, which reported in May 2020, found that early progress on implementation had been good, but that it was too soon to form a view as to whether the actions underway were significantly improving workplace culture. The first Annual Review encouraged a greater focus on the recommendations requiring inter-agency action, and ongoing attention to whether the work underway was achieving the intent of the Culture Review's recommendations.

The first Annual Review noted the impact of the 2019-20 bushfire crisis and the COVID-19 pandemic on implementation of the Culture Review recommendations. The demands of COVID-19 have continued to have considerable impact on the resources and focus of the public health system, including pressure on elective surgery, increased demand for mental health services, and workforce surge required for the additional demands of COVID-19 testing and vaccination. The stability of implementation of the Culture Review recommendations has also been affected to an extent by changes in senior leadership in the three health organisations over recent years.

The Review recognises these challenges and appreciates that the health system has multiple significant demands upon it, including responding to increasing community demand, managing an unprecedented public health crisis, and implementing an ambitious agenda of change and growth across the public health system. Nevertheless, it is important that the three health organisations do not succumb to the idea that culture reform is in some way a secondary matter that can be addressed once more pressing matters have been resolved. Rather, establishing and ensuring a positive workplace culture will greatly support the health system in achieving success across all its many demands.

Foundations

A number of foundational pieces of work have been undertaken that support implementation across the recommendations of the Culture Review. These are set out here, and will be referred to at various points specific to individual recommendations.

Culture Review support and governance

A Culture Review Implementation Branch ('the Culture Review Branch') was established in the Health Directorate from April 2019 to lead the planning and support the implementation of the recommendations of the Independent Review. The Branch has had between 3 and 4 staff reporting to a Branch Manager over the past two years.

The Culture Review Branch has had the following functions:

- Strategic advice
- Working with each organisation to ensure a collaborative and collegiate approach to implementing, monitoring, and reporting on the recommendations of the Culture Review
- Establishing the program methodology and ongoing program management, including risk management and mitigation
- System-wide communications, including development and delivery of a communications strategy and action plans
- Project management for system-wide initiatives, including procurement, contract management and project implementation[1]
- Development of the Organisation Culture Improvement Model (OCIM) and assessment tool (see below)
- Foundational work to develop an evaluation strategy and dashboards for monitoring progress, impact, and effectiveness
- Support for the three health organisations to develop organisation-specific workforce dashboards.
- Secretariat for:
  - Culture Reform Oversight Group[2]
  - Culture Review Steering Group[3]
  - Three sub-committees of the Oversight Group (working groups)
  - Workforce Data Working Group

1 This included procurement and project management for the ANU research, co-development of the Workplace Culture Framework, the HR functions review, the Training Analysis, annual reviews and Management and Leadership training programs. These are all described in the relevant sections of this report.

2 See recommendation 18

3 See recommendation 18

- Management Foundations Project Working Group
- Respect Equity Diversity Working Group
- Oversight and management of budget and associated governance
- Coordination and drafting of Biannual Update and other government matters related to culture reform, and

- Ongoing engagement with Ministers and stakeholders.

In 2019, the ACT Government provided $12M in funding over 3 years for the implementation of the Culture Review. This funding was initially provided to ACT Health Directorate and was intended to be allocated to projects that were aligned with achieving Culture Review outcomes, to be determined by the Steering Group (comprising senior management of the three health organisations). However, after the first year, funding was allocated to system-wide initiatives including development of management and leadership programs, the remaining funding divided proportionately between the three health organisations to deliver culture reform activities as they saw fit, with quarterly reporting on expenditure to the Steering Group.

Workplace Culture Framework

To provide an evidence-based framework for improving workplace culture in response to the Culture Review, the Culture Review Branch commissioned the ANU to develop a system-wide Workplace Culture Framework.

The report, *ACT Public Health System, Investing in our people: A system-wide evidence-based approach to workplace change*, was delivered by the ANU in May 2020. It presented findings from an extensive survey of established scientific research and additional exploratory research involving interviews, workshops, and an online questionnaire of stakeholders from across the health system. The ANU report presented a Workplace Culture Framework to support the implementation of the Culture Review recommendations relating to organisation behaviour, workforce and leadership.

The Workplace Culture Framework identified five workplace change priorities for the health system:

1. Organisational trust – We need to improve the trust in our organisations, and decisions must be fairly and transparently made and applied.
2. Leadership and People Skills – We need to build our people skills at work, as well as investing in specific people management and leadership training to support us all.
3. Workplace Civility – We need more inclusive workplaces with respectful interactions between each other.
4. Psychological Safety – We need to be able to raise concerns and suggest new ideas in open, supportive, safe, and accepting work environments.
5. Team Effectiveness – We need more clarity in our roles and to develop our skills to do our jobs effectively. We need to ensure that workloads are more balanced within teams.

The key elements of the Workplace Change Framework recommended were to:

- Establish expectations across the system
- Build knowledge through education
- Develop people and leadership skills
- Track and measure outcomes

Necessary implementation drivers identified by the Workplace Culture Framework were:

- The three health organisations CEOs support a strategic and system wide approach and measurement of progress
- Organisation values, policies and procedures support and align with the workplace change priorities
- Leaders model expected behaviours and skills
- Knowledge and skill development follow evidence-based principles of training, and
- The workforce attends training and is supported by leaders to do so.

Organisation Culture Improvement Model

The three health organisations adopted an Organisation Culture Improvement Model (OCIM) designed to assess progress against the five identified priorities from the Workplace Culture Framework. The OCIM outlines the actions and elements that each organisation needs to develop to progress organisational maturity across each of the five workplace change priority areas: organisational trust, leadership and people skills, workplace civility, psychological safety, and team effectiveness. A four-level scale is used to assess the maturity of the organisation.

All three organisations assessed their maturity status in 2020, and retrospectively assessed it as at 2019. The three organisations assessed their maturity overall as having been in the first (lowest) level in 2019, and moving close to the second level on most scores in 2020.[4]

4 The full assessment scores against each priority area are set out at Appendix B

Implementation of the culture review recommendations

The Review was tasked with reporting on the extent of progress made with culture review implementation against the original plans outlined in the Culture Review, and the impact on the workforce culture from the changes introduced to date. This Part analyses actions taken and outcomes produced against each recommendation of the Culture Review.

Values

Recommendation 1

That the three arms of the ACT Public Health System should commence a comprehensive process to re-engage with staff in ensuring the vision and values are lived, embraced at all levels, integrated with strategy, and constantly reflected in leadership. To achieve this the Health Directorate should take the lead in providing the necessary tools and guidelines and coordinate the implementation by Canberra Health Services, Calvary Public Hospital, and the Health Directorate.

The Culture Review noted that how the values of an organisation are understood and adopted broadly by the entire workforce is key to strengthening the organisation's culture.[5] The review found that there was a discrepancy between the stated and lived values of each of the three organisations in the health system and that this must be addressed.

This recommendation has not been substantively changed or amended since the Culture Review. However, in practice, the recommendation was implemented by the three health organisations separately, rather than in a coordinated process as envisaged by the recommendation.

All three health organisations have engaged positively in affirming and promulgating the values that underpin quality health care and organisational effectiveness.

The Health Directorate implemented the ACT Public Service values of Respect, Integrity, Collaboration, and Innovation. An extensive consultation process was undertaken with staff to define the behaviours that represent the values and these have been embedded in corporate documents, posters, and other departmental products. Annual Director-General Awards have been established that are aligned with the values, and staff are recognised for making an outstanding contribution. Other initiatives implemented to reinforce the values include the 'Care to Share' and 'Team Spotlight' series, published on the internal Culture Review Implementation site, to recognise colleagues or teams that are living the values.

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The Directorate has included training about capabilities and values in its recruitment and selection training.

Canberra Health Services also involved staff in a consultation process, which included conversation starters and workshops to define the organisation's values of Reliable, Progressive, Respectful and Kind. Individuals and teams who consistently exemplify the Values can be recognised within their divisions and branches, with an emphasis on celebrating a different value during each quarter of the year. The annual CEO Awards ceremony celebrates individuals and teams who exemplify the vision and values through their work. The behaviours that demonstrate the values have been expressed in the FOCIS-SED material produced by CHS to make explicit the expected behaviour.

Canberra Health Services revised its performance planning template, so that employees now articulate goals specifically related to organisational values. Job descriptions and duty statements all incorporate the demonstration of CHS values, and applicants must address the demonstration of organisational values in the selection process. The importance of selecting prospective employees on the basis of their demonstration, understanding and application of values-led behaviours is a core component of CHS' selection panel training program, with strong messages on the importance of selecting prospective employees, not only on the basis of their technical proficiency, but also their behaviours.

The Medical and Dental Appointments Advisory Committee has recently introduced the assessment of values-led behaviours as an integral component of all recruitment drives. Applicants are assessed against the demonstration of values-led behaviours, in addition to clinical competence.

Calvary PHB has developed a Values in Action Framework (VIAF) which has been mapped to the mission, vision, values, and behaviours to ensure that the organisation has the culture, workplace capability and agility to deliver healthcare in an ever-changing environment. The VIAF is to be applied in decisions on recruitment, performance, development, and succession. The values of Hospitality, Healing, Stewardship and Respect have been embedded in the Performance Development Planning process and the Mary Potter Awards, which celebrate staff who are exemplars of the Spirit of Calvary PHB and are aligned to the organisation's values. All staff are being trained in the Values in Action (70% completed to date).

The First Annual Review found that the focus on vision and values was a positive start, while recognising that a focus on values does not necessarily result in improved behaviours in the workplace.[6] The Recommendation of the Culture Review was not only that values should be adopted, but that the leadership of the three organisations should ensure the vision and values were lived and embraced at all levels.

The best way to ascertain the extent to which the vision and values are lived at all levels will be through the results of staff surveys that enable staff to provide direct feedback on their experience. All three organisations are conducting staff surveys in 2021. For both the Health Directorate and Canberra Health Services, these will be detailed surveys that will include questions that address the extent to which staff see the values are lived and which can be analysed for the experience of staff in different areas and by job family. For Calvary PHB, the

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survey is conducted at a national level by Calvary as an organisation-wide engagement survey of employee engagement. The survey does not ask staff whether they experience the values of the organisation being practiced in the workplace. However, staff are asked whether they know what is expected of them at work, and managers are encouraged, when discussing the staff survey, to include the expectation that all staff should behave in accordance with the values.

As this Review was commissioned to report before the results of the 2021 staff surveys are available, it is not straightforward to form a view as to the extent to which staff feel that the values are lived as sought by this recommendation of the Culture Review. Pulse Surveys conducted by Canberra Health Services on a quarterly basis provide insight into CHS employee engagement and ask some questions relevant to the values. Further insights have been provided by staff who were consulted in focus groups across all three organisations, and by stakeholders who represent various clinical sectors in the workforce.

Staff surveys

In November 2019, the Health Directorate and Canberra Health Services conducted their biennial employee survey which created a snapshot of the workplace culture and to set a benchmark for tracking workplace culture improvements. The 2019 surveys generally paint a picture of a less than engaged workforce. In the Health Directorate, overall engagement was at 42%, although this was higher than the benchmark for other ACT Directorates at the time; but only 22% said they would recommend the Directorate as a good place to work. On the other hand, staff rated the Directorate more highly on feeling valued and being treated with respect. In Canberra Health Services, engagement was at 40%, which, while lower than other State health services, was a continued improvement from earlier years (it had been at 34% a decade earlier). Not quite 30% of staff said they would recommend CHS as a good place to work. Calvary PHB conducted an employee engagement survey in August 2020. This survey used a different methodology. Staff were asked 12 standard questions that measure employee engagement; the scores indicated overall results in the lower quartiles of benchmarks for comparable organisations. In addition, staff were asked some Calvary-specific questions, including on patient care and staff ability to speak up about safety or conduct.

Canberra Health Services has conducted follow-up Pulse Surveys since November 2020. The Health Directorate advised that it intends to initiate pulse surveys from November 2021. For both organisations, this is a commendable approach that enables regular monitoring of and response to employee experiences and concerns.

The CHS Pulse Surveys measure staff engagement, plus two Net Promotor questions and one client/patient care question. They are designed to be a 'temperature check' of employee experience and satisfaction. Although the Pulse Surveys do not expressly ask questions as to whether staff agree that the values guide decisions and practices in the workplace, there are questions that assess views on CHS achieving its vision ('there is a strong sense of purpose and direction') and the CHS value of respect ('there is a climate of 'Trust and Respect' throughout the organisation). In the most recent Pulse Survey (June 2021), there had been a 2-point decline since March 2021, and a 4-point decline since the 2020 Survey, in ratings of agreement that there is a strong sense of purpose and direction; there had been no improvement in ratings of agreement that there is a climate of trust and

respect (31%). On most measures of engagement, the scores have been declining since the 2019 survey, with many of the ratings of engagement being scored positively by only about a third of the respondents; scores amongst medical officers are even lower. The proportion of staff who would recommend CHS as a good place to work has also declined. While CHS will await the full 2021 Workplace Culture Survey, these scores would suggest that staff are not seeing positive indications of the culture improving, which likely also indicates that staff do not feel strongly that the values are being lived.

The detailed survey data available to Canberra Health Services and that will be available to the Health Directorate, broken down by organisational units and comparable to data from previous surveys, enables proper attention to be paid to areas of concern and learnings to be generated from areas showing improvement. While the ACT Health Directorate will be using a slightly different set of questions as part of the ACTPS survey, it is expected that tracking of progress will be able to be achieved via analysis of responses to comparable questions. The survey approach taken by Calvary is somewhat more limited, surveying on a small number of questions primarily relating to employee engagement. Calvary PHB may need to consider whether this instrument is giving management adequate granular data and insights into key issues of potential concern for staff, and whether it is able to illuminate matters of concern to particular job families, such as medical officers or nurses.

Good data on organisational culture depends on high response rates to staff surveys. Staff participation in surveys is likely to be higher if staff feel confident that management takes heed of their views and staff can see that action is taken to address issues of concern. Ensuring that results are made available to staff, staff are consulted on the priorities for action, and management regularly informs staff of progress on those priority areas will all assist in motivating participation in future surveys, as well as more broadly increasing overall trust in management.

Given the importance of staff survey data to assessing the impact on organisational culture, the Review recommends that analysis of the 2021 staff survey results for all three health organisations be reviewed carefully by the Oversight Group when considering the ongoing implementation of the Culture Review and the findings of this Review. There should be an ambitious approach to the levels of employee engagement and culture improvement seen in the staff surveys. The survey tool that has been used by both Canberra Health Services and, in the past, the Health Directorate provides benchmark data from comparable health and public sector organisations, which show average engagement across those sectors. Similarly the survey tool used by Calvary PHB benchmarks results against a global database of other organisations. The Review would encourage the three organisations not to be content with only matching benchmark averages, which sit at a fairly uninspiring level of around 40-45%. High performing organisations with cultures of ambition and success score much more highly on employee engagement, in the range of 60% and over. The public health system should be aiming for a strongly engaged workforce with positive attitudes to change and pride in their workplace.

Staff and stakeholders

Interviews with staff and stakeholders showed there was broad knowledge and awareness of the values by staff in all three organisations. Staff welcomed the greater focus on values but conveyed mixed views as to whether values are being lived in their organisations. Some did reflect that behaviour consistent with the values had become more evident, but many continued to express dissatisfaction with poor behaviours that were seen as inconsistent with stated values, such as verbal abuse, reprisals for unwelcome feedback, workplace incivility, and lack of respect. Staff felt particularly aggrieved where they saw colleagues or managers acting inconsistently with the values but not being held accountable, or even being promoted notwithstanding the behaviour. Given that both Canberra Health Services and Calvary PHB have explicitly stated that behaviour alignment with the values will be part of performance and promotion decisions, it will be important that this commitment is being seen in practice.

> *"Mostly everyone does [live the values]. There is a small percentage that don't but unfortunately this over-shadows the ones that do"*
>
> *"In my area, I see people demonstrate commitment to living the values, however at times I don't see the values being lived between departments"*
>
> *"some people behave without honesty and integrity – they talk the talk but not walk the walk"*
>
> *"We are all aware of the values in my team, it's drilled in"*
>
> *"we aren't treated with respect"*
>
> *"the messaging coming through from the CEO on values is good"*
>
> *"there has been good work done but there's a mismatch between espoused and lived values"*

Conclusions

The three organisations have done good work in explicating and promulgating organisational values. It is particularly welcome that values expectations are built into performance management and selection processes; to be effective, it will be necessary that decisions in these contexts place meaningful weight on whether behaviour is consistent with the values. Some improvements are being anecdotally reported in the extent to which the values are lived, but staff have also expressed concerns that values-aligned behaviour is not consistently expected or demonstrated. Close consideration should be given to expected 2021 staff survey information, and real focus given to what needs to be done if staff are not positive on the values being lived. It will be important to ensure that staff see a level of effort and commitment to living the values, commensurate with the effort that went into developing and promoting them.

Measuring organisational effectiveness

Recommendation 2

That Canberra Health Services and Calvary Public Hospital in conjunction with the Health Directorate, develop an appropriate suite of measures that:

- Reflect on elements of a great health service – both culture and strategy
- Monitor patient/client perspectives of outcomes/experience, and
- Engage clinicians in their development.

The Culture Review emphasised that organisational effectiveness is the combined impact of culture and strategy. The Review concluded that appropriate measurement and monitoring of performance is a necessary element of demonstrating ongoing and durable change in culture and building a great health service. Particular areas of concern noted in the Culture Review were the lack of appropriate measures for outcomes that matter to patients and communities, inadequate engagement of clinicians in developing such measures, the need for measures that monitor quality and timeliness of clinical interventions as well as measures of patient experience more broadly, and inadequate attention on measures of staff well-being and development.

While no formal decision has been taken to change or amend this recommendation, it is apparent that the approach taken to its implementation has departed from the original recommendation.

The focus of the original recommendation was on the development of a system-wide suite of measures of health system performance, including patient satisfaction as well as culture change. In practice, the only measures developed or monitored by the three organisations in relation to this recommendation have been measures of culture change.

Although work was undertaken by the Health Directorate in 2020 to propose an approach to measure the effectiveness of improvement initiatives on culture and strategy, the three organisations were unable to agree on shared approaches or system-wide measures. Some measures of organisational culture tracking have been agreed, primarily the annual assessment under the OCIM and the regular staff surveys. No system-wide dashboard has been adopted and the three organisations have opted not to apply consistent staff survey approaches and not to explicitly survey staff with questions based on the priorities from the Workplace Culture Framework.

The Review was advised that work is to resume on developing consistent key indicators to measure the impact of interventions on workforce effectiveness across the system, with the establishment of a Workforce Data Working Group to commence from October 2021.

The Review was also advised that reporting mechanisms have been established within both CHS and Calvary PHB to collect patient feedback. CHS advised that it measures performance

against its strategic priorities, including dashboards on Safety and Quality. CHS adopted the Partnering with Consumers Framework in October 2020, which describes how CHS develops, implements, and maintains its systems to partner with consumers and their carers.

The framework identifies the following measures:

- Consumer feedback monitoring
- Patient survey
- Patient story
- Timely care measures.

The Review was not provided with any information on how the consumer feedback data is being used or whether any assessment of the measures has been undertaken to date.

CHS also advised that its 2021 Workplace Culture Survey will measure Safety & Quality, which are elements of the CHS Exceptional Care Framework, in the Client Engagement section of the survey.

Calvary PHB advised the Review that a Partnering with Consumers Committee (PCC) has been developed in early 2021 as part of Calvary PHB's Clinical Governance to ensure that feedback is collected from consumers and is shared with the relevant functions in the hospital. This process does not appear to include any measures that would monitor trends over time or analyse data from consumer feedback. As mentioned above, Calvary staff surveys also include questions on staff perception of support for patient care.

It is a positive first step that both Canberra Health Services and Calvary PHB have commenced systems to collect patient feedback and/or to measure staff perceptions of quality care. This, together with the work on improving workforce data as outlined above, will be important contributions to the development of system-wide measures of performance of the public health system.

The Review considers that work should be re-invigorated to develop and implement agreed system-wide measures of performance of the health system that would give valuable performance data to clinicians and administrators for continuous improvement and that would enable the Minister to provide the Canberra community with meaningful information on the performance of the public health system.

Conclusions

The Health Directorate, Canberra Health Services and Calvary PHB should work together, drawing on the input and involvement of clinicians and on experience and systems in other jurisdictions, to develop a suite of measures that reflect on key elements of a successful health service – both culture and strategy – and that measure health system performance, patient outcomes and experience, and staff well-being and development. The elements of the Organisation Culture Improvement Model, which all three organisations have adopted, will be useful components for the measurement of culture, as well as measurement of staff experience via well-focussed staff surveys. Work needs to be done to identity and agree key measures for measurement of health system strategy and performance.

Addressing bullying and harassment

Recommendation 3

That a program designed to promote a healthier culture to reduce inappropriate workplace behaviour and bullying and harassment be implemented across the ACT public health system. The model adopted should be based on the Vanderbilt University Medical Centre Patient Advocacy Reporting System (PARS) and Co-worker Observation Reporting System (CORS).

The Culture Review found that bullying and harassment was raised as a significant concern by staff in surveys and by stakeholders in multiple submissions to the Review. While noting the difficulty of making exact comparisons, the Culture Review found that bullying and harassment were experienced in the ACT health system at higher levels than in the NSW health system, and that ACT health staff had less confidence than NSW comparators in how their organisation resolves complaints and grievances.

This recommendation has not been substantively changed or amended since the Culture Review.

Speaking Up For Safety

The Review recommended the introduction of a Vanderbilt-style reporting system for unprofessional behaviour. The system is based on an early intervention model in which a staff member receives feedback and coaching to modify their behaviour, with a graduated escalation process into more formal interventions and disciplinary responses. The intent is that the majority of cases of inappropriate behaviour are addressed at the local level and in ways that lead to changed behaviour, with improved outcomes for patients and staff.

Both Canberra Health Services and Calvary PHB have adopted the Cognitive Institute's Speaking up for Safety (SUFS) program, which is based on the Vanderbilt model and was one of the programs suggested by the Culture Review. This program aims to provide staff with skills and confidence to speak up respectfully and effectively about safety issues to prevent unintended patient harm. Building on this is the next level program, Promoting Professional Accountability (PPA), which is designed to identify, engage, and hold accountable staff who demonstrate repeated unprofessional behaviour. Canberra Health Services has committed to delivering the PPA program from April 2022; Calvary PHB is intending to rollout the PPA program from the last quarter of 2021.

These programs are designed to be delivered through a train-the-trainer model, with staff representatives from a range of disciplines across both CHS and Calvary PHB having already completed accredited training, giving both organisations the capability to deliver SUFS seminars to all staff. The Cognitive Institute recommends that SUFS training is delivered to 80% of staff in the first 12 months to ensure a culture shift and to lay the foundations for implementing the professional accountability layer. Launched by Calvary PHB in March 2020 and CHS in February 2021, training has been delivered to 74% of Calvary PHB staff and 40%

(3300) of CHS staff so far; CHS has advised that all remaining staff will be trained over coming months.

Participant feedback from the SUFS training workshops has been generally positive, with high proportions of staff (88% - 96%) from both CHS and Calvary PHB agreeing that the knowledge and skills provided by the training had increased their confidence to speak up about safety concerns, and indicating that they plan to speak up when they observe behaviour that may compromise safety.

When asked what the most positive aspects of the training were, staff responded:

> *"empowering staff to use the Safety CODE to assist them to escalate situations in a respectful and effective manner"*
>
> *"becoming aware that I have permission to speak out regardless of who to. I now realise I'm equally responsible for injury if I don't speak out"*
>
> *"empowering staff at all levels to act if they feel unease"*
>
> *"awareness of how speaking up can potentially save lives"*
>
> *"as a new nurse it was comforting to know that it's okay to check and be checked by my colleagues…and to learn ways I can speak up"*
>
> *"gives us all a voice and permission to speak up about our safety concerns"*
>
> *"I really liked the promotion that 'someone has got your back'. We are in this together and want to get it right"*

It will be important for both CHS and Calvary PHB to ensure that the SUFS training makes clear that the 'speaking up' approach applies, not only to clinical behaviour and decisions, but also to interpersonal behaviour such as incivility and bullying, which also risk patient safety due to their impact on team behaviour and workplace engagement.

The implementation of the Promoting Professional Accountability program is essential to back up the training on speaking up. Training staff to speak up will not be effective if staff experience inappropriate responses when they do speak up or observe that there is a lack of accountability for inappropriate behaviour even when it is identified.

With regards to the Health Directorate, it was determined through consultation with the Cognitive Institute that, as SUFS is primarily a clinician-focussed program, it was not appropriate for the Directorate. Nevertheless, there was discussion and agreement in the Directorate to pursue other measures to encouraging a speaking up culture about inappropriate workplace behaviour. This will include: education and setting expectations, embedding values and behaviours, reinvigorating the network of contact officers for Respect, Equity and Diversity (REDCO), investing in manager and leader training, 'bystander' education, and ensuring robust communication and messaging to the workforce. Some progress has been made to develop and invest in some of the elements, however, this approach is at an early stage.

Handling of complaints

Although the explicit recommendation of the Culture Review – to implement a Vanderbilt - style model – is being implemented, it is necessary to recall that the purpose of the recommendation was to "reduce inappropriate workplace behaviour and bullying and harassment". Other work has also been underway to address the intent of the recommendation more broadly.

Foundational work was undertaken across the health system in late 2019 and early 2020 to understand current processes within each organisation for managing workforce complaints and grievances, and to identify gaps and opportunities for improvement. Actions taken have included:

- Canberra Health Services — improving information for staff on the complaints process, making process improvements, refreshing and upskilling REDCO, increasing support for people who lodge a complaint, providing training for leaders in having early conversations to de-escalate conflicts, providing feedback and counselling to staff about whom complaints have been made, and using complaint numbers and other data to identify problem areas for proactive attention.
- Calvary PHB —the REDCO network has been refreshed and training has been provided. Information is soon to be provided to staff to uplift staff awareness of the REDCO network and complaints process. Various actions are underway to improve the complaints process and to provide better support to staff.
- Health Directorate— in the process of identifying priorities for action for both REDCO and complaints and grievances. Initial information was provided to staff about REDCO, however there is acknowledgement that additional engagement is required. Quarterly meetings are undertaken with REDCOs to invest in training to build knowledge and skills to respond as matters arise.

Extent of bullying and inappropriate workplace behaviour

The data on complaints in the Health Directorate does not indicate any substantial change in complaints, with low numbers of formal complaints across the past two years. The data from CHS shows an increase in complaints in 2020-21; however CHS considers this could be as a result of greater staff awareness of their right to complain about inappropriate behaviour and greater confidence in the procedures for raising concerns about bullying. The data from Calvary PHB show a 33% drop in complaints from 2019-20 to 2020-21. No data was available from the three organisations to assess whether there has been any improvement in the timeliness of handling complaints of bullying, or whether staff felt more satisfied with the process or outcomes.

Good work has been done by CHS and Calvary PHB, and is underway in the Health Directorate, to improve the processes for handling complaints of bullying, to raise staff awareness, and to provide support. More could be done to better understand staff experience of the complaints process. The HR dashboards provided to the Review indicated workload on hand for the HR teams in handling bullying and harassment, but did not include

information or analysis on trends, and no information on the timeframes for managing these complaints or on the extent to which complainants felt that the process had addressed their concerns. These issues are at the heart of the concerns by staff considered in the Culture Review: that complaints were not handled well, that processes took too long, and that outcomes did not address the problem.

Canberra Health Services advised of a number of specific instances in the past year where action has been taken in relation to complaints of poor behaviour, including clinical staff and in senior positions. These actions have included counselling, warnings, performance requirements, demotions, and terminations. It is encouraging to see that action is being taken in some cases. To impact on the pervasive concerns of staff that bullying and other poor behaviour persist, it will be necessary for all three health organisations to take a consistent and determined approach to requiring better behaviour and sanctioning poor behaviour.

Staff and stakeholders interviewed by this Review continued to express significant concern about both the occurrence of inappropriate workplace behaviour and the response to complaints. There were some positive views that bullying had decreased in places.

> *"The amount of bullying has decreased"*
>
> *"There has been improvement in management of bullying behaviours"*
>
> *"Going in the right direction to gain trust in employees to report on inappropriate behaviours"*
>
> *"There has been a significant shift in culture regarding bullying/poor behaviour"*

However, most staff feedback, particularly in Canberra Health Services, reflects a view that little has changed.

> *"Lots of young doctors experience bullying"*
>
> *"It is way beyond incivility in some areas"*
>
> *"Still need extensive work with clinical managers to educate on how to manage before it escalates and/or becomes accepted behaviour"*
>
> *"there is no respect for nurses – the behaviour has got worse"*
>
> *"there have been no changes in staff when there should have been, known perpetrators are still in their positions"*
>
> *"there are still some transgressors who haven't been exited"*
>
> *"everyone is afraid to complain because the complainant gets victimized"*
>
> *"there is a culture of fear"*
>
> *" even when complaints are upheld – nothing happens"*

"The low levels of confidence that incidents of bullying and harassment and underperformance would be reported and acted on is extremely concerning."

Reducing inappropriate workplace behaviour is the key deliverable for this recommendation. While improving awareness of and processes for complaint handling are helpful actions, the primary focus should be on preventing the behaviour in the first place. Formal complaints of bullying with escalation into channels for disciplinary action should be the last resort not the only tool. Formal complaint processes should be streamlined as much as possible, particularly to reduce the time taken to resolve matters, and this will be more achievable if the numbers of complaints reaching that stage are minimised by reducing the occurrence of the behaviour.

Reducing the occurrence of poor behaviour has to begin by establishing to all staff the expectations of workplace behaviour, training leaders at all levels in how to model appropriate workplace behaviour and how to respond at a local level to instances of inappropriate behaviour in their teams, and holding people to account if inappropriate behaviour continues.

Some work has commenced that seeks to address problems of inappropriate workplace behaviour. Canberra Health Services has commenced a pilot, in one clinical unit, of the program SCORE (Strengthening a Culture of Respect and Engagement), an evidence-based and award-winning civility program developed by Steople (NSW).[7] The aim of the program is to transform a poor culture of disrespect, by addressing long term issues, facilitating safe and honest discussions, and teaching new skills which will result in the cultivation of an improved workplace culture. While the pilot has not yet been fully evaluated, CHS advised that the unit where the pilot was conducted had shown considerable improvement in measures of engagement in the June 2021 Pulse survey compared to the 2019 staff survey. CHS has advised that, if the pilot program evaluation is positive, other work units will be selected to undertake SCORE based on evidence of need. The Review was not advised of any similar program underway in Calvary PHB. Implementing specific interventions to address problematic behaviour and poor culture is a good step. The Oversight Group should seek information on the outcomes of the SCORE pilot, with a view to implementation across all three health organisations if it is successful.

While endorsing the pilot of SCORE as a positive step, the Review would encourage all three health organisations to adopt a more broad-based approach to setting and reinforcing behaviour expectations for all staff, not only addressing 'hot spots' with remedial interventions. The CEOs of each organisation should ensure that the stated values of their organisation are translated into a clear set of behaviours, which are communicated clearly and consistently to all staff, modelled by leaders at all levels, and embedded in the performance expectations of all staff. Calvary PHB's Values in Action Framework is a good example of this approach. Performance feedback and promotion decisions should reinforce the expectations of appropriate workplace behaviour; failure to back up organisational statements on behaviour with action on poor behaviour will undermine staff trust that their organisation means what it says.

7 In 2019, Steople won the College of Organisational Psychologists Workplace Excellence Awards for the SCORE Program under the Organisational Development Category.

Implementing these steps does not need to be a protracted process. Good work has already been done on establishing the values, and the Workplace Culture Framework has already established the nature of the skills people will need. While strengthening the consequences of inappropriate behaviour on performance outcomes, promotions and other employment arrangements may need to be progressed in consultation with industrial representatives as required under existing arrangements, unions and professional organisations consulted for this Review expressed strong and consistent views that their members want to see change in workplace behaviour. It should be expected that they will work cooperatively with the management of the three health organisations to implement systems that produce that result, including holding people to account who do not demonstrate appropriate behaviour despite clear expectations and support to do so.

Leaders at all levels will need training and support to improve their capabilities in instilling appropriate standards for workplace behaviour in their teams. This was a key priority area in the Workplace Culture Framework that all three organisations have adopted. The Review discusses management and leadership training at Recommendation 13.

Conclusions

Canberra Health Services and Calvary PHB should continue with the rollout of Speaking Up for Safety and move as soon as possible to implement the Promoting Professional Accountability Program. The Health Directorate should institute an appropriate program to empower staff to call out inappropriate behaviour. All three organisations should set clear expectations for staff about appropriate workplace behaviour and equip managers and leaders at all levels to uphold those expectations both for themselves and in their teams. Positive workplace behaviour should be rewarded; inappropriate behaviour should have clear consequences, including in performance appraisal, selection, and promotion decisions, and in firm outcomes of disciplinary processes. For behaviour at the serious level of bullying, all three health organisations should ensure they have efficient and effective means to handle and resolve complaints and should monitor timeliness, outcomes, and participant experience.

Partnerships and relationships

The Culture Review found that there needed to be improved engagement and stronger relationships both within the public health system and with external partners:

- between the three organisations – the Health Directorate, Canberra Health Services and Calvary PHB
- between acute care and community-based health services
- between the Clinical Divisions at CHS, and
- with external bodies, including universities, NGOs, NSW Health, and consumers.

This range of relationships was the subject of a series of recommendations in the Culture Review. This section will report on the implementation of each of those recommendations. However, more broadly, it is important to keep in mind that the overall thrust of these recommendations was to instil a more engaged and less insular approach across the health system. A more open and engaged system will increase professional development and satisfaction, improve systems and knowledge within the health system, and enhance the attractiveness of the ACT health system as a destination for health professionals, all of which will conduce to improved health care for the ACT community.

Recommendation 4

The ACT Health Directorate convene a summit of senior clinicians and administrators of both Canberra Health Services and Calvary Public Hospital to map a plan of improved clinical services coordination and collaboration.

The Culture Review found that there had been tensions in the relationships between the three health organisations and a lack of coordinated planning between the two hospitals in clinical services planning and provision. The Culture Review considered there should be better coordination, more transparent systems of performance management and reporting, and greater clinician employment flexibility between the two hospitals. The Culture Review recommended that a summit of senior clinicians and administrators of CHS and Calvary PHB map a plan for improved coordination of health services and participation of clinicians across the health system.

This recommendation has not been substantively changed or amended since the Culture Review. However, in practice, there has been much more focus on questions as to whether and how to hold a summit, than on developing a plan for improved collaboration and coordination, which was the intent of the recommendation.

The plans for a summit in 2020 were derailed by the need for the health system to prepare for and respond to the COVID-19 pandemic. The response to the pandemic itself did involve greater collaboration and coordination, which could form the basis for a more systemic approach to improved coordination going forward. While efforts to progress this have been limited, more action has been developing in recent months.

A networking event was held in February 2021, attended by the two Health Ministers and senior executives and clinicians from the three health system organisations. The event provided an opportunity for senior clinicians and executives to discuss future coordination and co-operation between Canberra Health Services and Calvary PHB, and lay the foundations for future collaboration.

Topics discussed include clinical service coordination and collaboration between CHS and Calvary PHB, and learnings from the COVID-19 experience. Overall, the group concluded that, while clinicians work together well on a personal and clinical level, more should be done to formalise clinical networks for specified areas of practice, and to identify and collaborate on some specific cross-territory initiatives.

The efforts by clinicians to work together on some specific initiatives and to form ongoing networks are pleasing. The Review would encourage a focus on developing ongoing systems for collaboration, rather than on a one-off summit. These could include:

- regular formal meetings between the two hospitals to resolve specific identified issues and improve cross-Territory communication
- regular informal networking events, and
- formal clinical networks.

While advancing these plans for ongoing collaboration, clinicians and administrators should not lose sight of the practical issues identified by the Culture Review concerning the mobility of medical officers between the two hospitals. The First Annual Review raised these issues again, including the need for support for Junior Medical Officers rotating between the hospitals and the concerns of Visiting Medical Officers who practice in both services.[8]

More broadly, there is work to be done to improve relationships between the three health organisations. Many staff still spoke of "us and them" attitudes between various parts of the public health system, and criticised unhelpful attitudes and behaviours they observed. The CEOs of the three health organisations and their executive teams should take the lead in exemplifying respectful and collaborative behaviours, and expect their staff to do the same. There is nothing to be gained from competitive or adversarial behaviour, especially in a small public health system such as that of the ACT.

Over-arching issues of structure, funding and governance of the elements of the public health system were raised in these consultations. While those matters are beyond the scope of this Review, it may be worthwhile for the Health Directorate to consider the extent to which health service coordination could be improved under current or potential governance arrangements.

Conclusions

The ACT would benefit from improved co-ordination of public health services in the ACT. While substantive change to the governance arrangements for health services is beyond the scope of this Review, clinicians and senior administrators should, to the extent feasible within the existing arrangements, adopt a collaborative and system-wide approach. Formal

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clinical networks and other means to enable a whole-of-Territory approach to clinical matters to be developed. Barriers to clinical collaboration and mobility should be vigorously addressed.

Recommendation 5

The CEO of Canberra Health Services should review mechanisms to better integrate clinical streams of the community health services within the Clinical Divisional Structures.

This recommendation has not been substantively changed or amended since the Culture Review.

CHS has made a concerted effort to link community health services with broader governance processes and meetings. Expectations have been recalibrated that, although not physically located within the main hospital campus, staff are involved in governance mechanisms and there is an expectation to participate.

CHS is proposing to monitor and evaluate the integration of community health services through the quarterly Workplace Culture Pulse surveys to track attitudinal change, available data on meeting attendance and frequency, annual portfolio and organisation OCIM assessments, and the 2022 Workplace Culture Survey.

Recommendation 6

That the ACT Health Directorate re-establish open lines of communication with the NGO sector and other external stakeholders. The proposal [by NGOs] to establish a peak NGO Leadership Group to facilitate this new partnership is supported.

The Culture Review identified the need for better relationships and improved collaboration with health sector NGOs and peak bodies, in recognition of the benefits of reducing avoidable demand, facilitating better care coordination, and enhancing strategic policy development. The Culture Review particularly noted the need for NGO input on design, funding models and governance of strategies to improve health policy. One practical step recommended by the Culture Review was the creation of an NGO Leadership Group to facilitate a reinvigorated partnership with the Health Directorate.

This recommendation has not been substantively changed or amended since the Culture Review.

The NGO Leadership Group has been established with the inaugural meeting held on 23 October 2019. The purpose of this forum is to provide a platform for collaboration and engagement between NGOs, ACT Health Directorate, Canberra Health Services and Calvary PHB.

The NGO Leadership Group meets bi-monthly and is jointly Chaired by the CEO of Carers ACT and the Deputy Director General, ACT Health Directorate, with membership including representatives from:

- Carers ACT (Co-Chair)
- ACT Health Directorate (Deputy Director-General – Co-chair)
- Canberra Health Services
- Calvary PHB
- Alcohol and Other Drug Association ACT
- ACT Council of Social Services
- ACT Mental Health Community Coalition
- Health Care Consumers Association
- ACT Mental Health Consumer Network
- Winnunga Nimmityjah Aboriginal Health and Community Services
- Sexual Health and Family Planning ACT
- Capital Health Network

The NGO Leadership Group provides a platform for collaboration and engagement between NGOs, the Health Directorate, CHS and Calvary PHB. The group aims to enhance the quality of strategic policy development and service planning in the ACT with a particular focus on the delivery of health services by non-government organisations. It is a mechanism to share strategic advice and operates to an agreed workplan. The agenda also regularly includes COVID-19 advice and updates for high-risk settings relevant to the sector.

The establishment of the NGO Leadership Group is a positive step and has been welcomed by the NGOs consulted for this Review. It is important to recall that the establishment of the Group was not the sole aim of the Culture Review's recommendation. Rather it was to be one vehicle for improving the relationship with NGOs in order to improve input to policy development and better coordination of care.

The Health Directorate recognises that NGOs are a significant part of the public health system and that effectively engaging with them in strategic policy development and service planning through collaborative design and consultation assists to ensure health services meet the needs of our community. The Health Directorate engages with approximately 70 organisations to deliver a range of health, advocacy and sector development services, as well as using the NGO Leadership Group as a mechanism for consultation and advice on the engagement of, and messaging to, NGOs as partners in the delivery of health care. The operation and effectiveness of the NGO Leadership Group is to be evaluated this year, with the evaluation report expected in November 2021.

NGOs consulted in this Review were overall positive about the improvements in communication and engagement by the Health Directorate, particularly at Executive level, while noting that the attitude of openness and partnership had not necessarily reached all parts of the Directorate. NGOs welcomed the establishment by Calvary PHB of a Community

Advisory Council. Concerns were expressed that CHS had not demonstrated the same willingness to engage constructively.

NGOs want to see genuine collaboration and involvement and an attitude of respect for the knowledge and experience that health sector and community NGOs can contribute both to health policy development and to models of care. The Health Directorate recognises the benefit of an engaged and open relationship with NGOs and sees that the culture and mechanisms to achieve this are maturing. The Directorate noted that the role played by NGOs may vary for different projects, from consultation through to co-design. It would be beneficial for both Calvary PHB and CHS to review the effectiveness of their arrangements for consultation and collaboration with relevant NGOs.

Conclusions

The three health organisations should commit to an engaged and collaborative relationship with NGOs and peak bodies that recognises and draws upon the valuable input NGOs bring to both policy design and coordination of care. CEOs and senior leaders of both organisations should model and expect of their staff respectful and collaborative approaches, with clarity about the role that NGOs are being asked to play on any particular project.

