Chief Psychiatrist's Review

Clinical Governance Climate in WA Mental Health Services

May 2013

This report is as a result of the Chief Psychiatrist's responsibility under the *Mental Health Act 1996* to monitor standards of care.

It is provided in confidence to mental health services to assist in their continuing quality improvement of clinical service delivery.

This document is not intended for public release.

Dr Nathan Gibson
CHIEF PSYCHIATRIST

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

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Acknowledgement

This review was completed by Dr Rowan Davidson during his tenure as the Chief Psychiatrist of WA. Minor amendments have been made leading to the sign off by the current Chief Psychiatrist, Dr Nathan Gibson.

Executive Summary

The Chief Psychiatrist has responsibility under the *Mental Health Act 1996* to monitor standards of psychiatric care across the State of Western Australia. In exercising this responsibility he conducts Clinical Governance, Thematic and Targeted Reviews of Mental Health Services (MHS) in Western Australia (WA).

This report summarizes the data collected during the third Thematic Review entitled "Clinical Governance Climate in WA Mental Health Services". The aim of this review was to establish a base line of Clinical Governance Climate across all public MHS. An organisation's climate or culture is the sum total of what it does and is directly influenced by staff beliefs (Field, 2009). If staff believe that the organisation has a clearly defined set of core managerial values and strong leadership they are more likely to engage in meeting the mission of the organisation and subsequently in sustained improved practice.

In 2009 the Department of Health conducted a Climate Survey to determine the organisational climate of the Department. The return rate was 43% and the findings indicated an overall improvement (previous survey conducted in 2006) in relation to blame culture, employee engagement and improvement and shadow culture (DoH, 2009). However, there remained room for improvement in relation to the reporting of bullying, trust in management and leadership. The Office of the Chief Psychiatrist (OCP) also conducted Climate Surveys of 15 of the 19 mental health services undergoing Clinical Governance Reviews (CGR) during the same period. The results of the OCP survey also supported that further attention be paid to issues of leadership and organisational culture. A review of the 500 recommendations made across all CGR (OCP Clinical Governance Trends 2003 – 2009) found that a total of 31 recommendations were made in relation to Leadership and Organisational capability hence the use of the Clinical Governance Climate Questionnaire (CGCQ) in the current review.

A total of 1,117 MHS staff participated in the Review which involved responding to a 70-item modified version of the CGCQ developed by Mr Tim Freeman, University of Birmingham. For the purpose of this review the items on the CGCQ were conceptualised using the Chief Psychiatrist Clinical Governance Framework which includes four pillars of Clinical Governance and eight associated Areas of Inquiry. The data was captured using Survey Monkey, a web based data collection tool and was subsequently copied to Microsoft Excel for further examination and analysis.

The results section begins with a presentation of demographic data. The Reviewer considers the overall response rate and the response rate from each of the professional groups to be representative of the sector. Similarly, there was good representation of both clinicians and non clinicians across a range of streams and settings as well as the length of time employed. The clinical and non clinical data was collapsed given the similarity in responses.

A total of eight recommendations were made with one in the area of Leadership and Organisational Capability, two in the area of Clinical Risk Management, one in Clinical Performance and Evaluation – *Research & Effectiveness*, two in the area of Professional Development and Management – *Staffing & Staff Management* and two in the area of Professional Development and Management – *Education, Training and Professional Development*. Details of the recommendations are presented in the final section of the report.

This Report, following approval by the Director General of Health, will be sent to the all WA MHS with a request that they complete the Action Plan located in Appendix A with implementation of the Recommendations scheduled for audit in 2013.

Background

The Chief Psychiatrist has responsibility under the *Mental Health Act 1996* to monitor standards of psychiatric care across the State of Western Australia. Clinical Governance Reviews of mental health services (MHS) were systematically conducted during the period 2003 – 2009. In 2010 the Chief Psychiatrist developed a Thematic Review Program which enabled targeted monitoring of MHS in relation to the consistently emerging themes associated with the CGRs. The Thematic Review Program focuses on one domain, or a series of related domains, of clinical care and provides a snap shot of all West Australian (WA) MHS in relation to that specific area of clinical care.

A total of 19 Clinical Governance Reviews (CGRs) were conducted between 2003 and 2009 followed by a series of three Thematic Reviews conducted between 2010 and 2012. In 2005, the Clinical Governance Climate Questionnaire (CGCQ) was introduced as part of the CGR process. The implementation of the Questionnaire was done as part of a collaborative relationship with Tim Freeman of the University of Birmingham in the United Kingdom. The CGCQ was utilised to measure the implementation of Clinical Governance within WA MHS.

This report reflects the results associated with the latter data set only. Reference will be made to the initial data in relation to trends that appear and the subsequent impact on the recommendations.

The following sections summarises the background of the Clinical Governance Framework, the development of the CGCQ, the review methodology including the context in which the data was analysed, the results and the recommendations.

Context

Clinical Governance Framework

There are four pillars of clinical governance (bold), with eight areas of inquiry (Italics).

- ***Leadership and Organisational Capability***
  The organisation has a clear vision and strategies for achieving the vision. There is effective leadership and a governance structure which is integrated within the mental health service. Staff are committed to the organisation, have expertise in change management and create an environment that allows innovation.

Consumer Value

- ***Consultation and Consumer / Carer Involvement***
  As the central point of clinical governance is to provide high quality healthcare for the patient, it is essential that their views and the families/carers on how this should be achieved are captured.

Clinical Performance and Evaluation

- ***Clinical Audit***
  A process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria.

- ***Research and Effectiveness***
  Clinical effectiveness can be achieved when the best available clinical knowledge, evidence and information are made accessible to healthcare professionals who have day-to-day responsibility for planning, implementing and monitoring patient care.

- ***Use of Information to Support Health Care Delivery***
  The use of information phase relates to the assessment of amount of information collected by the MHS on patient experience, outcomes, processes and resources and how the MHS utilises this information in developing strategic direction and changes to practice as appropriate to the meaning of the findings for quality mental health care.

Clinical Risk

- ***Clinical Risk Management***
  Effective implementation of risk management systems, policies and procedures requires local leadership from both clinicians and managers. There needs to be clear understanding of the MHS objectives for risk management and effective reporting and dissemination of results.

Professional Development and Management

- ***Staffing and Staff Management***
  To get the best from staff and maximise their contribution to an organisation, it is essential that the right staff are doing the right job with the right skills and support.

- ***Education, Training and Professional Development***
  All staff should have the opportunity to become involved in training and development activities, research, development of reflective practice, peer supervision and building in protected time to allow individuals to improve skills and knowledge within their specialist areas.

Clinical Governance Climate Questionnaire

Tool Development

The Clinical Governance Climate Questionnaire (CGCQ) was developed by Tim Freeman of the Health Service Management Centre, University of Birmingham, United Kingdom in a study entitled

"Measuring progress in clinical governance: assessing the reliability and validity of the Clinical Governance Climate Questionnaire".

The overall aim of the study in order to provide a valid and reliable measure of clinical governance climate by reducing a pool of clinical governance climate indicators developed via previous qualitative research. In addition the research aimed to examine the underlying factor structure, the internal consistency and external validity of the model.

The initial set of 157 indicators was developed following nine focus groups with health care professionals across four healthcare Trusts. Participants were from a range of professions including nursing, medical and managerial. The pool of items was then reduced to 60 with the six factor 60 item measure (CGCQ) achieving high internal consistency and external (discriminant and construct) validity in a study population of healthcare Trust staff. The factors were conceptualised as:

- Planned and Integrated Quality Improvement (21 items)
- Proactive Risk Management (11 items)
- Climate of Blame and Punishment (9 items)
- Working with Colleagues (6 items)
- Training and Development (8 items)
- Organisational learning (5 items)

Respondents were asked to respond to each item using a 5 point likert scale including Strongly Agree, Agree, Neither, Disagree and Strongly Disagree.

Current Use

For the purpose of the current review ten additional items were added and the 70 items were conceptualised using the Clinical Governance Framework as a guide. A copy of the measure is located in Appendix A.

- Leadership and Organizational Capability (20 items)
- Clinical Risk Management (21 items)
- Research and Effectiveness (11 items)
- Staffing and Staff Management (7 items)
- Education, Training and Professional Development (11 items)

In addition the likert scale was modified removing the "Neither" option. While it is recognised that the addition of the ten items and the removal of one of the response options would alter the psychometric properties of the measure it was consider acceptable, in this instance, given its practical application in establishing a baseline of the Clinical Governance Climate across WA public MHS.

The data was captured via Survey Monkey with all WA public MHS staff (Clinical and Non Clinical) invited to complete the CGCQ on line. The Non Clinical staff had an amended version of the CGCQ with 30 clinical questions being removed as they were considered inappropriate for non clinical staff and leaving a total of 40 items on the non clinical version.

