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Division of Occupational Psychology

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Implementing culture change within the NHS: Contributions from Occupational Psychology

Occupational Psychology in Public Policy (OPIPP) Group Report

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Editors

Louisa Tate

Emma Donaldson-Feilder

Kevin Teoh

Becky Hug

Grace Everest

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Tel: 0116 252 9523; E-mail: P4P@bps.org.uk.

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The British Psychological Society
St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK
Telephone 0116 254 9568 Facsimile 0116 247 0787
E-mail mail@bps.org.uk Website www.bps.org.uk

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- The recruitment process within NHS hospitals should move beyond the assessment of academic attributes alone, considering other values such as integrity, empathy and resilience. NHS hospitals are advised to adopt a system of 'values-based recruitment'. In particular, situational judgement tests (SJTs) are proposed as a reliable method for assessing non-academic attributes for high volumes of applicants.
- Staff should be provided with structured, organisation-wide reflective spaces through which to manage the psychological challenges posed by the healthcare context. This could be achieved through the use of Schwartz Center Rounds, and by promoting other forms of reflective practice such as in-house mediation services and learning sets.
- Work design should be regarded as fundamental to improving care quality, and important lessons in good practice can be learnt from the experiences of other safety critical sectors. Aspects of work design include the physical layout of wards, which where possible should enhance patient safety by allowing a clear 'line of sight' to all patients.

Leadership

- Effective team leadership is crucial in increasing individual team members' engagement and well-being, and thereby the likelihood of compassionate care. A 'collective leadership' approach should be adopted, with leaders influencing team activity so as to ensure innovation, a focus on quality, and continuous improvement. Tools such as 360-degree feedback sessions can be deployed to further these aims.
- In order to foster a continuous learning culture, NHS leaders should be assisted with developing coaching and mentoring skills that enable them to play a more pivotal role in the process of informal learning. Local autonomy and bottom-up customisation at team or community practice level is crucial, with staff being empowered to influence the design of learning workbooks.
- The composition of hospital boards is important in raising overall organisational performance, with efforts required – such as more open and transparent selection processes – to increase the representation of women, clinicians and non-executive directors. Attention should be paid to improving the behavioural styles adopted by board members, such as through holding open board meetings, employing patient surveys and modelling appropriate behaviours.

Organisational culture change

- The NHS must ensure 'psychological safety' among its staff in order to create and sustain cultures of transparency and openness. The psychological dimensions of meaning making, belonging and contribution should be addressed when diagnosing and intervening to improve psychological safety.
- There are a number of core critical issues to take into account when leading culture change, including gaining top management commitment, making a robust business case, bearing in mind people's propensity to resist change, and leadership of culture change plans by a small team of employee representatives.

Introduction

> *'In the end, culture will trump rules, standards and control strategies every single time, and achieving a vastly safer NHS will depend far more on major cultural change than on a new regulatory regime.'* Berwick Review, 2013, (p.11)[1]

Following the landmark publication of the Francis Report on 6 February 2013, the result of a public inquiry into Mid Staffordshire NHS Foundation Trust, the monumental task of implementing its recommended culture change within the NHS has dominated the healthcare policy landscape. Indeed, more recently Francis has launched an independent review into creating an open and honest reporting culture in the NHS.[3] This contribution from the British Psychological Society Division of Occupational Psychology presents a series of chapters by occupational psychologists, each drawing on evidence and expertise from the field to address the question of how this culture change can be implemented within the NHS. Robert Francis QC identified an 'unhealthy and dangerous culture' as sitting at the heart of the serious failures uncovered at Mid Staffordshire Hospital, and emphasised these as being symptomatic of a wider cultural problem within the health system. In particular, the Francis Report highlighted a failure in many cases to put the patient first, and pinpointed several common characteristics of NHS hospital trusts which contributed to this failure, including a lack of candour; low staff morale; disengagement by medical leaders; and cultures of inward-looking secrecy and defensiveness.[2] The report led to the release of several other landmark reports, among them Don Berwick's influential review into 'Improving the Safety of Patients in England'[1]. Commissioned by the Government in response to the Francis Report, the Berwick review powerfully distilled the lessons learned from the Francis Inquiry and detailed the necessary changes.[1]

Whilst the Francis Report makes a total of 290 recommendations, it includes certain core recommendations for NHS culture change that relate closely to some of the key knowledge areas of occupational psychology.[4] In particular, a central tenet of these recommendations is a call for a shift towards 'patient-centred' care across the NHS, whereby the quality of care in general – and patient safety in particular – is adopted as the top priority.[1] To achieve this, ensuring that staff are engaged and supported to deliver compassionate care, creating stronger healthcare leaders, and developing a climate of transparency, openness and candour, are emphasised as paramount. As has been recognised by a number of NHS institutions, a new organisational culture, one devoted to continual learning, must take root in order for patient experience to be improved.

Overall, these key recommendations of the Francis Report and Berwick review carry far-reaching implications for the organisational development of NHS hospital trusts, and have served to push the quality of care in the NHS into the policy and political spotlight, leading to it being 'scrutinised more in the past year than in any other since 1948'.[5] Indeed, in the year since its publication, the agendas of every key organisation playing a part in healthcare policy and practice – from the royal colleges to health think tanks, the Health Select Committee and the Department of Health – have been shaped by the need to address the areas detailed.

Our intention in producing this collection of chapters is not to rehearse the valuable analyses that have been produced by these organisations, but to shed light on the utility of employing occupational psychology evidence and expertise when embarking on the practical implementation of NHS culture change. The need to move the discussion on at this stage from *'what'* needs to be done and to *'how'* to make NHS culture change a reality has been widely recognised, including by The King's Fund, which has reflected that 'the real challenge is not in the diagnosis and prescription for the problem, it is ensuring that the remedy is administered effectively'.[6] Likewise, the Royal College of Nursing remarked in its response to the Francis Report that, 'Robert Francis has set out a clear direction for the future of the health service; the onus is now on all of us to make sure we follow it.'[7] This report aims to contribute to these objectives by offering an occupational psychology perspective on the practical steps required to deliver organisational culture change within the NHS. The Berwick review highlighted the fact that 'good people can fail to meet patients' needs when their working conditions do not provide them with the conditions for success', and argued that in pursuing a positive NHS culture, a 'measured and balanced response, anchored in science and evidence, serves the nation well'.[1] Occupational psychology as a discipline is concerned with the performance and well-being of people at work, and with how individuals, small groups and organisations behave and function. Its aim is to increase the effectiveness of the organisation and improve the job satisfaction of individuals.[8] Therefore, occupational psychologists, as scientists of people at work and with practical experience of intervening in a range of organisational contexts, have much to offer here in terms of helping NHS policy makers and hospital trusts to understand how the working conditions for success can be created and sustained.

Running alongside the report's central theme of how to embed care that is focused on patient safety, many of the following chapters include recommendations that are rooted in the concept of collective and participative leadership, detailing how NHS hospital trusts can develop more collaborative relationships between healthcare leaders and their staff. In particular, there is a concern throughout with ensuring that reforms are implemented via bottom-up processes of co-production.

In recognition of the low morale and lack of candour identified by the Francis Report as existing among some NHS hospital staff, and building on the recommendation to embed a culture that 'fosters wholeheartedly the growth and development of all staff',[1] the first section of this report is focused on staff selection, well-being and empowerment. We open our discussion with a chapter by Fiona Patterson et al., who employ occupational psychology evidence on personnel selection to show how values-based recruitment methods can ensure the continual recruitment of compassionate staff into the health service. Subsequent chapters in this section explore how, once compassionate staff have been recruited, NHS hospital employees can be supported in their development on the job. Barbara Wren and Chris Clegg et al. detail the steps required to create working conditions that are conducive to the delivery of compassionate care. In particular, Wren elaborates on the interventions, such as providing reflective space through Schwartz Rounds, that are key to managing staff experience so as to ensure 'psychologically safe' environments, and Chris Clegg et al. look at how to empower and engage staff through effective job and workspace design.

An emphasis on the integral role played by leaders in enabling staff engagement and embedding organisational culture change at a broader level has been a defining feature of

current policy discussions on NHS culture change, and forms the basis of our second set of chapters on leadership. Beverly Alimo-Metcalfe and Juliette Alban-Metcalfe examine how leaders can facilitate high-performing teams by creating a developmental culture that is open and responsive, innovative and quality-focused, while Rosalind Searle and colleagues explore the necessary composition and behavioural styles of hospital boards. The 'overarching goal' specified within the Berwick review, that of 'continually and forever reducing patient harm by embracing wholeheartedly an ethic of learning',[1] is addressed by Dr Michal Tombs-Katz's chapter, which discusses how leaders can foster a continuous learning culture by building work environments based on open communication and bottom-up processes of co-production.

Finally, the concluding section of this report aims to provide a more general review, drawing on lessons from occupational psychology, of how organisational culture change can be embedded and sustained throughout all areas of the healthcare system. In particular, Joanna Wilde's chapter employs a model of psychological imperatives to explore how 'cultures of transparency and openness' can be built, and Michael Wellin closes the discussion by giving an overview of how culture change can be managed, detailing key points to bear in mind. Thus, by employing occupational psychology evidence and expertise, each of the chapters explore different aspects of organisational culture – from the boards to the wards of hospitals – that must be addressed simultaneously in order to create an NHS that is patient-centred and safety focused.

References

[1] Berwick, D. (2013). *A promise to learn, a commitment to act: the Berwick Review into patient safety*. National Advisory Group on the Safety of Patients in England. London: Department of Health. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

[2] Francis, R. (2013, 6 February). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive summary*. Available at: www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

[3] Gov.uk. (n.d.). *Whistleblowing in the NHS: independent review*. Available at: www.gov.uk/government/groups/whistleblowing-in-the-nhs-independent-review

[4] Division of Occupational Psychology (2014). *Occupational psychology as a career option*. Available at: http://dop.bps.org.uk/public/careers-qualifications/careers-qualifications_home.cfm

[5] QualityWatch (2013, October). Is the quality of care in England getting better?: *QualityWatch Annual Statement 2013: Summary of findings*, p.1. Health Foundation and Nuffield Trust.

[6] The King's Fund (2013, 6 February). *Our response to the final report of the Mid* Staffordshire NHS Foundation Trust Public Inquiry. Available at: www.kingsfund.org.uk/press/press-releases/our-response-final-report-mid-staffordshire-nhs-foundation-trust-public-inquiry

[7] Royal College of Nursing (2013, July). *Mid Staffordshire NHS Foundation Trust Public Inquiry Report: Response of the Royal College of Nursing*. Available at: www.rcn.org.uk/__data/assets/pdf_file/0011/530948/004477.pdf

[8] British Psychological Society (2014). *Careers: Occupational psychology*. Available at: http://careers.bps.org.uk/area/occupational

NHS Staff: Recruitment, staff well-being, engagement and empowerment

Values-based recruitment for patient-centred care

Fiona Patterson, Lara Zibarras & Helena Edwards

About the authors

Professor Fiona Patterson is an expert in the field of assessment and high-stakes selection, based at the University of Cambridge.

Lara Zibarras works as a Lecturer in Organisational Psychology at City University and is a Research Fellow with the Work Psychology Group.

Helena Edwards (née Murray) is a Senior Consultant at the Work Psychology Group, specialising in the development and evaluation of high stakes assessment and selection methods.

Introduction

The Mid Staffordshire NHS Foundation Trust Public Inquiry[1] report highlighted the critical role played by the workforce in ensuring the provision of high quality and safe healthcare services and, in particular, the significance of staff values and behaviours on the level of care and patient experience. We emphasise the important role that can be played by a values-based recruitment (VBR) system that prioritises the assessment of an individual's values when selecting for NHS roles and NHS-funded training courses, as an effective means of achieving an NHS workforce aligned with the values outlined in the NHS constitution.[2] In particular, recruiting staff on the basis of their values is crucial to achieving the NHS's constitutional aspiration to 'put patients at the heart of everything it does'.[1]

The VBR programme currently being taken forward by Health Education England (HEE)[3] aims to deliver a system to recruit staff into the NHS that prioritises high quality care and patient experience, for NHS funded training posts and for all new NHS employees, by March 2015. This programme encompasses three work streams: project 1 – recruiting for values in higher education institutions (HEIs); project 2 – recruiting for values in the NHS, in partnership with NHS employers; and project 3 – an evaluation of the VBR programme to measure its impact in higher education institutions (HEIs) and NHS employment. The author of this chapter (Patterson), alongside other members of the Work Psychology Group,4 conducted project 3, undertaking a review of the evidence relating to VBR in terms of concepts, methods and effectiveness. A number of key messages have been identified following this review of evidence, which should assist those responsible for recruitment in understanding the issues around VBR in more detail and provide a platform from which effective practice can be agreed. Firstly, it is important to recruit individuals with the right values, whose principle motivation is the delivery of high quality, safe and compassionate care for patients; second, it is also important to understand that VBR should be approached as one part of a multi-faceted approach to embedding appropriate NHS values. The reasons for poor standards of care[1] are complex, varied and frequently grounded within highly contextual factors, with no single 'silver bullet' to fix existing problems where they occur and avoid future ones. Indeed, workload pressures, cultural issues, poor leadership and staff support and development are just a few of the

other aspects that require attention in addition to recruitment and selection, and it is these other aspects of organisational culture that are addressed within the following chapters of this report.

Within the context of the NHS, VBR aims to attract and select students, trainees and employees on the basis that their individual values and behaviours align with the values of the NHS constitution. This chapter briefly introduces the concept of VBR by first considering how values are defined in the occupational psychology research literature. We then briefly discuss how various selection methods might be useful for VBR, presenting a case study demonstrating how values have been measured using a situational judgement test (SJT), and how these tests might be applied more extensively in the NHS context.

Values as defined by the occupational psychology literature

Values are a set of *enduring beliefs* that a person holds about what is good or desirable in life,[5] thought of as 'preferences' or 'principles'.[6] Values as preferences (also known as work values) are attitudes that indicate the preferences individuals have for various environments.[6] Values as principles (or personal values) are guiding principles regarding how individuals feel they ought to behave. Work values predict vocational choice and job satisfaction, whilst personal values are predictive of a broad range of behaviours across various life domains,[7, 8] and because they relate to how individuals feel they ought to behave, personal values have a motivational impact on behaviour in general.[7] In the context of VBR, both work and personal values are important to include.

In addition, when considering assessment tools in the context of VBR, it is important to note that personality and values are distinct constructs (see Parks and Guay[9] for a review). In short, personality relates to *enduring dispositions*, whereas values relate to *enduring goals*. Values and personality are both believed to impact behaviour, decision-making, motivation, attitudes, and interpersonal relations.[9] Yet, there are also important differences. Values include an evaluative component not found in personality. Values relate to what we believe we ought to do, while personality relates to what we naturally tend to do. Personality traits do not conflict with one another (i.e. one can simultaneously express the personality traits of Extraversion and Conscientiousness), yet values can conflict as some are pursued at the expense of others.

Organisational theories focusing on values

A number of theories are discussed in the occupational psychology literature that focus on the context of employee's values and their impact on the organisation and the workforce. Two such theories are the attraction–selection–attrition (ASA) theory,[10] and socialisation theories.[11-13] The ASA theory is based on the notion that 'the people make the place',[14] where, over time, the values and personalities of the workforce become increasingly homogeneous as individuals are 'attracted' to an organisation based on their values; 'selected' due to value congruence; and where value congruence is low, 'attrition' will occur. Within the NHS context, individuals with previous knowledge of the organisation (e.g. those with family working in the NHS) may pre-judge its values prior to employment and may be attracted (or not) accordingly.

Socialisation theories have also been linked to the development of values within an organisation following recruitment.[11-13, 15] Small changes in individual values have been

shown following initial employment, [15, 16] with 'value internalisation' being the subtle change in an individual's values over time[15, 17, 18] and with both managers and colleagues acting as role models that impact on the values of new recruits.[17] In terms of VBR, individuals recruited into the organisation with optimal values for the delivery of high quality, competent and compassionate care may be at risk of a change in their values, either via socialisation or attrition if placed within teams where suboptimal values are evident. Therefore, VBR is only one component of the actions required to embed optimal values in the healthcare context.

The impact of value congruence on outcomes

'Value congruence' represents the extent to which an individual's values are similar to the organisation in which they work. When using VBR recruitment methods, this construct is used to measure the level of 'fit' an individual has with the organisation's values, with a number of types of 'fit' described as: 'Person–Organisation' (P–O) fit, 'Person–Environment' (P–E) fit, and 'Person–Culture' (P–C) fit.[19] Some argue that organisations do not have 'values' as such, but rather that organisational values are actually represented (and measured) by the workforce.[15, 18, 20] This is important because the NHS constitution is frequently used to describe the values of the organisation, and the content of the constitution was developed by healthcare leaders and policymakers. However, the concerns raised following recent inquiries into poor standards of care[1] suggest that variation exists across the NHS with regard to how individuals, teams and institutions operate. The NHS constitution may accurately represent the values in some NHS areas, but be more aspirational in other areas.

A key objective of the VBR agenda within the NHS is to ensure that recruitment leads to the outcomes identified as crucial by the Francis Report and Berwick review; in particular, demonstrating care and compassion towards patients. However, most of the literature describes the impact of value congruence on other outcomes (largely from the employee perspective) such as job satisfaction.[21] Research shows that when an individual's values closely match those of the organisation they report a significant increase in job satisfaction,[16, 17-23] organisational commitment,[24, 25] and decrease in intended turnover or attrition.[15, 16, 21, 23]

Effective selection methods for VBR

Selection practices within many healthcare professions have tended to focus on assessing academic ability alone, and yet research shows that a range of other attributes (such as integrity, empathy and resilience, which relate to the NHS values stipulated as necessary by the Francis Report) are important for the implementation of high quality care focused on patient safety.[26, 27] Historically, it has been difficult to measure such attributes on the scale required to assess large numbers of applicants.[28] A key challenge for NHS recruiters lies in how best to assess desired values reliably; as large scale interviewing can be costly and the use of personality measures is problematic since there is limited evidence to support their predictive validity[29] for selection purposes in high stakes settings.

Recruitment processes generally take place in two stages: (1) initial pre-screening and shortlisting of applicants, and (2) final stage selection. This is particularly important where high volumes of applicants apply for a position, as in the case of NHS Trusts.

Pre-screen and shortlisting

The methods often used for this stage of recruitment include personal statements, references, SJTs and personality assessment. There is little evidence to support the validity and reliability of references, and although the candidate acceptability of personal statements is high, this approach is susceptible to coaching. Consequently, these methods are likely to be ineffective for VBR. Although there is evidence for the validity and reliability[31] of personality assessments, they are also susceptible to faking and coaching.[32] Personality assessments may be more useful to drive questions at interview during the final stage of selection. SJTs have improved validity over other selection methods,[33-35] and can be mapped against the organisational values that must be embedded to ensure positive NHS culture change. Although SJTs can be costly to develop, their scalability is good since they can manage high volumes of applicants (for example, online and/or through automated marking). As such, SJTs are likely to be an effective method for pre-screening applicants in terms of VBR.

Final stage selection

Although traditional interviews lack validity and reliability,[36] and are thus ineffective for VBR, structured interviews have better predictive validity[37] and should be considered an effective method for VBR if designed and implemented in a robust manner. Many higher education institutions use group interviews during the selection of students onto health profession degree programmes. Whilst this approach can appear cost effective and feasible in terms of time and workload, evidence for the validity and reliability of group interviews is lacking,[38] and they may represent a 'false economy' with good candidates being missed. Thus, group interviews represent an ineffective method for VBR. Assessment centres (also known as selection centres), on the other hand, are able to manage large volumes of candidates, where they are assessed on an individual basis rather than as part of a group. When designed appropriately, using a multi-trait, multi-method approach with worked examples, this method can be a valid predictor of job performance.[39] Although relatively expensive to design, assessment centres are an effective method for VBR during the final stages of selection. Therefore, SJTs offer both a valid and reliable selection method that can be cost effective for VBR in the context of NHS hospitals and ultimately contribute to a positive culture change.

We present a case study below that outlines how SJTs have been used in practice to assess the values of medical school graduates.

