Submission No 14

REVIEW OF INQUIRY INTO COMPLAINTS HANDLING IN NSW HEALTH

Organisation:

Name: Suppressed

Telephone:

Date Received: 1/08/2006

Subject:

Summary

Partially Confidential

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General Purpose Standing Committee No2
Parliament House
Macquarie Street
SYDNEY NSW 2000

I wish to make some comment to this Committee as:

- **a person who has been a health employee for more than 25 years and is a current employee of NSCCAHS (Hence I worked in health prior to the initial establishment of Area Health Services and many other major changes.)**
- **a person who is an Allied Health Professional with formal qualifications in Health Information Management and has training and experience in quality and accreditation**
- **a health professional, who has experienced the consequences of raising valid concerns and issues, experienced the associated "systems" processes and cultural ramifications of such.**

Context

I have read the published submissions of this committee and would state that it is recognized that much significant, valuable and important change has been initiated and is progressing.

The amalgamation of Area health Services and system redesign, however, is far from complete. While recognizing the enormity of the changes and complexity of associated change processes; for many staff communication within the Area Health Service (and subsequently between community and other health service interfaces) of changes, mechanisms and processes for such – along with daily operational communication generally has been significantly 'impaired' and inadequate. It is recognized we are in transition and staff are repeatedly requested to be patient, however, sound timely communication is a vital part of any change process and essential for functional and effective daily operations.

Much emphasis in the press and present politics has been placed on 'nurses' and 'doctors' almost to the exclusion of all other, Allied Health professionals and non-clinical healthcare disciplines and support staff. This is detracting from the recognition and ability of all healthcare professionals and support staff to be valued, and work together effectively as a 'team' for the primary purpose of patient care.

Healthcare is not just doctors and nurses – nor is healthcare just hospitals, emergency departments, theatres and inpatients. All disciplines of staff are important and necessary to the provision and delivery of patient care, health promotion and health service delivery. This, throughout the continuum of care, across the various health service interfaces both internal and external to Area Health Services, within hospitals and the other public health facilities and

units that comprise Area Health Services. There are multiple interfaces between these other services and the Area Health services apart from the Emergency and planned admission services. All of which are essential and important to the delivery of health services and patient care to the community and need to operate together in balance – as a whole.

While projects, programmes and targeted activities can and do help to address, manage, monitor, evaluate, report and progress complex and difficult issues – it should not result in the marginalization or detriment or exclusion of other aspects of health service delivery and integrated patient care. Slicing and dicing creates more gaps for things to fall through and is not "real life". The gaps and other interfaces need to be monitored and managed as well – at the same time and in harmony.

At the present time, many staff are, uncertain of organisational structures and staff roles and responsibilities from one week to the next. The staff, of some services are yet to discover what structural and other changes will be made to their particular services, where they will end-up and who they will be responsible to.

Human Resource restructuring and staffing in some Area Health Services has only recently been progressed and continues.

Allocations of discipline mixes, backfilling various disciplines, hours, responsibilities, issues to staff development of some disciplines etc, are because of transition effects, considered by some, to be vulnerable to local 'turf' issues and various political issues, or simply occurring after the horse has bolted.

In this AHS there have been significant economic and budget issues on top of the situation existing prior to the amalgamation, that raised other types of angst and fears at various staff levels throughout the Area Health Service.

During this substantial and significant period of change there is now a background of national industrial change and 'threats' to the Union movement as such. Irrespective of the different viewpoints, perceived and actual problems with different Unions, or the Union movement as a whole. This fact, and the unknown eventual outcome in the NSW Public Health Arena is a very significant concern impacting on staff and the preparedness to raise and address the more sensitive, difficult issues with potential ongoing harms, reprisals and threat of organisational games towards the complainants/issue raisers that continue over long periods of time.

Many things (including raising and having issues and concerns dealt with - that fall, or are perceived to fall, outside the current targeted areas, projects or immediate focus of restructure at a point-in-time) are more complex than before and the end of the transition phase to many at this point appears to be as illusive as the pot of gold at the end of a rainbow.

The level of confusion, uncertainty, angst and fear varies between service domains and locations, disciplines and levels of staff, at any point-in-time. While some report being reasonably ok others state they are surviving by just trying to focus on getting through any given day or week and avoid raising the hard issues or concerns or longer term matters that arise.

Some general systemic issues that previously impacted on clinical, non-clinical and support staff are now written-off or automatically perceived as amalgamation or change/transition problems and difficulties.

However, frustrated staff and including some groups of staff, endeavoring to tackle, track and progress particular significant issues, have commented that the present situation has resulted in having a novel set of new tools for the cleverly creative or traps for the unsuspecting; e.g. - avoid, loose, delay unwanted issues by recycling or passing them through the various change processes and structural reorganizations – possibly until the amalgamation has been completed.

