CDHB Staff Wellbeing Research Report

May 2017

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Introduction

Since the Canterbury earthquake sequence in 2010-2011, the Canterbury District Health Board [CDHB] has undertaken three employee wellbeing surveys – in 2012, 2014 and 2016. The results of the 2016 Staff Wellbeing Survey, in which over 4,042 employees [42% of all staff] participated, identified some key themes which the CDHB wanted to explore in greater depth through focus groups. To do so, CDHB partnered with Resilient Organisations Limited to run a series of focus groups exploring the complex nature of staff wellbeing.

In total, 12 focus groups and six individual or small group discussions were conducted with a wide range of staff from across a range of CDHB divisions, occupations and locations. Over 130 volunteers participated in these sessions. It should be noted that due to sample size and self-selection, the data collected through the focus groups are not representative of all views across the CDHB. However, they do provide a rich source of information on the factors affecting staff wellbeing.

This report represents an analysis of the 2016 Staff Wellbeing Survey, focus groups and interviews and other important data available from within the CDHB. The structure of this report is as follows:

Background and Context

Overview of the CDHB Wellbeing Survey 2012-2016
Wellbeing Survey 2016
Focus Group and Interviews

Findings: Challenges and Opportunities for Improvement

External Environment

- Earthquakes Impacts
- Demographic Changes
- Increasing Complexity of Health Needs
- High and Variable Demand
- MoH Targets and KPIs
- *Our Health System*

Work Environment

- Amenities and Infrastructure
- Leadership
- Workplace Processes
- Organisational Culture
- Staff Resources

Personal Environment

- My Mental Health
- My Physical and Psychological Safety
- My Job Performance
- My Work / Home Balance
- My Clarity and Confidence at Work

Summary

Background & Context

Overview of previous CDHB Wellbeing Surveys

The CDHB has conducted organisational-wide staff wellbeing surveys in 2012, 2014, and 2016. Approximately 2,100 staff members participated in the 2012 survey, 2,300 staff participated in the 2014 survey, and 4,042 people [42% of all staff] participated in the survey undertaken in July-August 2016.

Over time, information derived from these wellbeing surveys has assisted the CDHB to gauge the ongoing challenges faced by staff following the 2010-2011 earthquakes, and has highlighted areas in which the CDHB might direct focus and resource to assist staff with their recovery.

The results have led to the development of a variety of programmes and initiatives designed to support staff wellbeing, such as:

- regular access to experts in a range of fields, including practical advice on financial, legal and earthquake-related insurance issues;
- free confidential counselling [in the period since 2011, the CDHB has increased investment in counselling support programmes by 40%];
- sleep and shift work tips and the impact of fatigue; and
- a range of physical activity programmes.

In 2013 this work was recognised when the CDHB won the National Workplace Wellbeing Award for the best new wellbeing programme.

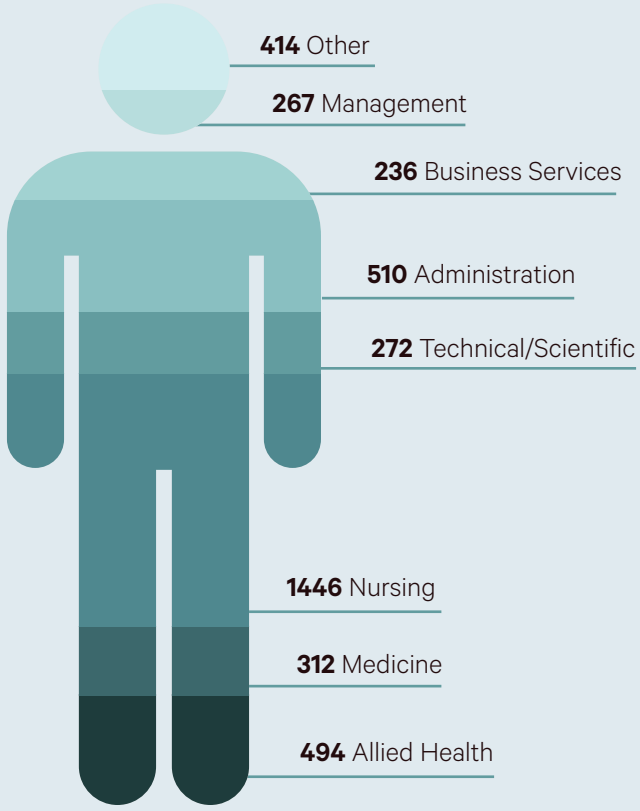
While the CDHB has made progress, there is an underlying, ongoing and strong commitment to continue to better the wellbeing of staff. It is recognised that doing more to support the wellbeing of the CDHB's people will increase work satisfaction, reduce stress and anxiety and, ultimately, improve the patient experience.

The information gained from the 2016 Staff Wellbeing Survey [the Survey] and the associated focus groups will inform the development of a comprehensive CDHB Staff Wellbeing Strategy that will help the CDHB continue to support the wellbeing of our people.

Wellbeing Survey 2016

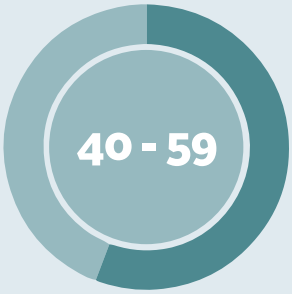
The Survey was an iteration of previous surveys conducted in 2012 and 2014. The increased response of staff [an increase of over 1,600 people from 2014] indicates the increasing awareness of wellbeing as an issue pertinent to staff, an increasing commitment to communicating these issues, and a confidence that the organisation will respond to the priorities that people identify.

4042 respondents in total



91 people did not answer this question

40% of respondents have only experienced post-quake CDHB



55% of respondents were **40-59** years of age

Key Findings

The Survey provided timely insight into the wellbeing needs, priorities and opportunities of an unprecedented number of respondents. The Survey and subsequent focus groups have helped to develop a clearer picture of the actions required to further enhance wellbeing.

The results of the Survey bear out that there are things that are working well, and that staff continue to face challenges, both in their personal and professional environments.

Despite all the challenges staff have faced since the major earthquakes of 2010 and 2011, the vast majority of survey respondents feel engaged and fulfilled. 89 per cent feel they make a contribution to the success of the CDHB; just one per cent disagree, while another 10 per cent neither agree nor disagree. In response to a question about the extent to which their work is fulfilling, 74 per cent feel their job is fulfilling. What is abundantly clear is that the CDHB's people are highly engaged, they find their jobs fulfilling, and they want to be part of solutions. This is an ideal environment for taking a broader approach to supporting staff wellbeing.

