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Assessing Workplace Culture in the Australian Healthcare Setting

Literature Review, Gap Analysis and Recommendations for a Minimum Data Set for a Culture Assessment Tool

STEOPLE AUSTRALIA

This report was commissioned by A Better Culture and was produced by Steople with significant input from Whereto Research.

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EXECUTIVE SUMMARY

This report has been commissioned by A Better Culture with the support of the Royal Australasian College of Medical Administrators (RACMA). This project aims to improve the quality and effectiveness of data collection on culture in the Australian healthcare sector. The ultimate objective is to be able to use this data to provide actionable insights to improve workplace culture and foster healthier working environments.

While workplace culture is the primary focus of this work, however, we recognise and appreciate the significance of cultural safety in this space. This report must be read with an understanding that workplace culture in healthcare is inextricably linked to systemic racism, colonisation, and the ongoing impacts of cultural harm experienced by Aboriginal and Torres Strait Islander peoples. Experiences of workplace culture are shaped and influenced by values and behaviours, as well as how systems respond under pressure. We must not lose sight of this as we explore and make recommendations for a broad approach to assessing and improving workplace culture in healthcare.

The report presents the findings of the 'Explore phase' towards producing a tool for culture measurement and improvement in the Australian healthcare sector. Steople and WhereTo Research have partnered with a Better Culture to understand the current state of culture measurement through an environmental scan and literature review. We have reviewed many tools currently being used to assess culture or aspects of culture, and have identified several gaps in the depth, breadth, and scope of current measures. Furthermore, for this initial phase, 8 key stakeholders (senior members of various health entities from around Australia) were also engaged to articulate their lived experience with existing measures, as well as to highlight specific needs and potential challenges in developing a minimum data set for a culture assessment tool.

We have used insights from this 'Explore phase' to inform our recommendations.

Findings

There is limited consensus on the essential dimensions of culture

- There is a lack of consensus on exactly what the dimensions or elements of culture are and what needs to be measured. Subsequent gaps identified stem from this foundational issue.

The scope of existing surveys fails to sufficiently capture culture

- Existing surveys vary in their purpose and scope, many of which have multiple outcomes of interest. No tools captured sufficient information on culture itself, particularly across the broader healthcare sector.

The measurement of culture is confused with the measurement of outcomes and adjacent culture-related constructs

- Most tools measure culture-related themes and concepts such as engagement, satisfaction, and climate but not pure culture. Most existing surveys aim to measure many different concepts, leading to confusion and a lack of clarity. Other tools seem to measure the outcomes of culture, such as harassment, bullying, and discrimination, rather than culture itself.

Existing surveys do not explicitly capture the shared, underlying values and beliefs that guide behaviours and practices

- Existing tools fail to ascertain *why* members of a workplace behave the way they do from a values perspective. To better understand and improve culture, we identify the need for a tool that can extract deeper insights into the underlying values that dictate how all members of a workplace do and should conduct themselves.

The drivers of culture are rarely linked back to the elements of culture

- Insights from existing surveys do not provide sufficient information to guide specific and actionable improvement. Findings and outcomes are not linked back to culture dimensions and levers creating a knowing-doing gap.

Recommendations

To address the gaps identified, we propose the following focus areas for the development of a robust survey tool that can comprehensively assess culture and inform an achievable pathway to change.

1. Agree and articulate the fundamental dimensions of organisational culture specific to the healthcare context in Australia. Through our research, we have identified that these are: **Human Centred, Respect and Civility, Safety (including Cultural Safety), Performance, Power and Trust.**
2. Develop a user-friendly, flexible framework and approach to defining the ideal culture relevant to a specific healthcare context.
3. Define and measure the levers for culture change to inform actions for improvement. These are categorised into: **Leadership, Systems and Structures, Processes, Strategy and Environment**
4. To ensure the addition of a new survey is meaningful, it is critical that findings from measures of culture are linked to outcomes.
5. Proactively include and embed First Nations voices, knowledge and perspectives in all future culture work, moving beyond consultation to co-design, leadership and shared decision-making.

BACKGROUND

Project Context

A Better Culture was established under a grant from the Australian Government to repurpose unspent funds from the Specialist Training Program, specifically to address findings reflective of workplace culture. Since its establishment, A Better Culture has been engaging in ongoing dialogue and advocacy with a broad range of stakeholders, including government officials, board members, specialist medical colleges, and associations. A Better Culture has fostered strong relationships and garnered support for the project's initiatives, ensuring alignment and collaboration across various organisations. This work has involved establishing working and reference groups and conducting environmental scans and gap analyses. Topics addressed have included healthcare worker cultural safety, workplace behaviour expectations, career-long learning and development, measurement and action as well as identification of strengths, weaknesses, and opportunities within existing policies and programs on bullying, discrimination, harassment and racism.

A critical next step is to support the health sector in measuring and tracking progress in cultural change over time, while also finding ways to reduce complexity, simplify approaches and avoid negative consequences of progress tracking like survey fatigue.

This project represents a significant opportunity to better understand culture in the healthcare sector, and support and measure positive shifts in culture over time. This includes enabling a clearer line of sight of strengths and culture detractors and hotspots to allow for the identification of factors impacting culture, culture-shaping action and supporting funding and policy decisions.

A Better Culture is concurrently developing a proposal for an overarching strategy to address the longstanding issues in the culture of the healthcare sector.

Project Objective

The specific aim of this project is to support improvements to the quality and effectiveness of data collection on culture in the Australian healthcare sector by:

- Identifying practices and gaps in existing methods of measuring workplace culture in the Australian healthcare sector.
- Developing a minimum data set for a culture assessment tool that represents best practice as a standardised approach that ensures data comparability and reliability across organisations.
- Developing recommendations for a clearinghouse or like approach that might facilitate the aggregation and dissemination of industry-wide data, providing actionable insights to improve workplace culture and foster a healthier working environment.

EXPLORE: LITERATURE REVIEW AND GAP ANALYSIS

Organisational or workplace culture is significant for health workforce members at all career stages and is closely related to outcomes such as workplace experience, engagement and satisfaction. (Belias & Koustelios, 2014; Braithwaite et al., 2017; Hogan & Coote, 2014; Meng & Berger, 2019; Scanlan et al., 2020). As consistently reported, healthcare professionals, and notably doctors in training, currently experience high levels of incidence of bullying, harassment, discrimination and racism, lack the confidence and safety to report and speak up, and may be working in strained conditions (workload, resourcing). This is evident across multiple surveys conducted by key bodies and agencies in the healthcare sector across Australia (People Matters, MTS), and yet, the urgency of the need for action is not visible.

In this analysis, we have examined the current state of culture in the healthcare context. We have then reviewed a significant number of tools currently being used to assess culture or aspects of culture and identified several gaps in the depth, breadth, and scope of current measures outlined in this section.

Methodology

We used a staged methodology to review current practices, identify gaps in existing methods of measuring workplace culture in Australian healthcare settings, and develop our recommendations outlined in this report.

- We conducted an environmental scan of survey tools currently used to measure workplace culture and experience.
- We completed a comprehensive literature review and have drawn on several theories, models, and frameworks that underpin our understanding of workplace culture, particularly those that define and shape cultural factors within the healthcare sector.
- We conducted stakeholder interviews with key stakeholders in the healthcare sector to test, explore and validate our findings.

Table 1: Explore Phase Methodology

Survey Tool Evaluation	Examined >20 tools used across the health and public sectors including eight tools specifically focusing on what is commonly described as 'safety culture'. This process identified the target audiences, key purpose and measures, culture-related themes and constructs, survey properties, design and administration methodologies.		
Literature Review	We conducted a thorough literature review and drew input from systematic reviews, meta-analyses, and independent and peer-reviewed studies to broaden our understanding of the current culture in the healthcare sector and identify local and international measurement tools used in the industry and their respective strengths and limitations. Our search methodology combined terms from Category A with terms from Category B. We also added terms from Category C for more fruitful A+B combinations. Our search criteria were primarily focused on healthcare settings in Australia, New Zealand, the UK, the USA, and Israel.		
	Category A	**Category B**	**Category C**
	Culture Workplace Culture Organisational Culture Engagement Cultural Safety	Bullying Racism Harassment Incivility Psychosocial Health Psychosocial Risk Safety Culture Leadership Healthcare Hospital Clinicians Medical Practitioners Doctors in Training Workplace Experience	Survey Measurement Scale Cultural Competency
Stakeholder Engagement	Interviews with eight key stakeholders in the healthcare system concerning the development of a new cultural measurement tool for healthcare settings, including experience with current tools and potential challenges. Stakeholders, in this phase of the work included senior members of various health entities around Australia.		

What is Culture?

Culture has been defined in many ways. A simple and yet easily understood definition of culture was articulated by Kennedy and Deal in 1982: culture is "the way we do things around here". A more nuanced definition provided by Cooke and Szumal (1993) is that "culture is the shared values and beliefs that guide how members of an organisation approach their work and interact with each other".

For the purposes of developing a robust culture assessment tool and maintaining consistency with other work done by A Better Culture, we will use the following definition of "Organisational culture", which is the *shared values, beliefs, attitudes, and practices that characterise an organisation* (Catling & Rossiter, 2020; Sutherland & Watters, 2024).

We emphasise that the notion of 'shared values' should not be equated with or mistaken for sameness. In a complex system like healthcare, diverse worldviews, perspectives and identities are both inevitable and essential. Referring to shared values invites a broader perspective – one that identifies core unifying principles that support diverse expression within a common framework. The aim is not to enforce uniformity or conformity through top-down directives. Rather, it is to establish a shared foundation that actively values and makes space for difference at all levels of the system (Moreton-Robinson, 2015)

A key area of work for A Better Culture is the gap in Cultural Safety programs and training which focus on the patient experience but are generally mute on the impacts on healthcare workers of a lack of cultural safety in their workplaces. While cultural safety is not the primary focus of this proposed survey, it is not possible to decouple workplace culture form the cultural safety experiences of Aboriginal and Torres Strait Islander staff.

Defining Key Terms

We believe it is important to differentiate culture from other words used in this space that are closely aligned with 'culture' but differ from it.

Table 2: Key Definitions

Key Term	Definition
Climate	The surface features of underlying culture; a reflection of the current state and experience of an environment (Flin et al., 2006)
(Occupational)Safety Culture	An organisational culture that places a high level of importance on safety beliefs, values, and attitudes and is shared by the majority of people in the company or workplace (Worksafe Queensland). Aspects of general safety culture may include and are not limited to psychological safety, physical safety and psychosocial safety. *Safety culture, while frequently used to refer to patient safety below, is a concept that can be applied to many industries where there is potential risk to employees. Note that we differentiate this from 'patient safety', defined below.
Patient Safety Culture	A pattern of individual and organisational behaviour, based upon shared beliefs and values that continuously seeks to minimise patient harm, which may result from the process of care delivery (Kristensen & Bartels, 2010). *While there can be some overlap between safety culture and patient safety, the use of the term patient safety is limited to the healthcare context. We recognise patient safety as part

	of the broader concept of safety culture and therefore do not use these terms interchangeably.
Engagement	A person's enthusiasm and involvement in their job (Bayasgalan, 2015); the harnessing of an organisation's members' selves to their work roles (Kahn, 1990). The higher the level of engagement, the more discretionary effort they are likely to put into their work.
Satisfaction	How happy and fulfilled employees are with their jobs, encompassing their overall experience and contentment with their roles and the organisation (Spector, P.E. 1997)
Psychological Safety	A work environment in which employees feel safe to express themselves and take risks without fear of negative consequences such as humiliation, punishment, or discrimination. (Safety Australia Group, 2023)
Cultural Safety	Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families, and communities. Culturally safe practice is the ongoing critical reflection of health Practitioner knowledge, skills, attitudes, practicing behaviors and power differentials in delivering safe, accessible, and responsive healthcare free of racism. (Australian Health Practitioner Regulation Agency, 2019)
Psychosocial Health	The physical, mental and social state of a person (Safe Work Australia). Often, the prevalence of mental stress, bullying and harassment are seen as indicators of poor psychosocial health. However, Safe Work Australia suggests these outcomes provide a limited gauge of the psychosocial health and safety status of Australian workplaces.
Wellbeing	A delicate balancing act between an individual's social, emotional, psychological and physical assets (resources) and the liabilities (challenges) they are facing in life and work at any one time. When individuals have more challenges than resources, their seesaw dips, along with their wellbeing and vice versa. (Dodge, Daly, Huyton and Sanders, 2012) *Note: we deliberately use this term infrequently and cautiously in this report. This is approach has been deliberate and in acknowledgement of the high levels of cynicism expressed by stakeholders to wellbeing interventions they have experienced and their experience of lack of focus on physical and psychological and psychosocial safety which are substantial inhibitors of their wellbeing.*

These definitions are critical to this project because many surveys that claim to assess culture measure other factors, most typically the constructs outlined above, and/or they measure the outcomes or impact of culture. This project aims to produce a more pure and objective measure of culture in healthcare.