Context

Every year, nearly 8,000 final year medical students apply for junior doctor posts in the two-year Foundation Programme, which is a requirement for all medical graduates wishing to work as doctors in the UK. Competition into the programme is intensifying due to the expansion of UK medical schools and the ever-increasing number of international applications.

The Department of Health recommended that an SJT was implemented to assess professional attributes, judgement and employability for a Foundation Programme post and to replace the open-ended competency based application questions previously

used. The SJT presents applicants with scenarios they are likely to encounter as a Foundation Year 1 (F1) doctor and asks how they would react in these situations. Their responses are scored against a pre-determined key defined by subject-matter experts. The SJT ensures candidates selected have the aptitude and values required of a successful doctor.

Key issues and how these were addressed:

In order to understand and define the attributes required to be successful in the role, a job analysis of the F1 doctor role was undertaken. A person specification was developed based on this analysis. Each year, educational supervisors, clinical supervisors and other Foundation Programme experts contribute to the development of new test questions based on the person specification. These questions are further reviewed, including input from Foundation doctors to ensure that the hypothetical situations are realistic and appropriate. From the job analysis, five target domains were identified to be assessed in the SJT and each item is designed to measure one of these. The five target domains are outlined in Table 1 along with examples of the kinds of scenarios which might be included under each.

Table 1: SJT Target Domains and Example SJT Scenarios

Commitment to professionalism	E.g. Issues of confidentiality such as hearing a colleague talking about a patient outside of work
Coping with pressure	E.g. Dealing with confrontation such as an angry relative
Effective communication	E.g. Gathering information and communicating intentions to other colleagues
Patient focus	E.g. Taking into account a patient's views/concerns
Working effectively as part of a team	E.g. Recognising and valuing the skills and knowledge of colleagues, when faced with a disagreement about a patient's care

Outcomes and evaluation:

The SJT has been in operational use since 2013, and to date approximately 16,000 medical school graduates have completed the test with results informing their allocation to foundation programme places alongside a measure of educational attainment. Each year the SJT is subject to full psychometric analysis and results consistently show that the SJT is a reliable, valid and appropriate method for foundation selection. Applicant reactions to the test have been positive, with the majority of students indicating that the content of the test seems fair, relevant to the Foundation Programme, and appropriate for their level. Work is underway to assess the predictive validity of the SJT, comparing performance on the test with performance on the foundation programme. This will examine the extent to which the SJT is able to predict a doctor's attitude and values in the job.

Conclusion

This chapter, on the basis of a large body of occupational psychology research, including an international review of selection practices for the healthcare professions,[40] has suggested that situational judgement tests (SJTs) are a valid and reliable method for assessing a broad range of important non-academic attributes for high volume values-based selection. Since SJTs can be designed in a format that can manage high volumes of applicants (e.g. machine-marked), SJTs are an effective method for pre-screening applicants in terms of VBR in NHS hospitals. The Foundation Programme SJT provides a case study for implementing a robust and consistent approach to assessing aptitude and values for high volume campaigns. Our evaluation of selection methods indicates that SJTs should be expanded across the NHS to ensure that staff are recruited for values that are conducive to patient-centred care. However, it should be noted that key to the success of the Foundation Year 1 SJT was the initial work to define the job role through thorough job analysis, the involvement of subject matter and key stakeholders throughout the development phases and the ongoing evaluation and analysis. Conducted in a robust way, this could provide the methodology for the design, implementation and long-term evaluation of a values-based SJT applied across the NHS.

References

[1] Francis, R. (2013, February 6). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary*. Available at: www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

[2] Department of Health (2013). *The NHS Constitution: the NHS belongs to us all*. London: Department of Health. Retrieved 17 April 2014 from: www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf

[3] Health Education England (2014). *Values based recruitment*. 2014. Accessed 7 August 2014 from http://hee.nhs.uk/work-programmes/values-based-recruitment/

[4] Work Psychology Group and NHS Health Education England (2014). *Evaluation of values-based recruitment (VBR) in the NHS*. Available at http://hee.nhs.uk/wp-content/uploads/sites/321/2013/11/Literature-Review-Full-Report.pdf

[5] Schwartz, S.H. (2012). An overview of the Schwartz theory of basic values. *Online Readings in Psychology and Culture, 2*(1), Article 11.

[6] Ravlin, E.C. & Meglino, B.M. (1987). Issues in work values measurement. In L.E. Preston (Ed.), *Research in corporate social performance and policy*, pp.153–183. Greenwich, CT: JAI Press.

[7] Locke, E.A. (1997). The motivation to work: What we know. In M.L. Maehr & P.R. Pintrick (Eds.), *Advances in motivation and achievement,* pp.375–412. Greenwich, CT: JAI Press.

[8] Schwartz, S.H. (1992). Universals in the content and structure of values: Theoretical advances and empirical tests in 20 countries. In M. Zanna (Ed.), *Advances in experimental social psychology*, pp.1–65. San Diego: Academic Press.

[9] Parks, L. & Guay, R.P. (2009). Personality, values and motivation. *Personality and Individual Differences, 47*(7), 675–684.

[10] Schneider, B., Goldstein, H.W. & Smith, D.B. (1995). The ASA framework: An update. *Personnel Psychology, 48*(4), pp.747–773.

[11] Cable, D.M. & Parsons, C.K. (2001). Socialization tactics and person-organization fit. *Personnel Psychology, 54*(1), pp.1–23.

[12] Bauer, T.N., Maertz, C.P., Dolen, M.R. & Campion, M.A. (1998). Longitudinal assessment of applicant reactions to employment testing and test outcome feedback. *Journal of Applied Psychology, 83*, pp.892–903.

[13] Chao, G.T., O'Leary-Kelly, AM., Wolf, S., Klein, H.J. & Gardner, P.D. (1994). Organizational socialization: Its content and consequences. *Journal of Applied Psychology, 79*(5), pp.730-743.

[14] Schneider, B. (1987). The people make the place. *Personnel Psychology, 40*(3), pp.437–453.

[15] De Cooman, R., De Gieter, S., Pepermans, R., Hermans, S., Du Bois, C., Caers, R. & Jegers, M. (2009). Person–organization fit: Testing socialization and attraction–selection–attrition hypotheses. *Journal of Vocational Behavior, 74*(1), pp.102–107.

[16] Meglino, B.M. & Ravlin, E.C. (1998). Individual values in organizations: Concepts, controversies, and research. *Journal of Management, 24*(3), pp.351–389.

[17] Maierhofer, N.I., Griffin, M.A. & Sheehan, M. (2000). Linking manager values and behavior with employee values and behavior: A study of values and safety in the hairdressing industry. *Journal of Occupational Health Psychology, 5*(4), pp.417–427.

[18] Ostroff, C., Shin, Y. & Kinicki, A.J. (2005). Multiple perspectives of congruence: relationships between value congruence and employee attitudes. *Journal of Organisational Behavior, 26*(6), pp.591–623.

[19] Kristof-Brown, A.L., Zimmerman, R.D. & Johnson, E.C. (2005). Consequences of individuals' fit at work: A meta-analysis of person-job, person-organization, person-group, and person-supervisor fit. *Personnel Psychology, 58*(2) pp.281–342.

[20] Van Vianen, A.E.M. (2000). Person-organization fit: The match between newcomers' and recruiters' preferences for organizational cultures. *Personnel Psychology, 53*(1), pp.113–149.

[21] Verquer, M., Beehr, T. & Wagner, S. (2003). A meta-analysis of relations between person-organisation fit and work attitudes. *Journal of Vocational Behavior, 63*, pp.473–489.

[22] Kristof, A.L. (1996). Person-organization fit: An integrative review of its conceptualizations, measurement, and implications. *Personnel Psychology, 49*(1), pp.1–49.

[23] Amos, E.A. & Weathington, B.L. (2008). An analysis of the relation between employee-organization value congruence and employee attitudes. *Journal of Psychology, 142*(6), pp.615–631.

[24] Hoffman, B. & Woehr, D. (2005). A quantitative review of the relationship between person-organisation fit and behavioural outcomes. *Journal of Vocational Behaviour, 68*, pp.389–399.

[25] Flood, P.C., Turner, T., Ramamoorthy, N. & Pearson, J. (2001). Causes and consequences of psychological contracts among knowledge workers in the high technology and financial services industries. *International Journal of Human Resource Management, 12*(7), pp.1152–1165.

[26] Patterson, F., Ferguson, E., Lane, P., Farrell, K., Martlew, J. & Wells, A. (2000). A competency model for general practice: Implications for selection, training, and development. *British Journal of General Practice, 50*, pp.188–193.

[27] Patterson, F., Ferguson, E. &Thomas, S. (2008). Using job analysis to identify core and specific competencies: Implications for selection and recruitment. *Medical Education, 42*, pp.1195–1204.

[28] Cleland, J., Dowell, J., McLachlan, J., Nicholson, S. & Patterson, F. (2012). Research report: Identifying best practice in the selection of medical students (literature review and interview survey). Available at: http://www.gmc-uk.org/Identifying_best_practice_in_the_selection_of_medical_students.pdf_51119804.pdf

[29] Tett, R.P., Jackson, D.N., Rothstein, M. & Reddon, J.R. (1999). Meta-analysis of bidirectional relations in personality-job performance research. *Human Performance, 12*(1), pp.1–29.

[30] Ferguson, E., James, D., O'Hehir, F., Sanders, A. & McManus, I.C. (2003). Pilot study of the roles of personality, references, and personal statements in relation to performance over the five years of a medical degree. *British Medical Journal, 326*(7386), pp.429–432.

[31] Salgado, J.F. (1997). The five factor model of personality and job performance in the European Community. *Journal of Applied Psychology, 82*(1), pp.30–43.

[32] Birkeland, S.A., Manson, T.M., Kisamore, J.L., Brannick, M.T. & Smith, M.A. (2006). A meta-analytic investigation of job applicant faking on personality measures. International *Journal of Selection and Assessment, 14*(4), pp.317–335.

[33] Patterson, F., Carr, V., Zibarras, L., Burr, B., Berkin, L., Plint, S., Irish, B. & Gregory, S. (2009). New machine-marked tests for selection into core medical training: Evidence from two validation studies. *Clinical Medicine, 9*(5), pp.417–420.

[34] Lievens, F. & Patterson, F. (2011). The validity and incremental validity of knowledge tests, low-fidelity simulations, and high-fidelity simulations for predicting job performance in advanced-level high-stakes selection. *Journal of Applied Psychology, 96*(5), pp.927–940.

[35] Koczwara, A., Patterson, F., Zibarras, L., Kerrin, M., Irish, B. & Wilkinson, M. (2012). Evaluating the validity of tests of cognitive ability, applied knowledge and situational judgement for postgraduate selection. *Medical Education, 46*(4), pp.399–408.

[36] Terpstra, D.A., Mohamed, A.A. & Kethley, R.B. (1999). An analysis of Federal Court cases involving nine selection devices. *International Journal of Selection and Assessment, 7*(1), pp.26–34.

[37] Huffcutt, A.I. & Arthur, W. (1994). Hunter and Hunter (1984) revisited: Interview validity for entry-level jobs. *Journal of Applied Psychology, 79*, pp.184–190.

[38] Tran, T. & Blackman, M.C. (2006). The dynamics and validity of the group selection interview. *Journal of Social Psychology, 146*(2), pp.183–201.

[39] Patterson, F., Ferguson, E., Norfolk, T. & Lane, P. (2005). A new selection system to recruit general practice registrars: Preliminary findings from a validation study. *British Medical Journal, 330*(7493), pp.711–714.

[40] Prideaux, D., Roberts, C., Eva, K., Centeno, A., McCrorie, P., McManus C. et al. (2011). Assessment for selection for the health care professions and specialty training: Consensus statement and recommendations from the Ottawa 2010 Conference. Medical Teacher, 33(3), pp.215–223.

Managing staff experience to improve organisational culture

Barbara Wren

About the author

Barbara Wren is a Consultant Psychologist and Schwartz Round Lead at the Royal Free London NHS Foundation Trust, as well as Director of Wren Psychology Associates.

Introduction

Staff experience sits at the heart of organisational culture change in the NHS, and is intimately related to patient experience.[1] The drive to improve organisational culture derives to a significant extent from the concern that patients have suffered needlessly and that their clinical outcomes have been compromised whilst using healthcare services.[2] National data from staff surveys and other sources tell us that staff are suffering too.[3, 4] Psychological theories provide us with sophisticated models to understand the sources of staff suffering, and frameworks from which to derive, develop and evaluate interventions for prevention, treatment and rehabilitation.[5] In this chapter, such work is related to the healthcare context, with an examination of how approaches rooted in psychological theory can be employed to help staff manage the very predictable risks to which healthcare work exposes them.

The healthcare context

The healthcare context is a fast paced, rapidly changing, hugely demanding and rewarding setting in which to work. Healthcare staff are usually intrinsically motivated to do the work they do and are values-driven in their relationship to work. Yet, work design is changing in ways that test this relationship, increase the level of demands and reduce the support and control available to staff, an imbalance known to contribute to ill health at work. When combined, these factors pose particular challenges that can lead to increased anxiety, and it is through helping organisations to understand the impact of this anxiety, and to manage it, that psychologists can make an important contribution to improving staff experience and managing organisational culture.

Anxiety is managed by staff through various means, some more functional than others, that can be broadly categorised in terms of 'creating defences' or 'creating meaning', i.e. by creating a self- protective distance between oneself and what is difficult, or by making sense of what is happening. These methods of creating defences or creating meaning occur at both an individual and an organisational level,[7] and psychologists can assist healthcare organisations in understanding the impact of defences on effective and safe organisational functioning, enabling them to more consciously manage these defences as well as helping managers and their staff to manage meaning. Thus, considering the different aspects of the healthcare context from the perspective of the psychological challenges that it poses to staff opens new possibilities for understanding, and it is this approach to understanding staff experience that is outlined below.

Large-scale organisational change and increasing levels of job insecurity

Psychological theories of child development, which inform models of learning and training used in occupational psychology interventions,[8] describe the necessary conditions for optimal learning and growth as being a sense of safety and containment combined with stimulation and challenge. It is the combination of these elements that is key, with each synergistically interacting with the other to facilitate learning and produce positive behaviour. Currently, the organisational culture in the NHS often produces insecurity and competition without adequate containment, thereby reducing safety, increasing anxiety and fear and disabling learning. In his review into improving patient safety in England, Berwick wrote that 'fear is toxic to both safety and improvement'.[3] The 'fear' Berwick refers to is leading to high levels of anxiety in individuals and systems. At the same time this limits access to reality-based ways of managing this anxiety that would involve helping to understand stressors from a 'whole system' perspective in order to address them effectively.

One healthy way in which psychology shows us that humans manage their anxiety is through our 'attachments'.[9] That is, we seek out relationships that make us feel confident, competent and reassured and which provide us with opportunities for growth. NHS staff often face a psychological quandary about which attachments will provide safety and help them manage anxiety, and are unsure whether to look to organisational attachments, attachments to their colleagues, attachments to professional groupings or attachments to patients. These decisions can be made especially difficult in an NHS context of insecurity, competition and job cuts. One attachment that has huge potential to mitigate the impact of anxiety is staff relationships with management, with staff who feel well supported by management better able to manage their anxiety and therefore more able to learn and be effective in their role.[10] However, NHS managers are one of the most highly stressed occupational groups in the UK,[11] and psychology shows that to help others feel contained[2] one must be adequately contained oneself; a fact that is at the heart of thinking about the relationship between staff and patient experience. There is limited capacity for containing management relationships in the NHS due to some of the issues described here, and due to skill limitations. Many staff consequently alleviate their anxiety through other means, for example through their relationship with patients, returning them to the original values that brought them into healthcare but often increasing the divide between corporate culture and staff experience. Thus, NHS staff can often feel committed to and motivated by their clinical role, and yet psychologically harmed by their organisations. This conflict increases the risk of burnout and ambivalent organisational commitment, which can in turn thwart centrally led culture change initiatives such as those being undertaken in response to the Francis Report and Berwick review.

Increasing cost containment pressures

As a result of pressures to contain NHS costs, many staff may have to orient themselves to the provision of 'good enough' care. This can lead to anxieties about patient safety and open up the challenge of managing patient relationships in a different way, for example by having to be quicker in consultations, manage expectations downwards and prioritise or ration services. Giving staff space to reflect on the impact of this experience is vital in order to avoid unhealthy ways of coping with cost containment pressure. The need for good 'translators' in management roles – who are able to conceptualise service priorities at an

operational, strategic and clinical level at the same time, to ensure they are integrated, and to promote meaningful dialogue between different parts of the healthcare system – has never been more acute. However, with tired staff and limited containment, these approaches are difficult to undertake and the result is often 'splitting'[3], with staff feeling they have bad managers and good doctors, for example, or good and bad nurses, or worthy and unworthy services. Splitting leads to scapegoating and destructive relationships, all too common features of the healthcare culture.

Increased life expectancy and management of chronic conditions

Depending on a member of staff's speciality within the NHS, much healthcare work now involves helping to reorient patients and families to manage chronic conditions, usually in the community rather than in hospital. Rather than providing discrete episodes of care, new skills are required to manage long-term relationships whilst helping readjustment to illness. The challenges posed by the need to manage the intimate and dependent relationships at the heart of chronic conditions require support and understanding, and opportunities for staff to renew themselves and process the complex feelings that may be generated by this work.

The nature of healthcare work

Healthcare work involves daily exposure to the reality of distress, decay and disfigurement, and to the possibility of death. Menzies Lyth,[12] who was a child and adult psychoanalyst and organisational consultant, and wrote widely about the process of change in individuals and organisations, has highlighted the organisational defences that healthcare staff employ to protect themselves from this reality. The need for staff to have a sense of detachment carries with it the risk of disengagement from the emotions necessary to cultivate compassionate and safe relationships with patients and colleagues, and this detachment can be seen as lying at the heart of the failings identified in the Mid Staffordshire Inquiry.[3]

The various elements of the healthcare context described above pose predictable psychological challenges for NHS staff. These challenges can be anticipated and managed by:

- Providing space for reflection, for example by adopting the 'Schwartz Center Round' model and promoting other forms of reflective practice such as learning sets.
- Regularly considering whether work design promotes helpful defences, and supporting and enabling a reality based management function in hospitals
- Consciously paying attention to the content of the work, its emotional impact and the structure and design of jobs, roles and teams.
- Paying attention to the processes supporting the work, including review of work, meetings, supervision, and management of risk.
- Ensuring that the skills and resources of management at every level are treated as being of crucial importance.

Psychology services derived from a combination of clinical, occupational and health psychology theoretical frameworks have huge potential to help NHS organisations address these areas, and the case studies below provide some practical examples of effective interventions.

Case study A: Providing a systemic intervention to build resilience

Background

In 1999, the Royal Free London NHS Foundation Trust established an in-house psychology service led by the author. The service provided individual therapy and management and organisational consultancy to all hospital staff and departments. The service worked at the interface between individual and organisational functioning and tackled 'downstream problems' by implementing 'upstream solutions'. For example, an in-house mediation service was established after identifying conflict as the source of a large number of referrals for individual therapy.

Situation

In one particular year, the psychology service received a large number of referrals from the same clinical area.

- Many junior staff were referred for stress management.
- Staff were distressed, tearful and feeling overwhelmed by patient demands.
- Middle managers were contacting the consultancy service independently of each other, and asking for help with managing 'difficult people'.
- Two senior managers contacted the service asking for coaching to provide support as they prepared to compete with external providers for the on-going provision of this service (they were only partially successful).

It was hypothesised that there were difficulties in containing pressure and emotion in this service in the context of a fight for survival.

Intervention

An intervention comprised of two 10-month learning sets was offered to two groups of middle managers:

- Each set met every six weeks for three and a half hours with no set agenda.
- Staff were encouraged to bring any current concerns and had a fixed amount of time when the group focused exclusively on the issue they had arrived with.

Outcomes

- Over time, the groups had the experience of being heard and helped without needing to act, developed an awareness of typical patterns of responding to problems, and understood the themes linking their varied experiences.
- The interventions led to the development of alternative ways of thinking about difficulty. In particular, staff reported higher levels of resilience and satisfaction with work, and a stronger sense of support from colleagues. Thus, using systemic psychological theory to hypothesise about the problem and to develop a solution which strengthened resources enabled the group to move away from a focus on difficult and/or stressed staff and onto shared challenges in the work they were doing as well as a recognition of the range of resources they had available to manage complexity.