Methodology

Aim

The aim of Thematic Review 3 was to establish a baseline of the Clinical Governance Climate across all WA public MHS.

Participants and Procedures

Thematic Review 3 was conducted between August and September 2012. A total of 1,117 mental health staff completed the questionnaire with 854 clinical staff and 263 non clinical responding. It should be noted that clinicians working in a non clinical role were allowed to complete the non clinical version of the measure.

The number of responses received in relation to the current survey was significantly higher than similar surveys conducted previously. In a previous survey a total of 428 responses were received. By comparison the current survey showed a 38.3% increase in the response rate. Although the reason for the increase is not entirely clear it can be suggested that the on line methodology has facilitated clinicians' responses.

In particular there were substantially more responses from medical and allied health staff than in the previous review.

Analysis

The data was collected via Survey Monkey and exported to Excel for further analysis. Frequencies were run on demographic data. During the analysis it was noted that although the Survey Tool was developed to force respondents to complete all the questions, some items were skipped and therefore the totals in the data sets and graphs below may vary if respondents skipped a question.

The data for each of the Clinical Governance pillars is presented in two formats. The first format is via a table representing each item and their respective response categories. This is followed by a graph showing the percentage totals for Strongly Agree and Agree versus the percentage totals for Strongly Disagree and Disagree.

Comments and in some instances recommendations are only provided for items in which there was at least a twenty percent difference between the Strongly Agree and Agree versus the percentage totals for Strongly Disagree and Disagree.

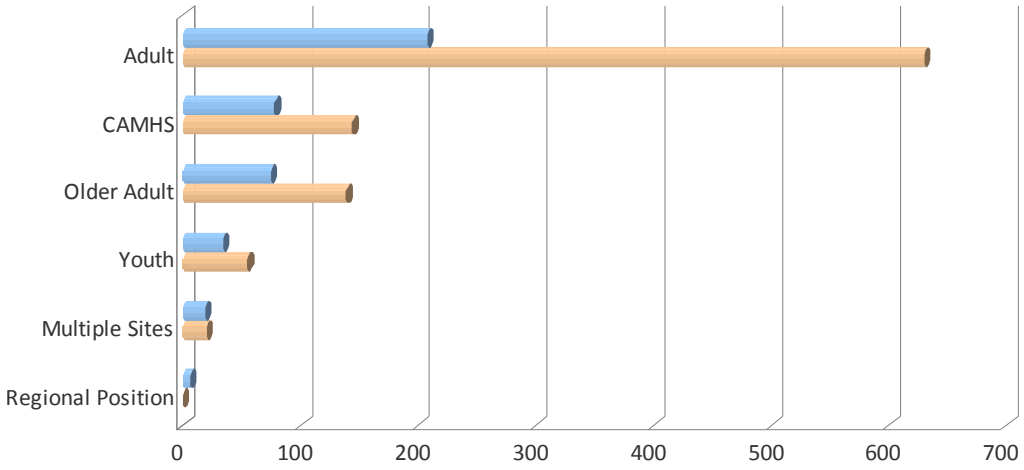
The table is provided to enable MHS to identify any additional areas that may require wish to implement change.

Respondent Demographic Information

For the purpose of the current report the demographic information for the Clinical and Non Clinical respondents have been amalgamated and are presented below. The remainder of the responses will be divided into Clinical and Non Clinical sections of the report.

Participants were asked to respond to a series of demographic items including the length of time they had been employed by the MHS, their professional alignment and the stream and setting in which they were currently employed. The 1,117 respondents equated to a 30% response rate. It is unclear exactly what factors have contributed to the large numbers of MHS staff responding to the questionnaire. Issues such as ease of completion, anonymity, and timing of the review in relation to current changes in the mental health system may have influenced staff to respond. Figures 1 to 9 and Tables 1 to 10 summarise staff responses.

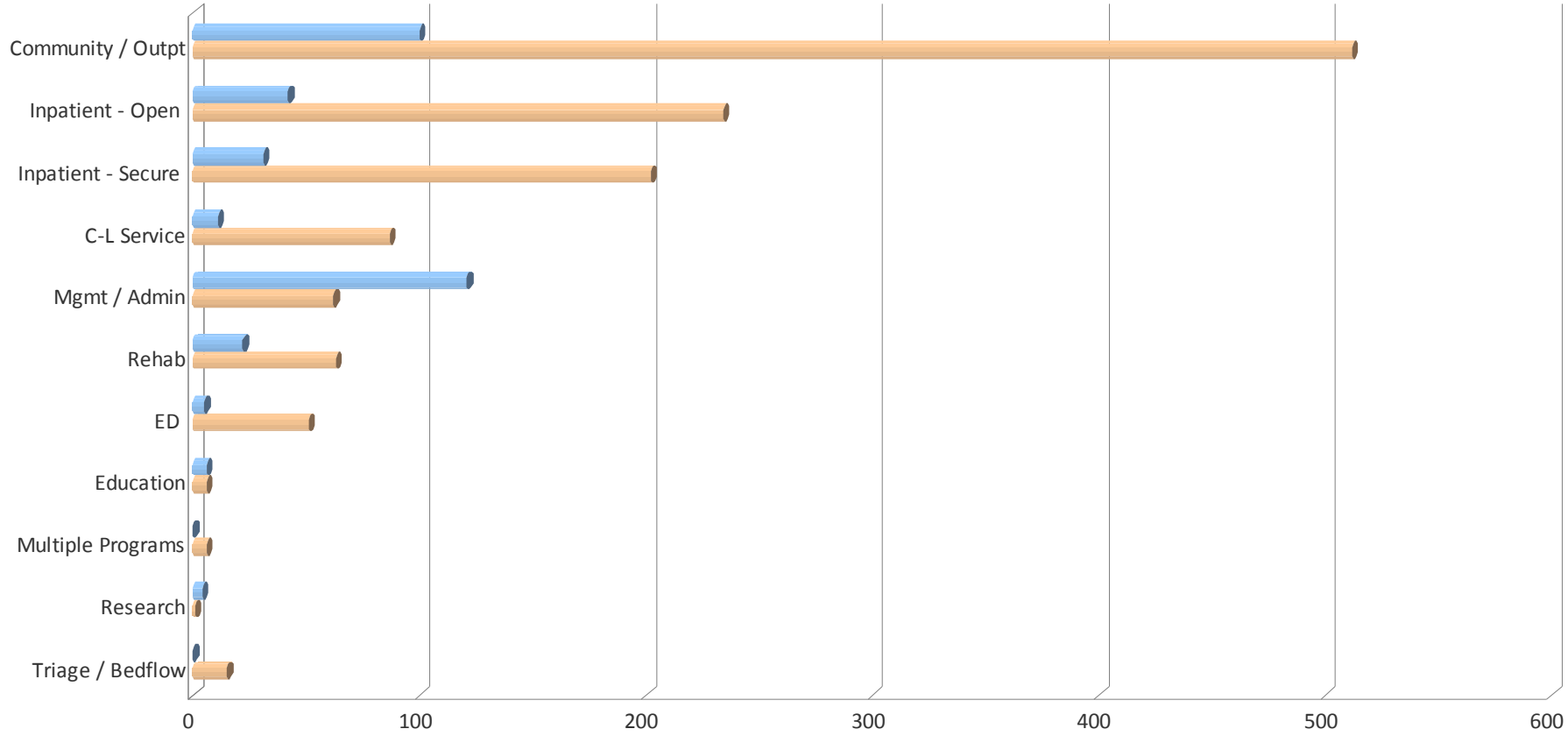
Figure 1: Respondent's Employment by Stream



	Regional Position	Multiple Sites	Youth	Older Adult	CAMHS	Adult
Non Clinical	6	19	34	75	78	208
Clinical	0	20	55	139	144	630

The review was able to capture responses from staff working in each stream along with those working across multiple sites and in regional positions. The response rate of just over 30% was considered to be representative of the sector.