Further Explanations and Definitions of Key Concepts

Beyond understanding the differences between culture and related constructs, it is important to clearly articulate and define key concepts that continue to be discussed and confused in the literature and practice.

Culture Factors

- We have defined 'culture' as *the shared values, beliefs, attitudes, and practices that characterise an organisation.* The 'culture factors' are the elements or dimensions of culture that are used to describe both the current and ideal culture. We use the terms "elements" and "dimensions" interchangeably.

Culture-related Constructs

- These concepts are related to culture but are fundamentally different constructs such as engagement, satisfaction, patient safety and climate. We have used the terms "constructs" and "concepts" interchangeably.

Levers for culture change

- These elements shape and influence culture and represent the specific 'levers' that an organisation can actively adjust to positively impact culture.

Outcomes from Culture

- These are the positive or negative consequences of or from the current culture. Outcomes can be displayed in a range of measures such as increasing levels of turnover, burnout or absenteeism. Outcomes can also include specific negative behaviours and incivility demonstrated by an increased prevalence of harassment and discrimination. The outcome of a negative culture is likely to also be visible in "culture-related constructs", such as low levels of engagement or low satisfaction levels.

The Current State of Culture in Healthcare

We understand that the healthcare sector is complex and faces unique pressures spanning from financial, governance and policy to service delivery, and psychological, emotional and professional stressors for workers (Nightingale, 2018; Søvold et al., 2021; Williams et al., 2015). Despite this complexity, people remain at the centre of healthcare. With this in mind, the industry as a whole must critically reexamine the current culture and landscape in which healthcare providers operate.

In this section, we explore the results of satisfaction and engagement surveys across the sector that identify the impact and outcomes of the current state of healthcare culture. It is critical to note that culture will be unique to each organisation and at a more micro level to teams within each organisation. For the purposes of this project, when we reference research and findings relating to contributing factors, outcomes or culture within the healthcare sector, it is related to identified and significant trends at the sector level.

Negative Behaviours – Bullying, Harassment, Racism and Discrimination

Surveys administered to members of the Australian healthcare workforce flag negative behaviours like bullying, harassment, racism and discrimination consistently, bringing attention to organisational and system-wide culture. For example, the 2023 Medical Training Survey (MTS), a national, profession-wide survey of doctors in training in Australia, found that 1 in 3 medical trainees had experienced or witnessed bullying, harassment and/or racism in the last 12 months. Survey results also indicated a low rate of reporting of incidents experienced (32%) or witnessed (25%). These findings have been replicated in the 2024 MTS, which also reported that 1 in 3 (33%) of doctors in training had experienced and/or witnessed at least one negative behaviour. Bullying was identified as the most experienced negative behaviour (12%) or witnessed (18%), with the most common source being senior medical staff. Of the 21% of doctors in training who reported experiencing bullying, harassment, racism and/or discrimination, 52% identified the source as someone in their team, and 40% indicated that this was their supervisor (MTS, 2024). It was further identified that the incidence of experiences of bullying, harassment, racism and/or discrimination was higher for Aboriginal and/or Torres Strait Islander Trainees.

The results of the MTS do not occur in isolation. They are consistent with findings from the most recent Resident Hospital Health Check (QLD), which reported that 35% of respondents experienced and/or witnessed bullying, discrimination or harassment, yet only 25% of incidents were reported due to concerns of negative consequences (81%). In the 2023 People Matter Employee Survey, PMES (NT), respondents in the healthcare workforce reported experiencing bullying (36%), physical abuse (2%) and/or sexual harassment (8%). Furthermore, 86% of respondents attributed this to an internal source, and 76% of incidents were not formally reported. Similarly, the 2024 PMES (NSW) found that a greater proportion of members of the health workforce (H) reported experiencing negative behaviours compared to the public sector (PS). Experiences of bullying (H=26%, PS=14%), sexual harassment (H=7%, PS=5%), threats or physical harm (H=13%, PS=10%) discrimination (H=10%, PS=8%) and racism (H=5%, PS=4%) were reported accordingly.

Research, both in Australia and internationally, finds that there is a relatively high prevalence of negative behaviours (bullying, harassment, racism, discrimination) among healthcare providers, including doctors in training. For example, a meta-analysis of 57 cross-sectional studies found that 59.4% of medical trainees had experienced some form of harassment or discrimination during their training (Fnais et al., 2014). In addition, and consistent with the MTS, consultants are most commonly cited as the source of these negative behaviours (Fnais et al., 2014). In another systematic literature review of 45 papers, the prevalence of bullying ranged

from 4-87% across a range of healthcare professionals, including doctors, nurses, midwives and allied health professionals (Lever et al., 2019).

Addressing Workplace Bullying

Workplace bullying is a prevalent issue in healthcare settings and many high-pressure, high-stakes environments and is a critical and negative consequence of workplace culture. The most common key forms of bullying in the healthcare sector include exclusion from work activities, withholding crucial information, spreading rumours, and receiving hostile reactions from colleagues (Palanski & Vogelgesang, 2011). Contributing factors include high-pressure work environments, inadequate management skills, and power imbalances with the power differential – the latter being a significant contributor to the culture of many health settings (Cummings et al., 2014.; Malik et al., 2020).

Power differentials may be uniquely experienced by Aboriginal and Torres Strait Islander trainees. These dynamics are often felt more acutely due to intersecting factors such as historical power relations, cultural obligations, and the heightened scrutiny and expectations placed on First Nations staff (Garvey et al., 2009). Hierarchical behaviours that may be perceived as routine or neutral by non-Indigenous colleagues can carry deeper meaning and emotional toll for Aboriginal and Torres Strait Islander trainees, particularly in environments where racism, lateral violence, or cultural isolation are also present. (see Durey & Thompson, 2012; Browne et al., 2016).

This suggests a need for behavioural change, skill and style shifts and values alignment through increased reinforcement and enabling of above-the-line and below-the-line behaviours.

Recognising Incivility and Its Impact

Incivility, while less visible than bullying or more violent behaviour, is another pervasive issue, characterised by low intensity but disruptive behaviours, often without conscious intent of harm or negative impact. This low-intensity but negative behaviour, when repeated, can significantly impact the individual's mental health and emotional affect, substantially reducing psychological safety and negatively impacting individuals and teams.

A survey by the Australian Nursing and Midwifery Federation (ANMF) (Vic Branch) highlighted that nearly all members experienced some form of incivility in the past six months, with common behaviours including impatience, moodiness, and negative attitudes driven by a sense of entitlement (Palanski & Vogelgesang, 2011). Interviews with healthcare workers highlighted that gendered incivility, often manifesting as dismissive behaviour from male colleagues towards female workers, contributes to a hostile work environment. While these incidents may seem small on their own, the cumulative effect can severely drain psychological resources, leading to heightened stress and decreased job satisfaction amongst workers and has been found can escalate over time to bullying and harassment if left unchecked (Leiter et al., 2012).

For Aboriginal and Torres Strait Islander staff, repeated exposure to racial microaggressions as well as more blatant racism, can have profound effects on professional goals and wellbeing (Milroy & Frayne, 2025). In original research on behalf of the Lowitja Institute, Milroy (Yindjibarndi and Palyku) and Frayne used exploratory mixed methods to seek greater understanding of the experiences of Indigenous GP registrars. The impacts of racism and exclusion are pervasive, not only for immediate wellbeing, but also for an individual's sense of confidence, identity, and belonging (Milroy & Frayne, 2025). Though sometimes less overt, the prolonged exposure to racial microaggressions contributes to psychological distress, emotional exhaustion, symptoms of anxiety and depression, isolation and maladaptive coping (Dudgeon et al., 2021; Garvey et al., 2009; Paradies et al., 2015).

Garvey et al. (2009) reported self-confidence as a significant finding in their qualitative investigation of Indigenous Australian medical students' perceptions of training. Self-confidence was recognised by participants as a critical factor for success, yet they also uniformly indicated that they lacked the confidence needed to succeed in their training. However, factors like support from family, friends, group work, Indigenous doctors and contact with senior Indigenous students provided encouragement and confidence. This is consistent with research that points to similar protective and encouraging practices, including mentorship and networking with other Aboriginal practitioners, and accessing Aboriginal community where a sense of safety and acceptance can be felt (Garvey et al., 2009; Milroy & Frayne, 2025). Alongside these practices, the nuance of race or culture-based discrimination and ill-treatment must be accounted for when assessing uncivil behaviours in a workplace.

Understanding Work-Related Violence in Healthcare

Work-related violence in healthcare is a critical concern influenced by multiple factors. Key contributors include the clinical conditions of patients, clients, or consumers, which can escalate tensions. Furthermore, the emphasis on prioritising patient rights to treatment can sometimes overshadow the health and safety of healthcare workers. A lack of consequences for aggressive behaviours exhibited by patients and visitors further compounds this issue. Additionally, the challenges of staff shortages and increased workloads create a high-stress environment where there is a shared shift in expectations, increased passive acceptance and a culture where healthcare workers increasingly view incidents of violence as "part of the job". There is also a pattern that suggests aspects of a 'heroic culture' where enduring the stress, challenges and adversity of the environment becomes a cultural norm and associated with strength.

Provider Safety

In the current context, experiencing and witnessing negative behaviours, often demonstrated by senior staff, and calling out or reporting these may have real or perceived repercussions. Nearly seven in ten (69%) doctors in training who had experienced bullying, harassment, discrimination and/or racism indicated that the incident had adversely impacted their medical training. Four in ten (38%) rated this impact as moderate/major.

Despite consistent reports of negative behaviours and incivility, initiating change is undeniably challenging. One possible contributing factor to the lack or slow pace of action and change is low levels of psychological safety, indicated by a fear of speaking up or reporting incidents (safety voice) (Noort et al., 2019; Peadon et al., 2020).

According to the 2024 MTS, 26% of incidents witnessed, and 33% of incidents experienced were reported. For Aboriginal and/or Torres Strait Islander Trainees, the rates of reporting are higher than the general cohort, at 35 and 39% respectively. Of significant concern is the lower rate of reported follow-up for Aboriginal and/or Islander Trainees, with 31% of those who reported events they had experienced confirming follow up, (compared with 48% of the general cohort) and 21% of reports of witnessed events being followed up (compared with 44% of the general cohort.

Understanding the barriers to reporting provides valuable insights into the perception and confidence in existing reporting structures. Respondents cited "Nothing will be done if I do report it" as a primary blocker for reporting incidents witnessed. In contrast, "Concerns about repercussions" was cited as a primary blocker for reporting incidents experienced. Table 3 below compares the barriers to reporting in more detail. The experience of this culture and the social norms that apply to the safety of reporting inform and further reinforce these beliefs.

Table 3: Factors Preventing Reporting Incidents Witnessed vs. Experienced (MTS, 2024)

Factor	Witnessed	Experienced
Nothing will be done if I do report it	39%	52%
Concerns about repercussions	36%	46%
I feel it is not the accepted practice to report it	22%	25%
Lack of support	19%	26%
Lack of processes in place	13%	13%
Wasn't provided information on how or who to report to	13%	12%

Additionally, according to RANZCP, 52% of respondents in the 2023 exit survey said they did not report negative behaviours due to concerns of repercussions (78%) and doubts about reporting mechanisms (48%), further reinforcing the presence of cynicism and low belief that action will be taken as a result of survey findings. Importantly, for many Aboriginal and Torres Strait Islander trainees, existing reporting pathways may not be perceived as culturally safe or trustworthy. This relates to a concern that experiences may be minimised or dismissed by non-Indigenous leadership. Furthermore, trainees may feel deterred from reporting incidents due to fear of intimidation, a lack of trust in confidentiality, doubts about procedural fairness and concerns about future opportunities and/or reputational damage (Abhary et al., 2018). In many ways, this is consistent with the concerns of the broader trainee population; however, we must acknowledge the depth and gravity of impact on Aboriginal and Torres Strait Islander trainees when reporting systems lack a trauma-informed approach and fail to offer culturally grounded support.

On balance, these results show that concerns about actions following reporting are far more likely to prevent someone from formally calling out negative behaviours than their lack of knowledge about how to or who to go to. For doctors in training, it is evident that physical and psychological safety is actively challenged from an internal and external perspective and can have a detrimental effect. For Aboriginal and Torres Strait Islander Trainees, this is compounded by a lack of cultural safety and differences in the diligence of follow-up of their concerns.

Undoubtedly, healthcare is a complex and chronically stretched industry, and many of these negative results are the consequential outcomes of an organisational culture that struggles to prioritise patient and provider safety, care, and inclusion. These fundamental issues with the current culture, beliefs, and norms must be addressed to improve outcomes.