See Wren et al.[13] for a further description of this and other similar UK services.

Case study B: The introduction of Schwartz Rounds

Background

In 2009, with the help of the Point of Care Programme at the King's Fund, the Royal Free London NHS Foundation Trust piloted Schwartz Rounds, which provided an opportunity for an organisation-wide reflective space. 'Schwartz Center Rounds'[14] originated in the United States and provide a forum for healthcare staff to come together once a month to explore the non-clinical aspects of caring for patients – the psychological, social and emotional challenges. They were piloted in two UK hospitals (the Royal Free London NHS Foundation Trust and Gloucester Hospitals NHS Foundation Trust), and four years later are still running successfully in both hospitals. Data from the USA has shown that the presence of Rounds in hospitals led to better teamwork, reduced staff stress, and enhanced staff 'likelihood of attending to psychosocial and emotional aspects of care' and enhancement of staff beliefs about the importance of empathy'.[15]

Format

- Each Schwartz Round lasts for one hour and includes a presentation of a patient experience by a multi-disciplinary panel who go on to describe the impact that the patient experience has had on them.
- Following the patient experience presentation, there is then time and space for the audience to reflect with the panel on similar experiences of their own.

Outcomes

- The rounds are restorative, allowing staff to constructively process difficult work experience and gain reassurance and support.
- Rounds equip staff with new ways of thinking about difficulty, reduce isolation, develop a sense of community, and role model coping with difficult emotions.[15]
- Staff reported that the presence of the Rounds makes them feel proud to work for their organisation and reconnected to the values that first brought them into healthcare.[16]
- The implementation of Schwartz Rounds has been recommended in the Department of Health's response to the Francis Inquiry
- The Point of Care Foundation[17] is now rolling out Schwartz Rounds across the UK and provides support, mentoring and training to new organisations starting Schwartz Rounds. The author works with the Point of Care Foundation and has led on the use of clinical and occupational health psychological theory to develop the training and mentoring model that is provided to healthcare organisations to support successful implementation of Schwartz Rounds.

Conclusion

Psychology has much to contribute to the improvement of healthcare culture post-Francis, both in providing evidence-based assessments and in conducting well planned interventions. Interventions should be targeted at different levels of the system: individual, role, team and departmental, and must be sophisticated, responsive and systemically derived, even if their focus is on individuals. Interventions also need to take into account the range of factors impacting on staff experience, the unique demands of different healthcare specialties, the need for renewal among tired staff who are anxious about change, job insecurity and exposed to what are often experienced as limitless demands. The development of psychology based intervention clusters that are regularly reviewed and realigned to emerging staff, patient and organisational priorities will be key to ensuring the successful implementation of NHS culture change recommendations.

References

[1] Maben, J. (2010). The feel good factor: Evidence for a link between staff wellbeing and the quality of patient care. *Nursing Standard, 24*(30), pp.70-71.

[2] Francis, R. (2013, 6 February). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary*. Available at: www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

[3] Berwick, D. (2013). *A promise to learn, a commitment to act: the Berwick Review into patient safety*. National Advisory Group on the Safety of Patients in England. London: Department of Health. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

[4] Ballat, J. & Campling, P. (2011). *Intelligent kindness: Reforming the culture of healthcare*. London: Royal College of Psychiatrists.

[5] Wren, B. & Michie, S. (2203). Staff experience of the health care system. In S. Llewellyn & P. Kennedy (Eds.), *Handbook of clinical health psychology*, pp. 41-60. Chichester: Wiley.

[6] Karasek, R.A. & Theorell, T. (1990). Healthy work, stress, productivity and the reconstruction of working life. New York: Basic Books.

[7] Obholzer, A. & Roberts, V.Z. (1994). *The unconscious at work*. London: Routledge.

[8] Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York: Basic Books.

[9] Cassidy, J. & Shaver, P.R. (2008). Handbook of attachment theory, research and clinical applications. New York: Guilford Press.

[10] Chartered Institute of Personnel and Development (1999). *Line management behaviour and stress at work*. Available at www.cipd.co.uk/NR/rdonlyres/898B09D3-6F8A-49AF-BD11-66EC76B086D4/0/stress_at_work_updated_guidance_for_line_managers.pdf

[11] Williams, S., Michie, S. & Patani, S. (1999). *Improving the health of the NHS workforce*. London: Nuffield Trust.

[12] Lyth, I.M. (1990). Social systems as a defence against anxiety. *Human Relations, 13*, pp.95-121.

[13] Wren, B., Schwartz, A., Allen, C., Boyd, J., Gething, N., Hill-Tout, J., Jennings, T., Morrison, L. & Pullen, A. (2006). Developing occupational health psychology services in healthcare settings. In S. McIntyre & J. Houdmont (Eds.), *Occupational health psychology: European perspectives on research, education and practice*, pp.177–204. Nottingham: Nottingham University Press.

[14] Schwartz Center (2014). *Welcome*. Accessed 7 August 7 2014 from www.schwartzcenter.org

[15] Goodrich, J. (2011). *Schwartz Center Rounds: Evaluation of the UK pilot*. London: King's Fund.

[16] Wren, B. (2012). *Schwartz Rounds: Creating new spaces and having new conversations in healthcare organisations*. Paper presented at OPUS International Conference, London, November 2012.

[17] The Point of Care Foundation (2014). *Home*. Accessed 7 August 2014 from www.pointofcarefoundation.org.uk

Work design for compassionate care and patient safety

Chris W. Clegg, Lucy Bolton, Ryan Offutt & Matthew Davis

About the authors

Chris Clegg is Professor of Organisational Psychology at Leeds University Business School.
Lucy Bolton is a Researcher in Organisational Psychology at the Socio-Technical Centre, Leeds University Business School.
Ryan Offutt is a Researcher in Organisational Psychology at the Socio-Technical Centre, Leeds University Business School.
Matthew Davis is a Lecturer in Socio-Technical Systems at Leeds University Business School and an Associate Fellow of the British Psychological Society.

Introduction

This chapter argues that work design is a key enabler of the delivery of compassionate care and patient safety in the NHS. By 'work design', we mean the organisation of work on hospital wards and the design of physical workspaces. In this view, compassionate care is provided in the daily routines and working practices of those working with patients on wards. In turn, these routines and practices are heavily influenced by how clinicians spend their time; the dominant goals and metrics that are pursued, prioritised and measured; the processes that are followed and enacted; the social interactions enabled by the layouts; the technologies in use; the expectations of managers and others, and the skills and attitudes of the staff.

Using insights from occupational psychology, we argue that work design is fundamental to improving care and to ensuring that what happened at Mid Staffordshire does not happen again. Furthermore, our reading of the various reports and debates surrounding the Francis Report is that work organisation as a topic has to date been under-recognised and under-specified (though for brief exceptions, see for example, Francis executive summary[1] 1.202 and Berwick,[2] section IV, Box [3]). Our aim is to fill this gap, offering a complementary set of ideas that adds to the analyses offered by Francis and others. In addition, we offer some caveats on the potential confusions and clashes that may result from two emerging rhetorics – one focused on standards, compliance and inspection, versus the other on staff empowerment and trust.

The **objectives** of this chapter are to:

- Draw on our experiences as occupational psychologists working in a range of other sectors
- Offer a complementary view to the Francis Report and Berwick review, focusing on the role of work design as a core component of the delivery of care on hospital wards
- Make systemic recommendations for the improvement of work design at ward level

Lessons from other sectors

Before discussing the topic of work design, we draw on our experiences of working in a range of other sectors. The value of drawing from other sectors of work is illustrated by the experience of the Virginia Mason Hospital[3] in Seattle, which has succeeded in learning from manufacturing companies (such as Toyota and Boeing) to reduce waste, for example in terms of waiting times and staff movement, and improve patient safety.

Experiences from major disasters

An analysis of a wide range of large scale disasters and accidents in safety critical industries reveals some commonality with the failures in patient care and safety that occurred in Mid Staffordshire, from which there are important lessons to learn. For example, analyses of what happened at the Hillsborough Football Stadium Disaster,[4, 5] King's Cross Underground Fire,[6] Bradford City Stadium Fire,[7] Piper Alpha Oil Terminal Fire[8] and BP Deepwater Horizon Oil Disaster[9] reveal some common systemic failings.[10] These common factors include:

- A focus on certain goals to the exclusion of safety ('managerial headlights' focused in the wrong place).
- Lack of clarity over responsibility for safety.
- Complacency, especially amongst senior managers.
- Poor or fragmented leadership.
- A separation between the top of the organisation and those on the ground who deliver the services.
- A failure to learn lessons from previous failures and external experts.
- A lack of empowerment of (and trust in) those on the ground to respond to problems as they occur.

Experiences from the pursuit of quality in manufacturing companies

There has been a long-standing international debate within manufacturing industry on the optimal way of pursuing quality and the respective roles of shop-floor staff and quality inspectors. The lessons from this sector are that:

- Front-line staff must retain primary responsibility for quality, with quality representing an explicit priority in their role even if there may be some investment in a separate quality function (for example, in safety critical industries).[11, 12]
- Front-line staff need to be empowered to act when things go wrong. In Japanese manufacturing systems for example, a problem is never handed on for someone else to solve and if something is not right, they 'stop and fix it'.[13, 14]
- Well-designed systems make problems visible so that they can be understood and rectified.[15]
- Quality cannot be 'inspected' in after the event, when it is too late, too expensive and counter-productive.[16]
- Whilst there are roles for operational and behavioural standards and for the pursuit of compliance, 'non-compliance' on the part of staff can often indicate a badly designed system.
- There is a place for inspections and audits, but in large part these are to help the operators deliver the best quality possible, not to take responsibility for it.

The manufacturing sector shows that an over-emphasis on inspections, standards and compliance can create a vicious circle, with inspections becoming adversarial processes in which staff become defensive and tempted to hide problems of poor quality. Such vicious circles can lead to the creation of ever more complicated regimes that soak up and waste scarce resources whilst failing to add value. The overwhelming long term direction of travel in manufacturing has been to move away from heavy investments in external inspection

and improve quality by empowering front-line staff to put things right; a conclusion that is supported by the analyses of the major disasters above.

In light of these lessons from other sectors, there are grounds for concern in the call from the Care Quality Commission to 'Join Mike's Inspection Army'.[17] This is substantiated in the views being expressed regarding the 'punitive and overbearing' culture in the NHS.[18] There remains the potential for a confusing and debilitating cultural clash between the rhetoric of inspection and compliance on the one hand (with its connotations of top-down 'command and control', substantiated by the military language), in contrast with the rhetoric of care, listening and empowerment on the other. Indeed, Chris Hams[19] argues the NHS has relied too much on inspection and regulation, advocating a shift towards bottom-up approaches incorporating staff engagement and commitment.

The role of work design

There is a longstanding tradition of research into work design by occupational psychologists and others, focused on the daily working practices of who does what, where and when, and on the job designs of key actors working on the wards.

Broadly, the findings in this area are that:

- Empowering people results in higher performance and higher quality.[20]
- Staff usually prefer to be empowered and respond positively to the experience.[21]
- Work design is a core part of a larger organisational system and these systemic elements need to be 'joined-up' in their design and operation.[22]

Our view is that compassionate and effective care is undertaken in the hourly and daily praxis of hospital wards and this primarily involves doctors, nurses, healthcare assistants, cleaners, patients and their families, carers and friends. The critical enablers of care lie in the organisation of work for these key actors. In this view, care is provided through a set of patient-centred tasks or activities, which include, for example, feeding and administering drink, drug dispensing, relieving pain, sleeping, toileting, bed-making, cleaning, tidying, communicating about health and care, chatting and conversing, monitoring, responding, reassuring, and providing help (e.g. regarding reading, lighting, noise, shopping, TV and radio, etc.). These are everyday tasks that need to be agreed and prioritised as parts of the roles of the key actors in the NHS.

Existing research on work design in hospital wards:

Healthcare tasks

- Nurses spend around 17 per cent of their time on non-essential paperwork and clerical tasks.[23]
- 27 per cent of nurses report they do not have administrative or clerical support.[23]
- 69 per cent of nurses report that IT systems have increased the time they spend on paperwork and administration.[23]
- Nurses spend around 15 per cent of their time on bedside care.[24]
- Health care assistants spend around 30 per cent of their time on bedside care.[24]
- A focus on certain metrics (such as infection control) serves to reduce the attention to other aspects of the quality of care and in particular, those which are not measured.[25]

Ward layouts

- The physical design of healthcare facilities has an impact on both staff and patients.[26]
- Staff involvement in the redesign of their wards has positive effects for both staff and patients.[27-29]
- Quieter wards are associated with faster patient recovery and the use of fewer analgesic drugs.[30]
- Patients who have access to external views are reported to recover more quickly than those without.[30]
- Different ward layouts have an impact on the ability of nurses to observe and monitor their patients. For example, old-fashioned Nightingale wards (large rooms with beds around the sides and with a central nurse station) are associated with the highest level of direct care and with lower workloads, whilst Bay wards (a central nurse station with surrounding bays containing small numbers of beds) generate heavier workloads for staff.[31]

Our interpretation of the above research is that nurses and other ward staff can often spend too much of their time undertaking routine clerical and computing activities, following the requirements of a managerial and financial set of goals, priorities and metrics and feeding the needs of the bureaucracy. This has distanced them from their patients, both physically and psychologically. In this view work organisation can be seen as part of a complex system that evolved in Mid Staffordshire hospital in a chronically dysfunctional way, with the chronic problems at Mid Staffordshire appearing similar to the common problems underlying the acute disasters in other sectors described earlier. The solution requires new work designs that trust and empower front-line staff to deliver compassionate care, supported by other systemic changes.[31]

What this means for hospital wards: Recommendations

On the basis of the above analysis, we make a set of inter-related recommendations that are summarised below and in Figure 1, using a systems framework.[22]

Goals and metrics

- On each ward, explicit goals and simple metrics are needed that are focused on daily care activities. The quality of care must be a priority goal. Metrics in support of goals in this area will need careful design to achieve the right balance between empowering staff and external validation.
- Feedback should be provided against these goals and metrics (see below).
- Daily care activities need to be agreed as priorities above all managerial and financial activities, and this will need to be agreed at multiple levels and by all the key stakeholders.

People

- Ward staff need to be empowered and trusted to undertake care and safety roles, and to respond to the needs of their patients as they arise.
- Ward staff need to be trained in their care roles and in the cultural norms and expectations regarding the care of patients. Examples of potential training include:
  - Role plays of appropriate behaviours under realistic circumstances on their wards.
  - Discussions on priorities and how to handle conflicting demands.

- Direct inputs from patients on their experiences of care during their 'patient journey' (i.e. walking a mile in their shoes).
- Imparting lessons and experiences from other relevant sectors (see below).

- Staff need to be reassured that, in the event of lack of time, care activities (alongside clinical and medical work) take priority over managerial and financial tasks. This view and its application will need to be consistent at all levels in the healthcare system (including the statutory framework).

Working practices and processes

- The various roles (for all people working on the ward) need to include specific care activities and have key performance indicators (KPIs) attached to these, based on the metrics above.
- Agreement, clarity and transparency are required about the care roles on each ward.
- There need to be quick and direct feedback loops from patients (and their families, friends and carers) regarding their care. There is opportunity for experimentation to develop cost-effective feedback systems. Examples of such feedback systems could include:
  - Direct feedback from patients and their visitors using simple electronic (push-button) technologies.
  - The use of charts above hospital beds.
  - Displays of aggregated feedback on each ward using colour-coding systems.
  - Regular patient surveys.
  - The collection and collation of data by volunteer visitors, and
  - The regular posting of such results on ward patient information boards
- Feedback systems need to operate openly, in as near real time as possible, and in the right language for both patients and staff.
- New processes to support empowered staff should include, for example, systems for 'stop and fix it' (when any member of staff can stop the ongoing work in the event of poor safety or care, acknowledging the need to prioritise clinical emergencies) and 'continuous improvement' (which involves team-based discussions for improving local work, often held on a daily basis.
- Existing activities and processes may need to be simplified, dropped or re-allocated. Techniques to do this include process re-engineering (streamlining processes and cutting out waste) and value stream mapping (understanding and improving workflows in complex systems). Such techniques and their underlying philosophies again help demonstrate that there are substantial lessons to learn from 'good practice' in other sectors. We note, for example, that value stream mapping is already a part of the existing NHS Productive Ward Programme.

Infrastructure

- Ward layouts, wherever possible, need to support daily care roles and make the provision of safe care 'easy'. For example, the layouts should allow 'line of sight' to all patients to enable easy monitoring and response, and should promote effective working by reducing wasteful trips for equipment, materials and information.
- Ward layouts should help make 'problems visible' (as opposed to hidden out of sight).

Technology and tools

- There need to be tools to support the above, for example, to enable quick and easy feedback from patients on the metrics for quality of care and safety (see above).

Culture

- Norms and expectations need to be established and reinforced regarding the centrality of patient care and the need for transparency.
- These are complex systems and their design needs to be 'joined up' to deliver effective services.
- The direct involvement of ward staff in the design of their work needs to be part of this new culture (see Figure 1).
- NHS staff need to be open to learning about 'good practice' from other safety critical sectors. Learning lessons from elsewhere should be a cultural norm. Moreover, such external lessons should be part of training inputs within the NHS.

Process of change

- There is a need for an agreed national framework on these issues, in particular with regard to goals and metrics, the priority given to care activities and the need for well-designed work organisations.
- There needs to be a local agreement on the above on each and every ward.
- Staff need to be actively engaged in the discussion of all the issues above. Each local ward will need to involve all the relevant staff in local discussions and agreements on the provision of care under all the headings above. Such 'user-centred' design is practised in other sectors.

The inspection process needs to be designed to ensure it is aligned with the rest of the care system and to ensure it is not wasteful and counterproductive.

Concluding remarks

Since publication of the Francis Report there has been a great deal of discussion on how to improve the quality of care in hospitals. We believe there are six key points which emerge from our review and perspective, which complement other work. These are:

- There are powerful lessons to learn from elsewhere, in particular from the causes of major disasters and from the pursuit of quality in manufacturing industry.
- No amount of inspection or exhortation for change will deliver the cultural changes required, unless attention is paid to work design. Work design is an essential and core enabler of the new culture. The whole system needs to be 'joined up' to deliver high quality and safe care.
- Compassionate care can only be delivered by staff on the ground in the daily practice of their work on the wards. Thus far, the importance of work design has been relatively under-recognised and under-developed in the ongoing debates.
- The process of work design is a bottom-up ward-based approach to improvement, aligned with a top-down pursuit of change. Front-line staff will need to be directly involved in the design of their work to deliver compassionate care.
- An emphasis on care may mean that some non-value-adding activities have to go – hospitals need to review the processes and activities that are soaking up staff time and drop them, make them more streamlined, or get someone else to do them.

- Great care needs to be taken over the design of the emerging inspection regime to ensure it is not wasteful or counterproductive.