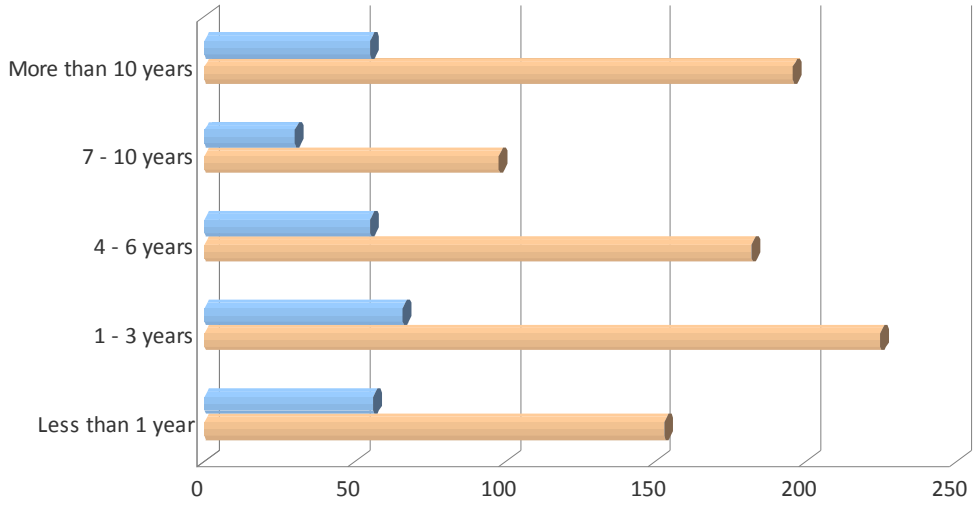
Figure 2: Respondent's Employment by Setting



	Triage / Bedflow	Research	Multiple Programs	Education	ED	Rehab	Mgmt / Admin	C-L Service	Inpatient - Secure	Inpatient - Open	Community / Outpt
Non Clinical	0	4	0	6	5	22	121	11	31	42	100
Clincal	15	1	6	6	51	63	62	87	202	234	512

Similarly, the responses above represented both clinical and non clinical staff working across a range of employment settings.

Figure 3: Length of Time Respondents Employed at MHS

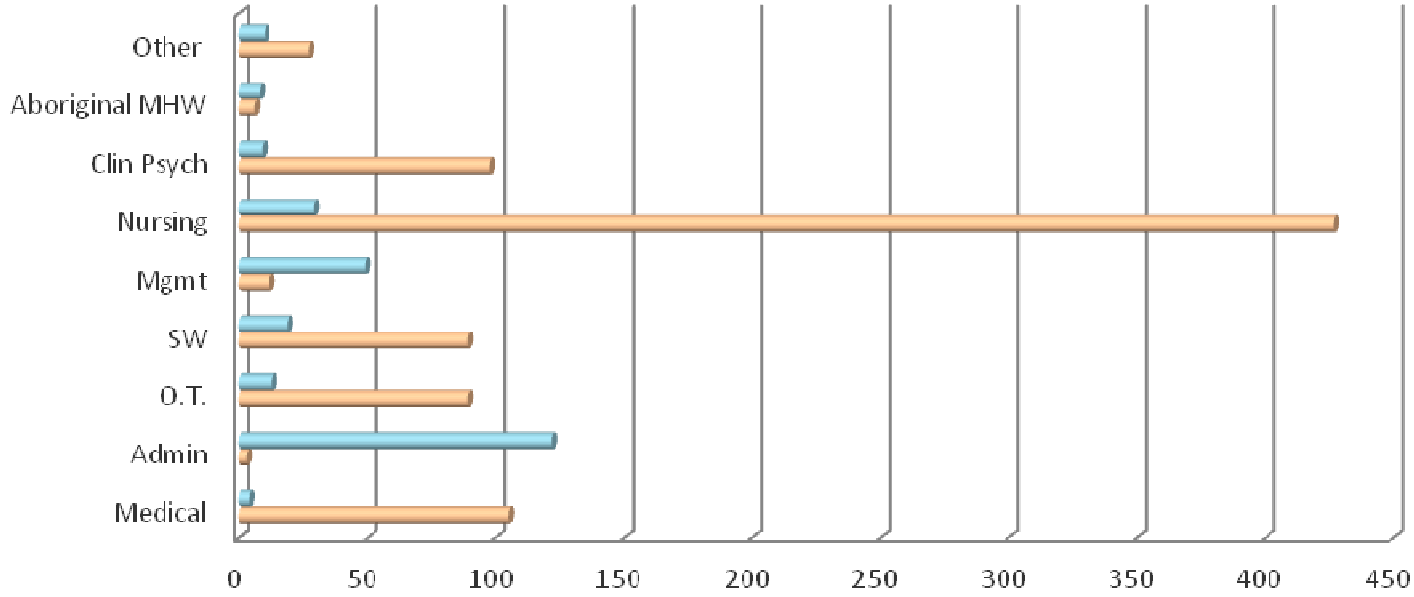


	Less than 1 year	1 - 3 years	4 - 6 years	7 - 10 years	More than 10 years
Non Clinical	56	66	55	30	55
Clinical	153	225	182	98	196

The respondents included both recently employed and long standing employees with the majority having been employed in the MHS for between 1 and 3 years.

Figure 4 on the following page summarises the response provided by each professional group. As with each of the other demographic areas a range of professions were represented including medical staff for whom the response rate is traditionally low.

Figure 4: Respondent's Professional Alignment



	Medical	Admin	O.T.	SW	Mgmt	Nursing	Clin Psych	Aboriginal MHW	Other
Non Clinical	4	122	13	19	49	29	9	8	10
Clinical	105	3	89	89	12	427	98	6	27

Notes: Other Category includes Pharmacy, Research, Education, Speech Therapy and Physiotherapy. The graph includes Clinicians working in a Non Clinical at the time of the review

Results of Data Analysis

In order to make sense of the data collected and provide practical recommendations that the MHS can implement a decision was made to group items with positive responses together and provide general comments in relation to these items. Items with a 40% or more response rate in the negative will be discussed and may incur a recommendation.

The results are presented by pillar and within each pillar by response category and by profession.

Each section begins with a table summarising the total number of responses to each item on that specific pillar across response categories. For the purpose of this table the Clinical and Non Clinical responses have been collapsed given that analysis indicates that there is very little difference between the Clinical and Non Clinical responses to items.

This is followed by graphical representation of the data using percentages of responses and finally the data is presented in a table by profession. For both the graph and the data by profession the response categories (Strongly Agree/Agree and Strongly Disagree/Disagree) have been collapsed with the category with the highest percentage being depicted in the by profession table.

The final table Recommendations are presented at the end of each section with a summary of all recommendations presented later in the report.

LEADERSHIP AND ORGANISATIONAL CAPABILITY

The organisation has a clear vision and strategies for achieving the vision. There is effective leadership and a governance structure which is integrated within the mental health service. Staff are committed to the organisation, have expertise in change management and create an environment that allows innovation.

Table 1: Leadership and Organisational Capability

	Strongly Agree	Agree	Disagree	Strongly Disagree
Long-term planning for quality improvement gets lost in the day-to-day	233	619	233	32
There is no support to deliver service changes	146	366	548	57
There is no clear vision of what it is that the organisation is trying to achieve	187	352	480	98
There are lots of quality improvement initiatives, but little real change	94	399	323	38
The first we know of quality improvements elsewhere in the organisation is when we feel their effects	49	422	355	28
Service improvements tend to be crisis-led	213	500	367	37
Quality improvement is imposed from above rather than built from below	174	527	374	42
People share a common vision of service delivery	47	308	363	136
There is mutual respect for everyone's contribution	102	559	331	125
There is pressure to 'solve' problems quickly rather than take time and do it properly	167	514	403	33
People don't seem to have shared service goals	123	449	484	61
People don't know about good practice taking place in other parts of the organisation	100	467	269	18
Immediate pressures are always more important than quality improvement	205	446	182	21
Quality improvement activity is largely a response to external pressure	122	407	292	33
People are motivated to improve quality	78	629	336	74
People are forced into making service changes, rather than encouraged to make them	167	486	427	37
People are highly motivated to make changes to clinical practice	45	342	392	75
The Executive / Management Team is proactive in addressing cultural issues	77	591	318	131
There is a positive, characteristic management style and a distinct set of management practices	88	508	351	170
The Director and Managers “practice what they preach”	90	528	335	164

Note - Shaded rows denote where questions were answered by clinical staff only (854 responses)

Figure 5: Overall Clinical Responses by Percentage - Leadership and Organisational Capability - Clinical Responses

