Department of Health and Human Services

The Director’s Toolkit

Chapter 11: Organisational culture and leadership

A resource for Victorian health service boards

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# About this Toolkit

This Toolkit is a resource to assist public health service board directors and other interested parties to better understand the role of directors of health service boards and the operating environment of the public sector health service entities they govern.

The development of the Toolkit is in response to DHHS recognising the need for a stronger emphasis on public sector health governance and enhancing the support tools available to directors of health services. Recent reports such as the *‘Targeting Zero’* review of quality and safety in the Victorian public health service have highlighted the need for greater oversight of clinical care systems across the state in the delivery of high quality, safe, person-centred care.

This accountability starts with the board.

The board of directors is held to be ultimately responsible for virtually every aspect of the health service’s activities. However, it is impractical and undesirable for a board to attempt to supervise minutia associated with the health service’s operation.

Good corporate governance requires a balance between compliance (with codes, regulations and standards) and oversight of operational and financial performance. The core purpose of good governance in health services is ensuring the delivery of high quality, safe and effective person-centred care.

Boards of high performing health services:

* understand the board’s role in governance
* discharge their legal duties
* ensure accountability to stakeholders
* understand stakeholder and management expectations
* effectively use board committees to enhance governance
* build a talented management team
* champion a productive and ethical culture
* make informed decisions
* actively contribute to strategy, and closely monitor strategic effectiveness
* ensure a disciplined approach to risk governance
* receive independent assurance
* actively engage externally on current and emerging issues relevant to their organisation and the political, social, and economic environment in which it operates.

By understanding the environment and the pressures the health service and its management face, the board can assure itself that the material risks are being identified and, most importantly, being managed. Such an approach enables the board to exercise its responsibilities in an active rather than a reactive manner and minimises ‘surprises’. The board should be alert to the red flags or risk indicators that may impact the organisation’s performance.

In preparing this Toolkit, DHHS, in its stewardship role, has not attempted to establish a model or pattern for the optimum composition and conduct of a health service board and instead has provided insight and guidance as a practical resource for health service directors.

For guidance, on the initial pages of chapters 1–14, there are a number of red flags, plus a list of pertinent questions that directors of health services may ask.

In addition, the Toolkit documents and summarises information on roles and responsibilities and consolidates statutory and policy-based elements, including those in the *Health Services Act 1988* (Vic), the *Ambulance Services Act 1986* (Vic), the *Mental Health Act 2014* (Vic), other acts, and policy and administrative documents.

Although this Toolkit sets out material of key importance to health service boards, the boards of other entities, such as, ambulance services, mental health services, aged care services, community health centres, and other private and not-for-profit entities delivering Victorian Government health services, may also find the material useful.

Historically, health service boards focussed on financial issues and chief executive performance. Quality of care was assumed, its oversight was left to clinical leaders and it tended to be poorly measured. That approach is being rewritten today, spurred by mounting evidence that organisational factors, including high-level leadership, influence quality of care.\*

**\*Source**: Bismark, Marie M, Walter, Simon J and Studdert, David M, *The role of boards in clinical governance: activities and attitudes among members of public health service boards in Victoria*, Australian Health Review, (2013), 37, p682–687. Available from the CSIRO here: <http://www.publish.csiro.au/ah/pdf/AH13125>

# Acronyms and definitions

The following acronyms and definitions were current at date of publication.

