

4. Culture

Organisational culture (defined as the organisation's prevailing pattern of beliefs, attitudes, values and behaviours) has a profound impact on staff and systems performance. The influence of the predominant culture in Queensland Health on all aspects of operation has been very evident to the Review and one of the major findings, if not the most important, is that if the changes recommended in this Review are to have any lasting value the underlying culture of the organisation must be addressed.

4.1 Queensland Health culture

4.1.1 The current culture: feedback from district visits and submissions

It was reported during district visits, that bullying, and intimidation on the one hand, and blaming and avoiding responsibility on the other typify part of Queensland Health's culture. Descriptions such as "tribalism", "tokenistic consultation", "no culture of teamwork" and a "culture of power and control" were repeated themes throughout the consultation.

This should not distract from other very positive aspects such as a culture of dedication towards patient care and wellbeing which was also very strongly evident during district visits. Staff were described as being "helpful and supportive", "committed to a standard of care for patients" and "having pride" in the services they provide.

The Review received reports and saw evidence of disempowered clinical teams and clinicians frustrated with slow formal decision-making processes and constrained by overly prescriptive and at times conflicting policies and procedures. In many cases, these policies and procedures were written in a manner designed to hinder rather than encourage or enable. The traditional bureaucratic style of leading and managing which relies upon such formal authority and regulation has permeated the organisation and inadvertently suppressed initiative.

In this environment it is understandable that relationships between health service managers and clinicians become strained. Doctors and nurses believe the balance of power within acute hospitals has moved too far to the side of formal authority and administration, driven largely by financial imperatives around budgets, measurement of throughput and economising in the use of staff resources and materials.

At the same time administrators and managers feel the clinical workforce with a primary focus on the health care requirements for each individual, has little concern about cost and less inclination to accept responsibility for broader service delivery considerations (such as allocation of scarce resources to deliver care for large populations of individuals).

4.1.2 Cultural surveys

As part of the Review process, the results of an independent culture survey were examined. This report confirms the finding of the Interim Report which found that staff are experiencing very significant work pressures, and in this environment are experiencing a higher than usual rate of dysfunctional interpersonal relationships. The survey confirms direct reports received about bullying and intimidation but suggests that this may not be as prevalent as anecdotally reported and reveals that it is much more prevalent in districts than in Corporate Office.

The results provide a wide range of views and experiences of work within Queensland Health. A number of people have indicated that they enjoy their work and have included positive responses and comments. Levels of workplace morale, professional interaction, and professional growth are not significantly below the benchmark. However, there are also a number of very negative reactions and comments, with some hope expressed that these issues may be dealt with as a result of the current enquiries. Staff recorded unfavourable scores on many of the organisational climate variables, particularly low participative decision making and high workloads.

Staff perceive a difference between their own work values, which they define as professionalism, teamwork, service quality and a patient-centred focus, and those of the management and bureaucrats within the Department, which they see as primarily focused on meeting budget performance standards. Overall attitudes and behaviours in the Health Service Districts are less positive than those reported in the central units.

Staff safety was raised as an important issue for many because of the risk of violence from patients and the public.

Reasons most frequently nominated for bullying behaviours were the hierarchical structure of the Department, the stress imposed on the system due to budgetary and workload pressures and the focus on financial rather than patient outcomes. Senior leaders were rated at or near 50 percent on aspects such as vision and inspiration, but were rated slightly lower on innovation and role modelling.

4.1.3 Specific examples of dysfunctional behaviours

A number of specific examples of dysfunctional behaviours resulting from the impact of culture on the organisation were reported repeatedly to the Review. Some of these are explored in more detail in this section.

Relationships between staff and managers

While there were reports of effective managers who engaged successfully with their staff and consulted about problems, there were many instances of varying degrees of dysfunction.

It was frequently reported that leaders, managers and supervisors have limited skill in dealing with difficult and often complex problems, in encouraging staff contribution to the resolution of problems, in engaging effectively with staff, and in dealing with particular staffing problems including staff who are troubled, disaffected or not performing.