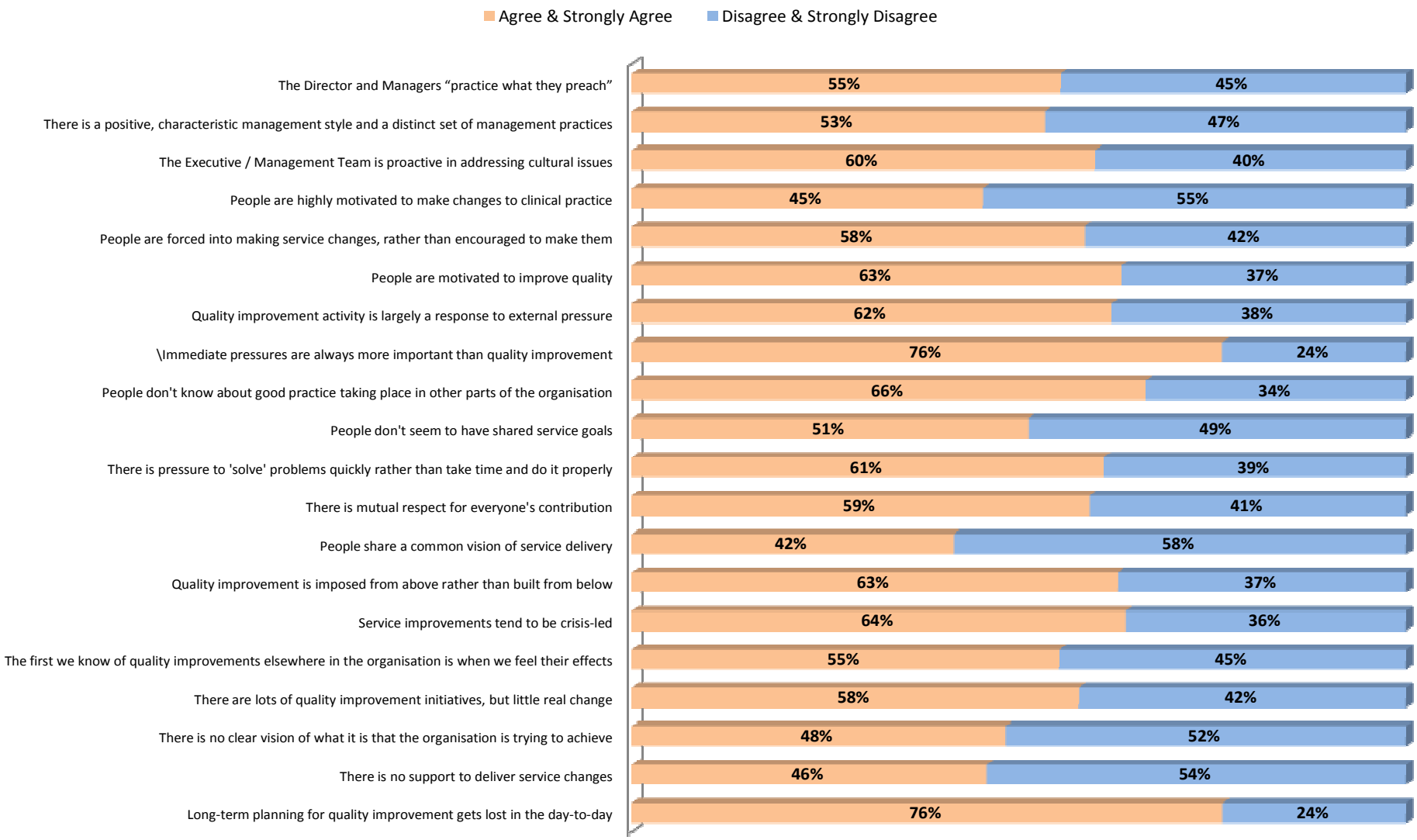


Table 2: Responses by Profession - Leadership and Organizational Capability

	LEADERSHIP & ORGANISATIONAL CAPABILITY	Medical (n = 105)	Nursing (n = 427)	Clin Psych (n = 98)	Social Work (n = 89)	Occupational Therapy (n = 89)	Other Clinical (n = 27)	Non Clinical (n = 275)
18	Long-term planning for quality improvement gets lost in the day-to-day	71%	82%	70%	78%	81%	73%	70%
24	There is no support to deliver service changes	59%	51%	67%	56%	57%	64%	58%
25	There is no clear vision of what it is that the organization is trying to achieve	55%	57%	60%	52%	52%	70%	61%
29	There are lots of quality improvement initiatives, but little real change	56%	63%	56%	53%	67%	64%	
33	The first we know of quality improvements elsewhere in the organization is when we feel their effects	56%	59%	60%	56%	54%	61%	
34	Service improvements tend to be crisis-led	69%	72%	50%	58%	65%	58%	57%
36	Quality improvement is imposed from above rather than built from below	63%	74%	56%	52%	57%	55%	53%
39	People share a common vision of service delivery	54%	64%	56%	60%	56%	52%	
40	There is mutual respect for everyone's contribution	71%	54%	62%	64%	55%	58%	73%
41	There is pressure to 'solve' problems quickly rather than take time and do it properly	66%	67%	52%	57%	71%	58%	53%
46	People don't seem to have shared service goals	58%	61%	63%	56%	54%	61%	53%
48	People don't know about good practice taking place in other parts of the organization	58%	69%	59%	72%	69%	61%	
50	Immediate pressures are always more important than quality improvement	73%	77%	73%	75%	82%	70%	
51	Quality improvement activity is largely a response to external pressure	54%	69%	52%	58%	56%	55%	
57	People are motivated to improve quality	76%	53%	81%	65%	66%	79%	65%
59	People are forced into making service changes, rather than encouraged to make them	57%	67%	52%	61%	61%	58%	50%
60	People are highly motivated to make changes to clinical practice	53%	64%	67%	52%	56%	55%	
63	The Executive / Management Team is proactive in addressing cultural issues	59%	56%	58%	52%	51%	55%	73%

LEADERSHIP & ORGANISATIONAL CAPABILITY		Medical (n = 105)	Nursing (n = 427)	Clin Psych (n = 98)	Social Work (n = 89)	Occupational Therapy (n = 89)	Other Clinical (n = 27)	Non Clinical (n = 275)
66	There is a positive, characteristic management style and a distinct set of management practices	56%	57%	61%	52%	57%	67%	68%
67	The Director and Managers "practice what they preach"	67%	56%	61%	60%	53%	73%	66%

Items shaded grey are clinical questions only and were not asked of the non-clinical staff

Key: Agree / Strongly Agree Disagree / Strongly Disagree

Summary – Leadership and Organisational Capability

The link between leadership and organisational culture and hence organisational capability has been extensively researched with the results indicating that strong leadership plays a significant role in staff satisfaction and performance and subsequently positive outcomes for patients (Casida & Pinto-Zipp, 2008; Daulatram, 2003; Denison & Mishra, 1995). If there is to be an improvement in service provision it is essential that we have a good understanding of the relationship between organisational culture, leadership behaviour and the job satisfaction of employees (Tsai, 2011). The Leadership and Organisational factor of the survey is focused on understanding just that.

The Leadership and Organisational Capability pillar consists of 20 items. Two of the items rated positively with the remaining 18 items receiving a 40% or higher negative response from respondents.

While 63% of respondents positively agreed with the statement "people are motivated to improve quality" and 60% of respondents reported that the Executive Management Team (the Team) "is proactive in addressing cultural issues" responses to the remaining 19 items suggest that MHS need to have a continued focus on this pillar.

In relation to how the Team is seen by the staff just over half of the respondents did not believe that they "practice what they preached" and while 53% reported there was "a positive, characteristic management style and a distinct set of management practices" 47% did not agree with the statement suggesting that MHS still have some work to complete in this area.

As can be seen from Figure 5 and Table 2 staff hold the perception that long term planning for Quality Improvement gets lost in the day to day operational requirements and that service improvements are often crisis led and imposed upon staff rather than being encouraged as part of everyday practice.

Staff also reported feeling pressure to resolve issues quickly which in turn may lead to the outcomes being less than optimal. Such pressures are often perceived as being applied externally and although it may lead to reactive change it is often not sustainable as it has not been instituted from within and on the basis of sound data and informed decision making.

In relation to changes within the organisation respondents were divided on the issue of there being "mutual respect for everyone's contribution", "people sharing a common vision of service delivery" and "the first we know of quality improvement elsewhere in the organisation is when we feel their effects". These results suggest that some MHS need to continue to work on ensuring that quality improvement in embedded in everyday clinical practice and is the responsibility of all staff and not just those who may have a particular interest in a specific practice area.

Recommendations

1. MHS continue to ensure that strong leadership is embedded at every level in the operational structure of the organisation.

CLINICAL RISK MANAGEMENT

Effective implementation of risk management systems, policies and procedures requires local leadership from both clinicians and managers. There needs to be clear understanding of the MHS objectives for risk management and effective reporting and dissemination of results.