| Acronym | Full description |
| --- | --- |
| AACC | Aged Care Complaints Commissioner |
| AAQHC | Australasian Association for Quality in Health Care |
| AAS | Australian Accounting Standards and Interpretations |
| AASB | Australian Accounting Standards Board |
| ABF | Activity based funding |
| ACAS | Aged Care Assessment Services |
| AGM | Annual General Meeting |
| AHPRA | Australian Health Practitioner Regulation Agency |
| AMA | Australian Medical Association |
| ASA | *Ambulance Services Act 1986* (Vic) |
| ASIC | Australian Securities and Investments Commission |
| AV | Ambulance Victoria |
| BBCAC | Building Board Capability Advisory Committee |
| BCV | Better Care Victoria |
| BMAC | Boards Ministerial Advisory Committee |
| CBC | Council of Board Chairs |
| CEO | Chief Executive Officer |
| CFO | Chief Finance Officer |
| COO | Chief Operations Officer |
| DHHS | Department of Health and Human Services |
| DMS | Director of Medical Services |
| DPC | Department of Premier and Cabinet |
| DPI | Declaration of Private Interests |
| DRG | Diagnosis Related Groups |
| DSM-V | Diagnostic and Statistical Manual of Mental Disorders, 5th revision. This the manual used primarily in the USA (but also widely used in Australia in addition to the ICD-10) for classification of mental disorders. |
| DTF | Department of Treasury and Finance |
| FMA | *Financial Management Act 1994* (Vic) |
| GiC | Governor in Council |
| HCC | Health Complaints Commissioner |
| HEER | Health Executive Employment and Remuneration Policy |
| HMI | Hospital Mortality Indicator |
| HPV | Health Purchasing Victoria, trading as HealthShare Victoria |
| HSA | *Health Services Act 1988* (Vic) |
| HSMR | Hospital Standardised Mortality Ratios |
| IBAC | IndependentBroad-based and Anti-Corruption Commission |
| IHPA | Independent Hospital Pricing Authority |
| ICD-10 | International Statistical Classification of Diseases and Related Health Problems, 10th Revision. This is the disease classification used in Australia cf. DSM-V  Notes:   * a CM suffix refers to Clinical Modification * an AM suffix refers to Australian Modification * a different number instead of 10 will refer to a different revision e.g. 9th revision |
| KPI | Key performance indicator |
| LHN | Local hospital network |
| LOS | Length of Stay |
| LTI | Lost Time Injury |
| MHA | *Mental Health Act 2014* (Vic) |
| MHCC | Mental Health Complaints Commissioner |
| MPS | Multi Purpose Service |
| NAESG | Non Admitted Emergency Services Grant |
| NDIS | National Disability Insurance Scheme |
| NEP | National Efficient Price (as determined by IHPA) |
| NSQHS Standards | National Safety and Quality Health Service Standards |
| NWAU | National Weighted Activity Unit against which NEP is paid (national equivalent of WIES) |
| OH&S | Occupational Health and Safety |
| OHSA | *Occupational Health and Safety Act 2004* (Vic) |
| OVA | Occupational Violence and Aggression |
| PAA | *Public Administration Act 2004* (Vic) |
| PDA | *Protected Disclosures Act 2012* (Vic) |
| PFG | Policy and Funding Guidelines (updated every year) |
| PMF | Performance Monitoring Framework |
| PRISM | Program Report for Integrated Service Monitoring |
| PSRACS | Public Sector Residential Aged Care Services |
| SCV | Safer Care Victoria |
| SoP | Statement of Priorities |
| SRHS | Small Rural Health Services |
| TRP | Total remuneration package (for an executive salary) |
| VAGO | Victorian Auditor General’s Office |
| VAHI | Victorian Agency for Health Information |
| VCC | Victorian Clinical Council |
| VGRMF | Victorian Government Risk Management Framework |
| VHA | Victorian Healthcare Association |
| VIFMH | Victorian Institute of Forensic Mental Health, also known as ‘Forensicare’ |
| VMIA | Victorian Managed Insurance Authority |
| VMO | Visiting Medical Officer |
| VPSC | Victorian Public Sector Commission |
| WIES | Weighted Inlier Equivalent Separation |

# Key definitions used in this Toolkit

|  |  |
| --- | --- |
| Definition | Full description |
| Consumers | ‘patients’ and ‘consumers’ are terms often used to describe users of health services. In this Toolkit, ‘consumers’ has been used, unless it is part of a publication title or a quotation, as patients are not the only users of health services. |
| Directors | In this Toolkit, all board directors are referred to as directors or chairs as applicable, and the roles and responsibilities are outlined as applying to all boards. This includes members of the board of Health Purchasing Victoria, (trading as HealthShare). |
| Enabling Acts[[1]](#footnote-1) | *Health Services Act 1988* (Vic) (**HSA**), *Mental Health Act 2014* (Vic) (**MHA**), *Ambulance Services Act 1986* (Vic) (**ASA**)(in some circumstances other acts may also be applicable).  If one Enabling Act is referenced such as the HSA, the reader should presume the other Enabling Acts may also apply and should check the other Enabling Acts for clarification. |
| HLA Bill | Health Legislation Amendment (Quality and Safety) Bill 2017 was introduced into Parliament in June 2017 in response to the *Targeting Zero* report and the Government’s response, Better, Safer Care. This Bill amends the Enabling Acts for health services, in particular relating to obligations for board directors and the composition and conditions of appointment of boards. |
| HPV | Health Purchasing Victoria (HPV) is the organisation established to assist the Victorian health sector ease cost pressures through collective, strategic purchasing for all health services. |
| Minister | In this Toolkit, Minister refers to the Victorian Ministers for Health, Ambulance Services, and Mental Health where applicable. |
| Patient Experience Survey | Collects data from consumers of health services in Victoria and is used as a key feedback mechanism in clinical governance to identify areas for improved provision of service or management of risks. It is a critical stakeholder engagement and performance management / monitoring tool. |
| People Matter Survey | Regular survey of health service staff undertaken by health services to identify workforce engagement, participation, concerns or other feedback. It is a critical stakeholder engagement and performance management / monitoring tool. |
| Health services | The term ‘health services’ is used to refer to both the ‘public hospitals’, ‘public health services’ and multi-purpose services listed in the HSA, as well as Ambulance Victoria (ASA) and VIFMH (MHA) unless otherwise specified. |
| Secretary | The Secretary of the DHHS. |
| Victorian Clinical Council | Victorian Clinical Council is a council of clinicians and consumers whose purpose is to provide leadership and direction to make the health system safer and provide better care to all Victorians. |