Culture Matters – The Case for Cultural Reform

Culture Influences Career Trajectory for Trainees and New Doctors

Culture, while seemingly invisible, is deeply felt across the employee lifecycle (Cacciattolo, 2014; Hogan & Coote, 2014). Beginning as early as medical school, there is a consistent emphasis on work culture for doctors, suggesting that culture is an influential driver of future career choices and career success. Medical Deans Australia and New Zealand administer surveys annually to final-year medical students across Australasia, forming the Medical Schools Outcomes Database (MSOD), a longitudinal collection of data. Findings from the

2024 survey show that alignment with personal values and atmosphere/work culture are the top factors influencing the choice of preferred area of medicine for students in their final year across Australia. (MSOD, 2024)

This is consistent with trends in New Zealand and findings from doctors at multiple points in their training. For example, doctors 1, 3 and 5 years after graduating also identified Atmosphere/work culture as the top 1 or 2 factors influencing their future choices. In the 2022 survey, doctors (8 years post-graduation) also identified Atmosphere/ work culture as the most influential factor in choosing their specialty in 2019, 2020 and 2021.

Importantly, the Medical Training Survey (2024) found that 29% of Aboriginal and Torres Strait Islander trainees are considering a career outside of medicine. This is alarming and points to serious flaws in the culture of their working environments. Additionally, this may have critical consequences on the future make-up of the workforce.

Despite the importance of workplace culture, significant challenges with the current culture across the industry are evident, spanning as far as tertiary members of the workforce. A study examining the workplace experiences of 67 consumer peer workers in New South Wales found the aspects of work that were most liked were “connecting with consumers”, “making a difference”, and “positive culture (team relationships)”, while most disliked factors were “attitudes of clinicians (workplace culture)”, role not valued by others, and lack of understanding of the role” (Scanlan et al., 2020).

Culture is Closely Linked to Employee Experience and Organisational Performance

Workplace culture and employee experience are strongly linked. When an alignment exists between employees' personal values and an organisation's cultural values, a sense of belonging, purpose and motivation is elicited across the workforce, resulting in a heightened sense of engagement. Furthermore, a strong culture that emphasises values such as teamwork, inclusivity, and performance can increase engagement exponentially, with organisations adopting a robust culture experiencing up to 72% higher employee engagement than those with misaligned or underdeveloped cultures. Recent studies show that organisations with highly engaged employees report 21% greater profitability and 17% higher productivity when compared to organisations with a disengaged workforce (Harter, 2018).

A robust organisational culture enhances employee engagement and plays a crucial role in employee retention, ultimately reducing recruitment and training costs. Employees who feel connected to the company’s culture and values are more likely to stay, reducing turnover and its associated costs. Additionally, a strong culture fosters an environment where employees feel valued and are motivated to perform at their best.

The converse is also true, where poor workplace culture can drive dissatisfaction and negative workplace perceptions and experiences. In a UK study, researchers conducted and analysed 48 qualitative interviews of healthcare staff across different specialties, roles and pay bands found culture was frequently cited as a contributor to and key theme in experiences of racialised inequities, negative day-to-day workplace experiences, lack of opportunities for growth and development, low valuing and esteeming and barriers to change, despite a diverse workforce (Woodhead et al., 2022)

Workplace Culture Can Impact Employee Mental Health and Wellbeing

The overall mental health and wellbeing of healthcare workers is alarming. Survey findings indicate that about 75% of healthcare workers report moderate to high levels of psychological distress, while 80% experience burnout and nearly 30% are considering leaving their current roles within the next year (Palanski &

Vogelgesang, 2011; Søvold et al., 2021). Heavy workloads often exacerbate this distress. Inadequate staffing levels limit opportunities for de-escalating potential conflicts, further contributing to incidents of work-related violence and aggression. When prolonged workplace stress leads to issues such as burnout, this increases the risk of long-term mental health issues for employees. This data alone is a compelling reason for cultural reform, with measurement of the factors that matter most being key to a focused effort.

Culture is Relevant to Patient Outcomes and Service Delivery

Workplace culture can also contribute to patient outcomes (Azzolini et al., 2018; Braithwaite et al., 2017). Positive organisational culture in a healthcare setting, for example, is consistently associated with patient outcomes, including reduced mortality rates, falls, hospital-acquired infections and increased patient satisfaction (Braithwaite et al., 2017).

Summary

On balance, workplace culture influences the trajectory of a practitioner's career and their experience in the workforce. Furthermore, issues such as psychological distress and burnout significantly increase the chances of long-term mental health issues. These feed forward to patient outcomes, organisational success, and the system's overall efficacy.

Current Methods for Assessing Culture

Culture shaping typically begins with understanding and defining the ideal state, the culture needed to deliver vision and strategy, drive and sustain performance and support individuals and teams to thrive. A baseline measure of the current state is then captured either with a quantitative or a qualitative measurement process, such as the narrative approach we use with many organisations. Once ideal and current cultures are well defined and understood, it is then possible to develop a strategic and impactful plan and enable cultural transformation in targeted and deliberate ways.

Throughout our review of currently available survey tools, we have found limited consensus on the dimensions of culture specific to the healthcare workforce, and little variation in the type or methodology of collecting data. Additionally, the healthcare sector faces unique challenges when assessing culture due to its multi-faceted and often niche setting in which many sub-cultures can exist.

While culture is typically measured using quantitative survey methods, there are also some qualitative approaches that help address cultural complexity. Narrative approaches to understanding culture offer a deeper and often transformative approach to understanding and evolving culture in positive ways. Unfortunately, these methods are often seen as lacking quantifiable benchmark data. However, when used in partnership with quantitative methods, it offers deep insights into culture with significantly less participant and researcher bias and positively contributes to shaping culture.

The following section reviews culture tools currently being used across the health sector in Australia and internationally.

Survey Tools Assessing Culture

The results of surveys currently administered provide valuable insights into the impact or outcomes of existing culture rather than a picture of the culture itself. Culture measures within the health sector tend to be included as a subset of questions in surveys with a larger scope, and few, if any, organisations or bodies use culture-specific surveys. We have reviewed surveys through the lens of target audience, key measures, outcomes, and culture-specific themes (Appendix B).

Interestingly, an individual may interact with a range of assessments across their career. Surveys may be directed to a broad and diverse population, such as those intended for use across the public sector, like the People Matters Employee Engagement Surveys. Other surveys are directed towards all health workforce members in a particular region, such as the Your Voice in Health Survey (WA). In comparison, many surveys are far more specific in scope and reach. The Medical Training Survey is limited to doctors in training across Australia. Distilling this further, medical colleges administer Trainee Exit Surveys pertaining to their respective specialties. Surveys, such as the Hospital Health Check, are also designed to address specific working environments.

Most, but not all, surveys are conducted annually, while others are administered at the end of a training cycle, and most surveys use a 5-point Likert scale for measurement. Survey length can vary, and we have found that the reliability and validity of all tools are not available. We also note that surveys can be iterative and may amend the content from year to year; for example, the RANZCP Trainee Exit Survey included items regarding workplace environment and culture for the first time in 2023.

Design Considerations

We recognise that there are several surveys supplied by different bodies that an individual may interact with throughout their training and medical careers. While this can benefit independent groups for their intended purposes, it also highlights several limitations.

On one hand, there are too many tools to complete and interpret to get an adequate idea of what culture is like at a sector level. As the scope varies from survey to survey, there may be limitations in how workplaces, specialities and other contexts assess and combine aspects or outcomes of culture and how these findings are used and compared. We also find that there is an overlap in content between many surveys. Consequently, there may be instances where completing multiple surveys with similar questions becomes exhaustive and exhausting. Survey design and the risk of survey fatigue can be a significant barrier to completion (Jeong et al., 2022), which may limit the accuracy of culture measurement and interpretation.

There is a risk that the samples are not representative of the total workforce. Low response rates perpetuate this problem and present a significant limitation to assessing and understanding the current state of workplace culture. Furthermore, there is the possibility of non-response error and response bias, influencing the conclusions drawn from survey results (Draugalis et al., 2008). The table below shows the reported response rate for a random selection of surveys conducted in 2023/24.

Table 4: Examples of Survey Response Rates

Survey (year)	Response Rate (n)
MTS (2023)	55% (22,337)
People Matter Employee Survey NT (2023)	26%
People Matter Employee Survey NSW (2023) Public sector Health	 53% (230,122) 47% (81,815)
People Matter Employee Survey SA Public Sector (2024)	35% (40,398)
BHD Survey, RANZCOG (2023) Total Trainees and Fellows	 17% (1,004) 26.2%
Trainee Exit Survey, RANZCP (2023)	55.1% (274)

Alongside survey fatigue, other possible reasons for low response rates across surveys include time commitment and workload, accessibility, confidentiality and trust, poor understanding of the survey purpose and, notably, a lack of belief that action will be taken (Klabunde et al., 2013).

In developing the culture assessment tool, the following aspects must be considered with the intention to minimise repetition, avoid redundancy and invite engagement, all while capturing data on culture as effectively and efficiently as possible: Survey length (factors and items), Content Repetition, Duration & Measurement Period, Time of administration, Time to complete, Reflective period (i.e. 6 months? 12 months?), Survey cadence (frequency), Follow up – pulse checks, Data collection methodology (e.g. Purely quantitative vs. Mixed Method).

Survey Tools Measuring Safety Culture

Secondary to surveys that generally assess workplace culture are a number of surveys used in Australia and internationally that focus on safety culture. For clarity, **safety culture** is defined as an organisational culture that 'places a high level of importance on safety beliefs, values and attitudes and these are shared by the majority of people in the company or workplace' (Worksafe Queensland). Safety culture is a construct applied to many industries, from healthcare to construction, and exists within the broader organisational culture (Vu & De Cieri, 2015).

In healthcare, safety culture is often framed through a more specific lens of patient safety, which is different from 'safety culture'**. Patient safety culture**, which can be considered one aspect of organisational culture, refers to 'a pattern of individual and organisational behaviour, based upon shared beliefs and values that continuously seeks to minimise patient harm, which may result from the process of care delivery' (Kristensen & Bartels, 2010). Essentially **patient safety culture** is where patient safety is prioritised and is consistently at the centre of all decisions and practices within the healthcare organisation.

Often there is some confusion between 'safety culture' and 'patient safety culture'. From the definitions above, these are distinct concepts; however, they are certainly related where safety culture is a driver of patient safety outcomes**.** We note the distinction between these terms and do not use safety culture, safety climate or patient safety culture interchangeably. Refer to Appendix C for a comparison of tools.

Methods of assessing safety culture

Safety is an important concept across a range of industries and contexts, allowing for several tools with this more general scope. From the tools reviewed, we found a notable emphasis on safety climate. For example, the Safety Climate Scale, NOSACQ-50 and PSC-12, all identify the attitudes, perceptions and behaviours that relate to safety in the work environment.

These tools vary in scope and depth; however, several key aspects distinguish safety culture/climate surveys from general surveys, and more specific patient safety surveys. First, and most importantly, the safety of workers and staff is highlighted. Secondly, data is collected through the lens of individuals, teams, and management (leadership); and finally, commitment to and compliance with safety structures and practices is captured.

The NOSACQ-50 is a powerful tool for ascertaining safety climate and is one of the more comprehensive safety surveys (50 items) we identified. This tool has been adapted and is available in over 45 languages, has sound reliability and validity, and offers international and industry benchmarks, including in healthcare. Importantly, this survey reveals perceptions of the safety climate rather than a representation of actual conditions, with results being used to identify areas for improvement across seven dimensions (Kines et al., 2011).

We also recognise that in order to facilitate a safe working environment, considerations beyond physical safety must also be made. Psychosocial health and safety are the core interest of a sub-set of tools available. For example, the Psychosocial Safety Climate Scale (PSC-12) is an example of a short instrument used in Australia to understand the attitudes and practices specifically relating to employee psychosocial safety and wellbeing. Similarly, the Safe at Work survey aims to support employers in identifying psychosocial risks in a workplace and informing them about improvement approaches. This is significant in light of recently amended legislation specifying employers' obligations to manage and protect employees from psychosocial hazards and risks (Safe

Work Australia, 2024), however, these surveys are highly specific to psychosocial risks, rather than addressing the larger issue of culture.

