

Actions and results from the Queensland Health “Better Workplaces” staff opinion survey

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Objectives

In April 2006, the Workplace Culture and Leadership Centre (the Centre) from Queensland Health launched the “Better Workplaces” initiative. The objective was to improve workplace culture and increase the capabilities of its leaders. A comprehensive program of leadership development complemented the workplace culture improvement strategy. As part of the initiative, the Centre launched a series of staff opinion surveys to monitor workplace culture improvement over time. To ensure the survey process was action oriented, the Workplace Culture Team developed a companion process ensuring the results were acted upon and tangible improvements were realised. This resulted in a comprehensive and robust process involving the development and implementation of action plans in every district and division in Queensland Health.

Setting

Queensland Health is a geographically dispersed, multidisciplinary, multicultural organisation comprising about 68 000 employees. Queensland Health staff provide admitted care in acute care public hospitals to about 3 million people per annum, as well as non-admitted patient services, including emergency services, in acute care public hospitals to about 10 million people. Queens-

land Health receives regular media attention that potentially impacts staff morale both positively and negatively. Immediately before the initiative, a Queensland Health Systems Review¹ had been undertaken, recommending focus be placed on the improvement of workplace culture, specifically by conducting staff opinion surveys to find out how staff feel about their working environment. The Workplace Culture Team developed subsequent processes to ensure action was taken following those surveys.

Participants

All Queensland Health staff were invited to participate in a confidential “Better Workplaces” staff opinion survey (the Survey), full details of which may be found in the article “Developing and implementing an action-oriented staff survey: Queensland Health and the ‘Better Workplaces’ initiative” in this issue of the Journal.² Due to the large size of the organisation, about one-quarter of staff participate in each survey round to enable appropriate resources to be directed towards participants at any point in time. A survey cycle therefore, consists of four rounds over a period of 2 years. The first survey cycle commenced in April 2006 and the second cycle in April 2008. Surveys are conducted in April and September of each year. Overall response rates recorded from

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each of the survey periods to date range between 29% and 37%, which were considered reliable data by researchers at the Community and Organisational Research Unit at the University of Southern Queensland (Core-USQ).

Methodology/sequence of events

The Survey was developed by the Workplace Culture Team in conjunction with researchers from Core-USQ. The Survey incorporates measures from the Queensland Public Agency Staff Survey (QPASS)³ together with items developed specifically for Queensland Health. Through the process of exploratory factor analysis with the data obtained in 2006, measures were labelled “clinical communication” (the extent to which staff agree that there is bidirectional information, both verbal and documentation for them to do their job); “clinical management” (the extent to which staff agree that there are adequate procedures and systems to support clinical work); “harmful behaviours” (includes behaviours perceived by staff as intimidation, harassment, bullying discrimination or blaming); and “trust in leadership” (the extent to which staff trust the leadership of multi-levels of management through behaviour such as openness and integrity in communication and interaction, support and fairness).⁴ Reliabilities ranged from an estimated Cronbach’s alpha of 0.65 to 0.96. The measures which were retained in subsequent survey rounds continued to be refined by researchers at Core-USQ and reliabilities from all datasets maintained at above the acceptable level of 0.7.⁵

An interactive database, iMO, developed by Core-USQ, was made available to those responsible for workplace culture improvement in districts and divisions. The database enables individuals to obtain data pertaining to specific groups such as work groups or occupational stream groups. Importantly, to protect the privacy of respondents, data are not available for groups with less than 10 respondents.

Once districts and divisions have received their results and have interrogated the database, action plans are developed and implemented at the local

level, addressing issues highlighted by staff in the survey.

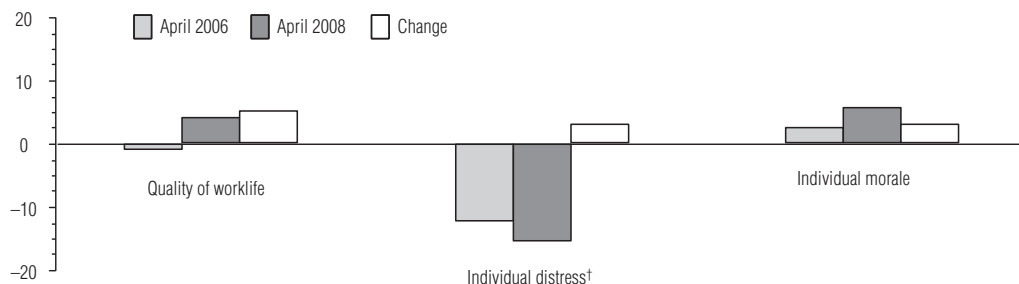
District and divisional executives provide information on the implementation of their action plans to the Queensland Health Executive Management Team as part of the performance reporting process. Implementation of staff survey action plans is a key performance indicator designed to facilitate Queensland Health valuing and developing its staff. To make sure accountability is maintained at the local level and that focus remains on improving workplace culture at an organisational level, the Workplace Culture Team provides additional reports to the Executive Management Team highlighting workplace culture improvement strategies being implemented by districts and divisions.

