Government of **Western Australia**
Department of **Health**

# Child and Adolescent Health Service (CAHS) Review of the morale and engagement of clinical staff at Princess Margaret Hospital (PMH)

## FINAL Report

**Produced for the Child and Adolescent Health Service Board**

May 2017

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# Acknowledgements

The reviewers would like to take the opportunity to acknowledge the contribution of the employees and stakeholders of Child and Adolescent Health Service (CAHS) and Princess Margaret Hospital for Children (PMH) in the review process.

This report has been produced using the information provided to the review from staff about the current conditions at PMH. Every effort has been made to ensure that the content accurately reflects the experiences presented to the review team, and there is no reference to staff names to protect confidentiality.


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# Disclaimer

All information and content in this material is provided in good faith by the Department of Health, Western Australia and is based on sources believed to be reliable and accurate at the time of development. Commercial and in-confidence data has been removed from this review

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# Executive Summary

The Review confirmed that there are genuine issues with the morale and engagement of staff at Princess Margaret Hospital which extends beyond that of medical staff. It is acknowledged that there appears to be differing views between Child and Adolescent Health Services (CAHS), PMH executive and staff on the extent of dissatisfaction. It was identified that these matters pervade across all directorates and all staffing cohorts including medical, nursing, allied health, and corporate staffs.

The current culture does not appear to be conducive to providing a supportive working environment for staff. There is an atmosphere of fear of adverse repercussions facilitated in part by a perceived high priority placed on operational and fiscal performance and associated reduction in staff across the workforce. Despite reported efforts to engage with staff by executive and senior management, staff repeatedly describe feelings of not being valued and not being heard or listened to. Claims of excessive micromanagement, poor communication and a lack of  a consultative and collaborative approach to problem solving featured prominently and consistently during discussions.

There have been various attempts to raise concerns regarding low staff morale, particularly during the last 12 months, and some consideration and action has been taken by management to address the concerns. However, in the reviewers' opinion, the significance of the matter does not appear to have been adequately acknowledged.  From a medical perspective, this has resulted in the Clinical Staff Association (CSA) largely disassociating itself from the current executive.

The reviewers acknowledge that the executive and management team are trying to achieve the best outcomes for the hospital.

The review has resulted in 9 key findings, further resulting in 16 recommendations for consideration by the CAHS Board.

# Introduction

The reviewers utilised the philosophy underpinning the Press Ganey survey methodology utilised by CAHS in 2016, to inform the basis of their review.  As stated in the Press Ganey Special Report – **2017 Strategic Insights: Achieving Excellence - The Convergence of Safety, Quality, Experience and Caregiver Engagement** (Patrick Ryan. Achieving Excellence) *"The quest for excellence in health care is a continuous journey. It starts with the understanding that, in our shared mission to reduce suffering, every patient should be assured safe, high-quality, coordinated care that is delivered with empathy and compassion. **To achieve this goal, we must also nurture an engaged workforce with an unyielding commitment to improving safety, quality and the overall experience of care."***

The report presents a cross-domain analyses that demonstrates the important relationships between safety, quality, patient experience and caregiver engagement. They found that organisations with the best performance on safety and quality measures have higher patient experience scores than those with bottom-quartile safety and quality performance. Similarly, **organisations with a highly-engaged workforce perform better on safety, quality and patient experience measures** than those with low engagement. And high performance in all of these areas influences financial outcomes.

Patrick Ryan states that **"The common denominator in all of these considerations is the caregiver workforce and the underlying organisational culture that supports physicians,**

**nurses and employees in the delivery of care.** Organisations that put the patient and family first and **nurture a high-performance, supportive culture** defined by meaningful work, engaged employees, strong leadership and accountability are best positioned to achieve success in today's consumer-driven marketplace."

## Background

This review has been initiated by the Board of CAHS supported by the Director General, Department of Health to address concerns that have been raised regarding the conditions, morale and engagement of clinical, primarily medical, staff at PMH, and any impact on safety and quality outcomes for patients at PMH.

Organisations, both internal and external to CAHS had raised concerns regarding low medical staff morale and disengagement with leadership. These organisations were the PMH Clinical Staff Association (CSA), the PMH Junior Medical Officer Society, individual medical clinicians (both junior and senior) and the Australian Medical Association (AMA).

The CAHS Board recognises that staff morale and engagement is critical to patient safety and the functioning of PMH and will be important to the success of the Perth Children's Hospital (PCH).

As the governing body of CAHS, the Board is responsible for the quality of health services provided by CAHS and for ensuring that its operations are carried out effectively, efficiently and economically.

Accordingly, the CAHS Board commissioned this review and received the support of the Director General of the Department of Health, as System Manager responsible for the WA health system, in respect of the commissioning of this review.

## Purpose and Scope

The purpose of the review was to identify the scope of issues relating to the conditions, morale and engagement of clinical, primarily medical, staff at PMH, and any impact on safety and quality outcomes for patients at PMH, and to make recommendations to the CAHS Board regarding actions to be taken, by CAHS, to manage and mitigate any issues, including the associated sequencing, timing and resource requirements.