# Organisational culture and leadership

Leadership and culture underpin the success of the health service. In a time of increasing complexity and significant growth in the expectations, responsibilities and risks that health service face, advanced capabilities and complex skills are required from directors. A director’s leadership and stewardship is critical to the safety and quality of healthcare for all Victorians.

## Questions that directors of health services should ask

* What sort of culture is the board creating and demonstrating to its staff?
* What sort of culture exists within the health service?
* How accessible and visible are we as directors?
* How clear are our values? How clear is our purpose (the why we exist which underpins our values)? What are our guiding principles (i.e. what helps us make decisions)?[[2]](#footnote-2)
* Do staff and consumers feel free to ‘speak up’ when they see something awry?
* Has an organisational culture been developed and maintained that creates an environment of openness, honesty and encourages the immediate reporting of bad news?
* How do we deal with bad news? Do we try to hide it, or do we welcome the feedback as an improvement opportunity? Do we celebrate feedback or dismiss it?
* Has the board considered how executive compensation aligns with the desired ethics and compliance culture?
* Does every staff member (clinical, non-clinical and volunteers) understand the important role they play in achieving our strategy?
* Do the health service’s internal and external auditors report that the culture is open and honest?
* Have any compliance investigations arisen from a cultural problem?

## Red flags

* The board has power factions that inhibit teamwork.
* Lack of director commitment and/or capacity e.g. poor attendance at board meetings and other major events of the health service
* The board suffers from a ‘group think’ mentality.
* A director has a clear agenda, bias or ‘bug-bear’ that they focus on rather than the issues.
* The board culture does not allow discussion of difficult, controversial or sensitive matters in the boardroom.
* There are regular and/or entrenched conflicts between leadership and the board leading to lack of direction for staff.
* Clinical leaders are disconnected from the organisation’s clinical governance processes and systems.
* People are afraid to raise concerns or report issues for fear of nothing happening, or for fear of being reprimanded.
* Staff engagement and satisfaction is not measured and is not a priority area of focus for the board.
* There are ongoing problems with staff turnover and complaints and/or high levels of sick leave.
* The CEO (or a specific executive) is the only executive the board ever hears from, with others not permitted to appear or present to the board.
* Directors by-pass the chair and question health service staff without the CEO or chair knowing.
* Poor patient experience indicators (e.g. rising complaints)

## Introduction to the chapter

The importance of culture in a health service and the board’s role in ensuring a ‘just’ culture exists is critical. Whilst culture is embodied throughout an organisation, the board is responsible for setting the expectation and ensuring that behaviours and values are lived. This chapter looks at:

* the importance of establishing a good culture
* identifying and addressing cultural issues
* managing culture in the boardroom.

What is a safety culture?

A safety culture refers to a culture whereby health service staff are supported, and their wellbeing prioritised. It includes:

* A just culture (balancing a no-blame approach with accountability)
* Providing staff with training and development opportunities
* ensuring the health and safety of their workplace – including mental wellbeing

In practice this involves giving staff the right opportunities to provide feedback about their workplace or colleagues regardless of their position – and to expect that a fair and transparent process is in place to address any issues in a proportionate and sensitive way.

## The tone at the top

The ‘tone at the top’ refers to the character and behaviour displayed by leaders of an organisation that forms a model of appropriate conduct for every level of the health service. Boards bear ultimate responsibility for their organisation’s culture, including:

* not just ‘what’ the values and practices of the organisation are, but ‘how’ the policies and processes are put into practice
* development and implementation of accountability mechanisms
* defining the ethical environment that underpins that culture
* ensuring a ‘just’ culture for the provision of safe, quality care.

As stewards of the organisation, boards must embed the ethical and behavioural culture into an organisation. Merely meeting legal requirements is not sufficient to satisfy the ethical concerns of the Minister, DHHS, employees, consumers, the community and other stakeholders.