All too frequently informal discussions to solve problems become antagonistic and subsequently lead to formal processes involving lengthy written correspondence, the lodgement of formal grievances and lengthy investigations with inconclusive outcomes. Of particular concern to staff is the use of internal officers for investigation of grievances resulting in possible bias and contributing to delays in dealing with the matter. Both parties emerge from such conflict with escalated feelings of anger, frustration and remembered resentment. The Interim Report also identified a contributing factor to the lengthy investigations and inconclusive outcomes being the variable skill level of staff appointed to investigate grievances.

Many staff reported examples of inaction or lack of appropriate and timely action by management in regard to staff who were not performing or who were exhibiting unacceptable behaviours such as bullying. There was also a perception reported that non-performance was managed by transferring or promoting staff. The impact of this failure to manage staff appropriately included an “unhappy workplace”, low staff morale, high absenteeism and people on long term stress leave. In the current environment of workforce shortages, this situation must be redressed.

Key factors in this appear to be:

- the length of time that it takes to manage non-performance (eg 12 to 18 month process)
- lack of expertise among managers in managing non-performance
- limited access to training for these managers
- lack of expert and timely advice from Human Resource personnel and
- attempts at managing non-performance leading to accusations of bullying and workplace health and safety claims.

Individual Performance Appraisal and Development (PAD) is a process for all staff to have the opportunity to engage with their supervisor for feedback (both positive and negative), career planning and professional and personal development. However, consultation undertaken for this Review indicates that the number of staff who had PAD plans in place varied across and within districts. Furthermore where PADs were routinely used, most staff did not view them as useful. This appears to be mainly due to the training and development goals identified in the PADs not being achieved and staff perceiving managers as failing to manage staff who are not performing up to standard.

Perverse use of the Code of Conduct

Codes of conduct are required for all Government Departments under s15 of the *Public Sector Ethics Act 1994* (Act). The purpose of a code of conduct is to provide standards of conduct for public officials consistent with the ethics obligations under the Act. The ethics obligations under Division 2 of the Act are respect for the law and system of government, respect for persons, integrity, diligence, economy and efficiency.

There has been much negative comment made by staff during consultations about misuse of the Code of Conduct within Queensland Health. It is considered by the Review that on occasions the Queensland Health Code of Conduct has been used as a tool to bully or intimidate Queensland Health staff. It is written in a style typically reflective of the formal prescriptive and bureaucratic aspects of culture, rather than an inspiring patient or consumer centred approach.

Openness and transparency

Another set of dysfunctional behaviours are those that inhibit the open sharing of information, particularly adverse performance related information about community access to health services and the quality of those health services. Numerous accounts were reported of individuals within the organisation preparing reports highlighting factual deficiencies, only to have these reports modified or suppressed at higher levels in the hierarchy.

The Review was told of examples of this occurring over more than two decades. Accounts of Cabinet, Ministers, Minister's advisors and support staff, senior public servants in Corporate Office and senior executive members of hospitals all reinforcing in various ways the need to suppress adverse information and highlight the more positive features of information. Sometimes patient confidentiality or public interest has been used as the rationale. While these are legitimate concerns they may not have been an issue in many instances reported.

Over many years this behaviour has become self perpetuating, with two very dysfunctional consequences. The first is the preparation of reports which fail to highlight problems. This inevitably reduces the emphasis on problem resolution and improvement to the detriment of health service quality and safety. The second is a tendency simply not to report, based on a previous expectation of having reports suppressed or receiving little feedback or negative feedback.

Patient versus clinician needs

While individual patient care is taken very seriously, consideration of the patients' needs from a non-clinical perspective is often lacking. Patient needs such as certainty in admission and discharge times, and coordination of various aspects of their care may be neglected to meet the convenience of the clinical workforce particularly in public hospitals which have a large focus on post graduate teaching of doctors.

An example of this issue is the scheduling of surgical procedures. This has evolved around the availability of procedural specialists and clinical support teams and operating theatre time. There are inevitable conflicts at times between emergency surgical procedures requiring theatre time and scheduled elective procedures resulting in cancellations. However there were numerous reports of theatres not being fully utilised during normal week day hours and a recognition that there is also capacity available, if staff were available, to work during evenings and/or on weekends.