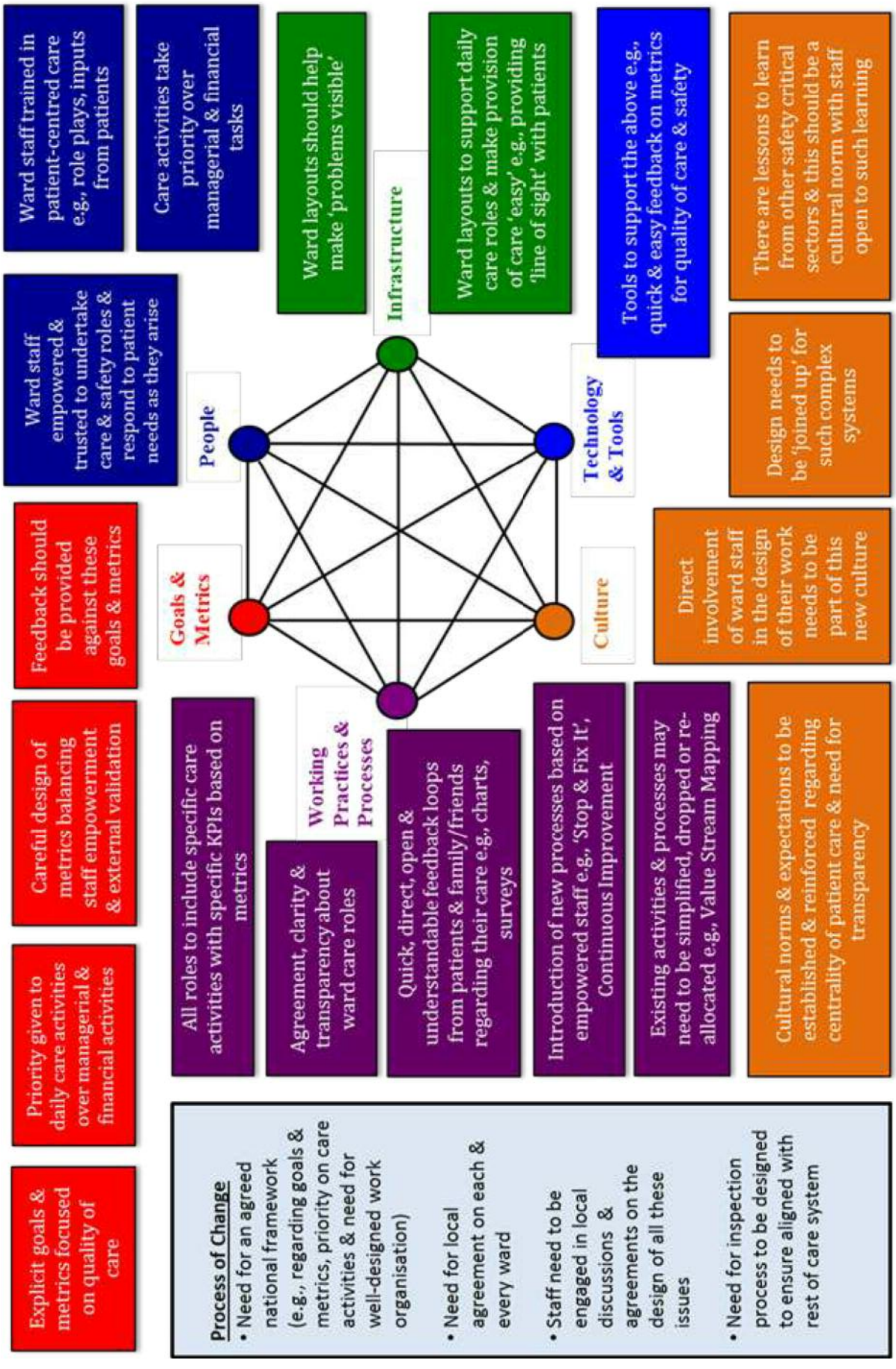


Figure 1: Systems framework for ward staff

References

[1] Francis, R. (2013, 6 February). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary*. Available from www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

[2] Berwick, D. (2013). *A promise to learn, a commitment to act: the Berwick Review into Patient Safety*. National Advisory Group on the Safety of Patients in England. London: Department of Health. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

[3] Association of American Medical Colleges (2012). *Virginia Mason Medical Centre: Applying LEAN methodology to lead quality and transform healthcare*. AAMC Readiness for Reform. Available from www.aamc.org/download/278946/data/virginiamasoncasestudy.pdf

[4] Taylor, P. (1989). *The Hillsborough stadium disaster, interim report*. London: Home Office.

[5] Taylor, P. (1990). *The Hillsborough stadium disaster, final report*. London: Home Office.

[6] Fennell, D. (1988). *Investigation into the King's Cross underground fire*. London: Department for Transport.

[7] Popplewell, O. (1985). *Committee of Inquiry in Crowd Safety and Control at Sports Grounds: Interim report*. London: HMSO.

[8] Cullen, H.L.W.D. (1990). *The public inquiry into the Piper Alpha disaster*. London: HMSO.

[9] Graham, B., Reilly, W.K., Beinecke, F., Boesch, D.F., Garcia, T.D., Murray, C.A. & Ulmer, F. (2011). *Deep water. The Gulf Oil disaster and the future of offshore drilling. Report to the President*. Washington DC: National Commission on the BP Deepwater Horizon Oil Spill and Offshore Drilling.

[10] Challenger, R. & Clegg, C.W. (2011). Crowd disasters: A socio-technical systems perspective. *Contemporary Social Science, 6*, 343–360.

[11] Womack, J.P. & Jones, D.T. (2003). *Lean thinking: Banish waste and create wealth in your corporation*. New York: Free Press.

[12] Morgan, J. & Liker, J.K. (2006). The Toyota product development system: Integrating people, process, and technology. New York: Productivity Press.

[13] Liker, J.K. (2004). *The Toyota way: 14 management principles from the world's greatest manufacturer*. New York: McGraw-Hill.

[14] Clegg, C.W. (1986). Trip to Japan: Human resources and synergy. *Personnel Management*, August, 35–39.15.

[15] Clegg, C.W. (2000). Sociotechnical principles for system design. *Applied Ergonomics, 31*, 463–477.

[16] Dorrell, S. (2014). *Implementing the Francis Report: holding the system to account*. The Francis Enquiry: The impact one year on. Nuffield Trust Event, 6 February, London, 2014.

[17] Care Quality Commission (2013, July 18). Join Mike's Inspection Army. News stories, 18 July 2013. Retrieved 13 October 2014 from www.cqc.org.uk/content/join-mike%E2%80%99s-inspection-army

[18] Thorlby, R., Smith, J., Williams, S. & Dayan, M. (2014). *The Francis Report: One year on: the response of acute trusts in England.* Evidence for better care. Nuffield Trust. Available from www.nuffieldtrust.org.uk/sites/files/nuffield/publication/140206_the_francis_inquiry.pdf

[19] Hams, C. (2014). *Reforming the NHS from within: Beyond, hierarchy, inspection and markets.* London: King's Fund.

[20] Birdi, K., Clegg, C., Patterson, M., Robinson, A., Stride, C.B., Wall, T.D. & Wood, S.J. (2008). The impact of human resource and operational management practices on company productivity: a longitudinal study. *Personnel Psychology, 61*, 467–501.

[21] Clegg, C.W. & Spencer, C. (2007). A circular and dynamic model of the process of job design. *Journal of Occupational and Organisational Psychology, 80*(2), 321–339.

[22] Davis, M.C., Challenger, R., Jayewardene, D.N.W. & Clegg, C.W. (2014). Advancing socio-technical systems thinking: A call for bravery. *Applied Ergonomics, 45*, 171–180.

[23] Royal College of Nursing(2013). *RCN employment survey 2013.* Accessed 9 May 2014 from www.rcn.org.uk/__data/assets/pdf_file/0005/541292/Employment_Survey_2013_004_503_FINAL_100214.pdf

[24] Kessner, I., Heron, P., Dopson, S., Magee, H., Swain, D. & Askham, J. (2010). *The nature and consequences of support workers in a hospital setting. Final report.* NIHR Service Delivery and Organisation Programme. Accessed 9 May 2014 from www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1619-155_V01.pdf

[25] Tadd, W., Hillman, A., Calnan, S., Calnan, M., Bayer, T., & Read, S. (2011). *Dignity in practice: An exploration of the care of older adults in acute NHS Trusts.* London: HMSO. Available at: www.bgs.org.uk/pdf_cms/reference/Tadd_Dignity_in_Practice.pdf

[26] Lawson, B. (2005). Evidence-based design for healthcare: Business briefing. *Hospital Engineering and Facilities Management, 2,* 25–27.

[27] Coopers, P.W. (2004). *The role of hospital design in the recruitment, retention and performance of NHS nurses in England.* Sheffield: Commission for Architecture and the Built Environment/ Price Waterhouse Coopers.

[28] Davis, M.C., Leach, D.J. & Clegg, C.W. (2011). The physical environment of the office: Contemporary and emerging issues. In G.P. Hodgkinson & J.K. Ford (Eds.), *International Review of Industrial and Organizational Psychology, vol. 26*, pp.193–235. Chichester: Wiley.

[29] Rechel, B., Buchan, J. & McKee, M. (2009). The impact of health facilities on healthcare workers' well-being and performance. *International Journal of Nursing Studies, 46*(7), 1025–1034.

[30] Ulrich, R. (2006). Evidence based healthcare design. In C. Wagenaar (Ed.), *The architecture of hospitals.* Rotterdam: NAi Publishers..

[31] Hurst, K. (2008). UK ward design: Patient dependency, nursing workload, staffing and quality – an observational study. *International Journal of Nursing Studies, 45*, 370–381.

[32] West, M., Baker, R., Dawson, J., Woods, M.D., Lilford, R., Martin, G., McKee, L., Murtagh, M. & Wilkie, P. (2013). *Quality and safety in the NHS: Evaluating progress, problems and promise.* Lancaster: Lancaster University Management School.

Leadership: Directing culture change and enabling staff well-being

Leading and managing high performing teams

Beverly Alimo-Metcalfe & Juliette Alban-Metcalfe

About the authors

Beverly Alimo-Metcalfe is Professor of Leadership at the University of Bradford School of Management, Emeritus Professor, University of Leeds and Founding Director of Real World Group.

Juliette Alban-Metcalfe is Chief Executive of Real World Group and Adjunct Associate Professor at the Centre for Sustainable Business and Enterprise, University of Southern Queensland.

Introduction

In addition to recruiting effectively, enhancing staff well-being and ensuring good work design, an understanding of what affects the social and psychological environment at team level will be critical in order for the NHS to successfully implement the Francis Report's[1] recommendations for fundamental culture change. In this context, 'teams' should be thought of as distinct units of professionals who work together with a specific remit, rather than team working that occurs between units of professionals in a joined-up manner.

The role of psychology in strengthening leadership and team working

Occupational psychology can play a critical role in providing evidence of the ways in which NHS leaders can create teams that are high performing, and the developmental steps they need to take to achieve this. Wider knowledge in the field, and recent research undertaken in the NHS relating to high-performing teams, has identified the critical importance of a range of team characteristics. Team characteristics are important not only in creating a culture of engagement and well-being – which are essential for sustaining high levels of performance – but also in strengthening a culture of innovation and a focus on quality and constant improvement, all of which are central to the Francis Report[1] and Berwick review[2] recommendations. Broadly, occupational psychology research shows us that the key characteristics required of high performing teams are:

- The team lead provides a clear sense of direction.[3-5]
- The team lead involves **all** key stakeholders (team members, patients, partners, colleagues) in developing the team's vision.[6, 7]
- All members of the team contribute to determining **how** to achieve the vision.[6, 7]
- Team members all have clear goals, roles, and a shared understanding of responsibilities.[3, 8]
- The team has clearly-defined processes and procedures.[3, 8]
- Team members have a high degree of autonomy and confidence in their ability to succeed, and are trusted to take decisions independently.[9, 10]
- A shared belief of 'team potency' exists, i.e. a sense of confidence in the team's ability, to deal with all challenges.[4, 11-13]

- Teams operate within a 'psychologically safe' environment enabling them to challenge, admit mistakes, and seek help without fear of ridicule.[14-17]
- Team members receive high levels of social support, including coaching.[18, 19]
- Team leads make the time to discuss problems and issues, despite having a busy schedule, and they celebrate individual and team achievements.[6, 7, 20]
- Team leads facilitate regular face-to-face communication within the team and regularly review progress on projects/goals.[21-22]
- Team leads regularly update the team and keep them informed of the wider context (for example, progress with change initiatives, decisions to be taken, etc.).[6, 20]
- Teams value different perspectives and minority views, rather than only 'established' perspectives.[13-23]
- Team culture encourages sharing of specialist knowledge, and how to apply it.[22, 24, 25]
- Team culture is open to change, enabling adaptation to external demands and cementing resilience to change-related pressures.[26, 27]
- Team culture actively encourages learning and promotes a 'no-blame' culture.[14, 15]
- Team culture encourages questioning of traditional ways of delivering services, generation of new ideas and approaches, and constructive debate
- Teams regularly seek feedback from patients and carers about how best to meet their needs and continually improve the quality of care.[6, 8, 20, 28]
- There are strong inter-team and inter-agency relationships, based on mutual respect, the sharing of information, and understanding of each other's roles.[29]
- Team leads promote strong inter-team and inter-agency collaboration and undertake joint strategic planning to improve the quality of services.[20, 30]

'Team working' vs. genuine team working

The evidence for the need to focus on effective teams at a 'unit' level comes in part from a large study by the Healthcare Commission in 2006, which found that whilst 92 per cent of NHS staff surveyed (based on all categories of NHS staff) said they work in teams, only 42 per cent reported working in well-structured ('genuine') teams; that is, those where team members report that they have:

- Clear team objectives;
- Interdependent working;
- Regular meetings to discuss effectiveness.[28, 31]

It follows, therefore, that many staff work in 'pseudo' teams, defined as poorly structured, and whose members report high levels of errors, accidents and poor staff well-being.[28]
If the NHS is to improve the quality of care it provides, the existence of 'pseudo' teams represents a significant challenge given that evidence shows a clearly positive relationship between team working and organisational performance in a range of healthcare and non-healthcare settings.[32]

Team members' well-being and provision of high quality care

A number of key studies show that team leadership which increases team members' engagement and well-being is crucial for understanding the factors that will create cultures

of high quality, compassionate care. As well as the Boorman Review,[33] which recognised that 'staff ill-health is … a serious barrier to the provision of consistently high quality patient care', a study by West and Dawson[34] has highlighted that levels of staff engagement in the NHS are significantly associated with not only patient satisfaction but also mortality rates. Numerous studies[35] have shown that the role of the team leader or line manager is vital to employee health, well-being and engagement and occupational psychologists have created frameworks that help managers understand what they need to prevent and reduce stress in their team and enhance and sustain employee engagement. Alimo-Metcalfe et al.[6, 7] have also found that those aspects of leadership culture which significantly predict levels of team engagement and well-being are also those that have been identified through longitudinal research as having a direct, causal influence on productivity.

Contemporary understandings of effective leadership

To further understand the context of these major studies highlighting the importance of team engagement, it must be noted that ideas of effective 'leadership' have changed in recent years. In particular, psychologists working in the academic field of leadership studies now look on notions of good 'leadership' as having shifted from a focus on the characteristics of 'leaders', to approaching leadership as a *collective or shared activity*, irrespective of one's role; a social process which emerges through collaborative relationships.[20, 36, 37] This new concept of 'collective leadership' presents challenges to an organisation such as the NHS, in which there exists a strong tradition of hierarchy, particularly within the clinical professions. Nonetheless, organisations such as the British Medical Association[38] have endorsed the recommendations for culture change detailed in the Francis Report and have signalled a shift in attitudes towards how the leadership role of doctors should be enacted; advocating a culture of empowerment and support rather than of blame, and is seeking ideas and experiences from its members in how to enable an open and honest culture.

Similarly, psychological notions of effective leadership in relation to teams have changed in recent years. Whereas traditionally team leadership has been seen as something a leader inputs to their team, the contemporary understanding is that leadership should be regarded as an outcome of team members working together collaboratively. Gary Yukl, a well-known US academic, encapsulates collective leadership as:

> *'a shared process of enhancing the collective and individual capacity of people to accomplish their work roles effectively … the leadership actions of any individual leader are much less important than the collective leadership provided by members of the organisation' (p.293).*[39]

Recent research by the co-author of this chapter, Alimo-Metcalfe et. al.[20] which consisted of a three-year investigation into effective team working across the NHS in Yorkshire and the Humber, uncovered similar findings on the components of effective team leadership, leading to a number of essential, practical implications for leadership and team development in the NHS. In particular, we found that exemplary team leadership operates through influencing the activity of teams so as to ensure three positive outcomes that can be regarded as critical foundations for high quality performance – innovation, focus on quality, and continuous improvement. The following case studies, based on this three year research investigation, provide examples of how teams and team leaders can be effectively developed:

Case study A: Leading to quality – South West Yorkshire Partnership NHS Foundation Trust

Background

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) led on a regionally funded project commissioned by Yorkshire and the Humber Strategic Health Authority, which ran from 2010 to 2013. The project, entitled *Leading to Quality*, was directed by Beverly Alimo-Metcalfe on behalf of the University of Bradford and undertaken by researchers from Real World Group and SWYPFT. This initial phase has now been extended by the Trust to conduct action research applying the findings to 10 Mental Health Teams (MHTs) of different types (both community and inpatient). The Leading Quality project at SWYPFT provides an example of the development of new, more effective ways of team working in Mental Health Teams (MHTs), as well as providing insight into the research informing the project.

Intervention

Rather than adopting assumed measures of quality, safety and effective care, the research began by exploring what service users and their carers believed to be the most important aspects of these crucial outcomes. The project aimed to create developmental workbooks for self-directed learning, providing background information and practical exercises for the team leaders and the teams themselves:

'Train-the-trainer' workshops

- Run over three non-consecutive days and facilitated by occupational psychologists.
- Train the trainer workshops sought to explain the research behind the proposed model of team working and leadership; describing the benefits of and appropriate application of 360-degree feedback; and discussing and agreeing on the best way of conducting the action research (based on the specific context and appropriate selection criteria of pilot teams).
- The final day of the workshop provided an opportunity for the coaches to understand and practice providing 360-degree feedback, at team and individual level and in an ethical way with maximum benefit for all participants.

Team 360-degree feedback sessions

- Teams themselves selected their reviewers, who provide them with quantitative and qualitative feedback on the proven dimensions of team leadership and team working.
- The feedback assesses team members' levels of well-being and positive attitudes to work, as well as the process outcomes of innovation, focus on quality, improvement and performance.
- Real World Group's 360-degree feedback tool was applied, based on the validated dimensions of team leadership (five dimensions) and team working (nine dimensions).
- A total of five reviewer categories were provided for the team to populate with individuals of their choice (as well as a 'self' category, where each team member can provide their own review). The reviewer categories are Service Manager or equivalent (the person to whom the Team Leader reports), Internal Clinical Teams, Internal Others and External Groups.

Facilitated feedback and action planning for each of the team leaders and teams, based on the 360-degree findings

- Feedback on the findings was provided by coaches, first to the team leader and then to the team members themselves.
- Team leaders viewed feedback on their own leadership, as well as the feedback provided to the team members. They were encouraged to share a summary (if not all) of their own feedback report with the team and explore this feedback. Team leaders then selected appropriate workbooks to utilise for ongoing development activities addressing key development needs at the team level.

Comment from SWYPFT:

'The Trust hosted the original LTQ research, which was sponsored by the Chief Executives of the six Mental Health/Community Trusts within the Yorkshire and the Humber region, to gain a greater understanding of the nature of the leadership challenge as part of the transformation agenda facing the NHS. The research examined both team leadership and team-working and provided a new evidence model of the relationship between these and team outcomes. The follow-on project provides a valuable opportunity for the Trust to enhance the quality of service provision and support employee well-being and engagement'.

Alan Davis, *Director of Human Resources and Workforce Development*

Case study B: Fit for the future – Rotherham Doncaster and South Humber NHS Foundation Trust

Background

Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) embarked upon a major development and culture enhancement programme in order to ensure that their leaders are fit for the future, and wanted to use the findings from the *Leading to Quality* research undertaken in South West Yorkshire Partnership NHS Foundation Trust as the basis of its design.

The 'Fit for the Future' project was launched in September 2013 and was formally concluded in terms of external support in July 2014. The programme was commissioned to provide space for leaders to reflect upon their leadership skills and behaviours, and the extent to which they are appropriate and effective in the new context of the NHS. The Trust sought to enhance key aspects of the leadership culture within its organisation, including the ability to achieve more with fewer resources, accommodate to shifting population demands, increase its partnership working and inter-agency connectedness and enhance continual learning, innovate and improve, and a keener sense of commercial awareness

Intervention

Participants on the programme were all leaders with line management responsibility from Agenda for Change Band 7 and above, up to and including board level.

- The RDaSH Chief Executive, Chris Bain, and her board participated in a development workshop to explore the leadership needs of the Trust going forward, and their role in creating the right culture.
- The board workshop and the rest of the programme were designed to provide research evidence and practical business case reasons for adapting leadership styles from what might have been previously useful; guidance on how leadership needs to be in future; and reflective exercises and discussion. Participants were also provided with practical exercises, tools and techniques that can be used with their own teams after the workshops.
- Participants undertook a series of one and two-day modules, on subjects including 'Building a Shared Vision of Quality Services', 'Engaging Your Team in Change' and 'Inspiring Your Team and Promoting Your Service'.