Whilst there are legal obligations and guidelines to support an effective ethics and compliance culture, the culture of an organisation cannot be dictated by rules and regulations alone. Culture is about behaviour and behaviour cannot be regulated. It is therefore the role of the board to ‘set the tone’ with respect to the types of behaviours it expects and accepts.

**Boards set the ‘tone at the top’, which influences the entire organisation**.

The board should ensure appropriate values, ethics and behaviours are upheld throughout the organisation. This means that the board and directors must:

* clearly articulate the expected behaviours and standards of ethical conduct and compliance
* lead by example and not only meet these expectations themselves but ensure that individuals within the organisation are held to account for their behaviours and conduct.

The ‘tone at the top’ should be underpinned by clearly articulated purpose, values and guiding principles supported by policies, a code of ethics and conduct, ongoing ethical awareness training and an ethics management process that is embedded across all the organisation’s activities.

## Structural risks to culture

It is the board’s responsibility to ensure that every person in the organisation acts appropriately regardless of their position.

Health services are large, complex entities. Even the small rural health services have multi-million dollar budgets and are one of the community’s largest employers. This, plus the range of regulatory regimes and other controls, necessitates structures that are typically hierarchical in nature. This allows for clear lines of accountability, responsibility and supervision of staff.

The higher up in the hierarchy, the less detail is known but the greater overview. In contrast, front line staff will be primarily absorbed in the day-to-day of caring for patients and leave the running of the larger entity to those further up the chain. This is the idea of the view of a forest (the board’s view); the trees (executive and management) and the leaves (units, teams and front line staff). In this analogy, the board is looking at the forest from above; they won’t generally notice a leaf on its own change but should if it starts to spread. Ideally, there are controls to prevent the infection but should one occur, before the issue spreads, it is noticed by management or the executive and acted upon.

This is a common description of hierarchical structures that are important for accountability. However, the risk of simplifying people’s roles like this, is that it can miss the critical role staff play in fulfilling the purpose and strategic objectives of the health service, and vice versa, the role that leaders play in enabling patient experience and quality of services on the ‘front line’.

**Command and control** is the hierarchical compliance based culture present in most large entities, including public entities like health services. It relies on rules with penalties if rules are broken and sometimes rewards to incentivise certain behaviour. The idea being that people’s self-interest to avoid a penalty will prevent them from being tempted to take advantage of a forbidden benefit. While a rules (with rewards and punishments) based approach will always have a place it has the potential to

“*invite misconduct where its reward is significant and either the risk of detection, or the punishment if caught, is perceived as acceptably low”.[[3]](#footnote-3)*

In this setting, the presence of incentives could also undermine the desired culture, if the incentive to reach a goal outweighs the risk to the individual (or entity) of how that goal is achieved. For example, improving performance on length of stay KPIs could increase the chance of early discharge. As such, while incentives or punishments have a place for reaching targets and compliance, they cannot be relied upon in isolation and can indeed undermine your cultural goals.

Ultimately, a culture that is informed by notions of ‘integrity, fairness, respect and dignity”[[4]](#footnote-4) is more effective at driving compliance with the actual goal of the rule, rather than crudely adhering to a rule as much as one has to.

There is a place for compliance with rules and working to achieve metrics, however, if decisions to comply are based solely on self-interest and not a greater principle or values proposition, then corruption is likely wherever the reward outweighs the risk.

To reduce the risks inherent in the command and control approach, the board must take a values based approach to the health service culture.

### Why ethical people make unethical choices

Carucci summarised the top reasons people make unethical choices as follows:[[5]](#footnote-5)

#### 1. It is unsafe to speak up

This could be from two main sources:

* the sense of futility (nothing will come of my report)
* fear of retribution

How the supervisor or management react to people reporting misconduct or other issues is the greatest factor – do management welcome and celebrate the report (see example on the right)? Or do they try to minimise it or treat it as a burden?

#### 2. Performance targets prioritised above all

While performance targets have a clear place in health services, the targets should not be such that they incentivise cutting corners, particularly if that increases the risk of error.

#### 3. Conflicting messages that feel unfair

Where leadership have one message in words but another in their actions can quickly lead to a sense of injustice.

#### 4. Insufficient positive role-models

The leaders of the organisation should set the tone and standard of conduct expected. This includes being a supervisor of a team all the way up to the CEO and the board.

The importance of taking action - thank you

Recently one of our Associate Nurse Unit Managers in ICU, Helen McCann, raised concerns with her Nurse Unit Manager Andrew Coe, Director of ICU Stuart Wilson and Director of Pharmacy Sue Kirsa, regarding a fluid chart that she found in circulation on one night shift. Helen recognised that this chart was not the standard one in use and that this version of the chart had the potential for errors to occur.