Recommendation 7

The initiatives already underway to develop a valued and more coordinated research strategy in partnership with the academic sector and others are strongly supported. These provide a mechanism to encourage professional development and address culture, education, training, research and other strategic issues.

The Culture Review recommended a more coordinated and active research strategy and partnership with academia, both to improve the underpinnings of health care quality and to enhance clinical engagement.

This recommendation has not been substantively changed or amended since the Culture Review.

Clinicians and academics consulted by this Review were united in recognising the need for research to be valued within the hospital system, pointing to the need for health systems to be learning environments, the benefits for attraction and retention of senior specialist clinicians, and the expanded opportunities and mindset that partnerships between hospitals and academia bring. However, they were also united in expressing frustration that systems and attitudes within the ACT health system did not encourage or enable the interplay between clinical practice and academic research that characterises high quality teaching hospitals.

Medical officers at CHS report that, although they are engaged on the basis of an 80:20 split between clinical and non-clinical time, with non-clinical time to be available for activities

such as teaching or research, in practice this is not honoured. Those doctors who do commit to academic work find that they have to undertake the work in their own time, or not at all. Staff specialists note that other jurisdictions manage effectively the interface with academic appointments and indeed value the learning that it brings into the health system; doctors nationally would expect this from a good teaching hospital and its absence limits Canberra's ability to attract clinical talent.

Clinical stakeholders considered that it was short-sighted of CHS not to more actively enable research engagement, not only in terms of attracting senior medical officers but also in relation to the building of a healthy culture among the Junior Medical Officers (JMOs) who will feed Canberra's future medical workforce. Research projects were also noted as opportunities for cross-disciplinary work, with flow-on benefits to engagement across the health system.

Academics at both the Australian National University (ANU) and the University of Canberra (UC) emphasised the importance of partnerships with academia for building the culture of learning and innovation that a good health system must have, as well as the specific benefits that patients derive when research improves treatment or clinical practice.

Clinicians and academics consulted for this Review overall considered that research was not sufficiently valued, and expressed frustration at the slow progress in implementation of the recommendation.

Efforts to progress the development of a research strategy have been progressed by the ACT Health & Wellbeing Partnership Board. The Partnership Board is responsible for identifying shared priorities and setting the overall framework to improve the health and wellbeing of the Canberra community and surrounding regions of NSW. This is to be achieved by integrating and driving more collaborative relationships across education, research and health service sectors. Membership includes the CEOs of the three health organisations, Dean of the College of Health and Medicine ANU, Executive Dean of UC, Executive Director of the Health Care Consumers Association, and CEO of the Capital Health Network.

The Partnership Board agreed in September 2020 to oversee the delivery of an ACT Health System Research Strategic Plan, which would lay out the overall system strategy, with operational and clinical research plans to be developed under that Strategy by the two hospitals. The Partnership Board established a Research Working Group which included broad representation across clinical and related disciplines from both ANU and UC, research and clinical leads from CHS, and research and program representatives from the Health Directorate. The Research Working Group developed a scope of works for the Research Strategic Plan, with a view to contracting out the development of the plan. However, approach to the market in 2021 failed to identify a suitable provider within the available budget.

The Centre for Health and Medical Research (CHMR) in the Health Directorate commenced work on a research strategy in mid 2021. This work is now being further developed by the Research Working Group with the continued involvement of the CHMR.

In parallel, CHS has established an Office of Research and Education, and has commenced the development of a CHS clinical research strategy. That strategy is expected to be released for consultation in late 2021.

Conclusions

Work on finalising a research strategy needs to be given greater momentum and be brought to a workable outcome with research priorities adopted and then actioned. The Culture Review emphasised the importance of research linkages for improving clinical engagement and enhancing the attractiveness of Canberra as an employment destination for talented clinicians. Research should be a core component of the ACT's health strategy, and part of fostering the kind of climate where innovation thrives in solving the clinical or organisational issues facing health services. Adopting a strategy alone will not be enough. The two hospitals must recognise the value of engagement with research, both by fostering open and positive relationships with academic institutions, and by enabling clinicians in a practical sense to undertake research by allocating and protecting time for that purpose.

Recommendation 8

That discussions occur between ACT and NSW with a view to developing a Memorandum of Understanding (MoU) for improved collaboration between the two health systems for joint Ministerial consideration.

The Culture Review recommended greater collaboration with NSW Health in order to break down the relative isolation of the ACT health system and to give clinicians greater exposure to the clinical experience, research opportunities, professional development and more mature culture of the larger NSW health system.

This recommendation has not been substantively changed or amended since the Culture Review. However, its implementation has become caught up with the broader issues of the negotiation of an intergovernmental agreement.

Work has been underway since September 2019 on the negotiation of a Regional Agreement between ACT and NSW. The draft Agreement deals, among other matters, with the workforce issues contemplated by the Culture Review, including arrangements to support access to professional development, education, and supervision for clinicians through a strong networked approach and to promote research initiatives through partnerships with research institutions.

As the proposed Agreement deals with a wide range of other matters that are outside the scope of this Review, it is not possible to comment on the likely timeframe or outcomes of negotiation of the Agreement between the two jurisdictions. The demands of COVID-19 response may also be impacting on the scope available in either jurisdiction to progress the Agreement. If the broader Agreement will involve greater time or complexity to be resolved, even after the current impacts of the pandemic are reduced, consideration should be given to whether arrangements could be made at a Directorate level to progress arrangements for professional opportunities and interactions with NSW Health. One option could be through the already established ACT and Southern NSW LHD Joint Operations Committee (JOC), which includes Canberra Health Services, the Health Directorate, Calvary PHB, adjacent NSW Health Districts, and the Capital Health Network. Although the JOC's primary roles are

operational, it also aims to enhance the culture and strengthen the relationships between jurisdictions.

There are also some arrangements on foot between CHS and NSW Health that enable JMOs and Registrars from the ACT to complete clinical rotations in areas of NSW adjacent to the ACT. These arrangements not only broaden the experience of ACT doctors during their training, but are considered beneficial for the impetus they may give some doctors to decide to practice in rural or regional areas during their careers and for the increased access to medical expertise in rural areas that these clinical rotations bring. These arrangements are welcome for the benefits they bring to doctor training, but do not address the broader issues raised by the Culture Review.

Conclusions

Efforts should be made to pursue opportunities for clinical mobility and access to professional development and research projects in NSW Health. This may be able to be finalised as part of the negotiations currently on foot for a broader inter-governmental Agreement, but if not, discussions should be progressed either through the JOC or at Directorate level to seek to progress more informal exchange and networking arrangements.

Clinical engagement

Recommendation 9

Clinical engagement throughout the ACT public health system, particularly by the medical profession, needs to be significantly improved. Agreed measures of monitoring such improvement needs to be developed through consensus by both clinicians and executives. Such measures should include participation in safety, quality and improvement meetings, reviews and other strategy and policy related initiatives

Recommendation 10

There should be a clear requirement for senior clinicians to collaboratively participate in clinical governance activities.

The Culture Review found there was a need for greatly improved clinical engagement across the health system. The Review exposed a problematic cycle of low morale amongst the medical workforce, frustration by clinicians with burdensome administrative processes, and disengagement with administration and governance leading to even less ability to positively influence hospital systems and practices. The Review noted that greater clinical engagement was necessary to improve the quality of health care and to ensure a culture that learns from adverse events.

The recommendation of the Culture Review was that the system needed to better enable clinician participation and that clinicians should take up those opportunities.

The Culture Review noted the need for clinicians to be involved in clinical governance as an integral part of assuring the delivery of quality health services and continuous improvement. This need has been formally recognised by the Australian Commission for Safety and Quality in Health care.

The Review found that, while there was good participation by nurses, midwives, and allied health workers, doctors were less likely to be appropriately involved.

These recommendations have not been substantively changed or amended since the Culture Review.

Canberra Health Services launched a Clinical Governance Framework 2020-2023 in August 2020. The Framework describes clinicians' role and responsibilities to ensure clinical governance works across CHS to ensure exceptional health care and embeds CHS' clinical governance approach. The CHS committee structure was reviewed and standardised to ensure that all levels of the organisation participate in all aspects of governance, including CHS' clinical governance quality and safety committees. Advisory Executive Committees have been established for Nursing and Midwifery, and Allied Health, with the Medical Advisory Executive Committee being progressed.

A number of activities have been undertaken to improve collaboration and participation in clinical governance by senior clinicians. These activities included:

- Convening the CHS Governance Committee
- Establishing the regular Clinical Directors Forum (see below)
- Inviting Clinical Directors to attend the Corporate Plan Review Committee meetings and high-level CHS committees, including the National Standard Committees
- A stocktake of all clinical leads on governance committees
- Attendance by senior clinicians to Divisional Quality and Safety meetings

Canberra Health Services also launched the Improving Medical Engagement and Culture (IMEC) Strategy in August 2020.

There are four IMEC Priority Areas, which were drawn from medical officer feedback:

1. Promote a safe and collegiate workplace
2. Improve communication with medical officers
3. Promote a medical voice in organisation decision-making and high-level committees
4. Ensure equitable workloads

The Clinical Directors Forum (CDF) has the responsibility to guide and progress the implementation of the IMEC. The purpose of the CDF more broadly is to provide a forum that brings together medical practitioners to discuss medical and patient care issues and to provide advice and feedback to CHS management on medical policy, workforce, quality, education and research issues. The CDF is chaired by the Executive Director of Medical Services and comprises Divisional Clinical Directors, various Medical Unit Directors representing professional specialisations, the Chief Medical Officer, and a number of other sector representatives.

As part of the IMEC, monthly Medical Officer Webinar and Q&A sessions have been held to share information, discuss best practice, ask questions, and seek input for change. Approximately 50 Medical Officers usually attend the regular Webinars or Q&A, and the recordings and slidedecks are made available online for medical officers who were unable to attend. Regular meetings have been held with JMO representatives and People and Culture representatives. Tailored webinars have been held to communicate new policies and procedures, to summarise changes and to provide an avenue for clinicians to ask questions, including nursing, midwifery and allied health clinicians.

The establishment of the Clinical Directors Forum has been welcomed by stakeholders consulted by the Review. It is performing a valuable function to ensure the views and knowledge of medical specialists are considered in the many executive decisions that impact both patient care and the medical workforce. It is helping to build relationships across speciality areas, which enhances patient care and increases engagement for those involved in the Forum. The Review strongly supports the continuation of the Forum and active engagement by CHS management with the views of clinicians brought together by the Forum.

"there used to be frustration that doctors didn't have a voice in the Executive. That has changed in the last 12 months"

"Information is being disseminated in more accessible forms"

"two-way communication is very welcome"

It is less clear that it is improving overall satisfaction and engagement for medical staff below the level that is represented on the CDF. It was agreed as part of the IMEC that the success of the IMEC would be monitored by feedback through the regular Pulse Surveys and periodic Q&A sessions with medical officers. While no information was provided to the review indicating that there had been Q&A session feedback about the success of the IMEC, there have been a number of Surveys of the medical workforce, including participation in the 2021 Pulse Surveys. Those surveys indicate that low levels of satisfaction and engagement persist, including low levels of trust in executive management, poor ratings for whether there is a culture of trust and respect and whether things are getting better, and negative scores on whether medical officers would recommend CHS as a good place to work. The response rate of medical officers to the staff surveys is low; while this means that it is not possible to be certain that the views of medical officers expressed in the staff surveys are representative, it is usually the case that more engaged workforces have higher response rates. Low response rates tend to indicate that the workforce is so distrustful and disengaged that it does not expect management to listen or to respond to their views.

Doctors who spoke to the review expressed frustration that consultation was not meaningful, and tended to consist of being told rather than having genuine input. Involvement in policy and governance committees by doctors and nurses was difficult when those meetings were not scheduled with awareness of clinical timeframes and availability. Clinicians felt undermined and devalued when day-to-day decisions on matters such as roster arrangements were taken by people in senior or administrative roles without regard to the impact on the medical workforce, or when clinicians were unable to influence inefficient and burdensome systems that added complexity and difficulty to the essential work of providing clinical services.

"there's no culture of daily/ongoing consultation and engagement – it's unilateral and adversarial"

"Clinicians have been there, and will be there for decades but are not being listened to"

"We want a positive culture – open to ideas and input and to feel valued."

Much good work has been done by CHS to establish structures and processes designed to involve clinicians in executive decision making, and to enable clinicians to be better informed and consulted on matters that affect them. Matters considered at the Webinars and Q&A sessions have included information and consultation on overtime arrangements, non-clinical work time, new clinical procedures, and the work towards a Digital Health Record. These are important issues to be raised with medical officers, though it is unclear how effective the Webinars are for consulting with the majority of medical officers given the low numbers that attend.

At senior levels, there is now much better engagement and involvement of clinicians. More needs to be done to ensure that medical officers who are not personally involved in the CHS Governance Forum or the Clinical Directors Forum are kept informed and involved. While attendees at the CDF are expected to cascade the matters discussed to the staff in their teams, there may not be an effective or well-established practice of doing so. The Review would encourage the CDF, in its role of oversighting the implementation of the IMEC, to give careful consideration not only to the operation of structures and processes for engagement, but to assessing whether these are effective in building a genuine culture of engagement for the clinical workforce.

> *"it would be good if the hospital could set up a better system for cascading information. Every Clinical Director might not be doing this well"*

> *"there needs to be more clarity about the role and expectations of Clinical Directors"*

Calvary PHB advised that its Clinical Governance Committee has been integrated into its formal governance hierarchy with reporting lines to Executive Management. Medical professionals have mandatory objectives in their Performance Development Plan that expect them to be engaged in business processes and initiatives. The extent of such involvement was unable to be determined from the information provided to the Review; however Calvary PHB did indicate that Medical Officers have been increasingly engaged in business-related initiatives (especially HR and WHS) for input, consultation and feedback. Calvary PHB is also developing a survey to assess VMO engagement.

As the Review understand that Calvary PHB's annual staff survey does not enable it to disaggregate responses by job family, Calvary PHB is not equipped with objective information to assess whether its changes to clinical governance have been effective, and whether clinical engagement and medical officer satisfaction are in fact improving.

Conclusions

Both Canberra Health Services and Calvary PHB need to ensure that the processes they have put in place to increase clinical engagement are achieving improved engagement in practice for their clinical workforces. Sentiment and satisfaction among clinicians needs to be regularly tested and appropriate action taken if the prevailing experience of clinicians does not match the optimistic outcomes sought to be achieved by changes to process and governance.

Recommendation 11

Canberra Health Services and Calvary Public Hospital should assess the appropriateness of the Choosing Wisely initiative as a mechanism for improving safety and quality of care, developing improved clinical engagement and greater involvement in clinical governance.

Adoption by the ACT health system of the Choosing Wisely initiative was recommended as an example of the benefits of clinical engagement, improving safety and quality of patient care and lowering the inefficiencies of unnecessary tests and treatments.

This recommendation has not been substantively changed or amended since the Culture Review.

The Choosing Wisely Initiative seeks to support consumer safety by identifying and reducing tests, treatments and procedures that are not evidence based and could potentially cause harm. The goal is to start conversations involving consumers and healthcare professionals about unnecessary tests, treatments and procedures, thus enhancing the quality of care.

CHS became a champion health service member of Choosing Wisely Australia and established a Choosing Wisely Low Value Care Steering Committee (CWSC) in February 2020 to provide leadership and coordination in adopting Choosing Wisely actions and other identified low value care initiatives in a coordinated, sustained manner across CHS. An increased number of senior medical officers were engaged throughout 2020 with a total of 22 consulted on specific projects or involved with working groups. Projects undertaken or in progress have covered such matters as pathology tests and imaging ordering and have involved senior clinicians in the development and delivery of education and the sharing of information with colleagues and junior doctors.

CHS conducted a baseline survey in June 2020 and a follow-up survey in March 2021, which found over 200% increase in awareness of Choosing Wisely amongst medical officers, and has found substantial reductions in ordering of tests and procedures on completed projects.

Calvary PHB endorsed the Choosing Wisely Initiative in June 2020 and has established governance arrangements and a communication plan and stakeholder engagement plan. Calvary PHB intends to implement processes to ensure treatments and tests are in line with up-to-date evidence, are patient focussed and with the goal to minimise unnecessary and low-value treatments, tests and practices.

Recommendation 12

That Canberra Health Services adopt the progressive evolution of clinically qualified Divisional Directors across each Clinical Division with Business Manager support and earned autonomy in financial and personnel management.

The Culture Review focussed on clinical leadership as an important aspect of clinical engagement and called for the clinical divisions to be led by clinical directors, who could be medical officers but could also where appropriate be nurses, midwives, or allied health professionals. Clinical leads would be supported by business managers to assist with administrative skills and knowledge. The Culture Review said that the frustration of burdensome administrative processes should progressively be reduced by upskilling clinical directors to be able to manage their own budgets and approvals within clear strategic goals.

This recommendation has not been substantively changed or amended since the Culture Review.

Canberra Health Services has largely implemented this recommendation. The CHS operating model requires that all Clinical and Unit Directors are suitably clinically qualified. Each clinical division is supported by quality and safety, finance, and HR Business Partners, dedicated to providing expert and timely advice.

The arrangements for business partners have been welcomed, helping to support divisions and units with advice on management issues. There is still frustration expressed about slow and inefficient procedures, with many matters requiring central approval rather than being delegated to clinical directors within budgets and organisational goals as envisaged by the Culture Review. Particular mention was made of extended delays and opaque processes for routine recruitment or procurement, which impact adversely on front line health services and on morale.

The Review would encourage continued evolution of the management role for Clinical Directors, with a view to increasing their 'earned autonomy' and improving operational efficiency. More streamlined and less burdensome administrative processes will, more broadly, improve both staff experience and organisational efficiency.

Recommendation 13

That an executive leadership and mentoring program be introduced across the ACT public health system specifically designed to develop current and future leaders. This program should include both current and emerging leaders.

The Culture Review recognised that clinical staff taking up roles of Unit and Divisional leadership will need to be appropriately trained in leadership and management skills. The Review recommended that a leadership and mentoring program be available for all clinical leads and executive personnel, and that reasonable time should be allocated for staff to undertake such programs.

Investment in leadership skills is vital for people placed in executive and middle management roles to be effective managers of people and leaders of workplace change.

This recommendation has not been substantively changed or amended since the Culture Review.

The Workplace Culture Framework found, based on extensive review of evidence, that people and leadership skills were essential in addressing the workplace change priorities. People skills are needed in order to meet the basic workplace needs of others, and to address workplace incivility, improve psychological safety, and build team effectiveness. Developing people and leadership skills was one of the four key steps identified by the Framework to achieve the desired workplace change. Having leaders model expected behaviours and skills was one of the five implementation drivers needed to support and sustain workplace change and outcomes.

The Organisation Culture Improvement Model (OCIM) provides the vehicle for the three health organisations to assess their maturity against key aspects of the inputs that will be needed to produce sustained positive workplace culture, including the approach to learning

and development, training, leadership development, and coaching and mentoring. All three assessed their status in June 2020 as being in the early stages of establishing the necessary maturity on these aspects, such as not having a leadership and development strategy or only being at a basic level or having a leadership training program but only having it available to a subset of leaders or being uncertain as to its effectiveness.

Considerable effort has gone into developing system-wide management and leadership training aligned with the Workplace Culture Framework that all three organisations have adopted. However, that work has taken a considerable time to bear fruit. The process of reaching agreement within the organisations on the desired training and seeking external providers to provide the training has now taken well over a year. It is expected a provider will be contracted in August 2021 for management fundamentals training, and for leadership training by the end of December 2021. Doubts over future funding may impact the development and implementation of the training programs.

In the meantime, the three health organisations have continued to deliver some training programs for managers and supervisors.

Canberra Health Services has a set of training programs for managers, most of which pre-dated the Culture Review, covering such matters as people management for front-line and middle level supervisors, introduction to management for new supervisors, training in performance management for managers at all levels including a number of specific programs for managing problematic behaviour or responding to grievances, and how to have difficult conversations.

These are all important matters for training, but the training is not mandatory and the numbers that have attended the training in the past two years are very low in proportion to the number of people in management or supervisory roles. A review of training programs conducted in 2021 (see recommendation 16) found that this existing suite of training programs was not well-aligned with the goals of the Workplace Culture Framework and that there was inadequate evaluation or analysis to determine if the training was meeting organisational goals.

CHS also advised that the CHS Executive cohort has participated in several leadership workshops over the past two years, to build and accelerate a cohesive executive group, develop key leadership technical skills and discuss the application of contemporary leadership approaches.

The Health Directorate has been running leadership training for middle management (Being a Conscious Leader) since 2019. It uses a group coaching approach to equip managers with practical skills for leading people strategically through change. The course is not mandatory; 105 staff members have attended the training since it commenced in November 2019. This course was also reviewed as part of the review of training programs conducted in 2021 and was found to be not well-aligned with the Workplace Culture Framework or to have an evaluation framework that enabled assessment of its effectiveness. Directorate staff may also access leadership training that is provided across the ACT public service, but no data was available as to the extent of uptake.

Calvary PHB draws on the management and leadership training provided for all Calvary sites, with four different levels of training: Senior Leaders; Established Leaders, for Executive

level participants; Emerging Leaders for front line managers and supervisors, and Foundational Leadership material available by online modules as base level management training for front line managers and supervisors. These programs, which were scheduled to commence in 2020, were delayed due to the impacts of COVID-19 and have now commenced delivery in the first half of 2021. Calvary also ran a Clinical Leadership Program as a pilot in 2019. The Program focussed on frontline clinical leadership education for nurses, such as guiding teams, managing change, good communication, and managing conflict.

Staff across the organisations were largely unimpressed about management capability and considered there needed to be more investment in management training.

> *"the leadership training is great but there needs to be more"*
>
> *"the people who most need management training don't go to it – they need to be targeted"*
>
> *"I asked for management training when I became a supervisor, but I was told to just work it out myself"*
>
> *"there is a document that articulates management expectations, but it's not supported with training"*
>
> *"maybe there is management training but if so, it has no profile"*
>
> *"people are put in charge who have no idea how to run things"*
>
> *"there is no training for managers, people go up in the ranks because they are next in line"*
>
> *"no follow up is done after training to see if it's working"*

Action on this front needs to be substantially increased and expedited to develop the capability of leaders and managers. As identified by the detailed evidence reviewed for the Workplace Culture Framework, effective leadership skills are critical to model and embed the changed behaviours that are needed to produce a positive workplace culture. The Framework identified core skills that need to be broadly instilled in managers and supervisors such as team building, goal setting, communication, psychological safety, performance improvement, empowerment, recognition, and alignment with organisational goals.

Effective people-centred leadership is a critical element of creating a healthy workplace culture. On a range of matters where this Review has found more effort is needed to produce the desired change, inadequate leadership and management capability is likely to be a key contributor. Many of the excellent initiatives that have been launched by the Executive leadership of all three health organisations have not penetrated successfully through to the experience of front line staff due to a lack, in the management layers below, of awareness of their role in driving change and capability to do so effectively. This must be addressed if the clear commitment of the three health organisations to improve workplace culture is to be achieved.

The Review understands that some doubt has been expressed about ongoing investment in management and leadership training, which was being developed with additional funding provided for the implementation of the Culture Review. The Review would strongly encourage the three health organisations to see investment in management and leadership capability as a core aspect of business as usual, not a special one-off event attributed to the Culture Review.

Conclusions

There needs to be substantial and ongoing commitment to developing leadership and management capability in all three health organisations. Leadership and management training should focus on the elements identified by the Workplace Culture Framework and should be regularly evaluated for its effectiveness. Promotion into and performance management in leadership roles should be based equally on leadership behaviours as on technical skills. The pathway to establishing and maintaining a positive and productive workplace culture depends on effective management and leadership at all levels.

Human resources

Recommendation 14

The three arms of the ACT public health system should review their HR staffing numbers and functions in response to the concerns staff have expressed regarding timeliness and confidence in current HR procedures, and the future needs for HR, as proposed in this Review.

Recommendation 15

The recruitment processes in the ACT public health system should follow principles outlined in the Enterprise Agreements, Public Sector Management Act 1994 and relevant standards and procedures.

The Culture Review noted the important role the Human Resources (HR) function should play in resetting culture, and that HR should be helping to fulfil the strategic goals of the health system by helping to acquire, develop and retain the needed health workforce with aligned attitudes and behaviours. However, the Review found many shortcomings in the HR function. The Review made three specific recommendations about HR: to review their functions, properly align their recruitment processes with relevant laws and procedures and improve their training offering. The Culture Review also highlighted the need not just to review the HR function, but to take action across a range of HR policies and processes: workplace safety, recruitment processes, long-term acting arrangements, JMO recruitment, staff development, supervisor teaching time, mobility of staff between the two hospitals, performance development, misconduct processes, HR systems and data, people skills, and training in general.

This recommendation has not been substantively changed or amended since the Culture Review.

The Culture Review recommended an overall review of HR staffing numbers and functions in light of the many concerns expressed by staff. That review has been conducted and a report on the HR functions of each of the three health system organisations was provided in December 2020 ('the HR Functions Review').

The aim of the HR Functions Review was to contribute to the development of a high-performance HR model that actively supports the implementation of organisational strategy as well as fostering positive workplace culture across the ACT public health system and within each organisation. The Review sought to articulate the HR functions, resourcing requirements and capabilities required to deliver on strategic and operational commitments.

Four priority areas for improvement were identified where current practice does not yet match best practice approaches. These areas were consistent across all three health organisations, and are:

1. Recruitment
2. Performance Management
3. HR Metrics
4. Strategic Workforce Planning

The findings indicate that priority should be given to enhancing processes in these areas to build capability of HR staff and managers, and further develop the maturity and effectiveness of the services delivered.

Work is underway to respond to the priorities of the HR Functions Review.

Canberra Health Services has undertaken some restructuring of its People & Culture Division and intends to undertake further work to address capacity and capability deficits with a focus on quality service delivery and future organisational requirements. A People Committee has been established to oversight the implementation of the Our People Framework, which includes a commitment to making CHS a Great Place to Work, including being well-led, collaborative, and safe, with strong leadership and a positive culture.

On the four priority areas identified by the HR Functions Review, the action that has been taken is as follows:

Recruitment: CHS has been conducting training in the recruitment process, with over 300 staff having completed selection training in the past 2 years. Training is mandatory for panel chairs before undertaking a selection process. A merit-based, rather than seniority based, process has been implemented in 2021 for advancement to Senior Staff Specialist positions.

Performance Management: A revised approach to assist staff with performance discussions has been developed and cascading performance frameworks have been put in place, following a review that was completed in late 2020. Training is being developed to support the new framework.

HR metrics: Dashboards of key people metrics have been developed that were developed in consultation with executives and other stakeholders. Feedback in November 2020 was to the effect that management in line areas welcomed the new dashboards.

Workforce Planning: Organisational Workforce Plans are being developed for the 4 major classifications (Medical, Nursing and Midwifery, Health Professionals and Administration), which are expected to be completed over 2021-22. These will be foundational plans, with more detailed work on job families to follow.

The Health Directorate is considering the report as part of a service redesign and restructure of HR and culture improvement functions. Implementation activities have so far been limited. Nearly 200 staff have attended Recruitment and Selection training and work is underway to evaluate the Directorate's recruitment activities. A workforce data dashboard has been developed. Staff have been consulted since mid 2021 about improvements to the performance management and development process including education and training, and

plans are being developed to respond to those consultations. Work has not commenced on workforce planning.

Calvary PHB has also undertaken some limited activities to implement the recommendation, including re-structuring of the HR teams and training to build their capability. People dashboards are now provided to line managers.

It is positive that all three organisations have developed more useful dashboards to enable managers to be aware of workforce data and trends. These are an important tool that enables line managers to understand their workforce patterns. Desirably, they should also be used by HR as a tool for strategic thinking and workplace change, and refined if necessary to collect and reflect the right data. For example, dashboards that report on the amount of accrued leave enable managers to identify and address problems with staff not taking leave sufficiently to be refreshed; an additional and more strategic layer would see data being tracked to identify patterns such as high or increasing levels of personal leave, which can be an indicator of workplace dysfunction. Similarly, data on the numbers of cases on hand of complaints and grievances are a useful means of tracking and managing workload; a more strategic layer would track the trend over time in number of cases, time to resolution, and outcomes, and would link case incidence with other potential indicators of workplace culture issues that need to be addressed. Data on trends over time in numbers of temporary contracts and length of time on higher duties would also be useful for all three organisations to better understand the drivers of this issue, raised by many staff as problematic for both individual job security and for workforce culture change, and to develop strategies to improve.

The Review would encourage all three organisations to treat their HR data as a source of insights and a basis for more strategic attention to workforce issues, not only as a tool for routine management and monitoring.

More broadly, while the HR functions review identified numerous areas requiring attention in all three organisations, progress has been limited in addressing these and more should be done in order to establish the capabilities that HR needs to support the organisations. CHS has work underway on most of the four priority areas, but there is scope for considerably more ambition in developing capability and momentum. Both Calvary PHB and the Directorate have made only limited progress in responding to the HR Functions Review.

Undertaking the HR Functions Review seems to have been taken by the three organisations as the key required outcome of Recommendation 14. However, the HR Functions Review was supposed to be a means of identifying the key areas for action so that the underlying problems identified by the Culture Review would be addressed. Those most urgently highlighted by the Culture Review included: reducing the high numbers of long term acting arrangements, reducing the protracted time taken for recruitment processes, improving attraction and retention, improving the management of complaints of poor behaviour and misconduct, and implementing effective performance development processes. The report card on these is mixed.

None of the organisations were able to provide data on trends over time in the number or length of higher duties arrangements. The proportion of staff on temporary contracts has remained stable. Senior staff considered that the extent of temporary contracts could not be addressed without greater funding certainty, and that little could be done in any event

on the extent of higher duties arrangements. Current data provided as at June 2021 by Calvary PHB and CHS indicated that the average length of time on HDA was 18 months and 9 months respectively and the average time on temporary contracts was about 13 months. Staff interviewed by the Review expressed frustration with the instability caused by temporary contracts.

> *"Long term contracts have been rife"*
>
> *"Rolling short term contracts"*
>
> *"Jumping between contracts – always waiting. Permanent positions are few and far between"*
>
> *"People are going for too long in temporary contracts – Executive won't fill permanently"*

Staff also considered that the extent of long term acting arrangements was a hindrance not only to organisational stability and progress on workforce culture, but to fairness in recruitment.

> *"We can't recruit to ongoing positions so we can't get the right people to fix the culture"*
>
> *"many temporary positions, they're not there long enough to fix the systemic problems"*
>
> *"Positions are not being advertised or only in one place with short turnaround because someone is acting in the position"*

Staff expressed continued frustration with delays in recruitment processes, which was one of the key issues identified by the Culture Review.

> *"It's very difficult to fill positions, there are tons of administrative roadblocks"*
>
> *"the approval steps take too long"*
>
> *"we have staff shortages, and recruitment delays make it worse"*
>
> *"it's still cumbersome, you never know where it's up to, many approval steps involving different areas, it takes months"*
>
> *"then after all the effort, it takes so long that you lose the person to another role before you get to appoint them, very dispiriting"*

Data from the Health Directorate indicated that the average time for positions to be filled was 40 days in 2020-21, slightly up from 38.4 in 2019-20. These timeframes are within normal benchmarks. Dashboards of human resources data in Calvary PHB do not provide any data on time to fill. Data from CHS indicated that time to fill had improved significantly since 2018, now at 63 days in 2021 compared to 141 days in 2018. This is a good outcome, but may not be seen in all areas given the extent of frustration expressed by clinical and administrative staff. The hospitals in particular may need to more closely examine the

processes for recruitment to ascertain whether clinical staff can be given more support to manage the demands of recruitment against the pressure of clinical work, and whether the 'earned autonomy' foreshadowed in Recommendation 12 could help to address the delays caused by needing multiple approval steps external to divisions.

Recommendation 16

The range of training programs for staff offered by the ACT public health system should be reviewed with respect to their purpose, target audience, curriculum, training styles and outcomes so that they address the issues raised in this Review.

The Culture Review considered that there was a need to improve the people management skills of people at all levels of management in the health system. It noted that, while there was an array of training opportunities relevant to people management, these should be reviewed to ensure that training provided a coherent program and responded to the issues raised in the Review.

This recommendation has not been substantively changed or amended since the Culture Review.

A consultancy was engaged in late 2020 to undertake a review of existing people training programs being delivered within each organisation, and reported in March 2021.

There is a more well developed program for training in CHS, compared to both Health Directorate and Calvary PHB. This was reflected in the number of training programs that were assessed, with 10 programs being identified for assessment by CHS and only one each in Health Directorate and Calvary PHB.

The review included an assessment of why current training programs may not be having the impact required or expected and why learning is not being translated into changed behaviours by managers and staff. It also included an assessment as to the degree that current people training programs align to the five priorities identified in the Workplace Culture Framework as well as the Workplace Skills Development Model under that Framework.

The training review found that the courses overall had low alignment with the Workplace Culture Framework and inadequate evaluation methodologies. In short, these training programs are not focusing on the right things, and are not being evaluated to determine if they are producing the intended results. The review recommended changes to course delivery, a greater focus on evaluation and regular review of the training offering, and accountability in performance management for applying the learning from training courses.

Although the review has been conducted as recommended by the Culture Review, there does not appear to have been a great deal of action since then to reframe or re-align the training programs. Canberra Health Services advised that it is developing comprehensive evaluation plans and that it will use the results of its 2021 staff survey to guide revision of its training programs.

Conclusions

As discussed in relation to Recommendation 13, it is essential that there is a more determined focus on delivering appropriate training in order to equip managers and staff at all levels with the skills they need to foster the necessary changes in workplace culture. This should not be seen through the lens of budget stringency, as if it were merely an additional cost, but should be seen as an investment in capability that will lower costs currently expended on unproductive matters such as unscheduled absences, workforce attrition and replacement, and handling complaints and grievances. Furthermore, creating a more positive workplace culture will ameliorate the adverse impacts on patient care and productivity that arise from low engagement and poor morale, and will increase the attractiveness of the ACT public health system for future talent across its workforce.

Implementation

Recommendation 17

Should the recommendations of this Review be accepted, a public commitment should be jointly made by the Ministers for Health and Wellbeing, and Mental Health, the Director-General ACT Health Directorate, the CEO Canberra Health Services, the General Manager Calvary Public Hospital and key representative organisations to collectively implement the recommendations of this Review to ensure ongoing cultural improvement across the ACT public health system.

Recommendation 18

A 'Cultural Review Oversight Group' should be established to oversight the implementation of the Review's recommendations. The Group should be chaired by the Minister for Health and Wellbeing, and include the Minister for Mental Health, the Director-General ACT Health Directorate, the CEO Canberra Health Services, the General Manager Calvary Public Hospital, Senior Executives across the ACT public health system, the Executive Director Health Care Consumers Association of the ACT, President of the AMA (ACT), Branch Secretary ANMF (ACT), and Regional Secretary CPSU.

Recommendation 19

That the 'Cultural Review Oversight Group' auspice for the next three years, an annual, independent and external review of the extent of implementation of the recommendations of the Review and consequent impact on cultural changes within the ACT public health system.

The Culture Review recognised that there was scepticism across the health system as to whether recommendations arising from the Review would be effectively implemented. The Review's recommendations on implementation were directed to ensuring there was public and high level commitment to action, and mechanisms to ensure implementation was pursued over time.

These recommendations have not been substantively changed or amended since the Culture Review.

The Minister and the CEOs of the three health organisations fulfilled the Culture Review's recommendation on commitment by publicly committing in 2019 to implement the Review's 20 recommendations and to work together to improve the workplace culture within the ACT public health system.[9]

As recommended by the Review, a Culture Review Oversight Group was established in 2019 to oversight the implementation of the Review's recommendations. The Oversight Group comprises the Ministers for Health and Mental Health, the CEOs of the three health organisations, representatives of the health workforce, representatives of doctors and health care consumers, and representatives from academia. The members of the Oversight Group also committed to work together to implement the Culture Review's recommendations and to drive positive and enduring culture change.[10] The Oversight Group has met regularly since its establishment, on a bi-monthly basis.

An Implementation Steering Group supports the Culture Review Oversight Group, to more closely manage the implementation plans for the various recommendations, to discuss and share information on key issues, and to coordinate efforts across the Health portfolio. The Implementation Steering Group comprises the CEOs of the three health organisations supported by their respective corporate or human resources managers. The Group meets every 6-8 weeks and has met regularly since the Culture Review.

Other measures to support the implementation of the Culture Review have been the provision of funding of $12m over three years and the establishment of the Culture Review Implementation Branch in the Health Directorate, to lead the planning and support the implementation of the recommendations of the Culture Review.[11]

The Oversight Group has evolved over time in its approach to oversighting the implementation of the Review's recommendations. At times, it has chafed at the feeling that its role is limited to receiving reports on progress rather than actively driving it. There has sometimes been tension between the roles of members as representatives of a particular sector or group, and their roles as contributors to a collegiate process of change. Where members have fallen into defending the interests of their own organisation rather than working collaboratively to achieve agreed shared outcomes, this has not been helpful in achieving the outcomes of the Culture Review. Structural issues, such as the funding arrangements for Calvary PHB and the divide of responsibilities between the Health Directorate and Canberra Health Services, have sometimes impacted the necessary spirit of collegiality.

These issues have been actively considered in recent workshops and there appears to be a good spirit towards working collaboratively and constructively together. That commitment to collaboration, focussing on shared aims rather than pursuing separate agendas, will be crucial to the ongoing success not only of implementation of the Culture Review, but of developing and implementing system-wide approaches focussed on all aspects of high quality care in the public health system.

9 See appendix C

10 See appendix D

11 See Page 5 for description of the Culture Review Implementation Branch role and functions

Going forward, the Review encourages the Oversight Group to review its operations and agenda to ensure that it is focussed on the key drivers of workplace culture change. Part V of this Review sets out a proposed approach to establish a sustainable program beyond the three year arrangements and funding that were specifically established for the Culture Review implementation.

The roles and responsibilities of the Oversight Group and the Steering Group, and the communication lines between them, should be further clarified. The Oversight Group should operate in a similar mode to a Board, with responsibility for strategic guidance and with all members expected to focus on the shared goal of improving culture, rather than using the meetings as the forum for airing bilateral issues that have other forums for their resolution. The Implementation Steering Group should, as a minimum, have responsibility to work together to progress action and outcomes on particular issues that the Oversight Group identifies as needing action or resolution between the three health organisations. More broadly, it should share information and learning between the three health organisations on what is working well or not, and identify opportunities for more strategic partnership work.

There needs to be greater clarity and agreement between the three health organisations as to the matters that require a system-wide approach, such as the identification and monitoring of health system data and overall commitments to the key aspects of workplace culture improvement, and the matters on which details can vary to reflect the different functions and nature of the three organisations. For example, it was necessary for all three organisations to commit to a greater focus on values that uphold both staff and patient well-being and to take action to ensure the values are lived throughout their organisations, but it is not essential that the values are expressed in identical terms. Conversely, it will be unhelpful if the three organisations decide to measure and monitor health system performance differently, or to depart from the commitment to monitoring the improvement of organisational culture consistently. On some matters, identical arrangements will not be strictly necessary, but adopting a shared approach may be efficient, in that each organisation need not 're-invent the wheel'; for example, improvements to make HR data reporting more meaningful could be adopted across the different organisations.

As well as a strong commitment to collaboration to underpin culture reform, there needs to be a commitment to action. The recent establishment of Working Groups under the Oversight Group to progress particular issues is a positive step, but there needs to be ongoing willingness of Oversight Group members and their organisations to put in time and effort to make these Working Groups effective. Culture reform has to be seen as core business for all members, not an added burden or an optional extra.

That theme – that culture reform is core business – needs to inform not only the work of the governance bodies progressing the implementation of the Culture Review, but the work of all three health organisations in developing and applying systems of health care and in managing and developing their workforces.

Change management and communication

Recommendation 20

As a result of this Review, the Culture Review Oversight Group should engage with staff in the development of a change management strategy which clearly articulates to staff, patients/clients and the community the nature of the issues to be addressed and the mechanisms for doing it.

The Culture Review considered it was obvious that there needed to be effective communication with staff, stakeholders, and the community about the implementation of the Review. Indeed, all significant organisational change depends on an effective change management strategy of which clear and ongoing communication is an essential component.

This recommendation has not been substantively changed or amended since the Culture Review. However the three organisations have failed to agree on system-wide change management or communications strategies and have made only limited inroads into establishing or implementing organisation-specific strategies.

Change management

Attempts were made to establish a Change Management Approach in 2020. A proposed change management approach was tabled at the Implementation Steering group in October 2020 but the Steering Group did not agree to the proposed approach. The three organisations preferred to adopt their own approaches to change management, so that other organisational changes as well as culture reform could be addressed. However, it does not appear that a change management strategy was then adopted in any of the organisations.[12]

Communication

The Culture Review Steering Group endorsed a Communication and Engagement Strategy ('the Communication Strategy') in November 2019. The Strategy was developed by the Culture Review Branch based on extensive consultation with the communication teams across the three health organisations. Following endorsement of the Strategy, the Culture Review Branch developed intranet and internet pages to share information about the background and progress of the Culture Review across the health system. Several joint communications workshops and regular meetings with each organisation were held from July 2019 through to June 2020, seeking to bring the three health organisations together to deliver the objectives of the endorsed strategy. However, at this point, despite the three organisations having endorsed the Communication Strategy, it became apparent that there

12 Calvary provided the Review with guidelines and policy on change management applicable to all Calvary institutions, but no change management plan for implementation of the Culture Review

was a lack of willingness to implement it. The issue was raised as a high risk with the Steering Group in July 2020, but does not appear to have been substantively addressed.