The review examined:
- The specific issues raised, in recent times, by PMH medical staff and their representative bodies, including but not limited to; morale, engagement, leave management, medical administrative matters and alleged staff shortages
- The workplace culture of medical staff at PMH, and the interface with medical administration and executive, and vice versa; and
- The efficiency and effectiveness of the medical administration processes at PMH

This report does not purport to document every single issue and concern raised by staff that met with or provided written submissions to the review team. While a number of staff feedback on a vast array of matters that impacted on them or their department specifically, the review team felt that in reporting to the Board, it was necessary to focus on the essence rather than the detail of the issues brought up and identify systemic matters that had organisation-wide application or were a significant risk to the organisation as a whole.

# Methodology

The review was undertaken at PMH from the 20 March to the 28 April 2017, with the review team meeting with over 200 staff during this time, 119 of these as individuals

In undertaking the review, the review team:

1. Met with relevant medical staff members, including medical leaders and medical executive, and relevant members of the PMH and CAHS executive and CAHS Board

2. Met with representatives of, and considered submissions from, relevant associations and projects within PMH such as the Junior Medical Officer (JMO) Wellbeing Project, the CSA, and the PMH JMO Society

3. Met with the Board Chair, and considered reports provided to the CAHS Board's Safety and Quality Committee

4. Reviewed the results of the recent staff survey administered by Press Ganey™

5. Examined the processes and supporting documents in place to guide the conduct of medical administration practices at PMH and the extent to which these are understood and applied;

6. Investigated the level of engagement between PMH and CAHS executive and clinical staff at PMH

7. Examined the impact of any issues raised throughout this review in relation to the quality of care delivered at PMH by reviewing safety and quality related data, as well as receiving anecdotal feedback from PMH and CAHS staff; and

8. Although this was primarily a review focused ostensibly on medical staff engagement, upon request from the Board, the review team also met with, and considered submissions from, nursing, allied health, administrative, clerical and corporate support staff during the course of the review

The review process adopted a semi-structured interview approach with a range of multidisciplinary senior executives, managers, and front line staff including doctors in positional and non-positional leadership roles, junior medical officers including Resident Medical Officers (RMOs), services registrars and vocational trainees (basic and advanced training positions).

All staff were invited to participate by way of voluntary single interviews but also via the following group forums held at the PMH site:

- Clinical Staff Association (CSA)
- RMO (Resident Medical Officer) Society
- Allied Health Heads of Departments
- Allied health staff forum
- Clinical Nurse Manager forum
- Clinical Development Nurse forum
- Frontline Nursing staff forum
- CAHS, Child and Adolescent Mental Health Service (CAMHS), Child and Adolescent Community Health Service (CACHS) and PMH executives

In addition, the review team accommodated requests to meet with recent past employees of PMH and external consultants previously engaged by PMH executive to undertake functions which were considered relevant to the review.

The review team also accepted over 196 written submissions using a secure email address that only the review team had access to. Of significance, 111of these were anonymous submissions and submissions from staff via a third party.

In order to inform the review process the following internal and external organisational documents were reviewed (including but not limited to):

- CAHS Organisational Chart and Committee documents including review of strategic, operational and education structures
- PMH workforce build
- PMH medical rostering and payroll information
- Press Ganey – Voice of Staff 2016 Survey results, CAHS executive Overview and presentation to staff
- Post Graduate Medical Education documents
- PMH Medical Workforce Structure
- JMO rostering practices (including STARS)
- Medical Project team & Medical Workforce Action Plan Status Update
- Medical Practitioners Employment Arrangements (Contracts and Credentialing) Review
- PMCWA Accreditation Review - Princess Margaret Hospital/Perth Children's Hospital December 2016
- CAHS Medical Practitioners Employment Arrangements (Contract and Credentialing) Review March 2016
- PMH Junior Medical Officer Wellbeing Project  August 2016
- Mandatory training documents – RMO and registrar
- RMO and registrar Roster changes audit
- CAHS/PMH Significant Risk Register
- Minutes from PPMH Safety and Quality Committee
- Australian Council of Healthcare Standards (ACHS) Report of the Conditional Survey for the ACHS Evaluation and Quality Improvement Program Child & Adolescent Health Service Survey date: 28 February 2012
- ACHS Organisational Review Summary 2014
- ACHS Clinical Indicator Results 2016
- CAHS Safety and Quality Report to the Board – Safety and Quality Committee
- Health Round Table (HRT) reports 2016
- Children's Healthcare Australasia Benchmarking Report 2014/2015
- Press Ganey Child and Adolescent Health Service 2016 Voice of Staff
- John Mero Workshop Program, February 2016
- Price Waterhouse Cooper:  Child and Adolescent Health Service ABF / ABM Reconfiguration and Reform Program Phase 1 & 2 (Diagnostic): Report - December 2014
- Price Waterhouse Cooper Child and Adolescent Health Service ABF / ABM Reconfiguration and Reform Program Tactical Savings Work stream: Report – December 2014
- PMH Junior Doctor Engagement Forums Summary of Forum Outputs (Andrea Lloyd)
- Optum – CAHS Employee Assistance Program Annual Report 2016

# Discussion

Significant transformational events are currently occurring at PMH which include those listed below; however these were not found to be the fundamental cause of low morale and poor engagement of staff:

- Planning of the PCH
- Planning of the move of services from PMH to the PCH,
- Delays in commissioning of, and move to the PCH, and
- Fiscal pressures associated with the adjustment to Activity Based Funding

In fact, while staff recognised that the move would initially be hectic, stressful and create additional work, there was a genuine level of excitement about the new hospital and the benefits it would bring for the children and parents of Western Australia.  In addition, staff displayed sound awareness of the financial pressures that the health service and health system more generally was under, and appeared receptive to being a part of the solution towards improved efficiency.