Patients may prefer to have more certainty in the timing of elective procedures even if this meant attending theatre at different times such as evening sessions or on weekends. The availability and preparedness of clinicians to work at such times would of course need to be tested.

4.2 Queensland Health culture: what have been the influences?

Achieving a more supportive culture is a difficult undertaking, because culture exists in the present form for good reason. That is, the prevailing patterns of attitudes, values, beliefs and behaviours reflect the manner in which staff have learned over the years to contend and deal with their working life and experience within Queensland Health be this in Corporate Office, a zone, an acute hospital or a community health service in a district.

The Interim Report explored the origins of various aspects of the current culture in Queensland Health. These are:

- Contemporary hospitals have their origins in earlier models of military hospitals and historically have exhibited a highly mechanised authoritarian model of control and management.
- Between and within these traditional hierarchies, different professional streams were accorded different levels of rank, authority, status and standing with quite traditional roles, responsibilities, authorities and accountabilities. Conflicts have always been present but traditionally were subjugated by the rule of authority.
- Clear and concise lines of responsibility and decision accountability have been an essential feature of the running of acute hospitals where life and death decisions, clear instructions and immediate responses are an essential part of efficient operation.
- As hospitals can be turbulent places individuals seek to create their own small area of predictability or stability. Threats to these domains are repelled decisively and at times aggressively. Hence the term “tribal” being commonly reported to the Review to explain inter-group conflict.
- Queensland Health is a large centrally controlled government bureaucracy, which has depended in part upon traditional formal governance arrangements, structures, systems and procedures.
- On a more positive note, clinicians have been committed both individually and collectively to undertake their work in the best interests of patients and to develop their professional discipline through teaching of junior staff and research.

A further contributing factor to the current organisational culture and climate has been the focus during the last ten years on budget integrity. Over this period Queensland Health has changed from an organisation that always exceeded its budget by significant amounts, to one that meets allocated budgets. There has been an expectation driven by very firm and at times threatening and bullying behaviour by leaders, managers and supervisors at every level to achieve budget imperatives and to do better with less. The clear message has been that failure to perform to budget will not be tolerated. Staff recount that a number of District Managers’ contracts have not been renewed (up to a dozen) over recent years because they failed to address budget imperatives.

Staff willingly concede that budgets are important, but feel that the manner in which cost consciousness and budget efficiency have been driven, has been responsible for a high degree of bullying, intimidation, threats and retribution, and has induced behaviour in the organisation that is certainly not in the best interests of patients, nor in the interests of workforce harmony.

A final factor which significantly influences the culture prevalent throughout Queensland Health are the conflicting interests inherent in such a large multidisciplinary organisation. Examples are:

- the conflict between the optimal care for an individual patient and the overall benefits derived for the population and
- the current model of service delivery which relies on extensive use of doctors in training for various specialties. The primary motivation for doctors during this training program (particularly those who plan to pursue careers outside of the public system) is acquiring experience and knowledge they need to meet the requirements of the respective colleges.

4.3 The mandate for cultural change

There are many good reasons for seeking change to the prevailing culture in Queensland Health but two developments in recent years make change an imperative.

Firstly, undergraduate training and education of the hospital workforce now occurs in educational settings quite removed from service delivery. Today's health professionals are older (and more confident) at the time of graduation and are taught to enquire, challenge, question, to reason and to debate. Hence when they enter the service delivery environment they do not automatically accept the authoritarian models of operation. The professions are also changing and traditional rank and status structures are being and have been seriously challenged.

Secondly, in recent decades the range of health related technologies has grown exponentially. While these developments have brought enormous benefits for patients and communities they have also generated further specialisation and increased the fragmentation and complexity of health services. Modern medicine requires a multi-disciplinary team approach to effectively deliver this broad range of quite complex services. Conventional bureaucratic organisational structures and traditional health professional boundaries and approaches are no longer sufficient to ensure the delivery of effective, efficient and safe health care. This challenges the tribal boundaries within and between the various clinical streams. In particular the response of individuals working within such a complex and at times perplexing environment can be to restrict their activities and interest to the immediate setting that they can understand and control.