89% feel they are making a contribution to the success of CDHB

74% feel their job is fulfilling

65% feel the CDHB supports them to work in keeping with their professional values

The Survey identified opportunities to improve staff wellbeing and organisational resilience. Areas for improvement identified in the Survey are shown below.

32% of CDHB staff continue to be reporting poor emotional wellbeing

38% report excessive workloads

35% report not feeling valued

30% report poor physical work conditions

30% report increased administration and compliance duties

29% report poor communications

Focus Group and Interviews

Focus Group Structure

Following the increased response to the Survey, the CDHB decided to explore the findings in further depth. To do this, all staff were provided the opportunity to volunteer to be participants in wellbeing focus groups.

Two hundred and fifty staff volunteered to participate in the focus groups. From those volunteers, 12 focus groups of 8-12 staff were formed based on availability and division or professional group. In addition, there were six individual or small group discussions with senior members of staff. The makeup of the focus groups is summarised below:

Makeup of 2016 Focus Groups

Where	Who
Ashburton	Ashburton and Rural
Chch Campus 1	Cross Campus Services
Chch Campus 2	Women's and Children's
Chch Campus 3	Medical Services
Chch Campus 4	Surgical Services
Burwood	Older Persons Health and Rehabilitation
Princess Margaret Hospital	Older Persons Health and Rehabilitation
Oxford Tce 1	Non clinical
Oxford Tce 2	Non clinical
Oxford Tce 3	Nursing
Hillmorton	Specialist Mental Health Service
Princess Margaret Hospital	Specialist Mental Health Service

The focus groups covered a range of divisional and service groupings. It should be noted that due to relative size and number of focus groups, and the self-selecting nature of participation, the findings are not representative of all CDHB staff. While the number of focus groups relative to the size of the organisation could be considered low, there was a sufficient level of consistency and repetition of information drawn from the focus groups to suggest that a larger number of focus groups would not have added significantly to the findings.

Focus group findings illustrate that while each staff member experiences wellbeing individually, there are a number of themes which are shared. These are discussed in greater detail below.

FINDINGS:
Challenges and Opportunities For Improvement

Summary

Wellbeing is a complex and wide ranging construct which is impacted by many things across many settings.

The focus groups and interviews explored the main drivers and factors influencing staff wellbeing. What emerged from these conversations was that there is a range of environments that shape staff wellbeing:

The focus to further enhance staff wellbeing is to design strategies that influence the external and work environments, in addition to building on the successes already achieved through a wellbeing programme focused at the individual level [personal environment].

Specific themes to emerge from the focus groups with the potential to positively impact on staff wellbeing can be summarised by the following statements:

- Acknowledge I'm under more pressure than ever before as I do my best for patients and the system.
- Lead and manage me consistently, and give me every opportunity to impact decisions.
- Continue to ensure that decision-making puts people [including me] at the centre.
- I need technology that helps me do my job well, making it easier.
- Give me more autonomy at work, and simplify our bureaucratic processes that can waste my time.
- Clearly communicate not only the big picture but the things that are directly relevant to me.

Focus groups participants working at the Christchurch campus identified a unique set of challenges, including overcrowding, ongoing repairs, noise and uncertainty, distance between services and facilities, and a lack of parking. Factors identified elsewhere in the CDHB included the amount of change post-quake, the speed of change and its overlapping nature; high caseloads and delivering services in substandard facilities [Specialist Mental Health Services]; limited and variable access to services [Ashburton and Rural]; and uncertainty over how previously separate services would best integrate and work together [new Burwood campus].

The themes above have the potential to have a positive impact on staff wellbeing across the organisation. However, consideration will also need to be given to more specific opportunities in particular parts of the organisation.

Fundamental to realising the wellbeing opportunity defined by the key findings and themes is leadership that is distributed more broadly and deeply throughout the organisation. Leaders, managers and staff must also be enabled by processes that are simpler, easier and more integrated so time is not wasted, and they need to be supported with the appropriate capability and resources to achieve the vision for *Our Health System.*

It is also clear that there is a strong desire from people to be involved in coming up with solutions and ways to continue to make things better.

While many specific opportunities have emerged that the CDHB can address [such as making processes simpler, easier and more integrated], there are other things for which the fix is not so obvious. For example, the national focus on targets has been identified in focus groups as having a detrimental impact on wellbeing. While there was an acknowledgement that the right targets can provide focus in terms of service delivery, there needs to be a focus on managing and mitigating the negative unintended impacts of targets that may not reflect the provision of health care in the Canterbury context.

The illustration below depicts the environments and factors impacting on staff wellbeing.

The remainder of this report presents findings from focus group conversations, organised by the *environment* to which they relate.

The External Environment

The External Environment refers to the community where staff and patients live, and the broader Ministry of Health [MoH] and Canterbury Health System and CDHB systems.

Summary

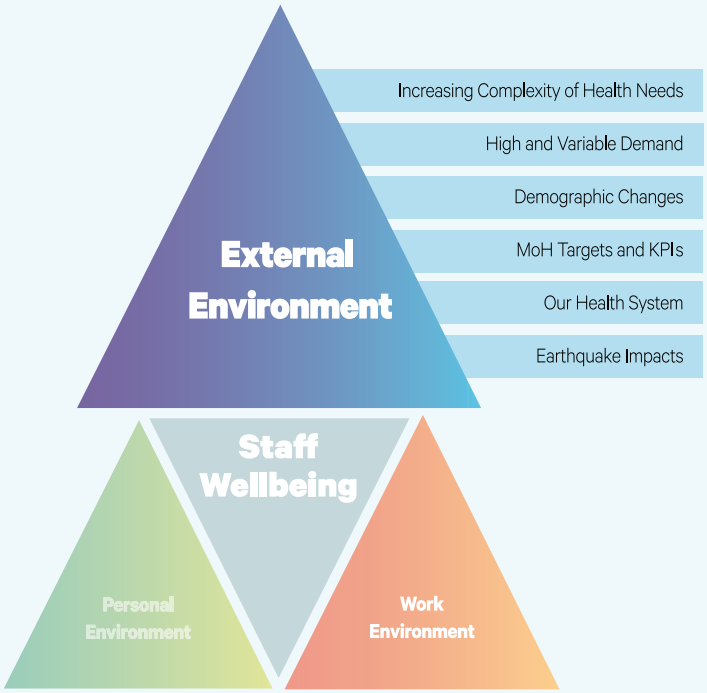
There are a number of external factors impacting the CDHB operating environment. The Canterbury earthquakes and their far-reaching effects have impacted many of the over 9,500 people that are employed by the CDHB and the 9,000 others who work across the Canterbury health system. They have also resulted in significant damage to CDHB facilities, brought about unparalleled disruption to many services, and adversely affected the health of the communities the CDHB serves.