The Culture Review Branch continued to operate the internet and intranet pages, adding new content about progress of culture reform and putting up information and guides for staff and managers, including a newsletter, articles and videos focussing on staff recognition and values, toolkits for managers about the Workplace Culture Framework, and weekly articles promoting work on culture reform across the health system. However, the content for material outside the Branch's own activities has had to be sourced from social media channels and intranet sites, as neither CHS nor Calvary PHB has engaged with the Culture Review Branch to provide tailored communication material.

Little appears to have been done within CHS or Calvary PHB to foster access to the Culture Review material produced centrally. None of the communications created by the Culture Review Branch have been shared with CHS staff through their internal channels. There is a link to the Culture Review Implementation page on the CHS intranet but, as the link has not been promoted through CHS internal channels, few staff are accessing it. Calvary PHB staff do not have access to the Culture Review Implementation page on the intranet; instead all content is sent to Calvary PHB for distribution to staff through its internal channels. Calvary PHB advised that culture review communications are shared with staff, however it is unclear to which staff it is distributed or by what means.

Further efforts have been made throughout 2020-21 to re-invigorate the approach to communications. The launch of the Workplace Culture Framework in November 2020 provided an opportunity to shift the system-wide communications from the Review findings, towards a narrative focussed on the changes being produced for the benefit of the health system and the community. A launch event was held and material was produced for staff, including a video, a manager's tool kit, and guides to the five priority change areas of the Workplace Culture Framework. However, the three health organisations did not participate in the launch and neither CHS nor Calvary PHB have promoted internally the video or other materials on the Workplace Culture Framework.

The Culture Review Branch consulted with the three organisations through December 2020 to March 2021 to propose a new phase of communications, focussing on regular progress updates, the roadmap for change, and engaging stories of real change happening 'on the ground'. There does not appear to have been any take-up of the new proposal in CHS or Calvary PHB. There has been a greater drive more recently in the Health Directorate to incorporate culture-related messaging into current communications channels, promote more actively the Culture Review Implementation material and to develop new opportunities to showcase the impact of culture reform. Increasing engagement with the culture review material on the intranet suggests this is having a positive effect.

Both Canberra Health Services and Calvary PHB have developed their own communication approaches.

CHS adopted the Fostering Organisation Culture Improvement Strategy (FOCIS) and associated Communication Action Plan in December 2020. The FOCIS Communication Plan is to promote a number of initiatives that are being or will be implemented in 2021 that are focussed on making CHS a 'great place to work'. These are: The Speaking up for Safety program; the regular staff survey; a revamp of the performance framework; and attention

on building management and leadership capability. Neither the FOCIS strategy or the Communication Action Plan reference the Culture Review, or demonstrate a plan to bring together meaningfully for staff the many disparate initiatives that have been commenced as outlined throughout this Review.

Calvary PHB developed the 'Great Workplaces Deliver Great Outcomes' communication strategy in March 2020. That strategy envisaged three phases of Inform, Involve, and Inspire. Under the strategy, Calvary PHB has established a Great Workplaces Intranet, established a bi-annual staff newsletter, and has added updates on the Great Workplaces Program to its executive meetings and its quarterly leadership forums. The promotional material for the Great Workplaces Program states that its intent is to implement the outcomes of the Culture Review. The 'Inform' stage of the communications plan underpinned the launch of Great Workplaces, including with all-staff communication from the Regional CEO. The 'Involve' stage of the plan envisaged the launch of new policies such as the Occupational Violence strategy and the Values in Action Framework. The 'Inspire' stage of the plan indicated there would be regular staff feedback, updates, and information sessions. However, the plan provided to the Review did not attribute responsibility for any of these ongoing actions, and action appears to have somewhat petered out. Communication information from the past year provided to the Review comprised the Great Workplaces newsletter of December 2020 and updates on Speaking Up for Safety.

Interviews with staff across the health system showed that few had any knowledge of the work that was being undertaken to implement the findings of the Culture Review:

> *"We've heard about it – heard more informal things from other nurses than managers"*
>
> *"What was communicated wasn't relevant"*
>
> *"Never heard the outcome of the review"*
>
> *"It doesn't filter down to teams"*
>
> *"What has happened didn't flow through"*
>
> *"A lot has been done, but it's not well communicated – lack of coordination"*

The lack of knowledge or awareness of culture reform is of concern. The Culture Review was seen by staff as a great opportunity for change. A lack of visible action on major change tends to lead to disappointment and cynicism, and a reduced willingness to believe that anything will change. The lack of belief that positive change is happening is reflected in staff sentiment: in CHS, in the June 2021 pulse survey, only 27% of staff agreed that 'Things are getting better all the time' and 39% agreed that 'Change in CHS means better things to come for me'. Both of these scores were lower than the previous survey results on the same questions. The Health Directorate will need to examine its survey scores to assess whether staff are receiving adequate communication on the change program. Calvary PHB may need to use other measures to assess its communication efforts given that the employee engagement questions asked in its survey do not cover awareness of workplace change programs such as the Great Workplaces program.

Organisational change is only successfully effected when people in the organisation adopt the change. Especially in large and complex organisations, achieving change will not happen by chance and will not be effective if it is implemented in an ad hoc way. For any change process, people need to have a clear understanding of the reason for change and the direction of change, to be equipped with the tools and capabilities to make the change, and to keep receiving information and reinforcement that the change is achieving the desired results. There needs to be a systematic focus on ensuring all the levers for change are operating in a joined-up way. For example, if there were a change management strategy on foot, either at a system level or in each of the organisations, it would have become apparent at an earlier stage that the slow progress in rolling out management and leadership training at all levels would impact the effectiveness of the plans and measures being adopted at executive levels in the organisation.

There also needs to be much more coherent and deliberate communication about culture change. It is much easier for staff to understand and embrace change that is delivered with a simple clear message than to make sense of a plethora of different initiatives.

There is no one right way to communicate change. Good material has been produced by the Culture Review Implementation Branch, which could be incorporated into communication efforts in the three organisations even if they have decided that they wish to adopt their own branding and approach to communication. But consistent communication, tailored to the various segments of the workforce, and based strongly on change management principles, will be essential for staff to understand, adopt, and believe in the promise of culture change.

Conclusions

All three health organisations should adopt a much more coherent and vigorous change management and communication strategy, assign ongoing responsibility to specified positions, ensure action continues to be taken to monitor and adjust the change strategy as needed, and regularly reinforce communication messages across multiple channels and at all levels.

Effectiveness of planning and implementation

Governance arrangements

The governance arrangements put in place to progress the implementation of the Culture Review were sound. These included the establishment of oversight involving all key stakeholders, a steering group of the CEOs of the three organisations that needed to take action to implement the Culture Review, and a dedicated support function in the Culture Review Branch.

The governance bodies have met regularly and have continued to focus on the implementation of the Culture Review. However, as noted under recommendation 18, the members of the governance bodies have sometimes departed from their responsibilities to achieve the collectively agreed outcomes of the Culture Review and have instead pursued their own organisational goals and interests. It has taken some time, and the involvement of independent facilitation, to enable the honest conversations that need to be had to keep the groups focused on their shared outcomes. This will need ongoing attention.

Implementation delays

The support of the Culture Review Branch has been valuable in enabling the development and implementation of a large body of work. However, the effectiveness of this supporting role is only as good as the effectiveness of the action and decision making of the governance bodies to which it reports. On some matters where progress has been slower than ideal, such as the establishment of system-wide health measures or the adoption of change management and communication strategies, much time and effort has been expended for slim results, due to the difficulties the three health organisations had in agreeing on shared actions.

On several foundational matters, implementation has been slow, and there does not seem to have been sufficient sense of urgency in the governance bodies to change course or take action to expedite progress.

- The Workplace Culture Framework was a key piece of underpinning architecture needed to provide the foundation for the development of training and change strategies, but was not commissioned until September 2019 and not delivered until May 2020, a year after the commitment to implement the Culture Review recommendations. Perhaps as a result, the Framework seems to have had little impact on the range of activities the three organisations have been adopting to implement culture reform.
- The subsequent development of programs for the delivery of the people and leadership skills envisaged by the Workplace Culture Framework were not agreed between the three organisations in a timely way, such that requirements to be offered out to training providers were not ready until early 2021; further delays in the procurement process have led to there now being less than a year left of the Culture Review program without any substantial management and leadership training having commenced.

- Similar inertia has bedevilled the development of the research strategy envisaged by Recommendation 7.[13]

The lack of an agreed change management strategy has meant that the impact of delays in these foundational matters on the ability to achieve the intended culture reform outcomes has not been made as visible to the three organisations as it should have been.

There is a weakness in the structural arrangements that has allowed implementation on important measures such as these to drift. The Culture Review Branch, which has the central role to monitor and manage implementation, does not have any power to stimulate greater action by the three organisations, other than to report on emerging risks. Since the split of Canberra Health Services into a separate Directorate, the Health Directorate does not have any power or influence to require or expect alignment with strategic outcomes by CHS; and the contracting arrangements with Calvary PHB similarly do not enable any such expectation of action. Progress on all these matters has depended on effective collaboration and shared willingness to act with persistence and determination, and where these have been insufficient, there have been no levers to instigate change.

Focus on process

The third area that has impacted on effective implementation has been the tendency of the three organisations and the overarching governance bodies to focus more on process that on outcomes. Discussions and documentation show there has been more consideration of and reporting on whether certain actions and commitments were being implemented, than on whether real change was occurring. Program documentation provided to the Review reported in many places that certain recommendations were "complete" where all the actions that those responsible were prepared to undertake were completed but the thrust of the recommendation was clearly not achieved. On a wide range of matters, key people in the three organisations consulted by the Review appeared to be satisfied that matters were on track because processes had been reviewed or new strategies had been adopted, without there being any means to ascertain whether these were effectively addressing the relevant issue identified by the Culture Review.

Going forward

The Culture Review Branch should undertake a stocktake of the progress to date and the areas highlighted by this Review that need greater momentum, and propose to the Steering Group a consolidated and prioritised set of actions aimed at maximising the impact and effectiveness of the culture reform program over its final year of operation. These should be considered and discussed collaboratively by the Steering Group with a view to identifying the actions each organisation is willing and able to take, and the system wide measures to which they will commit. That plan should then be reviewed by the Oversight Group, with a view to agreeing an approach over the balance of the year that is focussed on achieving outcomes and on setting a path towards sustainable implementation.

13 See recommendation 7, Page 26

Sustainability

The Culture Review reported two years ago. The Government established dedicated funding and support for its implementation over a three year period. That period will come to an end at the time the third annual review is conducted, a little under a year from now. That timing should not be the end of culture reform in the ACT public health system. As this report has emphasised throughout, a positive workplace culture is an essential ingredient for performance and productivity in every workplace, and the health system needs to have an enduring commitment to fostering a healthy workplace culture. This should be a core commitment for the leadership of the three health organisations, and a responsibility for leaders at all levels throughout the health system.

In a practical sense, it is to be expected that, unless the three health organisations commit ongoing resources for the purpose, the Culture Review Branch will reduce its monitoring work and the support for specific programs of work will need to be absorbed by the three organisations as part of business as usual. It would be highly desirable if the three organisations can agree to maintain at least a small level of central oversight and support.

By the end of the current financial year, culture reform needs to have transitioned from a special activity focussed on the implementation of the 20 recommendations of the Culture Review, into an embedded part of normal business. This can be achieved by all three organisations anchoring in their strategic plans and their business plans the key components that remain to be fulfilled and that need to be ongoing, and ensuring that there is clear accountability in their structures for achieving expected outcomes. It will be critical that these elements of culture reform are not left at the level of aspirational statements, but are underpinned by plans and deliverables that are linked to the business responsibilities and performance expectations of specific people and positions.

Most importantly, the three health organisations must ensure that the strategies they adopt and the actions they commit to are being effectively communicated and implemented all the way to the front line. This will require sustained and determined effort to lift leadership capability at all levels.

The Culture Review's focus on workplace culture was explicitly linked to achieving the goals of a good health system. Achieving an effective and well-coordinated health system will require greater collaboration between the three health organisations, both on matters identified by the Culture Review such as system-wide measures of success and clinical co-ordination, and more broadly on health system performance. Enhanced governance may also be needed, and the Review would encourage the three health organisations to consider whether future governance models could fold ongoing consideration of culture into a broader collaboration on health system performance and co-ordination.

In Part IV, this Review recommended that the remaining work on Culture Review recommendations should be consolidated and prioritised for action. This should form the initial phase of transitioning culture reform into core business. Over the final 6 months of the Culture Review program, the three organisations should map the key outcomes of the Culture Review into their strategic and business planning processes. These should cover the following elements:

- Ensure the values are lived
  - The Workplace Culture Framework has already set out the steps to achieve the necessary workplace change: establish clear expectations, build people skills, and measure and report outcomes transparently
  - The OCIM will be a useful tool for the three organisations to continue to improve their capability across the spectrum of workplace change priorities
- Build employee engagement
  - A positive and productive workplace culture will help the three organisations to attract and retain talent and will improve performance and innovation
  - Steps to ensure greater engagement and satisfaction among clinicians are a core element of this focus area
  - Many of the improvements that need to be made are simply good management, such as having processes and systems that enable people to do their work, and instituting regular and meaningful two-way communication
  - There needs to be a clear focus on outcomes, not only processes
- Adopt an open and collaborative approach with partners, including academia, NGOs, professional bodies, and between the three health organisations
  - These relationships need to be lived, and focussed on shared objectives of a good health system and an engaged health workforce, not just reduced to an agenda of pro-forma meetings

The Review has been heartened by the commitment that all participants have consistently expressed towards making the ACT public health system an effective and high performing one. It is to be hoped this desire will now translate into an ongoing commitment to build and maintain the positive workplace culture that will underpin the achievement of that outcome.

Appendices

Appendix A: List of stakeholders consulted

Interviews

Stakeholders	Position/description
Minister Stephen-Smith	Minister for Health
Minister Davidson	Minister for Mental Health
Mrs Giulia Jones MLA	Opposition Health Spokesperson
Mr Mick Reid	Chair of the Independent Review into Workplace Culture and Reviewer for the Inaugural Annual Review
Karen Toohey	Discrimination, Health Services, Disability & Community Services Commissioner
Damian West	Deputy-Director General, Workforce Capability and Governance, Chief Minister, Treasury and Economic Development Directorate
Ms Di van Meegen	Facilitator, Culture Reform Oversight Group facilitated workshops
Culture Review Oversight Group	Minister for Health Minister for Mental Health Director-General, ACT Health Directorate Chief Executive Officer, Canberra Health Services Regional Chief Executive Officer, Calvary ACT Regional Secretary, Community and Public Service Union ACT President, Australian Medical Association ACT Executive Director, Health Care Consumers Association ACT President, Australian Salaried Medical Officers Federation ACT President, Visiting Medical Officers Association ACT Dean, College of Health and Medicine, Australian National University Executive Dean, Faculty of Health, University of Canberra

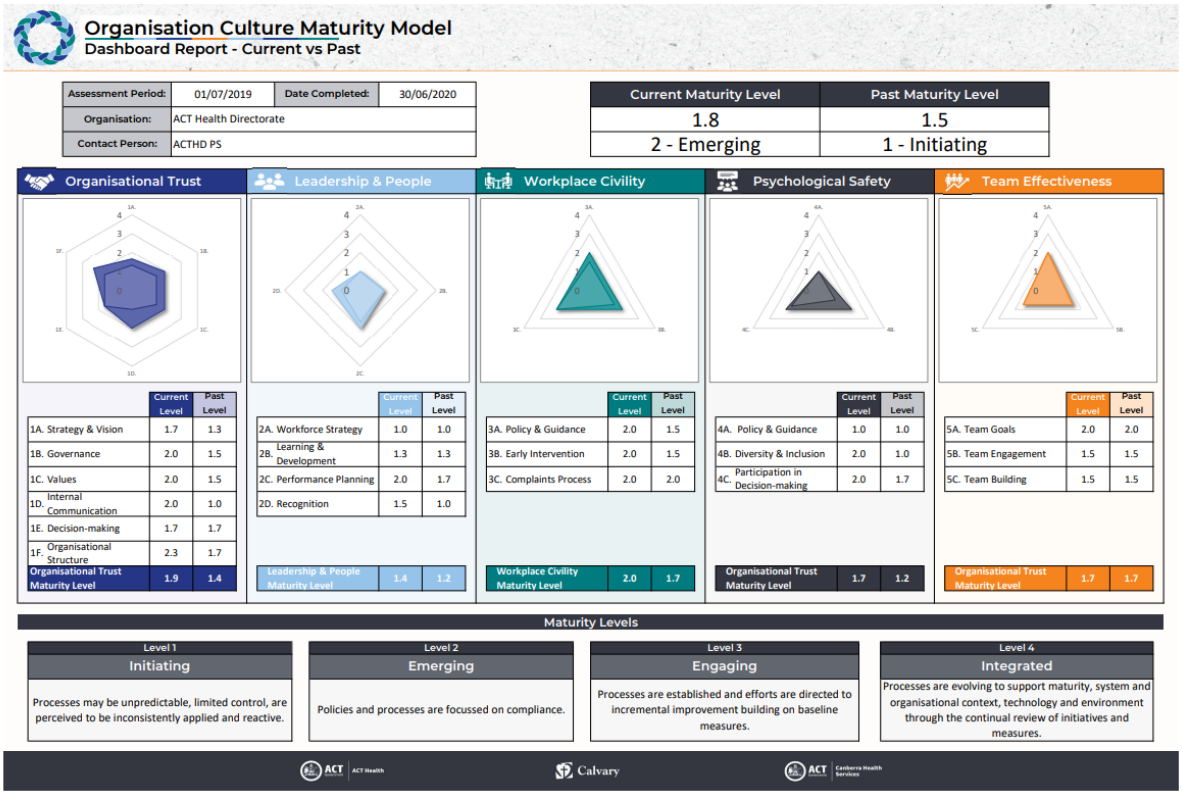
Culture Review Implementation Steering Group	Director-General, ACT Health Directorate Chief Executive Officer, Canberra Health Services Regional Chief Executive Officer, Calvary ACT Executive Branch Manager, People Strategy and Culture, ACT Health Directorate Executive Group Manager, People and Culture, Canberra Health Services
Rebecca Cross	Director-General, ACT Health Directorate
Bernadette McDonald	CEO, Canberra Health Services
Barb Reid	Regional CEO, Calvary ACT
Robin Haberecht	General Manager, Calvary Public Hospital Bruce
Meg Brighton	Deputy-Director General, ACT Health Directorate
Dr Dinesh Arya	Chief Medical Officer, ACT Health Directorate
Jacinta George	Executive Group Manager, Health System Planning & Evaluation, ACT Health Directorate
Raelene Burke and Kalena Smitham	Executive Group Manager, People & Culture, Canberra Health Services (outgoing and incoming)
Dr Nick Coatsworth	Executive Director Medical Services, CHS
Dr Ashwin Swaminathan	Clinical Director, Division of Medicine
Representatives from People and Culture Group	Canberra Health Services
Matthew Daniel	Secretary, Australian Nursing and Midwifery Federation (AMNF) ACT
Madeline Northam	Regional Secretary, Community and Public Sector Union (CPSU) ACT
Dr Peter Hughes	President, Visiting Medical Officers Association (VMOA) ACT
Darlene Cox	Executive Director, Health Care Consumers Association (HCCA) ACT
Lisa Kelly	CEO Carers ACT and Co-Chair NGO Leadership Group

Associate Professor Jeffrey Looi and Mr Steve Ross	Australian Salaried Medical Officers Federation (ASMOF) ACT
Dr Walter Abhayaratna	Australian Medical Association (AMA) ACT President
Dr Gert Frahm-Jensen	Royal Australasian College of Surgeons
Professor Imogen Mitchell	Executive Director of Research and Academic Partnerships, Canberra Health Services / ANU Professor, ANU Medical School Intensive Care Specialist, Canberra Health Services
Professor Russell Gruen	Dean, College of Health and Medicine, Australian National University (ANU)
Professor Michelle Lincoln	Executive Dean, Faculty of Health, University of Canberra
Professional Colleges Advisory Committee Members	Dr Ali Teate - Australian College of Midwives Dr Jessica Tidemann - Royal Australian College of General Practitioners Professor Jane Dahlstrom - Royal College of Pathologists of Australasia Dr Louise Stone - Australian College of Rural and Remote Medicine Stephen Jackson - Australian College of Mental Health Nurses Dr Fatma Lowden - The Royal Australian & New Zealand College of Psychiatrists Juliane Samara – Australian College of Nurse Practitioners
Clinical Leadership Forum Members	Shelley McInnes - Consumer Representative Toni Ashmore - Allied Health Professional Associate Professor Paul Craft - Clinical Director Cancer Ambulatory Support, Canberra Health Service
Culture Review Implementation Branch	Jodie Junk-Gibson, Executive Branch Manager People Strategy and Culture Branch Belinda Harris, Senior Director Program Management, Culture Review Implementation Suze Rogashoff, Strategic People Advisor

Focus groups

Stakeholder group	Organisation
Bowes Street Staff	ACT Health Directorate
Health Protection Service Staff	ACT Health Directorate
Staff	Calvary Public Hospital
Representatives and Members	Community and Public Service Union
Representatives and Members	Australian Nursing and Midwifery Federation

Appendix B: OCIM assessments



Organisation Culture Maturity Model
Dashboard Report - Current vs Past

Assessment Period:	01/07/2019	Date Completed:	30/06/2020
Organisation:	ACT Health Directorate		
Contact Person:	ACTHD PS		

Current Maturity Level	Past Maturity Level
1.8	1.5
2 - Emerging	1 - Initiating

Organisational Trust

	Current Level	Past Level
1A. Strategy & Vision	1.7	1.3
1B. Governance	2.0	1.5
1C. Values	2.0	1.5
1D. Internal Communication	2.0	1.0
1E. Decision-making	1.7	1.7
1F. Organisational Structure	2.3	1.7
Organisational Trust Maturity Level	1.9	1.4

Leadership & People

	Current Level	Past Level
2A. Workforce Strategy	1.0	1.0
2B. Learning & Development	1.3	1.3
2C. Performance Planning	2.0	1.7
2D. Recognition	1.5	1.0
Leadership & People Maturity Level	1.4	1.2

Workplace Civility

	Current Level	Past Level
3A. Policy & Guidance	2.0	1.5
3B. Early Intervention	2.0	1.5
3C. Complaints Process	2.0	2.0
Workplace Civility Maturity Level	2.0	1.7

Psychological Safety

	Current Level	Past Level
4A. Policy & Guidance	1.0	1.0
4B. Diversity & Inclusion	2.0	1.0
4C. Participation in Decision-making	2.0	1.7
Organisational Trust Maturity Level	1.7	1.2

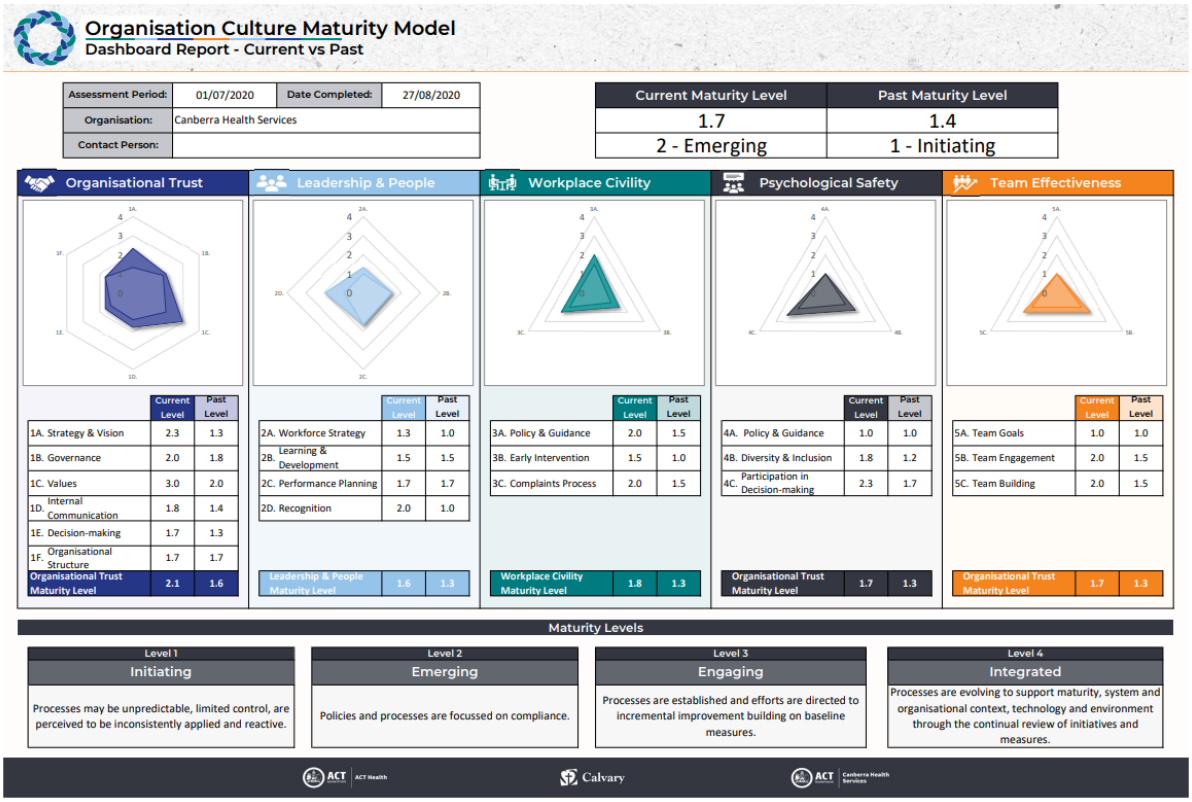
Team Effectiveness

	Current Level	Past Level
5A. Team Goals	2.0	2.0
5B. Team Engagement	1.5	1.5
5C. Team Building	1.5	1.5
Organisational Trust Maturity Level	1.7	1.7

Maturity Levels

Level 1	Level 2	Level 3	Level 4
Initiating	**Emerging**	**Engaging**	**Integrated**
Processes may be unpredictable, limited control, are perceived to be inconsistently applied and reactive.	Policies and processes are focussed on compliance.	Processes are established and efforts are directed to incremental improvement building on baseline measures.	Processes are evolving to support maturity, system and organisational context, technology and environment through the continual review of initiatives and measures.

ACT Health | Calvary | ACT Canberra Health Services



Organisation Culture Maturity Model
Dashboard Report - Current vs Past

Assessment Period:	01/07/2020	Date Completed:	27/08/2020
Organisation:	Canberra Health Services		
Contact Person:			

Current Maturity Level	Past Maturity Level
1.7	1.4
2 - Emerging	1 - Initiating

Organisational Trust

	Current Level	Past Level
1A. Strategy & Vision	2.3	1.3
1B. Governance	2.0	1.8
1C. Values	3.0	2.0
1D. Internal Communication	1.8	1.4
1E. Decision-making	1.7	1.3
1F. Organisational Structure	1.7	1.7
Organisational Trust Maturity Level	2.1	1.6

Leadership & People

	Current Level	Past Level
2A. Workforce Strategy	1.3	1.0
2B. Learning & Development	1.5	1.5
2C. Performance Planning	1.7	1.7
2D. Recognition	2.0	1.0
Leadership & People Maturity Level	1.6	1.3

Workplace Civility

	Current Level	Past Level
3A. Policy & Guidance	2.0	1.5
3B. Early Intervention	1.5	1.0
3C. Complaints Process	2.0	1.5
Workplace Civility Maturity Level	1.8	1.3

Psychological Safety

	Current Level	Past Level
4A. Policy & Guidance	1.0	1.0
4B. Diversity & Inclusion	1.8	1.2
4C. Participation in Decision-making	2.3	1.7
Organisational Trust Maturity Level	1.7	1.3

Team Effectiveness

	Current Level	Past Level
5A. Team Goals	1.0	1.0
5B. Team Engagement	2.0	1.5
5C. Team Building	2.0	1.5
Organisational Trust Maturity Level	1.7	1.3

Maturity Levels

Level 1	Level 2	Level 3	Level 4
Initiating	**Emerging**	**Engaging**	**Integrated**
Processes may be unpredictable, limited control, are perceived to be inconsistently applied and reactive.	Policies and processes are focussed on compliance.	Processes are established and efforts are directed to incremental improvement building on baseline measures.	Processes are evolving to support maturity, system and organisational context, technology and environment through the continual review of initiatives and measures.

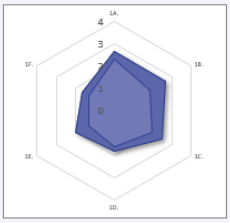
ACT Health | Calvary | ACT Canberra Health Services

Organisation Culture Maturity Model
Dashboard Report - Current vs Past

Assessment Period:	01/07/2020	Date Completed:	20/08/2020
Organisation:	Calvary Public Hospital Bruce		
Contact Person:			

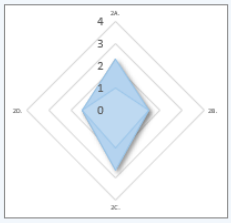
Current Maturity Level	Past Maturity Level
1.7	1.4
2 - Emerging	1 - Initiating

Organisational Trust



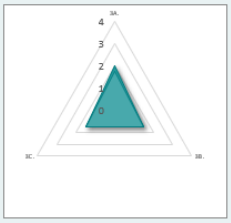
	Current Level	Past Level
1A. Strategy & Vision	2.7	2.3
1B. Governance	2.7	1.8
1C. Values	2.5	2.0
1D. Internal Communication	1.8	1.6
1E. Decision-making	2.0	1.3
1F. Organisational Structure	1.7	1.3
Organisational Trust Maturity Level	**2.2**	**1.7**

Leadership & People



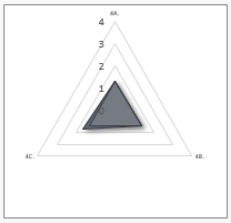
	Current Level	Past Level
2A. Workforce Strategy	2.3	1.0
2B. Learning & Development	1.5	1.5
2C. Performance Planning	2.7	1.7
2D. Recognition	1.5	1.5
Leadership & People Maturity Level	**2.0**	**1.4**

Workplace Civility



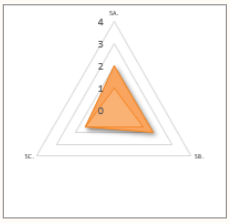
	Current Level	Past Level
3A. Policy & Guidance	2.0	1.8
3B. Early Intervention	1.5	1.5
3C. Complaints Process	1.5	1.5
Workplace Civility Maturity Level	**1.7**	**1.6**

Psychological Safety



	Current Level	Past Level
4A. Policy & Guidance	1.3	1.3
4B. Diversity & Inclusion	1.4	1.4
4C. Participation in Decision-making	1.7	1.3
Organisational Trust Maturity Level	**1.5**	**1.4**

Team Effectiveness



	Current Level	Past Level
5A. Team Goals	2.0	1.0
5B. Team Engagement	2.0	1.5
5C. Team Building	1.5	1.5
Organisational Trust Maturity Level	**1.8**	**1.3**

Maturity Levels

Level 1	Level 2	Level 3	Level 4
Initiating	**Emerging**	**Engaging**	**Integrated**
Processes may be unpredictable, limited control, are perceived to be inconsistently applied and reactive.	Policies and processes are focussed on compliance.	Processes are established and efforts are directed to incremental improvement building on baseline measures.	Processes are evolving to support maturity, system and organisational context, technology and environment through the continual review of initiatives and

Appendix C: Public commitment by the Ministers and three leaders of the ACT public health system

A public commitment was made by the Ministers and three leaders of the ACT public health system on 16 May 2019:

"We are committed to improving the workplace culture within the ACT public health system and through that, enhancing the standard of health care and services provided to the Canberra community.

We will work together to ensure all 20 recommendations of the review are addressed and implemented. This is our commitment to all who work in the ACT public health system and to the community.

We are focussed on embedding best practice to ensure the changes that are implemented from the review are enduring across the ACT's public health system. We will ensure strong governance is in place across all organisations and at all levels of leadership to drive the implementation of the recommendations.

We look forward to new beginnings and the continuation of work already underway to improve workplace culture within our organisations.

Together we are unreservedly committed to change for our staff and the community."

Appendix D: Public commitment by the Culture Reform Oversight Group members

A public commitment was made by the Oversight Group members on 4 September 2019:

"Together we are committed to driving positive culture change for our members, students and the community.

As organisations represented on the Culture Review Oversight Group, we state our commitment to work together with the Minister for Health the Minister for Mental Health and the three leaders of the ACT public health system to improve the workplace culture, and through that, enhance the standard of health care and services provided to the Canberra community.

Together, we will work to ensure all 20 recommendations of the review are addressed and implemented.

We are resolute in supporting the application of the best evidence available to ensure the approaches implemented from this review are enduring across the ACT public health system"

Appendix E: Biography of Renee Leon, Leon Advisory

Renée Leon was recently appointed Vice-Chancellor at Charles Sturt University. Previous to this, Renée was Secretary of the Department of Human Services from 2017-2020, having been Secretary of the Department of Employment from 2013-2017. Her other senior public service roles included roles as Deputy Secretary in the Attorney-General's Department and in the Department of the Prime Minister and Cabinet. She also spent three years as Chief Executive of the ACT Department of Justice and Community Safety, where she led the amalgamation of a broad range of public safety agencies into the Department.

Renée is qualified in Arts and Law and holds a Masters in Law from Cambridge University. She was awarded a Public Service Medal in 2013 for outstanding public service to public administration and law in leadership roles in the Australian Capital Territory and the Commonwealth.

Renée is a Fellow of the Australian Institute of Public Policy at the Australian National University. She has served on the Boards of the Australian Institute of Criminology, the National Australia Day Council, and the Australia New Zealand Policing Advisory Agency, and was a member of the Council of the Order of Australia.

ACKNOWLEDGMENT OF COUNTRY

ACT Health acknowledges the Traditional Custodians of the land, the Ngunnawal people. ACT Health respects their continuing culture and connections to the land and the unique contributions they make to the life of this area. ACT Health also acknowledges and welcomes Aboriginal and Torres Strait Islander peoples who are part of the community we serve.

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Culture Review **Implementation**

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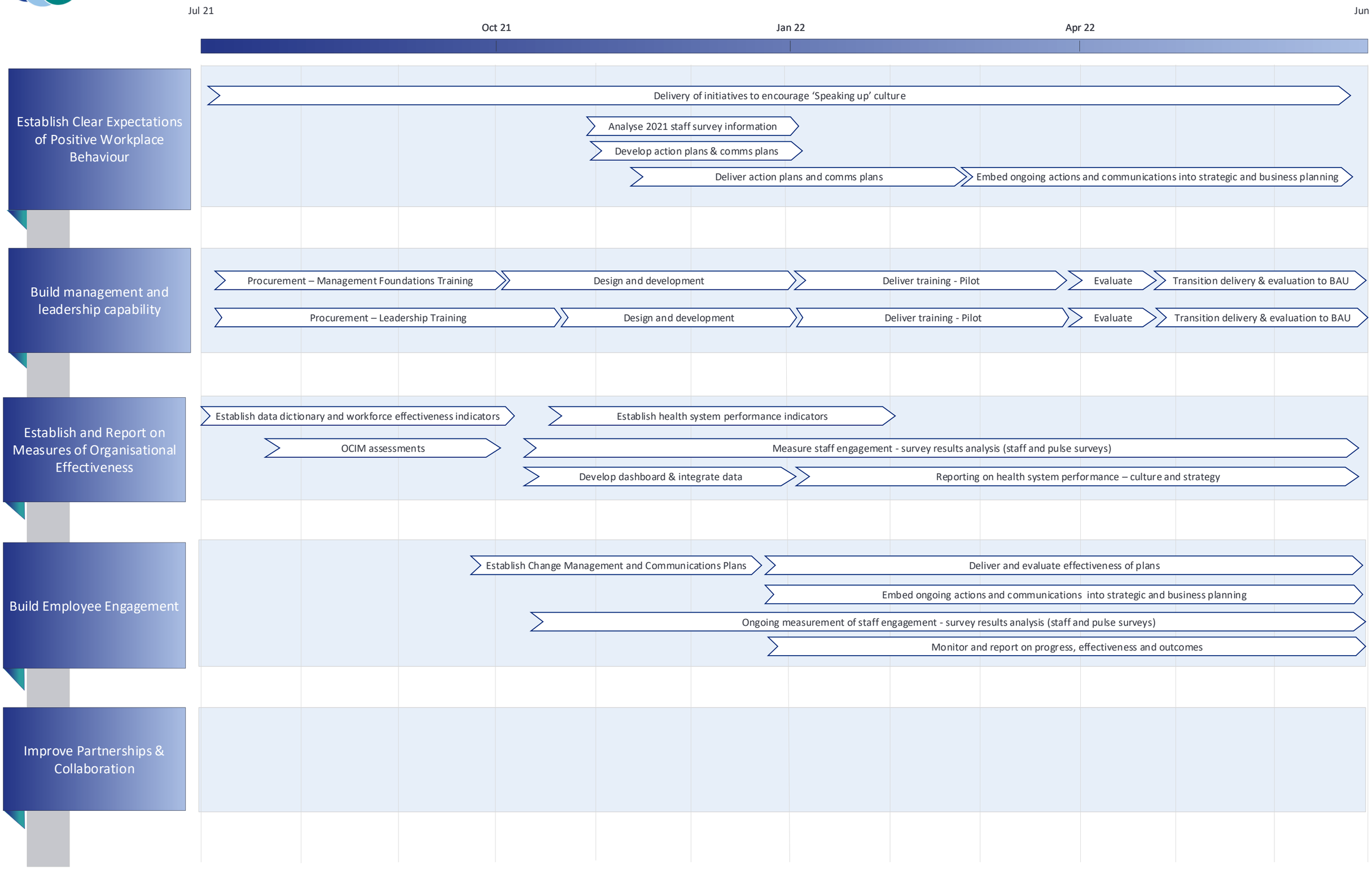
Project Plan to 30 June 2022



Culture Review **Implementation**

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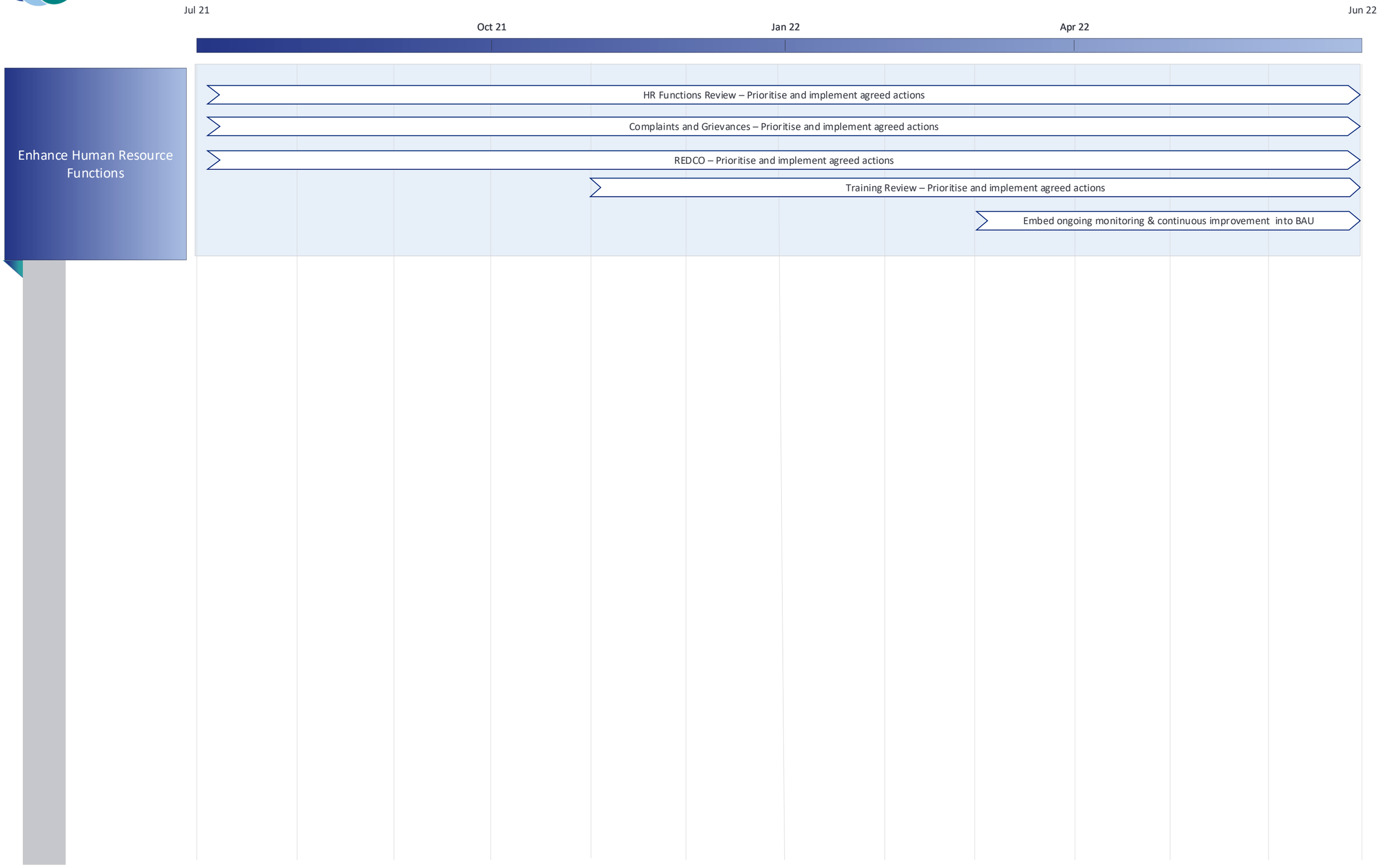

Attachment 2.1C.

