Organisational Culture and Performance in the NHS

Cultures for performance in health care: evidence on the relationships between organisational culture & performance in the NHS

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Contributors

- Rowena Jacobs (statistical analysis)
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Outline

- Policy context
- Theory (economic)
- Study design
- Findings
- Policy/Research implications.

"We are looking at a major ***cultural change*** for everyone ... a fundamental shift in ***culture*** ... empowering those who work in the NHS..." and "Clinical Governance needs to be underpinned by a ***culture*** that values lifelong learning..."

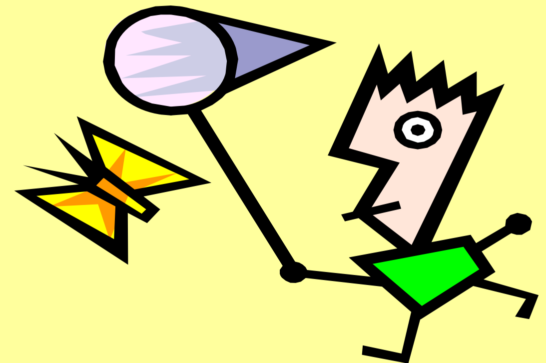
- A First Class Service

"A ***culture*** in which excellence can flourish"

- Donaldson & Muir Gray

"The NHS has to move from a ***culture*** where it bails out failure to one where it rewards success."

- The NHS Plan



Kennedy Report

"the culture of health care in the NHS which so critically effects all other aspects of the service which patients receive, must develop and change"

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Kennedy Report

- A culture of openness
- A culture of accountability
- A culture of quality & safety
- A culture of public service
- A culture of teamwork.

Underlying Logic

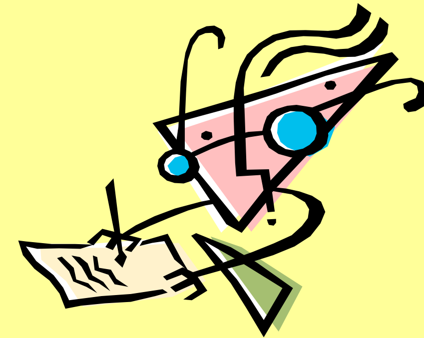
- Discernible cultures
- Bearing on performance
- Malleable
- Identify attributes
- Optimal mix
- Dysfunctional consequences.

Aims & Objectives

- Identifying & classifying the nature of cultures in NHS Trusts.
- Exploring empirical relationships between cultures of Trusts & their measured performance.
- Identifying the levers & barriers to culture change.
- Documenting the positive & dysfunctional consequences of culture change programmes.

Organisational Culture

- That which is ***shared*** within organisations:
  - beliefs, values, attitudes, norms of behaviour
  - routines, traditions, ceremonies, rewards
  - meanings, narratives and sense-making



- Helps define legitimacy & acceptability:
  - ***social and normative glue***

"The way things are done around here"

Working Definition

Organisational culture is the emergent result of the continuing negotiations about values, meaning and properties between members of an organisation (Seel, 2000).

By this definition, culture is not assumed to a priori controllable. Instead we consider that its main characteristics can at least be described and assessed in terms of their functional contributions to broader managerial and organisational objectives, including performance (Mannion et al 2005).

Theoretical Positions

- Anthropological, interpretive and process theory approaches

- ‘Old’ Institutional economics.

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Culture in Economic Thought

- Neoclassical
- Exogenously determined preferences
- Institutional
- Endogenous preference formation
- Culture as an internal institution
- Reduced transaction costs
- Complexity & uncertainty.

Economic Governance

Knowledge of the transformation process

Ability to measure outputs

	Perfect	**Imperfect**
High	Markets/Hierarchies	Markets
Low	Hierarchies	Culture

Principal

Information

Information asymmetry

Incongruent objective functions

Incentives

Agent

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Contested Nature of Culture:

(1) Organisations ***have*** cultures:

aspects that are (relatively) stable; that can (in part) be isolated and described; that can be targeted for change.

Culture as an Organisational VARIABLE.

