

7. Culture

7.1 Key findings

The organisation's culture has a profound impact on staff and systems performance. Culture is best defined as the prevailing pattern of behaviours, attitudes, values and beliefs which characterise an organisation. In the case of Queensland Health, it has been frequently reported during district visits, that at least a part of this culture can be described as one of bullying, threat, intimidation, coercion and retribution on the one hand, and of secrecy, covering up of faults, blaming, accusing and avoiding responsibility on the other.

Whilst these perceptions were strongly reported at certain staff forums, they reflect one aspect of the culture that makes up our public health system and Queensland Health the organisation. There are other very positive aspects such as a culture of dedication towards patient care and wellbeing which was also very strongly evident during district visits. To properly deal with the issue of culture will require enhanced 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.

This is an absolute imperative in any health service where honest, open and blame free behaviours and values are essential prerequisites for performance at every level but particularly for properly identifying risks to patient safety and managing and eliminating these unnecessary risks.

Achieving this 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 over the years have learned 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.

7.1.1 A survey of culture in Queensland Health

This Review commissioned the University of Southern Queensland to conduct an independent survey of culture in a number of districts and in a part of Corporate Office, to compare with earlier benchmarks. Additional questions to ascertain the cause of dysfunctional behaviour were also included in the survey.

The survey achieved a high (40 percent) response rate from staff in two targeted districts and part of Corporate Office. This is pleasing given the short time frame available.

Provisional results of this survey are below. Some details are also provided from the survey regarding staff views of bullying-type behaviour in Queensland Health:

Positive features:

- Relatively favourable scores on Individual and Workplace Morale, Professional Interaction and Professional Growth. These scores were not significantly different from benchmark levels from previous surveys in Queensland Health and the broader Public Service.
- Positive ratings to staff attitudes to patient care across the board.
- Bullying-type behaviours were reported by 70 percent as occurring rarely, never or sometimes in their workplace.
- 30 percent reported that this occurred often or very often.

Areas of concern:

- Relatively low levels of Participative Decision Making where the comparative benchmark is already significantly below the public sector Queensland benchmark.
- Relatively high levels of Excess Work Demands, showing a deteriorating situation.
- High levels of conflict and antagonism in the workplace, most likely to be related to work pressure and the powerlessness associated with decision making.

Those attitudes rated most positively by staff in the health service districts were:

- Staff dedication to patients
- Can do mentality
- Patients needs always come first

Those attitudes rated as most positively by staff in the corporate units were

- can do attitude
- staff dedicated to patients

The behaviours rated most positively by all work units were

- friendly
- cheery/happy

Views Regarding Bullying:

Respondents in the survey were asked to comment on their experience about a range of behaviours that may indicate bullying, intimidation and retribution.

These behaviours included conflict or antagonism, implied or real threats, exclusion or dejection, humiliating comments, loud abusive language, physical violence, being the brunt of practical jokes and having someone take credit for the work of another.

The most common responses regarding different bullying-type behaviours were that it occurred rarely, sometimes or not at all. Conflict or antagonism was reported as the most common bullying-type behaviour (by 88.8 percent of respondents). Where it did occur, it was likely to involve supervisors and leaders and or other occupational streams.

However, only a small number of respondents (6.6 percent) indicated they had never experienced any of the range of bullying-type behaviours, while 24.9 percent replied they had "rarely" or "never" experienced them.

It is of note that 14.4 percent of respondents considered they had been subject to implied or real threats at least once a month or once a week, while 29.6 percent of staff who responded indicated they had been subject to conflict or antagonism often or very often.

There was a significant difference in the responses from health districts and Corporate Office. Only 19.9 percent of district respondents indicated they have never or rarely been subject to bullying behaviours compared to 43.1 percent of Corporate Office respondents.

Leaders, supervisors and individuals across clinical streams were identified as the most common source of such behaviour (67.5 percent).

A majority (54.3 percent) of those who indicated that the behaviours had been occurring in their workplace reported that they had been happening for more than 5 years.

In summary, bullying is a very concerning issue but not quite as widespread as reported anecdotally. High levels of conflict and antagonism, however, are a feature. Both sets of issues, according to many of those surveyed, are often driven by a preoccupation with financial imperatives which are seen to conflict with standards of patient care and outcomes.

The full results of this survey and its validity for the whole Queensland Health organisation will be provided in the final report. However, at this point it is useful to explore the genesis of the dysfunctional aspects of culture.

- Hospitals historically arose from the military model (base hospitals) where specific categories of personnel were assigned rigid roles and responsibilities in strong formal hierarchies.
- Hospitals historically have exhibited this 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 eg levels within nursing, levels within medical streams, allied health stream, operations staff.
- Clear and concise lines of responsibility and decision accountability have been an essential feature of the running of acute hospitals for many years where life and death decisions, immediate and urgent decisions, clear instructions and immediate responses are essential parts of efficient operation. Conflicts have always been present but traditionally were subjugated by the rule of authority.
- On a more positive note, perhaps the strongest and most enduring part of this traditional culture is the commitment both individually and collectively to undertake work in the best interests of patients. People who join a health profession and choose to work in the public health system in particular do so for good reasons. These are frequently explained by a commitment to their professional discipline and interest in the well being of patients, and commitment to associated issues such as teaching of junior staff, progressing ones discipline

through learning and research and achieving improved health status for the community generally.