In addition, demographic changes are also putting pressure on the Canterbury health system. The Canterbury population is older than the New Zealand average, and it includes the largest total number of people aged over 65 cared for by any DHB in the country. Canterbury also has a rapidly growing population.

Both earthquakes and changing demographics are putting pressure on CDHB staff and services, specifically in the form of high and variable demand and increasing complexity of health needs in an environment that remains significantly constrained.

For the purpose of focus group discussions, the external environment was also defined as including entities that regulate and fund, provide or administer health services. Staff members who participated in the focus groups discussed the impact that shifting institutional systems and pressures had on their wellbeing, including pressures to meet Ministry of Health targets and KPIs, and the ongoing focus on integrating services across the Canterbury health system.

While it is not possible or realistic to remove or ignore measures such as targets, it is evident that we need to explore ways to manage and mitigate any of their unintended impacts.



High and Variable Demand for Services

Participants identified a number of external causes for increased and changeable workloads. The impact of the Canterbury earthquakes has created dramatic increases for some services in particular, including but not limited to mental health and related services. One focus group addressed the emerging demographic issues, including an ageing population, and the effect that could have on the capacity of the CDHB in the future.

Increasing Complexity of Health Needs

Focus group participants discussed ageing populations, consumer expectations of care, chronic conditions and co-morbidity as factors creating an increasingly complex health service environment. It was also noted that patients are increasingly stressed and strained, in part due to the built-up stresses from the earthquakes. Focus group participants cited this as all adding to workload pressures. Participants involved in mental health care noted the increased complexity of their patients and the increasing need for security, exacerbating the burden on staff.

Pressures to Meet Ministry of Health Targets and KPIs

A common stressor for staff related to institutional monitoring and evaluation obligations, specifically ESPIs [Elective Services Performance Indicators] and Key Performance Indicators [KPIs] on the work environment. First, some participants expressed this in terms of the impact on leaders and their resulting behaviours. For example, concerns were raised that decisions may be perceived as being made for the benefit of performance indicators rather than holistic care. Participants expressed concern that this approach has the potential for undesirable outcomes for patients. Additionally, some respondents cited concern at the belief that units and departments that do not meet targets risk losing funding, the threat of which puts them under additional stress and pressure. This leaves leaders, managers and staff knowing that despite their best endeavours, it may be made even harder for them.

It was reported by some that staff feel particularly stressed by these institutional monitoring and evaluation drivers, and feel they do not have time to provide the care they would like to for patients. Some felt the speed which patients are expected to be moved through the system is unrealistic. Such time pressure feels at odds with their core values of delivering high quality patient care, and creates a high stress environment for these individuals. Others feel that increasingly challenging performance targets are at the expense of staff wellbeing. Many participants felt that the funding for health care was simply inadequate.

Our Health System

There were high levels of support expressed for the vision of *Our Health System* – a more people-centred, community-focused and integrated approach. It was acknowledged however that the earthquakes and ongoing disruption had not only placed pressure on the hospital system, but also on primary care and a range of other services critical to the broader Canterbury health system.

It was also apparent that despite the significant work done to date, there remain a range of opportunities for collaborating across the health system in Canterbury to ensure that people stay well in their homes and that tertiary-level care is reserved for those who need it most. For instance, some clinical staff felt they were still receiving patients who did not need to present at hospital, partly driven by an ageing population and limited capacity in aged residential care.

Some participants also felt that the *Our Health System* process of integration, on top of disruptions caused by the earthquakes, has caused a sometimes overwhelming level of change for staff to negotiate in their day-to-day work.

Possible Solutions: External Environment

Focus group participants identified some solutions to the problems emerging from the external environments. The majority of these solutions focused on increasing healthcare resources in order to manage the flow of patient volumes and workload. Such an approach would require increasing resources for managing patients in the community, but also for increased advocacy and education on patient care options and self-care.

What was clear from many respondents was that the transformational pathway that CDHB has embarked on over nearly ten years toward a patient and community centred healthcare system has gone a long way to managing patient volumes and complexity. Notwithstanding, the focus group results suggest that some extra effort in a number of areas is required to help address some of the workload issues being faced.

To the extent possible, a co-creative approach to target setting would be beneficial for staff wellbeing. As noted above, Ministry of Health targets and KPIs put pressure on leaders, managers and staff. Targets reportedly led to undesirable outcomes where targets drive decisions; and processes based on these targets cause stress for staff who feel that they are not caring adequately for patients. Staff reported that they do not have control over this process and that makes them feel vulnerable and under-valued. Greater staff input into target setting may counteract some of these negative outcomes.

The Work Environment

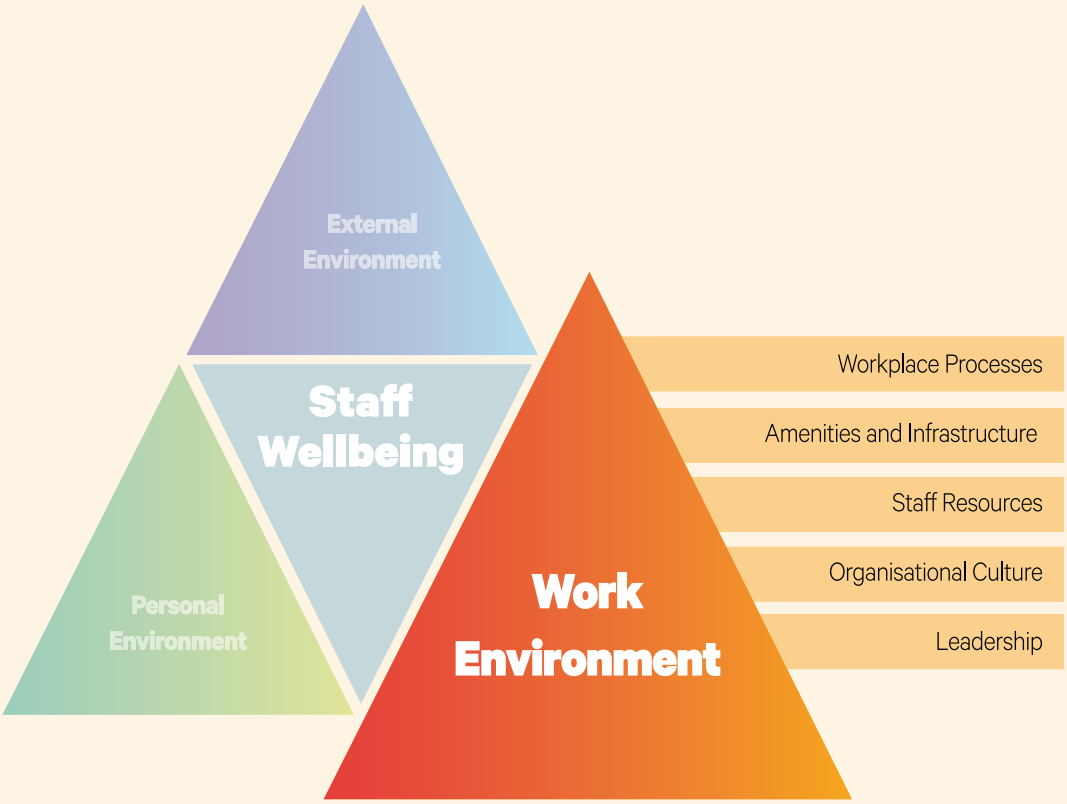
Earthquakes resulted in **14,000** damaged rooms in **200** buildings