(2) Organisations ***are*** cultures:

dynamic process of social construction; unstable & fragile insights; multiple perspectives; always open to challenge; about power & perceptions.

Culture as RICH DESCRIPTION.

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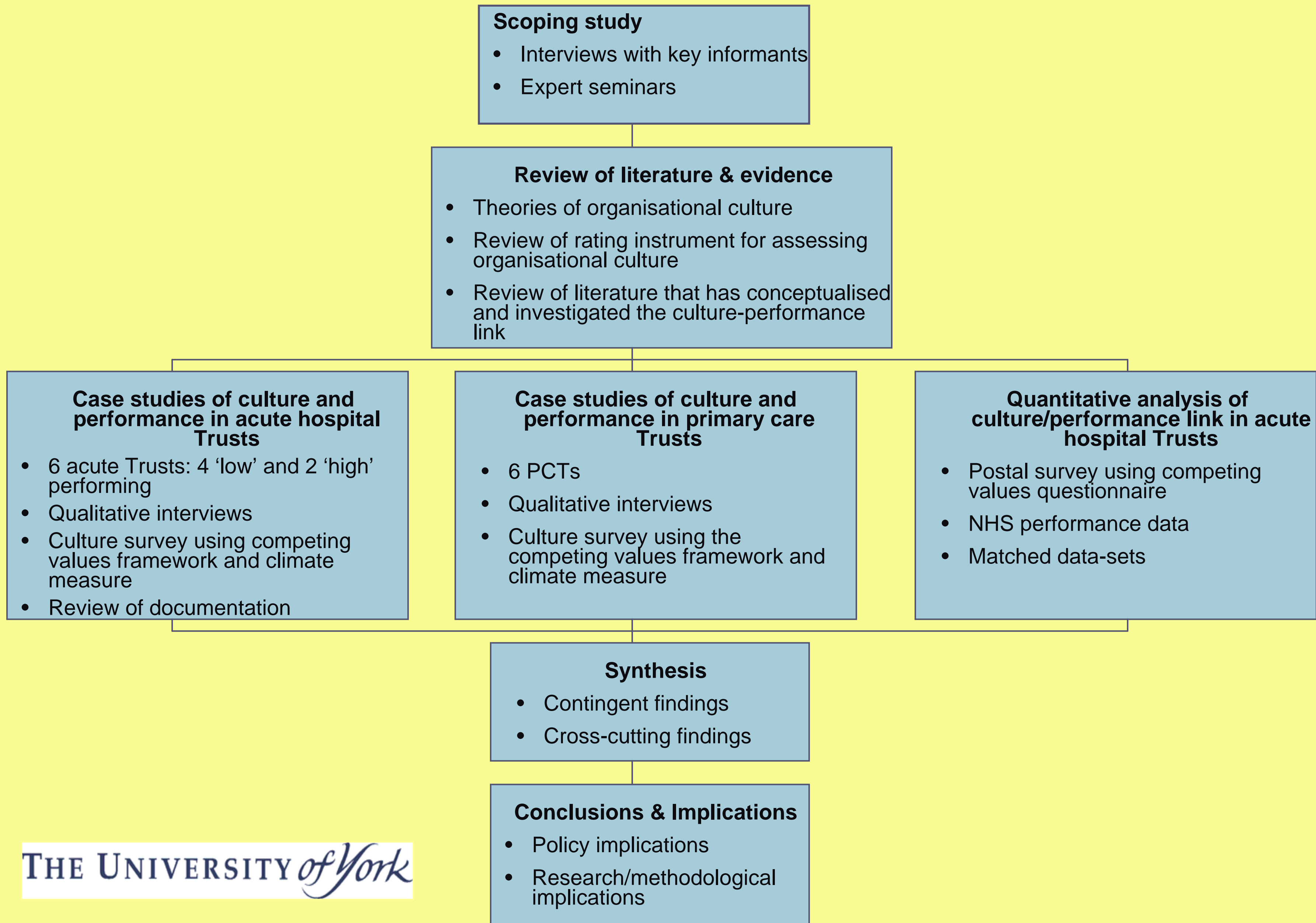
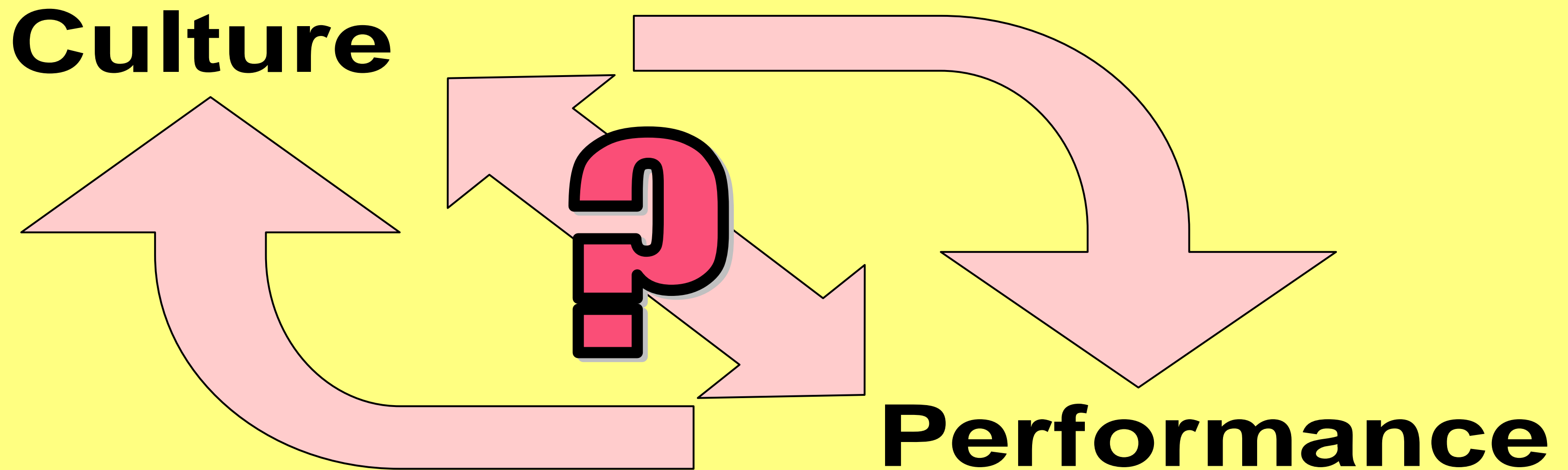
Research Design