Cultural safety is a critical component of addressing negative behaviours in the workplace, particularly those underpinned by racism. There is growing evidence that cultural safety training can improve the quality of healthcare delivery and outcomes for Aboriginal and Torres Strait Islander peoples, to the extent that it is now mandated in many healthcare settings (Elvidge et al., 2020; McGough et al., 2022; Moloney et al., 2023; West et al., 2021). However, when evaluating existing survey tools and frameworks, most focus primarily on assessing cultural safety for patients — not for healthcare providers themselves. For example, the Australian Institute of Health and Welfare's *Cultural Safety in Health Care for Indigenous Australians: Monitoring Framework* tracks improvements in patient access and experience but does not extend to workplace cultural safety for Aboriginal and Torres Strait Islander staff. While this work is vital to advancing health equity, it reflects a broader gap in workforce reform efforts. Cultural safety must also be embedded as a foundational element of workplace culture — not only to improve patient care, but to create safe, respectful, and culturally sustaining environments for Aboriginal and Torres Strait Islander health professionals. This is essential to shifting the underlying attitudes, values, and systems that continue to marginalise First Nations peoples within the health workforce.

Additionally, we recognise that the tools and frameworks evaluated in this section are largely rooted in Western or Eurocentric ideologies. In the Australian context, there is an opportunity to engage with Aboriginal and Torres Strait Islander communities to apply and embed a First Nations lens to the shared understanding of safety in the workplace. This captures a first-hand and more fulsome representation of what it means to feel safe.

On balance, we find that surveys under the safety scope tend to assess **safety climate** rather than safety culture, though there may be some implicit reference to safety beliefs and values. There are some references to psychosocial safety and cultural safety for patient care. However, communicating the importance of this for providers is lacking. These surveys contribute meaningful insights to understanding culture and climate but may not be sufficient if used in isolation.

Methods of assessing 'patient safety'

Academic commentary as well as the Australian Commission of Safety and Quality in Health Care, have traditionally considered 'patient safety' as the main cultural dimension of importance, hence the emphasis we see in many internationally recognised tools (Ulrich & Kear, 2014). These tools are not standardised or always mandated; they can be used at the discretion of the relevant bodies, meaning they may be used in conjunction with surveys administered across the public sector.

The Safety Attitudes Questionnaire (SAQ), developed by Sexton et al., is one of the most widely used tools to understand patient safety climate (Scale reliability =0.9). The SAQ allows for the measurement of perceptions and attitudes of frontline workers related to patient safety and has the capacity to prompt and measure the impact of interventions. A multi-factor analysis following a study of six cross-sectional surveys of healthcare providers in 203 clinical areas (n=10,843) in the USA, UK and New Zealand found six factors pertinent to safety culture attitudes. These were teamwork climate, safety climate, perceptions of management, job satisfaction, working conditions and stress recognition (Sexton et al., 2006). Notably, researchers suggest that climate is a more appropriate term to describe the scope of the SAQ, recognising that it can be challenging to measure and capture aspects of culture, like values, in a survey.

The Hospital Survey of Patient Safety Culture (HSOPSC) and the Australian Hospital Survey of Patient Safety Culture (A-HSOPSC 2.0) are examples of recommended tools that examine aspects of a 'patient safety culture' in the hospital context such as staff opinions on safety issues, medical errors and reporting. The ability to adapt the HSOPSC to fit the Australian context is a key strength; however, we find it may be limited in its scope and capacity to represent a diverse workforce.

Questionnaires on patient safety present an interesting case for considering how culture or climate data is collected. For example, Litchfield et al., (2021) compared two commonly used tools in the UK – PC-SafeQuest and MaPSaF, examining the strengths and limitations of two distinct methodologies (Litchfield et al., 2021). Through completion of the tools and focus group discussions, the study found that, on the one hand, PC-SafeQuest, a quantitative measure, was easy to use and highly relevant to the specific work environment of GP practices. On the other hand, the MaPSaF, which takes a qualitative workshop approach, lacked anonymity and was more challenging to complete, yet created valuable dialogue around perceptions of safety culture across a team. This has been shown to produce deeper insights and focus areas for action (Litchfield et al., 2021).

A recent study on the measurement of culture in the National Health Service (UK), demonstrated that despite a growing understanding of the importance of culture in patient care, the tools used to assess culture have changed very little over the past decade. For example, MaPSaF, identified by Mannion et al. in 2008, remains one of the top three tools today, even though it is not a measurement of culture. This suggests that healthcare professionals need additional support and resources to develop or identify new tools, as they may rely on familiar ones. This pattern also aligns with organisations using public sector engagement surveys, such as the People Matter Survey in Victoria, with the assumption that they are an effective cultural assessment when they are, in fact, measuring the outcome of culture rather than culture itself.

Thus, while it may be recommended that hospitals use the A-HSOPS 2.0 to assess patient safety culture, a thorough review of safety culture assessment modes conducted by the Australian Commission of Safety and Quality in Health Care (2017) ultimately concluded that "no single tool was considered to assess all major dimensions of safety culture adequately", and no tools could be recommended for large-scale implementation in a range of settings.

Summary

In conclusion, our review of existing tools highlights a range of themes and concepts currently being measured across engagement, satisfaction, experience, communication, and perceptions of safety. While these tools have a role in the improvement of programmes, organisations and workplaces, we find that no single tool provides robust and relevant information to address the major cultural issues in healthcare, particularly regarding doctors in training. Furthermore, most, if not all tools lack an informed cultural safety lens, specific to the Australian context.

Discussion

The following sections further evaluate the strengths, limitations and key gaps in culture assessment tools used in the healthcare sector in Australia.

Gap #1: There is limited consensus on the essential cultural dimensions

One of the greatest challenges with measuring culture is in the very nature of the concept. As outlined previously, we refer to organisational culture as the shared values, beliefs, attitudes, and practices that characterise an organisation (Catling & Rossiter, 2020; Sutherland & Watters, 2024). As culture itself is not always explicit or observable, it is essential to clearly articulate its dimensions. Organisations must clearly describe their current culture and define their desired culture using consistent factors and definitions. We find that the surveys and literature we have reviewed lack clarity on the dimensions of culture and, as a result, miss the depth and breadth required for a comprehensive assessment of workplace culture (Johnson et al., 2016; Kwon et al., 2015; Nightingale, 2018; Rimmer, 2023; Scott et al., 2003). See Appendix B and C for a comparison of tools and dimensions.

The same issue is present within the scope of safety culture, and even further in the more granular scope of patient safety culture. While many dimensions in the literature are aligned with broader organisational culture theory, there is a notable lack of consensus in practice and in the existing body of literature (Churruca et al., 2021; Kristensen & Bartels, 2010). For example, the table below illustrates a comparison between the ten key dimensions of patient safety culture identified by the Australian Commission on Safety and Quality in Health Care with a differing perspective of ten dimensions identified following a systematic review of 12 quantitative studies examining patient safety climate in the healthcare context (Flin et al., 2006).

Table 5: Comparison of Cultural Dimensions Reported in Literature

Australian Commission on Safety and Quality in Health Care	Systematic review of 12 quantitative studies on measuring safety climate (Flin et al., 2006)
• Leadership, particularly the support of safe practice • Systems, procedures and processes exist that normalise or enshrine patient safety, or which are adhered to • Resources for safety (such as staffing, equipment, training) • The quality of interpersonal relationships (such as teamwork, collaboration within and across units) • Communication, particularly about safety, including perceptions of being able to report and speak up • A focus on learning from mistakes, responding and improving systems • Individual staff characteristics and perceptions of their effect on work (such as job satisfaction, stress) • General awareness of patient safety and/or it being a priority • Other means of prioritising safety (such as through rewards and incentives) • Actual safety issues witnessed/reported	• Management/supervisors • Safety systems • Risk perception • Job demands • Reporting/speaking up • Safety attitudes and behaviours • Communication / feedback • Teamwork • Personal resources (i.e. stress) • Organisational factors

Following our assessment of survey tools, we are limited in our confidence to identify and support an existing 'best practice' for comprehensively assessing and subsequently improving culture in the healthcare context (Draugalis et al., 2008; Taras et al., 2009). There is also limited consensus on 'best practice' for measuring culture in healthcare identified in the literature (Sutherland & Watters, 2024). This is due to the complexity of the sector, the lack of consensus and understanding of what should be measured, and the range of specialties and sub-cultures that exist.

Differing views on what is considered most important for a thorough assessment of culture is a primary issue, where there is a lack of clarity on what needs to be measured. This creates a gap in the sector's ability to understand the current culture. The subsequent gaps we have identified stem from this foundational issue, and we identify the need to consolidate and articulate the fundamental dimensions for organisational culture specific to the health context in Australia.

Gap #2: The scope of existing surveys fails to sufficiently capture a pure measure of culture

Most tools currently being used have multiple focus areas, with data aiming to inform relevant bodies on factors like engagement, satisfaction, experience, training and resourcing. The value of these data should not be undermined or underestimated, as these surveys provide an opportunity to give feedback to improve current programs or workplaces. However, the broad scope of these surveys may create confusion as many constructs are measured in a single survey.

The MTS demonstrates this notion where there are 11 questions relating to "Culture within the trainee's setting". Of these 11 questions, 5 relate to support from other staff, and 4 relate to negative behaviours, not including a separate section on negative behaviours. This suggests that only two aspects of culture are being explicitly measured. For consistency, some medical colleges use the MTS as a basis for their own surveys (e.g. Trainee Exit Surveys), however, the insights gathered may be limited. For comparison, the Resident Hospital Health Check (AMA, QLD) includes a section on wellbeing and workplace culture consisting of 6 questions relating to satisfaction with facilities and training, workload, and support for mental health and wellbeing. Other sections include more detailed items on workload (hours worked, access to leave), negative behaviours and career progression.

In contrast, larger surveys administered to the public sector, like the People Matter Employee Surveys (VIC, Health), include a range of questions on organisational, safety and workgroup climate, with themes relating to negative behaviours and respectful/improper conduct, fair recruitment and promotion processes, psychological safety and error handling. The context of this survey is important as its primary aim is to build positive workplace cultures consistent with the public sector values and to improve the working environment for their employees. However, many questions focus on the outputs of culture reflected in the climate rather than the influencing input factors.

Surveys with a safety focus present an additional challenge where the scope can be too narrow. These surveys tend to be centred around safety climate and protocols relating to safety voice, error reporting, leadership and the team climate. Again, these surveys serve a purpose, particularly when identifying ways to mitigate risks. However, the two constructs can be confused, which may lead to a misunderstanding of the data. As a result, surveys with a safety focus fall short when trying to ascertain organisational culture through a holistic lens, as there are additional factors that contribute to and shape organisational culture that may be missed if safety culture assessment is used in isolation.

On balance, while there is some benefit to having a range of surveys where questions may be framed to fit the specific niche of practice, we have not identified a survey or tool that has the ability to capture sufficient information on culture itself, particularly across the broader healthcare sector. We recognise the need for a survey that is balanced in its depth and scope, focusing on a range of key dimensions that capture all aspects of organisational culture.

Gap #3: The measurement of culture is confused with the measurement of outcomes and/or adjacent constructs

Considering the limitations of scope, we have identified the inclusion of some culture-related items across our scan of current survey tools. From these items, some are measuring culture (that is, the elements or dimensions that define current culture); whereas many other items are not measuring culture at all. They are measuring culture-related factors and/or outcomes from a positive or negative culture. For example, they often measure constructs such as engagement, satisfaction or climate. These are different constructs or the consequence of and contributors to culture. In addition, these constructs may also be outputs from culture; for example, a mismatch between current and ideal culture could lead to lower levels of engagement or satisfaction.

Furthermore, surveys measure direct outcomes from culture and call this a culture survey. For example, survey items measure outcomes such as harassment, bullying, racism or discrimination. These factors are clearly outcomes of a poor culture and are not a direct and accurate measure of culture.

Across our assessment of survey tools, there is a reasonable spread of themes across true culture factors and outcomes from culture. We found that most surveys reviewed have multiple points of interest that largely revolve around satisfaction, experience and engagement of the workforce, constructs that relate to culture but do not align with our definition of workplace culture - *the shared values, beliefs, attitudes, and practices that characterise an organisation* (Catling and Rossiterm 2020). This means that while the questions highlighted *some* key culture-related or adjacent themes, many are framed in the context of climate and artifacts rather than the explicit dimensions of culture.