Table 3: Clinical Risk Management - Responses from Staff

	Strongly Agree	Agree	Disagree	Strongly Disagree
When things go wrong, there is an automatic assumption that 'someone is to blame'	123	363	507	124
Error reporting systems are basically a stick to beat clinicians with	55	186	710	166
People involved in clinical incidents are made to feel guilty	53	176	513	112
It is unsafe to be open and honest with colleagues	100	264	604	149
The emphasis is on how an incident happened, not who made the mistake	95	526	200	33
People who make mistakes are supported	77	667	316	57
We collect information on clinical risks	110	602	119	23
When there is an error, we look for failures in systems rather than blame individuals	84	660	313	60
Identified clinical risks simply remain unaddressed	85	213	479	77
Clinical risks are examined in a systematic way	45	523	232	54
We work in an atmosphere of blame	88	238	616	175
We don't collect information on the clinical risks that matter most	60	210	506	78
There is no common approach to risk management	75	287	436	56
When a clinical risk is identified, there is always action to address it	48	443	302	61
We systematically assess clinical risks	61	482	275	36
We don't address the accidents waiting to happen	142	385	536	54
Clinical risk policies are shared throughout the organisation	52	545	226	31
Clinical risk information is used routinely to inform decisions	47	517	256	34
Risk assessment processes are updated in the light of clinical incidents	70	583	172	29
When something fails, it is used as a learning opportunity	72	709	277	59
We react to problems, rather than try to prevent them	171	481	417	48

Note - Shaded rows denote where questions were answered by clinical staff only (854 responses)

Figure 6: Overall Clinical Responses by Percentage - Clinical Risk Management

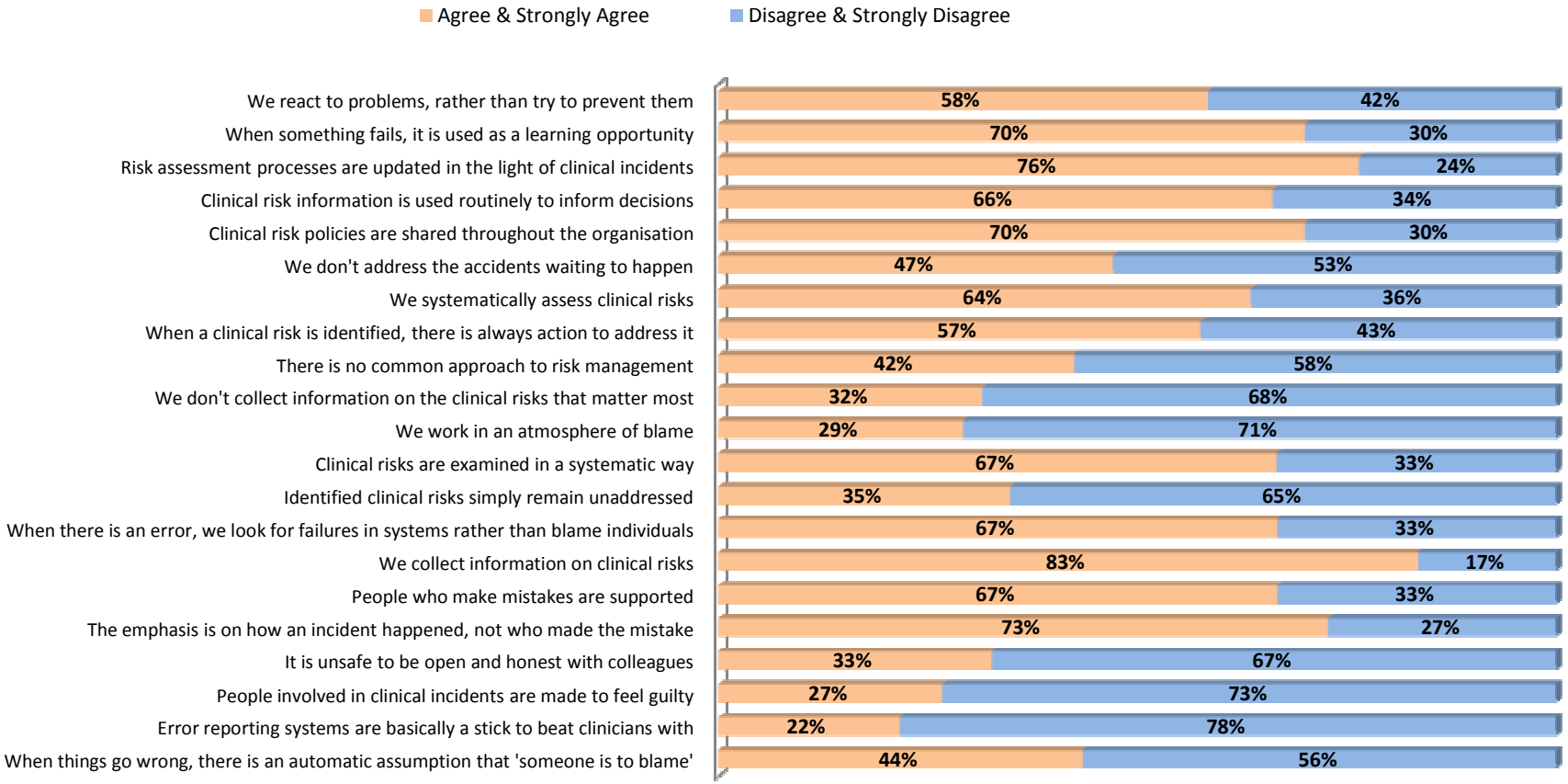


Table 4: Responses by Profession - Clinical Risk

CLINICAL RISK		Medical (n = 105)	Nursing (n = 427)	Clin Psych (n = 98)	Social Work (n = 89)	Occupational Therapy (n = 89)	Other Clinical (n = 27)	Non Clinical (n = 275)
1	When things go wrong, there is an automatic assumption that 'someone is to blame'	61%	59%	77%	70%	58%	73%	64%
3	Error reporting systems are basically a stick to beat clinicians with	75%	68%	90%	91%	75%	97%	86%
5	People involved in clinical incidents are made to feel guilty	73%	67%	85%	89%	67%	76%	
10	It is unsafe to be open and honest with colleagues	75%	60%	74%	75%	69%	79%	68%
11	The emphasis is on how an incident happened, not who made the mistake	82%	64%	84%	87%	69%	85%	
12	People who make mistakes are supported	66%	56%	76%	87%	60%	76%	75%
14	We collect information on clinical risks	84%	81%	85%	91%	79%	88%	
16	When there is an error, we look for failures in systems rather than blame individuals	75%	54%	82%	81%	61%	85%	73%
21	Identified clinical risks simply remain unaddressed	74%	55%	79%	80%	67%	73%	
22	Clinical risks are examined in a systematic way	73%	64%	69%	72%	61%	73%	
26	We work in an atmosphere of blame	73%	59%	86%	89%	62%	82%	78%
27	We don't collect information on the clinical risks that matter most	75%	62%	83%	78%	64%	73%	
30	There is no common approach to risk management	53%	51%	72%	74%	56%	61%	
35	When a clinical risk is identified, there is always action to address it	59%	50%	69%	67%	61%	76%	
37	We systematically assess clinical risks	66%	59%	71%	73%	62%	76%	
42	We don't address the accidents waiting to happen	55%	57%	72%	58%	51%	64%	57%
43	Clinical risk policies are shared throughout the organization	68%	69%	70%	78%	64%	76%	

CLINICAL RISK		Medical (n = 105)	Nursing (n = 427)	Clin Psych (n = 98)	Social Work (n = 89)	Occupational Therapy (n = 89)	Other Clinical (n = 27)	Non Clinical (n = 275)
52	Risk assessment processes are updated in the light of clinical incidents	83%	72%	81%	85%	71%	82%	
54	When something fails, it is used as a learning opportunity	76%	58%	84%	83%	64%	79%	78%
56	We react to problems, rather than try to prevent them	56%	67%	57%	54%	57%	55%	54%

Items shaded grey are clinical questions only and were not asked of the non-clinical staff

Key: Agree / Strongly Agree Disagree / Strongly Disagree

Summary – Clinical Risk Management

The Clinical Risk Management pillar has a total of 21 items associated with it. Fifteen of the items rated positively with the remaining 6 receiving a 40% or higher negative response from respondents.

The blame culture, identified and reported in previous Clinical Governance Reviews, conducted by the Chief Psychiatrist, appears to have shifted and a more "just culture" approach having been instilled. Despite this nursing staff were divided in their responses in relation to blame with 59% of nursing staff agreeing with the statement "When things go wrong, there is an automatic assumption that 'someone is to blame'". This is contrasted by their responses to the items below:

- Sentinel event reporting systems are basically a stick to beat clinicians with (68% disagreed)
- People involved in clinical incidents are made to feel guilty (67% disagreed)
- The emphasis is on how an incident happened, not who made the mistake (64% Agree)
- People who make mistakes are supported (56% Agree)

This suggests that MHS need to further instil the concept of a "just culture[1]".

In table 3 and 4 and Figure 6 respondents indicated that system learning is occurring and sighted the collection of clinical risk information to inform decisions, the sharing of risk policies across the MHS and the use of clinical incident data to improve clinical processes as examples of increased system awareness.