A paradigm shift in the pattern of behaviours, attitudes, values and beliefs is required if Queensland Health is to be able to address these issues.

4.4 Directions for change

The culture Queensland Health should aspire to is one which creates an environment where:

- services are oriented around the needs of patients, their families and the community
- the community is well informed about the services provided including:
 - how long they will need to wait for services

- how well the services meet best practice
- what risk there is of adverse events occurring and
- how to address concerns they have about the services
- individuals are provided with quality information about options and supported to make choices and provided with honest feedback on outcomes of their treatment
- staff are:
 - supported and valued for the contributions that they make to service delivery
 - provided with clear expectations of their duties and accept responsibility for them and
 - treated fairly and with respect
- information is shared in an open and transparent way to enable problem solving and service improvement
- conflicting priorities are resolved in a way that respects the rights and opinions of others and
- the interests of all staff can be aligned around a set of shared values.

The most important issues that need to be addressed are outlined in the following sections.

4.4.1 Leadership

The most critical ingredient in achieving the cultural change required is the changed style and behaviour of leaders within Queensland Health and its health services. It is the leaders who set direction, align different constituencies and motivate and inspire staff. Shared leadership should be increasingly relied upon to deliver the services necessary. Leaders will come from all sectors of health services, especially clinicians.

In a generic sense, it will be leaders at all levels in the organisation who must be:

- empowered
- share the same vision about reforms and the importance of re-establishing health and patient/consumer care priorities for the organisation
- set the desired example in respect to values and behaviour and
- assume influencing styles more in keeping with mentoring, guiding and supporting than are currently demonstrated in the organisation.

The difficult situation facing Queensland Health is to retain some of the gains made in efficiency and accountability over the past ten years but remove the unwanted “side effects” in terms of a lack of responsiveness and flexibility as well as the existing workplace conflict. There will be no perfect solution to this dilemma. However, the way forward must involve the building of trust, clinical leadership and decision making firmly linked to accountability by these clinical leaders. This will include accountability for patient outcomes and financial outcomes. It will be difficult for many clinicians and will require support and training. Some may simply not be willing to be accountable as it is personally difficult.

This will require a willingness of clinicians to expand their traditional professional leadership role from one that depends on their broadly respected and recognised expert knowledge, competence and experience, to new models of leadership focusing on system and service improvement and performance reporting, which will require a new set of organisation skills. They will also require a focus on priorities involving the needs of the population, in the context of restrained funding, as well as the needs of individual patients, which are sometimes conflicting. Clinical leaders need to drive reforms that are required in the redesign of models of health service delivery and new roles in the health professional workforce.

Chapters 5 and 6 explain the proposed approach to clinical leadership and the establishment of clinical networks which this Review supports as the best way to ensure meaningful input and decision making by clinicians to achieve health service enhancements.

Efforts to encourage clinical leadership require complementary changes in the traditional Central Office, hospital executive leadership style, to one of less command and control, to one more in keeping with strategic direction setting policy guidelines and reporting. The style of leadership required will depend more on enabling and supporting clinical networks and teams and providing information to ensure clinical objectives, outcomes and targets are achieved in a resource constrained environment.

The changes required are significant and profound and will require extensive leadership capacity building. Furthermore, members of the organisation will keenly observe the reform process, to see if it is based on fair and just principles supported by appropriate leadership.

The following principles will be important:

- That all existing managers and leaders have the opportunity to understand reform intentions and be supported to develop new leadership approaches before their suitability for providing ongoing leadership is judged.
- That once leadership development has been offered, leaders would be supported in their endeavours to lead and manage in more appropriate ways using more appropriate behaviours.
- The organisation takes steps to effectively assess whether leaders are setting the right example, and if leaders are unwilling or unable to do this, ensure that they are not in leadership roles. For example excellent clinicians who are not necessarily leaders should be able to pursue a career path which develops and maintains clinical excellence without leadership responsibility.
- The reforms are implemented in a way that encourages leadership to be shared at all levels in the organisation but particularly at levels closest to the point of health service delivery.