Table 6: Culture-Related Constructs and Outcomes Identified

Culture-Related Constructs	Outcomes
Employee Engagement	• Satisfaction with the work or role • Commitment to the organisation, profession or workplace • Motivation and morale • Sense of purpose and fulfilment in the job
Workplace Satisfaction	• Overall job satisfaction across teams • Perception of organisational support and resources • Satisfaction with teamwork and collaboration
Patient Safety Performance and Risk Management	• Perceptions of safety in the workplace • Engagement with safety protocols and practices • Safety voice and behaviour (e.g. willingness to report safety issues). • Frequency of adverse events, errors or practices • Improvement in patient safety outcomes (e.g. fewer incidents, better error reporting). • Effectiveness of safety protocols and risk management strategies.
Workforce Wellbeing	• Work-life balance • Hours worked / perception of workload • Mental and physical health support • Support available for dealing with stress and burnout

Diversity and Inclusion – Negative Behaviours	• Witnessing and/or experiencing:
	  ○ Bullying
	  ○ Racism
	  ○ Harassment (physical and verbal)
	  ○ Sexual Harassment
	  ○ Discrimination
	• Sources of negative behaviours
	• Efforts to promote diversity and inclusion
	• Perception of equality, fairness and respect in the workforce and workplace
	  ○ Lack of cultural safety and belonging for staff

Retention and Recruitment	• Staff turnover, tenure • Intention to stay and reasons for leaving ○ Workplace • Profession/specialty
Training and Career Development	• Training experience • Completion rates and satisfaction with training • Availability and quality of professional development opportunities • Mentorship and supervision • Career progression support • Transfer of learnings from training to practice

Note that the table above illustrates all major themes identified, and although collectively these themes appear balanced and comprehensive, they are not all present in a single tool. This highlights the need for a tool that captures this information in one place, expanding on and thoroughly examining the dimensions that create and contribute to culture.

In summary, based on the confusion of exactly what constructs we are measuring, it can be challenging to extract meaningful insights on the type and state of an organisation or workplace's culture, particularly when informing priority actions for cultural change.

Gap #4: Existing surveys do not explicitly capture the shared, underlying values and beliefs

We know that existing tools provide valuable information on the levels of engagement, satisfaction and experience of members of the sector, and it is evident, given the consistent reports of negative behaviours witnessed and experienced, that there is a critical need and a strong case for action and change. To achieve change, it is equally important to identify and understand the conditions, values or beliefs that facilitate and permit specific behaviours and practices, alongside collecting data on outcomes.

To reiterate an earlier point, we do not intend to equate the notion of 'shared values' with sameness and conformity. Rather, we aim to develop a framework that can capture a foundation of unifying values and beliefs that invites positive behaviours and thriving for all members of the workforce. While values may differ across environments, we emphasise that behaviours often reflect the underlying beliefs of a group or system. Clearly articulating these beliefs is essential to acknowledge, redirecting and ultimately improving behaviours and outcomes.

We can draw on a simple model where behaviours do not typically occur in isolation or as random events. Rather, specific behaviours can occur when the conditions, known as antecedents, are in place. Antecedents refer to the context, situation, or action that precedes a particular behaviour. Following this, there are consequences, referring to what happens as a result of or in response to the behaviours.

Using this framework, we find that current measures identify behaviours, for example, bullying and harassment, and consequences or outcomes, like low engagement or satisfaction. Yet, these tools lack the nuance to identify the antecedents that contribute to these outcomes. This leaves a gap in our comprehension of the factors in place that create current workplace and organisational cultures across the sector.

Further to this point, discerning whether employee experiences accurately mirror or align with the attitudes and values shared in an organisation or workplace helps identify pain points and specific areas of improvement which form the key drivers of culture shift. In this way, antecedents can provide meaningful clues on the true culture of a workplace by capturing incongruence or inconsistencies between assumed, shared values, behaviours and outcomes.

When surveys typically query workplace culture, questions that indicate values like "negative behaviours are not tolerated in my workplace" are common. In the 2024 MTS, 4 in 5 (81%) of respondents said that bullying, harassment, discrimination and/or racism was not tolerated in their workplace (espoused value), and there is strong confidence and knowledge for reporting. In isolation, these findings imply that the workplace culture for doctors in training may be one that is respectful and inclusive. However, 1 in 3 doctors in training continue

to witness and/or experience negative behaviours, and only 1 in 3 (experienced) and 1 in 4 (witnessed) of these respondents reported the incident. Upon further examination of the data, it is possible and likely that this mismatch may exist due to a fear of repercussions or consequences and the feeling that no action would be taken. In this instance, it is the incongruence between the artifacts (witnessing and experiencing negative behaviours) and the espoused value that "bullying is not tolerated" that reveals insights into the true culture and practices within the trainee setting.

Unfortunately, identifying visible issues often in the form of negative behaviours is not sufficient to inspire change. Rather, it is imperative to look deeper to understand why these gaps exist, and how to remedy them. We must examine the values that are shared and practiced, while also shining a light on things that may be missing or omitted. This may provide some direction, and perhaps a new angle for targeted actions. For example, strongly reinforcing the value and expectation that racism is not tolerated forms one piece of the puzzle. Building cultural knowledge and safety for providers forms another. Through such approaches, we may see a shift or strengthening of values that prioritise equity and fair treatment of all staff.

Thus, there is currently a gap in our ability to ascertain *why* members of a workplace behave the way they do**.** In order to better understand and improve culture, we identify the need for a tool that can extract deeper insights into the basic underlying values and assumptions that dictate how members of a workplace conduct themselves (Hogan & Coote, 2014; Shanafelt et al., 2019).

Gap #5: The drivers of culture are rarely linked back to the elements of culture

While existing surveys aim to use results for action, the content and nature produce limited insights for improvements. The focus is often on surfacing issues; however, it is important to look beyond this, identifying root causes and engaging more with the inputs than trying to fix the outcomes. Using the example of bullying, current surveys tell us that:

1. Trainees experience and witness bullying
2. Trainees do not report the majority of bullying incidents
3. Senior staff are a key instigator of bullying at work

From these insights, we fail to understand why bullying happens to the extent and scale it does (see Gap #4) and what could shift this. For example, is the culture of bullying related to misuse or mismanagement of power? Or perhaps, a lack of safety to report and be heard. Are there appropriate protective structures in place? Is this occurring because of a mismatch of expectations and poor role clarity? Understanding the drivers of these behaviours creates an opportunity for deep and meaningful change through specific and targeted solutions.

Currently there appears to be a lack of ownership of the cultural problems identified across the sector. We acknowledge that culture in healthcare is a complex notion, and the issues presented in the sector are doubly complex and deeply ingrained. However, simply identifying such issues enables an external locus of control and diminished accountability. Thus, the approach to culture change must take this challenge into account. Additionally, to uphold cultural safety, considerations should be made around implementing First Nations-led, non-punitive and culturally safe reporting systems, cultural supervision and external accountability reviews embedded in governance structures.

We find that given the scope and purpose of many existing surveys, organisations and workplaces may encounter a knowing-doing gap. This means that while surveys can identify issues (knowing), it may be challenging to identify and implement solutions to improve negative outcomes (doing). This is consistent with a lack of confidence in action following surveys which may deter individuals from participating in data collection. Subsequently, we identify the need for a tool that bridges this gap. The stakeholder interviews also identified a similar notion (see below). In introducing a new survey tool that warrants participation, ensuring that the findings link to the culture in real teams and workplace environments and have actionable, targeted solutions that evoke visible change is important.

STAKEHOLDER ENGAGEMENT

WHERE TO

Executive Summary

This summary report represents the views and perspectives of 8 key stakeholders in the healthcare system with respect to the development of a new cultural measurement tool for healthcare settings.

Stakeholders recognise the potential for better measurement of culture in healthcare settings to provide clear direction for managers and leaders to address cultural issues. But there they raised a range of risks and challenges, opportunities and recommendations for good implementation.

Most significantly, the issue of survey fatigue is likely to mean that the introduction of a new survey will face some resistance. Some felt this resistance derives from a sense that nothing gets done with the data collected from existing surveys, and nothing changes as a result. This suggests that providing clear, directional advice for administrators will be a key outcome for the project. The usefulness of the data for decision makers to better guide the development of workplace cultures will be a key point to communicate

Most stakeholders agree that cultural measurement and guidance are likely to have the greatest impact when they include all healthcare professionals, not just doctors. Healthcare teams are generally cross-disciplinary, and cultures, therefore, cut across different professions. It will be important for any culture survey to have a good perspective across these divides.

The organisation that functions as data custodian and owner of the data will also be important. The organisation will need to have the resources to deploy the survey (potentially on an ad-hoc basis) and provide results rapidly to ensure the overall effectiveness of the project. AHPRA has the contact details of every registered healthcare professional, which will make dissemination easier than going through thousands of different workplaces and will give the survey the required gravitas. ACSQHC also feels to some stakeholders to be a natural fit. RACMA also make sense as a data custodian. However, the degree to which each of these organisations are set up to implement and deliver the survey ongoingly is not, at this stage, clear.

Opportunities

Stakeholders identified a range of opportunities that a robust, reliable culture measurement tool can offer the healthcare sector. These included:

- Enhanced measurement and understanding of culture
- Delivering a system-wide perspective
- Professional development and support for early-career professionals
- Clear direction for identifying issues and improving cultures

Table 7: Opportunities Identified in Stakeholder Interviews

Enhanced Understanding of Culture	• More sophisticated measurement of cultural dimensions • Improved tracking of changes over time • Better connection between measurement and action • Opportunity to measure positive cultural factors rather than just negative outcomes • Better understanding of what makes successful healthcare teams • Better retention through improved cultures • Enhanced patient safety and care quality
A System-Wide Perspective	• Potential for standardised measurement across settings • Ability to identify and share best practices • More sustainable workplace practices • Improved inter-professional collaboration • Greater system resilience
Professional Development	• Enhanced support for early career professionals • More effective feedback mechanisms • Improved training environments • Better support for work-life balance • Enhanced leadership development focused on cultural competency • Greater emphasis on psychological safety • Clearer professional development pathways
Clear Direction for Identifying Issues and Making Changes	• Ability to identify cultural "hotspots" needing attention • Potential for more targeted, frequent pulse surveys rather than long annual surveys to measure change • Ensure that outcomes and levers for change are measured to provide clear directional advice

Challenges

Complexity and multidimensionality of culture

- Multiple intersecting professional cultures exist within healthcare settings (doctors, nurses, admin staff) that can conflict or create tension
- Culture varies significantly between departments, specialties and settings (e.g. emergency vs general practice)
- Historic hierarchical structures clash with modern collaborative approaches
- Different organisational cultures between public vs private, metropolitan vs regional settings
- Royal/traditional hospitals have distinct cultures from newer institutions
- Culture is highly localised - what works in one setting may not translate to another
- Difficult to measure culture consistently across diverse settings

Survey design and implementation

- Survey fatigue is a major issue - healthcare workers already complete multiple overlapping surveys
- Need to balance comprehensive measurement with a reasonable survey length
- Challenge of getting representative response rates - often only those with strong views respond
- Privacy and confidentiality concerns, especially in smaller workplaces
- Logistical challenges tracking staff who work across multiple settings
- Question of whether surveys actually drive meaningful change
- Risk of survey data being used punitively rather than constructively
- Need for actionable insights rather than just measurement

Structural / System issues

- Multiple stakeholders (colleges, unions, employers, regulators) with overlapping responsibilities
- Limited ability of any single organisation to affect cultural change
- State vs federal tensions in healthcare governance
- Resource constraints for implementing cultural initiatives
- Complex industrial relations environment
- Challenge of coordinating action across jurisdictions
- Difficulty establishing clear accountability for cultural improvement and absence of cultural governance frameworks

Workforce evolution and changing expectations

- Changing expectations between generations of healthcare workers
- Growing focus on work-life balance and wellbeing
- Shift from hierarchical to collaborative leadership styles
- Increasing workforce diversity requiring cultural adaptation
- Different cultural backgrounds affecting workplace interactions
- Evolution of training pathways and professional development approaches
- Growing recognition of psychological safety and support needs

Considerations for Implementation

Survey design

- Keep surveys concise but comprehensive
- Focus on actionable insights
- Enable longitudinal tracking
- Ensure mobile-friendly design
- Allow save and resume capability
- Include progress indicators
- Consider pulse survey options
- Balance depth vs response burden

Stakeholder engagement

- Early involvement of state health departments is critical
- Clear communication about purpose and benefits
- Coordination with existing survey programs
- Support from professional bodies and unions
- Buy-in from frontline workers
- Engagement of senior leaders
- Clear value proposition for participation

Governance

- Need for a respected national coordinating body (e.g. ACSQHC, AHPRA)
- Clear data governance frameworks, and respected data custodians
- Appropriate privacy protections
- Mix of public and private reporting
- Support tools for improvement
- Resources for implementation
- Clear accountability frameworks

Implementation approach

- Pilot testing in different settings
- Phased rollout
- Regular review and refinement
- Focus on practical improvements
- Support for local adaptation
- Building on existing initiatives
- Clear change management approach

RECOMMENDATIONS

The following section outlines our recommendations based on our evaluation of existing survey tools and literature review. We propose four key focus areas for developing a robust survey tool that can comprehensively assess culture and inform a pathway to change.