Key Findings from the Culture Review Implementation: Second Annual Review

1. Good foundational work has been done to establish strong frameworks for the reform of culture. This includes the Workplace Change Framework, the Organisation Culture Improvement Model, and the work the three health organisations have respectively undertaken to refresh and embed their organisational values.

2. Values need to be seen by staff to be lived at all levels. More needs to be done to establish expectations of positive workplace behaviour and to build leadership and management capability to uphold those expectations in practice. The rollout of Speaking Up For Safety in the two hospitals is a good start but will not be the only training and development that is required.

3. Formal changes have been implemented to ensure clinicians are involved in strategy and governance arrangements, and to increase the information and engagement opportunities for clinicians throughout the health system. Further development of clinical leadership capability and a willingness to listen and respond to front line clinical staff will be needed to ensure that clinician engagement improves at all levels.

4. The work that has been done to establish a research strategy is a positive start but needs more focus and momentum. The approach to research needs to be based in open and positive relationships between the health services and the universities, with genuine opportunity for clinicians to engage in research.

5. There is an opportunity and a need for improved collaboration and coordination across the health system, including between the Health Directorate and the health services, between the ACT and NSW health systems, and between health services and health consumers.

6. System-wide measures of performance, on both strategy and culture, should be developed and adopted for transparent reporting of progress.

VALUES

Recommendation 1

Key Findings:

- All three health organisations have engaged positively in affirming and promulgating the values that underpin quality health care and organisational effectiveness.
- Some improvements are being anecdotally reported in the extent to which the values are lived, but staff have also expressed concerns that values-led behaviour is not consistently expected or demonstrated.

Proposed Action:

- More needs to be done to establish expectations of positive workplace behaviour and to build leadership and management capability to uphold those expectations in practice.
- Close consideration should be given to 2021 staff survey information and real focus given to what needs to be done if staff are not positive on the values being lived.
- The Review recommends that analysis of the 2021 staff survey results for all three health organisations be reviewed carefully by the Oversight Group when considering the ongoing implementation of the Culture Review.

MEASURING ORGANISATIONAL EFFECTIVENESS

Recommendation 2

Key Findings:

- The only measures developed or monitored by the three organisations in relation to this recommendation have been measures of culture change.

Proposed Action:

- Work should be re-invigorated to develop and implement agreed system-wide measures of performance of the health system that would give valuable performance data to clinicians and administrators for continuous improvement and meaningful information on the performance of the public health system.
- ACT Health Directorate (ACTHD), Canberra Health Services (CHS) and Calvary Public Hospital Bruce (CPHB) should work together, drawing on the input and involvement of clinicians and on experience and systems in other jurisdictions, to develop a suite of measures that reflect on key elements of a successful health service – both culture and strategy – and that measure health system performance, patient outcomes and experience, and staff well-being and development.

ADDRESSING BULLYING AND HARASSMENT

Recommendation 3

Key Findings:

- Staff and stakeholders interviewed continued to express significant concern about both the occurrence of inappropriate workplace behaviour and the response to complaints.
- There were some positive views that bullying had decreased in places. However, most staff feedback, particularly in Canberra Health Services, reflects a view that little has changed.
- Good work has been done by CHS and CPHB to improve the processes for handling complaints of bullying, to raise staff awareness, and to provide support.
- More could be done to better understand staff experience of the complaints process.

Proposed Action:

- CHS and CPHB should continue with the rollout of Speaking up for Safety and move as soon as possible to implement the Promoting Professional Accountability Program.
- ACTHD should institute an appropriate program to empower staff to call out inappropriate behaviour.
- All three organisations should set clear expectations for staff about appropriate workplace behaviour and equip managers and leaders at all levels to uphold these expectations both for themselves and in their teams.
- Leaders at all levels need training and support to improve their capabilities in instilling appropriate standards for workplace behaviour in their teams.
- Formal complaint processes should be streamlined as much as possible, particularly to reduce the time taken to resolve matters.
- For behaviour at the serious level of bullying, all three organisations should ensure they have efficient and effective means to handle and resolve complaints and should monitor timeliness, outcomes, and participant experience.

PARTNERSHIPS AND RELATIONSHIPS

Recommendation 4

Key Findings

- There has been more focus on questions as to whether and how to hold a summit, than on developing a plan for improved collaboration and coordination, which was the intent of the recommendation.
- The ACT would benefit from improved coordination of public health services in the ACT.

- While advancing these plans for ongoing collaboration, clinicians and administrators should not lose sight of the practical issues identified by the Culture Review concerning the mobility of medical officers between the two hospitals.

Proposed Action:

- The CEOs of the three health organisations and their executive teams should take the lead in exemplifying respectful and collaborative behaviours and expect their staff to do the same.
- Clinicians and senior administrators should, to the extent feasible within the existing arrangements, adopt a collaborative and system-wide approach.
- Barriers to clinical collaboration and mobility should be vigorously addressed.

Recommendation 5

Key Findings:

- CHS has made a concerted effort to link community health services with broader governance processes and meetings.
- CHS is proposing to monitor and evaluate the integration of community health services.

Recommendation 6

Key Findings:

- The establishment of the NGO Leadership Group is a positive step and has been welcomed by the NGOs consulted for the Review.
- NGOs consulted for the Review were overall positive about the improvements in communication and engagement by the Health Directorate, particularly at Executive level, noting that the attitude of openness and partnership had not necessarily reached all parts of the Directorate.
- It would be beneficial for both Calvary PHB and CHS to review the effectiveness of their arrangements for consultation and collaboration with relevant NGOs.

Proposed Action:

- The three health organisations should commit to an engaged and collaborative relationship with NGOs and peak bodies that recognises and draws upon the valuable input NGOs bring to both policy design and coordination of care.
- CEOs and senior leaders of both organisations should model and expect of their staff respectful and collaborative approaches with clarity about the role that NGOs are being asked to play on any particular project.

Recommendation 7

Key Findings:

- Clinicians and academics consulted for the Review overall considered that research was not sufficiently valued and expressed frustration at the slow progress in implementation of the recommendation.
- The Culture Review emphasised the importance of research linkages for improving clinical engagement and enhancing the attractiveness of Canberra as an employment destination for talented clinicians. Research should be a core component of the ACT's health strategy, and part of fostering the kind of climate where innovation thrives in solving the clinical or organisational issues facing health services.

Proposed Action:

- Finalisation of the research strategy needs to be given greater momentum and be brought to a workable outcome with research priorities adopted and then actioned.
- The two hospitals must recognise the value of engagement with research, both by fostering open and positive relationships with academic institutions, and by enabling clinicians in a practical sense to undertake research by allocating and protecting time for that purpose.

<u>Recommendation 8</u>

Key Findings:

- Implementation of this recommendation has been delayed due to broader issues of the negotiation of the intergovernmental agreement.
- There are some arrangements on foot between CHS and NSW Health that enable JMOs and Registrars from the ACT to complete clinical rotations in areas of NSW adjacent to the ACT. These arrangements are welcome for the benefits they bring to doctor training, but do not address the broader issues raised by the Culture Review.

Proposed Action:

- Efforts should be made to pursue opportunities for clinical mobility and access to professional development and research projects in NSW Health. This may be able to be finalised as part of the negotiations currently on foot for a broader inter-governmental Agreement, but if not, discussions should be progressed either through the JOC or at Directorate level to seek to progress more informal exchange and networking arrangements.

<u>Recommendations 9 and 10</u>

Key Findings:

- Good work has been done by CHS to establish structures and processes designed to involve clinicians in executive decision making, and to enable clinicians to be better informed and consulted on matters that affect them.
- The establishment of the Clinical Directors Forum at CHS has been welcomed by stakeholders consulted by the Review, although it is less clear that it is improving

overall satisfaction and engagement for medical staff below the level that is represented on the CDF.
- Doctors who spoke to the review expressed frustration that consultation was not meaningful and tended to consist of being told rather than having genuine input.

Proposed Action:

- Both CHS and CPHB need to ensure that the processes they have put in place to increase clinical engagement are achieving improved engagement in practice for their clinical workforces.
- Sentiment and satisfaction among clinicians needs to be regularly tested and appropriate action taken if the prevailing experience of clinicians does not match the outcomes sought to be achieved by changes to process and governance.

Recommendation 11

Key Findings:

- Both CHS and CPHB have adopted the Choosing Wisely Initiative.

Recommendation 12

Key Findings:

- CHS has largely implemented this recommendation and the arrangements for business partners has been welcomed.
- There is still frustration expressed about slow and inefficient procedures, in particular extended delays and opaque processes for routine recruitment or procurement.

Proposed Action:

- The Review would encourage continued evolution of the management role for Clinical Directors, with a view to increasing their 'earned autonomy' and improving operational efficiency.
- More streamlined and less burdensome administrative processes will, more broadly, improve both staff experience and organisational efficiency.

Recommendation 13

Key Findings:

- Action on this front needs to be substantially increased and expedited to develop the capability of leaders and managers.
- There needs to be substantial and ongoing commitment to developing leadership and management capability in all three health organisations.

Proposed Action:

- Leadership and management training should focus on the elements identified by the Workplace Change Framework and should be regularly evaluated for its effectiveness.
- Promotion into and performance management in leadership roles should be based equally on leadership behaviours as on technical skills.
- The three health organisations should invest in management and leadership capability as a core aspect of business as usual, not a special one-off event attributed to the Culture Review.

HUMAN RESOURCES

Recommendation 14 and 15

Key Findings:

- It is positive that all three organisations have developed more useful dashboards to enable managers to be aware of workforce data and trends.
- HR data should be used as a source of insights and a basis for more strategic attention to workforce issues, not only as a tool for routine management and monitoring.
- While the HR functions review identified numerous areas requiring attention in all three organisations, progress has been limited in addressing these and more should be done in order to establish the capabilities that HR needs to support the organisations.

Proposed Action:

- The hospitals in particular may need to more closely examine the processes for recruitment to ascertain whether clinical staff can be given more support to manage the demands of recruitment against the pressure of clinical work, and whether the 'earned autonomy' foreshadowed in Recommendation 12 could help to address the delays caused by needing multiple approval steps external to divisions.

Recommendation 16

Key Findings:

- The training review found that the courses overall had low alignment with the Workplace Change Framework and inadequate evaluation methodologies. In short, these training programs are not focusing on the right things and are not being evaluated to determine if they are producing the intended results.
- Although the training review has been conducted as recommended by the Culture Review, there does not appear to have been a great deal of action since then to reframe or re-align the training programs.

Proposed Action:

- There needs to be a more determined focus on delivering appropriate training in order to equip managers and staff at all levels with the skills they need to foster the necessary changes in workplace culture.

Recommendation 17, 18 and 19

Key Findings:

- The Oversight Group has evolved over time in its approach to oversighting the implementation of the Review's recommendations.
- There has sometimes been tension between the roles of members as representatives of a particular sector or group, and their roles as contributors to a collegiate process of change.
- Structural issues, such as the funding arrangements for CPHB and the divide of responsibilities between the ACTHD and CHS, have sometimes impacted the necessary spirit of collegiality.
- The recent establishment of Working Groups under the Oversight Group to progress particular issues is a positive step, but there needs to be ongoing willingness of Oversight Group members and their organisations to put in time and effort to make these Working Groups effective.

Proposed Action:

- The Review encourages the Oversight Group to review its operations and agenda to ensure that it is focussed on the key drivers of workplace culture change.
- The roles and responsibilities of the Oversight Group and the Steering Group, and the communication lines between them, should be further clarified.
- The Oversight Group should operate in a similar mode to a Board, with responsibility for strategic guidance.
- The Implementation Steering Group should, as a minimum, have responsibility to work together to progress action and outcomes on particular issues that the Oversight Group identifies as needing action or resolution between the three health organisations.
- More broadly, the Steering Group should share information and learning between the three health organisations on what is working well or not and identify opportunities for more strategic partnership work.
- There needs to be greater clarity and agreement between the three health organisations as to the matters that require a system-wide approach, such as the identification and monitoring of health system data and overall commitments to the key aspects of workplace culture improvement, and the matters on which details can vary to reflect the different functions and nature of the three organisations.

Recommendation 20

Key Findings:

- The three organisations have failed to agree on system-wide change management or communications strategies and have made only limited inroads into establishing or implementing organisation-specific strategies.
- Interviews with staff across the health system showed that few had any knowledge of the work that was being undertaken to implement the findings of the Culture Review.
- There needs to be much more coherent and deliberate communication about culture change.

Proposed Action:

- All three health organisations should adopt a much more coherent and vigorous change management and communication strategy, assign ongoing responsibility to specified positions, ensure action continues to be taken to monitor and adjust the change strategy as needed, and regularly reinforce communication messages across multiple channels and at all levels.

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Culture Reform Oversight Group Meeting Paper

OFFICIAL

Agenda Item:	2.3
Topic:	**Organisation Culture Improvement Model Assessments**
Meeting Date:	13 December 2021
Action Required:	**Discussion**
Cleared by:	**Director-General, ACT Health Directorate**
Presenter:	Director-General ACT Health Directorate, Chief Executive Officer, Canberra Health Service, Regional Chief Executive Officer, Calvary Hospital

Purpose

1. To present the results of the 2021 Organisational Culture Improvement Model assessments for the ACT Health Directorate, Canberra Health Services and Calvary Public Hospital Bruce.

Background

2. In 2019, the Australian National University's Research School of Management (ANU-RSM) was engaged to apply an evidence-based approach for the identification of key workplace culture challenges and culture change priorities for the ACT public health system.
3. Through a co-design model, the Workplace Culture Framework (Framework) was developed. The Framework serves as a roadmap for the implementation of findings related to the organisational behaviour, workforce and leadership elements outlined in *the Final Report: Independent Review into the Workplace Culture within ACT Public Health Services*.
4. To apply the ANU-RSM research findings, the Organisation Culture Improvement Model (OCIM) was developed by the Culture Review Implementation Team.
5. The OCIM enables organisations to assess organisational culture maturity and measure ongoing progress in developing workplace culture in alignment with the five priority areas identified in the Workplace Culture Framework.
6. The OCIM was piloted in 2020 with each organisation conducting a baseline retrospective assessment at June 2019 and a current-state assessment at June 2020. As part of the June 2020 assessment each organisation identified targets to be achieved by June 2021.

Issues

7. Each organisation has undertaken the OCIM assessment as at June 2021 and identified targets to be achieved by June 2022.
8. Each organisation will present the results of their respective OCIM assessments to the Oversight Group and will provide an update on priority areas for improvement in 2021-22.

Recommendation

That the Oversight Group:

- *Note the information.*

Culture Reform Oversight Group
Meeting Paper

OFFICIAL

Agenda Item:	2.4
Topic:	**Employee Surveys**
Meeting Date:	13 December 2021
Action Required:	**Discussion**
Cleared by:	**Director-General, ACT Health Directorate**
Presenter:	Director-General ACT Health Directorate, Chief Executive Officer, Canberra Health Service and Regional Chief Executive Officer, Calvary Hospital

Purpose

1. To present the high-level results of the ACT Health Directorate, Canberra Health Services and Calvary Public Hospital Bruce 2021 employee surveys.

Background

2. In November 2019, the Health Directorate (ACTHD) and Canberra Health Services (CHS) conducted their biennial employee surveys. The ACTHD and CHS 2019 surveys were conducted by BPA Analytics.
3. Calvary Public Hospital Bruce (CPHB) conducted their annual employee engagement survey in August 2020. The CPHB 2020 survey was conducted by Gallup.
4. The employee surveys undertaken in 2019 and 2020 set the benchmark for tracking improvements to workplace culture.

Issues

5. All three organisations have conducted employee surveys in 2021.
6. Staff survey approaches differ across the System:
    a. The ACTHD employee survey was conducted July/August 2021. ACTHD implemented the ACT Public Service (ACTPS) employee staff survey for 2021. Questions were mapped to the 2019 employee survey designed by BPA Analytics, with additional baseline questioning linked to the 5 priority areas identified in the Workplace Culture Framework to support the design and measurement of impact of targeted initiatives.
    b. The CHS employee survey was conducted in October 2021. As with 2019, this survey was designed by BPA Analytics.

c. The Calvary national employee survey was conducted in August 2021. The survey, designed by Gallup, includes 12 standard questions that measure employee engagement. The survey also included CPHB-specific questions relating to patient care and staff ability to speak up about safety or conduct. CPHB does not explicitly survey staff with questions based on the priorities from the Workplace Culture Framework.

7. High-level results will be presented by Director-General ACTHD, Chief Executive Officer, CHS, and Regional Chief Executive Officer, CPHB.
8. High-level results have only been made available to the ACTHD and CHS early December. Further information allowing a deeper understanding is not available to either of the organisations at the time of the presentation to draw upon.

Recommendation

That the Oversight Group:

- *Note the information.*

Culture Review Implementation
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Culture Reform Oversight Group
Meeting Paper

OFFICIAL

Agenda Item:	2.5
Topic:	**Workforce Effectiveness Dashboard and Analysis**
Meeting Date:	13 December 2021
Action Required:	**Discussion**
Cleared by:	Rebecca Cross, Director-General ACT Health Directorate
Presenter:	Director-General ACT Health Directorate, CEO Canberra Health Service, Regional CEO Calvary Hospital

Purpose

1. To provide an update of the progress being made in reporting on Workforce Effectiveness data.

Background

2. Significant work has been undertaken by the Culture Review Implementation Team over the last 12 months in developing the ACT Workforce Effectiveness Indicators Model (WEIM). This includes agreement of workforce effectiveness data to be reported by the three organisations of the ACT public health system (Attachment A and B).
3. Agreement to report against specific workforce data will:
    a. Meet the intent of recommendation 2, '*That Canberra Health Services and Calvary Public Hospital in conjunction with the Health Directorate develop an appropriate suite of measures that: reflect on elements of a great health service- both culture and strategy; monitor patient/ client perspectives of outcomes/ experience; and engage clinicians in their development.'*
    b. Demonstrate the linkage between workforce effectiveness data indicators and broader organisation performance measures.
    c. Reinforce that indicators of positive culture are more wholistic in nature, and not solely based within Human Resource and People Functions.

Issues

4. There has been extensive consultation across the ACT public health system over the preceding 18 months to gain agreement for the reporting of data.

5. The Oversight Group, and the Visiting Medical Officers Association (VMOA) in particular, has sought information on how the prevalence of bullying and harassment is measured across the public health system.
6. There is acknowledgement that some of the recommended data sets are not currently available. However, the model enables reporting of available data across each of the three arms of the ACT public health system, with the intent to increase the reported data as mechanisms to capture the data mature or become available.
7. Opportunity exists for ACT Health Directorate (ACTHD) and Canberra Health Services (CHS) to enhance the collection and measurement of workforce related data with the implementation of the Human Resource Information Management System (HRIMS) scheduled for mid-2022; while the data sets for Calvary Public Hospital Bruce (CPHB) will evolve with the enhancement of systems within Little Company of Mary.
8. In addition, annual and pulse culture surveys regularly capture workforce views on key issues such as bullying and harassment. These sit alongside the data captured from within each organisation's human resources system as an important mechanism to capture and report on the state of workplace culture.

Current Status

9. There has been agreement by the three organisations to operationalise workforce data.
10. The three organisations have agreed on a draft 'Data Dictionary' to ensure consistency in the definitions, application, and measurement timeframe for operationalising a range of data indicators across the ACT public health system.
11. There has been agreement on the data indicators that will be initially reported on, with agreement in early 2022 to establish a project plan outlining proposed timeframes.
12. Further refinement of the Dashboard will occur throughout 2022.
13. The narrative report is at Attachment A and the Dashboard is at Attachment B.
14. In response to a request by Dr Peter Hughes, VMOA, a summary of the alleged bullying and harassment incidents reported within the three organisations of the ACT public health system is at Attachment C.

Recommendation

That the Oversight Group:

- *Note the development of the draft data dictionary; and*
- *Note that reporting of the agreed data indicators will be made available to the Culture Reform Oversight Group from December, and thereafter.*

Culture Review **Implementation**

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Attachment A.
Workforce Effectiveness Analysis.

Purpose

To provide a summary of the analysis of data represented in the Workforce Effectiveness Dashboard (Dashboard).

Background:

1. As agreed at the 27 October 2021 Culture Reform Oversight Group (Oversight Group), the launch of the ACT public health system dashboard would occur in the December 2021 meeting.
2. This sees the commencement of bi-monthly reporting on agreed workforce data metrics.
3. There has been acknowledgment that the Dashboard information and supporting analysis will mature as both organisational capability and confidence in data increases.
4. Some information was not available for all organisations at the time of reporting, such as Occupational Violence as the collection of this data has been captured differently from Canberra Health Services due to the different nature of the purpose of the organisation. Further work is underway to capture this data.
5. Information was not available from Calvary Public Hospital Bruce, however, is anticipated for future meetings.

Analysis

ACT Health Directorate

Growth in the number of casual and temporary employees has increased over the past 12 months due to the establishment of the Health Emergency Control Centre (HECC) to support the COVID-19 response. Planning is underway to support the changing nature of the work area is it progresses to a business as usual approach.

Diversity statistics show no significant change over the last 3 months.

Age and Length of service show no significant change over the last 3 months

The average hours of overtime hours per person was increased for ACT Health Directorate (ACTHD) during August and September with a slight decline in October. High overtime hours are observed during these months as a direct result of the HECC COVID-19 branch's response to the Delta outbreak, in addition to the broader ACTHD supporting the response.

Commencement and separation rates have remained steady throughout the year, with the ACTHD recruiting to positions at regular intervals. It is anticipated that there will be a slight rise in commencements during January and February due to seven bulk recruitment processes (ASO3-SOGA) in addition to a range of specialised roles such as resident medical officer, registrar, specialist and social work and psychology positions currently underway for the COVID-19 branch.

The ACTHD has commenced the implementation of exit surveys from October 2021 for staff departing the organisation. The response rate is expected to increase over coming months. Leave rates typically peak

during school holidays and the Christmas and New year period and then tend to remain steady through the rest of the year.

Canberra Health Services

Growth in headcount and FTE for Canberra Health Services (CHS) was seen in line with bulk recruitment to support the COVID-19 2021 response. There have been no significant changes in employment category, employment status or gender percentages over the last 12 months.

Diversity and inclusion remain a focus for CHS and over the last year there has been gradual growth in the Aboriginal and Torres Strait Islander workforce and our culturally and linguistically diverse workforce. Our staff who identify as having a disability has remained stable.

Age and Length of service show no significant changes over the last 12 months.

Average overtime hours per person increased during August and September as CHS responded to an increase in service demand to meet ACT Territory wide COVID Vaccination and testing needs. The average overtime hours per person have started to decline as testing and vaccinations service demand decreases and CHS staff return to business as usual.

February shows a spike in recruitment for CHS in line with Graduate Nurse and Junior Medical Officer intake rounds. CHS also experienced an increase in separation in the first and second quarters due to the previous year's nursing graduates and medical staff leaving to seek employment elsewhere or to expand their career progression and training not offered at CHS.

Leave continues to rise and fall during the year in line with school holidays and peak times for CHS. Note that leave in more recent months shows a decline as leave submissions are often submitted and processed in retrospect. These figures will be updated to reflect a more accurate representation in future reports. There has also been a decrease in leave requests due to inability to travel and border closure restricting travel nationally.

Preliminary Assessments continues to be undertaken thought the year with a slight peak mid-2021 due to a clustered issue requiring multiple preliminary assessments, this has since been resolved.

Recommendation

That the Oversight Group:

- Note the information provided in this paper.

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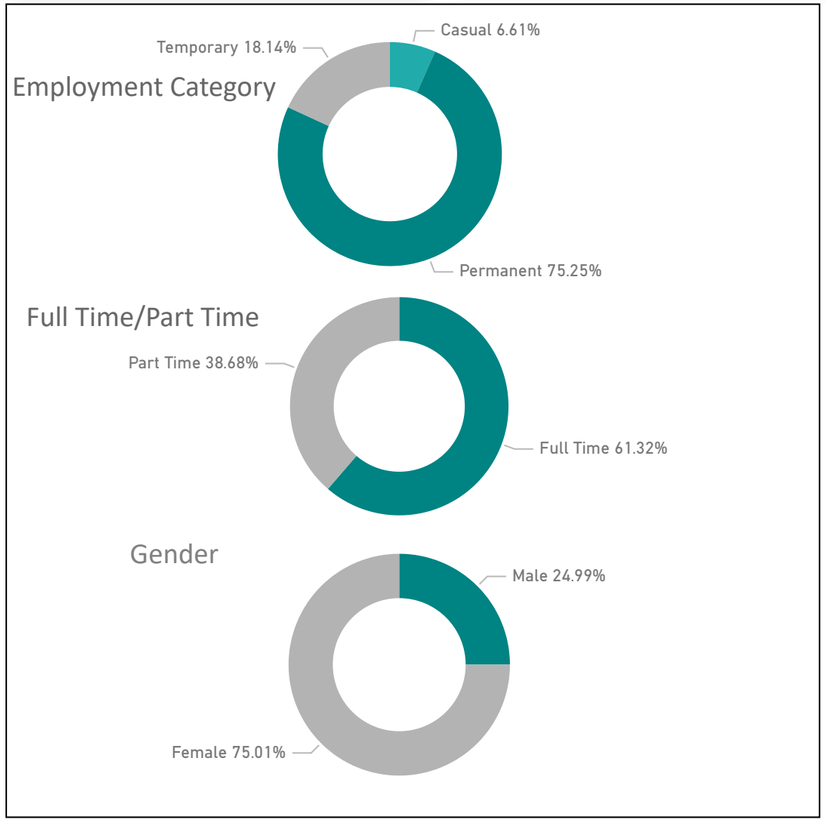
Workplace Effectiveness Dashboard

8/07/2020 27/10/2021

Canberra Health Services

7,864
Average of Headcount

6,797.1
Average of FTE



Calvary

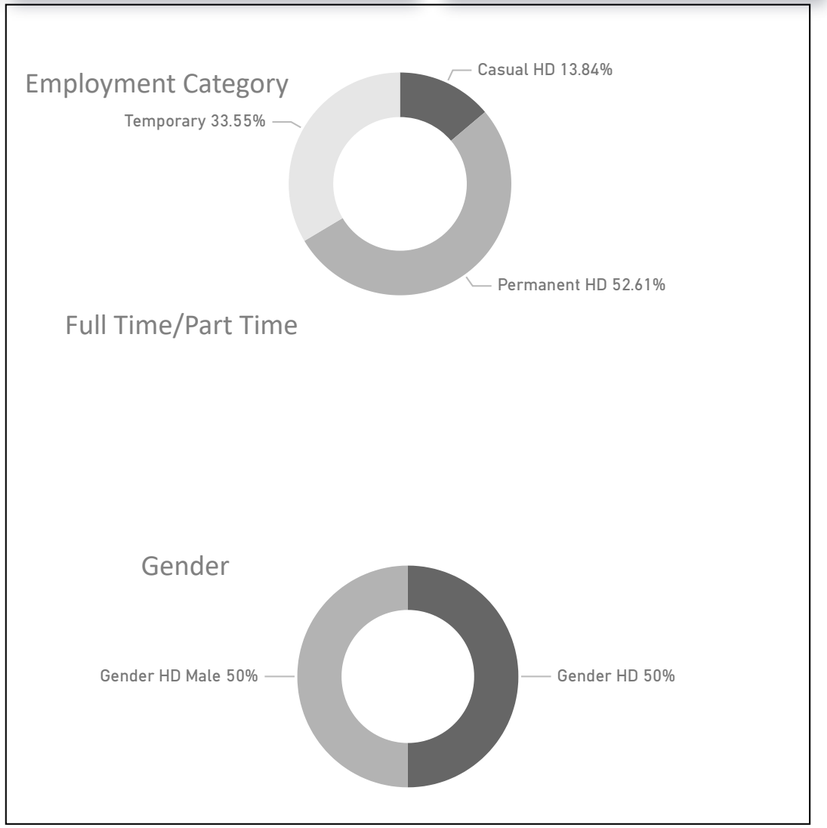
Average of Headcount

Average of FTE

ACT Health Directorate

874
Average of Headcount HD

803.5
Average of FTE HD



ACT Government | ACT Health
Calvary
ACT Government | Canberra Health Services

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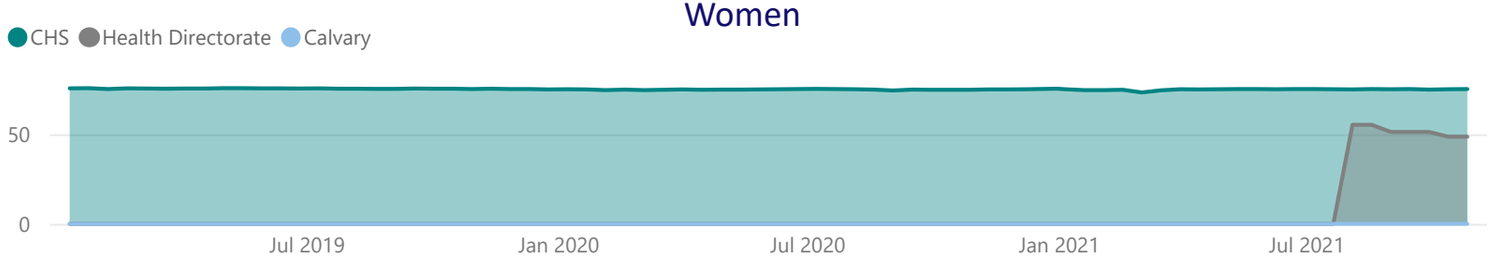
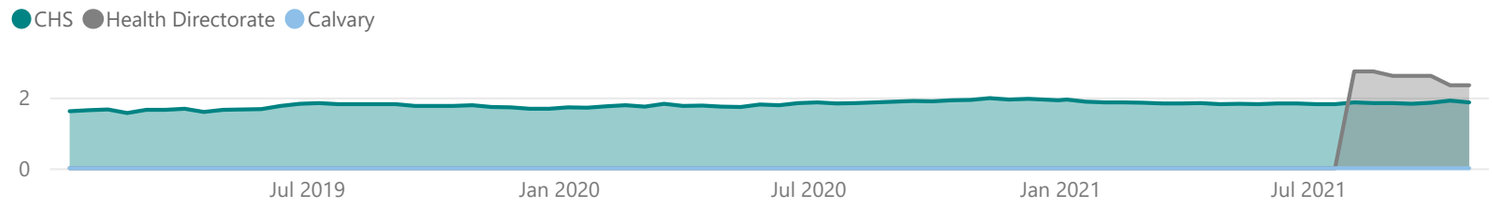
Diversity

9/01/2019 27/10/2021

Women



Disability



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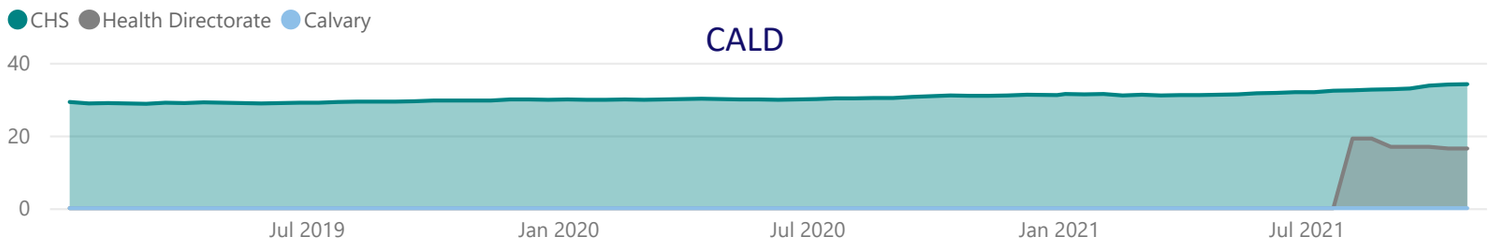
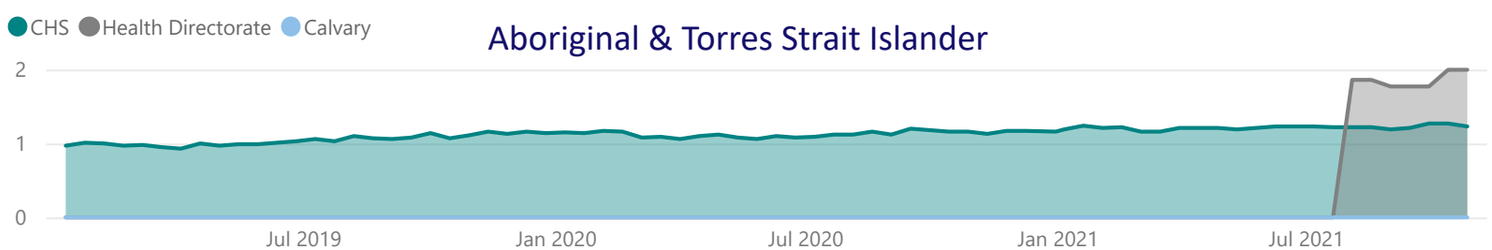


Aboriginal & Torres Strait Islander



	CHS	Calvary	HD
	75.12		51.64
	1.79		2.57
	30.41		17.39
	1.12		1.86

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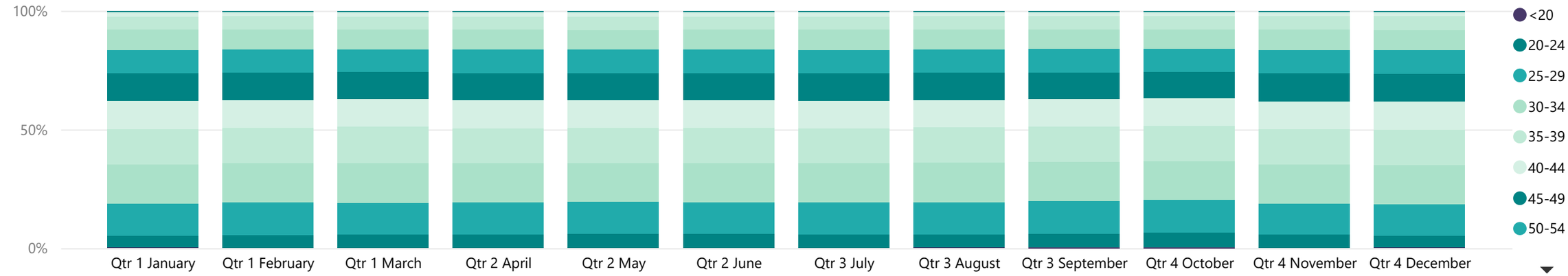
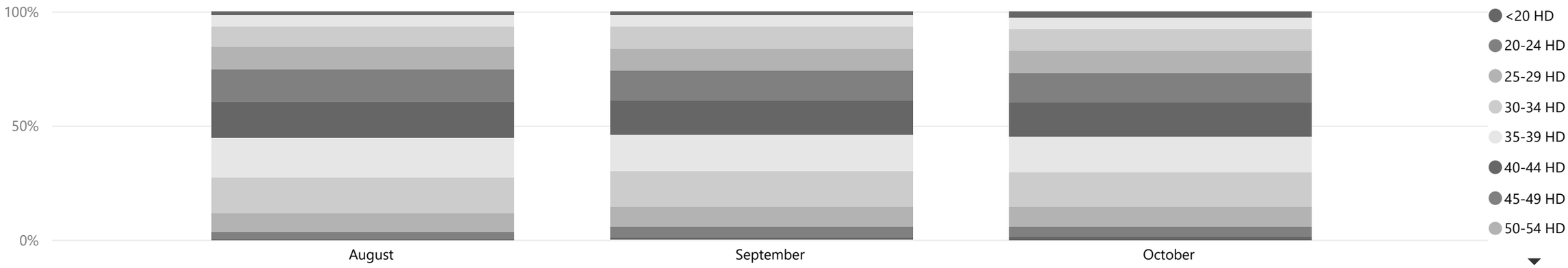
Age Profile

CHS



HD



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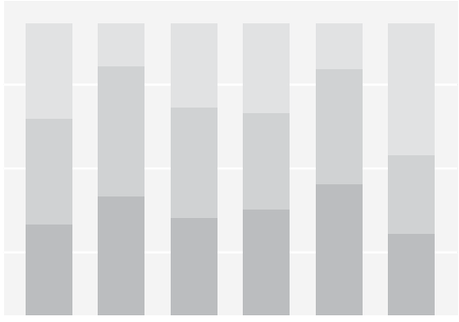
Calvary



ACT Government | ACT Health

Calvary

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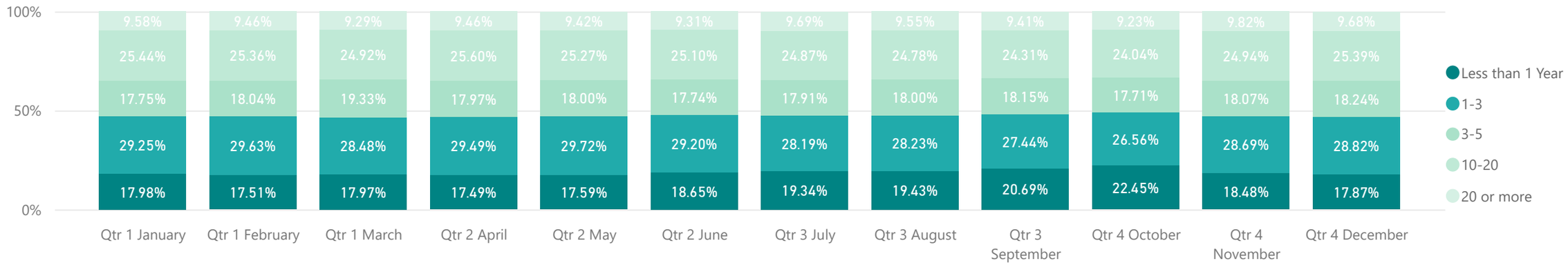
Length of Service

CHS



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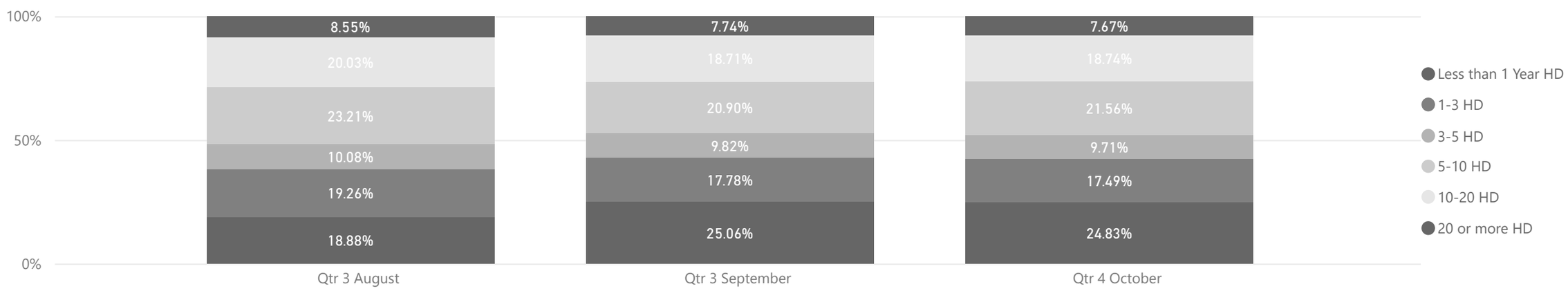

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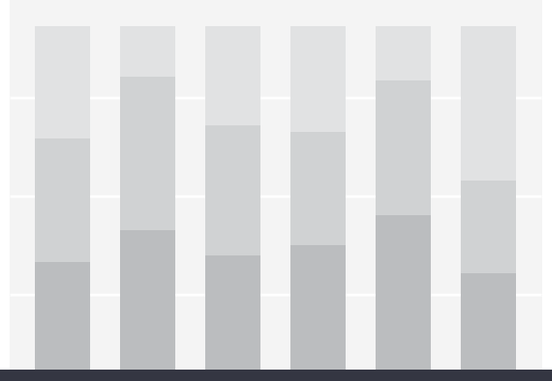
Calvary



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Calvary
ACT Government | Canberra Health Services

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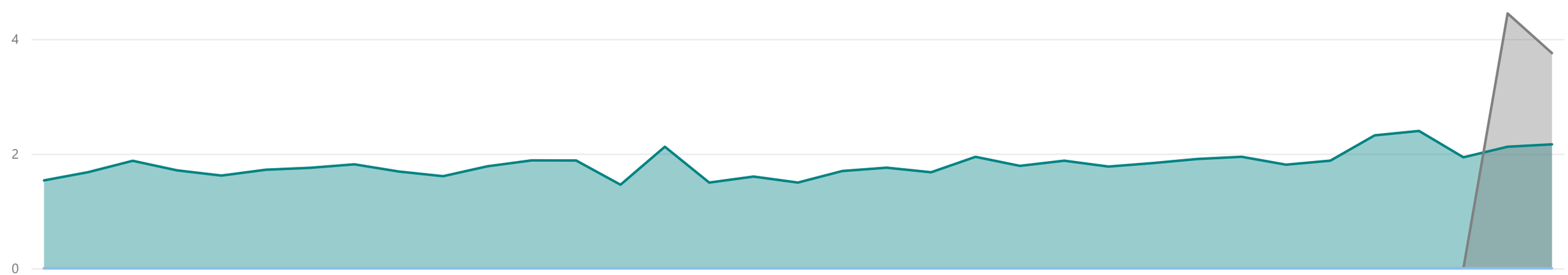
Overtime