Culture & Performance?



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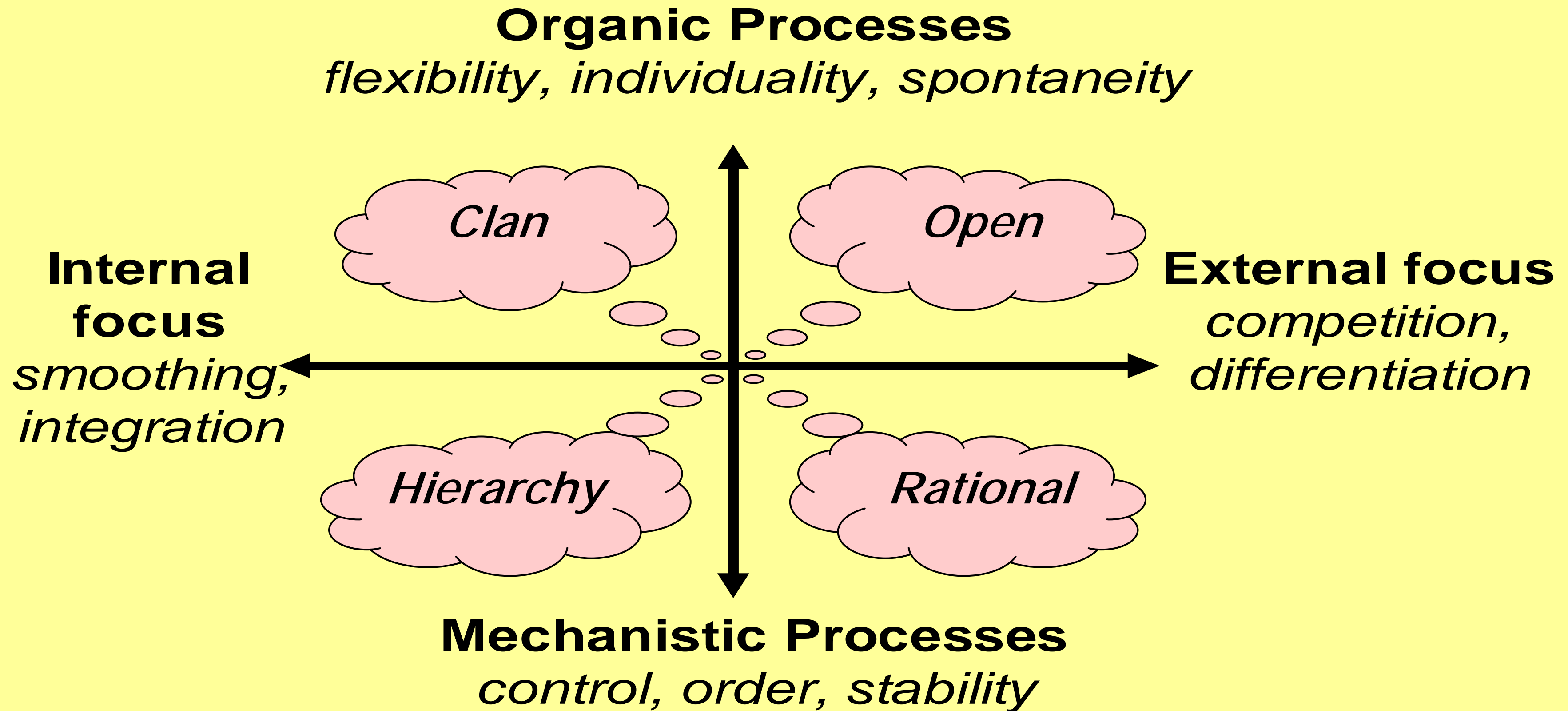
Quantitative Analysis

- Cross-sectional relationships between acute Trust culture & measured performance

- Competing values framework

- CHE acute Trust performance data base.

The Competing Values Framework



Characteristics of Cultural Types:

Clan	**Open**
cohesive, participative leader as mentor bonded by loyalty, tradition emphasis on morale	creative, adaptive leader as risk-taker, innovator bonded by entrepreneurship emphasis on innovation
Hierarchy	**Rational**
order, rules, uniformity leader as administrator bonded by rules, policies emphasis on predictability	competitiveness leader as goal-oriented bonded by competition emphasis on winning

Senior Management Team Culture

- National survey of board-level managers:
  - Data from 899 senior managers (response rate 60%)
  - Three or more responses from 170 NHS Trusts (86%)
  - Dominant cultural sub-types:

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Contingent Performance: Hypothesised Relationships

Clan	-	staff variables, option, morale, high trust
Developmental	-	waiting times, high star ratings
Hierarchical	-	data quality, financial balance
Rational	-	research revenue, high star ratings.

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Multinomial Logit Modelling

- Zero & one star ratings more likely in clan & rational than developmental
- Inpatient surveys on dignity & respect highest in clan cultures
- Staff opinion (morale) higher clan than rational
- Waiting times lowest in hierarchical culture
- Research activity higher in Trust with developmental, hierarchical & rational cultures compared with clan.

Partial Confirmation of a Priori Hypotheses

- Support for contingent relationship
- Clan (internally focused, concerned staff morale, poorer performers, patients dignity)
- Developmental (higher consultant & nurse salaries – concern for entrepreneurship)
- Hierarchy (high managers salaries – reflect greater emphasis on role managers)
- Rational (externally focused, less concern staff morale, research activity)
- Ordered probit model linking culture and star ratings.