An example of how would this leadership development would work:

District Manager Leadership Competency Assessment

When the District Manager (DM) undertakes the leadership development program the chair of the District Health Council would be encouraged to also be involved.

Following the program a fair and balanced review process should be undertaken by the District Health Council. This could comprise:

- preliminary informal feedback on how the DM is tracking 3 months after commencing the program. This enables the DM to address identified issues and
- formal review 6 months and 12 months into the program which would involve broadly based feedback from peers, subordinates and supervisors.

The criteria for assessing leadership performance will be based on the leadership behaviours promoted in the leadership program.

External support would be provided to District Health Councils to undertake this review process.

Similar processes to that described in the box above would be used to assess all senior leaders in the organisation. For example the Area Health Council could be responsible for review of the Area Health Service General Manager and Director-General.

It is proposed that the Auditor General will monitor the entire process to ensure assessment of all leaders is being carried out appropriately.

4.4.2 Team building

Another essential feature of culture change (perhaps the most important) will involve multi-disciplinary teams working together to establish an atmosphere of trust. Leadership at all levels will be encouraged and culture changed in Queensland Health when staff experience a new working environment which encourages, supports and depends upon multi-disciplinary teams discussing and sharing common values and objectives, developing new ways of addressing old problems, implementing change and experiencing success. Participation in team problem solving, workplace redesign, systems improvement and patient-centric care are essential to the development of an improved culture.

4.4.3 Promoting healthy relationships between staff and managers

The culture of Queensland Health will depend ultimately upon the behaviour of staff at all levels in the organisation. If staff understand the values of the organisation, how their role contributes to achieving health outcomes, are adequately supported and developed, and treated with fairness and mutual respect they will be more motivated to embrace cultural change and the reform agenda.

Communication with staff should be enabling and inspiring rather than punitive or constraining. This should encompass all written information including the Code of Conduct, policies, plans, instructions and guidelines. Most importantly relevant information will be shared.

The Review supports the recent decision by the Minister for Health to develop a new Code of Conduct for Queensland Health to set a high standard of behaviour for both managers and employees. However, it should be recognised that a commitment must be given to ensure that staff receive appropriate education on its purpose and application within Queensland Health along with a clear indication of their responsibilities as individuals towards acceptance of the code.

The new Code of Conduct must clearly be framed in a context of understanding the complex nature of healthcare. Whilst it is important that staff are cognisant of the government framework within which they work, their primary allegiance is to health and patient care. Values, professional ethics and allegiance to patient care should receive prominence in any revised code of conduct.

Managers and supervisors need to have the appropriate skills to manage and develop staff, undertake effective performance assessment and to deal with performance issues before they result in grievances. To undertake this they will also need to access support and training in the leadership and management behaviours that the organisation requires.

A process must be in place to monitor the performance of staff which relates to their primary duties. For staff in senior positions, a formal process in which roles and deliverables are agreed upon, recorded and regularly reviewed is required. The existing Queensland Health Performance Appraisal and Development (PAD) process appears to be a suitable tool to support this formalised process.

For other staff, more flexible approaches should be used, combining a mixture of formal and informal processes. There appear to be two key issues in implementing an effective performance appraisal process at more operational levels:

- that managers and supervisors take time to meet with staff on a regular basis to discuss and agree upon:
 - the expected contribution of that staff member (outputs)
 - the expected contribution of the staff member to the organisation's goals
 - the staff members training and development needs
- that staff see the process as a developmental (rather than punitive) process by being able to access their identified training and development needs.

There is no perfect system for performance appraisal and development. However, by taking a more flexible approach, it is likely that staff will increasingly view the process as relevant and use it to improve their performance.

Where there are concerns with staff performance or behaviour, managers and supervisors need to have the skills to deal with these issues in a manner that encourages learning and development. This is a difficult area and in recognition of this Queensland Health should provide access to training and skills development for managers and supervisors who need assistance. This could be through leadership programs as outlined in Chapter 14. Queensland Health should also establish a dedicated unit to provide human resource expertise and "coach" managers and supervisors when they are dealing with diminished performance or issues of inappropriate behaviour.