40 buildings have either been demolished or will be

50% of clinical services will have moved four times

Summary

Analysis from the focus groups has been grouped into five themes related to staff wellbeing. These themes are explored in the greatest detail as they are the areas over which CDHB has the most influence to effect change. The areas within the work environment where both issues and solutions were identified are:



Amenities and Infrastructure [the physical work environment]

Focus group participants discussed a number of facets of the physical work environment that impacted their work and their wellbeing. Many participants noted that the condition and efficiency of some infrastructure was significantly impacting their job performance, their psychological and physical safety, work / home balance and in some cases staff retention. Participants acknowledged that many of the issues around amenities and infrastructure are driven by the external environment [specifically earthquake impacts and health funding] and the challenges of an unprecedented facilities repair and rebuild programme.

Areas of concern for the amenities and infrastructure include:

- IT systems;
- hospital equipment;
- workspaces; and
- staff amenities.

IT Systems

A significant programme of work has been underway across the Canterbury Health System to replace a range of legacy and unconnected clinical information systems with a single integrated clinical information solution. It is in the context of this major IT transformation that concerns about IT reliability, change and integration were raised.

A number of participants stated that programmes and computers can be very slow and occasionally crash, and there is a lack of clear information available about the contingencies to manage these outages. This has the potential to impact patient care.

The frequent introduction of new systems and tools was linked to perceived workload and technology-related stress for some staff members. Frequent changes to the IT team has left a number of users feeling unsupported, insecure about their own ability to navigate IT problems that occur, or unsure about who to contact for support.

Technology integration was a concern raised by a number of participants across a range of focus groups. Patient information is often lodged across several independent systems. Participants noted inefficiencies resulting from transferring paper records to online records, and often having to enter the same patient data onto different, unintegrated systems. Some staff also raised the issue of access to computers on site, including a lack of mobile technology.

Hospital Equipment

Participants reported instances where hospital equipment is either available in insufficient quantity, ergonomically challenging to use [e.g. sluices], or old and subject to quality issues. Some participants also identified the opportunity to better manage resources in ways that could reduce waste and incentivise staff members to take a more conservation-focused approach to resources.

Workspaces

Focus group participants discussed a number of issues relating to the quality and quantity of workspaces. Lack of space to perform essential tasks and instances of patient overcrowding were mentioned. This was especially pertinent for Christchurch campus staff. Participants also identified that a lack of space means staff members have limited opportunities to take breaks for meals, debrief, provide mentorship, and engage in other forms of role-specific interactions. Participants acknowledged the complexity of the earthquake issues, and were concerned that CDHB's built infrastructure has not kept up with growing patient volume and complexity in an expanding city.

Other issues raised related to staff workspace amenities and standards that are conducive to wellbeing, including the inability of open plan offices to accommodate standing desks that some staff require for physical comfort, hot desks that are not equipped with phones or computers to support the administrative work meant to be conducted in these spaces, and issues of cleanliness in shared spaces. Participants described the cleanliness issue as being due to the perception that cleaning staff are not

provided with sufficient hours to ensure standards. Additionally, several participants remarked on poor air conditioning, ventilation, access to natural light, and insulation, along with noise pollution in some facilities.

Finally, the geographic distribution of some of the services means staff members can face significant challenges walking between buildings and arriving at their places of work in a timely fashion. The distance between offices and wards can be significant, and some staff members need to take multiple trips a day to meet with patients.

Staff Amenities

Participants noted that the availability or improvements of staff amenities would improve their wellbeing – particularly managing work / home balance. For example, it was noted that a number of staff members face significant challenges including suitable childcare arrangements while they are at work [particularly those who work shifts], and working parents would benefit from access to on-site childcare. Some staff members also remarked that the availability of basic amenities and services [such as pharmacy, shops and personal healthcare] is very limited for shift workers. Limited parking options, especially in central city locations, was another issue raised by participants.

Possible Solutions: Amenities and Infrastructure

Across the focus groups, the participants volunteered a number of solutions to address the challenges identified. The solutions proposed include:

- ensuring IT systems are centralised | integrated – this will help decrease workload and address service quality and patient safety concerns;
- improving resource management and waste minimisation through enhanced inventory and resource sharing systems;
- improving workplace design and booking processes to ensure that both private discussions and team and social exchanges can take place as needed; and
- improving access to services and amenities for staff and patients outside standard business hours.

Leadership

Leadership and management was one of the most frequently discussed themes across the focus groups. Areas discussed included behaviours aligned to CDHB values, processes, and consistency across the organisation; and the systems that support these [both the disciplines around supporting teams to work effectively together and IT support].

Leadership themes can be grouped into three key areas:

1. Pressure on leadership, related to the external and work environment and based on the current Canterbury and Canterbury health system context.
2. Leadership capability, related to the ability of leaders to support the delivery of services balanced against the individual requirements of staff, including:
    - communication;
    - decision-making and consultation;
    - workload management;
    - ways in which work is designed and role clarity within this; and
    - flexibility of when and how care is delivered balanced with individual working arrangements.
3. Leadership behaviours, related to the extent to which the behaviour of leaders reflect or model the values of the organisation, especially as they relate to:
    - treatment of staff; and
    - leaders looking after themselves.

The day-to-day pressures faced by leaders were clearly acknowledged by all focus groups. Participants noted that leaders at all levels face pressures such as resource constraints, gaps in training and coaching, time constraints, and demands to meet a range of targets.

Of the staff members who identified themselves as managers / supervisors:

10% feel extremely burdened by the responsibility to lead in the current context

60% feel somewhat burdened by the responsibility to lead in the current context

Pressure on Leadership

Almost without exception, focus group participants acknowledged the many challenges and pressures faced by their leaders, from internal parties to external agencies, and conceded their significant influence on a number of leadership behaviours.