CHS, Health Directorate and Calvary by Year, Quarter, Month and Day

CHS Health Directorate Calvary

Average Hours of Overtime per person



Year

Average Hours CHS

1.75

Average Hours HD

4.1

Average Hours Calvary

XX

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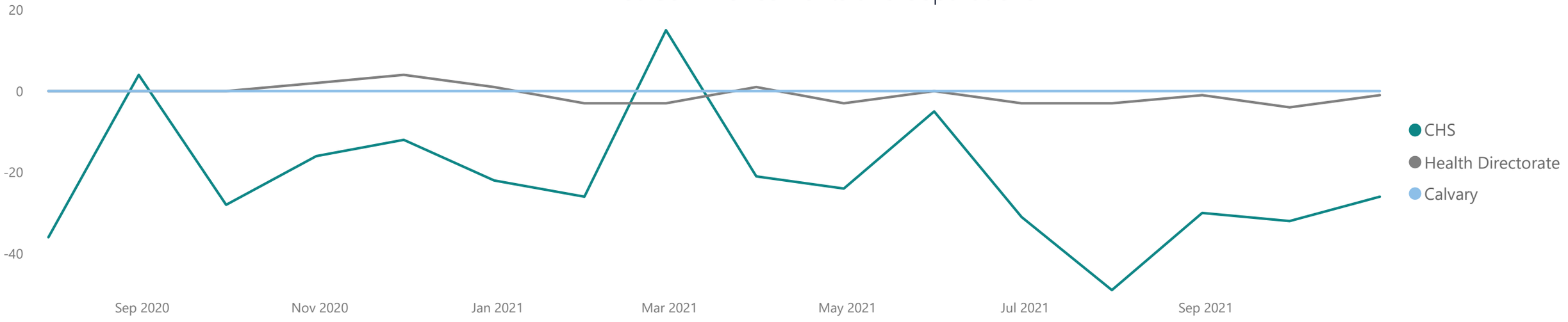
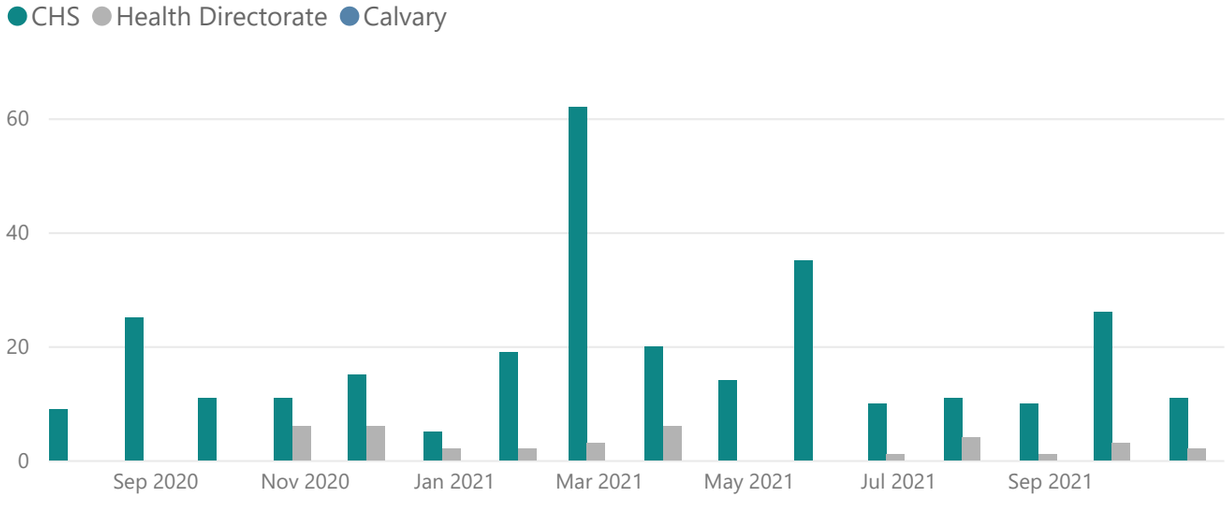
Commencements and Separations

31/07/2020 31/10/2021

Net Commencements and Separations



Commencements



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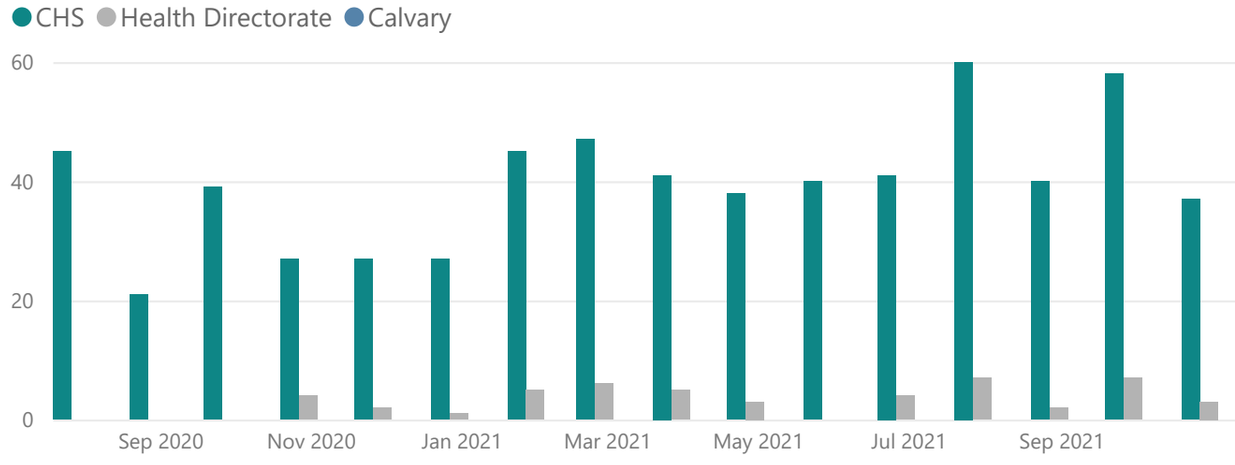

ACT Government | ACT Health

Calvary

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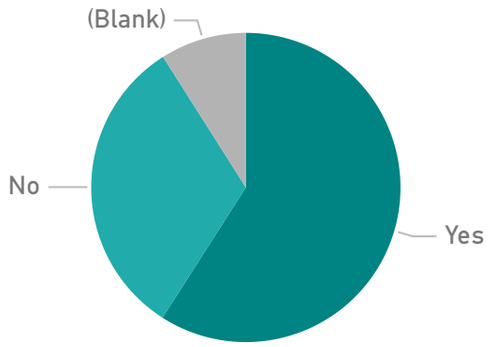
Exit Surveys and Leave

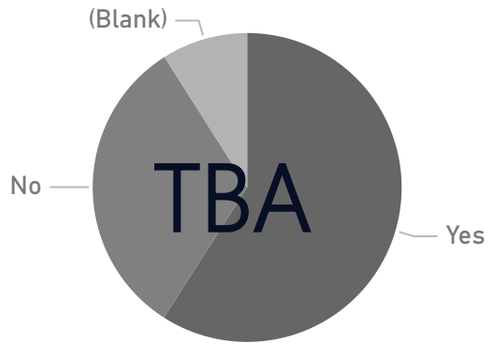
Exit Survey Responses - Would you work here again?

Canberra Health Services



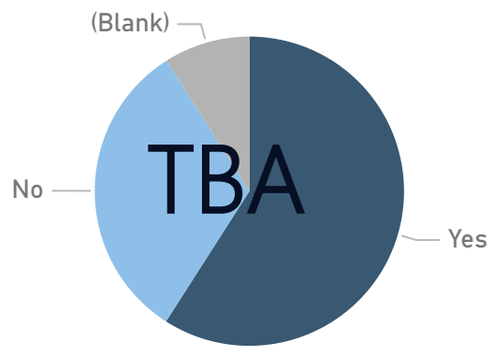
34%
Response rate

Health Directorates



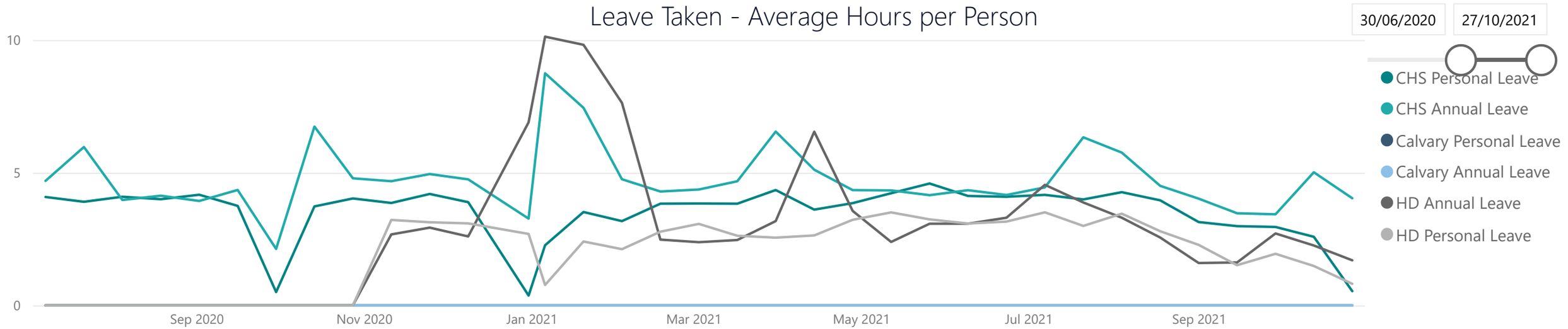
xx%
Response rate

Calvary



xx%
Response rate

Leave Taken - Average Hours per Person



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Calvary

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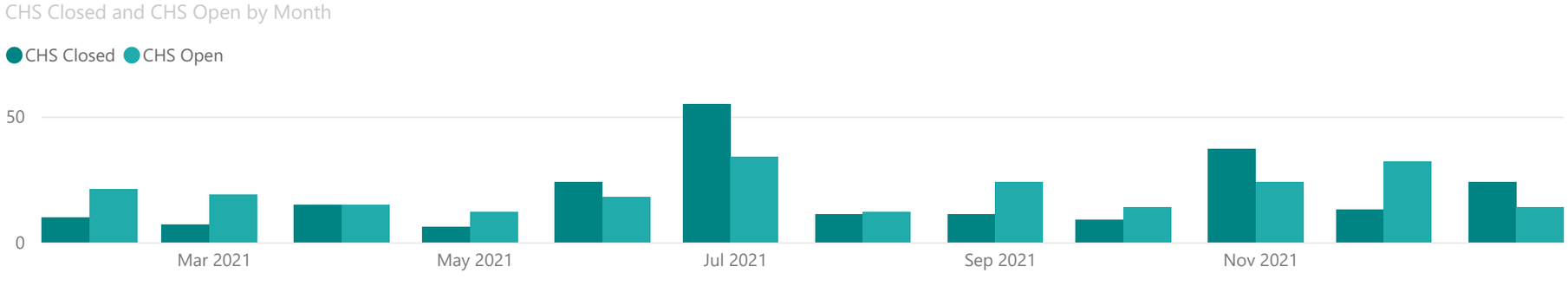
Preliminary Assessments

CHS



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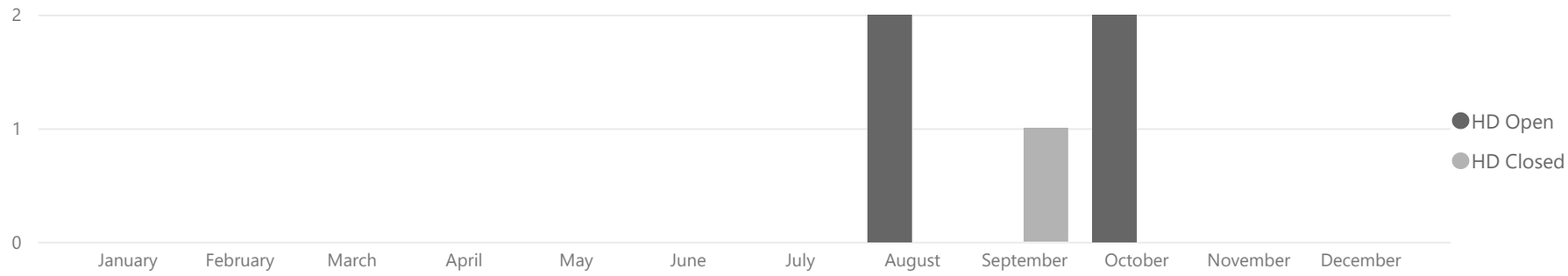
HD



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Calvary

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ACT Government | ACT Health

Calvary

ACT Government | Canberra Health Services

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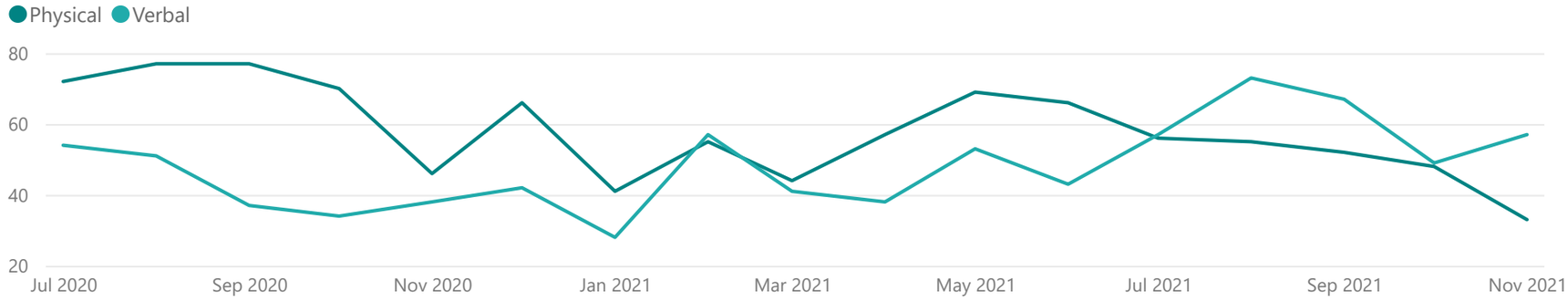
Staff Incidents

CHS



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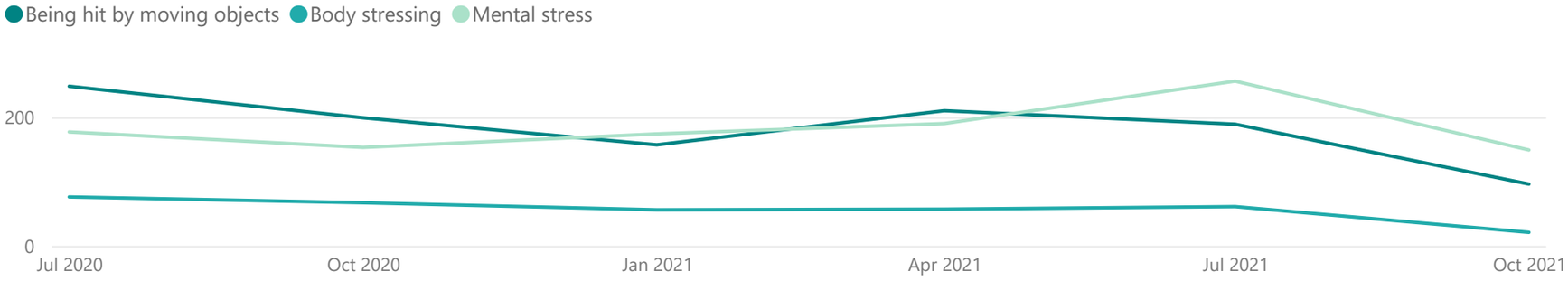
Occupational Violence

CHS



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Attachment C
Bullying and Harassment Data

Purpose

To provide a summary of the data related to bullying and harassment available across the ACT public health system.

Background:

1. Mr Peter Hughes, VMOA, requested a snapshot of the data available across the ACT public health system about the number of alleged bullying and harassment incidents.
2. Each organisation agreed to provide:
    a. preliminary assessments undertaken,
    b. number of matters referred to the Public Sector Unit (PSU) for investigation, and
    c. numbers of findings substantiated by the PSU related to bullying and harassment data.
3. There has been a focus by each organisation to invest in the accuracy of the recording and collation of data for conduct related matters.

Definition of Work Bullying and Harassment

(As defined in *Resolving Workplace Issues: Work Bullying, Harassment and Discrimination, 2019, CMTEDD).*

In the ACTPS work **bullying** is defined as unreasonable, undesirable behaviour that:

- Is repeated,
- Is unwelcome and unsolicited,
- Creates, or could create a risk to health and safety (including physical and psychological harm),
- Occurs between works of an organisation, and
- A reasonable person would consider to be offensive, intimidating, humiliating, and threatening.

Harassment is defined as:

A form of bullying, involving unreasonable and repeated behaviour directed at an individual or group of people on the basis of their particular characteristics. It can be written or verbal and includes intimidation, abuse, spreading rumours or gossip.

Preliminary Assessments

ACT Health Directorate

Numbers of preliminary assessments undertaken by ACT Health Directorate in response to allegations of bullying and harassment claims.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
2020	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
2021	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**2**	**1**	**0**	**0**	**0**	**4**

Table 1. Preliminary Assessments undertaken at ACTHD during calendar years 2020 and 2021.

There has been an increase in the number of Preliminary Assessments undertaken from 2020 to 2021 which is attributed to the ongoing culture and values reform work being conducted in the Directorate.

The Preliminary Assessments found the reported behaviours were either; not substantiated or would not be considered misconduct under section 9 of the Public Sector Management Act. Delegates determined that counselling or remedial actions such as facilitated discussions was the most appropriate action to resolve workplace issues. None of the behaviours examined within the Preliminary Assessments were referred to the Professional Standards Unit for Investigation.

Canberra Health Services

Numbers of preliminary assessments undertaken by CHS in response to allegations of bullying and harassment claims.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
2020	**9**	**9**	**6**	**3**	**10**	**6**	**6**	**5**	**0**	**2**	**2**	**2**	**60**
2021	**0**	**1**	**5**	**0**	**1**	**0**	**1**	**4**	**5**	**0**	**3**	**2**	**22**

Table 2. Preliminary Assessments undertaken at CHS during calendar years 2020 and 2021.

Table 2. summarises the number of new preliminary assessments undertaken for bullying and harassment by month. There has been a significant decrease in the number of preliminary assessments undertaken from 2020 to 2021 and this has been attributed to the heavy focus on early intervention and better training and management of complaints by CHS.

CHS has noted that there have been some fluctuations of reports throughout the period where there has been a heightened commitment by CHS in the COVID-19 response. However, to date, a more comprehensive examination of the factors has not resulted in identifying causation or other any other factors.

Calvary Public Hospital Bruce

Numbers of preliminary assessments undertaken by CPHB in response to allegations of bullying and harassment claims.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
2021	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**1**	**0**	**2**

Table 3. Preliminary Assessments undertaken at CPHB during calendar year 2021.

Table 3. summarises the number of new preliminary assessments undertaken for bullying and harassment by month.

Referrals to the Public Sector Unit for Investigation

Bullying and harassment investigations referred to Public Standard Unit from across the ACTPS Health Agencies (Including ACTHD and CHS)

	2016-17	2017-18	2018-19	2019-20	Total
PSU investigations relating to bullying and harassment within ACTPS Health Agencies	1	2	1	5	9
Substantiated findings of bullying and harassment within ACTPS Health Agencies	0	0	1	1	2

Table 4. PSU Investigations for the ACTPS Health Agencies relating to allegations of bullying and harassment.

Investigations by PSU by Organisation for FY 2020-2021.

	Investigations	Substantiated Findings
ACTHD	0	0
CHS	3	2

Table 5. PSU Investigations for ACTHD and CHS during FY 2020-2021.

The above table talks to the number of investigations undertaken and substantiated by PSU, referred from ACTHD and CHS.

CHS reported that they are being more considered and targeted in the matters being referred to the Public Sector Unit for investigation.

Findings in reviewing data

There are three findings evident from the reviewing the data. This includes:

- The most prevalent behaviour investigated and/or substantiated is 'inappropriate behaviour', including a lack of courtesy and respect, or use of offensive or threatening language/ intimidation,
- Most investigations relate to behaviours classified as 'failures of obligations' followed closely by 'interpersonal behaviour',
- Bullying and harassment culture within the ACTPS Health Agencies has been reported significantly in the media, although there are few allegations of bullying and harassment that are formally investigated or substantiated.

Future Focus

Further work is underway to provide data and analysis on the process of assessing referrals and the number of reports on bullying and harassment elevated through the Riskman system within each organisation. This will be provided to the February 2022 meeting.

Recommendation:

That the Oversight Group:

-note the information provided in this paper.

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Culture Reform Oversight Group Meeting Paper

OFFICIAL

Agenda Item:	3.1
Topic:	**Member Updates**
Meeting Date:	13 December 2021
Action Required:	**Discussion**
Cleared by:	**Director-General, ACT Health Directorate**
Presenter:	All members

Purpose

1. An opportunity for members to provide an update on progress being made, including initiatives, identified themes, collaboration and risks related to the implementation and progression of culture reform across the ACT public health system.

Background

2. The Culture Reform Oversight Group (Oversight Group) provides opportunity at each meeting for members to talk about progress, themes, and challenges in progressing culture reform across the ACT public health system.

Recommendation

That the Oversight Group:

- *Note the information provided by members about progress, themes, and challenges in culture reform across the ACT public health system.*

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Culture Reform Oversight Group Meeting Paper

OFFICIAL

Agenda Item:	4.1
Topic:	**Implementation of Recommendations**
Meeting Date:	13 December 2021
Action Required:	**For Noting and Discussion**
Cleared by:	**Executive Branch Manager, Culture Review Implementation Branch**
Presenter:	Executive Branch Manager, Culture Review Implementation Branch

Purpose

1. To provide the Culture Reform Oversight Group with an update on the progress made in implementing the recommendations of the *Final Report: Independent Review into the Workplace Culture within ACT Public Health Services* (the Review).

Background

2. This is a standing agenda item to provide an ongoing status update on the progress of work being undertaken to implement the Review recommendations.

Issues

3. There are a total of **92** Actions that need to be completed across the ACT public health system to implement the **20** Recommendations of the Review. A total of **65** Actions have been endorsed as complete.

4. The following table summarises the status of these actions:

On Track	**12** Actions in progress and on track to be delivered by the agreed date
At Risk	**5** Actions at risk of being delayed by more than 12 weeks
Delayed	**10** Actions delayed by more than 12 weeks
Completed	**65** Actions completed

10. The following table summarises the status of actions that are reported as **At Risk** or **Delayed**:

Action 2.2 – Measuring organisational effectiveness Implement and monitor a suite of measures	ACT Health Directorate	ACTHD requested closure of this action at the November Steering Group meeting. Additional information to be provided to the Steering Group for further consideration of request.	**Delayed**
Action 4.1 – Clinician summit Plan and conduct a first summit	ACT Health Directorate	A meeting is scheduled for 6 December to develop a plan to incorporate recommendations from the Second Annual Review. This will be progressed to the January Steering Group and an update provided to the February Oversight Group.	**Delayed**
Action 7.1 – Research strategic plan Review existing arrangements	ACT Health Directorate	Arrangements have been reviewed and agreed upon. An update paper will be provided to the January Steering Group outlining agreed arrangements, and the action will be assessed for completeness.	**Delayed**
Action 7.2 – Research strategic plan Produce academic partnership and training strategy	ACT Health Directorate	The draft strategy will be circulated to members of the Research Working Group in November 2021 and members of the Partnership Board in December 2021.	**Delayed**
Action 7.3 – Research strategic plan Implement academic partnership and training strategy	ACT Health Directorate	Once the draft research plan is consulted on and endorsed, the Research Working Group in collaboration with CHMR will generate an implementation plan for further consideration. Projected completion date for this recommendation has not yet been determined.	**At Risk**
Action 14.2 – HR Functions Review	ACT Health Directorate	Work is underway within the Health Directorate to consider and implement the recommendations of the HR Functions Review.	**Delayed**

Action 14.2 – HR Functions Review	Canberra Health Services	Work is underway within CHS to consider and implement the recommendations of the HR Functions Review.	**Delayed**
Action 14.2 – HR Functions Review	Calvary Public Hospital Bruce	Work is underway within Calvary to consider and implement the recommendations of the HR Functions Review.	**Delayed**
Action 16.2 – Training Review	ACT Health Directorate	Work is underway within the Health Directorate to consider and implement the recommendations of the Training Review.	**Delayed**
Action 16.2 – Training Review	Canberra Health Services	Work is underway within CHS to consider and implement the recommendations of the Training Review.	**Delayed**
Action 16.2 – Training Review	Calvary Public Hospital Bruce	Work is underway within Calvary to consider and implement the recommendations of the Training Review.	**Delayed**

11. Status of the implementation of Recommendations by each organisation is summarised below:

System-wide	**6 of 9** Recommendations completed
ACT Health Directorate	**2 of 11** Recommendations completed
Canberra Health Services	**8 of 12** Recommendations completed
Calvary Public Hospital	**4 of 10** Recommendations completed

12. A total of **9** Recommendations have been endorsed as fully completed by all responsible parties:

    a. *Recommendation 1 (Values)*

    b. *Recommendation 5 (Review mechanisms to better integrate clinical streams of the community health services within the Clinical Divisional Structures in CHS)*

    c. *Recommendation 8* (Memorandum of Understanding (MoU))

    d. *Recommendation 10* (Clear requirement for senior clinicians to collaboratively participate in clinical governance activities)

    e. *Recommendation 11* (Choosing Wisely program)

    f. *Recommendation 12* (Clinically qualified Divisional Directors across each Clinical Division with Business Manager support within CHS)

g. *Recommendation 17* (Public Commitment)

h. *Recommendation 18* (Culture Review Oversight Group)

i. *Recommendation 20* (Change Management and Communications Strategy)

Recommendation

That the Oversight Group:

- *Note the information contained in the Implementation of Recommendations document at Attachment A.*

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Implementation of Recommendations - Progress at 25 November 2021

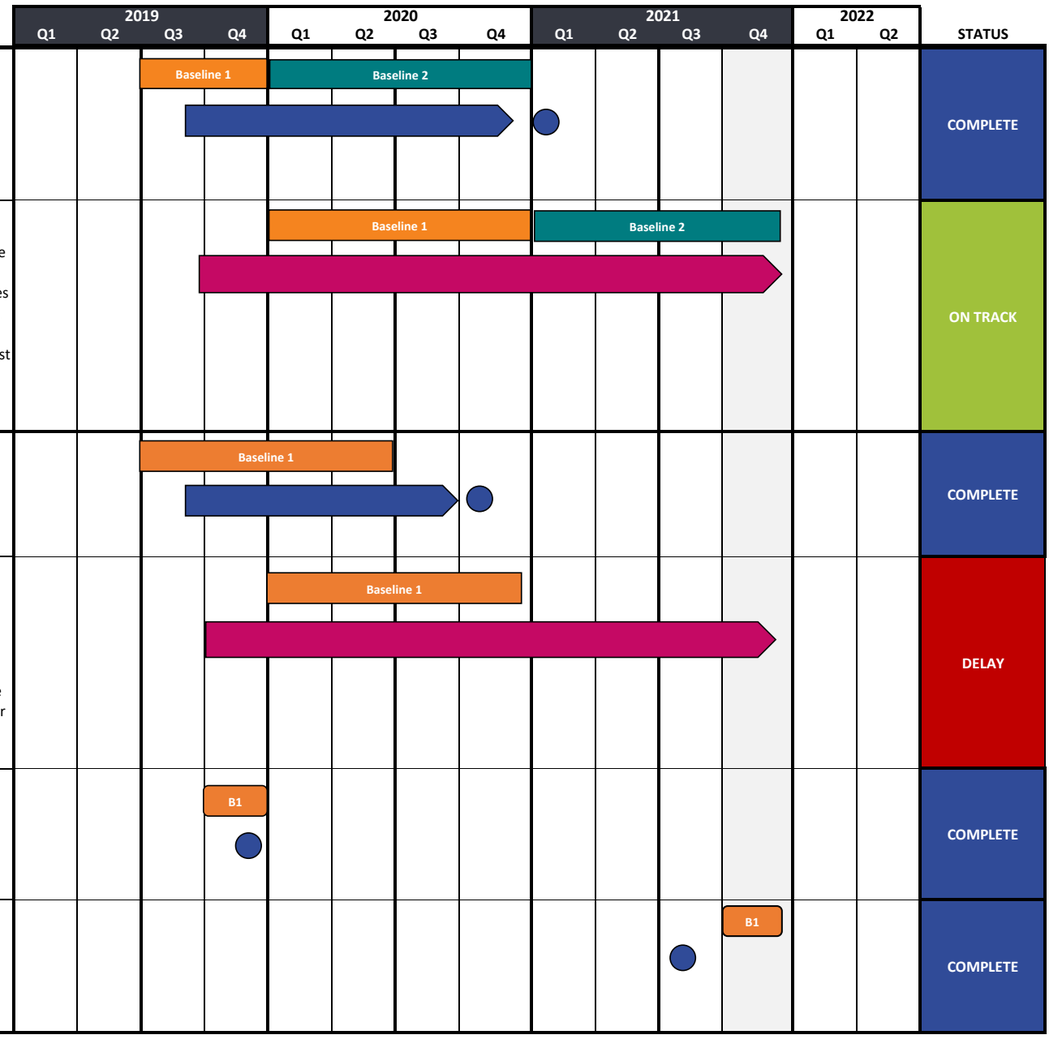
ON TRACK	AT RISK	DELAY	COMPLETE
Action is tracking to the agreed delivery date.	Action at risk of deviating more than 12 weeks from the agreed delivery date.	Action has exceeded the agreed delivery date by more than 12 weeks.	Action has been completed.

Key:

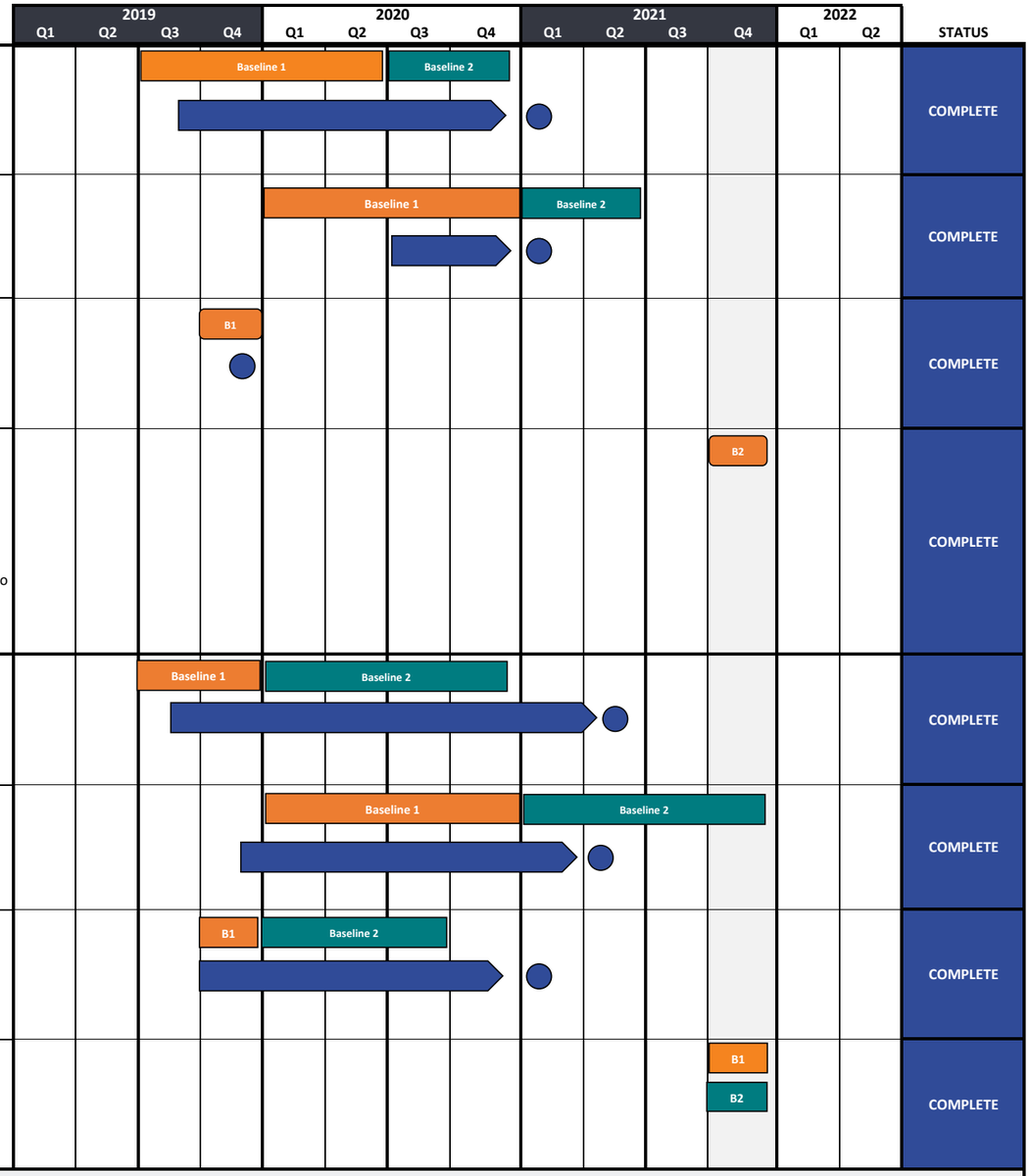
IMPLEMENTATION TIMELINE (As per Final Report)
ADJUSTED IMPLEMENTATION TIMELINE (Endorsed by Steering Group)
CURRENT IMPLEMENTATION STATUS
ACTION COMPLETED

RECOMMENDATION & RESPONSE	RESPONSIBILITY	ACTION	PROGRESS UPDATE	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2	STATUS
Recommendation 1 of the Final Report, March 2019 *That the three arms of the ACT public health system should commence a comprehensive process to re-engage with staff in ensuring the vision and values are lived, embraced at all levels, integrated with strategy and constantly reflected in leadership. To achieve this the ACT Health Directorate should take the lead in providing the necessary tools and guidelines and coordinate the implementation by Canberra Health Services, Calvary Public Hospital and the ACT Health Directorate.*	**People Strategy, ACT Health Directorate**	**A1.1.** Commence values and vision work	**Action has been completed**		Baseline 1													COMPLETE
		A1.2: Embed vision and values	**Action has been completed**			Baseline 1												COMPLETE
		A1.3: Evaluate	**Action has been completed** **Endorsed as complete at the Steering Group meeting of 25 November 2021** • ACTHD participated in the ACTPS WhoG survey 2021 with a 70% participation rate. Staff survey results will be analysed by the ACTHD Executive and worked through with divisions and branches to establish action plans. • The results will be reviewed by the Oversight Group in December 2021.								Baseline 1							COMPLETE
	People and Culture, Canberra Health Services	**A1.1.** Commence values and vision work	**Action has been completed**		Baseline 1													COMPLETE
		A1.2: Embed vision and values	**Action has been completed**			Baseline 1												COMPLETE
		A1.3: Evaluate	**Action has been completed**								Baseline 1							COMPLETE
	Great Workplaces Program, Calvary Public Hospital Bruce	**A1.1.** Commence values and vision work	**Action has been completed**		Baseline 1													COMPLETE
		A1.2: Embed vision and values	**Action has been completed**			Baseline 1					B2							COMPLETE
		A1.3: Evaluate	**Action has been completed**									Baseline 1						COMPLETE
	Overall Status of Recommendation 1: **This recommendation has been completed.**																	

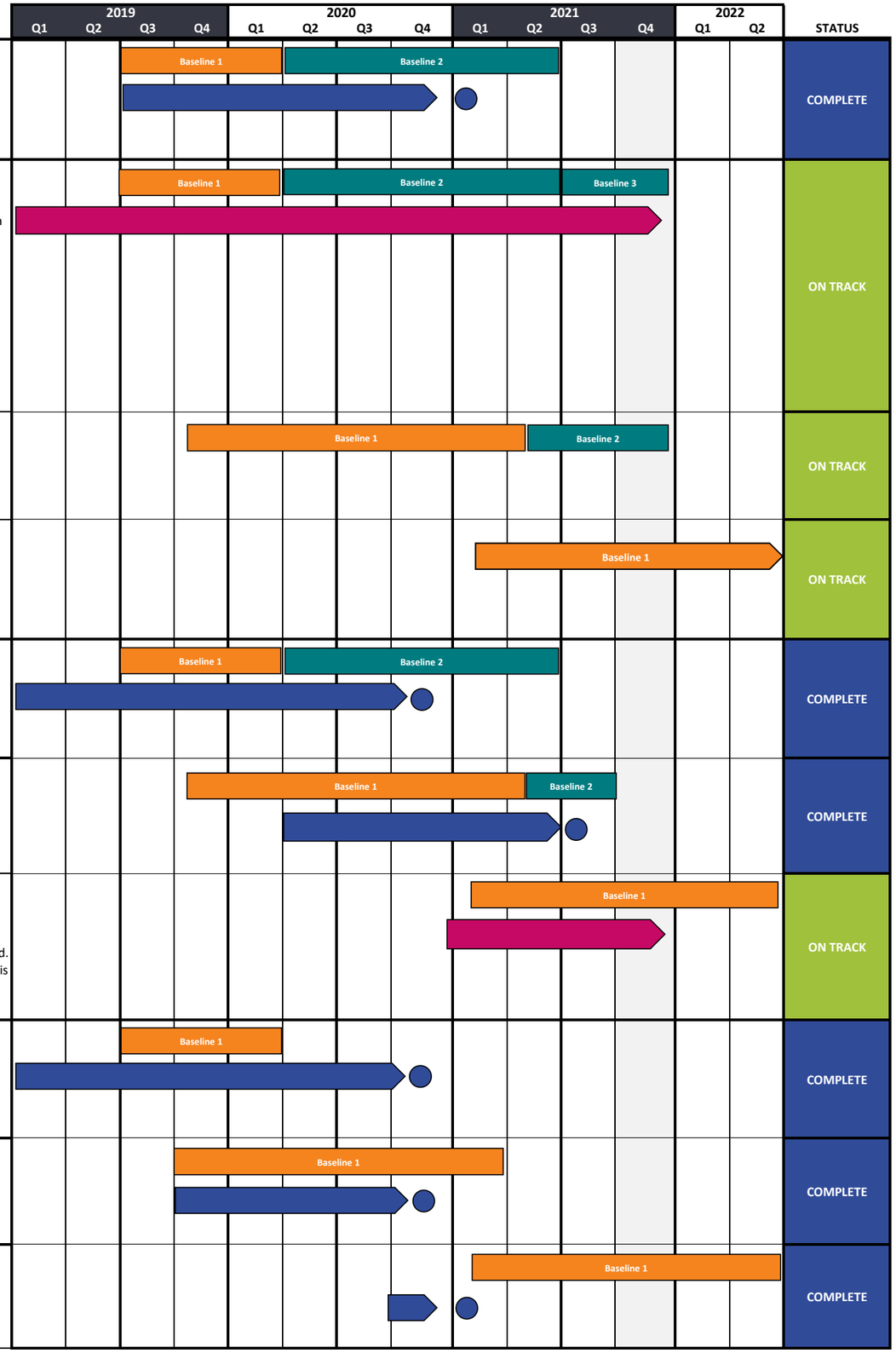
RECOMMENDATION & RESPONSE	RESPONSIBILITY	ACTION	PROGRESS UPDATE	STATUS
Recommendation 2 of the Final Report, March 2019 *That Canberra Health Services and Calvary Public Hospital in conjunction with the ACT Health Directorate, develop an appropriate suite of measures that:* • *reflect on elements of a great health service - both culture and strategy;* • *monitor patient/client perspectives of outcomes/experience; and* • *engage clinicians in their development.*	**System-wide, led by Culture Review Implementation Branch (CRI Branch)**	**A2.1:** Commence developing suite of measures	**Action has been completed**	COMPLETE
		A2.2: Implement and monitor suite of measures	**This action is in progress** • The Culture Review Implementation Branch has finalised the selection of a SOG B People Analytics position with commencement anticipated over the next four weeks. The People Analytics staff member will be integral in establishing reporting mechanisms and measures and metrics to ensure assessment of impact and effectiveness of initiatives implemented. • ACTHD, CHS and CPHB are working together to establish measures of health system performance, a system-wide reporting dashboard and regular reporting of progress against the agreed measures of performance.	ON TRACK
	People Strategy, ACT Health Directorate	**A2.1:** Commence developing suite of measures	**Action has been completed**	COMPLETE
		A2.2: Implement and monitor suite of measures	**This action is in progress** **Request for closure submitted to Steering Group at November 2021 meeting.** • ACTHD has established a workforce data dashboard. • A mid-point pulse survey in June/ July 2022 is planned. • ACTHD has completed the 2021 OCIM assessment. • The 2021 staff survey was undertaken in August with 70% participation rate. Results are expected to be received November 2021. Results will be analysed in November/December 2021	DELAY
		A2.3: Conduct 2019 staff survey (evaluate)	**Action has been completed**	COMPLETE
		A2.4: Conduct 2021 staff survey (evaluate)	**Action has been completed**	COMPLETE



RECOMMENDATION & RESPONSE	RESPONSIBILITY	ACTION	PROGRESS UPDATE	STATUS
	People and Culture, Canberra Health Services	**A2.1:** Commence developing suite of measures	**Action has been completed**	COMPLETE
		A2.2: Implement and monitor suite of measures	**Action has been completed**	COMPLETE
		A2.3: Conduct 2019 staff survey (evaluate)	**Action has been completed**	COMPLETE
		A2.4: Conduct 2021 staff survey (evaluate)	**This action has been completed** **Endorsed as complete at the November 2021 Steering Group meeting.** • The 2021 Workplace Culture Survey opened on 1 November and closed 15 November. It is anticipated results will be available towards the end of 2021/early 2022. Once received, these will be communicated to all staff. • The comprehensive results received from the 2021 Workplace Culture Survey will be used to improve the CHS workplace. Areas will be accountable for implementing actions to improve their local area. • Paper progressed to November Steering Group to close action.	COMPLETE
	Great Workplaces Program, Calvary Public Hospital Bruce	**A2.1:** Commence developing suite of measures	**Action has been completed**	COMPLETE
		A2.2: Implement and monitor suite of measures	**Action has been completed**	COMPLETE
		A2.3: Conduct 2019 staff survey (evaluate)	**Action has been completed**	COMPLETE
		A2.4: Conduct 2021 staff survey (evaluate)	**Action has been completed**	COMPLETE
	Overall Status of Recommendation 2: **AT RISK** • This Recommendation is on track to be completed within the agreed timeframe by Canberra Health Services and Calvary Public Hospital.			