Outcomes

Indications from the annual NHS Staff Survey already show that the organisation has significantly improved its ratings on a wide variety of measures. In addition, many participants have commented that they have applied and have noticed changes in leadership style, as well as witnessing its impact among colleagues.

Comment from RDaSH:

> *'…We found the programme stimulating, empowering and often very challenging and I am grateful to all colleagues who have engaged with me on this journey – the benefits from the experience will hopefully enhance the offer we make to our service users and their families, and enable us to improve further the experience of our workforce'.*

Christine Bain, *Chief Executive*

References

[1] Francis, R. (2013, February 6). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary*. Available at: www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

[2] Berwick, D. (2013). *A promise to learn, a commitment to act: the Berwick Review into Patient Safety*. National Advisory Group on the Safety of Patients in England. London: Department of Health. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

[3] Hackman, J.R. (2002). Leading teams: Setting the stage for great performances. Boston, MA: Harvard Business School Press.

[4] Schaubroeck, J., Lam, S.S. & Cha, S.E. (2007). Embracing transformational leadership: Team values and the impact of leader behavior on team performance. *Journal of Applied Psychology, 92*(4), 1020–1030.

[5] West, M., Baker, R., Dawson, J., Woods, M.D., Lilford, R., Martin, G., McKee, L., Murtagh, M. & Wilkie, P. (2013). *Quality and safety in the NHS: Evaluating progress, problems and promise*. Lancaster: Lancaster University Management School.

[6] Alimo-Metcalfe, B., Alban-Metcalfe, J., Samele, C. Bradley, M. & Mariathasan, J. (2007). *The impact of leadership factors in implementing change in complex health and social care environments: NHS Plan clinical priority for mental health crisis resolution teams (CRTs)*. London: Department of Health NHS SDO.

[7] Alimo-Metcalfe, B., Alban-Metcalfe, J., Bradley, M., Mariathasan, J. & Samele, C. (2008). The impact of engaging leadership on performance, attitudes to work and well-being at work: a longitudinal study. *Journal of Health Organization & Management, 22*(6), 586–598.

[8] West, M.A. & Markiewicz, L. (2004). *Building team-based working: a practical guide to organizational transformation*. Malden: Blackwell Publishing.

[9] Hyatt, D.E. & Ruddy, T.M. (1997). An examination of the relationship between work group characteristics and performance: Once more into the breech. *Personnel Psychology, 50*, 553–585.

[10] Kirkman, B.L. & Rosen, B. (1999). Beyond self-management: Antecedents and consequences of team empowerment. *Academy of Management Journal, 42*, 58–74.

[11] Gully, S.M., Incalcaterra, K.A., Joshi, A. & Beaubien, J.M. (2002). A meta-analysis of team-efficacy, potency, and performance: Interdependence and level of analysis as moderators of observed relationships. *Journal of Applied Psychology, 87*(5), 819–832.

[12] Tesluk, P.E. & Mathieu, J.E. (1999). Overcoming roadblocks to effectiveness: Incorporating management of performance barriers into models of work group effectiveness. *Journal of Applied Psychology, 84*, 200–217.

[13] Van der Vegt, G.S. & Bunderson, J.S. (2005). Learning and performance in multidisciplinary teams: the importance of collective team identification. *Academy of Management Journal, 48*(3), 532–547.

[14] Edmondson, A.C. (1996). Learning from mistakes is easier said than done: Group and organizational influences on the detection and correction of human error. *Journal of Applied Behavioral Science, 32,* 5–32.

[15] Edmondson, A.C., Bohmer, R. & Pisano, G. (2001, 21 October). Speeding up team learning. *Harvard Business Review,* 125–132.

[16] Nembhard, I. & Edmondson, A.C. (2006). Making it safe: The effects of leader inclusiveness and professional status on psychological safety and improvement efforts in health care teams. *Journal of Organizational Behaviour, 27,* 941–966.

[17] Wageman, R. (1995). Interdependence and group effectiveness. *Administrative Science Quarterly, 40*, 145–180.

[18] Burke, C.S., Stagl, K.C., Klein, C., Goodwin, G.F., Salas, E. & Halpin, S.M. (2006). What type of leadership behaviors are functional in teams? A meta-analysis. *The Leadership Quarterly, 17*, 288–307.

[19] King's Fund (2014). *Culture and leadership in the NHS: The King's Fund 2014 survey 2014.* Available from www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/survey-culture-leadership-nhs-may2014.pdf

[20] Alimo-Metcalfe, B., Bradley, M., Alban-Metcalfe, J. & Locker, A. (2013). *Leading to quality: An investigation of the impact of leadership & team working on staff morale and wellbeing, & team performance, among mental health teams within Yorkshire & the Humber Strategic Health Authority.* Bradford: University of Bradford School of Management.

[21] Bantel, K.A. & Jackson, S.E. (1989). Top management and innovations in banking: Does the composition of the top team make a difference? *Strategic Management Journal, 10*(S1), 107–124.

[22] Bunderson, J.S. & Sutcliffe, K.M. (2002). Comparing alternative conceptualizations of functional diversity in management teams: Process and performance effects. *Academy of Management Journal, 45*, 875–894.

[23] Gilson, L.L. & Shalley, C.E. (2004). A little creativity goes a long way: An examination of teams' engagement in creative processes. *Journal of Management, 30*, 453-470.

[24] Srivastava, A., Bartol, K.M. & Locke, E.A. (2006). Empowering leadership in management teams: Effects on knowledge sharing, efficacy, and performance. *Academy of Management Journal, 49*(6), 1239–1251.

[25] Tsui, A.S., Egan, T. & O'Reilly, C.A. (1992). Being different: Relational demography and organizational attachment. *Administrative Science Quarterly, 37*, 549–579.

[26] Cunningham, C.E., Woodward, C.A., Shannon, H.S. & MacIntosh, J. (2002). Readiness for organizational change: A longitudinal study of workplace, psychological and work place correlates. *Journal of Occupational and Organizational Psychology, 75*, 377–392.

[27] Jones, R.A., Jimmieson, N.L. & Griffiths, A. (2005). The impact of organizational culture and reshaping capabilities on change implementation success: The mediating role of readiness for change. *Journal of Management Studies, 42*(2), 361–386.

[28] West, M., Alimo-Metcalfe, B., Dawson, J., El Ansari, W., Glasby, J., Hardy, G., et al. (2012). *Effectiveness of multi-professional team working (MPTW) in mental health care: Final report.* NIHR

Service Delivery and Organisation Programme.

[29] Serva, M.A, Fuller, M.A. & Mayer, R.C. (2005). The reciprocal nature of trust: a longitudinal study of interacting teams. *Journal of Organizational Behavior, 26*(6), 625–648.

[30] Hartley, J. & Allison, M. (2000). The modernization and improvement of government and public services: The role of leadership in the modernization and improvement of public services. *Public Money & Management, 20*(2), 35–40.

[31] Dawson, J.F. (2007). *Diverse meanings and measurements of diversity: An extension of Harrison and Klein's (2007) typology.* Paper presented at the Academy of Management, Philadelphia, USA.

[32] Richter, A.W., West, M.A., van Dick, R. & Dawson, J.F. (2006). Boundary spanners' identification, intergroup contact and effective intergroup relations. *Academy of Management Journal, 49,* 1252–1269.

[33] Boorman, S. (2009). *NHS Health & wellbeing.* London: Department of Health.

[34] West, M. & Dawson, J. (2012). E*mployee engagement and NHS performance.* Available from www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf

[35] Donaldson-Feilder, E., Munir, F. & Lewis, R. (2013). Leadership and employee well-being. In S.H. Leonard, R. Lewis, A.M. Freedman & J. Passmore (Eds.), *The Wiley-Blackwell handbook of leadership, change and organizational development,* pp.155–173. Chichester: John Wiley & Sons.

[36] Gronn, P. (2004). Distribution of leadership. In G.R. Goethals, G.J. Sorenson & J.M. Burns (Eds.), *Encyclopedia of leadership*, vol 1, pp.351-355. Thousand Oaks, CA: Sage.

[37] Pearce, C.L. & Conger, J.A. (2003). *Shared leadership: Reframing the hows and whys of leadership.* Thousand Oaks, CA: Sage.

[38] British Medical Association (2014). *Promoting a positive culture in the NHS.* Retrieved 9 May 2014 from http://bma.org.uk/working-for-change/doctors-in-the-nhs/nhs-culture/culture-in-the-nhs

[39] Yukl, G. (1999). An evaluation of conceptual weakness in transformational and charismatic leadership theories. *Leadership Quarterly, 10*, 285–307.

Fostering a continuous learning culture in the NHS: The role of leadership

Michal Tombs-Katz

About the author

Michal Tombs-Katz is Senior Lecturer in Psychology at the University of South Wales.

Introduction

The Berwick review[1] highlights that *'The most important single change in the NHS would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end'* (p.5). The key theme that emerges from the recommendations made in Berwick's report is that leaders in the NHS are responsible for embracing and implementing a culture of continuous learning, at scale. This, it claims, will be a vehicle for continuous improvement in quality and safety. This chapter looks at the challenges the NHS is facing in terms of continuous learning, and offers some solutions from the field of occupational psychology for the NHS to use in the improvement of its current practices. The chapter is organised into three themes. These themes include thinking about continuous learning and the challenges the NHS is facing, considering the impact of leadership and the organisational context on continuous learning, and facilitating a culture of continuous learning in the NHS to improve quality and patient safety.

Thinking about continuous learning and the challenges facing the NHS

The NHS in England has long recognised the importance of becoming a learning organisation.[2] Indeed, the work of Health Education England reflects well written strategic policies of continuous learning and improvement for the benefits of patient care. In 1998, the government's quality strategy presented a blueprint for a new NHS, the aim of which was 'to create a culture in the NHS which celebrates and encourages success and innovation...a culture which recognises...scope for acknowledging and learning from past mistakes'.[3] In response to this document, Davies and Nutley[2] wrote a paper highlighting that building a learning organisation requires attention to some key cultural values including celebration of success, absence of complacency, tolerance of mistakes, belief in human potential, recognition of tacit knowledge, openness, trust, and being outward looking. However, the Francis[4] and Berwick[1] reports bring to light some major gaps in the implementation of these recommendations. A culture where 'bad news become unwelcome and over time, silenced', where 'loud and urgent signals of poor quality and deterioration of care are muffled and explained away' (p.8), is a culture that fails to embrace its strategy for continuous learning. A continuous learning culture is one where employees change their behaviour upon deepening and broadening of their skills, knowledge, and worldviews.[5] For this to occur the main challenge for leadership in the NHS is to address the barriers that inhibit motivation and volition and prevent workers from fully engaging in the learning process, particularly informal learning.

Considering the impact of leadership and the organisational context on continuous learning

The following three case studies, taken from different sectors of work, illustrate how the successful implementation of a learning culture extends beyond policies and strategies and rests on leadership, resources, and relationships that support the informal learning process. Each case study provides an explanation of the context, and concludes with some key practical implications for the NHS.

Case study A: Organisational factors that impact the informal learning process[6]

It is often claimed that informal learning is more important than formal learning and that it comprises the majority of learning that occurs in the workplace.[7] In contrast to formal learning, informal learning may be intentional or incidental, it is not highly structured, and is a volitional behaviour.[5] Because of this, informal learning is complex and this case study illustrates factors associated with leadership and the work environment that act as barriers or enablers of learning:

- The philosophy of this organisation, a large manufacturing company in the US, encompasses a strong commitment to employee development. As with other companies experiencing the turbulence of the global marketplace, at the time of data collection the organisation was in the midst of implementing several changes.
- Ellinger[6] was interested in finding out examples of 'critical incidents' that relate to positive and negative contextual factors for informal learning in this manufacturing company. She conducted in-depth interviews with employees and asked questions such as 'what makes this an optimal environment for your informal learning?' and 'what prevents this from being an optimal environment for your informal learning'?

Positive critical incidents

- The positive critical incidents provided by employees indicated that informal learning is more likely to occur in the presence of learning-committed leadership and management (i.e. when managers act as coaches or mentors and provide space for learning), when the internal culture is committed to learning (i.e. being seen to invest in good quality training and encouraging sharing of knowledge), when work tools and resources are available to support learning and development, and when people are encouraged and supported in the formation of webs of relationships for learning.

Negative critical incidents

- Not surprisingly, the negative critical incidents reported by employees typically referred to examples where the opposite was the case, that is, when leadership and management are unsupportive and disrespectful and do not value learning, and where they tend to micromanage and tell staff what to do. Negative accounts also highlighted an internal culture of entitlement, where the work tools and resources do not support learning and development (e.g. budget constraints), and where people disrupt webs of relationships for learning.
- In addition to these, negative critical incidents also included examples where the workplace design inhibits learning (i.e. working in silos), where there is lack of time

because of job pressures and responsibilities, when there is too much change too fast, with no learning from other people's learning.

Key implications for practice:

- The findings from this study emphasise the importance of learning-committed leadership and management in the process of informal learning and toward building a learning culture.
- The NHS can educate leaders about the conditions that trigger informal learning as well as the process of informal learning.
- Managers and leaders should be assisted with developing coaching and mentoring skills that may enable them play a more pivotal role in the process of informal learning. In particular, leaders must be equipped with the skills to become adept at providing feedback and helping employees assess, evaluate, and reflect on the outcomes of their informal learning activities are critical competencies.
- Developmental attention should be given to employees who may need to further build teaming and collaborative skills, so that collective learning can be shared in organisations.
- Providing a physical infrastructure and resources that stimulate informal learning are also important considerations. For example, creating workplace designs and open spaces and facilitating opportunities for employees to meet, work, and socialize is fundamental to building networks and communities of practice that foster conditions for informal learning.

Case study B: The role of group and organisational perspectives for continuous learning[8]

Learning and the re-construction of ideas occur through observation, imitation, sharing, and reinforcement (i.e. social learning theory[9]). This is key to the informal learning process, as it recognises learning as being located within social relationships, such as networks or communities of practice. For organisations to learn and develop, they require the knowledge creation that occurs at a local level to travel beyond the boundaries of teams and communities. However, the extent to which this happens hinges on empowerment and effective communication. Teams and communities also need appropriate tools that they can use to communicate and share knowledge within and between teams and communities.

With the advancement of technology, more and more organisations are turning to electronic-based methods to support learning and development within teams. However, the effectiveness of such electronic methods hinges on certain conditions being recognised and met, including motivation and the availability of sufficient support and guidance. This case study illustrates how motivation and the usability of an electronic workbook can be leveraged through careful design and consultation with those who ultimately are expected to use it:

Situation

- The organisation in Mulholland et al.'s study, a large engineering company in the UK, was using a paper-based workbook, the aim of which was to support reflection on work practices in order to foster team development.
- The workbook was based on five company values and included a number of tools, activities, and metrics to guide the team planning process. The organisation believed that the workbook was in wide use and went on to develop and implement an electronic version.
- Mulholland et al. found that although the strategic development and dissemination of the tool had succeeded in increasing awareness of the initiative, it was not incorporated into everyday practice. This led to a series of interviews with 12 teams in the organisation that resulted in the development of a scaled-down version of the e-workbook, incorporating only the aspects that were in widespread use and removing unwanted parts.
- This scaled-down version was trialled, and despite the changes and improvements, the planning tool was not sustained by the teams. The main problem identified was that the scaled-down version failed to provide content that was specific to some teams.

Intervention

- Following the failure of the scaled-down workbook, a bottom-up approach was adopted that addressed the teams' needs instead of trying to provide a management-led solution.
- A customised planning tool was developed for each team, with the close cooperation of one individual from each team who was interested in the project.
- Suggestions made by the teams were taken on board, as a result of which the tool ended up looking very different from the generic look and feel of the earlier workbook.
- The new, customised planning tool was keenly utilised, and yet interestingly the plans constructed by the teams were remarkably similar. Thus, the modifications did not produce different content but were necessary for the motivation and acceptance required to facilitate continual learning.

Key implications for practice:

- High level strategies for continual learning initiatives and the use of learning tools such as e-workbooks can serve to set the wheels for learning in motion, but do not guarantee acceptance or constructive use.
- Local autonomy and customisation at team or community of practice level are crucial to facilitate effective and continual learning. The team or community should be empowered to express its own way of doing things and to influence practice in the design of learning workbooks.
- Strategic initiatives need to be interfaced with local autonomy in order to sustain low- and high-level support. The strategic initiative has to be connected with work practices on the ground. Thus, when senior hospital management are developing a new learning initiative, they should develop the overall methodology, concepts and terminology but should provide support for teams and communities to interpret and customise these, so as to ensure they are accurately aligned with the practicalities of individual jobs.

Case study C: How leaders stimulate employee learning[10]

Understanding the leadership behaviours and mechanisms that are conducive to creating the right conditions for learning to occur is key to the question of 'how to' stimulate a continuous learning culture. Leader–member exchange theory (LMX) is widely used by occupational psychologists, as it provides a description of the psychological processes that leaders can utilise to encourage and motivate employees' engagement in learning activities, both formal and informal:

Based on social exchange and reciprocity principles, LMX theory explores how leaders and managers develop relationships with team members and explains how those relationships can either contribute to growth or hold people back. A high quality relationship is characterised by the member having high levels of responsibility, decision influence, and access to resources. In contrast, low quality LMX relationships are characterised by leaders that offer low levels of support to the member, with members having low levels of responsibility and decision influence. According to this theory, the quality of the leader-member exchange relationship is theorised to be related to work and attitudinal outcomes, including engagement in learning. On the basis of this theory, Bezuijen et al.[10] proposed that high quality relationships create a feeling of obligation in members to reciprocate and employees in the high quality relationship group are likely to be more motivated to learn (i.e. set themselves learning goals) and engage more frequently in learning activities (formal and informal).

- Case study C is based on Bezuijen et al.'s study of seven organisations in the Netherlands, including health care, the police and social services.
- Bezuijen's questionnaire findings provide evidence that leaders tend to set more difficult and more specific learning goals for high-LMX members than they do for low-LMX members. By setting such goals and providing more feedback to high-LMX members, leaders encourage high LMX employees to develop themselves and live up to their leader's expectations.
- Bejuijen et al. found that high-LMX employees engaged in learning activities more frequently to show their loyalty and earn their leader's trust.
- Compared to employees in low-LMX relationships, employees in high-LMX relationships appeared more eager to succeed with difficult learning goals by engaging in learning activities.

Key implications for practice

- This study reveals that leaders are inclined to treat employees differently, and that they are more active and more effective in motivating and encouraging participation in learning when they have trusting, respectful, and reciprocal exchange relationships with their members. All members of staff with line management responsibilities in the NHS should be made aware of this tendency, and try to stimulate all employees equally to engage in learning, regardless of the exchange relationship.
- Bezuijen et al.[10] recommend that leaders should try to develop social bonds with more employees and learn about the development needs and expectations of low-LMX employees as well. Simply putting more effort into the relationship by having regular contact with employees and showing an interest has also been shown to be effective for improving the quality of LMX relationships.

Conclusion: Facilitating a culture of continuous learning in the NHS

A continuous learning culture requires the establishment of important sets of behaviours and processes by leadership and management. What do leaders do when something fails, for example? How do they treat the people who deliver bad news? How well are decisions delegated to owners of the problem? These are critical questions which deal with a learning culture.[11] For a continuous learning culture to be developed, **leaders at all levels within the NHS** (clinical and non-clinical) need to take accountability of the issue at hand and accept that a continuous learning culture is not only a function of a top-down strategy and formal training. The NHS should focus on changing the work environment to one that that is based on fairness, empowerment and open communication, all of which are the bedrocks for a culture that motivates continuous learning.

Leaders and managers should be aware of and learn how to change their behaviour in order to influence the psychological processes that drive motivation and inspire employees to fully engage with the informal learning process. They should ask themselves:

- Are we able to demonstrate learning values to the people we manage?
- Do we provide feedback and help our workforce to assess, evaluate, and reflect on the outcomes of their informal learning activities?
- What do we do to build trust amongst the teams we manage/lead? Do we, and if so how, empower the people we manage and listen to them? Do we let them know that they are listened to?
- Do we treat the people we manage equally and fairly? Do we provide all team members with opportunities to learn? Do we show all members of our team that we are interested in their development?