Leadership Capability

Participants across focus groups mentioned the inconsistency of leadership / management skills, particularly in regards to communication and decision-making. In many of the comments about leadership / management, it was apparent that the reference was to immediate supervisors and middle management.

Communication

The quality of information sharing, communication styles and listening skills emerged as the most salient issues pertaining to how people were communicated with. While personality was mentioned as a contributing factor relating to poor communication, another important factor noted by participants related to the perception about a lack of easy access to communication training for leaders.

Some participants felt that important conversations about change and day-to-day operations do occur, but there were views expressed that this is not as commonplace as it should be. This perception around the approach to planning and communicating changes hold significant implications for staff wellbeing, as they exacerbate feelings of insecurity and uncertainty.

A number of participants across the focus groups commented on the fact that some individual leaders exhibit poor listening skills or avoiding 'difficult' and 'honest' conversations, and as a result important issues can be left unheard and unaddressed. One of the detrimental consequences associated with avoidance of difficult conversations is the fact that poor performance is not appropriately handled and left to linger.

Information overload was also discussed; critical information and messages were often embedded in broader communications holding little relevance to a number of staff members. Given the nature of the clinical staff roles, with scarce opportunities to go over emails on a daily basis, participants felt that communications could be made shorter and more salient, and sent in a more timely fashion.

Decision-Making and Consultation

Inconsistencies in the decision-making by leaders was mentioned in relation to consultation processes, the approach taken to making decisions, and when decision-making should be centralised. In addition to this, some participants referenced inconsistencies to follow-up on plans and commitments made to staff, and how individual preferences in decision-making processes are addressed.

Some participants felt that there was opportunity for improvement on the part of a minority of senior leaders, whose decision-making can appear misaligned with the CDHB vision, and/or reactive. Communication around decision-making process was identified as an area which could be improved.

Workload Management

The main themes that surfaced from discussions about how leaders and managers manage staff workload related to the requirement to maintain role clarity and avoid scope creep as part of change processes, and the need to ensure sufficient flexibility for individuals with regards to work arrangements. Other issues raised by some participants around workload included the need for more consistent processes across the organisation and more thorough induction to support staff orienting themselves to a new work area quickly.

Ways in Which Work is Designed and Role Clarity

Participants raised the issue of role clarity across the CDHB. Some clinical staff members acknowledge limited knowledge of their leaders' role scope, of the roles of peers in other teams, and leaders' knowledge of staff members' roles. In some instances, staff members felt they lacked clarity around their own role scope and boundaries. Participants identified the need for leaders to recognise and deal with the unintended role creep as part of increased demand on services and any change processes. Some people also felt that better understanding of managerial roles and reporting structure would improve role clarity and performance overall.

Flexibility

Participants identified that leaders could apply more flexibility in how they manage team workloads. More adaptable and transparent processes and mechanisms to secure leave, and availability of work redesign options, were examples of how this could be achieved.

Leadership Behaviours

In addition to communication and decision-making skills, behaviours pertaining to treatment of staff and role modelling [including leader / manager visibility with respect to this] were given considerable attention across the focus groups.

Treatment of Staff

Some participants felt there were inconsistencies in the way leaders managed within and between teams with respect to issues such as overtime allowances, and balance between criticism and praise. These discrepancies were discussed and attributed to differences in leadership styles, training received, and individual personality, but also to the extent that the leader worked closely with their staff, and were knowledgeable of their specific roles and challenges. Regarding the latter, proximity [functional and physical] to leaders is mentioned as partly accounting for realistic leadership expectations concerning how time is prioritised at work.

Some participants felt that better understanding of clinical work would increase leadership success. Both one-on-one and team discussions with leaders were identified by people as areas which could either positively or negatively impact wellbeing. Situations that caused staff to feel unwilling to speak up, or embarrassed about making mistakes, were cited as having a negative effect on wellbeing. What was described as micromanagement was also experienced by some of the participants, and seen as undermining individual competence, experience, and autonomy.

Leaders Looking After Themselves

Participants commented that when it comes to ensuring staff engagement and wellbeing, a number of leaders fail to model appropriate behaviours, such as taking leave or breaks. Some participants were also concerned that in a constrained fiscal environment, leaders are perceived as engaging in self- and team-protective practices aimed at preserving the resources available. This behaviour reinforces any remaining organisational silos, negatively affecting patient flow, and was seen as hindering resource sharing and other forms of team collaboration that could improve patient care and staff wellbeing and motivation.

Leaders, particularly senior leaders, are also perceived by some as having low visibility in the organisation. Some new middle leaders and team leaders are only cursorily introduced to their team, which is seen to undermine relationship quality, trust, and support-seeking behaviours from staff. Some participants felt that more frequent interaction with leaders would improve communication and performance.

Possible Solutions: Leadership

Leadership was a theme that emerged in most of the focus groups, and as such merited considerable discussion around solutions to address the issues identified. The participants offered a number of thoughtful suggestions, primarily around the leadership selection processes, leadership development [e.g. consistency of communication and decision-making strategies and tools] and leadership processes [e.g. role clarity and supportive practice]. People acknowledged that leaders at all levels are subject to considerable pressure to deliver results, and this partly accounts for same of the behaviours above that could undermine wellbeing.

It is noteworthy that many of the solutions proposed by the participants signal a shared view that leaders and managers require further support and development in order to effectively balance performance demands with people-focused leadership activities. Systems and developmental practices targeting leadership roles could be improved and targeted at earlier career stages, and upon talent identification.

Several participants remarked on the fact that some leaders are 'uninspiring', and needed to be visible role models of approaches that support wellbeing. The positive exemplars mentioned throughout the focus groups indicate that flexibility and support comprise key features of 'good leaders'. Nevertheless, staff members appear to be unclear about what good leadership in the healthcare sector should look like. This suggests the need for better organisation-wide communication about the core leadership values and competencies espoused at the CDHB. There is also an opportunity to capitalise on positive exemplars, and to identify and address discontinuities between intended approaches to leadership and existing systems and practices.

Workplace Processes

The focus groups identified some frustration with a number of processes that underpin their day to day activities. Participants felt that some processes, while often aimed at improving work efficiencies and improving the work environment, may inadvertently be creating additional stressors for staff.
These include:

Workload Management

- Referral processes
- Rostering a 24/7 service
- Patient / workflow management
- Support services

Decision-making and communications

- Documentation and paperwork
- Organisational-level communication
- Team-level communication
- Change management

Workload Management

Referral Processes

A number of focus group participants expressed concern over the referral process. Current processes provide insufficient patient information for the next person to pick up and take action, which is particularly stressful when a service is at full capacity.