Responses also indicate that clinicians seeing the value in error reporting, feeling safe in reporting mistakes, and recognising that errors are being examined in a systemic rather than an individual context. There is an increased emphasis on how the incident occurred rather than who made a mistake.

There remains, however, a perception that MHS are reactive rather than proactive in relation to addressing some problems within the system with respondents being divided in their response to items related to addressing accidents that are seen as "waiting to happen". This is further highlighted with respondents reporting that while there is a systemic approach to assessing clinical risk there is not always an action to address the risk with 491 agreeing with the statement "When a clinical risk is identified, there is always action to address it" and 391 disagreeing.

Table 4 highlights the consistency of professional responses to clinical risk items. Responses were consistent with the exception of three items including:

- We don't address the accidents waiting to happen
- When things go wrong, there is an automatic assumption that 'someone is to blame'

All professions, other than nursing staff, disagreed with both of the above items. 59% and 57% of nursing staff respectively agreed that we don't address accidents waiting to happen and that when things go wrong there is an automatic assumption that 'someone is to blame'.

- We react to problems, rather than try to prevent them

All professions, except clinical Psychology and other Clinical, agreed that we react to problems, rather than try to prevent them. 57% and 55% of Clinical Psychologist and Other Clinical staff respectively disagreed with this statement.

Recommendations

2. MHS develops internal clinical risk audit processes to ensure that changes in clinical practice are data supported and sustainable.
3. The MHS develops a system level response of a 'just culture'[1].

1."Just Culture" - A culture that recognizes that competent professionals make mistakes and acknowledges that even competent professionals will develop unhealthy norms (shortcuts, "routine rule violations"), but has zero tolerance for reckless behaviour. media.mycarenet.org/2010AQR/faq-and-glossary/glossary.html

CLINICAL PERFORMANCE AND EVALUATION – RESEARCH AND EFFECTIVENESS

Clinical effectiveness can be achieved when the best available clinical knowledge, evidence and information are made accessible to healthcare professionals who have day-to-day responsibility for planning, implementing and monitoring patient care

Table 5: Research and Effectiveness - Responses from Staff

	Strongly Agree	Agree	Disagree	Strongly Disagree
Good practice ideas are shared with others outside the organisation	102	612	348	55
We have protected time for quality improvement activity	46	313	558	200
We work together across teams to make quality improvements	101	573	333	110
Good practice stays isolated in pockets	102	368	335	49
People share practice issues with others in different parts of the organisation	39	487	277	51
Teams from different parts of the organisation share their good practice	30	377	381	66
People devote time to disseminating good practice	34	317	449	54
There is no time to get together to share ideas	156	465	446	50
There is time to reflect on practice	53	343	346	112
Information is widely shared so that everyone can get the information he or she needs when it is needed	81	593	346	97
Confidentiality is observed when communicating sensitive material	238	726	120	33

Note - Shaded rows denote where questions were answered by clinical staff only (854 responses)

Figure 7: Overall Clinical Responses by Percentage - Research and Effectiveness

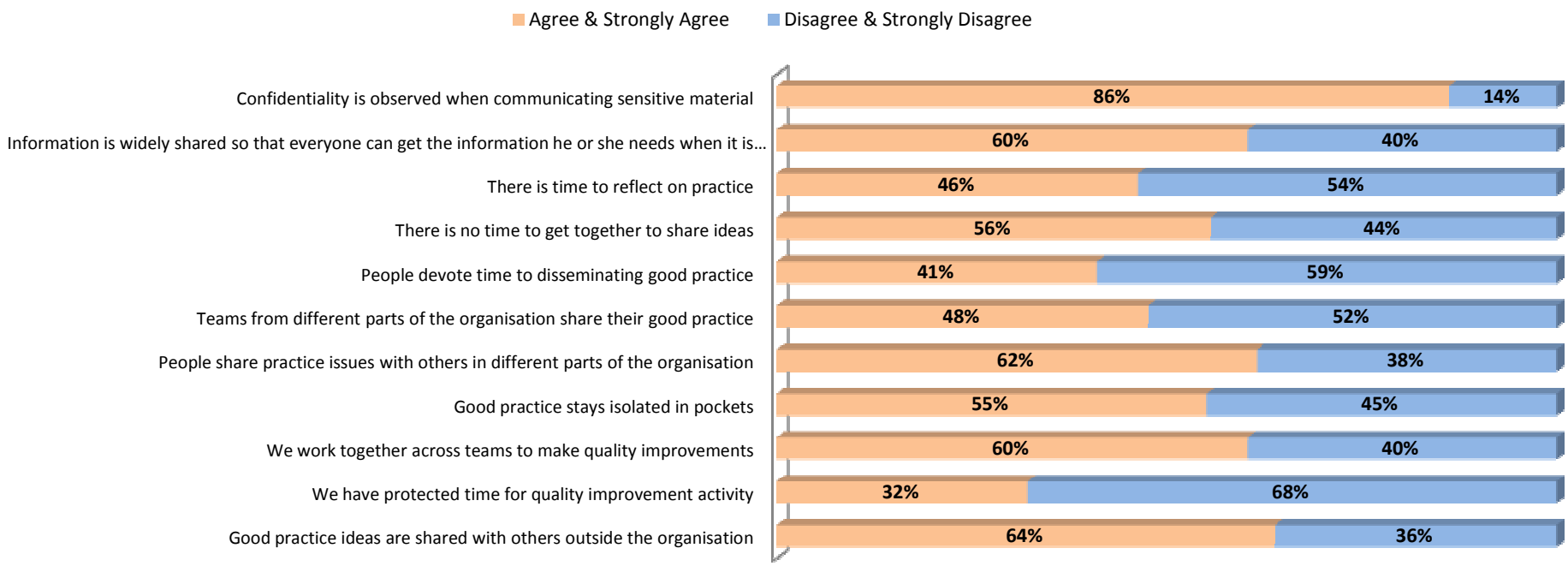


Table 6: Responses by Profession – Research and Effectiveness

RESEARCH AND EFFECTIVENESS		Medical (n = 105)	Nursing (n = 427)	Clin Psych (n = 98)	Social Work (n = 89)	Occupational Therapy (n = 89)	Other Clinical (n = 27)	Non Clinical (n = 275)
2	Good practice ideas are shared with others outside the organization	75%	56%	76%	70%	63%	61%	71%
9	We have protected time for quality improvement activity	66%	74%	55%	72%	79%	55%	60%
13	We work together across teams to make quality improvements	67%	50%	62%	58%	54%	67%	75%
20	Good practice stays isolated in pockets	54%	64%	65%	51%	54%	52%	
23	People share practice issues with others in different parts of the organization	73%	58%	65%	63%	62%	61%	
31	Teams from different parts of the organization share their good practice	56%	58%	57%	53%	52%	52%	
32	People devote time to disseminating good practice	53%	66%	60%	53%	61%	58%	
38	There is no time to get together to share ideas	50%	60%	56%	53%	60%	52%	54%
47	There is time to reflect on practice	51%	56%	54%	54%	57%	58%	
64	Information is widely shared so that everyone can get the information he or she needs when it is needed	69%	51%	66%	58%	55%	67%	71%
65	Confidentiality is observed when communicating sensitive material	89%	83%	90%	91%	85%	85%	88%

Items shaded grey are clinical questions only and were not asked of the non-clinical staff

Key: Agree / Strongly Agree Disagree / Strongly Disagree

Summary – Clinical Performance and Evaluation
Research and Effectiveness

The Research and Effectiveness Area of Inquiry consists of 11 items. Four of the items rated positively with the remainder receiving a higher than 40% negative response from participants.

733 (86%) of participants reported that confidentiality was observed when communicating sensitive information.

Responses indicate that the most significant issue, in this domain, is the lack of protected time that clinicians have to engage in quality improvement activities and this applied to all professions. Although it could be argued that quality improvement activities should be embedded into everyday clinical practice, therefore not requiring protected time, this may be an unrealistic target for MHS that are only just starting to embrace a continuous quality improvement model.

Coupled with the above respondents did not believe they had sufficient time to reflect on their current practice despite wanting to make changes to improve clinical practices. The latter was consistent across all professions. Respondents, did however, report that where good practice exists it is shared with others in different sections of the organisation. Medical staff, while reporting that good practice was shared within the organisation they did not agree that "good practice ideas are shared with others outside the organization".

Recommendations

4. The MHS ensures that all professions and clinical teams have allocated time to reflect on their clinical practice.

PROFESSIONAL DEVELOPMENT AND MANAGEMENT – STAFFING AND STAFF MANAGEMENT

To get the best from staff and maximise their contribution to an organisation, it is essential that the right staff are doing the right job with the right skills and support.