1. Dimensions of Culture - factors that contribute to the current culture
2. Ideal Culture - A framework to define the ideal culture for a specific healthcare context
3. Levers for change
4. Linking back to outcomes
5. Proactively including and embedding First Nations voices, knowledge and perspectives in all future culture work

Insights from the literature are captured across various specialties and professions, adding to the wider industry perspective. From here, we can extract several integral aspects that link to culture. These are Power and Leadership, Systems, Structures and/or Processes, Interpersonal Relationships and Behaviours, Learning, Development and Innovation, and Ethics, Risk, and Safety (See Appendix A). We will apply these concepts to our recommendations for the dimensions of culture and levers for change.

Dimensions of Culture

Based on the literature and research we reviewed; we have developed a framework that clearly articulates the dimensions of culture that consistently need to be measured within the health sector.

A number of key characteristics of professions in healthcare also help to guide what is most critical in assessing culture (Cosgrave, 2020; Rimmer, 2023; Taras et al., 2009). For example, there needs to be a strong consideration for the interpersonal nature of the work both from an internal and external (patient) perspective. Consideration must also be given to the high stakes in the work, and the importance of balancing safety and performance. Finally, healthcare is a multi-levelled and highly complex structure with many, often rapidly changing, dimensions. Therefore, consideration must be given to how power is viewed and used.

The following dimensions illustrated in Figure 1 represent the building blocks of workplace culture. That is, each component informs and influences the shared values, attitudes, and practices in a workplace. We recommend the following cultural dimensions for inclusion in the culture assessment tool:

Figure 1: Key Dimensions of Culture

Human Centred

The human-centred dimension reflects an organisational ethos that prioritises humanistic values to promote positive interpersonal experiences. These values are pivotal for fostering practices that encourage collaboration, participation and teamwork by creating an environment where individuals feel valued, supported, and empowered to perform at their best (Lepeley at al., 2021; Townsend & Romme, 2024)

Respect and Civility

A culture that encompasses respect and civility prioritises fairness, inclusion, and ethical behaviour where individuals treat each other with dignity, courtesy and impartiality, creating and environment rooted in mutual respect and constructive communication (Bijalwan et al., 2024; Clark & Walsh, 2016; Di Fabio & Kenny, 2018; Peng, 2023).

Safety

A safety culture prioritises physical, psychological, cultural and operational security of staff, creating an environment where individuals feel protected and supported to speak up, discuss and learn from mistakes, and maintain a steadfast commitment to high standards and the mental health and wellbeing of others (Carmeli, 2007; Parker et al., 2006).

Performance

Performance reflects an organisation's ability to achieve its goals by fostering agility, efficiency, and a commitment to the team purpose, where individuals are committed to shared objectives and prioritising patient needs, ensuring adaptability and alignment in a dynamic environment (De Waal, 2006; Lawler, 2003).

Power

Power refers to the way influence, authority and control are distributed and exercised within an organisation, shaping decision-making, autonomy, accountability and interpersonal dynamics (French & Raven, 1959; Keltner et al., 2003; Magree & Galinsky, 2009; Raven, 1965). Assessing values towards power aims to understand the power structure, as well as how power is possessed and used.

Trust

Trust is the foundation of positive workplace relationships, built on shared values, consistent actions, and emotional and cognitive connections between individuals. It encompasses a sense of reliability, authenticity, and belief in others' integrity, creating an environment where members feel safe and confident in the actions of their colleagues (Das & Teng, 1998; Fukuyama, 1995; Lewis & Weigert, 1985; Wicks et al. 1999; Jones & George 1998; Whitener et al. 1998; McAllister 1995).

Dimensions of Culture: Sub-Factors

Within each of these factors, we have identified a number of sub-factors (*Table 8)* that, together, provide a complete view of the type and state of workplace culture (A. Chatman & Choi, 2022; Churruca et al., 2021; Williams et al., 2015).

Table 8: Dimensions of Culture and Sub-factors

Factor	Sub-factor
Human Centred	• Supportive • Caring / Compassionate • Collaborative • Encouraging
Respect and Civility	• Justice • Fairness • Morals and Ethics • Equity and Inclusion
Safety	• Psychological Safety • Learning Culture • Safekeeping • Precision • Cultural Safety
Performance	• Agility • Efficiency • Patient Safety • Commitment to team and organisation • Interdependency
Power	• Directive • Acceptance • Blame • Shame • Empowerment
Trust	• Authenticity • Consistency • Reliability • Belief

Defining Ideal Culture

Once we have a clear understanding of an organisation's current culture, the next step is to create clarity about the culture needed to deliver against vision and strategy – i.e., the 'ideal culture'. This can vary between different organisations at a micro level but share universal characteristics across the healthcare sector, and in fact many sectors. Typically, the ideal culture should be linked to the long-term strategy of the organisation and this needs to be identified and articulated by those who most understand what the organisation is aiming to achieve over the long-term. We recognise that the healthcare sector is complex and highly nuanced. There are multiple entities that co-exist, each with their own unique needs based on the nature of work. For this reason, rather than setting a blanket 'Ideal Culture', we recommend a framework that enables organisations to agree on their ideal culture in a way that serves those unique needs.

The dimensions of culture will be the same for current and ideal cultures. However, the desired level of each element of culture is likely to be nuanced and different depending on their needs and aspirations. Whilst measurement of the 'current culture' would include all staff, measurement of the ideal culture would most likely be limited to a sub-section of staff, typically the top levels of leadership who are directly involved with setting and driving the long-term strategies of the organisation.

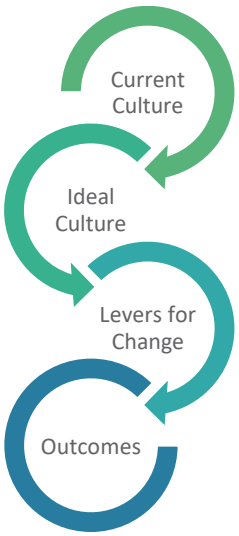
The flexibility within this framework presents a unique opportunity to build on each ideal culture. While culture should be linked to the long-term strategy, and inherently will have top-down influence, there is also space to consult with and gain insight from those embedded within the system. Hearing the perspectives of those impacted by top-down decisions could support more considered, informed and productive actions from leadership.

Levers for Change

Existing tools can provide insights into the experiences of people in a cohort, college or workplace; however, it is evident that simply recognising and documenting these experiences is insufficient to drive the way to improvement. This is because the issues identified are often deeply ingrained, highly complex, and have no dedicated custodian.

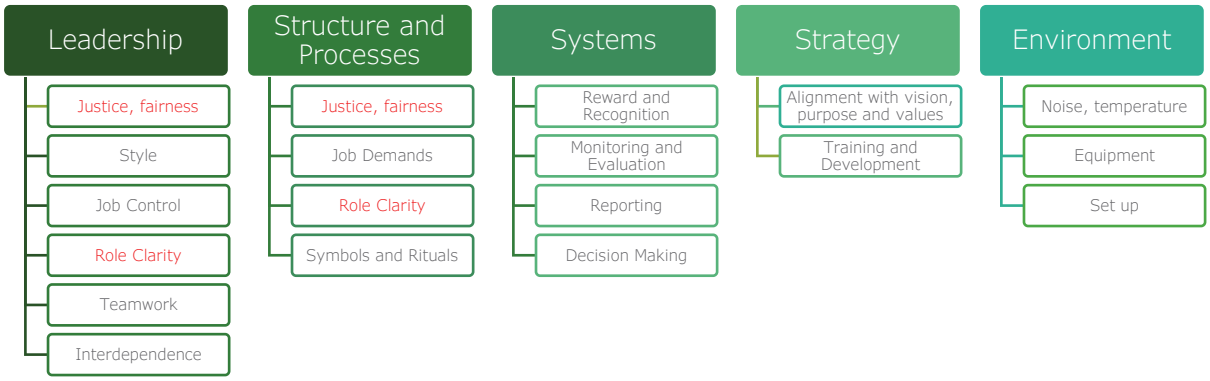
Whilst it is extremely useful to clearly articulate both the current and ideal culture for any organisation, this knowledge alone will not help drive true culture change. To do this, we need to understand the root causes of the gap between the current and ideal culture and the factors that are driving this gap. For this reason, we recommend the inclusion of "levers for change" as a part of the culture assessment tool. Once the current culture has been identified and measured against its ideal culture, it is imperative to provide guidance on actionable steps to shift the dial.

Figure 2: Pathway to Culture Change



We consider 'levers for change' to be points of influence, characterised as *specific actions, strategies or tools that can be modified to create meaningful transformations in a system or organisation.* To move towards an ideal culture, it is necessary to adjust the culture shaping factors (levers) in targeted ways.

Figure 3: Levers for Culture Change



We have categorised levers for culture change in healthcare into five groups, noting that there are some levers that overlap across factors, illustrated in Figure 3 below.

Together, the dimensions of culture and levers for change form the basis for items to be included in our proposed culture assessment tool (Baird et al., 2023; Cummings et al., 2014.; Edwards et al., 2015; Lever et al., 2019).

Linking Culture to Outcomes

The aim of these layers of measurement is to enable action and achieve positive outcomes across the healthcare sector. The Steople Culture Measurement framework recommends the following process:

1. Measure the current culture, including the dimensions of culture
2. Define the ideal culture for each organisation
3. Identify the key levers and actions for change
4. Implement actions/changes over time
5. Measure key outcomes and impact of culture shaping action

It is important to note that we need to measure both the outcomes from a positive culture or at least a movement towards the ideal culture and the outcomes from a more negative culture (or culture that is not aligned with your ideal culture). A list of positive and negative outcomes is listed below.

Table 9: Outcomes from Positive and Poor Culture

Outcomes from Positive Culture	Outcomes from Poor Culture
• High productivity and performance • High engagement • Higher physical and mental health • High safety	• Violence • Aggression • Bullying • Harassment • Racism • Stress • Discrimination • Burnout • Low productivity and performance • Low engagement • Absenteeism • Presenteeism • Poor mental health • Low safety

Note: this is a long list of possible outcomes. We do not suggest that healthcare organisations measure all these outcomes but rather, select key outcomes that they are seeking to achieve and set up regular assessments against key targets and then link these outcomes back to work that is being undertaken to improve the culture and work towards the ideal culture.

Future Steps Towards a Culturally Safe Health System

While project constraints have limited our ability to appropriately engage with Aboriginal and Torres Strait Islander stakeholders; we recognise that future efforts to shape the culture of healthcare in Australia must prioritise the sustained inclusion of First Nations voices at all stages of the process. This includes and is not limited to building culturally safe environments by addressing systemic racism and ensuring accountability going forward. Strengthening cultural assessment processes and deepening engagement with Aboriginal and Torres Strait Islander representatives—not only through consultation but through co-design, leadership, and shared decision-making—is essential. This work should be grounded in formal partnerships with Aboriginal and Torres Strait Islander stakeholders, including governance roles for ACCHOs, Elders, and health leaders. A

combined top-down and bottom-up approach, informed by lived experience and paced to allow for meaningful dialogue, will enhance the impact and integrity of this work. Embedding First Nations voices into policy and practice is a critical demonstration of commitment to cultural safety and will support genuine, system-wide cultural change.

Within the scope of the current work, several amendments were made to the survey tool following consultation, including the addition of:

- Hover text description of cultural safety
- One item on a lack of cultural safety in the workplace
- A dedicated section for cultural safety (5 items)
  - I can raise concerns about culturally unsafe practices without negative consequences
  - Professional development opportunities are available that address cultural safety and competence
  - I have access to culturally appropriate support networks when needed
  - I feel that my cultural background and identity are not respected in this workplace
  - I hesitate to share aspects of my cultural background due to fear of judgement or misunderstanding

As quantitative validation of the survey tool progresses, it is important to ensure diverse representation of participants. Additionally, it is critical to carefully consider who will act as a data custodian. This includes ensuring that discussions explicitly address First Nations data sovereignty. Aboriginal and Torres Strait Islander peoples have the right to control how data relating to their communities is collected, owned, used, and interpreted, in accordance with the *Maiam nayri Wingara* principles. In the Australian context, cultural safety cannot be meaningfully measured without First Nations-led oversight of data processes—including collection, storage, reporting, and use. Without this, there is a risk of repeating extractive practices where cultural information is taken from communities but used in ways that lack connection to their priorities and accountability to Indigenous governance (Kukutai & Taylor, 2016; *Maiam nayri Wingara, 2018*).

Any national survey tool — particularly one focused on culture — must embed Aboriginal and Torres Strait Islander data sovereignty as a foundational principle, not a retrofitted add-on.