Rostering a 24/7 service

Some participants felt that rostering needed to be considered within the context of both quality patient care and staff wellbeing. It also needs to be matched to demand in a way that provides as much certainty for staff as possible while allowing for flexibility to meet the immediate community needs on a day-to-day basis. What can make this challenging is ensuring sufficient gaps between night shifts and the return to day shifts; night shifts following off-days; and part-time workers having work concentrated

around a portion of the week and leaving several days without role / service coverage due to social rostering. Some participants also felt that sick leave and annual leave coverage are often insufficient.

Patient | Work Flow Management
Participants noted that when there was poor patient flow this could lead to unpredictable busy periods. For some units, there are no lulls in work at all. The differences in patient flow were largely attributed to the ability to lead cross service collaboration and behaviour that did not support this, along with a lack of acuity tools / workload models, and a disparity between work flow processes across professions. For non-clinical staff, poor workload management was attributed to misalignment of goals and a lack of clarity on priorities, which required more consistent leadership focus.

For clinical staff, a number of contributors to unnecessarily high workloads were identified, including:

- new technologies [taking time to upskill and learn how to use technologies];
- 'extra' work such as meetings, administration and education [personal development and assisting students], which are not reflected in staff time | capacity allocations;
- lack of patient flow [see Leadership section];
- increased patient numbers [see External Environment section];
- inadequate staffing [see Staff Resources section];
- lack of staff and support services at weekends, resulting in work batched up for Mondays;
- on-call responsibilities especially in specialty areas;
- where silos still exist [not a lot of cross-service knowledge / horizontal communication exchange] they perpetuate the need to "relearn" and hinder resource sharing to manage / decrease patient flow [e.g. surgical theatres do not communicate with each other] [see Organisational Culture section];
- not enough formal or informal recognition for increased workload caused by discretionary role coverage [there is a lot of goodwill in the place – people arrive earlier to pick up existing work]; and
- lack of clarity around organisational structure and who to report to.

Support Services
Some participants felt that support services [e.g. administrative staff] were often under-valued. Examples cited included the view from some that there is insufficient administrative support in some areas to effectively manage work flow for clinical staff, and to cover administrative duties of clinical staff. Some participants also noted additional workload generated from the absence of 24-hour support services such as pharmacies and ward clerks.

Decision-Making and Communications

Documentation, Paperwork and Information Management
Some participants felt there were increased demands around reporting [e.g. minor injury or patient complaint] and other forms of compliance. These require more time to carry out, but are not met with additional support. This, coupled with low system [IT and paper] integration can lead to a lot of work duplication. A number of the focus groups commented on difficulties getting effective information from the wealth of data the CDHB collects. This results in a plethora of data that doesn't necessarily lead to quality information and / or the capability to draw meaning from the data available. Some felt this was caused by lack of a systemic approach across the data analysts who are embedded in some divisions and in the central team.

Organisational-Level Communication

A number of participants felt that this was an area for improvement. Concerns noted included the volume of communication materials, such as emails, noticeboards, and multiple IT systems, which some staff feel is overwhelming or unmanageable. Daily updates are too busy or irrelevant, and the intranet is not up to date [for example with new staff names, current processes, location data]. Many believed that there is a lack of clear, concise, and relevant information that is readily available. For instance, there is no guide at the start of employment with the CDHB that outlines "who's who and what's what", including who owns different tasks and processes, and who needs to be involved in decision-making.

Communication around changes, in particular, were noted as being at times insufficient.

Team-Level Communication
The reported communication at department or team level varied notably. Many reported that their ward / team did not have regular meetings. Others noted that their meetings were ineffective or detrimental. Some suggested that open communication is not always encouraged and managers do not always share information [for example about conferences they attended].

Change Management
Change has been a regular feature at the CDHB; change stemming from external changes such as the earthquakes as well as internally driven change from the *Our Health System* initiative. Many participants expressed that pressure resulted from the constant change, particularly when change was perceived as random and uncoordinated, adding increased feelings of uncertainty and insecurity. Some feel that there is too much power held by some 'dictating' what should happen, both at operational and strategic management levels. Some participants described CDHB as a very 'deep' organisation. This leads to disconnects between the leadership team and staff on the ground. It is felt by some that issues are 'lost in translation' through layers of the organisation – and often filtered through the lens of stressed middle leadership.

Possible Solutions: Workplace Processes

A number of the solutions aimed at patient / workload management centred on better communication, clarity and understanding of what is done and by whom. In particular, support service staff noted that they often felt undervalued and could provide valuable input for managing workload for clinical staff. A common suggestion was for a unified acuity tool that will help to better manage the flows of patients through the CDHB, and the corresponding staffing needs.

Solutions for better decision-making primarily relate to more shared, transparent, open and diffuse decision-making. Staff clearly called for more meaningful engagement in decision-making and improved communications over decision-making priorities and processes. One focus group came up with a solution to establish a team to 'challenge change'. This team would have the responsibility to test any proposed change.

In a large organisation like the CDHB, processes form the foundation from which quality services are delivered. It is a real balancing act to create processes that offer consistency and fairness for both staff and patients, while also providing flexibility, and enable individuals to feel valued and empowered to and utilise their strengths. This idea of staff empowerment is a key driver in the '*Our Health System*' initiative, but there is still work to do to bring the vision to life in all parts. For any processes to be effective there also need to be quality managers and trust amongst staff to work towards a common set of values, processes and outcomes.

Organisational Culture

Across the focus groups, participants identified specific features of the CDHB's organisational culture that influence wellbeing levels of staff. Features of organisational culture that focus groups identified as having an effect on wellbeing include:

- inclusion and equity;
- ambition for *Our Health System*
- people at the heart; and
- patient flow.

Inclusion and Equity

Staff identified the need to capitalise on opportunities for greater inclusion and equity in terms of how

they work together and in working conditions e.g. leave allowances, extended work hours, and access to professional development.

Some staff reported that where hierarchies still existed, based for instance on rank or professional roles, it created tension. This circumstance can also lead to incivility, poor collaboration and communication. Some felt that there was low managerial accountability for handling complaints, and that if leaders were more aware of these issues, and acted more quickly to address them, this would add to a positive organisational culture, as would the overall performance of the organisation.

Ambition for *Our Health System*

The ambition outlined in the vision for *Our Health System* is for an integrated and connected health system that puts people at the centre. While staff acknowledged that the needs of the patient are paramount, it is apparent that this needs to be balanced with creating sustainable models of care that consider staff as the key enabler, and recognise high performance.

When we don't treat staff as people with individual needs, or take a 'one size fits all' approach, it was noted by some that staff aren't enabled to operate at their full potential at all times. Some people indicated that they could be better individually supported through improved parking, having childcare on site, and having more accessible areas for staff to relax and refresh.

