

Developing and implementing an action-oriented staff survey: Queensland Health and the "Better Workplaces" initiative

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QUEENSLAND HEALTH IMPLEMENTED the "Better Workplaces" staff opinion survey (the survey) in May 2006. The initiative stands as the largest single staff survey ever conducted in Queensland, and one of the largest in Australia. This case study outlines the process of this project, the outcomes to date and some of the pitfalls and successes along the way.

Logistically it involved 37 health service districts and 10 corporate areas spread across the state. The survey process incorporated four survey periods over two years. The aim of the survey was: to improve workplace culture at the local level and across the organisation as a whole. Workplace culture is defined by Cole as "The collection of unwritten rules, codes of behaviour and norms by which people operate, how we do things around here"¹ Queensland Health proposed to improve its workplace culture by listening to staff and developing and driving targeted action plans following the survey with each district and division to create a climate of trust, respect, and innovation among staff which will ultimately improve patient outcomes. "... The creation of a culture that is free of

blame and encourages an open examination of error and failure is a key feature of services dedicated to quality improvement and to learning."²

Setting

The "Better Workplaces" program was initiated by Queensland Health subsequent to the Queensland Health Systems Review (the review) conducted in 2005. The review resulted in a lengthy report with several specific recommendations that focused on the need for cultural change within Queensland Health. The rationale behind these recommendations was that:

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.³ (p. 56)

While workplace culture was being addressed by individual districts and divisions who had surveyed staff and subsequently implemented initiatives, there had never been an organisation-wide coordinated strategy designed to improve the workplace culture of the organisation in its entirety. Part of Queensland Health's response to the recommendations of the review was to form the Workplace Culture and Leadership Centre (the Centre). The "Better Workplaces" initiative was implemented by the Centre and incorporated a comprehensive program of leadership development and workplace culture improvement. Workplace culture improvement focused on implementing surveys and developing targeted strategies within each

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district in response. This was complemented by leadership development initiatives designed to improve the leadership capabilities of both clinical and non-clinical leaders. Leaders have significant impact on workplace culture which in turn influences how individuals and teams perform, which affects patient outcomes. Research indicates that improvements in quality of clinical care are positively associated with culture that emphasises teamwork and innovation,⁴ which reinforced the focus on leadership development in Queensland Health as being critical to the workplace culture improvement process.

External consultants were engaged to assist with the deployment of the “Better Workplaces” survey and the analysis and reporting of the results. The Community and Organisational Research Unit (*core*) at the University of Southern Queensland (USQ) was selected and continues to provide this service to Queensland Health.

Participants

Every Queensland Health staff member, irrespective of their vocation, was given the opportunity to anonymously complete the “Better Workplaces” staff opinion survey. Due to the size of the organisation, about one quarter participated in each of four rounds, over a period of 2 years, the first of which was in May 2006. The organisation strived to achieve the highest possible response rate to ensure the data collected was reliable. Response rates recorded from each of the four survey periods were 31%, 37%, 34% and 29%, respectively, which were considered reliable data by researchers at USQ.

Methodology

Staff were given 3 weeks to complete the survey. Despite the obvious economic and administrative constraints associated with coordinating such a large scale paper-based survey, it was considered that due to time and technical resource constraints, to achieve the best possible response rate, staff would have the opportunity to complete the survey online and in paper format. Survey responses

were sent directly to USQ, with no Queensland Health staff having access to completed survey responses. Districts and divisions provided contextual information relating to the climate in which their survey was completed to complement the analysis of the data provided by USQ.

The initial survey questionnaire comprised questions that measure individual outcomes and organisational climate from the organisational health research model developed by Hart, Griffin, Wearing and Cooper, the Queensland Public Agency Staff Survey (QPASS).⁵ This model proposed that positive work experiences mainly influence individual morale while negative experiences mainly influence individual distress.⁶ Specifically, the following QPASS measures were included: quality of work life, individual morale, individual distress, workplace morale, supportive leadership, participative decision making, role clarity, professional interaction, appraisal and recognition, opportunity for professional growth, goal congruence (the fit between personal and organisational goals), workplace distress, and excessive work demands.