Finally, culture reform will take time. There is an opportunity to use this time to engage fully with Aboriginal and Torres Strait Islanders to hear their lived experiences of racism, violence (including lateral violence) and cultural harm. There is also much to learn from deeper engagement with Indigenous frameworks – ones that invite curiosity in our ways of knowing, being and doing (Martin & Mirraboopa, 2003; Spiller et al., 2021). When workplaces actively recognise identity, prioritise cultural safety, and promote values such as respect, reciprocity, and collective care, they contribute to improved psychological wellbeing, motivation, and long-term engagement. For Aboriginal and Torres Strait Islander peoples, strong connections to purpose and community through work serve as protective factors that support both retention and high-quality practice. Embedding these strengths-based principles into workplace culture creates conditions where all members of the workforce can thrive.

The development and iteration of a culture assessment tool is one part of a much larger initiative to shift the culture of healthcare, and there is work to be done. Lasting transformations occur when we acknowledge and lean into this dialogue – looking forward with respect and understanding of the past – all of which contributes to a more sustainable and better equipped and supported workforce.

CONCLUSION

In summary, there is a strong case for cultural reform in the healthcare sector, and existing surveys highlight some of the key challenges staff, particularly trainee doctors, face. We found that there are no best-fit tools currently available to evaluate and improve organisational culture, a concept defined as *the shared values, beliefs, attitudes, and practices that characterise an organisation.* There is no doubt that these challenges are widespread, yet, through our review of existing tools, literature, and stakeholder interviews, it is evident that there are significant barriers to implementing realistic and meaningful changes.
Without addressing these fundamental building blocks of the social and physical environment for healthcare workers, the absence of ownership for the issues, like bullying, harassment, racism and discrimination, the health workforce face remains, and without clear direction, the same issues identified in existing surveys proliferate.

To move the dial, we recommend first, defining the dimensions of culture: Human-centred, respect and civility, safety, performance, power, and trust. The values within each of these dimensions creates culture, and also highlights opportunities for improvement. To address the knowing-doing gap, we have suggested a series of levers for change, which provide an actionable lens through which changes can be made. We recommend that culture should be linked to outcomes and these two concepts should be used in tandem rather than in isolation, and finally, we strongly recommend the proactive inclusion of Aboriginal and Torres Strait Islander voices in all stages of future work towards improving the culture of healthcare.

APPENDICES

Appendix A: Culture Frameworks, Models and Theories

Recognising that workplace culture is often invisible, intangible and complex must be at the forefront of our understanding of these concepts. Often in place of culture, the issues, effects and outcomes receive more explicit attention, rather than the shared guiding principles of how people in an organisation or workplace think, feel, value and act. As we have outlined above, we have chosen to use the definition of "Organisational Culture" which is the *shared values, beliefs, attitudes, and practices that characterise an organisation* (Catling & Rossiter, 2020). With this in mind, we will look deeply into the research on culture to help shape our development of recommendations for a minimum data set and culture assessment tool.

Researchers widely agree that shared values are the cornerstone of culture. Organisational culture has been described as "widely shared and strongly held values" (Chatman and Jehn, 1994), with these values reflected in the cultural artifacts of an organisation (Zammuto and Krakower, 1991). Edgar Schein, an organisational psychologist, defines organisational culture as the shared basic assumptions that a group develops as it learns to solve problems of external adaptation and internal integration. These assumptions are considered valid and are passed on to new members as the right way to think, feel, and act in response to challenges.

The shared principles, values and beliefs – what we call culture, underpin the physical, social and psychological environment and govern how members behave within that context by guiding norms and expectations. These assumed beliefs and values, however, can be difficult to articulate and may go unsaid. For this reason, we will draw on the differing theories and approaches to organisational culture to support our understanding, helping to define and describe criteria for developing a minimum data set for a culture assessment tool.

Edgar Schein's Levels of Organisational Culture (Schein, 2010)

Schein posits that organisational culture can be viewed as a pyramid with three levels: underlying assumptions, espoused values and artefacts. Working top-down, the artifacts are the surface level manifestations, or visible signs of culture in an organisation. These are easy to spot but are unable to provide deep insight or have much influence in change. Espoused values represent deeper indicators of culture, and include aspects like organisational values (mission, vision statements), company or team charters. These espoused values are based on the underlying assumptions, the deepest and most impactful level of organisational culture. The underlying assumptions are a more meaningful indicator of culture as this is where beliefs on how to act, work or behave, what success and failure looks like, and what is acceptable and appropriate lie. This is telling of what really matters and is valued in an organisation.

The Cultural Web Model (Johnson & Scholes, 1992)

The Cultural Web Model breaks down the complexity of culture into three key elements: stories, symbols and rituals, company and power structures, and control systems and routines. Together, this model describes the intersection of lived experiences and observations with structures and systems.

Competing Values Framework (Cameron & Quinn, 1983)

The CVF classifies cultures based on competing values: flexibility and stability, and internal and external focus. This is grouped into four clusters that describe an organisation's culture based on is matrix – Clan, Adhocracy, Hierarchy and Market.

Handy's Model of Organisational Culture (1993)

This model outlines four distinct types of organisational culture: Power, where control and decision-making are centralised around key individuals; Role, characterised by explicit procedures and clearly defined employee responsibilities; Task, which primarily relies upon collaboration to achieve project goals; and Person, where individual needs and autonomy are prioritised. This model highlights how differences in cultural values and priorities shape organisational behaviours and outcomes.

McKinsey 7S Framework

This model offers a holistic framework for analysing organisational effectiveness by aligning seven interconnected components. The hard elements—Strategy, Structure, and Systems—are tangible, measurable, and foundational to achieving organisational goals. The soft elements—Shared Values, Skills, Style, and Staff—are human-centric and shape organisational culture, influencing adaptability, employee engagement, and internal alignment. By emphasising the interdependence of these elements, the framework serves as a valuable tool for understanding and managing organisational behaviour.

How Culture Works Model (1997) - Human Synergistics developed by Robert Cooke

The How Culture Works model helps organisations assess and develop their culture by examining the relationship between cultural factors, causal factors, and outcomes. It identifies 31 causal factors, grouped into five categories, that influence an organisation's current culture. These factors act as levers to align the actual culture with the ideal culture, driving improvements in performance, employee well-being, and organisational outcomes. The model emphasises that the relationships between causal factors, culture, and measurable outcomes at the individual, group, and organisational levels are interdependent, with changes in one area impacting the others and driving overall success.

Hofstede's Cultural Dimensions (National Culture)

Hofstede articulates six critical dimensions for understanding culture with the view that assessing the value of each dimension gives insights into what is valued and how these values shape behaviour. The six dimensions are scored on a scale of 1-100.

- Power Index (high/low)
- Individualism vs Collectivism
- Masculinity vs Femininity
- Uncertainty Avoidance Index (high/ low)
- Long vs Short Term Orientation
- Indulgence vs Restraint

Integration of Literature

Although there is no true consensus on the foundational dimensions or levers for assessing and improving culture, we have identified several key themes. Extracting these shared factors between theoretical frameworks, literature and other tools being used in practice, guides our recommendations for a culture assessment tool, aiming to capture healthcare culture in the most whole and parsimonious way.

Malik et al. (2020) conducted an interpretive systematic review of 15 studies and 127 tools to identify possible cultural dimensions. Findings were organised into tangible (measurable and observable) and intangible (implicit or underlying assumptions) themes. Iterative coding following Schein's philosophy revealed 8 key tangible themes: leadership, communication systems, teamwork, training and development, organisational structures and processes, employee and job attributes, patient orientation, and blame and shame. Additionally, the review also extracted 9 intangible themes: power, communication openness, trust, commitment, psychological safety, morals and ethics, support, blame and shame, and cohesion (Malik et al., 2020).

In another systematic review of 63 studies, an analysis of 47 instruments examining safety culture identified the key dimensions of teamwork, professional satisfaction, safety climate, communication and working conditions (Nunes et al., 2024). A New Zealand study of organisational culture in community pharmacies identified eight dimensions: Leadership and staff management, valuing each other and team, Free thinking, fun and open to challenge, Trusted behaviour, Customer Relations, Focus on external integration, Providing systematic advice, Embracing innovation (Scahill et al., 2009).

The United Kingdom National Health Service (NHS) has also championed work to address culture in the health sector. Critical elements identified and used in the diagnostic tool include vision and values, goals and performance, learning and innovation, support and compassion, equity and inclusion and team working. Key factors that appear to impede culture change across a range of sectors include inadequate or inappropriate leadership, constraints imposed by external stakeholders and professional allegiances, perceived lack of ownership, and subcultural diversity within healthcare organisations and systems (Scott, 2003).

Table 10: Comparison of Culture Models/Studies and Dimensions

MODEL/FRAME	FACTOR 1	FACTOR 2	FACTOR 3	FACTOR 4	FACTOR 5	FACTOR 6	FACTOR 7	FACTOR 8	FACTOR 9	FACTOR 10
NOUS REPORT (LEVERS)	Leadership	Workplace Behaviours	Healthcare Workforce	Recognition & Consequences	Barriers To Change	Enabling Workplace Structures	Monitoring & Evaluation			
NHS CULTURE DIAGNOSTIC	Vision & Values	Goals & Performance	Learning & Innovation	Support & Compassion	Equality & Inclusion	Team Working				
SCHEIN	Leadership	Communication Systems	Teamwork	Training And Development	Organisational Systems and Processes	Employee And Job Attributes	Blame And Shame			
FACETS OF CIVILITY	Appreciating	Acknowledging	Including	Accepting	Accommodating					
PSYCHOSOCIAL HEALTH (REFERENCING WORKSAFE AUS MODEL)	Job Demands	Job Control	Organisational Support	Role Clarity	Workplace Relations	Organisational Change Management	Organisational Justice	Recognition And Reward	Environmental Conditions	Job Safety (Paraphrased)
OCI (CULTURE)	Achievement Vs Competitive	Self-Actualising	Humanistic Encouraging Vs Oppositional	Affiliative	Approval	Dependent	Avoidance	Power	Perfectionistic	Conservative
DENISON ORGANISATIONAL CULTURE INVENTORY	Adaptability	Involvement	Mission	Consistency						
OEI (LEVERS)	Influence	Decision-Making	Appraisal And Rewards	Goal Setting	Job Design	Complexity	Interdependence	Leadership	Communications	Bases Of Power
COMPETING VALUES FRAMEWORK (CVF)	Commitment	Communication	Development	Innovative Outputs	Transformation	Agility	Efficiency	Consistency And Uniformity	Timeliness	
MALIK ET AL. (2020)	Power	Communication	Openness	Trust	Commitment	Psychological Safety	Morals & Ethics	Support	Blame And Shame	Cohesion
NUNES ET AL. (2024)	Teamwork	Working Conditions	Safety Climate	Communication						
SCAHILL ET AL. (2009)	Leadership and Staff Management	Valuing each other and Team	Openness	Trusted Behaviour	Innovation	External Integration				

Appendix B: Existing Methods for Assessing Culture

Table 11: Comparison of Survey Tools

Survey	Administering Organisation	Target Audience	Purpose/Aim	Key Measures	Culture-Related Themes/Constructs	Survey Properties	Frequency of Administration
Medical Training Survey (MTS)	The Medical Board of Australia and AHPRA	Profession-wide survey of all doctors in training	- Insights into training satisfaction and challenges - Highlights areas for improvement in training delivery - Impact on retention rates and future career satisfaction	- Supervision quality - Workload and work hours - Access to teaching and educational resources - Support from clinical staff - Overall training experience	- Perception of workplace culture and organisational support - Mentorship effectiveness - Work-life balance - Career progression support	- 5-point Likert scale for most questions - Psychometric properties vary, continuously evaluated by educational institutions	Annually
Medical Colleges Trainee Exit Surveys	RANZCP	Trainees and Specialist International Medical Graduates	- Satisfaction with training programs - Identification of areas needing improvement - Factors influencing career decisions	- Training quality - Educational experience (teaching quality, resources, facilities) - Supervision quality - Clinical experience - Career readiness	- Mentorship effectiveness - Training and work environment quality - Professional development support - Work-life balance	- Typically uses 5-point Likert scale - Psychometrics depend on the administering institution, but robust measures	End of training cycle
	RANZCO	Trainees	- Satisfaction with training programs - Identification of areas needing improvement - Factors influencing career decisions	-Teaching and learning opportunities and support -Placement -Workplace and working hours -Learning resources and support	-Training and work environment -Support (workplace and professional development) - Negative behaviours		End of each term