Since the earthquakes staff have repeatedly gone above and beyond, making the extraordinary, ordinary. For some staff this has manifested itself in a culture that contributes to a martyr mentality, where staff have at times sacrificed personal health and wellbeing to care for the patient.

A critical component to providing health care is nurturing a culture that supports not just care, compassion, connectedness and communication with respect to patients, but legitimises having these conversations about the people who provide that care. This in turn stimulates collaborative and supportive practices.

People at the Heart

Some participants felt that the prevalence and process of change within CDHB can cause tension between services and staff. Change needs to be carefully considered and to emphasise a co-design process that puts people at the heart of the outcomes to be delivered. One of the challenges in the current post-quake environment is the frequency and pace of required change. While there have been a range of change processes that have been undertaken incredibly well, some have not been managed or led to the level the CDHB expects of itself. When this occurs it further undermines the ability of leaders to effectively implement better ways of working in often substandard facilities.

Patient Flow

Participants identified the need to have better connections across the system. Working to remove traditional occupational, hierarchical or geographic barriers where they exist was identified as an important way of also supporting staff wellbeing. This would include greater sharing of information and more integrated technology.

Possible Solutions: Organisational Culture

Participants identified the need for the CDHB to build on current efforts to develop a high trust, people-centred culture, underpinned by integrated, collaborative, and proactive change processes. There is considerable staff willingness to contribute to that ongoing effort. The solutions generated by the focus group participants can be organised around a number of guiding cultural principles and associated practices. These values encompass equality and equity, transparency, civility, care [staff and patients], participation, and collaboration. Some of the suggestions put forth included:

- consistency in treatment of staff across services and locations;
- increased accountability for uncivil behaviour;
- due consideration of personal needs and their implications for staff wellbeing and patient safety; and
- the adoption of high involvement work practices.

The underpinning theme of the solutions proposed by the participants, anchored in cultural principles and practices, is aligned with one of the CDHB's core tenets: people first. This presents a significant opportunity in that staff members share workplace values consistent with the ethos of the CDHB, and signal their willingness to contribute to shaping and reinforcing these values through processes and interactions. The input provided in the focus groups adds to the existing strategy by highlighting ways in which 'people focus' can be expanded from a patient-centric perspective to an approach that also considers staff contributions, goals, needs, and wellbeing.

The possible solutions put forth can be broadly sorted into two main categories:

1. features of interpersonal exchanges that contribute to a positive work environment [e.g., civility, recognition, and honesty]; and
2. formal practices and procedures that shape the workplace culture [e.g. high involvement and collaborative practices, supportive procedures, and accountability systems].

With appropriate support, expertise, and internal buy-in, a number of these suggestions can be actioned in the short term and involve few resources.

Staff Resources

With more than 9,500 employees, the CDHB is the largest employer in the South Island. CDHB employees are a large part of the health care system in Canterbury, and staff in all areas feel they are making a difference as seen in the Survey:

89% feel they are making a contribution to the success of CDHB

74% feel their job is fulfilling

65% feel the CDHB supports them to work in keeping with their professional values

Still, there are areas where improvements can be made to enhance the quality and length of service of staff, as well as the ability of staff to access the resources they need to fulfil their job requirements to their highest standard. Key areas of focus include:

- leave coverage;
- staff retention;
- job flexibility;
- people processes – recruitment and clarity;
- managing staff trauma; and
- staff competencies.

Leave Coverage

A number of participants felt that there was insufficient sick and annual leave cover, and that remaining staff are required to redistribute to cover for absentees. In some services, coverage is planned for day shifts but not night or weekend shifts. Specialty areas, in particular, noted a severe lack of pool resources to cover for planned and unplanned leave. Staff also identified work flow management and rostering as areas for improvement.

Staff Retention

Some participants identified attrition as an area of concern. Participants felt that potential factors contributing to attrition could be dissatisfaction, poor pay and lack of opportunity for advancement, work-family time conflicts, and disengagement. Ageing staff also contribute to ongoing turnover. Participants identified succession planning as an area for improvement. CDHB's current attrition rate is 9 per cent, which is consistent with the national rate, and is currently at a sustainable level for the delivery of services.

Job Flexibility

The lack of flexibility in the work environment was a key cause of stress. Many staff, particularly females who have young families, experience full-time shift work particularly challenging. Four on, two off shifts were also noted as being particularly challenging, yet the options for part time, regular hour roles [for example job sharing] are limited. Strict enactment of annual leave policies also increases staff dissatisfaction with their work and their ability to achieve work / home balance.

People Processes - Recruitment

A number of participants expressed the need to simplify and streamline recruitment processes. Some participants noted that people processes lead to longer than necessary periods of vacancies, and could lead applicants withdrawing from the recruitment process. Participants identified the need for more transparency and consistency when it comes to the recruitment processes. Some participants believed the CDHB could do more to attract quality staff.

People Processes - Clarity

Some participants called for greater clarity over who in the organisation is the most appropriate person for them to discuss work-related issues such as professional development and annual leave with. Participants were often not fully aware of the scope and breadth of the functions and role of the CDHB's People and Capability team, nor its structure. Participants identified the need to improve clarity and communication around people policies and processes.

Managing Staff Trauma

Some participants expressed concern over the way that work-related staff trauma and injury is dealt with. Due to the nature of their work, some staff are regularly exposed to traumatic events. Staff can also be exposed to emotional and physical abuse, particularly in specialty areas such as mental health. The degree and nature of trauma management is sometimes dependent on individual leaders – their experience in handling these cases, their empathy, and their availability to provide support. Participants identified this as an area for improvement.

Staff Competencies

Participants noted that older staff found it difficult to move between jobs / areas within CDHB, and this was contributing to staff attrition among the more experienced. Some felt that experienced staff could be better valued and recognised. Professional development and staff support, particularly new staff, were identified as weaknesses within CDHB. Some noted that CASP [Career and Salary Progression] places an unreasonable expectation on staff, and that salary increases could be performance-based. The PDRP system was also criticised by some participants. One aspect of staff development that participants identified for improvement was timely feedback, at both individual and team levels.

Possible Solutions: Staff Resources

In addition to calls for more staff, including cover for staff on sick or annual leave, the primary solutions generated by the participants were around allowing individual flexibility to find and use their strengths in their roles at CDHB. For clinical staff, a big part of this is having the ability to design and control their work environment. There were many suggestions around job sharing, team self-rostering, and work options and support services that would allow female staff to continue working while they have young children. Participants also felt that greater support from the People and Capability function and professional development opportunities would increase their loyalty to CDHB, as they would feel empowered to create a career path.