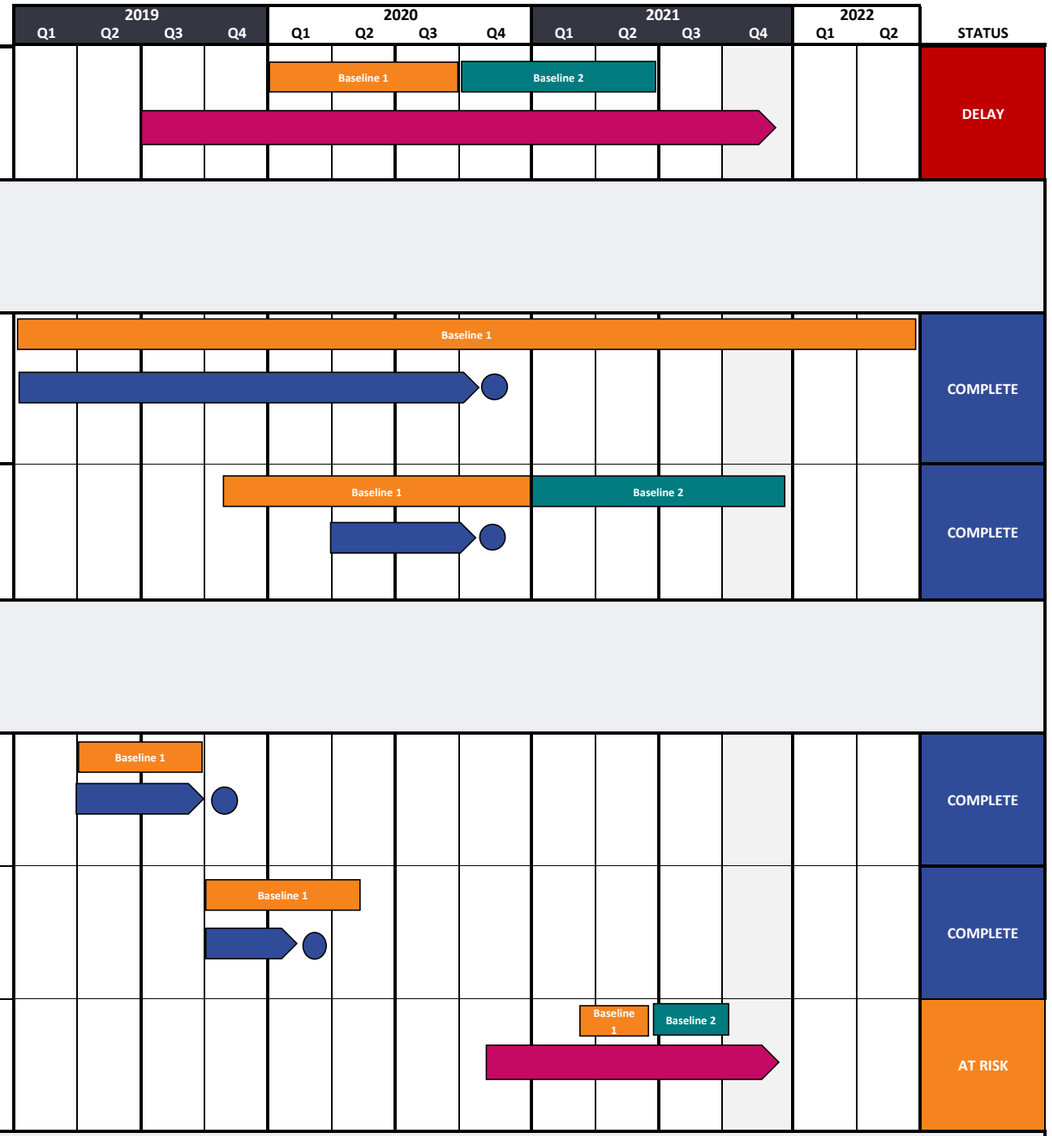


RECOMMENDATION & RESPONSE	RESPONSIBILITY	ACTION	PROGRESS UPDATE	STATUS
Recommendation 3 of the Final Report, March 2019 *That a program designed to promote a healthier culture to reduce inappropriate workplace behaviour and bullying and harassment be implemented across the ACT public health system. The model adopted should be based on the Vanderbilt University Medical Center Patient Advocacy Reporting System (PARS) and Co-worker Observation Reporting System (CORS).*	**System-wide, led by Culture Review Implementation Branch (CRI Branch)**	**A3.1:** Planning, procurement and foundation work	**Action has been completed.**	COMPLETE
	People and Strategy, ACT Health Directorate	**A3.1:** Planning, procurement and foundation work	**This action is in progress** • ACTHD are considering the commencement of a pilot of the Australian Healthcare and Hospital Association Bully Zero Class ACT Conduct program from December 2021. This is a communication skilling and behaviour change program with the purpose of fostering a positive, respectful, professional workplace culture. • ACTHD are reviewing the gaps identified in the complaints and grievances process and are identifying opportunities for improvement. • ACTHD are about to commence a review of the policy settings and the application of policy, guidelines associated with complaints, grievance, and misconduct. • Training is currently being explored to support capability development for all ACTHD staff with giving and receiving feedback.	ON TRACK
		A3.2: Implementation	**This action has not yet commenced**	ON TRACK
		A3.3: Program delivery	**This action has not commenced**	ON TRACK
	People and Culture, Canberra Health Services	**A3.1:** Planning, procurement and foundation work	**This action has been completed.**	COMPLETE
		A3.2: Implementation	**This action has been completed.**	COMPLETE
		A3.3: Program delivery	**This action is in progress.** • Face-to-face delivery of the SUFS program is recommencing with sessions being scheduled. Face-to-face delivery of the SUFS program is recommencing with sessions being scheduled. • Planning for the implementation of the Promoting Professional Accountability program is progressing.	ON TRACK
	Great Workplaces Program, Calvary Public Hospital Bruce	**A3.1:** Planning, procurement and foundation work	**This action has been completed.**	COMPLETE
		A3.2: Implementation	**This action has been completed.**	COMPLETE
		A3.3: Program delivery	**This action has been completed.**	COMPLETE



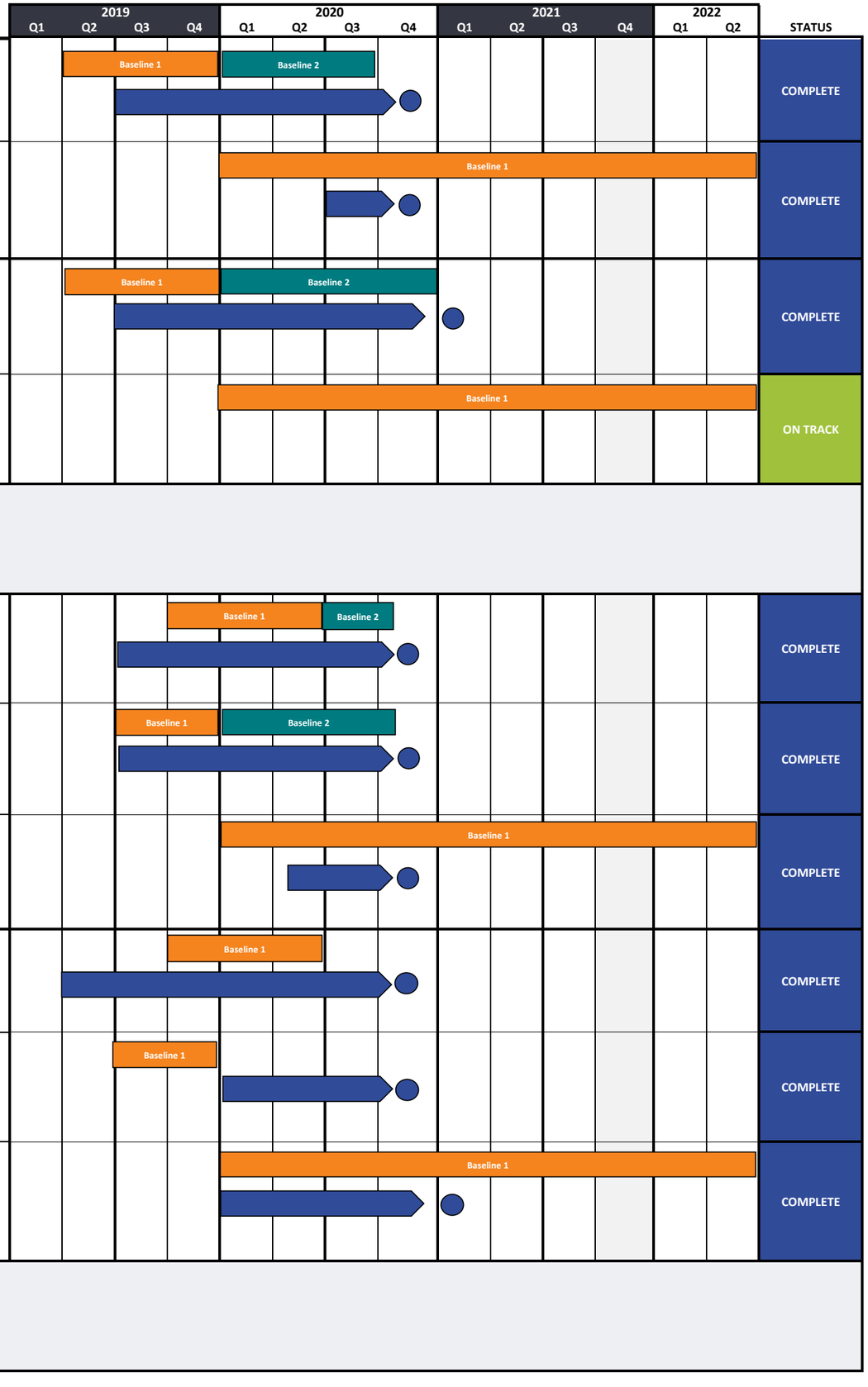
RECOMMENDATION & RESPONSE	RESPONSIBILITY	ACTION	PROGRESS UPDATE	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2	STATUS
			Overall Status of Recommendation 3: This recommendation has been completed by the CRI Branch and Calvary Public Hospital.															

RECOMMENDATION & RESPONSE	RESPONSIBILITY	ACTION	PROGRESS UPDATE	STATUS
Recommendation 4 of the Final Report, March 2019 *The ACT Health Directorate convene a summit of senior clinicians and administrators of both Canberra Health Services and Calvary Public Hospital to map a plan of improved clinical services coordination and collaboration.*	**Health Systems, Policy and Research, ACT Health Directorate**	**A4.1:** Plan and conduct first summit	**This action is in progress.**	**DELAY**
	Overall Status of Recommendation 4: Implementation of this recommendation is delayed by more than 12 weeks.			
Recommendation 5 of the Final Report, March 2019 *The CEO of Canberra Health Services should review mechanisms to better integrate clinical streams of the community health services within the Clinical Divisional Structures.*	**People and Culture, Canberra Health Services**	**A5.1:** Review mechanisms and integrate Community Health Services	**This action has been completed.**	**COMPLETE**
		A5.2: Evaluate	**This action has been completed.**	**COMPLETE**
	Overall Status of Recommendation 5: **This recommendation has been completed.**			
Recommendation 6 of the Final Report, March 2019 *That the ACT Health Directorate re-establish open lines of communication with the NGO sector and other external stakeholders.*	**Health Systems, Policy and Research, ACT Health Directorate**	**A6.1:** Commence re-opening of communication lines	**This action has been completed.**	**COMPLETE**
		A6.2: Establish NGO Leadership Group	**This action has been completed.**	**COMPLETE**
		A6.3: Evaluate	**This action is in progress.** • Procurement is underway for a Consultancy to undertake an evaluation of the NGO Leadership Group. • It is expected that the evalutation will commence in January and be finalised by March 2022.	**AT RISK**
	Overall Status of Recommendation 6: **On Track** This Recommendation is on track to be completed within the agreed timeframe.			



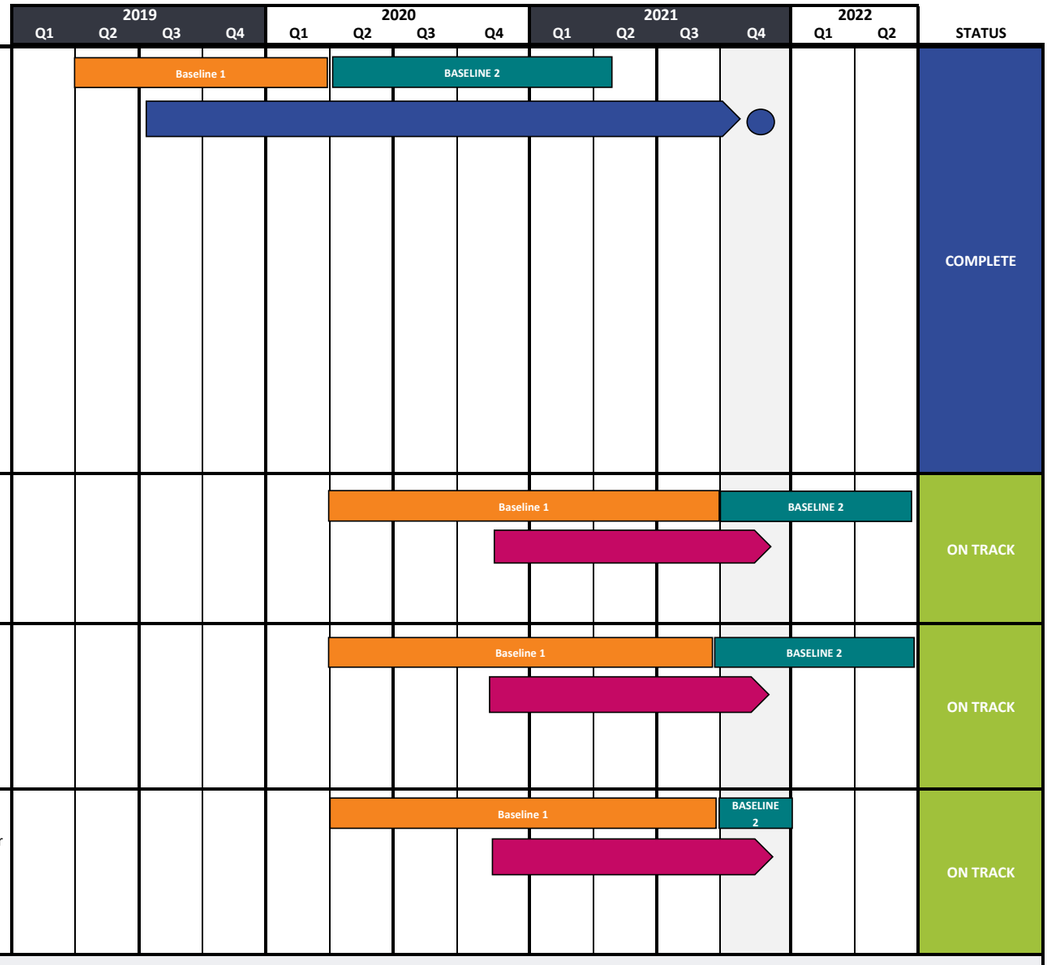
RECOMMENDATION & RESPONSE	RESPONSIBILITY	ACTION	PROGRESS UPDATE	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2	STATUS
Recommendation 7 of the Final Report, March 2019 *The initiatives already underway to develop a valued and more coordinated research strategy in partnership with the academic sector and others are strongly supported. These provide a mechanism to encourage professional development and address culture, education, training, research and other strategic issues.*	**Centre for Health and Medical Research, ACT Health Directorate**	**A7.1:** Review existing arrangements (develop relationships, define positions)	**This action is in progress.**		Baseline 1			Baseline 2										DELAY
		A7.2: Produce academic partnership and training strategy	**This action is in progress.** • Work continues on developing a coordinated research strategy in partnership with the academic sector and others. • The current working draft of the RSP titled Better Together: A Strategic Plan for Research in the ACT Health System is to be presented to and considered by the full Research Working Group on 24 November 2021. • Once the draft research plan is consulted on and endorsed, the Research Working Group in collaboration with ACTHD will generate an implementation plan for further consideration.			Baseline 1		Baseline 2									DELAY
		A7.3: Implement academic partnership and training strategy	**This action has not yet commenced.**					Baseline 1				Baseline 2						AT RISK
	Overall Status of Recommendation 7: **Delayed**																	
Recommendation 8 of the Final Report, March 2019 *That discussions occur between ACT and NSW with a view to developing a Memorandum of Understanding (MoU) for improved collaboration between the two health systems for joint Ministerial consideration.*	**Partnerships and Programs, ACT Health Directorate**	**A8.1:** Commence negotiations	**This action has been completed.**		Baseline 1													COMPLETE
		A8.2: Implement MOU	**This action has been completed.**					Baseline 1		Baseline 2								COMPLETE
	Overall Status of Recommendation 8: **This Recommendation is closed.** • This Recommendation was endorsed as closed by the Steering Group at the May 2021 meeting.																	

RECOMMENDATION & RESPONSE	RESPONSIBILITY	ACTION	PROGRESS UPDATE	STATUS
Recommendation 9 of the Final Report, March 2019 *Clinical engagement throughout the ACT public health system, particularly by the medical profession, needs to be significantly improved. Agreed measures of monitoring such improvement needs to be developed through consensus by both clinicians and executives. Such measures should include participation in safety, quality and improvement meetings, reviews and other strategy and policy related initiatives.*	**People and Culture, Canberra Health Services**	**A9.1:** Agree measures	**This action has been completed.**	COMPLETE
		A9.2: Ongoing monitoring and reporting	**This action has been completed.**	COMPLETE
	Great Workplaces Program, Calvary Public Hospital Bruce	**A9.1:** Agree measures	**This action has been completed.**	COMPLETE
		A9.2: Ongoing monitoring and reporting	**This action is in progress.** •Engagement with clinical staff members is ongoing through annual staff surveys and Choosing Wisely program.	ON TRACK
	Overall Status of Recommendation 9: **On Track** • This Recommendation has been completed by Canberra Health Services. • This Recommendation is on track to be completed by Calvary Public Hospital Bruce within the agreed timeframe.			
Recommendation 10 of the Final Report, March 2019 *There should be a clear requirement for senior clinicians to collaboratively participate in clinical governance activities.*	**People and Culture, Canberra Health Services**	**A10.1:** Develop governance participation plan	**This action has been completed.**	COMPLETE
		A10.2: Commence participation	**This action has been completed.**	COMPLETE
		A10.3: Monitor participation	**This action has been completed.**	COMPLETE
	Great Workplaces Program, Calvary Public Hospital Bruce	**A10.1:** Develop governance participation plan	**This action has been completed.**	COMPLETE
		A10.2: Commence participation	**This action has been completed.**	COMPLETE
		A10.3: Monitor participation	**This action has been completed.**	COMPLETE
	Overall Status of Recommendation 10: **This recommendation has been completed.**			



RECOMMENDATION & RESPONSE	RESPONSIBILITY	ACTION	PROGRESS UPDATE	STATUS
Recommendation 11 of the Final Report, March 2019 *Canberra Health Services and Calvary Public Hospital should assess the appropriateness of the Choosing Wisely initiative as a mechanism for improving safety and quality of care, developing*	**People and Culture, Canberra Health Services**	**A11.1:** Assess Program	**This action has been completed.**	COMPLETE
		A11.2: Implement and monitor	**This action has been completed.**	COMPLETE
	Great Workplaces Program, Calvary Public Hospital Bruce	**A11.1:** Assess Program	**This action has been completed.**	COMPLETE
		A11.2: Implement and monitor	**This action has been completed.**	COMPLETE
	<u>Overall Status of Recommendation 11:</u> **This recommendation has been completed.**			
Recommendation 12 of the Final Report, March 2019 *That Canberra Health Services adopt the progressive evolution of clinically qualified Divisional Directors across each Clinical Division with Business Manager support and earned autonomy in financial and personnel management.*	**People and Culture, Canberra Health Services**	**A12.1:** Conduct pilot	**This action has been completed.**	COMPLETE
		A12.2: Rollout full recommendations	**This action has been completed.**	COMPLETE
	<u>Overall Status of Recommendation 12:</u> **This Recommendation has been completed.**			

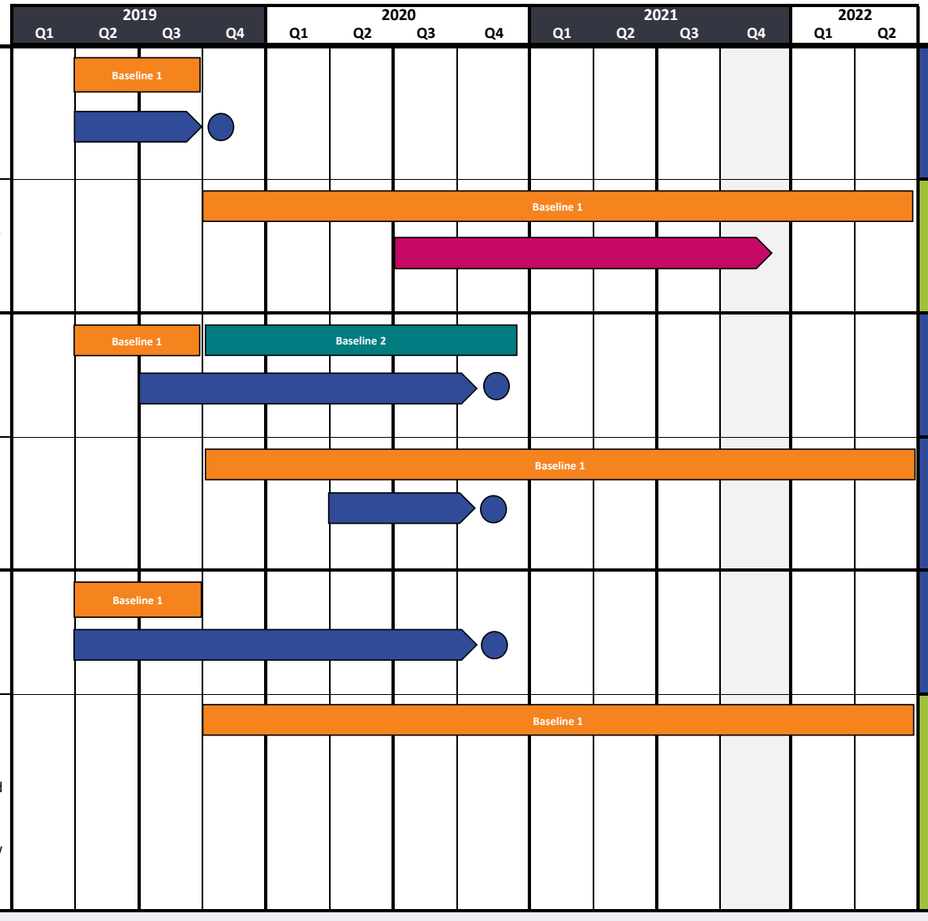
RECOMMENDATION & RESPONSE	RESPONSIBILITY	ACTION	PROGRESS UPDATE	STATUS
Recommendation 13 of the Final Report, March 2019 *That an executive leadership and mentoring program be introduced across the ACT public health system specifically designed to develop current and future leaders. This program should include both current and emerging leaders.*	**System-wide, led by Culture Review Implementation Branch (CRI Branch)**	**A13.1:** Planning	**This action is complete.** Management Training • An Open Tender for the design and delivery of management training for the ACT public health system was released in May 2021. Evaluation of responses was completed in September 2021. • Design of the training program is expected to be undertaken in consultation with key stakeholders within each organisation from mid-October, with a pilot of the program to commence within each organistion in the first quarter of 2021. Leadership Training • A pilot training program has been developed following consultation sessions with over 70 leaders from across ACTHD, CHS and CPHB. • The first cohort commenced training program in December 2021. • The leadership program will focus on the elements identified in the Workplace Culture Framework and will be regularly evaluated for effectiveness. • Values and values-based leadership will be a critical aspect to the training/ development. Mentoring • The Steering Group agreed at the May 2021 meeting that mentoring programs would be developed within each organisation rather than a system-wide approach.	COMPLETE
	People Strategy, ACT Health Directorate	**A13.2:** Implementation	**This action is in progress.** • The first cohort from ACTHD will commence the leadership training program in November 2021.	ON TRACK
	People and Culture, Canberra Health Services	**A13.2:** Implementation	**This action is in progress.** • Participants have been nominated for completing the first cohort of the leadership essentials workshop being held on 8 December 2021. • Collaboration continues with progressing the manager induction program.	ON TRACK
	Great Workplaces Program, Calvary Public Hospital Bruce	**A13.2:** Implementation	**This action is in progress.** • The first cohort from CPHB will commence the leadership training program in November 2021.	ON TRACK
	Overall Status of Recommendation 13: **At Risk** • This Recommendation is at risk of being delayed by more than 12 weeks from agreed timeline.			



RECOMMENDATION & RESPONSE	RESPONSIBILITY	ACTION	PROGRESS UPDATE	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2	STATUS
Recommendation 14 of the Final Report, March 2019 *The three arms of the ACT public health system should review their HR staffing numbers and functions in response to the concerns staff have expressed regarding timeliness and confidence in current HR procedures, and the future needs for*	**System-wide, led by Culture Review Implementation Branch (CRI Branch)**	**A14.1:** Conduct initial review	**This action has been completed.**	Baseline 1				BASELINE 2										COMPLETE
	People Strategy, ACT Health Directorate	**A14.2:** Implement changes	**This action is in progress.** • Work is underway within the ACTHD to shape current structure of People Strategy and Culture Branch to enable focussed work on addressing functions. • Functions within the ACTHD People Strategy and Culture Branch are being reviewed and staff are being recruited that have specific capability to enable the development of a high performing people function within the organisation.					Baseline 1				BASELINE 2						DELAY
		A14.3: Evaluate	**This action has not commenced.**								Baseline 1				Baseline 2			AT RISK
	People and Culture, Canberra Health Services	**A14.2:** Implement changes	**This action is in progress - Expected completion date revised to March 2022.** • Further findings have been implemented including the revised approach to assist staff engage in performance discussions and the development of a 'HR front-door' for staff to access advice. • Whilst progress has been made toward all open findings of the HR Functions Review, it has been identified additional time is required to fully implement the findings. • Paper progressed to November Steering Group to re-baseline completion of action until March 2020.					Baseline 1				BASELINE 2						DELAY
		A14.3: Evaluate	**This action is in progress** • Evaluation has been initiated and will fully be progressed once HR Functions Review findings are fully implemented.								Baseline 1				Baseline 2			AT RISK
	Great Workplaces Program, Calvary Public Hospital Bruce	**A14.2:** Implement changes	**This action is in progress** • Fit for Purpose HR structure has been designed, approved, and implemented at CPHB.					Baseline 1				BASELINE 2						AT RISK
		A14.3: Evaluate	**This action has not commenced.**								Baseline 1				Baseline 2			AT RISK

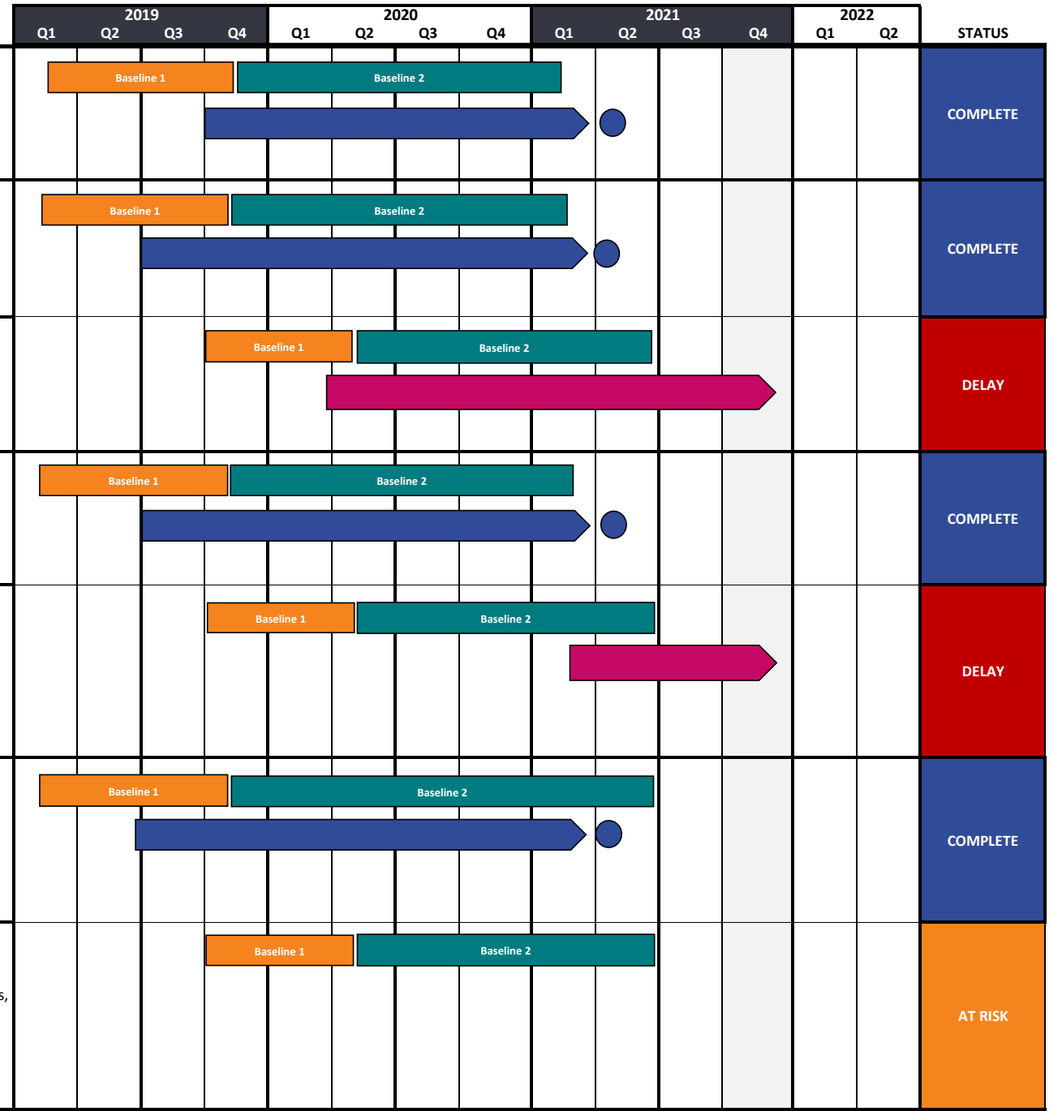
Overall Status of Recommendation 14:
At Risk

RECOMMENDATION & RESPONSE	RESPONSIBILITY	ACTION	PROGRESS UPDATE	STATUS
Recommendation 15 of the Final Report, March 2019 *The recruitment processes in the ACT public health system should follow principles outlined in the Enterprise Agreements, Public Sector Management Act 1994 and relevant standards and procedures.*	**People Strategy, ACT Health Directorate**	**A15.1:** Review staff advice including intranet material and implement changes as required	**This action has been completed.**	COMPLETE
		A15.2: Continually monitor/evaluate recruitment activity	**This action is in progress.** • ACTHD is currently undertaking a Recruitment Review with the objective being to assess the efficiency and effectiveness of ACTHD's recruitment processes and systems and to identify areas for continuous improvement in recruitment.	ON TRACK
	People and Culture, Canberra Health Services	**A15.1:** Review staff advice including intranet material and implement changes as required	**This action has been completed.**	COMPLETE
		A15.2: Continually monitor/evaluate recruitment activity	**This action has been completed.**	COMPLETE
	Great Workplaces Program, Calvary Public Hospital Bruce	**A15.1:** Review staff advice including intranet material and implement changes as required	**This action has been completed.**	COMPLETE
		A15.2: Continually monitor/evaluate recruitment activity	**This action is in progress.** • An updated recruitment system has been rolled out with further customisation and features. • Recruitment support material (e.g. Forms, Selection Panel Reports etc) was received and it is up to date. • The Recruitment policies and procedures are up to date. • A one of its kind New Staff Portal was created on the intranet site for managers and new staff to easily access required information.	ON TRACK



Overall Status of Recommendation 15:
On Track
• This recommendation has been completed by Canberra Health Services.
• This recommendation is on track to be completed by the Health Directorate and Calvary Public Hospital Bruce within the agreed timeframe.

RECOMMENDATION & RESPONSE	RESPONSIBILITY	ACTION	PROGRESS UPDATE	STATUS
Recommendation 16 of the Final Report, March 2019 *The range of training programs for staff offered by the ACT public health system should be reviewed with respect to their purpose, target audience, curriculum, training styles and outcomes so that they address the issues raised in this Review.*	**System-wide, led by Culture Review Implementation Branch (CRI Branch)**	**A16.1:** Conduct training program review	**This action has been completed.**	COMPLETE
	People Strategy, ACT Health Directorate	**A16.1:** Conduct training program review	**This action has been completed.**	COMPLETE
		A16.2: Implement changes	**This action is in progress.** • Work has not progressed on this action due to impacts of local outbreak on resourcing.	DELAY
	People and Culture, Canberra Health Services	**A16.1:** Conduct training program review	**This action has been completed.**	COMPLETE
		A16.2: Implement changes	**This action is in progress.** • An internal working group has been established to take forward the implementation of the findings. Prioritisation of findings was set and agreed. The working group held an action planning meeting in November to progress the review finding from the Fyusion report and an implementation plan is being developed to embed the recommendations into the people training programs. This project is on track to be completed by the end of December 2021.	DELAY
	Great Workplaces Program, Calvary Public Hospital Bruce	**A16.1:** Conduct training program review	**This action has been completed.**	COMPLETE
		A16.2: Implement changes	**This action is in progress.** • Various training programs have been successfully launched like OV De-escalation Training, Preliminary Assessment Training for Managers, Managing Difficult Conversations, Values in Action Framework. Speaking Up For Safety, etc. • A more comprehensive review of training programs is underway in consultation with L&D team.	AT RISK
	Overall Status of Recommendation 16: **At risk**			



RECOMMENDATION & RESPONSE	RESPONSIBILITY	ACTION	PROGRESS UPDATE	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2	STATUS
Recommendation 17 of the Final Report, March 2019 *Should the recommendations of this Review be accepted, a public commitment should be jointly made by the Ministers for Health and Wellbeing, and Mental Health, the Director-General ACT Health Directorate, the CEO Canberra Health Services, the General Manager Calvary Public Hospital and key representative organisations to collectively implement the recommendations of this Review to ensure ongoing cultural improvement across the ACT public health system.*	**Minister and Executive**	**A17.1:** Deliver public commitment	**This action has been completed**		Baseline 1													COMPLETE
	<u>Overall Status of Recommendation 17:</u> **This recommendation has been completed.**																	
Recommendation 18 of the Final Report, March 2019 *A 'Cultural Review Oversight Group' should be established to oversight the implementation of the Review's recommendations. The Group should be chaired by the Minister for Health and Wellbeing, and include the Minister for Mental Health, the*	**Minister and CRI Branch**	**A18.1:** Commence group activities	**This action has been completed.**		Baseline 1													COMPLETE
		A18.2: Bi-monthly group meetings	**This action has been completed.**		Baseline 1													COMPLETE
	<u>Overall Status of Recommendation 18:</u> **This recommendation has been completed.**																	
Recommendation 19 of the Final Report, March 2019 *That the 'Cultural Review Oversight Group' auspice for the next three years, an annual, independent and external review of the extent of implementation of the recommendations of the Review and consequent impact on cultural change*	**System-wide, led by Culture Review Implementation Branch (CRI Branch)**	**A19.1:** Annual Review (2020)	**This action has been completed.**						Baseline 1									COMPLETE
		A19.2: Annual Review (2021)	**This Action has been completed.** • The second independent annual review was undertaken by Ms Renee Leon. • The final report is scheduled to be released in November 2021.									Baseline 1						COMPLETE
		A19.3: Annual Review (2022)	**The final independent annual review will be undertaken in the second quarter of 2022.**													Baseline 1		ON TRACK
	<u>Overall Status of Recommendation 19:</u> **On Track**																	
Recommendation 20 of the Final Report, March 2019 *As a result of this Review, the Culture Review Oversight Group should engage with staff in the development of a change management strategy which clearly articulates to staff, patients/clients and the community the nature of the issues to be addressed and the mechanisms for doing it.*	**System-wide, led by Culture Review Implementation Branch (CRI Branch)**	**A20.1a:** With staff, collaboratively develop a communication strategy	**This action has been completed.**			Baseline 1												COMPLETE
		A20.1b: With staff, collaboratively develop a change management strategy	**This action has been completed.**			Baseline 1				Baseline 2								COMPLETE

RECOMMENDATION & RESPONSE	RESPONSIBILITY	ACTION	PROGRESS UPDATE	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2	STATUS
			Overall Status of Recommendation 20: **This recommendation has been completed.**															

Culture Review **Implementation**

our journey of positive change

Culture Reform Oversight Group Meeting Paper

OFFICIAL

Agenda Item:	4.2
Topic:	**Program Risk**
Meeting Date:	13 December 2021
Action Required:	**Noting and feedback**
Cleared by:	**Executive Branch Manager, Culture Review Implementation Branch**
Presenter:	Executive Branch Manager, Culture Review Implementation Branch

Purpose

1. To provide the Culture Reform Oversight Group with an update of key program risks identified for the Culture Review Implementation Program.

Background

2. Project risk and issues management is proactive throughout the life of the program. The early consideration of risks at the outset and as an iterative process will have significant implications for the overall success of the Culture Review Implementation program.
3. The risk register is intended to be a living document that is reviewed monthly and updated as required.

Issues

4. There are **48 active** risks identified in the Program Risk Register.
5. The overall risk profile for the Program is as follows:

Risk Category	Low	Medium	High	Extreme
Commercial	1	0	0	0
Financial	1	2	1	0
Governance	1	4	0	0
People	0	5	0	0
Project	0	6	0	0

Reputation and Image	1	2	0	0
Stakeholder Management	0	4	1	0
Strategic	0	19	0	0
TOTAL	**4**	**42**	**2**	**0**

6. No new risks or issues have been identified during this reporting period.
7. An Executive Summary of risks with a risk rating of **High** and **Extreme** is at Attachment A. This summary also includes risks which were reported as having a risk rating of **High** during the previous reporting period.
8. The Risk Register continues to be reviewed monthly to assess the effectiveness of existing controls and to identify and execute additional treatments.

Consultation

9. The Culture Review Implementation Team is facilitating regular meetings with the culture leads within each organisation. These regular meeting provides a forum to discuss risks or issues that have been identified within each organisation, ensure dependencies are identified and managed across the system, and ensure local risks are captured on the Program Risk Register and appropriately escalated to the Culture Review Implementation Steering Group.