Longitudinal Analysis

- Repeated cross-sectional surveys
- 2006/07 (T2) and 2007/8 (T3)
- T1 (899)
- T2 (826)
- T3 (739).

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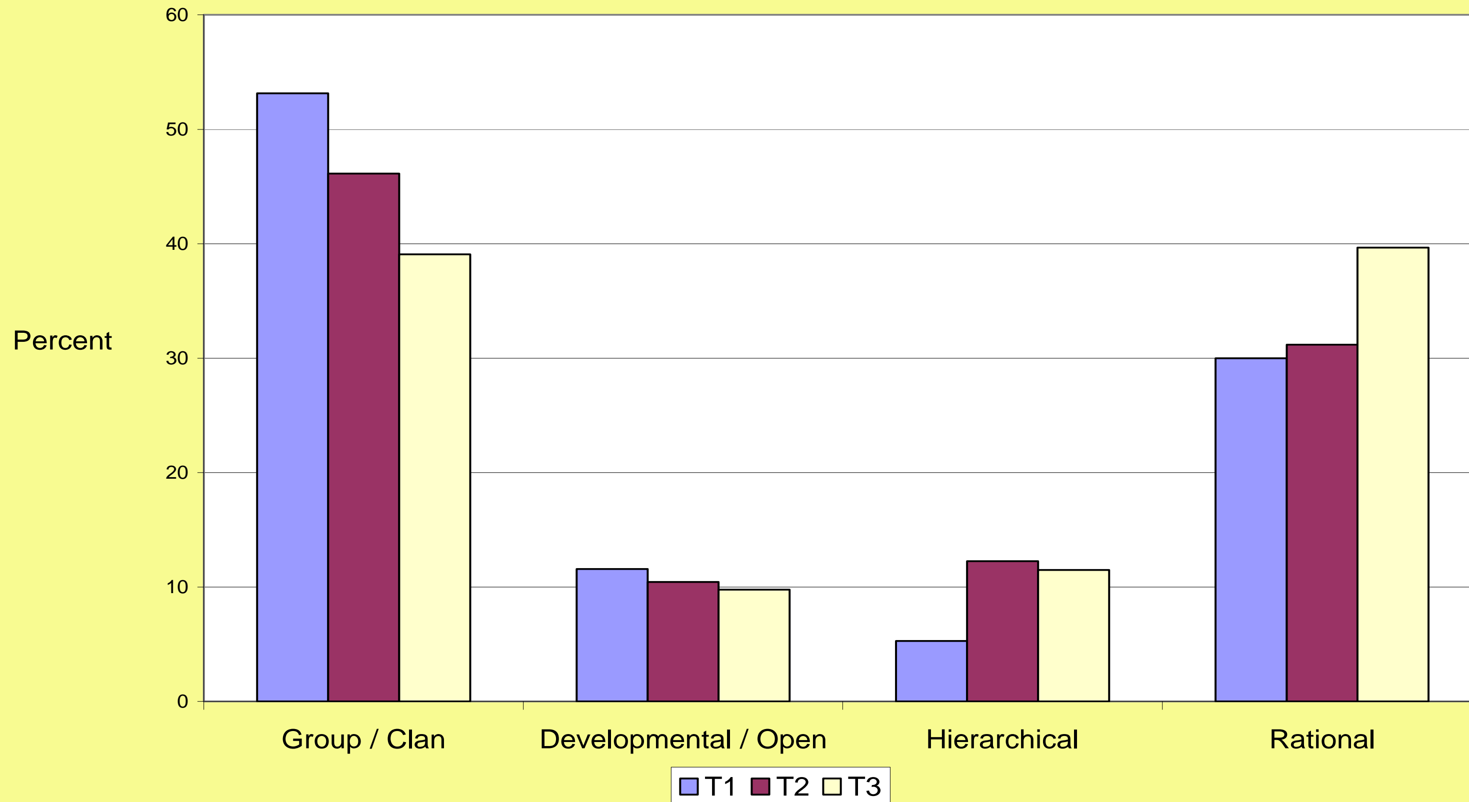
Frequency distribution of culture type by Trusts, Board members only, weighted (2001-2008)