In addition to the QPASS measures outlined above, appropriate questions were developed through reviewing and modifying questionnaires that were utilised in similar organisations. These questions focused on harmful behaviours, trust in leadership and aspects of clinical work practices and were refined to reduce the overall number of questions while retaining the reliability of the measures (estimated Cronbach's alpha ranged from 0.65 to 0.96). The measures assessed: work area management practices, confidence in processes to resolve harmful behaviours, workplace health and safety, teamwork, clinical work, and support for managing others. The overall prevalence of harmful behaviours in the workplace was also collected. The phrase “harmful behaviours” was intended to capture all of what individuals might separately refer to as harassment, abuse, intimidation, or bullying in the workplace. Levels of trust in the leadership of the organisation were measured for multiple levels of leadership; including the immediate Supervisor, Senior Manager and District/Divisional Executive. Aspects of

leadership such as the making of fair and transparent decisions, communicating with staff, doing what they say they are going to do and listening and being responsive to staff were included in the measurement constructs. With organisations with high trust outperforming organisations with low levels of trust by nearly three times,⁷ collecting such information and implementing strategies addressing any gaps in leaders' skills is arguably one of the key components of the survey and its subsequent action plans. Finally, free-text comments were invited from respondents outlining realistic suggestions for improvement and information on where aspects of their working lives had improved.

Outcomes/follow-up actions

Preliminary results became available to executive management 6 weeks after the survey closed, with final reports presented to executive teams after about 12 weeks. District and divisional reports were published on Queensland Health's internal website following staff presentations. The report of the overall results for Queensland Health was published on the Internet, in line with the philosophy of greater transparency. (See <http://qheps.health.qld.gov.au/betterworkplaces/culture/interpret.htm>)

Strategically, the survey results informed organisation-wide initiatives to address leadership, harmful behaviours and workplace health, among other issues. For example an "Energising from Conflict" workshop was developed and implemented by the Workplace Culture and Leadership Centre as a direct result of the survey indicating a high occurrence of harmful behaviours, particularly in the clinical environment (from colleagues, managers and the public). Workplace culture information pertaining to specific target groups such as nurses, emergency departments or Indigenous health workers is available to those responsible for policy development and planning for those groups. This may assist in the development of strategies at an organisational level. Successes of initiatives developed specifically for such groups can then be measured over time.

An interactive database developed by USQ has been made available to those responsible for workplace culture improvement (specifically, local coordinators in districts and divisions and the Workplace Culture Team). The database, enables individuals to obtain data pertaining to specific groups and facilitates a targeted approach to action planning. Importantly, to protect the privacy of respondents, data are not available for groups with fewer than ten responses. A demonstration version of this database is available from <https://psych.sci.usq.edu.au/core/sec/downloads/imo.zip>. Details for accessing the database are available from the USQ authors.

Additionally, the free-text comments collected in the survey are categorised and entered into another database. This database is available only to the Workplace Culture Team who provide comments pertaining to individual districts and divisions to the executive of these work areas.

Integral to the workplace culture improvement process is an action-oriented plan to address issues highlighted in the survey. The Workplace Culture Team established a comprehensive action planning process to ensure the focus remained on workplace culture improvement. After providing all staff with the opportunity to receive their results, districts and divisions are required to submit an action plan targeting the issues in the survey. In addition to being a resource to local coordinators by providing expert advice on the development of strategies to address workplace culture improvement, the Workplace Culture Team assesses local action plans to ensure they are relevant, achievable and measurable. Progress of the plans is monitored over time by the team and is incorporated as part of performance agreements of executives.

The Workplace Culture Team designed a number of resources to assist local change agents, such as the information guides "Supporting your Staff" and "Participative Decision Making", to be used by local areas to assist with the development of their action plans. (Information guides may be found at <http://qheps.health.qld.gov.au/betterworkplaces/culture/resources.htm>) Work areas are encouraged to consult other data including

WorkCover, absenteeism and leave data before formulating the plan. Examples of actions implemented as part of the initiative include:

- reducing the level of harmful behaviours, through education strategies (code of conduct training) and encouraging team-building activities;
- addressing harmful behaviours from the public, by promoting a “zero tolerance for violence” project;
- improving the levels of communication across a district, by introducing district newsletters and developing strategies to improve communication between teams (both clinical and non-clinical); and
- improving trust in leadership, and in particular the District Executive, by rotating the location of executive meetings to allow executive team members to be present in rural areas.

The root of most of the action plans involves improving the relationships among co-workers and their managers. Improving and maintaining such relationships should provide the foundations of improved workplace culture.

Progress on action plans is reported biannually to the Workplace Culture Team, who in turn brief the Executive Management team. District and divisional executives are held accountable to achieve the targets or outcomes identified as part of their plan through key performance indicators contained in performance agreements.

Integral to the action planning process is staff consultation and communication. Districts and divisions are encouraged to link the positive workplace culture changes to the survey process by referring to the survey when delivering and implementing a strategy. This ensures staff understand that the changes being implemented are related to issues they raised and increases the credibility of the process by ensuring staff see that management have listened and acted on issues they have raised.