Recommendation

That the Oversight Group:

- *Note the key program risks identified for the Culture Review Implementation.*

Executive Overview of the Culture Implementation Program Risk Register – 15 November 2021

Risk Rating	Risk	Source	Impact	Controls (best of)	Status
Medium	*Risk Ref ID: 43* *Sustainability of workplace culture reform after program ends*	• Program duration is not sufficient to implement the key outcomes of the Culture Review and build the foundations required for enduring culture reform. • Lack of agreement on the strategic approach for ensuring sustainability of culture reform across the system. • Insufficient governance to oversee strategic delivery and monitoring of outcomes following completion of the formal program. • The Culture Review Implementation Branch, which is responsible for leading and monitoring the implementation of the recommendations of the Culture Review and delivery of system-wide programs of work is funded up to end of financial year. • Lack of centralised team to ensure continuous and sustained improvement and measurement of progress across entire health system following end of program. • Outstanding and ongoing actions required to address the key issues identified in the Culture Review are not integrated into core business prior to completion of formal program. • Unclear responsibilities and accountability for action following completion of formal program. • Capability and capacity within each organisation to manage and sustain culture reform. • Budget and resourcing constraints.	• Culture reform is not sustained after program ends. • Inconsistent, or ineffective approaches that lack strategic direction are applied across the system resulting in continuation of the key issues raised in the Culture Review. • Effectiveness and impact of interventions is not measured or evaluated to inform targeted approaches and ongoing improvement. • Insufficient action and lack of transparent monitoring and reporting of outcomes results in a lack of trust in the ACT public health system.	• Steering Group and Oversight Group to consider findings and recommendations of the second annual review, 2021 OCIM assessments, workforce data trends and 2021 workplace culture survey results when considering future strategic direction. This data will be reported to Steering Group and Oversight Group in December. • Oversight Group to consider ongoing governance arrangements following completion of formal program.	Decreasing

Risk Rating	Risk	Source	Impact	Controls (best of)	Status
High	*Risk Ref ID 29 and Issue Ref ID 10* *Change management and communication*	• Endorsed communications and engagement strategy and associated action plans are not delivered by organisations. • Lack of organisation-specific communications plans to support messaging on action, progress, and outcomes. • Insufficient communications within organisations to inform workforce of action, progress, and results. • System-wide communications developed by CRI team are not shared with staff. • Communications are not timely. • Timing of release of communications is not planned/managed across system. • Engagement with internal and external stakeholders managed separately by individual organisations resulting in mixed or inconsistent messaging. • Insufficient change management capability within each organisation to support complex organisational culture change. • Effectiveness of communications and engagement activities is not measured or monitored.	• The impact and effect of actions on workforce culture is insufficiently monitored and managed within each organisation and across health system. • Readiness and capacity for change, and impact of change is not assessed or managed. • Actions necessary to facilitate sustained organisational culture change are not identified. • Capabilities and training required to support the change are not identified. • Staff do not understand what has happened, what change is happening, what this means to them, what they need to do, and the benefits of change. • Expectations of staff not clear. • Staff do not develop and adopt the required capabilities and behaviours. • Staff do not feel informed, prepared, or ready to participate in culture reform activities. • Poor engagement with workforce undermines organisational trust and successful culture reform. • Issues impacting the implementation of initiatives are not identified and managed in a timely way.	• CRI Communications and Engagement Strategy was endorsed by the Steering Group in November 2019. • CRI Communications and Engagement Action Plans have been developed in consultation with the three organisations. • Phase 2 Action plan is currently being delivered within the Health Directorate. • CRI Branch are developing communications for internal and external stakeholders, as per the Phase 2 Action Plan. • CRI Branch are working collaboratively with ACTHD, CHS and CPHB communications and media teams to ensure a consistent approach to messaging for the release of the Annual Review. • Discussions have recommenced with CHS to ensure alignment of communications actions to the endorsed communications and engagement strategy.	Decreasing
Medium	*Risk Ref ID 22 and Issue Ref ID 10* *Loss of key personnel compromises delivery of program*	• Changes in key leadership positions across the system. • Loss of key personnel responsible for leading, directing or supporting the Culture Review implementation.	• Speed of decision making and action is reduced due to limited knowledge or understanding of the program, past and present context and decisions, strategic direction, and environment in which the culture program operates. • Impact to stakeholder relationships and engagement. • Efficient and effective delivery of culture implementation is compromised. • Failure to deliver objectives and outputs.	• Strong governance structure established to oversee strategic direction for program. • Documentation of key decisions and agreed approaches through Steering Group and Oversight Group papers and action logs. • Strategic direction and key priorities for final months of program agreed by Steering Group.	Decreasing
Medium	*Risk Ref ID 37* *System-wide measures of health system performance*	• System-wide measures of performance (both strategy and culture) are not agreed or adopted.	• Failure to report on progress and impacts of change on the performance of the public health system. • Lack of transparency in reporting of outcomes results in a lack of trust in the ACT public health system.	• Measures of culture change have been agreed and adopted by all three organisations. These include annual OCIM assessments, and regular workplace culture surveys and pulse surveys. • The Culture Review Implementation Branch has finalised the selection of a SOG B People Analytics position, with commencement anticipated over the next four weeks. The People Analytics staff member will establish reporting mechanisms and develop measures and metrics to ensure assessment of impact and effectiveness of initiatives implemented. • The three organisations are working together to establish measures of health system performance, a system-wide reporting dashboard and regular reporting of progress against the agreed measures of performance.	Improving

Risk Rating	Risk	Source	Impact	Controls (best of)	Status
Medium	*Risk Ref ID 48 and Issue Ref ID 11* *Management and leadership training*	• Lengthy negotiations required with each organisation to reach a shared agreement on requirements for system-wide management and leadership training. • Delivery of management and leadership training to commence during final six months of program. • Availability of key personnel and key stakeholders is impacted due to increased pressure on health system in responding to pandemic.	• Speed of decision making and action is reduced due to loss of key program resources and availability of key stakeholders and decision makers as a result of increased pressure on health system. • Failure to attract potential tenderers to deliver the leadership program due to short contract length. • Failure to deliver management and leadership training for the ACT public health system to increase management and leadership capability and address the key issues raised in the culture review.	• Discussions occurred at the October Steering Group meeting, with an agreement to pursue a select procurement process through the Whole of Government Vendor Panel. • Provider has been selected to design and deliver a pilot leadership program. First cohort to undertake training from November 2021.	Decreasing
High	*Risk Ref ID 50* *Ongoing funding is not committed for management and leadership training*	• Funding for delivery of the system-wide management and leadership training programs is provided under the Culture Review Implementation program. • Funding for delivery of these programs is not committed beyond end of financial year.	• Failure to increase management and leadership capability to address the key issues raised in the culture review.	• Discussed at August and October meetings of Steering Group. Recommendation to refer issue to HR Matters Working Group to explore options. • Pilot programs to be delivered under Culture Review Implementation program. Evaluation of both programs will occur at end of pilot to assess effectiveness of programs in achieving the desired outcomes.	Same

Culture Review **Implementation**

our journey of positive change

Culture Reform Oversight Group Meeting Paper

OFFICIAL

Agenda Item:	4.3
Topic:	**Working Group progress**
Meeting Date:	13 December 2021
Action Required:	**Noting**
Cleared by:	**Director-General, ACT Health Directorate**
Presenters:	Working Group Representatives

Purpose

1. To provide the Culture Reform Oversight Group (Oversight Group) with an update of the progress made with the three Working Groups.

Background

2. As an outcome from the Oversight Group workshop on 18 March 2021, it was agreed that three working groups would be established to:
   - Develop solutions to matters that impacted the system,
   - Develop a model to adopt and support effective discussion, and
   - Agree on the scope of work and a work program.

3. Initial meetings of the three working groups were held in June 2021, with discussions focused on the purpose of each working group and scope.
4. The Terms of Reference for each working group are at Attachment A.
5. The Chairs of each working group are confirmed as follows:
   a. System-wide HR Matters – Ms Rebecca Cross
   b. Professional Transition to Work – Professor Nick Brown
   c. Early Intervention – Ms Barb Reid.

Issues

6. Subsequent meetings of the three working groups have been held during August, October and December 2021. Progress for each working group, including key discussions and outcomes for each group is provided below.

Professional Transition to Work Working Group

7. The fifth meeting of the Professional Transition to Work Working Group was held on 25 November 2021.
8. Agenda items for this meeting included scope of work, additional membership, discussion on the identified projects and associated work plan for the working group.
9. The group has agreed that the scope of work would include:
    a) Preparation for work (university education and placements); and
    b) Professional transitioning into and commencing work (first 18 months).
10. The group agreed to undertake a deep dive into the evidence to understand what is currently being done vs best practice. This will include a review of scientific literature, including the Rapid Evidence Assessment on the topic of 'Transition of Student to Clinician', and investigation into what is being done elsewhere in Australia and overseas. However, the first phase of this is to undertake an 'audit' to understand what is being undertaken in the ACT to support the transition of early career professionals within the ACT public health system.

Early Intervention Working Group

11. The fifth meeting of the Early Intervention Working Group will be held on 9 December. A verbal update will be provided to the Oversight Group outlining the outcomes from the meeting.
12. At the fourth meeting of the working group, Mr Peter O'Halloran, Chief Information Officer Digital Solutions Division ACTHD presented an update on the Digital Health Record (DHR) Implementation to enable discussion and understanding of the impact of COVID-19 and the recent Lockdown on the project. Mr O'Halloran responded to questions from the group on the impact of the implementation of the DHR on organisational culture, and the proposed approach to communication and change management.

System-wide HR Matters Working Group

13. The fourth meeting of the System-wide HR Matters Working Group was held on 1 December 2021 with the focus of the meeting being a range of matters relating to system-wide Industrial Relations matters, including the development of a principles-based consultation model and the development of a work program.

Recommendation

That the Oversight Group:

- *Note the updates provided for the three Oversight Group Working Groups.*

Culture Review **Implementation**

our journey of positive change

Culture Reform Oversight Group Meeting Paper

OFFICIAL

Agenda Item:	4.4
Topic:	**Culture Reform Oversight Group Meeting Minutes**
Meeting Date:	13 December 2021
Action Required:	**Noting**
Cleared by:	**Director-General, ACT Health Directorate**
Presenter:	Director-General, ACT Health Directorate

Purpose

1. To provide Culture Reform Oversight Group (Oversight Group) members with the previous meeting minutes for 9 August and 27 October 2021 and agreed action items.

Background

2. At the Oversight Group meeting of 9 August 2021, it was agreed that the Oversight Group minutes, and action items would be made available in the noting section of the meeting pack, and that members would raise items as an exemption.

Issues

3. The purpose of having the minutes as a noting item was in response to feedback that more time and emphasis was required in the Oversight Group to discuss items that were future focussed and may have an impact on the culture reform program.
4. The minutes from the Oversight Group meeting held on 9 August 2021 are at Attachment A.
5. The minutes from the Oversight Group meeting held on 27 October 2021 are at Attachment B and also include the following documents:
    a. NGO Presentation at Attachment B.1
    b. Article (Glisson & Williams; 2015. Assessing and Changing Organizational Social Contexts for Effective Mental Health Services) at Attachment B.2, and
    c. Article (Ndjaboue, Brisson & Vezina; 2012. Organisational Justice and Mental health: A Systematic Review of Prospective Studies) 2012 at Attachment B.3.
6. The action items from the Oversight Group meeting held on 27 October 2021 are at Attachment C.

Recommendation

That the Oversight Group:

- *Note the minutes from the out-of-session Steering Group meeting of 22 June 2021, and*
- *Note the minutes from the 3 August 2021 Steering Group meeting will be distributed to members once they are finalised.*

Culture Review Oversight Group Minutes

OFFICIAL

9 August 2021
1:00pm to 3:00pm
via WebEx

Members:

- Ms Rachel Stephen-Smith MLA, Minister for Health (Chair)
- Ms Emma Davidson MLA, Minister for Mental Health (Deputy Chair)
- Ms Rebecca Cross, Director-General, ACT Health Directorate (ACTHD)
- Mr Dave Peffer, Interim Chief Executive Officer, Canberra Health Services (CHS)
- Ms Barbara Reid, ACT Regional Chief Executive Officer, Calvary, ACT (Calvary)
- Ms Darlene Cox, Executive Director, Health Care Consumers Association ACT (HCCA)
- Ms Madeline Northam, Regional Secretary, Community and Public Sector Union (CPSU)
- Mr Matthew Daniel, Branch Secretary, Australian Nursing and Midwifery Federation ACT (ANMF)
- Professor Walter Abhayaratna, President, Australian Medical Association ACT Limited (AMA)
- Dr Peter Hughes AOM, President, Visiting Medical Officers Association ACT (VMOA)
- Professor Russell Gruen, Dean, College of Health and Medicine, Australian National University (ANU)
- Professor Michelle Lincoln, Executive Dean, Faculty of Health, University of Canberra (UC)
- Dr Jeffrey Looi, President, Australian Salaried Medical Officers' Federation ACT (ASMOF)

Apologies:
Nil
Staff present:

- Ms Meg Bransgrove, Senior Adviser, Office of Minister Rachel Stephen-Smith MLA
- Ms Eliza Moloney, Adviser, Office of Minister Emma Davidson MLA
- Ms Suze Rogashoff, Director CRI Branch, Office of the Director-General, ACTHD (Secretariat)
- Ms Jodie Junk-Gibson, Executive Branch Manager, People Strategy and Culture Review Branch, ACTHD (Adviser)

Item 1 Welcome

The Chair welcomed members and formally opened the meeting through an Acknowledgement of Country.

The Chair welcomed Mr Dave Peffer to the Oversight Group meeting, as Interim CEO of Canberra Health Service.

The Chair noted that the meeting would be shortened by one hour due to an unavoidable commitment that both Ministers were to attend.

Item 2 Presentations

2.1 ACT Public Health System Culture Review Implementation – Second Annual Review

The Chair welcomed and re-introduced Ms Renee Leon to members, noting that all members had met Ms Leon through the annual review interview process. The Chair advised that Ms Leon would provide a summary of the findings to date.

Ms Leon thanked members for their involvement in the process and noted the positive engagement with all the stakeholders she had met with to date.

Ms Leon spoke of the critical role of managers and leaders in influencing culture change and noted that a focus for all organisations moving forward was to develop leadership and management skills.

Key findings reported included:

- Culture impacts performance in all organisations
- Culture matters to health service delivery
- Sustaining positive workplace culture is core business
- Good foundational work
- Scope for better whole-of-system collaboration
- Mixed views from staff on values in action
- Focus being on measuring culture, requiring work on health system measures
- More work required on prevention of bullying
- Summit should be a focus of renewed thinking on how the recommendation might be implemented in the current context
- Requirement for ongoing clinical collaboration forums
- NGO Leadership Forum- leadership group established
- Partnership Board is progressing
- MOU with NSW- some engagement but further work required
- Improving medical engagement and culture strategy
- Leadership training requires progression
- More strategic approach to HR required across the system
- Oversight Group requiring more system-wide focus
- Communications on initiatives not linked to culture reform

2.2 Speaking Up For Safety

Mr Peffer provided a brief presentation about Speaking Up For Safety (SUFS) at CHS and the progress being made. The aim of the program is to embed 'speaking up', through partnering with the Cognitive Institute. At the time of the presentation CHS had:

- 23 accredited staff trainers (doctors, nurses/ midwives, health professionals and administrative staff),
- A target of 80 per cent staff trained by September 2021,
- Held 200 workshops during May-July, which approximately 3,300 attended. Of the people who attended there were 400 senior and junior doctors and Visiting Medical Officers, and 1,300 nurses and midwives.

Mr Peffer acknowledged that there were some challenges that required working through.

2.3 Presentation by Dave Peffer on progress being made in organisational areas

Mr Peffer provided an overview of the work being undertaken in 15 areas identified from the Independent Culture Review. Mr Peffer indicated that each division at CHS has a localised action plan based on individual results and implementing local measures. Results from staff surveys and pulse surveys were presented.

He outlined that CHS has:

- Refreshed visions and values
- Developed strategic plans
- Developed a range of frameworks.

Mr Peffer also reinforced that there is more work to be done.

Item 3 Management of Allegations of Bullying and Harassment

The Chair advised the group that this item would be held over. Work has been done in providing information and data on bullying and harassment across the ACT public health system, but further work is required to consolidate the information to represent the ACT public health system.

ACTION: Ms Junk-Gibson to present data at a future meeting in a consolidated way.

3.2 Working Group Progress

An update on each of the Working Groups was provided to the Oversight Group. Good progress was being made in each of the three WG's:

-Professional Transition to Work

-HR Matters

-Early Intervention.

Item 5 Member Organisation Updates

5.1 Member Updates – verbal

	Summaries provided by all members.
Item 6	**Information Items**
	6.1 Culture Review Implementation Program Plan **6.2 Implementation of Recommendations and Project Plan** **6.3 Culture Review Implementation Program Risk**
Item 7	**Other Business**
	7.1 Oversight Group Communique and 7.2 Oversight Group Key Messages The Chair requested that the communications documents be updated after the meeting and feedback sought from members out of session prior to clearance and publishing and distribution. **ACTION**: Secretariat to update Communique and Key Messages document and circulate to members for feedback and comments.
	Meeting closed at 3:00pm

Next Meeting: 27 October 2021

Culture Reform Oversight Group Minutes

27 October 2021
2:00pm to 5:00pm
via WebEx

Members:

- Ms Rachel Stephen-Smith MLA, Minister for Health (Chair)
- Ms Emma Davidson MLA, Minister for Mental Health (Deputy Chair)
- Ms Rebecca Cross, Director-General, ACT Health Directorate (ACTHD)
- Mr Dave Peffer, Chief Executive Officer, Canberra Health Services (CHS)
- Ms Barbara Reid, ACT Regional Chief Executive Officer, Calvary, ACT (Calvary)
- Ms Darlene Cox, Executive Director, Health Care Consumers Association ACT (HCCA)
- Ms Madeline Northam, Regional Secretary, Community and Public Sector Union (CPSU)
- Mr Matthew Daniel, Branch Secretary, Australian Nursing and Midwifery Federation ACT (ANMF)
- Professor Walter Abhayaratna, President, Australian Medical Association ACT Limited (AMA)
- Dr Peter Hughes AOM, President, Visiting Medical Officers Association ACT (VMOA)
- Professor Russell Gruen, Dean, College of Health and Medicine, Australian National University (ANU)
- Dr Jeffrey Looi, Australian Salaried Medical Officers' Federation (ASMOF)
- Professor Nick Brown, representing Professor Michelle Lincoln, Executive Dean, Faculty of Health, University of Canberra (UC).

Apologies:

- Professor Michelle Lincoln, Executive Dean, Faculty of Health, University of Canberra (UC).

Guests:

- Ms Lisa Kelly, Chief Executive Officer, Carers ACT.

Staff present:

- Ms Jacinta George, Executive Group Manager, Health System Planning and Evaluation
- Ms Jodie Junk-Gibson, Executive Branch Manager, People Strategy and Culture, Corporate and Governance Division, ACTHD (Adviser)
- Ms Gabrielle Elliott, Business Manager, ACTHD (acting Secretariat).

Item 1	**Welcome**

The Chair welcomed members and formally opened the meeting through an Acknowledgement of Country.

The Chair also congratulated Dave Peffer on his permanent appointment to the position of Chief Executive Officer, Canberra Health Services.

Item 2	**Minutes of the previous meeting**

2.1 Approval of minutes

The Chair apologised for the lateness of meeting papers being circulated and that the minutes from the previous meeting were not available.

Item 3	**Presentation**

NGO Leadership Group

Jacinta George, Executive Group Manager, Health System Planning and Evaluation and Lisa Kelly, Chief Executive Officer, Carers ACT spoke to the meeting paper and outlined key achievements in strengthening collaboration with the NGO sector - evidenced in the highly cohesive response to COVID-19 where NGOs felt connected, engaged and part of the health response.

There is work being done to determine how we might expand the roles of NGOs to identify further options for more effective health service delivery – for example for long stay patients and through Care Closer to Home.

It was acknowledged that there will be instances where there are issues, however both presenters echoed that there is a strong joint commitment to seeing beneficial outcomes through a co-designed health system.

Attachment A. Presentation by Jacinta George

Item 4	Decision and discussion items

4.1 Findings of the second Annual Review

The Chair spoke to the summary of key findings from the second annual review report (Report) and noted that work has progressed well across the ACT health system, but there is still work that needs to be done on our cultural reform journey.

In summary, the key findings of the Report are that:

- organisational values need to be seen by staff to be lived and demonstrated in actions at all levels,
- management needs to uphold their commitment to positive workplace culture,
- more work needs to be done to progress the Research Strategy,
- there is a need to build on collaborations strengthened through COVID-19, and
- system-wide measures of performance for transparent reporting should be implemented.

The Chair welcomed a discussion about what is next on the reform journey, including building momentum and maintaining oversight of our progress. There was acknowledgement that further discussion will occur about the system-wide culture sustainability at the December meeting.

Dr Looi raised concerns about ASMOF's involvement, particularly regarding Recommendation 18. The Chair noted that ASMOF's continuing representation is welcome.

Several members flagged that the short window of time available to read meeting papers might make it difficult to have considered reflections to inform meaningful discussion on the Report. The Chair noted that this would be the first of several discussions and apologised for the late circulation.

There was discussion around the effectiveness of messaging on the culture reform journey and the level of staff knowledge about progress. There was agreement that culture reform messaging is intended and required to be reflected in daily actions rather than specific communications.

The CEO CHS noted that it will shortly be three years since the Review, and that there may be the need to consider the balancing fresh information and plans while acknowledging the contribution of those staff that took time to contribute to the initial Review.

Members also discussed the need for a governance structure that has clear authority and territory-wide oversight. There was discussion about whether this would need to be a separate Board or whether the Oversight Group could be effectively utilised through the commitment of individuals' and collective responsibility.

The Group reflected on the Report's findings of continued poor workplace culture and bullying, and what might be done by the health services and unions to see improved outcomes. It was acknowledged that the core role of unions is to represent their members and that on occasions the application of some administrative processes within the

Directorate and health services management may not have contributed to the right outcome, which has led to protracted and deep-seated issues in the workplace.

The DG ACTHD advised the Group that the System-wide Human Resources Working Group has been established to identify administrative processes where there are inconsistencies evident across the system and recommend actions to resolve. Several members raised governance, administrative procedures and clear accountability as issues affecting outcomes and significant change.

ACTION: Professor Imogen Mitchell, Chair of the Clinical Leadership Forum is to attend the next Culture Review Oversight Committee to discuss approaches to a learning health system that may help bring issues together.

ACTION: The Report will be included on the agenda for the next CROG meeting to allow for further reflection and discussion on how the members drive collective action and ensure sustained momentum for cultural reform.

ACTION: Dr Jeffrey Looi provided two articles for consideration by the members. Articles will be circulated with the minutes.

4.2 **Workforce Data**

The Group welcomed the progress being made on workforce effectiveness data.

The Executive Director, HCCA expressed interested in seeing the impact on safety and quality of healthcare noting so much of it is about workforce.

CPSU indicated that there was interest in being able to understand the numbers of staff being considered for permanent roles, reinforcing the secure workforce working group underway across the ACTPS.

ACTION: EBM People Strategy and Culture ACTHD to facilitate the development of a paper providing narrative for the workforce dashboard to be provided at the December meeting.

4.3 **Working Group Progress**

a. Transition student to clinician

Professor Brown discussed the proposed work plan and the focus of the working group being on three main areas. These include transition programs, and in particular what training is currently embedded to support emotional regulation and critical thinking skills; mentoring, role modelling, preceptorship and supervision in place across the jurisdiction; and lastly socialisation and networking. The initial focus is to identify what transition programs are in place across the jurisdiction, and will be followed up through engagement with identified stakeholders.

b. Early consultation

Mr O'Halloran provided an update on the DHR project and discussed the potential issues and areas of concern that may impact organisational culture. Implementation timeframes

have been impacted significantly by the recent COVID-19 outbreak in the ACT. The following issues were noted:

- Decreased availability of clinical staff due to additional pressures on system.
- Restrictions on EPIC staff coming from Melbourne and overseas to support project.
- Entire DHR program team redeployed to frontline to support COVID-19 outbreak response.
- Team productivity decreased during remote working arrangements. DHR team returned to office prior to lockdown.

Mr O'Halloran discussed the approach adopted for governance and engagement with clinicians. The go-live date has been postponed, with positive feedback having been received about this decision. Mr O'Halloran stated that training will be delayed in alignment with the adjusted schedule. Training will ramp up 8-10 weeks prior to go-live. It was noted that there are issues with workforce supply which may impact recruitment of trainers. The need to locate additional training spaces was also noted as an issue.

An update was provided from members about the impact of COVID-19 on work across the ACT public health system.

c. System-wide HR matters

DG, ACTHD reported that there was discussion about how leadership and management training was embedded within the ACT public health system post 30 June 2022. Discussion focussed on the ability to centralise some funds available through the annual oncost budget process for each employee to invest into the ongoing training to build the capability required to lead and shape our future workforce.

Item 5 Member Updates

Summaries provided by all members.

Item 6 Implementation of Recommendations and Project Plan

A summary was provided on the implementation of recommendations, and the current delays. The update allowed an outline about the reasons for the delays and the anticipated progress by the December Oversight Group. There was acknowledgement that there would be potentially one recommendation expected to be completed by the 13 December meeting, with an additional four actions completed. The recommendation expected to be completed was Recommendation 1- embedding values.

Item 7 Other Business

There was agreement that there would no longer be a Key Messages document, as this was a duplicate of the Communique, and that the Communique would be progressed post-meeting.

Next Meeting: 13 December 2021, 3.30pm – 5.00pm, DG Conference Room, 6 Bowes St Woden.

ACT Government | ACT Health

NGO Leadership Group: 2 Years

Jacinta George Executive Group Manager, Health System Planning and Evaluation

Two different worlds…
Same Goal

Achievements

- Relationships and Networks
- Broader view of issues
- How to communicate for effect
- COVID - sharing information and experiences
- Codesign - the commissioning approach

Challenges & the Future

- Cascading the relationships through our organisations
- Outcomes/impact approach
- Could an NGO deliver that service? Expanding the role of NGOs in the system
- Building evidence bases and documenting the things that matter

Is the NGOLG the best way to achieve the result?

Assessing and Changing Organizational Social Contexts for Effective Mental Health Services

Charles Glisson and Nathaniel J. Williams

Children's Mental Health Services Research Center, University of Tennessee, Knoxville, Tennessee 37996; email: cglisson@utk.edu, nwilli39@utk.edu

Annu. Rev. Public Health 2015. 36:507–23

The *Annual Review of Public Health* is online at publhealth.annualreviews.org

This article's doi: 10.1146/annurev-publhealth-031914-122435

Keywords

organizational culture, organizational climate, ARC, OSC, mental health services, evidence-based treatments, implementation, innovation

Abstract

Culture and climate are critical dimensions of a mental health service organization's social context that affect the quality and outcomes of the services it provides and the implementation of innovations such as evidence-based treatments (EBTs). We describe a measure of culture and climate labeled Organizational Social Context (OSC), which has been associated with innovation, service quality, and outcomes in national samples and randomized controlled trials (RCTs) of mental health and social service organizations. The article also describes an empirically supported organizational intervention model labeled Availability, Responsiveness, and Continuity (ARC), which has improved organizational social context, innovation, and effectiveness in five RCTs. Finally, the article outlines a research agenda for developing more efficient and scalable organizational strategies to improve mental health services by identifying the mechanisms that link organizational interventions and social context to individual-level service provider intentions and behaviors associated with innovation and effectiveness.

INTRODUCTION

Children and adults across all demographic groups experience mental health problems that significantly lower their quality of life and contribute to increased disability and mortality. This group of children and adults includes 46% of the US population who experience mental health problems at some point in their lives and 6% of the population who face chronic and persistent mental illnesses that often require long-term or intermittent care (68, 69, 80). Moreover, a large proportion of the children and adults who receive mental health services do not benefit from care (76, 108). Their outcomes are poor because they receive services from providers who do not use effective treatments or because they encounter various barriers that interfere with the availability, responsiveness, or continuity of the services they seek (30).

Numerous complex factors affect the outcomes of mental health services, but the availability, responsiveness, and continuity of the services and the specific treatment models used in those services are, in part, functions of the social contexts (e.g., cultures and climates) of the organizations that provide the service (32). Mental health service organizations vary in social context and are not equally effective even when they serve similar populations with similarly trained clinicians (39, 111). Our review suggests that the social contexts of organizations that provide mental health services can be accurately assessed and improved and that improvements in social context are central to the successful implementation of effective services (38, 39).

Our review describes strategies for assessing and changing the cultures and climates of mental health service organizations that may be especially important in meeting the current demand for improved services to troubled youth, abused children, traumatized war veterans, and other populations in critical need of accessible and responsive mental health care. We also describe a research agenda for developing more efficient and transportable organizational interventions by identifying the mechanisms that link organizational interventions to behavior change at the individual service provider level. The mechanisms must be identified to develop focused interventions that can be efficiently implemented in a variety of mental health service settings (e.g., mental health clinics, child welfare systems, veterans' hospitals, primary care settings).

Social context has long been associated with successful innovation implementation and outcomes. For example, we know from decades of empirical studies in various academic disciplines that social context is instrumental in facilitating or inhibiting the successful implementation of innovations within the social networks of communities defined by geographical locale (e.g., city, village) or profession (e.g., farmers, physicians) (93). We have also learned that social contexts within organizations are powerful determinants of an organization's readiness to implement innovations and predict which organizations will be the most innovative (70, 72). For example, social context is a factor in surgical teams' successful implementation of new state-of-the-art, surgical procedures (24). Moreover, the social context of mental health and social service organizations is associated with both successful innovation implementation and effective outcomes (39, 85).

Social contexts are interpersonal networks of individuals characterized by norms, expectations, and shared perceptions that influence individual behavior (93). The characteristics of organizational social contexts affect many types of behavior, including innovation adoption, staff turnover, commitment, tenacity in solving complex problems, collaboration, and task engagement (51). Several social processes account for these context-based behaviors, including group learning, mimicry, sanctions, identity formation, competition, schema formation, and meaning construction (10, 20, 28, 101, 102). These processes explain the similarity of behavior observed within the same social contexts as well as the variation of behavior observed between different social contexts. We have known for some time that such processes explain why the effectiveness of organizations varies and

why some organizations are more likely to adopt and implement innovations successfully (48, 65, 91).

The social contexts of organizations that provide mental health and social services are associated with differences in both individual service provider behavior and client outcomes (1, 3, 4, 34, 35, 37, 44, 47, 82, 97, 98, 110). Moreover, organizational research in many sectors, including medicine, customer service (e.g., banking), and various professional fields (e.g., information technology), explains how organizational social contexts determine whether an organization is innovative, that is, whether it is an early adopter of new ideas, tools, and practices that could improve its effectiveness (15, 51, 86, 88, 94). Studies from both outside and within mental health include several frameworks developed specifically for understanding innovation (19, 48, 52). Most of these frameworks conceptualize organizational social context as a multidimensional construct (e.g., culture, climate) that affects all phases of innovation from adoption to sustainment (2). Despite this work, few service improvement and innovation implementation efforts in mental health services actually address organizational social context. Instead, most service improvement and innovation efforts focus on technical training at the individual level without addressing contextual characteristics such as culture and climate that support or inhibit the successful implementation and outcomes of that training (12, 79).

DIMENSIONS OF ORGANIZATIONAL SOCIAL CONTEXT ASSOCIATED WITH INNOVATION AND EFFECTIVENESS

The challenge of organizational innovation and effectiveness has played a central role in the history of organizational research and practice for well over a century (e.g., 103). The history of these efforts reflects a transition from the simplistic, mechanistic assumptions regarding individual work behavior in nineteenth-century organizations to more recent, complex views of the roles played by social context, cognition, and perception (13, 62, 77, 106). Early approaches, best represented by Frederick Taylor's (103) "scientific management," were based on the "top down" assumption that work behaviors can and must be carefully specified, explicitly linked, and tightly controlled by organizational leaders to improve productivity and efficiency. Although subsequent empirical studies and increasingly complex views of work behavior and performance challenged many of these early assumptions, Lisbeth Schorr (99) noted almost a century later that the underlying philosophy of these mechanistic models was still evident in the managerial approaches taken in mental health and social service organizations: "We are so eager, as a body politic, to eliminate the possibility that public servants will do anything wrong that we make it virtually impossible for them to do anything right" (p. 65).

Moving beyond the early mechanistic models, the sociotechnical model of organizational effectiveness explained an organization's effectiveness as a function of the fit between the organization's social context and the characteristics of its core technology (13, 105). The origin of the sociotechnical model is associated with a landmark study in Great Britain that described the failed efforts to implement the innovative "long-wall" method of coal mining (104, 105). The failure was linked to an intricate set of shared behavioral norms and expectations that had evolved over generations of British coal miners. The incongruence between the established social norms of the coal miners and the tasks required by the innovative long-wall technology contributed to psychological distress and turnover among the miners and reduced productivity.

Today, the fact that an organization's social context is associated with its capacity for innovation and effectiveness is generally accepted, and two dimensions of social context—organizational climate and culture—are mentioned most often (62, 96, 107). The terms have distinct histories. Organizational climate appeared first in the 1930s when Lewin (74) studied how the "atmosphere"

or "climate" engendered by a work group's leader affected the behavior of group members. The term climate reflected the psychological impact of the work environment on employees' well-being, motivation, and performance (61).

Studies of organizational culture—defined as the shared behavioral norms, values, and expectations in an organization—emerged several decades later in the 1970s (50, 90). The term organizational culture borrowed heavily from sociological and anthropological research on social culture and studies of communities, indigenous groups, and other socially defined collectives. The two terms, organizational culture and organizational climate, began to be used interchangeably by some writers in the 1990s, but a comprehensive thematic analysis of the literature in the latter part of that decade confirmed a distinction between culture and climate that continues among many organizational researchers (107).

Our view is that culture and climate differ in important ways. Organizational climate is created by employees' shared perceptions of the psychological impact of their work environment on their own personal well-being and functioning (41, 60). The perceptions that are shared by employees in a given work environment represent an agreement in their appraisals of the meaning and significance of their work (60). The perceived impact of a work environment on each individual's personal well-being has been labeled psychological climate (63). When individuals in the same work environment agree on their perceptions of the psychological impact of their work environment, their shared perceptions define the organizational climate of that particular work environment. The difference between psychological climate and organizational climate can be illustrated with the notion of perceived room temperature. Room temperature can be understood as individual-level appraisals of being too hot or too cold. If all the individuals in a room agree that the room is either too hot or too cold, the group's shared perception of the room's temperature can be described (the group is either too hot or too cold) while retaining the idea that each individual is experiencing the temperature (each individual is either hot or cold).

Individual-level job performance, psychological well-being, withdrawal, staff turnover, job satisfaction, organizational commitment, and motivation as well as organizational-level innovation, productivity, and performance have all been associated with organizational climate (15, 88, 96). Moreover, the organizational climate of mental health and social service agencies has been empirically linked to service quality, treatment planning decisions, clinician attitudes toward evidence-based treatments (EBTs), staff turnover, and youth mental health outcomes (1, 4, 34, 37, 39, 40, 82, 98). Climate has also been described as mediating the effect of organizational culture on individual-level work attitudes and behavior (3, 40).

Organizational culture is defined as the behavioral norms and expectations that characterize a work environment (17, 41, 107). These norms and expectations guide the way employees in a particular work environment approach their work, direct their priorities, and shape the way work is done. New members of an organizational unit are acculturated through social processes such as modeling, reinforcement, and sanctions (53). Many writers emphasize that organizational culture is a layered construct consisting of deeply held assumptions and values that translate into normative expectations and behavior. However, several studies suggest organizational culture is transmitted more through behavioral norms and expectations than through internalized values or assumptions that may not be explicit or known (26, 54, 57, 58).

The effects of organizational culture on individual and organizational outcomes have been widely studied, and the number of such studies has increased during the past decade. Wilderdom (109) identified 10 studies of the association of organizational culture and outcomes prior to 2000, whereas a subsequent review by Sackmann (94) and a meta-analysis by Hartnell et al. (51) a decade later identified 55 and 84 such studies, respectively. Organizational culture has been associated with a variety of outcome criteria, including service quality, innovation, employee work attitudes,

organizational growth, and performance (73, 84). Among these studies, organizational culture explained 35% of the variance in innovativeness among hospital units, 46% of the variance in earnings among customer service organizations, and 38% of the variance in performance behavior and standards among customer service organizations (94).

Organizational culture in the context of mental health and social services has been empirically linked to clinician attitudes toward EBTs, sustainability of newly adopted treatment programs, access to mental health services, service quality, staff turnover, and mental health outcomes (1, 3, 34, 35, 39, 40, 110). In summary, culture-based behavioral norms and expectations within an organization guide individual behavior, and variation between organizations' norms and expectations explains differences in organizational innovation, performance, and outcomes (51, 71).

ASSESSING ORGANIZATIONAL CULTURE AND CLIMATE IN MENTAL HEALTH SERVICES

Numerous instruments are used in health and mental health settings to assess organizational culture and climate, but many have inadequate psychometric properties. Moreover, several have unreported or poorly reported psychometric properties or have been applied in just a single study (25, 31, 100). Emmons et al. (25) found highly variable and poor score reliabilities across studies (i.e., $\alpha < 0.70$), factor structures that were unique to each study, use of a single rater to assess an organization's culture and climate, and inappropriate composition models for constructing items and aggregating individual-level responses.

The Organizational Social Context (OSC) measure was developed over a 30-year period to address these types of problems in assessing the organizational cultures and climates of mental health and social service organizations (36, 41, 44). The OSC is designed for both research and practice (e.g., 11), and US national norms are available for child welfare and mental health settings, respectively (36, 41). The availability of national norms permits organizational culture and climate profiles to be estimated for an organization in relation to a nationwide sample of similar organizations.

OSC Measure of Organizational Culture

The OSC measure of organizational culture relies on line workers' responses to items assessing three dimensions of behavioral norms and expectations that guide their work behavior (41). The three dimensions are proficiency, rigidity, and resistance. Clinicians in proficient organizational cultures report they are expected to be responsive to the unique needs of each of the clients they serve and to have up-to-date knowledge and clinical skills. Clinicians in rigid organizational cultures report they are expected to closely follow a host of bureaucratic rules and regulations and have limited discretion and authority in completing their work. Clinicians in resistant cultures report they are expected to suppress change or innovation in their work environment through either active or passive strategies that maintain the status quo. Organizational cultures that produce the best clinical outcomes for youth, the best clinician attitudes toward EBTs, highest service quality, and longest program sustainability are those that expect high levels of proficiency and low levels of resistance and rigidity compared with national norms (1, 34, 39, 41, 85).

OSC Measure of Organizational Climate

The OSC measure of organizational climate includes three dimensions of employees' shared perceptions of the psychological impact of their work environment on their own well-being and

functioning (41). The three dimensions are engagement, functionality, and stress. In engaged organizational climates, clinicians describe their work-related accomplishments as personally meaningful and report they are personally involved in their work with clients. In functional climates, clinicians report that they receive the levels of support and cooperation from coworkers and administrators needed to do their jobs and have a clear understanding of their roles in the organization and how they contribute to its success. In stressful climates, clinicians report high levels of role overload, role conflict, and emotional exhaustion in their work. Organizational climates that produce the best outcomes for youth, lowest employee turnover, positive clinician attitudes toward innovation (e.g., EBTs), and highest service quality are those with high levels of engagement and functionality and low levels of stress compared with national norms (1, 35, 41, 85).

OSC Reliability and Validity

The reliability and validity of the OSC have been established in multiple studies, including two studies with nationwide samples (36, 41). The OSC factorial validity was confirmed in a nationwide study of 1,154 clinicians in 100 children's mental health clinics in 26 states (41) and in a nationwide sample of 1,740 child welfare caseworkers in 81 child welfare systems (36). These studies provided evidence of moderate to excellent internal reliabilities ($\alpha \geq 0.70$) for each of the six dimensions of culture and climate assessed by the OSC, as well as evidence of within-organization inter-rater agreement and between-organization differences in line worker responses.

The validity of the OSC is based on associations with clinician turnover, program sustainability, service quality, and employee work attitudes (i.e., job satisfaction, commitment) in multiple samples across hundreds of organizations (e.g., 34, 35, 39, 41, 44, 85). The validity of the OSC in predicting service outcomes has been supported in numerous prospective studies, including a nationwide, seven-year longitudinal study of youth served by child welfare systems (35) and a randomized controlled trial of mental health service programs for youth (39). The associations among the multiple dimensions of the OSC and various criteria also support the construct validity of the culture and climate dimensions on the OSC (e.g., 1, 34, 41, 44, 85).

CHANGING ORGANIZATIONAL SOCIAL CONTEXTS FOR EFFECTIVE MENTAL HEALTH SERVICES

The association of organizational culture and climate with innovation, service quality, and outcomes suggests that organizational interventions that improve social context can be used to support EBT implementation and improve service effectiveness. Although many organizational interventions have been designed to improve culture and climate, few have been tested in mental health and social services, and almost none have been tested in randomized controlled studies in actual work settings (87). One exception is the Availability, Responsiveness, and Continuity (ARC) model of organizational effectiveness. ARC is a team-based, participatory, phased process designed to improve organizational culture and climate in mental health and social service organizations, support innovation, and remove barriers to effective service. Five randomized controlled trials (RCTs) of ARC have been conducted in the Midwest, Northeast, and Southeast regions of the United States. These RCTs show that ARC improves organizational social context, increases job satisfaction and commitment, supports EBT implementation, reduces staff turnover, and improves service outcomes (33, 38, 39, 42, 43).

Changes in organizational culture and climate that support innovation and improve effectiveness are created with three ARC intervention strategies. The first ARC strategy embeds five principles of service system effectiveness within the organization to guide ongoing organizational

innovation and service improvement efforts. The second ARC strategy trains teams of clinicians to use organizational component tools that are necessary to identify and address barriers to service innovation and effectiveness. The third ARC strategy promotes shared mental models (e.g., openness to change, psychological safety) among clinicians and administrators to support service innovation and improvement efforts. Each of the three strategies is discussed below in more detail.

Embedding Principles of Organizational Effectiveness

ARC embeds five guiding principles within an organization to guide positive change efforts and improvements in service system effectiveness (42). This strategy is supported by written ARC manuals and an ARC specialist who explains the principles and helps organizational members apply the principles in their improvement efforts. The principles are based on the idea that service barriers emerge in any organization to misdirect the attention and efforts of individual-level providers who are attempting to serve clients. The five ARC principles guide efforts to identify and address those service barriers by focusing service provider efforts on improving the well-being of the organization's clients. This focus is critical to improvement efforts because principle-based, contextual support for individual-level efforts that benefit others is an important motivator in developing service providers' commitment to making a prosocial difference through their work (46). The five ARC principles are to (*a*) be mission-driven not rule-driven, ensuring that all actions and decisions contribute to clients' well-being; (*b*) be results-oriented not process-oriented, measuring success by how much client well-being improves; (*c*) be improvement-directed not status quo–directed, continually working to be more effective in improving clients' well-being; (*d*) be relationship-centered not individual-centered, focusing on networks of relationships that affect services and clients' well-being; and (*e*) be participation-based not authority-based, ensuring that policy and practice decisions that affect client well-being involve everyone with a stake in the decision.

Twelve Organizational Component Tools to Improve Services

The ARC strategy uses 12 organizational component tools (e.g., feedback, teamwork, task redesign) through 3 stages to encourage and support collaboration, participation, and innovation within a service system. These 12 components include empirically supported organizational change strategies selected from several decades of research (e.g., 83, 92) and adapted for mental health and social service organizations. The component tools are taught and supported with the *ARC Training Manual* and *ARC Facilitator's Guide*. The University of Tennessee Children's Mental Health Services Research Center website (**http://cmhsrc.utk.edu**) provides additional information about these components and materials.