Table 7: Staffing and Staff Management - Responses from Staff

	Strongly Agree	Agree	Disagree	Strongly Disagree
People have a good knowledge of the skills of their colleagues	93	677	279	68
Colleagues are dishonest with each other	46	209	686	176
People don't know what their colleagues expect of them	48	357	651	61
Colleagues don't seem to understand each others role's	81	354	594	88
Everyone has the same standing, regardless of professional background	92	352	433	240
A bullying culture exists	169	249	505	194
Fear of reprisal stops staff from raising concerns	183	331	479	124

Figure 8: Overall Clinical Responses by Percentage - Staffing and Staff Management

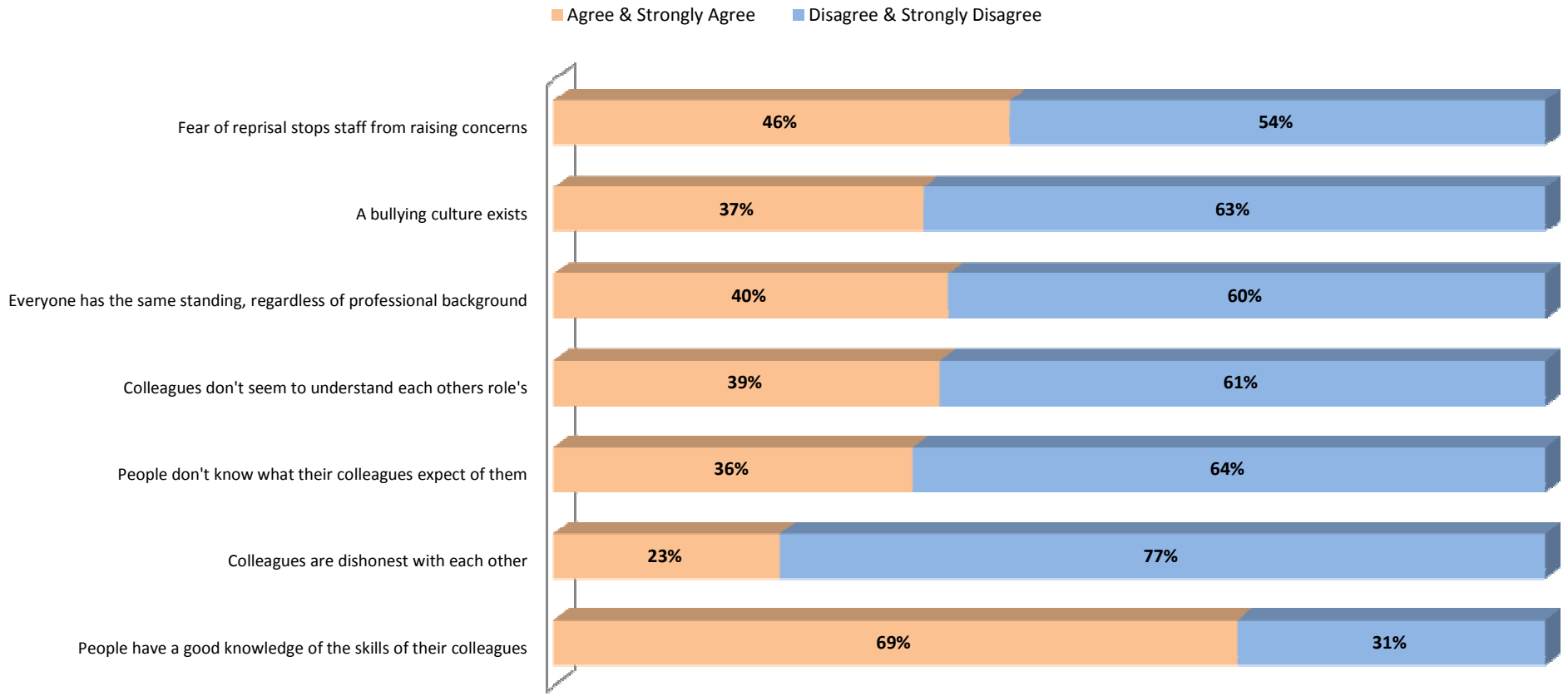


Table 8: Responses by Profession – Staffing and Staff Management

STAFFING AND STAFF MANAGMENT		Medical (n = 105)	Nursing (n = 427)	Clin Psych (n = 98)	Social Work (n = 89)	Occupational Therapy (n = 89)	Other Clinical (n = 27)	Non Clinical (n = 275)
8	People have a good knowledge of the skills of their colleagues	72%	66%	80%	72%	65%	73%	69%
19	Colleagues are dishonest with each other	84%	70%	89%	88%	78%	79%	78%
45	People don't know what their colleagues expect of them	73%	60%	74%	65%	60%	67%	63%
53	Colleagues don't seem to understand each other's role's	75%	58%	70%	60%	57%	61%	59%
55	Everyone has the same standing, regardless of professional background	51%	68%	52%	62%	67%	70%	53%
61	A bullying culture exists	73%	52%	79%	71%	61%	64%	66%
62	Fear of reprisal stops staff from raising concerns	62%	58%	66%	62%	51%	70%	61%

Items shaded grey are clinical questions only and were not asked of the non-clinical staff

Key: Agree / Strongly Agree Disagree / Strongly Disagree

Summary – Professional Development and Management
Staffing and Staff Management

The Staffing and Staff Management Area of Inquiry consists of 7 items. Five of the items rated positively with the remainder receiving a higher than 40% negative response from respondents.

Responses indicate that the majority of staff knows what is expected of them; they have an understanding of other clinician's roles and have a good knowledge of the skills of their colleagues.

While 63% of respondents denied there was a bullying culture within MHS 37% still believed that a bullying culture remains in existence. This is consistent with the responses to the item "fear of reprisal stops staff from raising concerns" to which 46% agreed and 54% disagreed suggesting that there remains a unhealthy culture in some pockets of services MHS.

Although the majority of respondents (77%) indicated that their colleagues are honest with each other 60% disagreed with the statement "Everyone has the same standing, regardless of professional background" suggesting that model of professional silos remains active within MHS which inevitably leads to power struggles within the treating teams and overall MHS and is not in the best interest of the patient.

Recommendations

5. The MHS continues to actively work to maintain and improve an anti-bullying culture.
6. The MHS develops a multidisciplinary approach to treatment where all professions are valued and have strong professional roles within the governance of the team.

PROFESSIONAL DEVELOPMENT AND MANAGEMENT – EDUCATION, TRAINING AND PROFESSIONAL DEVELOPMENT

All staff should have the opportunity to become involved in training and development activities, research, development of reflective practice, peer supervision and building in protected time to allow individuals to keep up to date with their specialist areas.

Table 9: Education, Training and Professional Development - Responses from Staff

	Strongly Agree	Agree	Disagree	Strongly Disagree
Critical appraisal skills training is available to those who want it	25	417	350	62
Career development needs are addressed alongside strategic needs of the service	122	517	354	124
Staff appraisals are used to punish staff	24	72	731	290
Technical help with evidence based practice is available	39	438	316	61
Appraisal does not identify the real development needs of staff	120	505	453	39
There is no training available in searching for research evidence	93	368	352	41
Development needs are regularly assessed	53	439	514	111
There are few opportunities to use new skills learned as part of development	75	417	571	54
I have been provided with the opportunity to participate in clinical supervision	169	477	138	70
The clinical supervision model within the MHS is effective for me in my current role	122	393	245	94
The service considers clinical supervision to be an important aspect of staff support	144	436	191	83

Note - Shaded rows denote where questions were answered by clinical staff only (854 responses)

Figure 9: Overall Clinical Responses by Percentage - Education, Training and Professional Development