One unique idea was to create a 'Hire a Hubby' service that could be a fix-it service. It wouldn't have to necessarily be a facilities maintenance type service, but could be a 'crack IT team' that could come in and work through a problem, or a team to help sort out rostering issues. At the heart of the idea was a team that had the flexibility and skills to move around and problem-solve where needed.

A common sentiment across focus group participants was that the CDHB needs to become even more people-centred, alongside and in support of being patient-centred. There was an overwhelming sense that staff are truly dedicated to quality care for patients. A people-focused approach which encompasses both staff and patients is vital in the effective delivery of health care services. This is a key underpinning enabler of the vision of *Our Health System*. The participants expressed their need for the flexibility and opportunity to develop a successful and fulfilling career they can feel proud of. In general, staff already draw a great deal of meaning and sense of impact from work [89 per cent feel they are making a contribution to the success of CDHB and 74 per cent feel their job is fulfilling]. Some participants noted that CDHB would benefit greatly by enhancing this sentiment and letting people use that motivation to grow in their roles.

The Personal Environment

22% of staff live in a damaged environment or surrounded by construction work

21% of staff have additional financial burdens

19% of staff are dealing with EQC / insurance issues

19% of staff are making decisions about house damage, repairs and relocation

Summary

To date the existing staff wellbeing programme has largely focused on supporting the challenges faced by staff in the 'personal environment'. Due to its success, there are high levels of awareness of the programme [88 per cent of those answering the survey were aware of it].

When staff are supported in maintaining their mental health, work / home balance, and when they feel physically and psychologically safe, and clear and confident in their professional capacities, then job performance will improve. Similarly, when systems are in place to enhance working relationships and support and encourage high performance, staff members' physical and emotional wellbeing will improve.

Analysis of the focus group feedback identified five themes in the personal environment which provide opportunities for improvement. These are:

- my mental health;
- my safety [physical and psychological];
- my job performance;
- my work / home balance; and
- my clarity & confidence

My Mental Health

Staff members discussed experiencing anxiety, depression, sleep disturbances, impaired cognitive functioning, and "burnout" [characterised by chronic exhaustion and decreased empathy / disaffection, directly related to, or exacerbated by, the impact of the earthquakes on their home and work environments]. Some participants specifically mentioned feeling stressed as a result of pressures at home and perceived barriers in the workplace. These challenges were primarily identified in relation to workforce pressure [e.g. increased patient loads, staff shortages attributed to uncovered leave periods and slow replacement of staff after resignations] and physical resources [e.g. technology, equipment, crowded and noisy environments]. Participants also identified that stress and exhaustion contribute to staff illness, and that pressure either to work despite feeling ill, or to return to work before feeling fully recovered, can mean staff feel unwell for longer.

My Work / Home Balance

Poor work-life balance and related work-family conflict were discussed by a number of focus group participants. These issues have the potential to spill over between the home and work environments.

My Job Performance

When staff are physically, mentally, and emotionally unwell, or have insufficient resources and support to be their best, job performance suffers. In turn, when job performance suffers staff are less likely to experience wellbeing. Feelings of pressure to perform without adequate resourcing can lead to less motivation and job satisfaction, with staff feeling less likely to engage in proactive and solutions-focused behaviours at work.

Some focus group participants identified the need for acknowledgement of excellent performance along with high workload, and to encourage staff to engage in continuous learning and seek professional development.

My Physical and Psychological Safety

The CDHB has a number of processes and systems in place to ensure employee safety – both physical and psychological. However, some participants reported feeling physically unsafe due to patient-on-staff confrontational or violent encounters. It is acknowledged that the organisation and wider health system is under intense demand and resourcing pressures and that these materially impact upon individuals and influence their behaviours. The perception of risk was exacerbated by sub-standard facilities, or construction work, that limit the options around ensuring staff safety.

With regards to psychological safety, issues identified by participants included behaviours not aligned to the values of the organisation, people feeling pressured to continue working long hours in response to our community's increasing needs post-quake, and a lack of awareness of all the opportunities to influence decisions related to their work.

Participants identified the opportunity for leadership and managers to provide greater mentoring and support to staff, and to encourage the utilisation of support mechanisms for both staff and management. Resourcing and time pressures were also acknowledged as having a significant impact upon leadership and management at all levels. Participants also felt that work relationships are enhanced by supportive and collaborative team behaviour, which in turn reduced conflict and enhanced job performance through better collaboration and problem solving. There were many examples given of where this is the case and the opportunity is now available to build this through the organisation.

My Degree of Clarity and Confidence at Work

Focus group participants identified a range of factors as having a negative impact on staff wellbeing, including:

- instances of lack of clarity regarding role scope and other staff members' roles;
- instances of unfocused communication that is not tailored to the needs of individual staff members;
- examples of low confidence in technology supporting doing the job well; and
- uncertainty regarding the location of services now and in the future.

These issues have been exacerbated by the scale and complexity of delivering health care during the biggest health facilities repair and redevelopment in New Zealand's history. While there are a number of CDHB initiatives and programmes of work with respect to the issues raised above, there is the opportunity to better connect and integrate the successes across the system that have been achieved to date.

Some felt that new staff could be better inducted to their new job or socialised in the CDHB. In addition, the high frequency and fast pace of organisational change were mentioned as factors contributing to fatigue.

Summary

Over recent years, huge advancements have been made to improve the patient journey in Canterbury. What the 2016 CDHB Wellbeing Survey and the associated focus groups have made clear is that for CDHB [and, by extension, the Canterbury health system] to reach its potential, our people need to be enabled to use their knowledge and experiences to make the CDHB a better place to work.

The information gained from the 2016 Wellbeing Survey and focus groups will be used to design strategies that build upon, and extend, our existing staff wellbeing programme. For this work to be successful, it must address the common themes which have emerged through this process, including:

1. Acknowledging our people are under more pressure than ever before as they do their best for patients and the system.
2. Leading and managing our people consistently, and giving staff every opportunity to impact decisions.
3. Continuing to ensure that decision-making puts our people at the centre.
4. Providing technology that helps our people to do their job well, and makes it easier.
5. Giving our people more autonomy at work, and simplifying bureaucratic processes that can waste staff time.
6. Clearly communicating not only the big picture, but the things that are directly relevant to our people.

While there are frustrations and issues, there's also a lot of hope and commitment to making things better. There is strong alignment across CDHB staff, managers and leaders in relation to the priority of ensuring that processes are simple, easy and more integrated; a strong desire for staff to be involved in coming up with solutions and ways to make things better; and the collective will to develop a health system that is focused on not wasting staff time.

There's no magic bullet for improving wellbeing – it's affected by many individual, team organisational and whole-of-system factors. What there is, however, is a collective will and determination to continue to work together to make it better for the people of Canterbury by making it better for the people of *Our Health System*.