While the intended focus of the review was predominantly on the medical workforce, it became clear early on to the Board Chair and reviewers that nurses, allied health staff and nonclinical staff also wished to be included in the process.  Generally speaking, while slight nuances in concerns raised differed from discipline to discipline and person to person, common themes of concern did become evident during the course of the review. A common thread of disengagement with the executive, use of one way communication and fear of retribution for not being 'on board' with management-initiated plans and initiatives was apparent.

For many staff there was a lack of clarity regarding the CAHS Executive and PMH  Executive, their composition and roles/responsibilities, with many referring only to "the Executive". There was less uncertainty when it came to the role of the Chief Executive with most staff identifying this position as having overall responsibility and accountability for the conditions.

The majority of people (over 90%) participating in the review stated that PMH was a very unhappy  place to work with many remarking morale was the worst they had experienced in a number of  years. A number stated they had recently, or were in the process of resigning, and a proportion (approximately 10%) expressed the view that they would move elsewhere if an opportunity became  available. Of those staff that were positive about the operational changes occurring in the hospital, there was still a degree of criticism regarding the adequacy of consultation and  communication strategies employed.  Some key individuals identified by the executive as  "champions of change" and "on board" with executive decisions still expressed reservations  regarding the lack of effectiveness communication and management style.

What was quite profound to the review team was the number of staff from across the hospital who spoke of fear of retribution, including loss of employment or loss of career development, if they were to speak up, express concerns or views contrary to those of the management team or executive. Staff commented that many of their colleagues, including senior medical staff of long standing tenure, were not comfortable speaking with the review team for this very reason. These comments were supported by the large number of anonymous submissions received. Staff spoke of a perception that the widespread use of short term contracts was also being used as a mechanism for staff compliance.

It should be recognized that the current executive has adopted an ambitious body of work with tight timelines to prepare hospital staff to transition to the PCH, in addition to finding efficiencies and improvements in governance in current hospital operations. The most notable changes have included:

- Major structural changes to the way PMH had previously operated, an example of which was the move from two major divisions - medical (PMCCU) and surgical (SSCCU) with line of reporting to a medical and nursing co lead; to separate groupings of medical, nursing, outpatients, inpatients and allied health. It is understood that this structure allows greater flexibility in the movement of nursing, allied health and clerical staff and addresses historical inequities between specialist departments

- Given the large number of relatively small departments existing at PMH, mergers were planned to make for a more efficient reporting and governance structure

- The executive also moved to address the issue of financial sustainability through a number of means including the benchmarking of workforce numbers with other entities. As a result, in a number of areas, numbers of staff (primarily junior doctors and allied health and administration and clerical staff) were reduced

- Responsibility for the annual junior doctor recruitment process was moved from Medical Administration to Workforce, to introduce greater rigour and support in addressing public sector standard requirements

While the above decisions would appear to be not unreasonable, and certainly not within the remit of the review team to question, the perception that they were implemented using an autocratic managerial approach with little consultation or response to concerns raised by members of staff has led to emotional trauma for many and an unwillingness to engage.

To elaborate, the change in the established fundamental lines of reporting at PMH was believed to have been changed with little or no effective consultation with PMH staff. The result for many Heads of Departments was loss of line management over clerical, nursing and allied health staff and for many of them the perception of the breakup of their specialised teams treating children with chronic disease. In their view this made it more difficult to provide quality, holistic patient care. While the executive tried to correct perceived inequities between departments, HoD's of well-established internationally recognized research orientated departments saw the redistribution as unfair and rewarding mediocrity. The merging of departments was for many a fait accompli. While the merging of small departments might be logical the proposed merging of two large departments would appear to have been forced despite the clear opposition of senior members of staff from both areas, with resulting flow on effects to staff underneath.

When junior medical staff (especially RMOs) were determined to be excessive in number, RMOs were tasked with creating a safe sustainable roster and received input from senior medical staff and HoD's towards achieving the reduction. However medical staff did not have confidence in the methodology used to determine final JMO numbers. The new roster proposed a reduction of 11 RMOs and was presented to the executive. It's reported that there was a lengthy period of time with no feedback, followed by the production of a new roster by executive with a reduction of approximately 30 RMOs. This was introduced despite objections from the JMOs and consultant staff who felt the rostering unsafe for patients and untenable in the long term.