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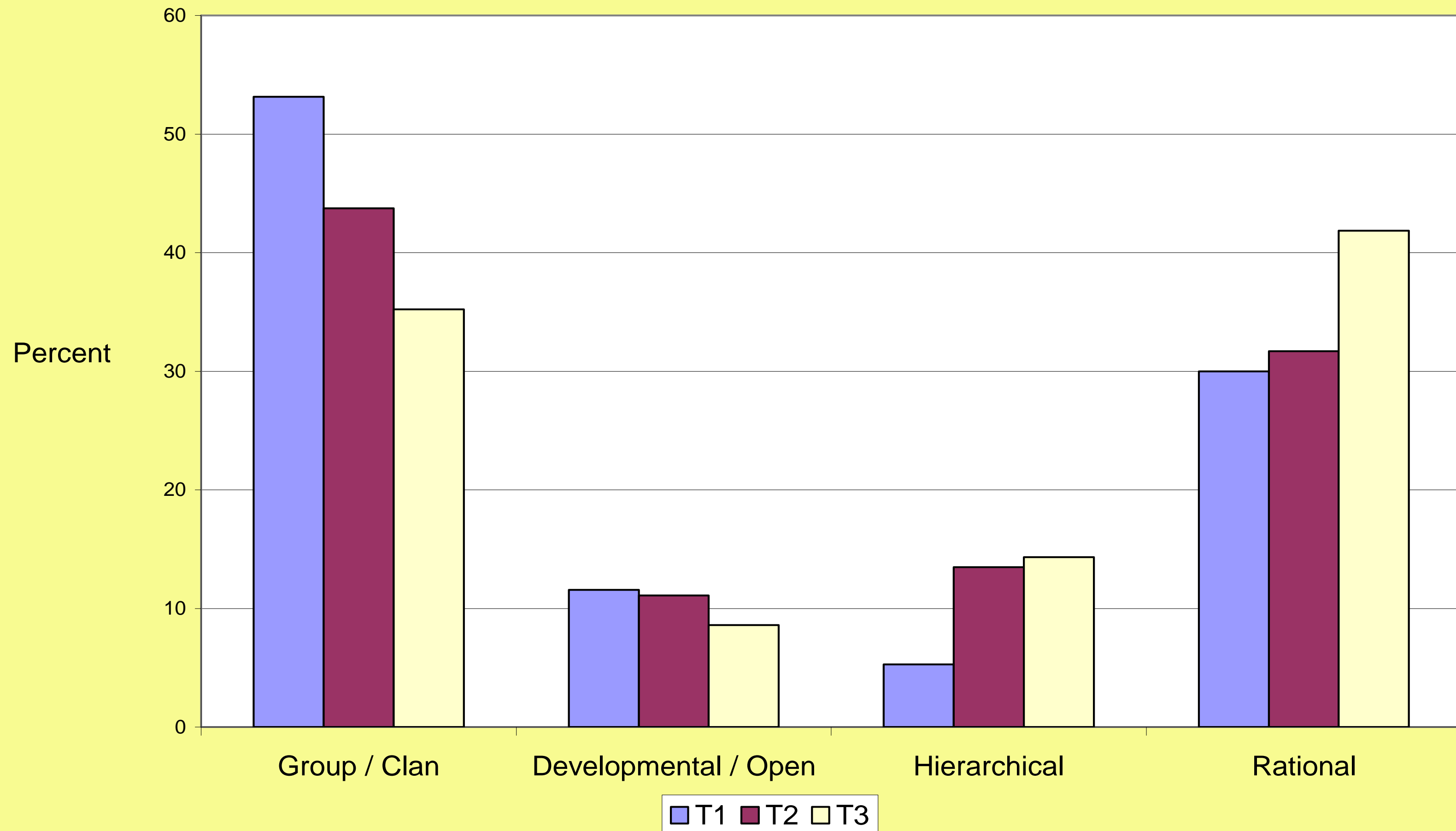
Frequency distribution of culture type by Trusts (senior and middle managers) weighted, 2001-2008



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Trust Case-studies

- Purposeful sample of 6 hospital Trusts
- 4 ‘high’ performing
- 2 ‘low’ performing.