References

[1] Berwick, D. (2013). *A promise to learn, a commitment to act: the Berwick Review into Patient Safety*. National Advisory Group on the Safety of Patients in England. London: Department of HealthAvailable at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

[2] Davies, H.T.O. & Nutley, S.M. (2000). Developing learning organisations in the new NHS. *British Medical Journal, 320*(7240), 998–1001.

[3] Department of Health (1998). *A first class service: quality in the new NHS*. London: Department of Health.

[4] Francis, R. (2013, 6 February). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive summary*. Available at: www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

[5] Noe, R., Clarke, A.D.M. & Klein, H. (2014). Learning in the twenty-first -century workplace. *Annual Review of Organizational Psychology and Organizational Behavior, 1*, 1–31.

[6] Ellinger, A.D. (2005). Contextual factors influencing informal learning in a workplace setting: The case of 'reinventing itself company'. *Human Resource Development Quarterly, 16*(3), 389–415.

[7] Sessa, V. & London, M. (2006). *Continuous learning in organizations*. Mahwah, NJ: Lawrence Erlbaum.

[8] Mullholland, P., Zdrahal, Z. & Domingue, J. (2005). Supporting continuous learning in a large organization: The role of group and organizational perspectives. *Applied Ergonomics, 36*, 127–134.

[9] Bandura, A. (1962). Social learning through imitation. In M.R. Jones (Ed.), *Nebraska Symposium on Motivation*. Lincoln, NE: University of Nebraska Press.

[10] Bezuijen, X.M., van Dam K., van den Berg, P. & Thierry, H. (2010). How leaders stimulate employee learning: A leader-member exchange approach. *Journal of Occupational and Organizational Psychology, 83*, 673–693.

[11] Mallon, D. (2010). *High-impact learning culture: The 40 best practices for creating an empowered enterprise*. Oakland, CA: Bersin & Associates.

Trust boards and governance: Composition and behavioural styles

Rosalind Searle, Alison Legood & Kevin Teoh

About the authors

Rosalind Searle is Professor of Organisational Behaviour and Psychology at Coventry University.

Alison Legood is a Lecturer in Work Psychology within the Work and Organisational Psychology Group, Aston University Business School.

Kevin Teoh is a Research Assistant and PhD candidate in Organisational Psychology at Birkbeck, University of London

Introduction

A Chinese proverb contends that 'fish rot from the head', implying that those at the top of organisations have a disproportionately high impact on it. In the wake of a series of hospital scandals, issues of governance and the capability and actions (or failure to act) of those at the top of the NHS have highlighted the role those in board level positions play in the functioning of hospitals.[1, 2] As stressed in both the Berwick review and Francis Report, the quality of leadership and governance at the top of NHS Trusts has been shown to be essential to patient safety and Trusts' performance, as well as to the conduct of those within these organisations. The topic of governance commands prominence and policy importance as a result of the high levels of change underway within the health sector, including the devolution of decision-making and the inclusion of new health care providers and commissioners.[3] Boards are faced with the challenge of balancing the demands of multiple internal and external stakeholders. Improving governance and accountability are critical matters that those at the top have to address, while at the same time developing a coherent strategy in order to deliver high organisational performance6. In this chapter, the governance and the executive within the NHS is considered in relation to psychological theory and research concerning corporate governance and boards. Recommendations are made in three areas which are crucial to enhancing the effectiveness of NHS Trust boards. These include: effectively balancing compliance and performance functions; board composition and underrepresentation; and achieving transformation via changes in behavioural styles.

Improving board effectiveness: The role of occupational psychology

Psychology plays an under-appreciated role in the development of practices within corporate governance, which are more commonly the domain of accountancy, law, and economics. In the following discussion, we seek to show how occupational psychology underpins and offers key insights into how boards' effectiveness can be improved, which have hitherto been insufficiently acknowledged.

The role of boards: Balancing compliance and performance

All management boards, especially those in the healthcare sector, have two important roles to fulfil:[4] conformance and performance. Each of these has both an internal and external focus (See Table 1). *Conformance* emphasises the achievement of short-term goals, externally through compliance with regulations and stakeholders ('accountability), and internally through the oversight and monitoring of standards ('supervision'). The Department of Health requires boards to ensure the achievement of excellent standards of care quality and patient experience. The second role focuses on *performance*, and involves a longer term perspective to identify and deliver the goals of the organisation. Externally, this involves the development of core values and long term plans ('policy formulation'); and internally the implementation and review of these plans ('strategic thinking').

Table 1: Board functions[4]

Conformance/Short term	Performance/Long term
Internal	
Supervision Appointing, overseeing and rewarding senior management	*Strategic thinking* Agreeing strategic direction
Monitoring finances and key performance indicators	Reviewing and deciding long-term plans, including resource allocation and investments
Managing risks	
External	
Accountability Ensuring external accountabilities to regulators and stakeholders are met	*Policy formulation* Determining the organisation's mission and values
Ensuring compliance responsibilities (e.g. audits, inspections and reporting)	Deciding long-term goals
	Developing appropriate policies and systems

During periods of ambiguity and change, however, clarity, guidance and support from the top is vital to retain staff focus on patient-centred care, and so avoid governance issues being reduced to mere box ticking.[1, 3] Similarly, myopic attention on performance can be achieved at the expense of clinical care, quality and compliance,[1] with this lack of oversight this creates evident in the high profile examples highlighted in the Keogh review.[5] Despite the need for balance, a survey of 15 primary care Boards in England and Wales showed a tendency towards over attending on financial and administrative related issues.[7] This is not surprising given that Monitor[8] recently reported that 26 per cent of NHS Trusts were predicted to be in financial deficit for 2013–14. The challenge for boards, however, is in striking an appropriate balance between conformance and performance, with those attentive in both strategy and governance more effective.[3, 9-12] Possible steps that can be taken to ensure this include:[6, 13, 14]

- Ensuring as part of selection that all board members understand their role and this need for balance.
- Provision of thorough induction, ongoing training and development, and annual performance management which reinforces this attention on both aspects of the role.

- Boards should identify the impact of how they work on their own and their staff's degree of engagement, morale and well-being. This can be done via anonymous 360 ratings (e.g. *B360*) or self-assessed evaluations (e.g. *Board Self-Assessment Questionnaire*).
- Ensure the board is aware of key compliance issues, including responsibilities, deadlines, and stakeholders involvement.
- Attention to devolve appropriately aspects of conformance functions to lower levels of management to enable a greater focus on performance.
- When decision making and responsibility is delegated to those at lower levels of the organisation, ensuring adequate oversight is retained to enable the board to detect and attend to problems.
- Recognise the limitations and subsequent implications of the range of data and processes within healthcare, (e.g. mortality rates, self-assessed board evaluations).
- Assess on an regular basis (e.g. annually) the purpose, values, vision and corporate culture of the organisation and ensure it remains appropriate in a changing environment.
- Encourage intelligent naivety, whereby staff are encouraged to query and clarify, helping to challenge routines and frame issues differently.
- Develop diversity at all levels, especially the board, as a means of facilitating different thinking styles, backgrounds and experience in approaching issues and identifying new solutions (see below).
- Evaluate the types of information presented to the board, in terms of its relevance and quantity, in order to reduce information overload and poor decision-making.

Board composition and diversity

There has been growing research examining the impact of board composition and diversity on organisational performance,[15, 16] including on the executive within a healthcare setting.[2] For example, in one review of 19 English NHS Trusts' board effectiveness, Chambers et al.[17] identified a number of key features present within 'high performing trusts'. Specifically, these included more female board members and more active non-executive directors, which were associated with better staff and patient experience and higher financial and clinical performance. The lack of diversity within hospital boards through appointment of members from a similar background is an issue which needs to be improved as part of NHS culture change.

The rationale behind diversifying boards lies in overcoming 'groupthink'. Groupthink is a social psychology phenomenon characterised by the domination of distinct ways of thinking, typical in cohesive groups. Groups characterised by groupthink often fail to adopt more critical and less entrenched decision-making. Accordingly, boards comprised of figures with a diverse range of backgrounds and experiences are likely to have a broader set of knowledge and perspectives, which can be drawn upon to enable a breadth of perspectives to be considered, thus suppressing the emergence of groupthink. It is worth noting that while the underlying logic for diversifying boards is applicable to all under-represented groups,[2] the majority of our understanding in this area is constrained to the underrepresentation of clinicians and women at board level, as well as the engagement of non-executive directors.

Clinician representation

Clinicians are still in a minority on UK health boards,[21] yet they can provide medical expertise and credibility, help direct scarce resources and promote more effective communication between management and clinical staff.[22, 23] It is therefore not surprising that those with greater inclusion of clinicians have been linked to enhanced financial performance,[24, 25] clinical effectiveness[26, 27] and greater patient satisfaction,[21] as well as reduced levels of mortality.[21, 27] The Francis Report[1] stressed the detrimental impact where a profession has neither a voice at the board level, nor is able to make their concerns heard by the leadership. Significantly, where there are low levels of clinician participation, a more general disengagement occurs amongst junior medics, with concerns even involving standards of patient care left unpursued. Interestingly, the same benefits were not found for directors from other clinical domains, such as nursing or other allied health professions.[21]

Female representation

In contrast to clinicians, the underrepresentation of women at board level is not unique to the healthcare sector, and remains an issue in both the public and private sectors. Psychological studies have coined terms including the 'glass ceiling'[i] 'glass cliff'[ii] and 'labyrinth' to describe the lack of women in senior leadership positions.[28] Within the health context, female directors have been found to enhance hospitals' clinical and financial performance.[2, 29] In other sectors, women executives are typically more conscientious in their preparations, more devoted to issues of monitoring and governance, more benevolent than their male counterparts, and ask more challenging questions.[30, 31, 32] The attraction of women candidates to board roles, however, can be problematic as their life and career trajectories can differ from their male counterparts such that neither potential candidates nor headhunters may recognise the transferability and value of their skills.[33]

Non-executive director representation

A final important group that can further enhance the effectiveness of boards are non-executive directors, who should make up half of NHS boards. These are leaders drawn from other the public, private and third sector backgrounds.[2, 34] Evidence highlights the value that diversity in experience, expertise and background non-executives bring.[2, 35] Specifically, non-executives are pivotal in raising the attention of the board and providing knowledge about governance; they can refocus CEOs' attention onto compliance, and boards with a governance focus are shown to perform better.[3] However, the challenge can lie in non-executive directors engaging and understanding how health organisations operate.[36] For example, the Francis Report[1] singled out the detrimental impact to Mid-Staffordshire NHS Trust of non-executives who remained aloof from operational concerns, even where they constituted a potential risk to patient safety. Thus, all of this further underlines the importance this group has in developing more effective healthcare boards.

Interventions to encourage board diversity

There is a growing emphasis on the importance of ensuring these key groups are represented and engaged at board level, bringing both the appropriate skills and a

i The glass ceiling refers to women's lack of advancement into leadership positions despite no visible barrier

ii The glass cliff explains that woman are typically appointed to precarious senior leadership positions where failure is often inevitable. The Labyrinth describes the career progress faced by women. See DOP Women at the top for more information

demonstrable commitment to NHS values. Where the NHS is regarded as a problem and failing sector, through its portrayal in the media and in government performance tables, there can be a decline in the calibre and size of the recruitment pool (see [56] for comparable push and pull factors within recruitment and retention at all levels within child protection social worker). Measures that can be taken to do so include:[19, 32, 34, 36-38]

- developing a clear strategy and action plan to enhance the diversity of the Trust's board, and making this information available to the public;
- utilising an open and transparent selection process where equality and diversity are important themes throughout the recruitment process;
- advertising and holding awareness raising sessions for non-executive positions in order to reduce the reliance on recruitment through personal contacts and friendship networks, which erode diversity of perspectives;
- emphasising key competencies and skills of candidates, instead of previous health experience;
- establishing a standard requirement to include clinical representation on each board;
- effectively managing the time commitments and responsibilities of non-executive directors, and providing support for newly appointed non-executive directors to learn about the organisation, its people and its context; and
- conducting and making public the results of skill audits of board members, to ensure an effective balance of knowledge, skills, expertise, and backgrounds.

Achieving transformation through changes in behavioural style

Boards have it within their power to transform organisations simply by the way they behave with each other and with other stakeholders. Psychology theories, such as upper echelons theory,[40] explain how those at the top of any organisation play a critical role in developing and maintaining a positive culture. Senior executives set the tone for the behaviour within the organisation, and are a key referent for enforcing policies.[6, 41] For example, bullying or overassertive behaviour by board members undermines the board's effectiveness and can create an environment for other staff to follow suit.[3, 42-45] Boards should therefore be made aware of the influential part they play in terms of behaviour modelling and the salience of their actions for observers further down the hierarchy.

Within the healthcare sector, research has found that cultures which emphasise openness, trust and patient care are linked with improved staff well-being and satisfaction, being more responsive to error detection, the breaking down of professional distinctions, and better hospital performance.[42, 46, 47] Such cultures emphasise the sharing of knowledge, information and innovation, which are also important in helping reduce costs and achieving savings, lower waiting times, and produce greater throughput of day cases. Encouraging and dispersing decision-making throughout the organisation enhances discretion and autonomy through more participative decision making, and has been shown to facilitate trust.[48, 49] Similarly, trust and openness can be improved by engaging and acting with staff feedback and concerns.[50-52] Indeed, studies have found an open climate for communication to be a key predictor of trust in senior management and subsequent positive attitudes towards the organisation, such as affective commitment.[35, 50]

By creating cultures of safety and ensuring realistic expectations individuals, whether patients or staff, will feel safe but also supported to raise their legitimate concerns. This approach, coupled with demonstrations of their ethical behaviour, attracts followers' attention and awareness, enhancing adherence towards ethical standards.[53] The development of safety culture is essential in ensuring that compliance functions, described earlier in the chapter, are not restricted to checklists and paperwork.[36] The board therefore plays a pivotal role in signalling how important patient care and clinical issues are to the organisation. The involvement of the board in clinical issues, especially in leading quality committees, has been associated with lower morbidity rates and better quality of care.[26] Despite this, a review of board agendas of 60 trusts revealed that only 14 per cent of items related to clinical issue and patient care.[54] Furthermore, it matters how and when clinical items are presented in agendas.[41] When items are presented as information, rather than for discussion, or when clinical items are scheduled for the end of board meetings, discussions tend to be shorter and lacking in depth.

The board's role in developing a healthy organisational culture should be part of a wider organisational intervention. However, there are a number of actions boards should take as part of this process, including:[6, 13, 34, 47, 52, 54, 55]

- Leadership development programmes that identify key behaviours, and gather 360 information on whether and how these behaviours are being demonstrated. This will directly raise awareness and knowledge of leadership behaviours. Attention on modelling of such behaviours by top team members in all their interactions, especially with each other, hospital staff, patients and their families, and other stakeholders.
- Treating all board members respectfully, with zero tolerance of bullying or 'over-assertive' behaviour in meetings or interactions – e.g. through the use of yellow and red cards.
- Recognising the importance of staff and patient surveys as a mechanism for gathering insight on these stakeholder groups' concerns. However, such information must be used to create and deliver change, and such communicated back to stakeholders to show the board are listening and do act.
- Holding open board meetings and publicising board level discussions and decisions on key issues.
- Ethical conduct can be increased by training. However, simple behaviours, including talking openly about dilemmas and board members acting in an ethical fashion, can influence the performance of others, raising the quality of the care and service patients receive.
- Open and available leaders, not mere gestures, are required, with leaders that are genuinely available and willing to listen, and to act and address concerns. Part of this includes transparent communication and the re-calibrating of user and staff expectations where certain services or quality of service cannot be offered.
- Committing to clinical care and patient experiences by setting aside a fixed proportion of time, early on in board meetings, to discuss clinical issues.
- Speaking to patients, their families, and staff, who have been involved in a serious harm incident, or who have raised concerns about their experiences of the NHS trust.
- Developing a framework for the information required to assess clinical quality and maintain patient safety.

Conclusion

One caveat to consider is that while suggestions are made to help enhance board effectiveness, there are no golden rules or 'right' structure. Instead, the suitability and effectiveness of these suggestions need to be considered and evaluated in relation to the context in which the board and trust is set.[2] In addition, effective board governance is a complex and dynamic procedure, and it is beyond the scope of this chapter to consider all aspects of it. However, in summary, through the more effective directing of recruitment and selection, and attention towards how those at the top behave, the transformation required among NHS hospital cultures can be greatly enhanced so as to ensure they achieve more inclusive, safe and high quality patient care.

References

[1] Francis, R. (2013, February 6). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary*. Available from www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

[2] Chambers, N., Harvey, G., Mannion, R., Bond, J. & Marshall, J. (2013). Towards a framework for enhancing the performance of NHS boards: A synthesis of the evidence about board governance, board effectiveness and board development. *Health Services and Delivery Research, 1(6)*. Available from www.journalslibrary.nihr.ac.uk/__data/assets/pdf_file/0004/86305/FullReport-hsdr01060.pdf

[3] Storey, J., Holti, R., Winchester, N., Green, R., Salaman, G. & Bate, P. (2010). The intended and unintended outcomes of new governance arrangements within the NHS. In National Institute for Health Research Evaluations, Trials and Studies Co-ordinating Centre, *Executive summary for the National Institute for Health Research Service Delivery & Organisation Programme*. Author: Southampton.

[4] Garratt, B. (2010). *The fish rots from the head: The crisis in our boardrooms: Developing the crucial skills of the competent director*. Surrey: Profile Books.

[5] Keogh, B. (2013). *Review into the quality of care and treatment provided by 14 hospital trusts in England: Overview report*. London: Department of Health. Available from www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

[6] Alimo-Metcalfe, B. (2012). *Engaging boards: The relationship between governance and leadership, and improving the quality and safety of patient care*. London: King's Fund. Available from www.kingsfund.org.uk/sites/files/kf/engaging-boards-beverly-alimo-metcalfe-leadership-review2012-paper.pdf

[7] Abbott, S., Smith, R., Procter, S. & Iacovou, N. (2008). Primary care trusts. *Public Policy Administration, 23*, 43–59.

[8] Monitor (2014, June 18). *Monitor: regulating NHS Foundation Trusts. Fourth Report of Session 2014–15*. House of Commons, London. Available from www.publications.parliament.uk/pa/cm201415/cmselect/cmpubacc/407/407.pdf

[9] Emslie, S. (2007). *Exploring the factors that measure the performance of boards of directors of NHS Foundation Trusts and their association between board and organisational performance.* Unpublished MSc dissertation. Birkbeck, University of London.

[10] Lee, S.Y.D., Alexander, J.A., Wang, V., Margolin, F.S. & Combes, J.R. (2008). An empirical taxonomy of hospital governing board roles. *Health Services Research, 43*, 1223–1243.

[11] Barrett, D. & Windham, S.R. (1984). Hospital boards and adaptability to competitive environments. *Health Care Management Review, 9*, 11–20.

[12] Ferlie, E., Fitzgerald, L. & Ashburner, L. (1996). Corporate governance in the post 1990 NHS: The role of the board. *Public Money Management, 16,* 15–21.

[13] Rowell, H., Rowntree, H., Jones, S., Edwards, M. & Arnold-Forster, J. (2006). *The intelligent board.* London: Dr Foster.

[14] Garatt, B. (2005). Can boards of directors think strategically? Some issues in developing direction-givers' thinking to a mega level. *Performance Improvement Quarterly, 18*(3), 26–36.

[15] Dalton, D.R., Daily, C.M., Ellstrand, A.E. & Johnson, J.L. (1998). Meta-analytic reviews of board composition, leadership structure, and financial performance. *Strategic Management Journal, 19*, 269–290.

[16] O'Connell, V. & Cramer, N. (2010). The relationship between firm performance and board characteristics in Ireland. *European Management Journal, 28*, 387–399.

[17] Chambers, N., Chambers, N., Pryce, A., Li, Y. & Poljsak, P. (2011). Board brilliance revealed: Study into top performing boards finds 19 top organisations. *Health Service Journal*, 20-22.

[18] Janis, I.L. (1982). *Groupthink: Psychological studies of policy decisions and fiascos* (2nd edn.). Boston, MA: Houghton Mifflin.