Helen and the team acted promptly – the form was removed immediately, has been appropriately replaced and the issue resolved with no harm to patients. This is a great example of staff acting quickly and proactively to ensure that our patients remain safe. The team also used this as a learning to discuss at subsequent team huddles.

Recently, I spoke with the leaders of our organisation and we discussed the importance of escalating matters such as this, and of course matters of safety and clinical risk. Our goal is to improve our workplace such that all staff feel comfortable to escalate matters, and are also encouraged to see escalation as part of their responsibility to ensure our staff and patients are kept safe and that we deliver high quality care

Thank you to Helen, Andrew, Stuart, Sue and others in the ICU and Clayton campus teams. This is a great example of escalation taking place, and individuals in leadership and management positions listening and taking action.

Extract from Monash Health’s iNews ( March 2017)

Values based frames of reference ask ‘how do you behave when no one is looking?’

In particular, the health service senior leaders, including the executive and the board, should demonstrate a high standard in their decision making.

## Ethical based frameworks

This leads to what might appear to be a cultural conundrum: **blame versus accountability**. Many would regard accountability as being the person to blame for something going wrong. In a completely self-interested world, that is more or less true. This is where values or ethical based frameworks and guiding principles are required for a positive health service culture.

People work for a health service for a variety of reasons, but they must also unite behind a common purpose. There are values that all at the health service can stand behind, such as patient experience and safety. These are simply rallying points for all staff that also help them when making decisions.

Some examples of values statements in our current health sector include:

* no one is harmed in our hospital(s) / Zero avoidable harm
* patient centred care is at the forefront of everything we do
* health services serve the community and its most vulnerable
* health services have duty to use public funds in an efficient and effective way
* all staff, patients and guests of our health service deserve to be safe and be treated with respect
* stop wasting the patients time.

All health service board’s should consider which values and goals they wish to focus on, that will be a rallying point for all of their organisation to stand behind. When values are included in accountability, it makes the decision making process a greater question than merely personal risk and reward. For example, the DHHS vision is

To achieve the best health, wellbeing and safety of all Victorians so that they can live a life they value

Underneath this, are six value statements with outcomes that DHHS aim to achieve by focusing on these values. These are rallying calls to Victoria’s health sector to not merely rely on compliance but relate to these common values when making decisions.

### Embedding innovation

Learning from our successes and failures is one of the most reliable paths for continued improvement. A success or failure is merely a single outcome for that instance. There is a need to act to promote the successful outcome or to prevent/mitigate the poor outcome to maximise the benefit of that learning opportunity. However, to only act once on that outcome risks the ‘knee-jerk’ response which treats learning and innovation as add-ons. A good outcome can be better and a better outcome better again. A poor outcome can have its frequency or impact reduced or avoided.

Blame focuses on the past; accountability focuses on the future. A just culture enables the health service to learn from mistakes.

To succeed in embedding innovation, services require a culture that enables learning as part of core Business as Usual. A necessary element of this is the idea of a ‘just culture’. A just culture should not be confused with merely ‘no-blame’ – for this would neglect accountability. Nor does a just culture seek to prosecute anyone who errs – for this would suppress reporting. A just culture embraces both no-blame and accountability enabling learning from mistakes.

“Blame-free is not accountability free… we can create such accountability not by blaming people, but by getting people involved in the creation of a better system to work in.”

- Sidney Dekker, *Just Culture: Balancing Safety and Accountability,* (2012) 2nd Edition, Ashgate publishing Pty Ltd, p.83.

### Blame or accountability?

A more constructive way of considering blame versus accountability in a health service setting, particularly from the board’s point of view, is that the person accountable must own the outcome but also the actions to resolve the issue. Blame focuses on the past and the event. While there is certainly a place for understanding how and why a risk crystalised, the purpose of understanding should be to best determine how to avoid or mitigate it being repeated – not to shoot the messenger.

In striving to achieve the best health and wellbeing for all Victorians, the government is committed to ensuring Victoria’s health system has a positive culture focussed on four key areas. These are:

* Safety and wellbeing
* Learning and continuous improvement
* Quality and outcome focussed
* Respect, equity and diversity.[[6]](#footnote-6)

Not blaming someone for a mistake does not mean there is no accountability or no one taking responsibility. Rather, it shifts the focus to intent and impact instead of focusing purely on persecution of the practitioner/mistake-maker. A ‘just’ culture seeks to provide the health service and the practitioner with the opportunity to:

* take responsibility for the wrong and be accountable
* remedy the error/issue
* ameliorate the impact of the error/issue
* avoid or mitigate future errors/issues of that kind and potentially extend learnings to other situations
* encourage reporting and facilitate a reporting culture.