Outcomes

The combined response rate for the organisation across the first four survey rounds (cycle one) was about 33%, with close to 20 000 valid responses received over the 2-year period. While each survey round experienced its own specific characteristics (such as media attention or an organisational restructure), which may have affected individuals’ responses to the survey questions, generally, the results for the four periods were consistent. Results were provided initially to Queensland Health by Core-USQ in a report format, with more targeted information available through interrogation of the database.

Positive indicators for the first survey cycle (2006–2007) were that “individual distress” was low, the level of “peer support” was pleasingly high and that measure, along with “role clarity”, consistently achieved the highest QPASS scores. “Trust in immediate supervisor” was consistently at a commendably high level relative to “trust in senior manager” and “trust in district executive”. (Differential scores for the different levels of managers was the trend throughout the survey cycle.) Clinical work measures such as “clinical communication and multidisciplinary team support for patient care” scored highly. Respondents consistently indicated that relationships among

I Individual outcome measures for April 2008 respondents across Queensland Health



† Negative scores desirable.

co-workers and availability of the right materials and equipment to do their job were the best indicators of quality in their workplaces.

Key challenges for the first survey cycle were the high levels of “workplace distress” (a perception that other staff in the workplace feel frustrated, stressed, tense, and anxious and depressed about their work), which stood in contrast with the relatively low levels of “individual distress” (the individual’s self-assessment of their levels of feeling tense, afraid, unhappy, anxious, negative, uneasy and depressed at work). It was identified through regression analysis undertaken on Queensland Health’s survey data by researchers at Core-USQ that failure to address the high levels of workplace distress may result in the rise of individual distress in coming years. The level of “excessive work demands” was high across all survey periods. While scientific research indicates that poor role clarity is a primary contributor to the perception of excessive work demands,⁶ due to aforementioned high levels of role clarity, it is clear that this is not the case for Queensland Health staff. The level of trust in district executive was lower than desirable. In all four survey rounds in cycle one, the percentage of respondents who reported experiencing some level of harmful behaviour in their work area in the 6 months before the survey being conducted was about 30%. The behaviour was being experienced predominantly from co-workers followed by supervisors, and then by members of the public. About 30% of respondents who experienced

harmful behaviour did not report the behaviour. The main reason cited for not reporting the behaviour was that there was a perception that nothing would be done. Respondents consistently indicated that recognition for work and leadership and supervisors’ skills most needed improvement in their workplaces.

Results were available at the district/divisional level, and more in-depth analyses were conducted (utilising iMO) and presented to executive teams by work group, work function or occupation stream (providing the group had more than ten respondents). District or divisional reports are available on local intranet sites. The report presenting information pertaining to the organisation as a whole is available on the Queensland Health website.

Each district and division developed and implemented action plans targeting issues raised in their survey results. Due to similarities of the results across the organisation, a number of the strategies in action plans were similar. Some examples of the actions implemented include: increasing staff involvement in decisions that affected them, by forming focus groups and forums; education and training to manage harmful behaviours; team building; improved communication processes; and increased focus on rewards and recognition initiatives. These strategies, together with a comprehensive suite of leadership programs targeting clinical and non-clinical executives, emerging clinical leaders, managers and supervisors across the organisation,

2 Organisational climate measures for April 2008 respondents across Queensland Health



have paved the way for increased trust, improved capability and greater accountability for Queensland Health's leaders.

Additionally, strategies were initiated at an organisational level as a result of the staff opinion survey results. For example, action learning programs targeting leaders have been developed, such as "Energising from Conflict", which was informed by survey results indicating a high occurrence of harmful behaviours, particularly in the clinical environment.

In 2008, the second cycle of surveys commenced. This enabled workgroups to compare their own results over time (5-star benchmarking)⁴ and evaluate the successes of the initiatives implemented as part of their action plans.

A new scoring and reporting system, the Measurement of Outcomes Index (MO-Index)^{7,8} was introduced in 2008. It is based on Rasch modelling and is a logarithmic transformation of cumulative item odds ratios. The MO-Index standardises scores for ease of interpretation and comparison and ascertains the contribution that an individual item makes to each survey measure. From the transformation, derived scores are converted linearly to outcome units, and workgroups aim for scores of ± 8.8 , which represent a commendable score for positive and negative indicators respectively. Consideration is given to the effort required to change workplace culture when a work group has scored a very high or very low score, by increasing the number of outcome units required to shift from a middling score to a

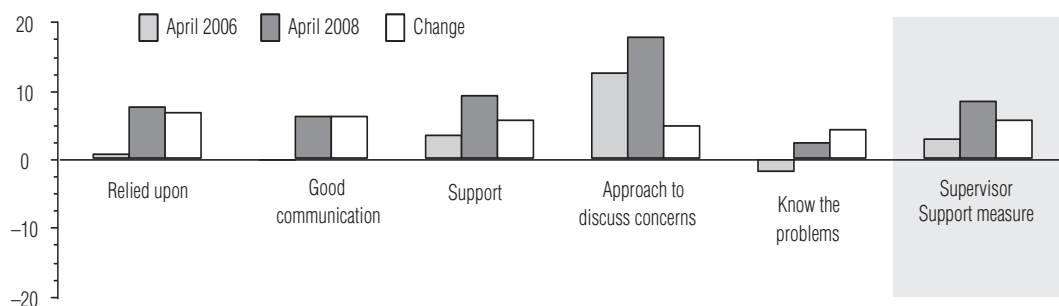
commendable score and a commendable score to an outstanding score.