Problems and constraints

There have been a number of hurdles to overcome throughout the initiative. An organisational

restructure occurred part way through the first survey cycle, adding logistical considerations to the process. The restructure reduced the number of health service districts from 37 to 20, requiring considerable demographic and process realignment. Districts increased in size and changed reporting structures, placing increased pressure on individual districts to manage their communication strategies and existing workplace culture action plans sensitively. The processes initially implemented by the Workplace Culture Team were adapted to enable reporting and action planning (occurring at the district level) to continue to progress as desired and be reported as seamlessly as possible. Strategies were put in place to ensure that workplace culture at the local level remained the focus, while ensuring organisational accountability and consistency were retained.

In order to achieve a response rate of at least 30%, local district coordinators undertook various strategies including the use of promotion and marketing materials developed and distributed by the Workplace Culture Team, such as posters and pens. However, despite such support and incentive, there were certain issues which hampered achievement of consistently high response rates.

The large metropolitan hospitals generally achieved lower response rates than their rural counterparts. The precise cause of this is as yet unclear, however anecdotal evidence suggests that there could be a number of contributors such as smaller numbers in rural areas enabling local coordinators to spend more time with respondents and explain the survey process and possible outcomes to them.

When asked to participate in a staff opinion survey, some staff were sceptical and apprehensive. Anecdotal evidence suggested that this was mainly due to staff perception that: 1) they could be identified through the demographic data and 2) that nothing was going to be done with the information the organisation received (based on previous experiences).

To address the issue of confidentiality, an education strategy was undertaken by the Workplace Culture Team and the area coordinators to inform potential participants about the restrictions

placed on obtaining information from the survey. For example, no data are available for groups who have fewer than 10 respondents. Information was disseminated explaining the sequence of numbers at the bottom of the survey questionnaires (which assists the scanning software to locate answers on each separate page on the survey). Finally, participants were invited to swap their entire surveys with a colleague before commencement. Such a concern with personal identification in the survey could indicate a level of distrust, which inhibits the collection of truly representative data on which to develop appropriate action plans.

To address the issue of staff perceptions that nothing would be done as a result of the survey findings was a more complex task. Increasingly it has become evident that districts that had independently undertaken staff surveys before the "Better Workplaces" initiative, and had implemented tangible actions as a result of information obtained from them and communicated those outcomes back to staff, achieved higher response rates than others. In these work areas the senior leaders played a major role in modelling the behaviour, including doing what they say they are going to do and encouraging a culture of openness and trust. In areas which had not experienced such dynamic workplace culture-focused leadership, the challenge was greater. To provide these staff with inspiration that changes were occurring elsewhere in the organisation, a case study booklet highlighting positive workplace improvement was developed and distributed by the Workplace Culture Team. The booklet focused on changes being made at the local (ie, ward and work unit) level. Local coordinators made significant efforts to encourage staff to participate in the survey so that results for their work areas could be analysed and that they could achieve changes similar to those identified in the case studies booklet.

Discussion

Given that the key objectives were to listen to staff and develop and drive action plans with each district and division in order to create a climate of trust, respect and innovation, it could be said that to date the initiative has been a success. The

survey continues into its second cycle which commenced in 2008. Once districts and divisions have completed the survey for the second time they will have the ability to compare their results from the second round with those from the first. It will become evident then whether actions implemented at the local level and organisation-wide strategies such as the leadership development program have been successful.

A new methodology for reporting workplace culture has been developed by USQ and will be introduced as part of this second cycle of surveys. The methodology is called the Measurement of Outcomes Index and is based on Rasch modelling theory. Scores are measured in outcome units and all scores previously recorded have been transitioned into this format. It is anticipated that the second cycle will enable Queensland Health to accurately measure improvements over time, and by continuing to focus on workplace culture, make it a good place to work. A second article entitled "Results and Actions from the Queensland Health, 'Better Workplaces' Staff Opinion Survey" is available, highlighting specific results from the survey and actions developed to address these.

There has been considerable learning from the process which could be applied to any large, multidisciplinary and geographically dispersed organisation, particularly with regard to developing a level of trust. Trust is increased when leaders do what they say they are going to do and communicate their actions to staff. Drucker states that for leaders to gain the trust of their staff, there must be congruency between a leader's beliefs, his/her words and his/her actions and these must be consistent.⁸ It is hoped that increased trust in leadership within the organisation will encourage staff to respond to a survey without fear of identification or victimisation. Because relationships play a key role in building trust, strategies implemented as a result of the surveys to address this issue may assist in achieving a higher response rate to the survey in future years.

Competing interests

The authors declare that they have no competing interests.

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