As another example, one group of staff related how they were asked at 2pm on a Friday to provide by close of business on that same day the names of the people that could be released from employment including permanent staff. They reported they were informed that if they did not come up with names by the time required that the executive would. They were told they had been benchmarked against a secondary, predominantly adult hospital which they felt did not reflect the needs of children with chronic conditions.

A change to the recruitment process for registrars in 2017, while theoretically aligned with WA Health Recruitment and Selection (RSA) policy, was not believed to have been effectively communicated to those impacted. When risks to recruitment became apparent the process was continued despite the objection of senior medical staff who predicted a poor outcome for the organisation. The reviewers were informed that as many as ten paediatric trainees who were expected to continue at PMH in 2017 made other arrangements when they surprisingly did not receive initial offers of employment. Many of those who did not receive first round offers were cited as moving interstate. This has resulted in a less experienced registrar pool with RMOs stepping up into registrar positions with a number expressing concern over their relative lack o f experience. It has been recognized that this has resulted in a possible loss to WA of trained paediatricians in the long  term. Many felt the reputation of PMH as a training centre for paediatrics has suffered as a  result. This is a key cause of poor morale amongst the junior medical workforce in particular and  staff spoke of feeling undervalued, 'treated as a number', and frustrated by the lack of  acknowledgement or acceptance of the personal impact on our future medical workforce.

The majority of nursing staff who were interviewed were generally unhappy and cited changing and confusing reporting channels, lack of  consultation of changes, lack of transparency in appointments and short term contracts. Specialist nurses felt aggrieved when their specific JDFs aligned to their areas of  work, were made generic in nature. A number complained of receiving emails on a Friday  informing them they were to work on the Monday on a new ward with different skillsets needed  with both no thanks for their previous work, or consultation on the new arrangement.

A common thread from all staff was that it was not so much about the decisions being made but the lack of  consultation and the inability to provide input into decisions or to provide critical feedback. The   executive appears to have embarked on an ambitious program to bring PMH into line with  contemporary standards of safety and quality, financial accountability with clear lines of  accountability while preparing to move to a new site with different models of care. Their reported  autocratic approach and managerial style however along with the timing and scale of change  has resulted in a largely disengaged, unhappy and fearful workforce.

The reviewers were not able to establish from any staff a vision, strategic plan or intent for PMH/PCH. Staff spoke of a general feeling of 'chaos' with 'lots of things happening all at once and quickly' with no visible overarching plan or documented step-wise approach. Some senior members of staff conceded that perhaps too much change was taking place, not all of which was essential prior to the move to PCH. A focus on process and speed of task has perhaps negatively impacted on staff safety and wellness.

The PMH review has revealed significant tension in the current environment impacting on the morale and engagement of medical staff at Princess Margaret Hospital; however, findings suggest that the issues also apply to the broader workforce at PMH. Causative factors contributing to current tensions include:

- Review of and implementation of CAHS organisational structure
- Review of workforce build requirements for the existing hospital impacted by implementation of a workforce build for the commissioning of PCH
- Speed of organisational change
- Requirements to address current funding model deficits impacted by the introduction of ABF methodology
- Long term temporary workforce arrangements
- Impact of infrastructure and process development and commissioning of PCH

# Summary of Discussion

Outcomes of discussion with stakeholders were broadly grouped into themes as follows:

1. Culture
2. Governance
3. Change Management
4. Workforce
5. Impact on Quality of Care
6. Positive Feedback

Broad findings are listed as follows:

## Culture

- A legitimate disparity exists between the view of CAHS/PMH executive members and staff members regarding the significance of the problem
- Based on staff feedback during the review and findings of formal surveys[1] staff unhappiness and low morale is evident at PMH. Many staff interviewed (~80% or more) identified features from the  current climate that indicate a major failure in leadership with a management style that is non-supportive and at times frankly dismissive
- This appears highlighted by the fact that many employees have been employed at PMH for a considerable period of time and report a worsening of the culture over the last few years
- There is a broad held  view amongst those interviewed that teaching, training and research is no longer highly valued by the organisation and has been somewhat decimated by a heavy focus on service delivery and compliance, and with staff reductions, a reduction in availability of non-clinical time. Junior medical staff in particular spoke of a real risk to the organisation's reputation and ability to attract future graduates
- Staff spoke of fear of perceived targeting & retribution for voicing opinions at odds with those of management,  including the executive. This appears to have had the effect of sending  a widespread 'message to staff' throughout the organisation against speaking up
- There is a widespread perception that those who do not fully support new arrangements may be sidelined from career progression opportunities
- A management style is described of 'paying lip service' to transparency, a  lack of meaningful consultation and lack of staff engagement. Staff expressed a view that executive "talked the talk" but didn't "walk the walk"
- There appeared to be an inconsistency between executive and staff in regard to expectations of accountability

## Governance

- Effective engagement and communication methodology between senior management and staff is lacking, despite efforts to engage staff. Staff gave many examples of communication from the executive that was perceived to be inappropriate and poorly timed.
- Many staff related the changes in leadership style and tone to the current CE and his new executive structure; however others report that there has been a history of poor communication and transparency in style that has been in place for many years and is not attributable to this. What is more apparent, is that with executive changes over recent years, and the introduction of new governance arrangements, staff report uncertainty regarding governance structures and individual executive team member roles and responsibilities