It should be notable that a just culture provides the opportunity for people to take responsibility for their wrong. Indeed, a just culture does not work without accountability and responsibility for actions.[[7]](#footnote-7)

This statement should not be controversial but it is worth reflecting on and recalling that blame and accountability are often confused. This is not about persecution of the mistake-maker/practitioner; it is about listening, learning and making positive changes in line with the values of the health service.

It is important that people see and understand both the consequence of an error/issue and the consequence of reporting the error/issue. Reporting an error or issue (even if you were the mistake-maker responsible) should be celebrated and the impact of it communicated. That does not mean there are not consequences for the party responsible, but the consequence should:

* be reasonable and proportionate to the intention of the practitioner
* follow the principles of natural justice
* ensure a focus on learning from the error/issue rather than persecution
* focus on mitigating the impact of the error/issue and preventing future comparable errors/issues
* demonstrate that the health service heard the complaint and acted on it in a way that will not prevent people from reporting in the future.

“It’s important to talk about the positive examples of ethical behavior, not just the bad ones. Focusing on the positive reasons you are in business and reinforcing the good things people do strengthens ethical choices as ‘the norm’ of the organization.”

- Jonathan Haidt, Professor of Business Ethics at NYU

## Principles of an effective health service culture

A strong and robust health service culture needs to include a range of elements. Boards should focus on fostering:

* a ‘just’ culture of safety, fairness, transparency, learning and improvement in which staff are empowered and supported to understand and enact their roles and responsibilities
* a culture based on integrity and ethical standards that are set and demonstrated from the board through to all levels of the organisation
* an innovative, outward-looking culture that is open to new ideas and practices
* visibility of leadership and a board that actively demonstrates the desired conduct and behaviours of the organisation
* an organisational culture that supports staff to pursue safe practice and to speak up when they have concerns (i.e. a culture where ‘bad news’ is OK)
* a culture where conflicts of interest are avoided or managed appropriately and transparently.

### Developing a ‘just’ culture

Recent focus has been placed on the development of a ‘just’ culture within the Victorian health services, particularly with respect to clinical governance. The focus is on developing an organisational culture whereby health service staff are supported and their wellbeing prioritised. In practice this requires boards to ensure the development and implementation of systems that support staff in training, development, health and safety (including mental health and wellbeing).

In the context of clinical governance, this is especially important as it involves not only supporting staff, but enabling them to work collaboratively and respectfully with clinicians and consumers in such a way that the overall experience for all participants is as positive and equitable as possible.

Caring for our patients – all voices count

Recently a child was admitted to one of our wards and, during this admission, had a MET Call for tachycardia. A cardiac technician, Jess Cseh was requested to complete an ECG which demonstrated a tachyarrhythmia. Jess attempted to communicate this to the treating team at the bedside, but her input was dismissed. Instead of accepting this decision, Jess remained concerned and returned to MonashHeart where she escalated the issue to Prof Sarah Hope. Sarah communicated directly with the team involved and ICU regarding appropriate treatment. Fortuitously the arrhythmia settled spontaneously, but recurred later in the admission.

Without the escalation from Jess, this diagnosis could have gone unnoticed by the treating team. Sarah praised Jess for her diligence and for escalating her concerns.

I continue to encourage all staff, no matter what level you are or where you work, to speak up if you are concerned about anything you come across in your work practices.

Andrew Stripp, CEO, Monash Health -Extract from Monash Health’s iNews (3 May 2017).

### Developing a culture where ‘bad news’ is communicated

Recent case studies in the health sector highlight the importance of building an organisational culture that supports the giving and receiving of ‘bad news’ i.e. creating an environment of openness and honesty and the presentation of the hard truth.

A KPMG-sponsored survey[[8]](#footnote-8) found that only 55 percent of respondents believe that their organisation is effective at keeping the board aware of the key risk issues. This is a board culture issue.

A culture where an early warning system for problems exists can provide for timely and appropriate intervention and/or the redefining of strategy. A climate in which full disclosure is delivered in a timely manner should be fostered by senior management and endorsed by the board to encourage employees to immediately bring forth concerns.

This also reflects the importance of ensuring the focus is not on persecution of the reporter and/or person who erred; rather, the focus is on learning from the reported issue/error.

## How to identify good and bad culture

In simple terms, organisational culture can be defined as ‘how we do things around here’. In practice, culture represents the way that people within the organisation behave towards each other e.g. how they engage with one another and with patients; the care taken place when performing tasks, the adherence to guidelines and protocols.