Some particular staff endeavoring to validate "the message sent/same message received – as such" only had other present communication difficulties magnified and reiterated.

I note, within the Area Health Service variance in the knowledge and understanding of some of the introduced changes, and awareness of some 'new' publications amongst various disciplines, services, locations and levels of staff. This includes the Incident Management System, Clinical Governance Unit and the different perceptions of what 'they' are, mean, do, whether they are relevant to all patient clinical care disciplines, does that exclude/include non-clinical people – if so how, when, where etc, etc.

CONCERNS – re complaints handling

In reading the Introduction and the body of the Joint Submission to this Committee, it is recognized and appreciated (from the perspectives of a healthcare worker, a member of the community and as a patient) that many significant good things have occurred and that the potential for many more good things to keep occurring is there.

But there are some 'difficult' but important gaps**. These significant gaps pertain to 'real life' in which all health care staff: clinical and non-clinical, direct and indirect care, hands-on and hands off – work together for the primary purpose of patient care.**

The current improvements and mechanisms are at points: too exclusive to certain groups of staff and the system also makes it problematic (and more difficult or threatening) for certain types of systemic and other complaints, issues and matters to be put-forward, by other healthcare staff – both clinical and non-clinical.

Complaints Management and the cultural change surrounding it, needs to be embraced and applied holistically to all healthcare staff and all systems. It is essential that such occur more broadly – in fact, also in relation to the 'other systems' and issues that can impact on individuals who raise sensitive or difficult matters.

Systems can be good or bad and good systems can have problems or difficult times. No system operates in isolation from 'other' systems including the overarching systems.

As a health care worker - I would still pose and ponder some questions:

Is an individual or a group of individuals/healthcare staff - no matter where they work or what their allocated duties – able to raise issues that are relevant to patient care - in all its forms, and the other structures and services that underpin such, without becoming targets/victims or suffering any combination of various harms?

- Issues that are or maybe: sensitive, complex, multifaceted, entrenched, controversial, threatening, unpopular and that may cross numerous organisational structures and operations and particularly certain types of systemic issues - without fear of becoming a victim or coming to harm and grief?

  E.g: a target for payback allegations; suffering various types of harms or reprisals; having matters deliberately pushed into an 'employee relations – IR arena' to subsequently be played organisational snooker with; of finding out how the 'big systems' actually treat such; being 'labeled' as a difficult complainant or stereotyped in other ways; being branded as mentally defective; being denied meaningful work, ostracized and isolated; denigrated and humiliated; or suffering discriminations within 'lawful' boundaries.

  Can those issues be raised genuinely and considered discussed, explored in a civilized and humane manner without being pulled into a full-scale nightmare of previously unknown proportions because of the way – The *other* System/s work?

- Where such health care staff have raised issues and do experience some of the hard subsequent realities/other fears (or believe they may be, or in danger of having such happen) are they able to have those realities/other fears handled more appropriately than in the past. With real fairness and objectivity, sensitively, without having to plead and beg for their need/right for legitimate genuine affirmative action in relation to such issues? Or will they be subjected to further detriment or harm?
  (This is particularly important where staff have been stereotyped or labeled by the system or other staff – often on the basis of rumor, gossip, or the machinations of others for whatever reasons at point-in-time, etc.)

This I believe will be one of the most important and defining indicators of successful cultural change with regards to complaint handling within the health system and significantly benefit the provision and delivery of patient care and services.

And in association with the above:

Are Human Resource and other senior organisational staff, now, better equipped and skilled to support such staff with those "sensitive and difficult issues" ? Including, where necessary, the more skilled mediation, balancing or defusing of 'other' staff who target them with trumped up or payback allegations because 'they think' or 'have been told about this person' or may be intimidated by false stories they have heard about the person or because they do mean the person some form of harm?

Or, is the 'culture' and reality still such, that in conjunction with or because of 'The bigger systems' that it is still more expedient for the organisation 'to snooker' such staff?

- Are healthcare staff now more safely or comfortably, able to provide information (that they believe is of some relevance to patient care/management/overarching issues to) appropriate parties and certain types of investigations – without being threatened, intimidated or questioned as to 'what business it is of yours', by others and end-up coming to 'grief' or in-fear of such?

- Are some staff still reluctant and fearful of, or not raising <u>some types of important issues</u> even where one of the new systems are in place and they are familiar with the system? Why?

Complaints handling and the culture of such in the Health System still has some complex, difficult core issues that must be addressed and improved for 'patient care' in all its forms - and to genuinely protect or assist healthcare staff (from whatever discipline, service or area) who raise or have raised issues/matters that engender reprisals or harms in various forms.