- There is a perception of increased 'layers of bureaucracy', despite job losses at the coal face, and consequent delays in the timeliness of decision making and added complexity of process around things that impact on morale such as the issuing of contracts and approval of leave
- Staff gave examples where information or advice from staff to Executive relating to plans or proposals was disregarded

## Change Management

- Change fatigue is clearly evident
- While staff acknowledge pressures related to the planning and move to PCH they overwhelmingly feel that the current state of morale is largely unrelated to this plan. Overwhelmingly, staff interviewed stated that the move to PCH would not in itself be a remedy for the low levels of morale, and in fact, feared the 'transfer' of the current culture and morale from one place to the next
- Major changes to the governance structures, reporting lines, rosters, recruitment and departmental structures have occurred with a genuine perception of no or minimal consultation
- Changes by executive to provide more flexibility with Nursing, Clerical and Allied health staff is viewed by medical staff as breaking down of well-functioning teams
- Overwhelmingly, staff interviewed confirmed support and indeed recognition of the need for change, including financial restraint, however felt that poor engagement to date, and had reduced their appetite to engage in change. There was a comment that change was being done 'to' staff and not 'with' staff

## Workforce

- The current workforce governance structure contains two reporting lines differentiated by governance (decision-making) authority and management of processes. This has resulted in confusion and critical delays in decision-making related to appointment and management of the medical workforce
- It was highlighted that a chronic shortage of experienced staff within the medical workforce team with the required skill set to manage the medical workforce portfolio has resulted in pressure exerted on those working within the team and potential delays in management of the workload. Senior & Junior medical staff interviewed indicated that they felt the review and recruitment of junior medical officer's during 2016 (for 2017) did not follow a practical methodology, nor meet the safe rostering requirements for the hospital in spite of significant input from the JMO staff.
- All registrars interviewed reported a perceived change in the selection process for the recruitment of registrars which was not effectively communicated to them and this has led to a loss of a cadre of experienced junior staff. The high volume of staff on temporary including short term contracts has precipitated a culture of insecurity and vulnerability amongst staff and has contributed towards a culture of fear of 'speaking up' this is further compounded by current staff shortages described by staff
- The high number of employees, and more importantly, managers, holding 'acting' positions is adversely impacting organisational processes and ability to effectively engage staff. The review team understands that the proportion of acting positions is dependent on numbers of staff who are contributing to the PCH Commissioning
- Many staff feel there is not an open and equitable process for appointments to jobs
- Lack of access to leave is cited by staff as a major contributor to low morale

Medical staff interviewed also made comment on the following

- Lack of clarity around medical workforce governance and decision making

- The split model of governance which appears to need clarification and communication to the medical  workforce (administration) team and clinicians at all levels
- Clarification and definition of responsibilities between human resources, industrial relations and medical workforce along with explicit policy and process regarding accountability for recruitment numbers and processes at executive level including development of an executive sign off process on work force provision and accountability re implementation
- Lack of well-defined and agreed JMO workforce provisioning plan for dealing  with current shortage (recruitment strategy) and 2017/18 recruitment requirements; recruitment numbers to be based on safe rostering principles, take into account leave liability as per award provisions and allow sufficient protected teaching and training time as determined by PMCWA and College requirements
- Lack of an organisational Communication Plan
- Poor contract management processes including a significant number of staff operating in acting or fixed term positions
- Inadequate solutions to address leave management
- Consideration by CSA of vote of no confidence in executive based on JMO staffing issues

## Impact on Quality of Care

A genuine commitment to the provision of safe, high quality care to patients and families is clearly evident across all levels of the organisation and staff are clearly passionate about ensuring that the  children of Western Australia receive world class care. Notwithstanding that the understanding  of contemporary principles, standards and associated policy for safety and quality may be  variable in some workforce areas. There is a belief by a number of senior clinicians that the  importance and efforts placed on ensuring policy and process compliance by the organisation is  disproportionate to the focus that should be placed on the ability to demonstrate quality clinical  outcomes.

While the executive's commitment to being a patient centered organisation is clearly commendable, staff expressed frustration and annoyance at the communication style with which it is being delivered and an inference that this focus has been lacking in the past.

Data relating to performance in a variety of safety and quality spectrums indicate trends are on or near target or comparative with historical trends and there were no particular spikes or peaks that were of significance. The volume of complaints from consumers appears relatively stable during the last two years, as do numbers of serious clinical incidents. Source of consumer dissatisfaction relating to communication and environmental components are not inconsistent with findings at other hospitals. Investigation of serious events is undertaken appropriately and scrutinised at a very senior level, although timeliness of the completion of incident investigation reporting is poor. This has been acknowledged by the executive as something requiring improvement. The time allocated to the review itself did not allow for in-depth audit of patient outcomes.