4.4.4 A fair and effective grievance process

While an effective grievance process is endorsed, Queensland Health needs to provide managers and supervisors with training and development in communication and management strategies to reduce the potential for grievances. The number of grievances should be monitored as an indicator of workforce climate.

The management of grievances should also be monitored with a view to more timely resolution. All grievances should be logged in the complaints database (discussed in Chapter 9). A dedicated team should monitor adherence to these timeframes and escalate variations for resolution. Managers responsible for resolving these grievances should be provided with additional “coaching” support through a dedicated team of human resource staff with the expertise in this area.

Given the variable skill level of staff appointed to investigate grievances, Queensland Health should review current arrangements and consider contracting the private human resource sector to conduct investigations. This may result in more timely investigations with staff who have the up-to-date procedures with reduced potential for bias.

4.4.5 Ongoing monitoring of organisational culture

Some areas within Queensland Health, including some districts, have previously used staff surveys (similar to one discussed in 4.1.2) to gauge the attitudes of their staff. The information gained from this most recent survey can now be added to the database and should form the basis of ongoing conduct of workplace culture and staff satisfaction surveys to enable Queensland Health to monitor and understand trends in organisational culture over time.

Results of these surveys should be discussed with staff locally with necessary facilitation and support. This will give staff greater confidence that they will be involved in developing appropriate local responses to issues raised. It will also be incumbent upon management to ensure that an appropriate organisational response occurs at all levels.

Surveys would optimally be carried out at two yearly intervals to enable this monitoring to occur.

4.4.6 Accountability

The challenges which lie ahead in regard to positive culture change in Queensland Health should not be underestimated. It will require insight about the totality of the organisation’s culture, so that reform and renewal activity can build upon the strengths of Queensland Health’s culture and devise strategies, leadership arrangements, systems and structures that will systematically extinguish the negative aspects and replace these with more positive behaviours as a basis of building improved relationships which will lead eventually to the improved culture desired.

Chapters 5 and 13 propose new external checks and balances that will assist in keeping Queensland Health accountable in pursuing the quantum of change that is necessary. This includes a Health Commission reporting to a Parliamentary Committee and an increased role for the Auditor General in monitoring Queensland Health's progress in achieving the recommendations of the reform agenda.

Recommendation 4.1

Appoint a senior executive leadership team able to demonstrate positive leadership behaviours.

Existing senior managers should demonstrate required leadership behaviours and be genuinely committed to processes to eradicate bullying and other inappropriate aggressive or coercive behaviours. They should be supported in this through leadership development programs.

Leadership style and behaviours should be monitored to ensure only those leaders with the capacity to influence culture in the manner desired remain in critical leadership positions.

Clinical leadership should be fostered and encouraged and progressively relied upon to be responsible and accountable for many of the functions currently performed by executives in Corporate Office and district hierarchies and executives.

Written correspondence, especially the Code of Conduct, formal policy and guidelines should be written in an enabling rather than constraining manner.

Staff should be encouraged to form allegiances to a new set of organisation values that are patient and consumer centric whilst maintaining a performance and efficiency orientation.

Surveys of workplace culture and staff satisfaction be undertaken regularly across the organisation so that all districts can monitor their progress with cultural change through time.

Recommendation 4.2

New approaches are developed to deal with staff conflict and grievances to be supported by

- access to training for managers where required to ensure that they have the skills to manage and develop staff and undertake performance assessments
- formalised performance assessment processes for senior executive staff and more flexible approaches for other staff which involve regular discussions with managers and supervisors, monitoring access to agreed training and development opportunities, clarifying expectations and reviewing performance
- local access to industrial and human resource expertise to assist managers in effectively dealing with difficult and complex human resource issues
- a system to monitor the effective and timely resolution of grievances and
- a review of the effectiveness of the current internal process of investigation with a view to utilising private sector Human Resource expertise in this area.