Methods

- Culture survey of key staff groups
- Depth-interviews with senior staff
- Review internal/external documentation
- Rich picture relationship culture/performance.

Targets for Culture Change

- Patient focus
- Corporacy
- No blame
- Team working
- Control & accountability.

Levers & Facilitators

- Training & education
- External assessments
- External organisations
- Raising status of nurses
- Reactions to critical incidents.

Barriers to Culture Change

- Vestiges of the old culture
- Lack of resources
- Influence of professional bodies
- Government policy

Dysfunctional Consequences

- Tunnel vision
- Bullying & intimidation
- Erosion of public trust
- Ghettoisation
- Insensitivity.

Key points of divergence in the cultures of apparently 'high' and apparently 'low' performing hospital Trusts

Cultural characteristics	**'High' performing Trusts**	**'Low' performing Trusts**
Leadership style:	Transactional	Charismatic
Management integration:	Fully integrated	Cabalesque / clique
Management orientation:	Corporate	Pro-professional
Senior management preoccupation:	MMeeting national	Own group maintenance
Senior management team turnover:	Low performance agenda	High needs
Middle management:	Strong, empowered	Under-developed, emasculated
Accountability:	Clear	Opaque
Rewards:	Performance related	Patronage
Information systems:	Highly developed	Under-developed
Performance management:	High priority	Low priority (financial)
Recruitment policies:	Staff to fit culture	Undiscriminating
Local health economy engagement:	Proactive	Reactive
Taboos:	Not hitting targets	Challenging senior management

Key Finding 1

Culture matters

Policy Implication

Some justification for government's case for targeting culture change.

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Key Finding 2

Organisational culture & performance linked in a contingent manner

Policy Implication

Need to develop cultures in health care organisations that are aligned with key policy objectives of NHS.

Key Finding 3

Important cultural differences between ‘high’ & ‘low’ performing Trusts

Policy Implication

A range of cultural factors need to be addressed to improve performance (see below).

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Key Finding 4

Leadership of paramount importance

Policy Implication

Matching leadership styles to performance needs.

Key Finding 5

A strong & empowered middle management tier an essential element of a high performing organisation

Policy Implication

Attention focused on developing an empowered & effective centre of middle management

Move from performance enforcer to facilitator.

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Key Finding 6

High quality information systems underpin robust accountability systems

Policy Implication

Need to invest in effective information systems as a means of underpinning open, transparent & focused systems of accountability for performance.

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Key Finding 7

An active human resources function underpins the formation & maintenance of performance-conducive cultures

Policy Implication

Selection of staff to fit performance culture but workforce capacity limited.

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Key Finding 8

Inter-relationships within local health economy are important for securing high performance

Policy Implication

Incentives to adopt a ‘whole-economy’ perspective and collaborative working

Need to train & support key boundary spanners

Some assessments of quality of local relationships in accountability arrangements.

Key Finding 9

Embedding desirable cultural traits in organisations requires an alignment of national & local policies

Policy Implication

Develop consultation processes.

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Key Finding 10

Dysfunctional consequences of culture change are likely

Policy Implication

Need to be anticipated & closely monitored & policies put in place to mitigate them.

Key Finding 11

Performance is a contested & complex concept

Type I & Type II errors

Policy Implication

Great care in how report, interpret & act on performance data.

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Background

- Growing international interest in managing organisational culture as a lever for health care improvement.
- Underpinning many recent reforms is the notion that a major cultural transformation must be secured alongside structural and procedural change.
- Prompted a practical need to understand what instruments and tools exist for assessing cultures in health care contexts.
- To determine the culture assessment tools being used in the English NHS and assess whether they are fit for purpose.

Aims

In view of the widespread policy, managerial and clinical interest in this area, we wanted to know what tools are used currently in the English NHS to assess organisational cultures and how well these tools meet the practical requirements and domains of interest of those interested in assessing and changing cultures within their organisation.