Comments made by the Chairs of the various Consumer Advisory Councils did not elicit any areas of concern about patient care.  The chairs were complimentary about the efforts that had been made by the organisation in increasing its level of consumer engagement through consumer advocacy and representation. A comment was made however in relation to the adverse media attention that had already been received about staff morale at PMH and the alarm that this had caused for parents presenting to the hospital. This observation was mirrored by a number of nursing staff during the course of the review and is a risk that will need considered management in the course of further communications surrounding the morale and engagement of staff at the hospital.

Of concern was the overwhelming message from staff interviewed that while patient safety and quality of care appeared largely unaffected to date, there is a significant risk that patient safety will be compromised should conditions remain unchanged. The reviewers believe that this risk will become realized, if the recommendations are not actioned. The reviewers heard repeatedly that staff were going above and beyond to keep their patients unaffected by issues with morale.

Also of concern were comments by some staff that the current culture was not conducive to the reporting of clinical incidents and that they believed underreporting was prevalent, inferring that any risk to patient safety was not being adequately captured. While the incident numbers on paper appear to dispute this with greater numbers of incidents reported in 2016 compared with 2015 overall, it cannot be ignored that the fear of retribution already alluded to in this report would tend to support the comments of the staff. Similarly, while staff spoke positively about the intentions of the 'Speaking up for Safety' program by the Cognitive Institute scheduled for introduction within PMH, most felt that in the current climate it would be met with cynicism and difficulties with engagement.

Whilst acknowledging some positive aspects to the new STARS model such as increased after-hours registrar cover, difficulties in attending handover due to the new roster process were raised. Ramifications for patient safety were explored, in addition to the obvious impact that these changes were having on junior medical staff wellbeing and early recommendations were put to the CAHS Board Chair during the course of this review. In addition, staff expressed some concern with the availability of MET team coverage after hours and the reviewers acknowledge that this is currently being considered by the PMH Safety & Quality Governance Committee.

## Positive Feedback

It is important to note that the reviewers received positive feedback during the course of conversation with review participants as documented below:

- Passion and commitment of staff to their patients and families
- The love for the organisation, its purpose, and the pride of staff for the caring of the children of WA
- Goodwill of staff to go above and beyond to ensure the delivery of best care possible is clearly evident
- A dedication to teaching, training and research exists
- Dedication to being world-class facility was regularly described
- Excitement exists at the proposed move to the new PCH, despite the delays and adverse media attention
- The acceptance by staff of a required change agenda, current fiscal constraints and a genuine interest in improving service delivery and embracing new models of care
- Good collegiality between clinical disciplines as well as between junior and senior clinicians
- Reference to some of the good initiatives that have been tried or are in place that are generally well received, for example:

  - Introduction of "The Huddle"
  - Creation of Allied Health director position, and
  - Increased visibility of allied health at the executive table

# Key Findings

1. There has been a fundamental failure of leadership within the hospital with non-engagement of staff resulting in low morale and disillusionment.
2. Staff reported a feeling of chaos, doing too many things at once with no obvious plans or overarching strategy and decisions; it is perceived outcomes get changed with little communication.
3. At present, there is no documented evidence to suggest that patient outcomes are being compromised as a result of low morale.
4. However, without change the current situation will almost certainly impact on safety and quality at PMH and requires greater acknowledgement.
5. There is a lack of appreciation by the executive of the profound general unhappiness and low morale of PMH staff.
6. Evidence of poor morale has been apparent and documented for some time.
7. Priorities to date have largely been about the PCH project and changes to practice prior to the move at the expense of PMH business as usual.
8. There is a genuine concern that the current culture should not be reflective of, nor should be transferred to the new PCH facility.
9. A need for staff empowerment has been identified with a perception by staff that no one is advocating for them.

# Other Reflections

1. It was noted that the current subcommittee structures do not align with the governance structure in order to facilitate communication across the organisation.
2. The current CAHS/PMH organisational leadership model is unnecessarily complex and not well understood by staff.
3. It is relevant to acknowledge that the role of 'leadership' is not just limited to the executive, but that other senior positions within the organisation have a role in influencing and informing the culture of the organisation.

# Recommendations

## Interim Recommendations

The reviewers provided an update to the Chair of CAHS board on Tuesday 11 April 2017, in regard to the immediate risks that were considered relevant as interim recommendations as outlined below:

1. A consistent approach to management of overtime should be implemented immediately.
2. All legitimate claims to overtime should be paid, and JMOs should be informed of these changes.
3. Handover to be included within rostering practice and to be paid. For practical and patient safety purposes the working day for RMOs should coincide with business practices of the hospital generally.
4. Review of STARS roster required to ensure that the after-hours roster is not negatively impacting on ability to authorize leave of Junior Medical Officers (JMOs). In particular in regard to the practice of using leave relief positions to staff the STARS roster.

5. Provision of decision making governance by executive to the medical workforce team to support immediate advertising and recruitment of current medical (JMOs) vacancies is recommended.