Evidence of good and bad culture can be found in a number of ways, and with either quantitative or qualitative information – noting that information can come from a variety of sources. Examples are provided in the table below.

|  |  |
| --- | --- |
| Examples of good culture | Examples of poor culture |
| Engaged staff who hold themselves and others to account. | Conflicts between leadership leading to lack of direction for staff. |
| Clearly stated values that are displayed prominently throughout the organisation | A disengaged board, CEO and executive that are unwilling to see and hear bad news. |
| Leaders conduct regular walk-arounds and ask staff and patients questions related to the safety, effectiveness and person-centred care being experienced and delivered | Isolated and inward-looking culture that is unsupportive of learning and developing and cultivates a fear of speaking up. |
| Feedback is welcomed and celebrated as an opportunity to improve. | Clinical leaders who are disconnected from the organisation’s clinical governance processes and systems. |
| Staff and clinicians proactively seek and promote improvement opportunities. | Staff turnover and sick leave levels are high. |
| There is a sense of pride of the health service amongst staff and the community. | Complaints are left outstanding for long periods of time. |
| Staff survey response rates exceed 40 percent. | Suggestions are not given by staff as they feel that any suggestions for improvements have not or will not be implemented. |
| Attendance at training or organisational events is high. | Innovation is viewed as an ‘add-on’ and not part of business as usual. |
| Work health and safety indicators are positive (low LTIs, low near misses, high quality incident reporting). | Leaders focus on blame rather than learning |

Table 11.1 Examples of good and bad culture

Example ‘above’ and ‘below’ the line behaviours

‘Above the line’ behaviours

* Collegiate and supportive.
* Respectful of the opinion of others.
* Sharing the common purpose.
* Listening and attentive.

‘Below the line’ behaviours

* Aggressive towards others.
* Dismissive.
* Disengaged / distracted (i.e. checking phone/email).
* ‘Gossiping’ or complaining outside the boardroom.

## How to address cultural issues

Cultural change doesn’t happen overnight. It is a process of change that can take several months, even years. Given that culture is about behaviours, there can be varying levels of engagement and willingness to change.

Boards can turn the ‘poor’ into ‘good’ and address cultural issues in practical ways that include:

#### Instruments and tools

* Clearly defining the expected behaviours and values of the organisation.
* Including cultural / value training in board and staff induction.
* Communicating the values clearly within the organisation through both passive (e.g. posters, intranet) and active (including values as part of meetings, language used in emails).
* Reinforce the value in how the board and management communicate (e.g. ‘say it once, say it again and the say it once more’).

Develop cultural documentation (e.g. policies, charters and KPIs).

* Take action in response to patient surveys, staff engagement and community engagement feedback.
* Board member walk-arounds, direct visibility of culture through events (directors should be conscious of how the walk-arounds are conducted).
* Transparency in relation to bad news, empowering staff to raise issues, ensuring appropriate responses to feedback and no attempts to ‘cover up’.
* Board chair actively asks individual directors to speak out during meetings (demonstrating inclusive leadership).
* Designated question time for each board member.
* Celebrating successes in all areas of the health service including having a rewards and recognition program to celebrate staff who exemplify the desired culture
* Look for opportunities to inject good culture into the organisation.[[9]](#footnote-9)



Figure 11‑1 #hello my name is one example of a 'how' to improve culture between staff and patients

## Boardroom dynamics

Board culture underpins board dynamics and has a decisive influence on performance. A well-functioning board generally displays coherence, trust and common values between directors, encourages and has regard to differing viewpoints and opinions, and is able to reach a decision without animosity. Healthy boardroom dynamics will encourage sound decision-making that delivers value to stakeholders.

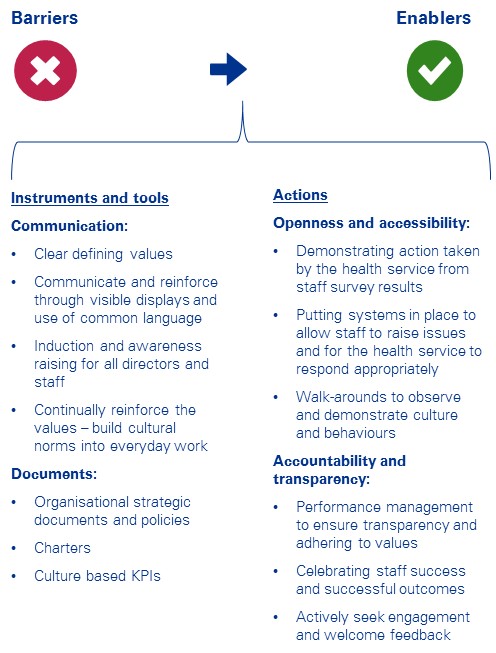


Figure ‑ How to address cultural issues (Source: KPMG)

### Establishing an effective boardroom culture

DHHS’ *Health Service Governance Model Conduct Charter*[[10]](#footnote-10) provides guidance on how health services can define and build an effective board culture. It provides a template for health services to use to develop their own conduct charter and also spells out the key elements of director responsibilities, including:

* the importance of board culture
* your role as a director
* collective and individual conduct requirements
* collective and individual accountabilities
* processes for managing performance, breach and conflicts.