[19] Garratt, B. (2003). *Thin on top: Why corporate governance matters and how to measure and improve board performance.* London: Nicholas Brealey Publishing.

[20] Sealy, R., Doldor, E. & Vinnicombe, S. (2009). *Increasing diversity on public and private sector boards (Part 1) – How diverse are boards and why?* London: Government Equalities Office.

[21] Veronesi, G., I. Kirkpatrick & F. Vallascas (2013). Clinicians on the board: What difference does it make? Social Science & Medicine, 77, 147–155.

[22] Mark, T.L., Evans, W.N., Schur, C.L. & Guterman, S. (1998). Hospital-physician arrangements and hospital financial performance. *Medical Care, 36*(1), 67–78.

[23] Bader, B.S., Kazemek, E.A., Knecht, P.R., Seymour, D. & Witalis, R.W. (2010). *Physician participation on the hospital board: A moving target.* San Diego, CA: Governance Institute. Available from www.witalis.com/pdf/BRP_2010_04_PhysiciansOnBoard.pdf

[24] Alexander, J.A. & Lee, S.Y.D. (2008). Does governance matter? Board configuration and performance in not-for-profit hospitals. *Milibank Quarterly, 84*, 733–758.

[25] Molinari, C., Alexander, J., Morlock, L. & Lyles, C.A. (1995). Does the hospital board need a doctor? The influence of physician board participation on hospital financial performance. *Medical Care, 33*(2), 170–185.

[26] Jiang, H.J., Lockee, C., Bass, K. & Fraser, I. (2009). Board oversight of quality: Any differences in process of care and mortality? *Journal of Healthcare Management, 54*, 15–30.

[27] Meyer, S., Goldstein, W. & Peter, J. (2004). Performance effects of physicians' involvement in hospital strategic decisions. *Journal of Service Research, 6*(4), 361–372.

[28] Ryan, M.K. & Haslam, S.A. (2005). The glass cliff: Evidence that women are over-represented in precarious leadership positions. *British Journal of Management, 16*, 81–90.

[29] Chambers, N. (2012). Healthcare board governance. *Journal of Health Organization and Management, 26*(1), 6–14.

[30] Terjesen, S., Sealy, R. & Singh, V. (2009). Women directors on corporate boards: A review and research agenda. *Corporate Governance: An International Review, 17*(3), 320–337.

[31] Adams, R.B. & Ferreira, D. (2009). Women in the boardroom and their impact on governance and performance. *Journal of Financial Economics, 94*(2), 291–309.

[32] Davies, E.M. (2011). Women on boards. London: Department for Business, Innovation & Skills. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/31480/11-745-women-on-boards.pdf

[33] Fitzsimmons, T.W., Callan, V.J. & Paulsen, N. (2014). Gender disparity in the C-suite: Do male and female CEOs differ in how they reached the top? *The Leadership Quarterly, 25*(2), 245–266.

[34] National Leadership Council (2012). *Building equality, diversity and inclusion into the NHS board selection process for chief executives and executive directors.* London: National Leadership Council. Available from www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-CEORecruitmentEXEC.pdf

[35] The Korn/Ferry Institute (2012). *What makes an exceptional independent non executive director?* Los Angeles, CA: The Korn/Ferry Institute. Available from www.kornferryinstitute.com/sites/all/files/documents/briefings-magazine-download/NED_report_lowres.pdf

[36] National Leadership Council (2009). *The healthy NHS board: Principles for good governance.* London: National Leadership Council. Available from www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-TheHealthyNHSBoard.pdf

[37] National Leadership Council (2013). *The Healthy NHS Board 2013: Principles for Good Governance.* London: National Leadership Council. Available from www.leadershipacademy.nhs.uk/wp-content/uploads/2013/06/NHSLeadership-HealthyNHSBoard-2013.pdf

[38] Doldor, E., Vinnicombe, S., Gaughan, M. & Sealy, R. (2012), *Gender diversity on boards: The appointment process and the role of executive search firms.* Manchester: Equality and Human Rights Commission. Available from www.equalityhumanrights.com/sites/default/files/documents/research/rr85_final.pdf

[40] Hambrick, D.C. (2007). Upper echelons theory: An update. *Academy of Management Review, 32*(2), 334–343.

[41] Machell, S., Gough, P. & Steward, K. (209). *From ward to board: Identifying good practice in the business of caring*. London: The King's Fund. Available from www.kingsfund.org.uk/sites/files/kf/From-ward-to-board_identifying-good-practice-in-the-business-of-caring-Sue-Machell-Pippa-Gough-Katy-Steward-The-Kings-Fund-February-2009.pdf

[42] Edmondson, A.C. (2004). Learning from failure in health care: frequent opportunities, pervasive barriers. *Quality and Safety in Health Care, 13*(2), ii3–ii9.

[43] Einarsen, S. & Hoel, H. (2008). Bullying and mistreatment at work: How managers may prevent and manage such problems. In A. Kinder, R. Hughes & C.L. Cooper (Eds.), *Employee well-being support: A workplace resource*, pp.161–173. Chichester: John Wiley.

[44] Tepper, B.J., Carr, J.C., Breaux, D.M., Geided, S., Hu, C. & Hua, W. (2009). Abusive supervision, intentions to quit, and employees' workplace deviance: A power/dependence analysis. *Organizational Behavior and Human Decision Processes, 109*(2), 156–167.

[45] Tepper, B.J., Henle, C.A., Lambert, L.S., Giacalone, R.A. & Duffy, M.K. (2008). Abusive supervision and subordinates' organization deviance. *Journal of Applied Psychology, 93*(4), 721–732.

[46] Jacobs, R., Mannion, R., Davies, H.T., Harrison, S., Konteh, F. & Walshe, K. (2013). The relationship between organizational culture and performance in acute hospitals. *Social Science & Medicine, 76*(1), 115–125.

[47] Rowling, E. (2012). Leadership and engagement for improvement in the NHS: Together we can. *The King's Fund Leadership Review*. Available from www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/leadership-for-engagement-improvement-nhs-final-review2012.pdf

[48] Hage, J. & Aiken, M. (1967). Relationship of centralization to other structural properties. A*dministrative Science Quarterly, 12*, 72–92.

[49] Dirks, K.T. & Ferrin, D.L. (2002). Trust in leadership: Meta-analytical findings and implications for research and practice. *Journal of Applied Psychology, 87*, 611–628.

[50] Searle, R., Weibel, A. & Hartog, D.N. (2011). Employee trust in organizational contexts. In G.P. Hodgkinson & J.K. Ford (Eds). *International review of industrial and organizational psychology*, vol. 26, pp.143–191.

[51] Laschinger, S., Leiter, M.P., Day, A., Gilin-Oore, D. & Mackinnon, S.P. (2012). Building empowering work environments that foster civility and organizational trust: testing an intervention. *Nursing Research, 61*(5), 316–325.

[52] Treister, E.D. & Rafaeli, A. (2014). *A group and individual level multi-culture analysis of aggression toward medical service providers*. Conference presentation at the Israel Organizational Behavior Conference, Tel Aviv, January 5–7, 2014.

[53] Jordan, J., Brown, M.E., Trevino, L.K. & Finkelstein, S. (2013). Someone to look up to: Executive-follower ethical reasoning and perceptions of ethical leadership. J*ournal of Management, 39*(3), 660–683.

[54] University of Plymouth (2006). An exploratory study of the clinical content of NHS Trust board meetings, in an attempt to identify good practice. London: Burdett Trust for Nursing.

[54] Schwartz, M.S. (2013). Developing and sustaining an ethical corporate culture: The core elements. *Business Horizons, 56*(1), 39–50.

[55] Conway, J., McCannon, J. & Gunther-Murphy, C. (2008). The new challenge in patient safety. *Healthcare Executive, 23*, 62–6.

[56] Searle, R. & Patent, V. (2012). Recruitment, retention and role slumping in child protection: The evaluation of in-service training organisations. *British Journal of Social Work, 43*(6), 1111–11291.

Organisational culture change

Building cultures of transparency and openness

Dr Joanna Wilde

About the author

Dr Joanna Wilde has worked as an organisational psychologist in a range of companies. She holds a fellowship with Aston Business School and is Chair of the British Psychological Society Work and Health Working Party.

Introduction

> *'For a common culture to be shared throughout the system, these… characteristics are required: Openness: enabling concerns to be raised and disclosed freely without fear, and for questions to be answered; Transparency: allowing true information about performance and outcomes to be shared with staff, patients and the public… This requires all organisations and those working in them to be honest, open and truthful in all their dealings with patients and the public'.*[1]

Building cultures of transparency and openness (CTO) has now been widely recognised as essential to increase the level of patient safety in the NHS. It requires us as a society to stop blaming those who are working diligently within the health system and start making NHS workplaces more effective and more compassionate towards their staff. Creating these essential conditions is a complex requirement in the NHS context, due both to the psychological factors that inhibit CTO and the range and type of NHS organisations included within the system. Each of these organisations have generated their own distinct cultural habits, developed in response to the policy context within which the NHS operates.[iii]

The following chapter explores the psychological factors which need to be managed effectively across the health system to enable transparency and openness. Effective intervention needs to be grounded in the specific context of the NHS, requiring the resources for support rather than being designed and imposed from a distance.[2, 3]

What do the terms transparency and openness mean?

As an organisational psychologist supporting culture change with senior leaders in large complex organisations, the author's starting point when intervening is to generate clarity to enable shared understanding, clear dialogue and the identification of the practices that are most relevant to support the change in habit required.[4, 5] In this context the 'client input' from the Francis Report[1] and NHS staff survey[6] have been used to generate the following potential definitions:

iii In the NHS (2013 figures) there were 211 commissioning groups, 160 acute trusts, 56 mental health trusts, 10 ambulance trusts, 34 community providers, 2,300 hospitals and 7,960 GP practices[8]

1. **Openness** is a characteristic of working relationships within an organisation that enables people to notice and act on errors to enable improvement and learning from experience. This is dependent upon the extent to which the psychological environment is safe.[7]
2. **Transparency** requires visibility of information and 'inferability' – the ability to draw accurate inferences from that information[9] which is manifested through the delivery of processed outputs (reports) at the organisation level. It is dependent on a system that has the characteristic of openness in working relationships defined above.[10]

How can openness be achieved?

Broadly, the psychological literature indicates that **openness** will be enabled through:

- The compassionate moderation[11] of counter-productive group processes that cause bias, silo thinking, groupthink, compliance, hostility, discrimination, apathy, learned helplessness and fear in the workplace.[10, 12]
- The design of grounded interventions that are highly supportive, low in hassle and have meaning for those impacted.[3]
- The presence of active and accessible role models, ideally from those with authority in the system.[13-15]
- The deployment of double loop responses to staff feedback, whereby feedback is used productively, its impact is shared and then evaluated so that the work of improvement becomes habitual; known as organisational learning.[16]

How can transparency be achieved?

Transparency is based on the practices outlined above, and requires:

- Intelligent and open signal detection; the 'passive' awareness of what is going on.[17]
- Evidence based practice; the 'active' collection of information held throughout the organisation.[18]
- Diagnostic approaches to evidence that infer system patterns rather than deploying simple measures that lead to unintended consequences.[2, 9, 19]
- Behavioural strategies within governance practices, ensuring report integrity by managing bias and groupthink.[20]

The challenge in the NHS

As has been noted, the extent to which a CTO can be built and sustained is directly linked to the degree of psychological safety in any system.[7,10] Predictors of low psychological safety are deficiencies in work design, role ambiguity, high demands, deficiencies in leadership behaviour and evidence of tolerance for bullying.[21, 22] In addition, a history of 'organisational trauma' described as survivor syndrome is predictive of low safety.[23] Restructuring and redundancy provide significant examples of factors that can create survivor syndrome, and the NHS was impacted by both of these in 2013.[8]

The above experiences generate perceptions that the organisation is dangerous, unfair and set in its ways. In such working contexts, people will 'keep their heads down', 'keep their mouths shut' and 'turn a blind eye'.

At the current time, there appears to be a belief that openness and transparency will be supported by the encouragement of whistleblowing in healthcare. However, public

whistleblowing can carry serious negative concerns for individuals and organisations and this suggests that this is not necessarily the most helpful approach to invest in. From other sectors of work, the evidence of physical retaliation, dismissal and bullying against whistle-blowers makes for very troubling reading. For example, 22 per cent of whistle-blowers report physical and violent retaliation, 75 per cent have a move to dismiss made against them and nearly all report bullying after raising a concern.[45, 47] More significantly however, is the substantial research evidence showing that, over the long term, such disclosures also have a serious detrimental impact on overall organisational effectiveness.[24, 25]

To build a CTO in the NHS and repair healthcare cultures that are currently 'silent',[26] we must build psychologically safe work environments for the 1.03 million staff in the NHS.[27] This includes all staff; those providing direct day-to-day care for patients, their managers and senior managers, and the clinical leaders and commissioners of services.[28] Such comments are in reality 'easy to say, hard to do' especially given two starkly contrasting features of the NHS context:

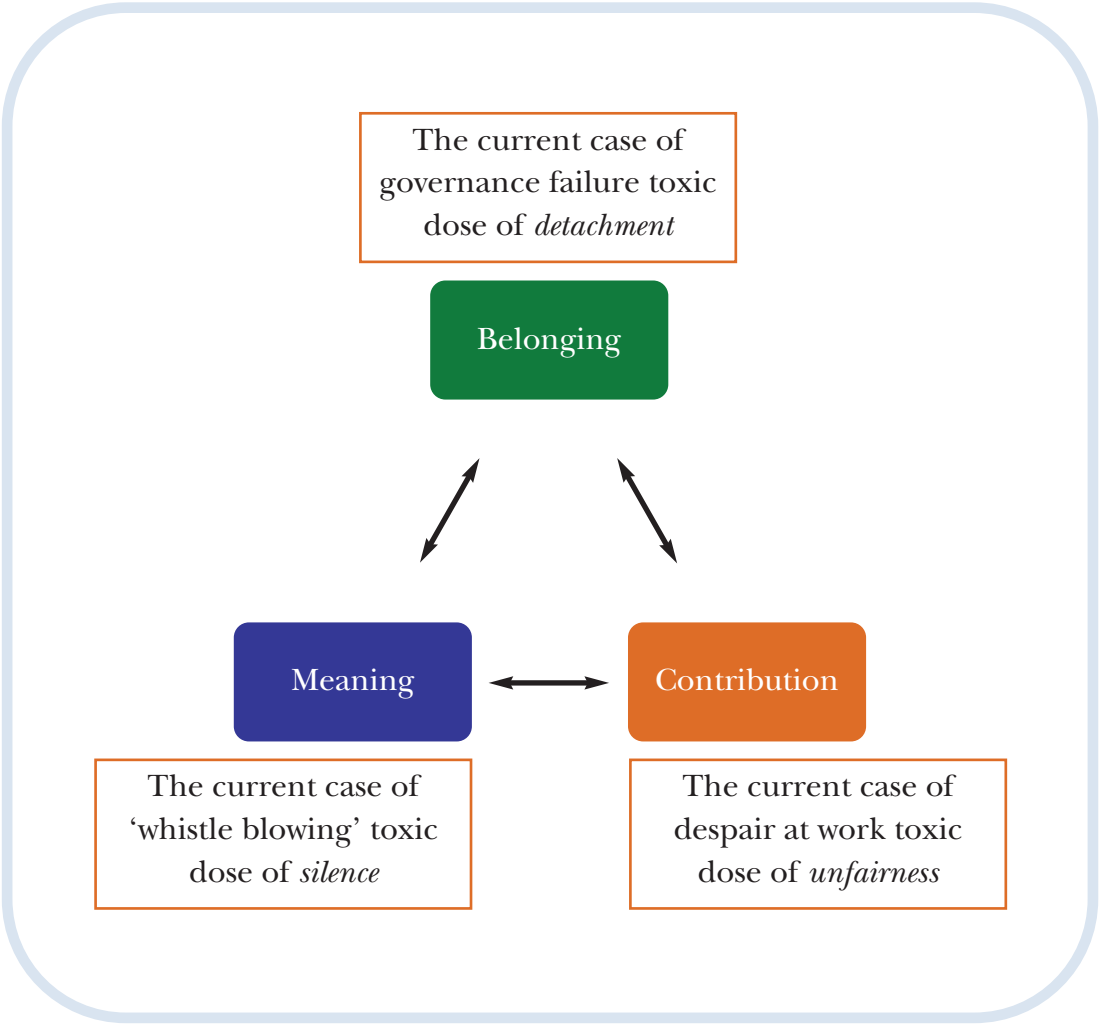
1. The psychological environment that we expect our NHS staff to work within is not safe. Over a quarter of NHS staff report physical and psychological violence from patients and the same levels of psychological violence from other NHS staff members. The figures equate to 300,000 of NHS staff being bullied or hurt by patients or managers every year. A further 72 per cent do not believe that anything would be done if they spoke up about their concerns. Of these, 14 per cent believe they would be punished for speaking.[6]
2. This complex NHS system works 24/7 and delivers exceptional levels of service to our society. One million people are seen every 36 hours with as astounding 81 per cent of patients giving a very positive (always) response to the question 'are you treated with dignity and respect?'[8]

These headline figures indicate a substantial 'compassion gap', whereby greater compassion is often shown to patients than is shown to NHS staff. To disengage and withdraw commitment and compassion in unsafe environments is a deeply rational response. It is self-protective of individual psychological well-being. It is now substantially evidenced that work environments characterised by low levels of fairness, and psychological safety is a serious risk factor for depression.[29] The current estimate is that mental ill health costs the UK economy £105 billion per annum and that dysfunctional workplaces,[30] such as that indicated by the NHS staff survey results, are a growing cause of this social problem.

Diagnosing and intervening to improve psychological safety

Based on the author's own professional practice, the following model outlines those diagnostic clusters that can help frame insight into the causes of poor practice and ensure interventions are designed so as to improve psychological safety:

Figure 1: Diagnostic clusters for developing OTC. (Wilde J. (forthcoming) Social psychology of organisations: Toxicity, resilience and intervention in the workplace)



In summary, these dimensions are as follows:

Meaning making refers to our need to make meaning out of the experiences in our lives. We read meaning into what is done, and specifically into the gap between espoused and actual behaviour.[31, 32] Studies of political skill[33] point to this capacity to work with meaning making in organisations as a distinct and teachable capability.
Belonging refers to the experience of being social animals that depend deeply on others for the lives we lead. A sense of shared group identity is essential for commitment to work projects.[34] The work of constantly reinforcing such social identity is a critical requirement from leaders, explicitly ensuring their decisions affirm distinct social identities shared by employees.[35]
Contribution is also a significant human drive and central to any consideration of the workplace. It is focused on the critical relationship human beings have with the work that they do. This is described as intrinsic motivation.[36, 37]

It is not possible to offer a full account of this model in this short summary, but this diagnostic approach has been applied to the issues raised in the Francis report to generate options for intervention in the NHS.