## Final Recommendations

In light of the findings, the reviewers make the following final recommendations to the Board:

### Morale and Engagement

1. Given the failure in leadership documented above, it is strongly recommended that there be an immediate change in leadership style, if not personnel.
2. Organisational vision and values be reviewed and agreed as a matter of priority and strategies identified to encourage and support appropriate behaviours within all levels of the organisation.
3. An open and honest acknowledgment of the current situation is shared with staff with an invitation to participate in developing a way forward.
4. Given the relative small size of CAHS a review of the multiplicity of governance structures be undertaken to ensure functional alignment and simplicity of communication mechanisms.
5. Progress the appointment of permanent executive positions throughout CAHS as a matter of priority, adopting a competitive and transparent recruitment process.
6. Create appropriate channels for the voice of clinicians to be heard by the Board.
7. Improve awareness and visibility for staff regarding the Board and CAHS executive structures, roles and responsibilities.
8. Create a PMH Medical Executive committee with decision making capability reporting through to the PMH and or CAHS Executive Committee.
9. Identify recommendations arising from Press Ganey Voice of Staff and Family Experience Surveys with a view to implementing a rigorous action plan to address issues, with progress to be reported to and monitored by the CAHS Board.
10. Review of the recommendations of the Barrett Values Centre – Child and Adolescent Health Service (CAHS) – FLP Participants 2015 with communication to PMH staff regarding intended actions and monitoring of progress by the CAHS Board.
11. Staff engagement and morale to be specifically captured on the PMH and CAHS significant Risk Registers and with identification of controls and treatment action plans and subsequent escalation to the Audit and Risk Committee and CAHS Board.
12. Plan for devolution of accountability and decision making to HoD level, including development and training opportunities as required.

### Workforce

13. Review the reporting and communication of accountability lines for JMO management with view to stabilizing medical workforce infrastructure.
14. Immediate address of PMH and PCH human resourcing issues including:
    a. Immediate planning for 2018 JMO recruitment
    b. Review of current and temporary and rolling contracts
    c. Strategies to implement provision of leave
    d. Introduction of a formalized pastoral care program for Junior Medical Officers (Doctors in Training)
15. Restructure of medical workforce team with clear role delineations, responsibilities and reporting lines for staff who are permanently appointed and own their job roles.
16. In association with recommendations 1 & 2 above a review of clinical service plans in conjunction with the appropriate clinical groups needs to clearly define and articulate a commitment to the resourcing and delivery of state-wide clinical paediatric services.

## References

1. Press Ganey. Child and Adolescent Health Service 2016 Voice of Staff Survey.
2. Ray Williams. The Rise of Toxic Leadership and Toxic Workplaces (2016).
3. The Kings Fund. Medical Engagement: A journey not an event (2014).
4. Spurgeon P, Long P, Clark J, Daly F. Do we need medical leadership or medical engagement? Emerald Group Publishing (2014).
5. Dickinson L, Bismark M, Phelps G, Loh E. Future of medical engagement. Australian Health Review (2015).

# Appendix 1: PMH Review Terms of Reference

**Review (the "Review") of the morale and engagement of clinical staff at Princess Margaret Hospital (PMH) – Terms of Reference**

## Contents

# 1. Background

This Review has been initiated by the Board of the Child and Adolescent Health Service (CAHS) supported by the Director General, Department of Health to address concerns that have been raised regarding the conditions, morale and engagement of clinical, primarily medical, staff at Princess Margaret Hospital (PMH), and any impact on safety and quality outcomes for patients at PMH.

These concerns have been raised by a number of sources, both internal and external to CAHS. The sources include the Australian Medical Association (AMA), the PMH Clinical Staff Association (CSA), the PMH Junior Medical Officer Society, and other individual PMH medical clinicians.

The CAHS Board recognises that staff morale and engagement is critical to patient safety and the functioning of PMH and will be important to the success of Perth Children's Hospital (PCH).

As the governing body of CAHS, the CAHS Board is responsible for the quality of health services provided by CAHS and for ensuring that its operations are carried out efficiently, effectively and economically. Accordingly, the CAHS Board is commissioning this Review into the conditions, morale and engagement of clinical, primarily medical, staff at PMH.

The CAHS Board have commissioned this Review and received the support of the Director General of the Department of Health, as System Manager responsible for the WA health system, in respect of the commissioning of this Review.

# 2. Purpose

The purpose of the Review is to identify the scope of issues relating to the conditions, morale and engagement of clinical, primarily medical, staff at PMH, and any impact on safety and quality outcomes for patients at PMH, and to make recommendations to the CAHS Board regarding actions to be taken, by CAHS, to manage and mitigate any issues, including the associated sequencing, timing and resource requirements.

# 3. Scope

The Review will examine:
- the specific issues raised, in recent times, by PMH medical staff and their representative bodies, including but not limited to; morale, engagement, leave management, medical administrative matters and alleged staff shortages.;
- the workplace culture of medical staff at PMH, and the interface with medical administration and Executive, and vice versa; and
- the efficiency and effectiveness of the medical administration at PMH.