### The role of the chair in boardroom culture: Inclusive leadership

The chair plays a critical role in facilitating effective boardroom dynamics. Robust, effective discussion should not be confrontational or be domineered by a select few. The chair’s role is to understand the different personalities on the board and ensure that everyone participates equally in the discussion.

If a dispute arises in response to poor behaviours, or any other alleged breach of the health services conduct charter, by one or more of the directors, the chair must work with the relevant individuals to find a constructive solution.

If issues continue with board dynamics, it is the role of the chair to raise this with DHHS.

A key strategy for the chair is to continually bring directors back to the goal of their question – this can assist in bringing back a derailed conversation and focus everyone on what is most important.

The *Health Services Governance Model Conduct Charter*[[11]](#footnote-11) provides the following guidance on dispute resolution:

In the event that disagreements or interpersonal conflicts could adversely affect the operations of the board, the parties to the dispute and the chair agree to:

* work together constructively, promptly and expeditiously to try to resolve the dispute;
* keep in mind the interests of the health service at all times;
* act in a manner proportionate to the seriousness of the breach, disagreement or conflict;
* attempt to address the matter directly and informally in the first instance, with the support of the chair or the Board Secretary where appropriate;
* if the dispute remains unresolved for ten working days, consider agreeing to the appointment of a mediator nominated by the chair, or if the chair is a party to the dispute by the Board secretary; and
* abide any agreement reached in mediation and also by the ultimate decision of the board (not including the board members in dispute or who have potentially engaged in a breach) about the outcome.

The chair will record in his/her own records the nature and outcome of the potential breach, disagreement or conflict. If appropriate, and applying the appropriate confidentiality, the Board Secretary will also record in the matter in the minutes of the board meeting.

If the chair is not displaying ‘above the line’ behaviours and causing friction in the boardroom, directors should raise this with the chair and failing a resolution, seek further guidance from DHHS.

‘Poor’ or ‘below the line’ behaviours should not be displayed – or tolerated – by any director.

More information on the role of the directors and the chair is in ***Chapter 8****: Productive meetings*.

## The board’s relationship with management

The working relationship between directors and management is one of the most influential factors in board effectiveness. Most productive relationships are built on mutual trust and respect, where both the board (and the chair in particular) and the CEO work in partnership, each with an acute appreciation of the vital role played by each other in building stakeholder value. Dysfunction can occur where either the chair or the CEO is overly controlling and this behaviour goes unchecked.

*“…organizational culture can dramatically affect both ethical conduct and reporting of misconduct, by establishing workplace norms, harnessing social identity and group loyalty and increasing the salience of ethical values.”[[12]](#footnote-12)*

### Shouldn’t need to be said…

It is a key responsibility of the Chair to ensure appropriate behaviour from the CEO and other presenters to the board, as well as the board’s behaviour to those presenters (and each other). Often behaviours are not discussed because many assume that it goes without saying that the behaviour was inappropriate – this assumption should not be relied upon. A board is composed of people from very different backgrounds and experiences and it is important that both the standard of behaviour expected is clear and that when that behaviour is not shown, it is corrected.

As the leaders of the health service, the board should role model both appropriate conduct and correcting inappropriate conduct in a fair and just manner. It should be clear to any person looking in that the board will not condone behaviour that intimidates, belittles or harasses another person.

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1. Please note, these acts may have been amended and/or updated after this Toolkit was published. When reviewing, please review the most recent version. [↑](#footnote-ref-1)
2. The Institute of Internal Auditors Australia, The Ethics Centre, Chartered Accountants Australia & New Zealand, Governance Institute of Australia, *Managing Culture: a good practice guide,* (December 2015). [↑](#footnote-ref-2)
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7. For example, the Civil Aviation Authority (CASA) will not use safety information in support of disciplinary action IF the reporter/wrong-doer has made taken action to prevent, mitigate, reduce reoccurrence, etc (see CASA reference at the end of the chapter). [↑](#footnote-ref-7)
8. Available from: www.kpmg.com.au [↑](#footnote-ref-8)
9. See, for e.g., Peter MacCallum Cancer Centre, *Patient Charter* (September 2016). [↑](#footnote-ref-9)
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11. DHHS, *Health Service Governance Model Conduct Charter*, 2016, p20 [↑](#footnote-ref-11)
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