Results from April 2008⁴ show that significant improvements have been achieved across the organisation. Specifically, there have been improvements in all indicators measuring individual outcome and organisational climate (see Box 1 and Box 2). Three negative indicators, individual distress, workplace distress and excessive work demands, are reported in Box 1 and Box 2. These measures have a target score of -8.8 outcome units, therefore negative scores are desirable.

Notably, the measures of individual distress, peer support and role clarity, which recorded favourable results in the April 2006 survey period, remained commendably high in 2008. Participative decision making and supervisor support were two measures many districts and divisions focused on as part of their action plans and, reassuringly, they were the two measures which shifted most significantly in a positive direction between April 2006 and April 2008.

The MO-Index enables workplaces to further interrogate their data and establish the relative contribution of each item to the score of a measure. For example, Box 3 highlights that not only has the measure for supervisor support improved over the 2 years, but that the item "supervisors can be relied upon" improved the most and "supervisors are approachable to discuss concerns" contributed the most to the overall score in April 2008.

3 Supervisor support measure for April 2008 respondents across Queensland Health



Aside from all QPASS measures showing improvement across the organisation, results show that harmful behaviours, which incorporate bullying, harassment and intimidation, have decreased by over 4% and respondents have indicated a much stronger level of satisfaction that action was taken when incidents were reported.

While at the organisational level results have improved since 2006, results for occupational stream groups also demonstrated improvement over time. Pleasingly, administrative, nursing, medical, dental, health practitioner and operational streams all experienced a positive shift in QPASS scores. For virtually all measures, medical officers reported greater positive change than any other occupational stream, with major improvement being recorded in workplace morale, which is now at a commendable level. Of particular note is the level of excessive work demands, which fell from a challengingly high level to a middling level.

Problems, conflicts and constraints

In the first survey cycle (2006–2007), a criterion-based interpretation of survey results (results that fall into pre-determined target ranges) was used. This was based on percentages and averages. However, averages do not take account of widely differing opinions, or that very low or very high scores are harder to shift than more middling scores. It was also not possible to drill down to

individual questions, and skewed responses for different questions made interpretation and comparison misleading.⁸

To address this, the MO-Index was introduced and commenced at the appropriate second survey cycle. This has been widely accepted by Queensland Health as it has afforded a more robust reporting methodology. More importantly it has provided the opportunity for greatly improved and more targeted action planning and more accurate and detailed reporting of results.⁸ The only difficulty experienced during the transition to the new methodology was the realignment of data from districts that had amalgamated during the 2007 district restructure.

Action planning is an integral part of the survey and workplace culture improvement process.² A number of difficulties were experienced in getting action plans completed by some districts and divisions. These frequently included the lack of a dedicated person to drive the development of the action plan, delays in gaining agreement on action plans due to lengthy but necessary consultation processes, and the increased size and scope of a number of districts that were amalgamated during the 2007 district restructure. A variety of approaches were adopted by these districts, which included completing action plans in a “service line”, “function” or “facility” format to ensure that local workplace culture needs were addressed as well as the needs of the district as a whole. This level of flexibility had the desired effect, in that action plans were developed to suit

local needs as well as whole-of-organisation requirements.

Providing Queensland Health staff with transparent documentation of their staff survey results is a fundamental principle of the "Better Workplaces" staff opinion survey process. Results were available to staff in numerous forms to enable as many staff as possible to have access to them. While some of the results indicated a need for substantial improvement, providing staff with base-level information on which to build was the first step in a potentially confronting process. Willingness of staff at all levels to embrace and own their results and then implement strategies to make workplace culture changes in either small or large work teams placed significant pressure on already stretched resources. The commitment to the process was a potential constraint, which was contingent on leadership commitment to make workplace culture change. The development of leadership commitment was supported through implementation of the leadership development program.

Discussion and lessons learned

Given that the key objectives of the "Better Workplaces" staff opinion survey initiative 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 second survey cycle results indicate improvement in all areas measured by the survey.

Ensuring staff are provided the opportunity to hear their results and contribute to strategies designed to improve them is a key to success when making a commitment to improving the workplace culture for 68 000 employees.

Given that the workplace culture of an organisation is directed predominantly by its leaders,

engaging those stakeholders is of utmost importance. Without the commitment of the executive management teams at both the organisation and district or division level, and supporting those leaders through activities and programs designed to increase their capabilities, improvements in workplace culture would have been difficult to achieve.

Competing interests

The authors declare that they have no competing interests

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