- Hospitals can be turbulent places especially when under intense patient workload pressures. People seek to create their own small area of predictability/stability to give some comfort amidst such turbulence. Threats to these domains are repelled decisively and at times aggressively. Hence the term “tribal” being commonly reported to the Review Team to explain inter-group conflict.
- Developments in recent years have placed significant strains on this traditional culture:
 - Training and education of hospital workforce now occurs in educational settings quite removed from the acute hospital work place. Continual direct experience with the hospital culture and environment does not really begin until graduation from university (in the case of allied health professionals, doctors and nurses, even though there may be some considerable periods of student training time).
 - Today's graduates contain higher percentages of mature age personnel and all graduates are taught to enquire, challenge, question, to reason and to debate. They do not automatically accept the status quo. The professions have also changed. Traditional rank and status structures are being and have been seriously challenged. These issues can place considerable pressure on a traditional culture in an organisation where the average age of senior clinicians (both doctors and nurses) is 46+ years.
 - Modern medicine requires multi-disciplinary team performance. This holds promise as the way forward.

It is against this background that reported negative aspects of culture need to be considered and understood. These aspects were variously reported and explored with staff at forums around the State as outlined below.

7.1.2 A cost minimising budget balancing imperative

During the last ten years, Queensland Health has changed from an organisation that always exceeded its budget by significant amounts, to one that meets allocated budgets. This has been described by staff as a process that has been driven by very firm and at times threatening and bullying behaviour to achieve budget outcomes often at the expense of reasoned and logical discussion and decision about patient care and clinical outcomes.

There has been an expectation backed with behavioural enforcement and threat by leaders, managers and supervisors at every level to achieve budget imperatives, to do better with less. There has been a clear message 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.

7.1.3 Management and supervision of personnel

It was frequently reported that leaders, managers and supervisors have limited skill 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 or disaffected.

All too frequently staff concede that problems are addressed through processes where verbal instruction evoked antagonism and formal processes involving lengthy written correspondence, the lodgement of formal grievances and lengthy investigations with inconclusive outcomes. All parties emerge from such conflict with escalated feelings of anger, frustration and remembered resentment.

While there were examples where the Review Team encountered reports of effective management, with teams that engaged successfully with their staff and consulted about problems, many staff focused on areas where systems are not working well and there was seen to be a degree of dysfunctionality.

7.1.4 The Queensland Health perception

Most district staff encountered, when raising adverse comment about Queensland Health, had Corporate Office in mind. This is usual in large organisations but the strength of negative sentiment was very evident in the Queensland Health case. They describe an entity disconnected from district frontline health service reality, obsessed with budget and cost control imperatives, and prone to develop and mandate a broad range of new procedures, policies and requirements. While these may be well intended, there was a sense that they were almost always poorly implemented ie. no or limited resources, unsuited to local circumstances and poorly coordinated.

In essence, an enormous frustration exists with the corporate entity.

Whilst staff acknowledge that Corporate Office has capable personnel that can develop well researched contemporary policy, the capacity for districts to effectively implement this has been completely over estimated, and frequently the content is unsuited to a districts circumstance.

7.1.5 Bullying and intimidation

Bullying, intimidation and retribution have been described repeatedly throughout the State as typifying part of Queensland Health culture. Descriptions such as tribalism, “bullying culture”, “tokenistic consultation”, “no culture of teamwork” and a “culture of power and control” were repeated themes throughout the consultation. Where bullying existed, there were examples of inaction or lack of appropriate and timely action by management. Some managers cited cases where they were not prepared to manage poor performance for fear of being labelled a bully.

This should not distract from the very positive behaviour of staff also described as being “helpful and supportive”, “committed to a standard of care for patients”, and “having pride” in the services they provide.

In many cases, the relationship between low staffing levels and low morale was clear. However, where there was evidence that strategies were in place, and management were seen to be trying to recruit, staff responded positively. Many stated that whilst they were working under pressure, at least management tried to recruit and kept them informed about what action was being taken.

7.1.6 Communication

Open communication appears to be an important issue for many staff at all levels of the organisation. Most quoted examples of both poor and exceptional communication skills by managers within the system. Staff described a situation of open communication as being the ideal workplace, but many felt that did not describe their local environment.

7.2 Principles for consideration

- Leadership, team development, empowered front line staff and appropriate health service reform strategies will best address negative aspects of culture
- Systems which encourage communication within Queensland Health that are more open and transparent
- A learning culture which resolves problems, learns from failures, and is better able to respond to changing situations and requirements in a self sustaining manner.
- Leaders, managers and supervisors who set the right example and demonstrate and expect a zero tolerance approach to bullying
- Leaders, managers and supervisors with skills to address and resolve interpersonal conflict in a timely, direct and fair manner
- Empowered staff involved in decisions which concern their workplace
- Strong systems of role delineation whereby responsibilities and accountabilities are well defined and understood at different tiers within the organisation
- Systems and an environment in which staff feel encouraged to raise issues of concern within a formalised process without fear of intimidation
- Easing the excessive workload pressures especially in the most pressured health services.