The ARC strategy creates within each organization a structure and a process for using the 12 component tools under the guidance and support of the ARC specialist (a trained expert who is external to the organization), the ARC liaison (a carefully selected internal champion who is identified by the ARC specialist in collaboration with the organizational leadership), the organizational action team (OAT), and ARC line-level teams. The ARC line-level teams are composed of direct service providers who are trained to identify and address service barriers in their work, while guided by the five ARC principles. The OAT is composed of members from all levels of the organization, including top leadership, middle management, and line-level service providers. Using the five ARC principles, the OAT is responsible for reviewing and implementing proposals submitted by the ARC line-level teams to address service barriers identified by the teams.

Collaboration. ARC specialists work in the collaboration stage with agency administrators, external stakeholders, and clinicians to incorporate three component tools. First, the ARC specialist supports the efforts of organizational leadership to introduce and explain the ARC change process and goals to organizational members and describe the organizational structures and processes that will be created to support service improvement efforts. These efforts focus on upper leadership's commitment to ARC, the five principles of service system effectiveness outlined above, and the provision of practical information about the ARC organizational structure and process. The ARC specialist works with upper leadership to (*a*) identify an ARC liaison among the upper organizational leaders who will champion the ARC effort within the organization and (*b*) create an OAT with representatives from each level (leadership, middle management, supervisors, and frontline staff).

Second, ARC specialists cultivate personal relationships with members of the organization (e.g., OAT team), external stakeholders (e.g., consumer advocates), and supervisory and frontline staff (e.g., ARC teams). These relationships are integral to framing the rationale for the improvement effort and work of the OAT and ARC teams. Third, the ARC specialist builds a network of relationships through meetings that focus on issues identified as important by the organizational leadership, line-level supervisors, and other stakeholders (43).

Participation. Five component tools form the ARC participation stage to establish organizational processes that are critical to engaging members in service improvement efforts. These component tools include team building, information and training, feedback, participative decision making, and conflict management. Using these tools, the ARC specialist trains frontline ARC team supervisors to use the ARC model of decision making and problem solving in the teams' efforts to identify and address service barriers. The *ARC Facilitator's Guide* instructs supervisors in how to conduct treatment team meetings that identify service barriers, develop proposals for addressing those barriers, and submit the proposals to the OAT for implementation. The organizational leaders and frontline team members are trained to assess the relative advantage of a proposed innovation, to apply the ARC principles in decision making, and to support efforts to identify and address service barriers.

Innovation. Finally, four ARC component tools compose the innovation stage in the implementation of changes to improve service quality and outcomes. The four component tools are goal setting, continuous improvement, job redesign, and self-regulation. The organizations' ARC teams are taught to use goal setting and continuous improvement procedures to address service barriers. Job characteristics are redesigned in this stage to eliminate service and innovation barriers. This process includes transforming job tasks, changing program practices and procedures, and training frontline staff. The development of plans to ensure self-regulation and stabilization of innovation adoption and implementation processes is the last step.

The ARC structures and processes can support various innovations as a function of the unique interests and service barriers identified by the line workers composing the ARC teams. Examples of ARC accomplishments are streamlining client referral processes, eliminating unnecessary paperwork, implementing new treatment models (e.g., EBTs), installing electronic medical record systems, modifying decision-making processes, establishing linkages among key personnel in different institutions (e.g., clinics, schools, juvenile courts), and improving intake procedures. The ARC model of organizational effectiveness views the capacity for innovation as an organizational characteristic that must be intentionally developed and sustained to support ongoing improvements in service delivery.

The Role of Shared Mental Models in Improvement Efforts

A third ARC strategy is to develop shared mental models (e.g., openness to change, psychological safety) among agency administrators, mid-level management, and frontline service providers to support innovation and service improvement efforts. Mental models are heuristically based cognitive processes that form the basis of reasoning and interpretation and influence individuals' behaviors (59, 81). Service improvement efforts depend on shared mental models among service providers that affect adoption and implementation success, are influenced by organizational culture and climate, and are malleable (59, 78). The notion of psychological safety, for example, promotes the participation of line-level workers in critically examining service barriers and proposing improvements in job-related tasks without fear of reprisal from peers or supervisors. Evidence shows that health care teams characterized by psychological safety are more effective in implementing complex innovations (24).

Five RCTs, including three published trials and two that have been recently completed, support the feasibility and benefits of ARC in improving both child welfare and mental health service systems. The trials have shown ARC to be successful in improving work environments, innovation, EBT implementation, and service outcomes (33, 38, 39, 43). The interventions were effective at both program and organizational levels and established that improvements in social context are associated with improved client outcomes.

MECHANISMS THAT LINK ORGANIZATIONAL INTERVENTIONS AND SOCIAL CONTEXT TO INDIVIDUAL BEHAVIOR

Organizational interventions are time and labor intensive and therefore expensive. Improvements in the efficiency and effectiveness of these intervention strategies require a better understanding of the mechanisms that link organizational interventions, organizational social contexts, and individual-level behaviors (95). Although organizational interventions have been shown to improve organizational social contexts and outcomes in mental health and social service systems, less is known about the mechanisms that link the interventions to individual-level behavior change (38, 39, 43).

Services researchers have noted the need for theory-guided development of implementation strategies that specify cross-level mechanisms linking organizational interventions to targeted changes in individual service provider behavior (49). A better understanding of specific change mechanisms is necessary for more efficient and effective innovation implementation strategies because it is not clear which specific strategies can or should be included (or eliminated) for a given targeted outcome. We argue that transforming organizational social context in a cost-effective and sustained way requires knowledge of the linking mechanisms that generalizes beyond any specific innovation, EBT, group of employees, setting, or organizational leader (112). The goal of identifying linking mechanisms is to provide the tools that enable organizations to pick the strategies that are most appropriate for their specific needs.

Improving our understanding of linking mechanisms requires research strategies that can overcome several challenges. Organizational studies must balance experimental control and intervention specificity with external (ecological and population) validity. Studies must test specific change mechanisms that occur in and link both organizational and individual levels. Implementation studies must also test change mechanism hypotheses across all phases of innovation: exploration, adoption, implementation, and sustainment. These challenges can be overcome with research that specifies a cross-level theory of organizational and individual behavior change and tests the theory within a research and development framework that incorporates the experimental control required

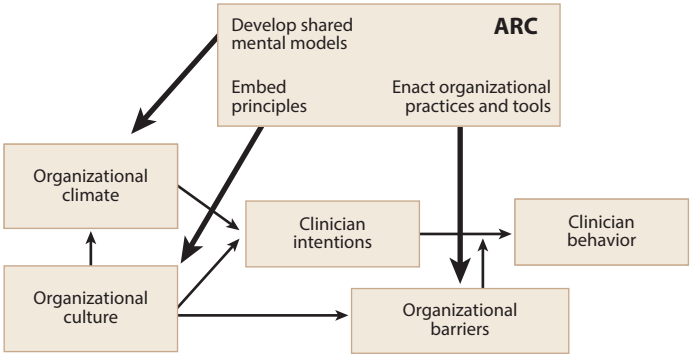


Figure 1

Theoretical model of cross-level change mechanisms, processes, and behaviors.

to assess specific change mechanisms. We propose a theoretical model and a research paradigm that contribute to this effort (112). Initial studies in a sample of 14 mental health organizations are testing our model in the context of an RCT of the ARC organizational intervention (see **Figure 1**).

The proposed model builds on research that describes the effects of planned behavioral change in human systems and incorporates four phases in identifying change mechanisms (22, 66, 67). First, the effort focuses on specifying a theoretically grounded intervention and conducting randomized trials to establish the efficacy of the intervention in the targeted outcome criteria. This first phase has been largely completed for the ARC model of organizational effectiveness as described above.

In the second phase, potential change mechanisms need to be identified and their links to targeted outcomes in a mediation framework assessed. Very little of this work has been completed with ARC or any other organizational intervention strategy. We define change mechanisms as intermediate changes that are activated by the intervention and serve as the basis of the intervention's effect. Change mechanisms in organizational interventions operate at the organizational and individual levels. In the third phase, change processes that contribute to improvements in the change mechanisms are to be identified. Work in this third phase has not begun for existing innovation implementation strategies. We define change processes as the active ingredients of the organizational intervention, which include the activities of the external organizational change agent (e.g., ARC specialist in our example) and the participating members of the service system (e.g., ARC liaison, OAT, and ARC teams in our example) that contribute to variation in the change mechanisms. Finally, in the fourth phase, empirical knowledge of the change mechanisms and change processes is to be used to improve the intervention or to develop new intervention strategies that use change processes more efficiently to affect the identified change mechanisms.

Our program of research integrates organizational culture and climate theory with well-established social cognitive theories of individual behavior and behavior change (5, 6, 10, 27). Our goal is to explain the links between organizational change processes, change mechanisms, and individual behavior change related to improvement efforts such as EBT implementation (112). Many human behaviors are explained by social cognitive theories, including the behavior of health and mental health practitioners (7, 16, 23, 89). Social cognitive theories can be integrated with organizational culture and climate theory with a focus on the role of social norms, perceived benefit, and self-efficacy in generating behavioral intentions, which are driven in part by organizational social context. In addition, the role of environmental barriers that may facilitate or constrain the enactment of behavioral intentions is included in both social cognitive theory

and in culture and climate theory (27). The meta-analysis by Godin et al. (45) found that the theory of planned behavior explained health care professionals' behaviors and that factors closely related to organizational culture and climate, including social influences, social/professional role identity, and beliefs about consequences, were all significantly related to behavioral intentions and behaviors. Moreover, clinicians' beliefs about their own abilities to act, which are reflected in our definition of organizational climate, contributed significantly to intentions and behaviors.

The model shown in **Figure 1** uses the theory of planned behavior to link organizational social context to clinicians' behavioral intentions and behavior. Behaviors related to the use of an EBT and other innovations require preparation, forethought, and sustained effort. Individuals develop intentions to pursue such behaviors and are more likely to enact the behaviors when environmental conditions support their intentions (5, 27). We argue that organizational social contexts contribute to the development of intentions to act and to the presence or absence of organizational barriers to enactment. In turn, the relationship between clinicians' intentions and their behaviors is moderated by the organizational barriers. The dual effect of culture and climate on intentions and barriers parallels research on innovation implementation and explains the influence of culture and climate on the adoption, implementation, and sustainment of EBTs and other innovations that has been established in many studies (1, 4, 9, 14, 18, 21, 29, 55, 56, 64, 75, 112). Evidence has also shown that organizational culture impacts other employee behaviors (e.g., turnover) directly and indirectly through its effects on organizational climate (3, 51, 111).

Change processes are represented by the three ARC strategies described previously. The three strategies (i.e., embedding guiding principles, enacting organizational component tools, and developing shared mental models) improve organizational culture and climate and reduce organizational barriers, which represent organizational-level change mechanisms. In addition, the strategies affect practitioners' intentions to act, which represents an individual-level change mechanism. This model therefore explains the implementation of EBTs and other innovation-related behaviors as a function of intervention change processes (ARC principles, organizational tools, and mental models) that impact organizational-level (organizational culture, climate, barriers) and individual-level (intentions) change mechanisms to influence individual behavior (e.g., innovation adoption, implementation, sustainment), as shown in **Figure 1**.

The innovation implementation process and other organizational improvement efforts have multiple stages. For example, the desired clinician behavior in the exploration stage may include search behavior directed at identifying an EBT that is relevant for specific clients. Organizational culture and climate impact clinicians' intentions to engage in search behavior and contribute to organizational barriers that moderate the effect of their intentions on behavior. Research suggests that a culture characterized by proficiency norms and a climate characterized by lower stress contribute to search behavior (1). In turn, a less resistant culture that is open to change would be expected to erect fewer barriers to the search behavior. Behaviors in the adoption, implementation, and sustainment phases can all be identified and assessed in a similar fashion. Organizational- and individual-level change mechanisms established in phase-two efforts will form the basis for phase-three studies focused on developing more efficient and scalable organizational intervention strategies.

SUMMARY

Organizational social context is central to innovation and effectiveness in mental health services and plays a key role in the adoption, implementation, and sustainment of EBTs. We have developed the OSC measure over the past three decades to assess the organizational culture and climate of mental health and social service agencies and have linked OSC profiles to clinician

behavior, service quality, and outcomes in numerous studies, including nationwide samples and RCTs. We have also developed and tested in five RCTs the ARC model of organizational effectiveness for creating the types of organizational cultures and climates that support innovation and service improvement efforts in mental health and social services. These assessment and intervention tools can be used to study and support EBT implementation and effectiveness as well as other innovation efforts (e.g., improving service quality, introducing electronic medical records, reducing staff turnover). However, changing organizational social contexts is a time-consuming and labor-intensive effort, and we need more efficient and transportable organizational interventions to improve the effectiveness of mental health service systems. Our review of numerous empirical studies shows that the implementation of innovations such as EBTs and service outcomes in mental health can be improved with organizational interventions that successfully shape social contexts. Future research efforts must focus on developing more efficient organizational intervention strategies for improving social context by identifying the specific mechanisms that link the organizational strategies to targeted individual-level intentions and behaviors.

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EDITOR'S CHOICE

Organisational justice and mental health: a systematic review of prospective studies

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ABSTRACT

The models most commonly used, to study the effects of psychosocial work factors on workers' health, are the Demand-Control-Support (DCS) model and Effort-Reward Imbalance (ERI) model. An emerging body of research has identified Organisational Justice as another model that can help to explain deleterious health effects. This review aimed: (1) to identify prospective studies of the associations between organisational justice and mental health in industrialised countries from 1990 to 2010; (2) to evaluate the extent to which organisational justice has an effect on mental health independently of the DCS and ERI models; and (3) to discuss theoretical and empirical overlap and differences with previous models. The studies had to present associations between organisational justice and a mental health outcome, be prospective, and be entirely available in English or in French. Duplicated papers were excluded. Eleven prospective studies were selected for this review. They provide evidence that procedural justice and relational justice are associated with mental health. These associations remained significant even after controlling for the DCS and ERI models. There is a lack of prospective studies on distributive and informational justice. In conclusion, procedural and relational justice can be considered a different and complementary model to the DCS and ERI models. Future studies should evaluate the effect of change in exposure to organisational justice on employees' mental health over time.

INTRODUCTION

Psychosocial stressors in the workplace, and their deleterious effect on mental health, have become an important public health issue.[1–4] Prospective studies have identified some psychosocial factors leading to physical and mental health problems.[1–3 5–7] Most of these studies preferentially used the Demand-Control-Support (DCS) model[8] and Effort-Reward Imbalance (ERI) model.[9] Previous systematic reviews on the effects of work stressors on mental health were limited to these models.[4] However, a third model, the Organisational Justice (OJ) model, has been recently proposed.[10 11] It has been argued that in today's rapidly changing work life, job control (from the DCS) may become less meaningful, as a result of the increased use of short-term contracts and the job insecurity that goes with them.[12] In fact, the current developments in the labour market, the recent changes in work characteristics across a range of organisational contexts, and the emphasis on occupational equity may reflect the growing importance of underemployment, redundancy and forced occupational mobility.[12] In this context, the OJ model, which has been found to be prospectively associated with physical health,[5 13] may become increasingly important to employees' mental health.[14] There are also some prospective studies on the effect of organisational justice on mental health,[13] but no systematic review has been conducted. The extent to which this model is related to mental health disorders and is independent of the DCS or ERI factors therefore remains unclear. To help answer these questions, we will review both, the theoretical framework and empirical studies, on organisational justice and mental health.

THEORETICAL AND EMPIRICAL BACKGROUND FOR THE ORGANISATIONAL JUSTICE MODEL

The organisational justice concept has developed out of a pre-existing conceptual framework called Adams' 'equity theory'. According to Adams,[15 16] individuals develop beliefs about what would be fair recognition for their work. Then, they compare themselves or someone else with a 'referent' in terms of the input/output ratio. A referent is another employee who is deemed to be equivalent in terms of duties and work status.[16] The inputs are effort, time, skill, loyalty, tolerance, flexibility and integrity. The outputs are salary and bonuses, job security, recognition, reputation and responsibilities/promotions. In some situations, the comparison may lead to a perception of unequal treatment between an employee and one or more referent(s), which could in turn lead to potentially negative outcomes. Adams points to possible emotional and/or physical problems as evidence of a relationship between inequity/injustice and health.[15]

Organisational justice refers to the equity in the rules and social norms that govern companies, particularly in terms of 'resources and benefits distribution (or *distributive justice*), processes and procedures conditioning that distribution (or *procedural justice*) and interpersonal relationships (or *interactional justice*)'. Interactional justice has two components: relational justice (degree of dignity and respect received from managerial authority) and informational justice (presence or absence of explanations from the managerial authority about new procedures).[5 7]

In theory, the OJ model can assess perceptions of workplace situations, even when the subject is not personally and directly concerned.[15] This seems to be one of the differences, when compared with the DCS and ERI models, which measure perceptions of individual situations. Indeed, one might perceive a balance between its efforts and compensation (control or rewards), but still perceive injustice when compared with other employee of the workplace.

The concept of organisational justice has grown in use over the last two decades.[5 7] The studies that had investigated this concept mainly focused on two components of organisational justice: procedural justice and relational justice. Organisational injustice measured as a single factor or by the above-mentioned components has been associated with adverse cardiovascular outcomes.[17–20] There is an emerging body of empirical research investigating whether deleterious effects on mental health can be observed. This paper aims to produce a systematic review of these studies.

OBJECTIVES

- To review prospective studies of the association between organisational justice and mental health in industrialised countries from 1990 to 2010.
- To evaluate the extent to which organisational justice has an effect on mental health independently of the DCS and ERI models.
- To discuss theoretical and empirical overlap and differences with previous models.

METHODS

Data were collected using three databases: PsychINFO (to identify psychosocial studies), Web of Science and Pubmed. The studies were first selected on the basis of their title and abstract. For practical reasons, articles had to be available in English or French. Second, the scientific literature was searched via the lists of references provided by selected papers, and by literature reviews or meta-analyses. The databases were searched with a combination of three types of search strings: (1) terms related to workplace exposure—(in) justice, organisational justice, relational justice, procedural justice, distributive justice and inequity; (2) terms related to medical issues—mental health, distress, depression, anxiety, fatigue, somatisation, psychological disorders, absenteeism, sickness absence and well-being; and (3) terms related to work setting—job, work, occupation, work stressors and psychosocial factors.

The studies selected for this review were those: (1) published between 1990 and 2010 (2) in a peer review journal, (3) which had a sample size of over a hundred subjects, (4) measured justice as an exposure factor, and (5) used mental health or its consequences as the outcome. This review was limited (6) to prospective studies (7) from industrialised countries. Papers on well-being were also included because these measures often contain items that may be related to mental health symptoms.[21] Sickness absence was included because mental health is often the primary or secondary cause of sickness absence among workers in industrialised countries.[1–3 5 6 22–24]

The studies included here had to present detailed and main results. Therefore, abstracts and short report studies were not considered. Duplicated studies were excluded; intermediate and final results of a single study were considered to be part of the same study. Two studies on fairness[25–27] were excluded, as their conceptual framework and measurement differed from the OJ model.

To determine whether the effect of organisational justice had been observed independently of DCS and ERI, we evaluated whether and how the studies controlled for these models. Emphasis was placed on the components of these models, which seemed to overlap conceptually with a justice component.

RESULTS

A total of 403 studies were identified via the database search. We identified a further nine studies from the listed references of selected papers, and five studies were from suggestions made by experts as presented in figure 1. Eleven prospective studies were selected based on reading of the abstracts, gathering of complementary information in the text and the application of selection criteria.

Of the eleven selected studies,[28–38] five examined mental health, two examined sickness absenteeism, two focused on well-being, and two looked at more than one of these outcomes. The components of organisational justice fell into the three categories: relational justice, procedural justice and distributive justice.

The populations under study were British civil servants in Whitehall II (approximately 30% of whom were women), hospital personnel in all of the Finnish studies (77% to 100% being women), a representative sample of Dutch employees (43% being women) from various companies in the SHAW cohort, and employees from three Swedish National Labour Market Administration agencies (56% being women).

The main survey instrument was a questionnaire derived from Moorman[39] but other instruments derived from Price and Mueller,[40] De Boer *et al*[41] and Darly[42] were also used in two studies. Most studies controlled for socio-demographic and lifestyle covariates (such as age, work position, baseline health and lifestyle factors), as well as for psychosocial factors from DCS or ERI models (8/10). All selected papers are presented here in the online supplementary table 1.

Relational justice

Relational justice was the most frequently measured component of organisational justice (10/11 studies). The 10 studies examining relational justice assessed it using 11 items (box 1).[28–38] These items refer to a worker's self-evaluation of his relationship with his immediate supervisor.

Most prospective studies (8/10)[28–38] controlled for other psychosocial factors (ERI, DCS), and found that relational justice had a significant effect on mental health (seven studies) or sickness absences (three studies). The increases in the effect measures ranged from 1.20 to 1.60 for psychiatric morbidity and almost all were statistically significant. The RR found, in the three studies on sickness absenteeism were modest but statistically significant, about 1.20 regardless of the participants' gender and type of recorded absence (long, short, certified or self-reported).[28 31 32] After adjustment for covariates from DCS and ERI, the observed associations remained the same in five studies,[28–37] it became marginally significant in two studies,[33 35] and non-significant in some of the results of a third study.[28] Two studies controlled specifically for social support (SS) at work, the effects remaining statistically significant.[29 30 32]

Two studies assessed the effects of change in relational justice and over time on mental health.[29 30] Favourable changes in relational justice, between baseline and follow-up, were associated in both genders with less risk of deteriorating mental health. The first study found a significant effect of relational justice on minor psychiatric morbidity in men (OR =0.75 (95% CI 0.60 to 0.94)), and a marginal significant effect in women (0.74 (95% CI 0.55 to 1.01)).[30] Adverse change was associated with a statistically significant increased risk of psychiatric morbidity: OR =1.81 (95% CI 1.48 to 2.21) for men and 1.74 (95% CI 1.31 to 2.30) for women. In the second study, statistically significant associations of the effect of change in relational justice with self-rated health were observed. The effect size and direction of these changes for both genders were similar to those of the first study.[29]

In another study,[32] it was observed that relational justice was the strongest predictor of medically certified sickness absence

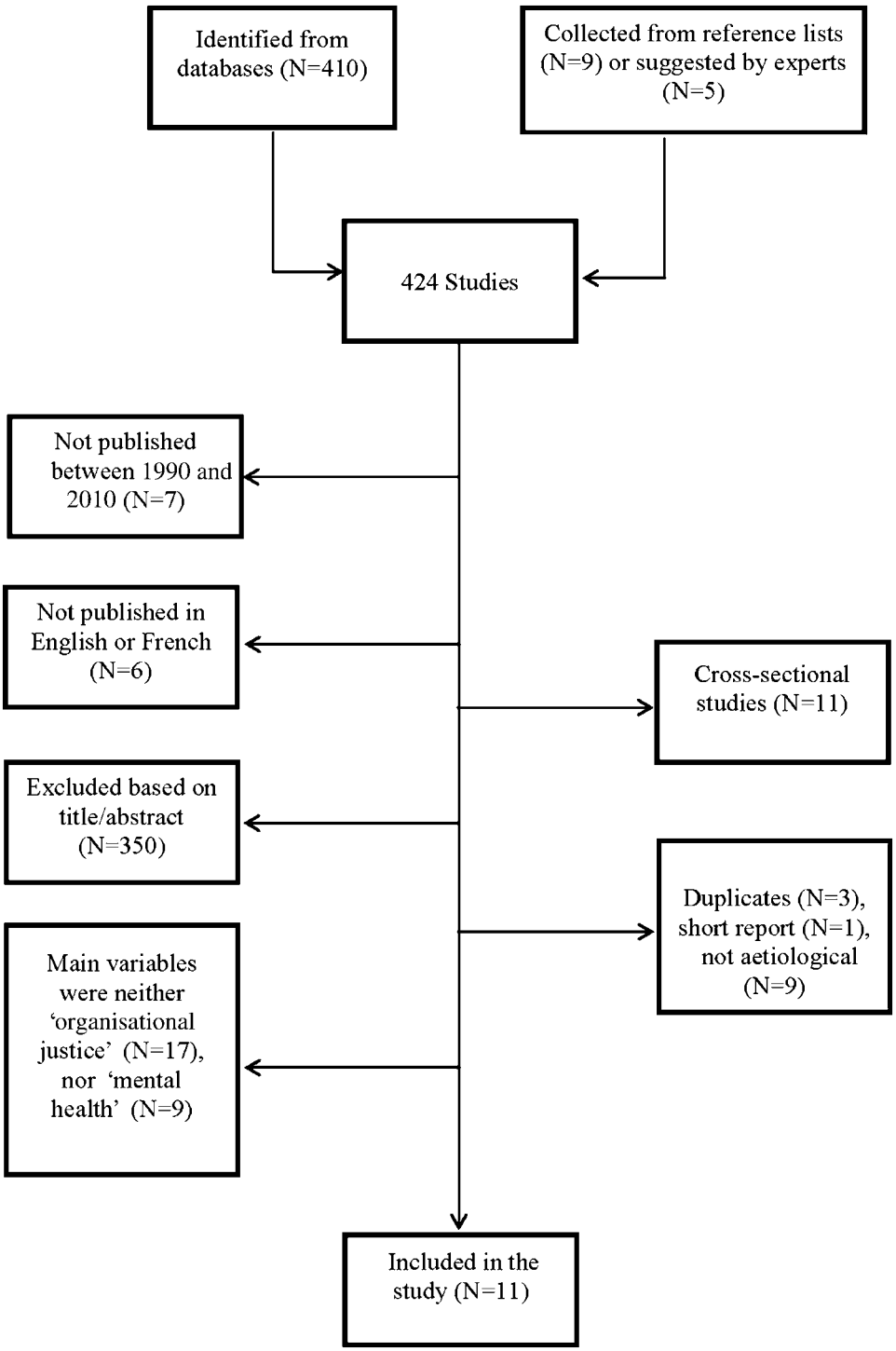

Figure 1 Selection process for identification of studies.

(RR =1.22 (95% CI 1.14 to 1.30), compared with procedural justice, workload, decision authority, skill discretion and hostility, which had smaller effects.

Procedural justice

Eight of the studies assessed procedural justice. Six of these studies used an indicator derived from the Moorman *et al* instrument.[31–36] There were a total of seven different items used in these six studies as shown in box 2. In the two other studies, the authors used four items derived from De Boer *et al*[41] or from Darly[42] (box 2).

The six studies addressing mental health outcomes evaluated psychiatric morbidity including depressive symptoms and medically certified depression. All those found significant associations.[32–36] In five studies, the relative effects ranged from 1.4 to 1.9. The remaining study found a statistically significant direct path between procedural justice and depressive symptoms ($p<0.001$ for the normal causality model) using path-analysis.[37]

Of the three studies on procedural justice and sickness absenteeism,[31 32 37] two found a significant relationship.[31 32 37] The first study found a slight but significant association between procedural justice and the risk of absenteeism: rate ratio =1.08 (95% CI 1.01 to 1.16).[32] In the second study, Elovainio *et al* (2004)[31] presented a structural equation model that also showed a slight but significant association between procedural injustice and sickness absenteeism ($p<0.001$). Using self-

Box 1 Items used to assess relational justice

1. Do you get consistent information from line management (your supervisor)?
2. Do you get sufficient information from line management (your supervisor)?
3. When you are having difficulties at work, how often is your supervisor willing to listen to your problem?
4. Do you ever get criticised unfairly?
5. Do you ever get praised for your work?
6. Your supervisor considers your viewpoint.
7. Your supervisor is able to suppress personal biases.
8. Your supervisor treats you with kindness and consideration.
9. Your supervisor takes steps to deal with you in a truthful manner.
10. Your supervisor shows concern for your rights.
11. Your supervisor provides timely feedback.

reported data on absenteeism assessed, with one item, a third study found no significant longitudinal path between procedural justice and absenteeism.[37] Likewise, one study found that procedural justice had a deleterious effect on psychosocial health ($p<0.01$).[38] Five out of the eight studies on procedural justice controlled for either the DCS model[31–34] or ERI model.[35] In these five studies, the effect of procedural justice remained significant, even after controlling for the other models. The three remaining studies did not control for any psychosocial covariates.

Box 2 Items used to assess procedural justice

1. Procedures were designed to hear the concerns of all those affected by the decision.
2. Procedures were designed to collect accurate information necessary for making the decision.
3. Procedures were designed to provide opportunities to appeal or challenge the decision.
4. Procedures were designed to generate standards so that decisions can be made with consistency.
5. Procedures were designed to provide useful feedback.
6. Procedures were designed to provide clarification about the decision.
7. Procedures were designed to represent all sides affected by the decision.
8. The organisation went about deciding to move in a way that was not fair to me.*
9. The way the management made the relocation decision was not fair to me.*
10. The organisation was fair to me in the way that it made the decision to relocate.*
11. The steps that the company took to make the relocation decision were fair to me.*
12. The opinion of employees is taken into account. **
13. All employees are treated in a similar way.**
14. Complaints of employees are taken seriously.**
15. People only regard their own interest.**

Items used in the studies of: *Liljegren and Ekberg[38]; **Ybema and Van den Bos.[37]

In one study, procedural justice was the strongest predictor of poor self-rated health (rate ratio =1.45 (95% CI 1.18 to 1.77), and the second strongest predictor of minor psychiatric morbidity (rate ratio =1.44 (95% CI 1.22 to 1.72) compared with workload, decision authority, skill discretion and hostility.[32]

Distributive justice

Two prospective studies evaluated the effect of distributive justice.[37 38] Distributive justice was measured with items evaluating salary justice, rewards and the appreciation received for one's work (box 3). The structural equation model was used to evaluate the effect of a lack of distributive justice on psychosocial health,[38] depressive symptoms[37] and sickness absenteeism.[37] In the first study, results showed a significant direct path with depressive symptoms and sickness absenteeism (χ^2 (68) =234.68, $p<0.001$ for the model with normal causality). More specifically, distributive justice was associated with a reduction in depressive symptoms and sickness absenteeism 1 year later, after controlling for baseline depressive symptoms.[37] In the second study, the authors observed that lack of distributive justice had a deleterious effect on psychosocial health (including role limitations due to emotional problems, social functioning, vitality and mental health), and that this association was statistically significant ($p<0.001$).[38] No control for ERI was performed in either study. Therefore, it was unclear whether this study measured the adverse psychosocial components of distributive justice, which were not assessed by the ERI model.

DISCUSSION

The 11 prospective studies measuring the effect of organisational justice on mental health, evaluated three different components: relational justice (10 studies), procedural justice (eight studies) and distributive justice (two studies). Organisational justice components were associated with mental health problems in most of these studies.

It has been postulated, that it is worth studying the relative contribution of each model to the explanation of well-being and health, in view of their differences and complementary

Box 3 Items used to assess distributive justice

1. How fair has the hospital been in rewarding you when you considered the responsibilities you have?*
2. How fair has the hospital been in rewarding you when you take into account the amount of education and training you have?*
3. How fair has the hospital been in rewarding you when you consider the amount of effort you have put forth?*
4. How fair has the hospital been in rewarding you when you consider the stresses and strains of your job?*
5. How fair has the hospital been in rewarding you when you consider the work that you have done?*
6. What do you think of your salary when you compare your work efforts with those of your colleagues?**
7. What do you think of the appreciation you get when you compare the number of tasks you have with those of your colleagues?**

Items used in two studies: *Liljegren and Ekberg[38]; **Ybema and Van den Bos.[37]

aspects.[12] Our second objective was thus to determine whether the effect of organisational justice on mental health could be observed independent of the DCS and ERI models. The results suggest that the OJ model does not completely overlap with the latter two, because the former assesses independent psychosocial work factors, which are not evaluated by the DCS or ERI models.

A possible explanation of the independent effects of organisational justice is that equity matters to people because it helps them to deal with uncertainty.[13 43] In fact, people seemed to use justice perception when they were concerned about potential problems associated with social interdependence and socially-based identity processes.[13] The OJ model differs from the DCS and ERI models in two important respects. First, it emphasises interpersonal rather than individual comparisons; thus, it includes features of the evaluation of a referent ratio in addition to individually-related features. Previous results suggested that people do take into account the experiences of others when they form justice judgements.[31] Hence, a difference between an individual and referent ratio (ratio of inputs and outputs) would define the stress-provoking component, especially as the current labour market provides less job security and few alternative choices for many employees.[16 35] A second difference between the OJ model and the DCS and ERI models concerns the assessment of procedural justice as a new psychosocial work factor, which measures the processes and procedures conditioning the distribution of work. The two next sections of this review will discuss the other aspects of the independent effects of organisational justice components.

Comparison with the Demand-Control-Support model

Relational justice may share some common ground with the SS component of the DCS model (especially with regard to SS from one's supervisor).[8] It has been recently stated that relational justice and SS are redundant.[44] In fact, relational justice refers to the degree of dignity and respect that employees receive from their supervisors, as defined by researchers who have evaluated its effects on mental health. To clarify the effect and contribution of relational justice, we examined whether the studies had adjusted their analysis models for the DCS model. Six studies had done so,[29–34] with three of them adjusting specifically for SS.[29 30 34] Of these three studies, two found a statistically significant effect of relational justice on mental health and therefore showed an independent effect of relational justice on mental health.[29 30] The third study found an effect but did not reach statistical significance.[29 30 34]

It has been pointed out that procedural justice cannot be dissociated from decision authority of the DCS model because items in the procedural justice index overlap with decision authority's existing construct.[44] In this review, we observed that only one item out of the seven derived from Moorman *et al* (number 3 in box 1) tended to overlap with decision authority. Of the eight studies on procedural justice, the associations remained statistically significant while controlling for DCS in four studies. Based on these observations, procedural justice can be considered an independent factor.

Comparison with the Effort-Reward Imbalance model

Relational justice may also share some common ground with the reward component of the ERI model.[8] We observed that the four studies (out of ten) on relational justice[28–30 35] controlled for ERI components. Statistically significant associations between relational justice, and different outcomes were observed in these four studies. In one of the studies,[28] even though further adjustments were made for ERI reduced associations, between relational justice and long-term sickness absence for all causes in men, the effects remained significant for both genders. One of these studies aimed to explicitly explore whether ERI and relational justice models were redundant or complementary in explaining self-rated health and psychiatric morbidity.[35] Concerning procedural justice and ERI, only one study (out of eight) assessed their independent effects.[35] The authors found statistically significant associations with self-rated health and psychiatric morbidity after adjustment for ERI.

It has been hypothesised that the distributive justice component overlaps with the theoretical framework of the ERI model, which was suggested by Siegrist (1996). This is because the conceptual and theoretical aspects of distributive justice and the ERI model refer to an equitable distribution of resources and benefits.[9 44] Although both models measure the ratio between inputs and outputs, it has been pointed out that distributive justice also focuses on interpersonal comparison, while ERI is based primarily on intrapersonal comparison.[35 45] As proposed by Kivimaki *et al*,[35] there is a major theoretical difference between the ERI and OJ models the former is concerned with reciprocity of exchange within a formal contract, hence reflecting the close links that exist between the work role's constraints and opportunities and the satisfaction of personal needs, whereas organisational justice focuses more closely on the managerial climate within formal organisations, and the quality of interpersonal relationships within the hierarchies. Therefore, distributive justice could measure information apart from what is assessed when using the ERI model, such as information related to the workplace situations. As presented previously, the effect of distributive justice on mental health was evaluated and demonstrated in two studies[37] but no control for ERI was performed. Therefore, it was not possible to determine whether or not it is an independent effect. Furthermore, future studies on distributive justice should control for ERI, in order to assess its independent effect on mental health.

The different theoretical models provide distinct and complementary information on the relationship between psychosocial work factors and health.[46] Therefore, it might be worthwhile to study the combined effect of OJ, DCS, and ERI models in order to better explain the effects of psychosocial work factors on mental health problems.

Strengths and limitations of available studies and perspective for future research

This review included eleven prospective studies, which have a number of strengths: a large sample size composed of women and men, workers from different occupational sectors and a participation rate ranging from 70% to 83%. As suggested by Rodwell *et al* (2009), the combination of outcome variables included in the present review, can provide a relatively comprehensive insight into the range of mental health effects associated with organisational justice components in the workplace.[47] Moreover, the theoretical background of organisational justice was well-defined and psychosocial factors of other models have been controlled as covariates in most studies. One plausible mechanism through which perceived organisational injustice may affect mental health is prolonged stress.[13] Previous research suggests that factors associated with justice perception may be related to factors that influence susceptibility to illness.[13 48] Furthermore, the prospective design of the studies included, suggests a causal relationship between organisational justice and mental health problems and their consequences.[49]

However, some limitations were observed. Available studies mainly focused on the relational and procedural aspects, and used different instruments to measure exposure. A standard, validated instrument to measure exposure seems necessary to improve the comparability of studies. Only two of the ten studies examined distributive justice, and to our knowledge, informational justice has rarely been analysed.[47 50] We suggest that informational and distributive justice be measured more often in order to provide a more complete assessment of organisational justice and to contribute to a better understanding of its effects on mental health. This would, in the long run, help to improve preventive efforts to reduce mental health problems for workers and employers.

Even though seven of the ten studies on relational justice adjusted for DCS or ERI models, only three of the studies adjusted specifically for the SS component. As mentioned previously, SS is the DCS component, which seems to conceptually overlap with relational justice. Adjustment for other components of DCS or ERI is therefore not sufficient to clarify the independent effect of organisational justice. It would be useful in future prospective studies to assess the effect of relational justice independently from SS at work.

Our analysis of items, used to measure the organisational justice components, showed that only items related to procedural justice (box 2) measured the workplace situations, even when the subject was not personally and directly concerned. For relational justice (box 1) and for distributive justice, the items used for measurement involved perception of individual situations. Organisational justice is only partly different from the DCS and ERI models.

Finally, there is a need for more prospective studies that would consider the effect of change (or cumulative effects) of the exposure to organisational justice. It has been shown that a single measurement of exposure generally leads to an underestimation of effect.[5 51 52]

CONCLUSION

This systematic review of eleven prospective studies showed that organisational justice is mainly assessed through two of its three components: procedural and relational justice. In most studies, these two components observed significant effects on mental health. The effects were independent of the DCS and the ERI models, which specifically assessed this independence. However, there is a lack of prospective studies on distributive justice and mental health. Likewise, there is a lack of prospective studies evaluating the cumulative effects of these exposures on mental health over time.

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Culture Reform Oversight Group
Action Items Register

OFFICIAL

Meeting Date	Agenda Item	Action Required	Officer Resp	Due Date	Status
11/06/2019	5.3	Members seeking clarification or updates on referrals to speak directly with D-G ACTHD, CEO CHS and Regional CEO Calvary.	Members	Ongoing	Ongoing
7/5/2021	3.2	**Culture Reform Oversight Group Terms of Reference** Secretariat to add Terms of Reference to the agenda for the June meeting. This item held over following finalisation of the Annual Review to consider recommendations on proposed agenda for February 2022.	Secretariat	December 2021	
7/5/2021	3.3	**Clinicians Summit – Recommendation 4** Secretariat to include an update from the CLF on Recommendation 4 at future Oversight Group meetings. This will be provided at the February 2022 meeting.	Secretariat	December 2021	
7/5/2021	3.5	**Culture Connect Newsletter** Members to advise Ms Junk-Gibson of ideas for articles in the newsletter, including case studies on high performing teams/examples of great workplace culture.	All	29/6/2021	Ongoing

Meeting Date	Agenda Item	Action Required	Officer Resp	Due Date	Status
7/5/2021	3.5	**Culture Connect Newsletter** Ms Junk-Gibson to pass on questions received in response to the newsletter to member organisations to they can pass this onto their members.	Ms Junk-Gibson	Ongoing	Complete
29/6/2021	4.1	**Workforce Dashboards – Measures of Success** Ms Reid to provide information to members on the timeframes for IT system changes at Calvary that would enable data analysis.	Ms Reid	9/8/2021	
29/6/2021	6.5	**Choosing Wisely Program Update** Ms Reid to provide an update on the implementation of Choosing Wisely at the December Oversight Group meeting. This will be provided to the February 2022 meeting.	Ms Reid	December 2021	
09/08/2021	3.2	**Data on Bullying and Harassment** Information from three organisations to be provided in consolidated way. Attachment C at Agenda item '2.5- System-wide Dashboard and Analysis' of 13 December 2021 meeting.	Ms Junk-Gibson	December 2021	
27/10/2021	4.1	**Learning Health System** Professor Imogen Mitchell, Chair of the Clinical Leadership Forum requested to attend the next Culture Review Oversight Committee to discuss approaches to a learning health system that may help bring issues together. On proposed agenda for February 2022.	Ms Junk-Gibson	December 2021	
27/10/2021	4.1	**Second Annual Review** Discussion at December meeting	Chair	December 2021	
27/10/2021	4.1	**Articles** Dr Looi provided two articles for circulation to members.	Ms Junk-Gibson	November 2021	Complete

Culture Reform Oversight Group

Communique of meeting on 13 December 2021

The thirteenth meeting of the Culture Reform Oversight Group (Oversight Group) was held on Monday 13 December 2021.

The meeting was Chaired by Rachel Stephen-Smith MLA, Minister for Health.

Significant items discussed by the Oversight Group today included:

Second Annual Review of the Culture Review Implementation

Members continued discussion on the findings from the second annual review of the Culture Review implementation and discussed priorities for action.

Working Group Progress

Three working groups have been established to develop solutions for matters that impact the system. These working groups are:

- Professional Transition to Work Working Group,
- Early Intervention Working Group, and
- System-Wide HR Matters Working Group.

Members were updated on progress made by each working group.

Meeting schedule

The Oversight Group meets bi-monthly and its next meeting is scheduled for 27 October 2021.

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