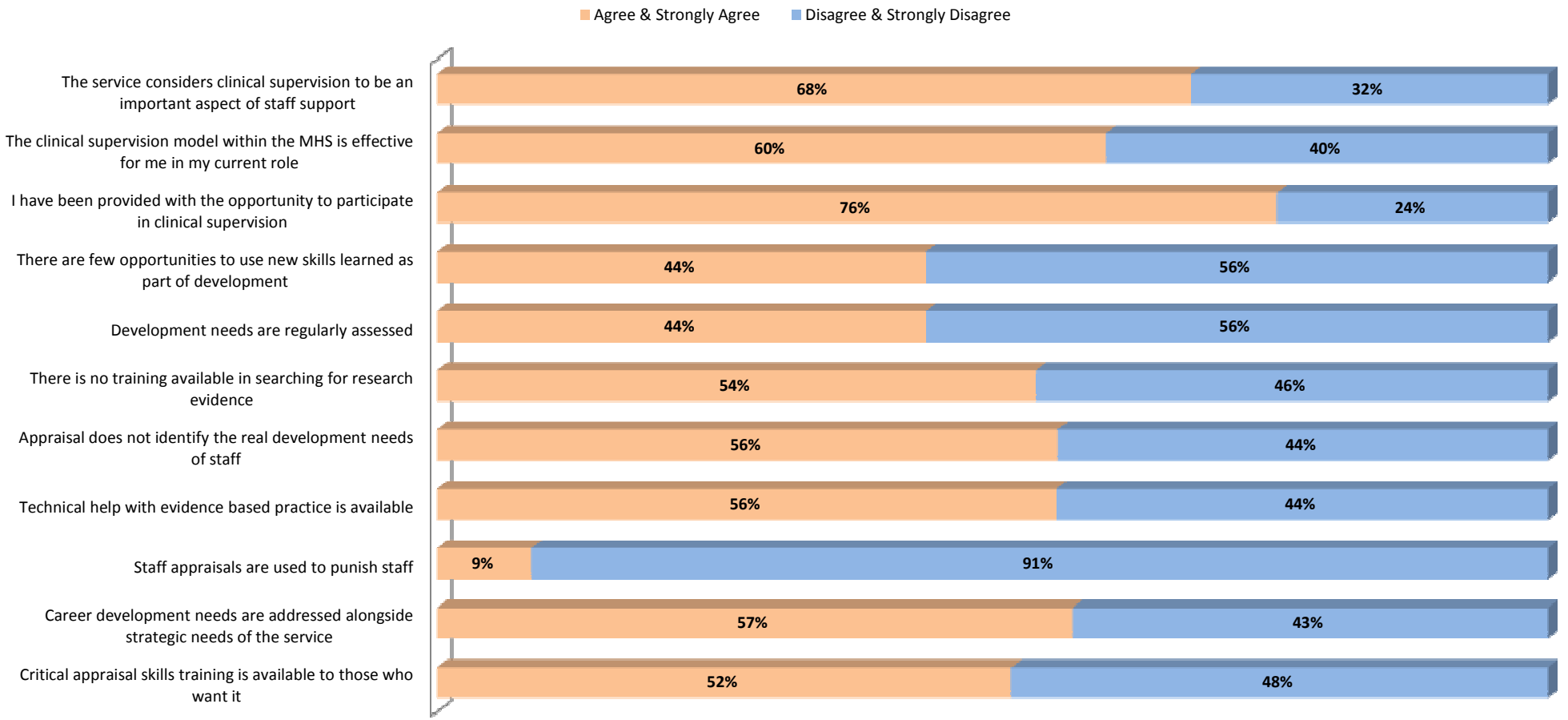


Table 10: Responses by Profession - Education, Training and Professional Development

EDUCATION, TRAINING & PROFESSIONAL DEVELOPMENT		Medical (n = 105)	Nursing (n = 427)	Clin Psych (n = 98)	Social Work (n = 89)	Occupational Therapy (n = 89)	Other Clinical (n = 27)	Non Clinical (n = 275)
4	Critical appraisal skills training is available to those who want it	53%	51%	58%	60%	56%	67%	
6	Career development needs are addressed alongside strategic needs of the service	61%	52%	67%	63%	53%	70%	66%
7	Staff appraisals are used to punish staff	90%	88%	96%	97%	88%	100%	95%
15	Technical help with evidence based practice is available	61%	52%	72%	55%	51%	61%	
17	Appraisal does not identify the real development needs of staff	64%	63%	59%	56%	56%	52%	52%
28	There is no training available in searching for research evidence	50%	59%	64%	60%	64%	58%	
49	Development needs are regularly assessed	58%	61%	51%	51%	64%	58%	52%
58	There are few opportunities to use new skills learned as part of development	63%	51%	74%	62%	51%	52%	59%
68	I have been provided with the opportunity to participate in clinical supervision	81%	66%	90%	89%	83%	82%	
69	The clinical supervision model within the MHS is effective for me in my current role	69%	53%	72%	74%	61%	55%	
70	The service considers clinical supervision to be an important aspect of staff support	76%	60%	83%	75%	69%	70%	

Items shaded grey are clinical questions only and were not asked of the non-clinical staff

Key: Agree / Strongly Agree Disagree / Strongly Disagree

Summary – Professional Development and Management
Education, Training and Professional Development

The Education, Training and Professional Development Area of Inquiry consists of 11 items. Four of the items rated positively with the remainder receiving a higher than 40% negative response from respondents.

Participants responded positively in relation to the three items concerned with Clinical Supervision. Traditionally the provision and uptake of Clinical Supervision has varied significantly by professional groups. The results of the current review indicate that MHS consider clinical supervision to be an important aspect of staff support (68% agreed), that clinical supervision models are effective (60% agreed) and that staff have been provided with the opportunity to participate in clinical supervision (76%). In examining the data by professions although still in the positive nursing had slightly lower positive responses than other professions. This may be the result of the Clinical Supervision model used in that they can engage in individual supervision, group supervision or peer review supervision, with the latter involving other professional groups.

While ninety percent of respondents disagreed that "staff appraisals are used to punish staff" they did however, report a lack of continuity between staff appraisals and the actual development needs of staff. This is further supported by 58% of respondents not agreeing with the statement that "development needs of staff were regularly assessed." Similarly only half of the respondents agreed that "career development needs are addressed alongside strategic needs of the service".

In relation to critical appraisal, technical and research skills respondents were split in their responses with 52% agreeing that critical appraisal skills training was available to staff who wanted it and 48% disagreeing that such training was available. Similarly, 56% reported that there was technical help with evidence based practice and 54% agreed that there was no training available to assist staff in searching for research evidence.

Recommendations

7. The MHS ensures that all staff has an annual staff appraisal and an associated relevant staff development plan.
8. The MHS ensures that all staff has access to training and support to assist with skills required for critical appraisal and quality improvement activities.

Recommendations

In light of the above findings the Chief Psychiatrist makes the following eight Recommendations.

1. MHS continues to ensure that strong leadership is embedded at every level in the operational structure of the organisation.

2. MHS develops internal clinical risk audit processes to ensure that changes in clinical practice are data supported and sustainable.

3. The MHS further develops a system level response of a 'just' culture'.

4. The MHS ensures that all professions and clinical teams have allocated time to reflect on their clinical practice.

5. The MHS continues to actively work to maintain and improve an anti-bullying culture.

6. The MHS develops a multidisciplinary approach to treatment where all professions are valued and have strong professional roles within the governance of the team.

7. The MHS ensures that all staff has an annual staff appraisal and an associated relevant staff development plan.

8. The MHS ensures that all staff has access to training and support to assist with skills required for critical appraisal and quality improvement activities.

References

Casida, J & Pinto-Zipp, G. (2008). Leadership-organisational culture relationship in Nursing units of acute care hospitals. **Nursing Economics**, 26(1):7-15.

Denison, DR & Mishra AK. (1995). Toward a theory of organisational culture and effectiveness. **Organisational Science**, 6:204-223.

Department of Health WA (2010). Chief Psychiatrist's Clinical Services Monitoring Program Clinical Governance Reviews: Clinical Governance Review Trends 2003 – 2009. Department of Health publication.

Lund, DB. (2003). Organisational culture and job satisfaction. **Journal of Business & Industrial Marketing**, 18(3):219-236.

Appendix A

ACTION PLAN FOR MENTAL HEALTH SERVICES

Action Plan Following Thematic Review Three

Clinical Governance Climate in WA MHS

Rec.	Recommendation	Action to Date	Further Action Required	Rec. Status
LEADERSHIP AND ORGANISATIONAL CAPABILITY				
1	MHS continues to ensure that strong leadership is embedded at every level in the operational structure of the organisation.	•	•	
CLINICAL RISK MANAGEMENT				
2	MHS develops internal clinical risk audit processes to ensure that changes in clinical practice are data supported and sustainable.	•	•	
3	MHS further develops a system level response of a 'just' culture'.	•	•	
CLINICAL PERFORMANCE AND EVALUATION – *RESEARCH & EFFECTIVENESS*				
4	MHS ensures that all professions and clinical teams have allocated time to reflect on their clinical practice.	•	•	
PROFESSIONAL DEVELOPMENT AND MANAGEMENT - *STAFFING & STAFF MANAGEMENT*				
5	MHS continues to actively work to maintain and improve an anti-bullying culture.	•	•	
6	MHS develops a multidisciplinary approach to treatment where all professions are valued and have strong professional roles within the governance of the team.	•	•	
PROFESSIONAL DEVELOPMENT AND MANAGEMENT - *EDUCATION, TRAINING & PROFESSIONAL DEVELOPMENT*				
7	MHS ensures that all staff has an annual staff appraisal and an associated relevant staff development plan.	•	•	
8	MHS ensures that all staff has access to training and support to assist with skills required for critical appraisal and quality improvement activities	•	•	