In undertaking the Review, the reviewers will:
1. interview relevant medical staff members, including medical leaders and medical executive, and members of the PMH and CAHS Executive and CAHS Board.
2. meet with representatives of, and consider submissions from, relevant associations and projects within PMH such as the Junior Medical Officer Wellbeing Project, the CSA, and the PMH JMO Society;
3. engage with, and consider reviews undertaken by, the CAHS Board's Safety and Quality Committee;
4. review the results of the recent staff survey administered by Press Ganey™;
5. examine the frameworks, policies and supporting documents in place to guide the conduct and behaviour of medical administration at PMH and the extent to which these frameworks, policies and supporting documents are understood and applied;

6. examine the framework, policies and supporting documents in place to guide the engagement between PMH and CAHS Executive and clinical staff at PMH and the extent to which these frameworks, policies and supporting documents are understood and applied; and

7. examine the impact of any issues raised throughout this review in relation to the quality of care delivered at PMH, and

8. noting this is primarily a review focussed ostensibly on medical staff engagement, the CAHS Board wishes the reviewers to interview nursing and allied health staff during the Review

The following is out of scope:
1. findings or judgements regarding the conduct or behaviour of individual doctors;

2. resolution of allegations, complaints and issues identified a part of the evidence gathering exercise; and

3. policy frameworks and mandatory policies issued by the Director General of the Department of Health.

## 4. Reviewers

The Review, on behalf of the CAHS Board, will be undertaken by Dr John Keenan, Ms Sandra Miller and Professor Gary Geelhoed. Professor Geelhoed as Chief Medical Officer, Department of Health will oversee the review.

## 5. Guiding principles

### Ethical

This Review should be approached in an ethical manner. It should be fair and without prejudice or dishonesty.

### Respectful

This Review should be undertaken in a manner which is respectful to all participants. All participants involved in this Review should act in a professional and respectful manner at all times.

### Procedural fairness

Procedural fairness must be applied to the review and it is important that:

- The review is conducted in a manner that ensures that all parties whose interests may be adversely affected by the outcome of the review are afforded the opportunity to present their views;
- The reviewers must be impartial; and
- The reviewers make findings based upon logically probative evidence, meaning material that tends logically to prove the existence or non-existence of a fact.

### Minimising intrusiveness

This review should minimise intrusiveness on the PMH workforce and not impact on delivery of care to patients.

### Confidentiality

This Review must ensure the confidentiality of any individuals who provide information or submissions to the Review. While transparency is highly encouraged, nonetheless, when providing the outcomes of the Review to the CAHS Board, the reviewers must give

consideration to any confidentiality or privacy considerations. It is important the reviewers be cognisant that the release of certain information could unfairly invade someone's privacy or affect their work or career. Advice should be sought if there are concerns regarding the release of any information.

### Record keeping

The reviewers must detail in a report how the findings and any recommendations were arrived at. This report will provide a record of the process applied and will provide an accessible and condensed record should the Review be subject to an external review. All documentation should be filed in accordance with the appropriate record keeping procedure of CAHS and in accordance with the *State Records Act 2000*.

## 6. Methodology

The purpose of this Review will be achieved primarily through interviews with relevant senior and junior medical staff, other clinical staff, and members of the PMH and CAHS Executive. The Review may also wish to seek submissions from relevant parties within PMH and externally.

The reviewers will provide a progress report to the CAHS Board by COB 7 April 2017. A copy of this report will be provided to the Director General of the Department of Health by resolution of the Board.

## 7. Deliverables

The reviewers will finalise the Review and provide a written report to the CAHS Board by COB 28 April 2017. Any extension must be agreed by the CAHS Board. A copy of this report will be provided to the Director General of the Department of Health by resolution of the Board.

The written report will include:

1. The reviewers' findings in respect of:

    a. the specific issues raised, in recent times, by PMH medical staff and their representative bodies, including but not limited to; morale, engagement, leave management, medical administrative matters, alleged staff shortages, and other issues as raised during this Review;

    b. the workplace culture of clinical staff at PMH, the interface with the Executive and vice versa;

    c. the interface between medical staff and medical administration and Executive, and vice versa; and

    d. the efficiency and effectiveness of the medical administration at PMH; and

    e. other issues raised by clinical staff interviewed by the reviewers.

    These findings should be supported by evidence or materials gathered during the Review;

2. Recommendations to the CAHS Board regarding actions to be taken, by CAHS, to manage and mitigate any issues, and the associated sequencing, timing and resource requirements.

3. Recommendations to the CAHS Board regarding actions to be taken, by CAHS, to manage and mitigate the impact of any issues on the safety and quality of care, and the associated sequencing, timing and resource requirements.

4. If, during the Review, it is clear that certain urgent actions need to be taken prior to finalisation of the Review, the reviewer should inform both the Board of the findings, and actions to be taken

5. If, during the Review, the reviewers consider there is a requirement for further internal assistance or external reviewer assistance, the Board and Director General should be informed.

## Endorsement

Reviewer - Dr John Keenan


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Signature

   /    /

Reviewer - Ms Sandra Miller


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Signature

   /    /

Reviewer - Professor Gary Geelhoed


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Signature

24 / 05 / 2017


Board Chair – Ms Deborah Karasinski


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Signature

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