Methods

- A national postal survey of Clinical Governance Leads in Acute hospitals and Primary Care Trusts in England (n=325).
- 275 (87%) of NHS organisations gave R&D approval and these were targeted in the survey.
- Obtained completed questionnaires from 212 respondents (77% of the NHS organisations contacted in the national postal survey).

Questionnaire

- The current use of culture assessment tools (or similar) in each organisation.
- Clinical governance managers' perceptions regarding the benefits and drawbacks of the culture tools used.
- And views on the extent to which extant tools meet their need when managing change and ensuring appropriate.
- Clinical cultures for quality/safety improvement.

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Results

- Third of organisations currently using at least one culture measurement instrument.

- By far the most frequently used culture instrument was the Manchester Patient Safety Framework (MaPSaf), recorded by 59 (29%) of the respondents.

- This was followed by the Safety Attitude questionnaire, and the Institute for Health improvement’s (IHI) Safety Climate Survey. A wide variety of other tools were used by very small numbers of organisations.

No. of respondents reporting having used a particular culture assessment tool

	Acute Trust [n=96]	PCT [n=116]	Total '212]
Manchester Patient Safety Framework (MAPSAF)	32	27	59
Safety Attitude Questionnaire	6	2	8
IHI Safety Climate Survey	7	0	7
National Staff Survey	2	3	5
National Patient Safety	3	1	4
Investment in people	2	1	3
Competing Values Framework	1	2	3
Stanford Patient Safety Culture Inventory	2	1	3
General Practice Learning Organisation Diagnostic Tool	1	2	3
AHRQ hospital survey on patient safety culture	1	1	2
Nursing Unit Cultural Assessment Tool	1	0	1
Organisational Culture Profile	0	1	1

Importance of culture attributes for high quality healthcare

N = 212	*Very important (%)*	*Somewhat Important (%)*	*Hardly/not Important (%)*
Senior management Commitment	96	4	0
Quality focus	94	6	0
Clear governance/ accountability	93	7	0
Patient centeredness	93	7	0
Safety awareness	93	7	0
Team working	92	8	0
Collaborative working	84	16	0
Blame free environment	74	24	2
Support for innovation	58	39	3
Customised care	45	54	1
Standardisation of care	39	59	2
Focus on cost effectiveness	40	56	4
Public service ethos	38	53	9
Prioritisation of choice	28	64	8

Findings

- Over 80% of those using MaPSaF found it relevant or very relevant to their needs, as compared with about 70% aggregated across all of the other tools
- The rather limited use of all other tools apart from MAPSAF preclude a more detailed analysis by tool.
- In terms of ease of use the vast majority perceived the instrument as easy to use, 80% for MaPsaf and 93% for the others.

Relevance and ease of use

	How relevant to healthcare?	
	MAPTSAF % [n=56]	Other tools % [n= 40]
Relevant	83	73
Fairly relevant	10	13
Hardly relevant	2	13
	How easy to use? MAPSAF % [n= =56]	Other tools % [n = 40]
Easy	66	80
Fairly easy	14	13
Hardly easy	12	7
Not easy at all	3	0

Findings

- More respondents believed that culture assessments should serve formative ends (85%) than summative purposes (65%).

- And almost a third in both acute and primary care settings “tended to disagree” that culture assessment should be used for summative purposes at all.

Findings

- Over 90% of respondents thought that senior management commitment, clear governance and accountability arrangements and safety awareness were very important organisational attributes to support them in their role.
- Responses in the open part of the questionnaire supported this view and revealed that there is a latent demand for measures of these cultural attributes
- In contrast only just over a quarter of respondents believed that the prioritisation of choice is was a very important cultural attribute.

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Conclusion

- Despite a plethora of culture assessment tools being described in the literature, relatively few of these have seen much use in the NHS.
- The extensive interest in understanding and shaping cultures at local level is not yet matched by widespread and sophisticated use of available instruments,
- Which are at any rate often poorly matched to the interests and aspirations of local clinical governance leads.

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