				-Bullying, discrimination, harassment -Professional capabilities -Future career intentions			
Six-monthly Trainee Survey	RANZCOG	Trainees	- Satisfaction with training programs - Identification of areas needing improvement - Factors influencing career decisions	-Overall training satisfaction -Depth and breadth of trainee experience - Organisation and processes -Teaching and Learning -DBSH -Skill Development -Supervision -Return to training after extended leave -Patient safety concerns -Intention to continue training -Work hours	-DBSH -Support from supervisors and consultants -Feedback -Workload/flexibility		Every six months
Supervisor Voices Survey	RACP	All RACP supervisors and educational leaders	-Inform enhancements to support services and prioritisation of advocacy efforts -Establish baseline data prior to implementation of education renewal initiatives -Regulatory requirement to	-Workload -Supervision quality -Wellbeing -Primary setting and college support -College resources	-Workload -Wellbeing -BHD	n/a	Bi-annual

			collect confidential feedback on supervision				
Discrimination, Bullying, Sexual Harassment and Harassment Survey (+ Check in Survey)	RANZCOG (BPA)	Trainees Specialist International Medical Graduates Associate Members (i.e. GP Obstetricians Fellows	-Quantify the extent of DBSH behaviours	-Prevalence of DBSH -Detail/specifics of behaviours experienced -Organisational factors that may impact DBSH behaviours	-How the college deals with DBSH -Fair treatment -Feedback -Reporting DBSH	-46 questions -Range of questions with options to add detailed open-ended responses -Some agreement scale questions -Conducted by an external third party	
Training Site Accreditation Survey	RANZCOG	Trainees	-Understand trainee experience and environment	n/a	-Perception of workplace culture -Morale -Tolerance for BHD -Department strengths/improvements	n/a	Every 2-3 years
People Matter Surveys (Australian States)	Victorian Public Sector Commission	All Vic Public sector employees	- Engagement levels and overall job satisfaction - Areas for improvement in leadership and organisational culture - Identification of burnout risks	- Employee engagement - Job satisfaction - Organisational commitment - Leadership effectiveness - Work-life balance - Employee well-being	- Leadership quality and effectiveness - Employee empowerment - Psychological safety - Support for professional development - Work culture perceptions	- 5-point Likert scale - High reliability and validity, consistent data across participating states	Annually
	NT-Department of Corporate and Digital Development (DCDD)	All employees of the NTPS	Clear understanding of employee engagement, workplace culture, and key areas for improvement, enabling informed decision-making	- Employee -Engagement -Leadership -Workplace Culture -Wellbeing -Learning and Development -Workplace Safety	Collaboration and teamwork Inclusivity and respect	Typically uses 5-point Likert scale Open-ended questions may be included to capture more detailed, personal feedback	Annually

			to enhance employee satisfaction, productivity, and organizational effectiveness	-Communication and Feedback -Diversity and Inclusion			
	SA Department of the Premier and Cabinet (DPC)	Public Sector Employees (SA)					Annually
Hospital Health Check (Queensland, SA, WA)	Queensland Health, Department of health and wellbeing (SA), Department of Health (WA)	Public Hospital and healthcare staff in each state	- Feedback on hospital culture - Staff well-being and satisfaction - Improvement opportunities in support structures and workplace behaviour	- Working conditions (staffing, resources, support) - Hospital facilities - Workplace culture - Bullying and harassment - Job satisfaction	- Staff perceptions of organisational support - Bullying and harassment awareness - Teamwork quality - Work-life balance	- Likert scale (usually 5-point) - Psychometrics vary across states and hospitals	Annually
Health Workforce Needs Assessment (Queensland)	Workforce Services	Healthcare professionals working in the public hospital system	- Insights into future workforce needs - Identification of skill gaps and training needs - Potential policy changes for workforce sustainability	- Workforce supply, demand, and distribution - Workforce satisfaction - Career progression - Workforce retention	- Workforce distribution and satisfaction - Retention strategies - Impact of workforce changes on care delivery	- Uses demographic data, workforce statistics, and predictive modelling - Psychometric properties vary based on context	Every 3-5 years
Australasian College for Emergency Medicine (ACEM) Sustainable Workforce Survey	Australasian College for Emergency Medicine (ACEM)	Emergency medicine professionals	- Identifies burnout risks - Evaluates workforce sustainability - Provides data for workforce development and	- Workload in emergency departments - Burnout and job satisfaction - Support structures for staff	- Burnout prevention - Workload management - Support for career longevity in emergency medicine - Job satisfaction	- 5-point Likert scale - Strong reliability and validity in emergency medicine settings	Biennially

			retention strategies	- Work-life balance			
Organisational Culture Checklist	Various HR departments, organizational consultants, leadership development teams, or academic institutions	All employees within an organization, leadership teams, and HR or organizational development professional	- Identifies cultural gaps - Suggests improvements in leadership, communication, and organisational effectiveness	- Leadership behaviours - Communication effectiveness - Decision-making processes - Organisational values - Work environment	- Leadership style (e.g., authoritative, collaborative) - Decision-making clarity - Organisational transparency - Workplace environment	- 5-point Likert scale - Reliability varies by context, tailored to each organisation	One-time or occasional
Australian WHS Survey	Centre for Work Health and Safety, NSW	Government Agencies and Regulators	- Identifies areas for improving workplace safety - Insights into staff engagement with safety systems - Evaluates organisational support for health and safety	- Workplace health and safety perceptions - Safety systems effectiveness - Hazard identification - Staff satisfaction with safety protocols	- Workplace safety climate - Staff perception of safety leadership - Trust in safety systems - Risk management practices	- Likert scale - High reliability, widely used across various industries, including healthcare	Annually
Medical Educational and Training Survey (METS)	Department of Health and Aged Care	Medical Students in Australian Universities, trainee doctors	- Provides feedback on training quality - Highlights areas for curriculum improvements - Provides insights into trainee satisfaction	- Teaching quality - Supervision quality - Workload and educational resources - Career development support	- Educational support (mentorship, teaching) - Clinical experience quality - Work-life balance - Work environment quality	- Likert scale (typically 5-point) - Psychometrics depend on conducting institution	Annually
Your Voice in Health Survey	Department of Health, WA	Employees in the WA health system	- Provides actionable data on workforce engagement and job satisfaction - Highlights areas for improving safety culture	- Employee engagement - Safety climate - Work culture perceptions - Organisational commitment - Job satisfaction	- Employee well-being - Psychological safety - Teamwork - Leadership effectiveness - Organisational commitment	- 5-point Likert scale - Strong reliability and validity; used in public health sector across Australia	Annually

Rural Health Workforce Survey	Rural Health Western Australia	Medical workforce in rural and remote WA	- Identifies challenges in rural workforce recruitment and retention - Evaluates workforce satisfaction and career support	- Workforce satisfaction - Retention and recruitment challenges - Training needs - Career progression	- Rural workforce retention - Career development in rural areas - Staff well-being and satisfaction	- Likert scale and demographic data - High reliability, focused on rural healthcare settings	Annually
Victoria Department of Health Survey	Rural Workforce Agency, Victoria Department of Health	All workers across health and mental health	- Provides insights into staff satisfaction and engagement - Highlights areas for improvement in leadership and communication	- Leadership effectiveness - Organisational culture - Employee satisfaction - Engagement levels	- Leadership behaviour - Organisational culture and climate - Staff morale and engagement	- 5-point Likert scale - High reliability, used across health services in Victoria	Annually
MSOD National Data	Medical Deans	Final year students enrolled in medical school	- Provides insights into workforce distribution, recruitment, and training needs - Evaluates career progression and job satisfaction trends	- Workforce demographics - Career progression - Training needs - Job satisfaction - Retention	- Workforce diversity - Career progression paths - Staff retention rates - Training gaps	- Mixed-methods (quantitative and qualitative) - Strong reliability across diverse datasets	Annually
Working Conditions of Junior Doctors Survey	The Australian Medical Association (AMA)	Junior Doctors and Medical Trainees	- Identifies burnout risks - Assesses support and satisfaction levels - Provides insights for policy changes	- Job satisfaction - Workload - Training quality - Support systems (mentorship, supervision)	- Mentorship effectiveness - Supervision quality - Workload and work-life balance - Professional development support	- Likert scale (typically 5-point) - Psychometric properties vary by institution	Annually
2024 Resident Hospital Health Check	The Royal Australasian College of Physicians (RACP)	Resident Medical Officers, Junior doctors and Registrars	- Provides insights into work-life balance, training environment, and overall job satisfaction - Suggests areas	- Job satisfaction - Training quality - Workload - Support structures - Professional development	- Work environment quality - Training and career support - Job satisfaction - Teamwork and support	- Likert scale; good reliability for hospital residency programs	Annually

			for improvement in residency programs				
The Nursing Unit Cultural Assessment Tool	Health Workforce Australia (HWA).	Nursing units, Nurse Leaders and Managers Healthcare Organizations	Behaviours Expectations Teamwork Communication Satisfaction Professional Commitment	-Assesses nursing culture in healthcare settings -Identifies aspects of the work environment that impact care delivery and staff satisfaction	Teamwork Communication	n/a	Annually
National Training Survey, UK	General Medical Council (GMC).	Doctors in training, Educational supervisors	Educational environment Workload Supervision quality Support Work-life balance	- Enhances training quality - Identifies factors influencing safety outcomes in training - Identifies training improvements	- Support from supervisors - Workload management - Safety in training environments - Team safety climate	- 5-point Likert scale - Robust statistical analysis applied to results	Annually

Appendix C: Existing Methods for Assessing Safety Culture

Table 12: Comparison of Safety Culture Tools

	Survey	Purpose/Aim	Factors/Measures	Survey Properties
Safety (general)	Safety Climate Scale	- Identifies how team attitudes toward safety affect patient outcomes and staff performance	- Safety behaviours - Team attitudes - Safety communication - Safety environment	- Likert scale - Strong reliability in predicting safety-related outcomes
	Nordic Safety Climate Questionnaire (NOSACQ-50)	-Diagnoses occupational safety climate -Evaluates safety climate interventions	- Management of safety priority, commitment and competence - Management safety empowerment - Management safety justice - Workers' safety commitment - Workers' safety priority and risk non-acceptance - Safety communication, learning and trust in co-workers' safety competence - Trust in the efficacy of safety systems	-50 items -4-pt. agreement scale -Used internationally across many industries
	Psychosocial Safety Climate Scale (PSC-12)	- short instrument to measure psychosocial safety climate (PSC) in workplaces in Australia -Assesses senior management values and attitudes toward care and practices in relation to employee psychosocial well being -Shows expected relationships with psychosocial risk factors	- Management commitment to worker psychological health - Management priority to worker psychological health - Organisational communication to worker psychological health - Organisational participation to worker psychological health	-12 items -5pt Likert Scale
	People at Work Survey	-Assists employers to identify psychosocial hazards and factors -Guides the implementation of psychosocial risk management in the workplace	- Job demands – role overload, emotional demands, group relationship conflict, group task conflict, role conflict, role ambiguity - Job resources – job control, praise and recognition, supervisor support, wo-worker support, procedural justice, change consultation - Workplace bullying - Psychological distress - Burnout, strain and sprain - Intentions to stay	- 10-15 minutes - 7-point Likert scale

Patient Safety	PC SafeQuest Safety Climate Survey	- Measures safety climate in primary care practices -Provides feedback for improving patient safety systems and processes - Identifies areas to strengthen organisational safety culture	- Safety climate - Leadership quality - Safety behaviours - Communication - Work environment	-30-items 5-point Likert scale - Strong reliability and validity, widely used in healthcare
	Safety Attitudes Questionnaire (SAQ)	- Identifies areas for improvement in patient safety, teamwork, and staff well-being - Highlights challenges in safety protocols	- Safety climate - Teamwork climate - Job satisfaction - Stress recognition - Perceptions of management (hospital and unit) - Working conditions	-36 attitudinal items 5-point Likert scale - High reliability and validity across healthcare settings
	Manchester Patient Safety Framework (MaPSaF)	- Provides insights into areas for improvement in patient safety practices - Helps organisations improve safety protocols and reporting systems	- Patient safety culture - Safety behaviours - Reporting errors - Learning from mistakes - Safety practices	- 60–120-minute workshop format - Mixed-methods approach (qualitative and quantitative) - High reliability for clinical safety outcomes
	Australian Hospital Survey of Patient Safety Culture Version 2 (A-HSOPS 2.0)	-Designed to measure staff perceptions of safety culture in Australian Hospitals -Identifies areas for improvement in patient safety attitudes and practices	- Supervisor, manager, or clinical leader support for patient safety - Teamwork - Communication/openness - Reporting patient safety events - Organisational learning- continuous improvement - Communication about error - Hospital management support for patient safety - Response to error - Handovers and information exchange	-35 items -Validated in 9 hospitals in Australia
	Hospital Survey on Patient Safety Culture 2.0 (2019)	-Designed to measure staff perceptions of safety culture in Hospitals -Identifies areas for improvement in patient safety attitudes and practices	- Teamwork - Staffing - Organisational learning – continuous improvement - Response to error - Supervisor, manager, or clinical leader support for patient safety - Communication about error	- 10 composite measures, - 32 items

		- Communication openness - Reporting patient safety events - Hospital management support for patient safety - Handoffs and information exchange

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