Ways to think about intervening

- **Role model the behaviour required at regulatory level:** Develop 'intelligent customer' approaches from commissioners and regulators, using the growing knowledge about organisational capabilities and routines that increase resilience in a system. Regulatory bodies can then work as effective stewards of NHS culture change rather than as scrutineers. Such stewardship requires inquiry skills, cross-cultural capability, political skill, requisite variety in team structures, and diagnostic approaches to evidence.[28] Once social norms have become established, as they have been across the NHS, only intelligent, long-term and subtle intervention will generate change to this very stable perceptual framework.
- The consistency, frequency and visibility of contradictory data needs to be high, constantly reinforced and sustained over an extended period in order to overcome the impact of 'confirmatory bias' whereby people only see evidence that confirms what they already believe.
- Positive managerial behaviour must be exercised as a critical requirement of transparent and open cultures; with managers being clear with staff about what is realistic, the constraints in the system and being actively interested in the well-being of staff. As emphasised by other chapters within this report, managers must role-model compassion so that employees more easily supported to act compassionately and report concerns.[38]
- Staff engagement processes should be developed that explicitly listen. For listening to be 'evidenced' to staff two steps are required that loop together. Firstly, listening should be actively **expressed** through such means as surveys, organisational development sessions or via 'yammer' type social media. Secondly, staff should be able to see the consequence in action, such as through action planning sessions, choice of what to track, and regular feedback from what they have shared and has been played back to them. Most such attempts are currently only partial and, hence dysfunctional. Full double loop approaches are essential for organisational learning and to prevent pluralistic ignorance.[39]
- Ensuring there is **time to talk**: Making space for talking enables peer-to-peer compassion and support, and heightens staff ability to reflect upon and improve their work approaches and learn from errors, thereby increasing organisational resilience. In contrast, the current level of staff overload in the NHS often means that only the immediate work priority gets attention.[40]
- It should be made **safe to speak within the system about areas of concern through a confidential disclosure** mechanism,[41] and which gives confidence that action will be taken. This needs to be linked with the design of approaches for intervening with compassion in situations where individual or group behaviour is inconsistent with transparency and openness, ensuring appropriate sanction for the behaviour and dignity for the perpetrator[12] hence removing the need to rely on external approaches to whistleblowing.
- **Deployment of 'free radicals' or brokers** across the organisation to model listening to all groups: These brokers should be focused on interpreting and translating meaning across all levels and disciplines within the NHS, a role that has been conceptualised as equivalent to that of the court jester, who served an integral role in keeping the 'king safe' through giving the truth a safe place. Such a role could take the form of mentor

sessions between CEOs and service users in the NHS, an internal organisational development consultant working across professional groups, or an external provider of group facilitation services.

- Build **NHS-relevant behavioural strategies** for managing groupthink at leadership group level: As explored by Searle et al.'s chapter in this report, the introduction of diversity in decision-making groups can disrupt the tendency to groupthink.[42] Since groups do not usually voluntarily invite this disruption, organisations need to have routines that make this the social norm.
- The development of **inquiry skills** has been identified as a core organisational capability to prevent the confirmatory bias that leads to 'system blindness'.[43] The introduction of cross-discipline peer review sessions in the NHS is an example of an approach that can increase open inquiry skills, as different ways of seeing are brought to bear on a situation. The literature on network structures, in this case the effectiveness of 'brokering' role in the functioning of multi-disciplinary teams in the health care context[44] also points to the positive impact of enabling loose boundaries around groups for overall system effectiveness.
- Put in place deliberate peer review processes or episodic team working. There are several approaches, these can be within discipline but across organisational groups or cross discipline, designed to deliberate inviting cross group boundary review – implemented with capability development in coaching and reflection skills.

References

[1] Francis, R. (2013, February 6). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary*. Available from www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

[2] Wilde, J. (forthcoming). *The social psychology of organisations: Toxicity, resilience and interventions in the workplace*. Oxford: Routledge.

[3] Neilsen, K. (2013). How can we make organizational interventions work? Employees and line managers as actively crafting interventions. *Human Relations, 66*(8), 1029–1050.

[4] Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes, 50*, 179–211.

[5] Jimmieson, N.L., Peach, M. & White, K.M. (2008). Utilizing the theory of planned behavior to inform change management: An investigation of employee intentions to support organizational change. *Journal of Applied Behavioral Science, 44*(2), 237–262.

[6] National Health Service (2013). *NHS Staff Survey 2013 – Results*. Available from www.nhsstaffsurveys.com/Page/1006/Latest-Results/2013-Results/

[7] Edmondson, A. (1999). Psychological safety and learning behavior in work teams. *Administrative Science Quarterly, 44*, 350–383.

[8] NHS Confederation (2014). *Key statistics on the NHS*. Accessed 6 August 2014 from www.nhsconfed.org/priorities/political-engagement/Pages/NHS-statistics.aspx#staff

[9] Michener, G. & Bersch, K. (2013). *Identifying transparency. Information Polity: The International Journal of Government and Democracy in the Information Age, 18*(3), 233–242.

[10] Dollard, M.F. & Bakker, A.B. (2010). Psychosocial safety climate as a precursor to conducive work environments, psychological health problems, and employee engagement. *Journal of Occupational and Organizational Psychology, 83*(3), 579–599.

[11] Dutton J.E., Workman K.M. & Hardin A.E. (2014). Compassion at work. *Annual Review of Organisational Psychology and Organisational Behaviour, 1*, 277–304.

[12] Hicks, D. (2011). *Dignity; the essential role it plays in resolving conflict*. London: Yale University Press.

[13] Moberg, D.J. (2000). Role models and moral exemplars. *Business Ethics Quarterly, 10*(3), 675–696.

[14] Gibson, D. (2013). Developing the professional self-concept: Role model construals. *Organization Science, 14*(5), 591–610.

[15] Carlin, A. & Duffy, K. (2013). Newly qualified staff's perceptions of senior charge nurse roles. *Nursing Management 20*(7), 24–30.

[16] Argyris, C. & Schon, D. (1978). *Organizational learning: A theory of action perspective*. San Francisco, CA: Jossey-Bass.

[17] Schwendimann, R., Milne, J., Frush, K., Ausserhofer, D., Frankel, A. & Sexton, J.B. (2013). A closer look at associations between hospital leadership walkrounds and patient safety climate and risk reduction. *American Journal of Medical Quality, 28*(5), 414–421.

[18] Briner, R. & Rousseau, D. (2011). Evidence Based I-O psychology: Not there yet. *Industrial and Organizational Psychology Perspectives on Science and Practice, 4*, 3–22.

[19] Harris, L.C. & Egbonna, E. (2002). The unintended consequences of culture interventions: A study of unexpected outcomes. *British Journal of Management, 13*(1), 31–49.

[20] Janis, I. (1972). *Victims of groupthink*. Boston, MA: Houghton Mifflin.

[21] Einarsen, S. (1999). The nature and causes of bullying at work. *International Journal of Manpower, 20*, 16–27.

[22] Hershcovis, M.S., Turner, N., Barling, J. et al. (2007). Predicting workplace aggression: A meta-analysis. *Journal of Applied Psychology, 92*, 228–238.

[23] Baruch, Y. & Hind, P. (1999). Perpetual motion in organizations: Effective management and the impact of the new psychological contract on 'survivor syndrome'. *European Journal of Work and Organizational Psychology, 8*(2), 295–306.

[24] Bowen, R.M., Call, A.C. & Rajgopal, S. (2009). Whistle-blowing: Target firm characteristics and economic consequences. *Accounting Review, 85*(4), 1239–1271.

[25] Dasgupta, S. & Kesharwani, A. (2010). Whistleblowing: A survey of literature. IUP *Journal of Corporate Governance, 9*(4), 57–70.

[26] Edwards, M, Ashkany, N.M. & Gardner, J. (2009). Deciding to speak up or to remain silent following observed wrongdoing: The role of discrete emotions and climate of silence. In J. Greenberg & M. Edwards (Eds.), *Voice and silence in organizations*, pp.83–109. Bingley: Emerald Group Publishing.

[27] King's Fund (2013, September 18). *You can't get the staff these days: the shifting NHS workforce*. Available from www.kingsfund.org.uk/blog/2013/09/you-cant-get-staff-these-days-shifting-nhs-workforce

[28] West, M., Baker, R., Dawson, J., Woods, M.D., Lilford, R., Martin, G., McKee, L., Murtagh, M. & Wilkie, P. (2013). *Quality and safety in the NHS: Evaluating progress, problems and promise*. Lancaster: Lancaster University Management School.

[29] Grynderup, M.B., Mors, O., Hansen, A.M. et al. (2013). Work-unit measures of organisational justice and risk of depression – a 2-year cohort study. *Occupational and Environmental Medicine, 70*(6), 380–385.

[30] Faculty of Public Health (2010). *No health without mental health*. Retrieved 6 August 2014 from www.fph.org.uk/the_cost_of_poor_mental_health

[31] Weick, K. (1995). *Sensemaking in organizations*. Thousand Oaks, CA: Sage.

[32] Czarniawska-Joerges, B. (1997). *Narrating the organization: dramas of institutional identity*. Chicago: University of Chicago Press.

[33] Silvester, J., Wyatt, M. & Randall, R. (2014). Politician personality, Machiavellianism, and political skill as predictors of performance ratings in political roles. *Journal of Occupational and Organizational Psychology, 87*(2), 258–279.

[34] Haslam, S.A., Ryan, M.K., Postmes, T., Spears, R., Jetten, J. & Webley, P. (2006). Sticking to our guns: Social identity as a basis for the maintenance of commitment to faltering organizational projects. *Journal of Organizational Behaviour, 27*, 607–628.

[35] Haslam, S.A. & Platow, M.J. (2001). Your wish is our command:The role of shared social identity in translating a leader's vision into followers' action. In M.A. Hogg & D.J. Terry (Eds.), *Social identity processes in organizational contexts*, pp.213–228. Philadelphia, PA: Psychology Press.

[36] Kovjanic, S., Schuh, S. & Jonas, K. (2013). Transformational leadership and performance: An experimental investigation of the mediating effects of basic needs satisfaction and work engagement. *Journal of Occupational and Organizational Psychology, 86*, 543–555.

[37] May, D.R., Gilson, R.L. & Harter, L.M. (2004). The psychological conditions of meaningfulness, safety and availability and the engagement of the human spirit at work. *Journal of Occupational and Organizational Psychology, 77*, 11–37.

[38] British Psychological Society (2013). BPS consultation response to NICE workplace policies and management practices. Leicester: British Psychological Society. Available from http://apps.bps.org.uk/_publicationfiles/consultation-responses/Draft%20BPS%20response%20to%20NICE%20draft%20scope%20consultation%20July%202013.pdf

[39] Gardiner, E. & Chater, N. (2013). Guarding against collective failures in organisations. *Nursing Management, 20*(2), 11.

[40] Rankin, A., Dahlback, N. & Lundberg, J. (2013). A case study of factors influencing role improvisation in crisis response teams. *Cognition, Technology and Work, 15*(1), 77–93.

[41] Lowry, P.B., Moody, G., Galletta, D.F. & Vance, A. (2013). The drivers in the use of online whistle-blowing reporting systems. *Journal of Management Information Systems, 30*(1), 153–190.

[42] Phillips, K.W. & Loyd, D.L. (2006). When surface and deep-level diversity collide: The effects on dissenting group members. *Organizational Behavior and Human Decision Processes, 99*, 143–160.

[43] Losada, M. & Heaphy, E. (2004). The role of positivity and connectivity in the performance of business teams. A non-linear dynamics model. *American Behavioural Scientist, 47*(6), 740–765.

[44] Currie, G. & White, L. (2012). Inter-professional barriers and knowledge brokering in an organisational context. *Organisation Studies, 33*(10), 1333–1361.

[45] Verschoor, C. (2013). Whistleblowing reaches center stage. *Strategic Finance, 95*(5), 4–16

[46] Bjerkelo, B. (2013). Workplace bullying after whistleblowing: future research and implications. *Journal of Managerial Psychology, 28*(3), 306–323

[47] Parmerlee, M., Near, J., & Jensen, T. (1982). Correlates of whistleblowers' perceptions of organizational retaliation. *Administrative Science Quarterly, 27*(1), 17–34

Managing culture change in the NHS: An overview

Michael Wellin

About the author

Michael Wellin is Director of Business Transformation Ltd consultants. A Chartered psychologist, Michael works with top management of profit and not for profit organisations to increase organisation performance, and lead, facilitate and support culture change

Introduction

This chapter addresses high level practical issues involved in changing NHS culture to align better with the requirements of the Berwick[1] and Francis reports[2]. Occupational psychology as a profession is well placed to provide insights about organisation culture, and practical ideas and actions for shaping and changing organisation culture. Changing culture is the organisational equivalent of a heart transplant for an individual. As with a heart transplant, there are no procedures that can 100 per cent guarantee success; however, occupational psychology provide powerful ideas, principles and practices for changing culture.

What we mean by organisation culture

Organisation culture 'is to an organisation what personality is to the individual',[4] and is frequently described as 'the way we do things round here'.[3] A more robust definition by Edgar Schein[5] defines it as 'the learned, shared and tacit assumptions on which people base their daily behaviour' (p.29). This definition implies that people may or may not be aware of the organisation culture they work in, but whether or not they are aware, culture is about employee beliefs that drive actions and behaviour in the workplace.

An effective way of illustrating culture is to reflect on our reactions and feelings when we come into contact with different organisations that provide the same service, for example, different coffee shops or different train companies. One of the main reasons why going on a Virgin train is different from going on a First Great Western train is because the two companies have different cultures. Exactly the same applies to patients' experiences of different hospitals.

The culture of an organisation is manifested in many different ways:[5] the physical environment (EasyJet: orange), the values the organisation claims it upholds (Tesco: 'Every little helps') or the founders' beliefs (Steve Jobs' obsession with usability and detail at Apple). Organisation culture is found in the stories people tell, the symbols they use, the rituals and routines people follow, and in the way power is exercised.

Within an organisation different subcultures are likely to exist – for example, one among top management who are responsible for the strategic direction of the enterprise, another among operations illustrated by those providing the organisations service e, such as manufacturing or service provision, or among sales who are responsible for initiating new customer and client relationships. Inevitably there are often clashes between these sub cultures in organisations, especially between operations and sales. The entangled relationship

between different subcultures within the NHS is more complex than in many organisations. The current impetus for patient safety and care generated by the Francis and Berwick reviews does however provide real momentum for Trusts to examine and change their own cultures.[9]

Research from non-healthcare settings[10, 11] has shown culture is important because it is one of the main drivers of actions and behaviour at work, including organisational safety, customer service and care, and ultimately overall organisation performance. There is limited, albeit growing, evidence[9, 12-14] for a similar effect involving the culture of healthcare organisations, leading to the Francis Report and Berwick review identifying culture as one of the key drivers of patient care and safety.

Culture change recommendations made by the Francis Report and Berwick review

Key recommendations for changes in NHS culture have been put forth by the Francis Report and Berwick review, some of which are summarised below, and have been explored in greater depth within the previous chapters of this report:

1. *Openness, transparency and candour (Chapter 7)*

Perhaps the most important culture change requirement is for greater openness, transparency and candour, so that individual employees and patients can freely raise concerns without fear in the knowledge that these concerns will be discussed and addressed. It also means that data about patient care quality and safety will be shared openly with all relevant parties, including when a patient may have been harmed.

2. *Leaders should focus to a greater extent on patient care quality (Chapters 4, 6)*

An overall shift in leader behaviour is recommended, which gives more priority to patient care and safety. Leaders need to focus more of their energies on supporting their teams' patient care efforts, inquiring about and reporting on these, and investing in and improving patient care. Patient care lies at the heart of NHS values and culture, and it should be a core part of every leader's role to advocate this actively.

3. *Encourage personal responsibility rather than blame (Chapter 2)*

Errors occur in all human activity, and despite the errors it is important to appreciate the good intentions of staff, and their desire to provide high levels of patient care. Individuals should be encouraged and recognised for taking responsibility for their work, rather than blamed whenever they make a mistake. Rather than being automatically punished and treated as misconduct, errors should be viewed as opportunities for learning and improvement.

4. *Create a learning organisation culture (Chapter 5)*

One way of improving patient care is through embracing an ethic of curiosity and learning. This will involve a culture that facilitates individuals to learn about new methods which improve patient care and safety, as well as learning from individuals' own and their colleagues' practical experience in caring for patients.

5. *Facilitate process improvement (Chapter 3)*

This concerns the creation of an ethos to improve both the design and implementation of organisation processes. This includes complaints procedures, and a single regulatory system which clarifies expectations and detects failure. A need has also been identified regarding the way quantitative targets should be used as a means towards an end of improved patient care, rather than becoming an end in themselves.

The extent to which any healthcare organisation may need to change to implement each of the above recommendations will vary. Some units may already achieve an excellent standard against all five culture areas, many may have strengths in some and have gaps in one or two.

A critical challenge when implementing these recommendations is to adopt a systematic method of evaluating how well an individual patient service organisation currently performs against them, and to use this to prioritise where change is most needed. Adopting a blanket approach to culture change by insisting all patient service organisations take actions against all five culture recommendations would be a recipe for failure.

Case study: Kingston General Hospital, Ontario – Patient focus changes[15]

Background:
Kingston General Hospital had struggled with underperformance across a number of areas, including high infection rates and poor financial performance. Public trust was revealed to have been at an all-time low when hospital leaders decided a change in culture was needed, specifically the development of a patient-centred care perspective.

Action:
To initiate the change process, the executive team attended a conference on patient-centred care, and fostered continual relationships and close liaisons with external organisations who were experts in this field. A 'Patient Advisory Council' made up of patients who had had difficult experiences was formed, and 50 patient advisor roles were created, to work with staff representatives to co-design the health service experience. This embedded patients in all levels of decision-making from top boardroom tables to frontline staff hiring panels, with a focus on quality, safety and service. Among the specific actions taken were new staff nametags to ensure that care team members can be better identified; clearer use of whiteboards to improve patient hand-overs; clearer signage; and bed-side charting to facilitate more patient face time.

Outcomes:
Four years after the intervention, infection rates had reduced and the hospital was in a position to balance its books for the first time in 16 years. The importance of this case study is that it suggests that culture change should not just be viewed as an end in itself – but as a real vehicle for improving organisation effectiveness, and performance. Culture change can be a vehicle for helping achieve both patient care and financial goals.

Critical issues to take into account when leading culture change

There are a number of important issues, based on applied occupational psychology theory and practice,[16-19] which need to be taken into account when planning and implementing an organisation culture change programme.

a) Create evidence-based goals for culture change

Starting culture change is like any other organisation change, such as investing in new technology or creating new buildings; goals and targets need to be created at the outset. In the case of culture, a clearly articulated vision about peoples' behaviour and their impact on stakeholders needs to be formulated, with explicit goals and a strategy for

achieving them.[9] This should entail the collection of robust data about the present culture and its strengths and weaknesses, using this to prioritise change. The evidence can be obtained from patient and employee feedback, as well as from hard performance indicators, for example readmission rates, infections rates, and legal cases for negligence.

b) Gain top management commitment to culture change

Whilst culture change can be initiated from the top or bottom of the organisation it is essential to gain top management commitment to whatever approach is adopted. First, culture change will require scarce resources – which people at the top control.[19] Resource allocation can often be taken as an implication of how valuable the change agenda really is to top management.[19, 20] Secondly, successful culture change interventions need to be aligned to other organisational priorities (i.e. the strategic goals of the organisation), which are decided at the top. The third reason for top management commitment is that they act as role models to others in the organisation in reinforcing the message, with senior management found to influence junior managers' behavioural intentions[21, 22] and determine their goals, objectives and priorities.[23]

c) Make a robust business case for culture change

At different implementation stages, people will question the need for culture change, and whether it is justified and/or cost effective.[16-24] It is therefore essential to have a clear rationale for culture change that has been fully documented and cost-justified. In the same way that investment in new operating theatres or a new building will need to be justified, so also there needs to be a full business case for culture change. This needs to include details about the anticipated financial costs and expected financial benefits, as well as the related labour and other resource costs.

d) It must be remembered that most people initially tend to resist change

Human nature means we often initially resist change.[25] We may know this from our own or others experience in attempting to give up smoking. This resistance to change stems from a combination of reasons including fear of the unknown, fear of failure, fears about loss of status or simply a preference for being within our comfort zones leading to reluctance to learn a new process.[26] Steps such as involving people in the change process, encouraging employees, really listening to their concerns and providing feedback, can be taken to overcome initial resistance.[18, 25] Moreover, it is imperative that culture change interventions not only repeatedly communicate the reasons for the organisation culture change, but also answer the all-important unspoken employee question 'What's in it for me?'.

e) Culture change is a journey best led by a small team of employee representatives

Culture change never occurs through a single transaction or intervention.[16] Whichever methods are adopted, and this report provides an extensive range of options, culture change needs to be seen as a journey lasting at least two years. This journey, however carefully planned, may encounter unexpected obstacles and road blocks – from groups of staff who offer unexpected resistance through to unexpected crises which distract attention from the culture change effort. To sustain the journey, culture change needs to be led by a small team of up to 12 which includes different stakeholders from across the organisation, including patients, health care processionals, managers as well as culture change experts. Small wins and milestones should be celebrated, further reinforcing the direction of change.[17]

f) Culture change, like any innovation, will face the unexpected

Innovation in any area of life involves experimentation, trial and error, and overcoming unexpected barriers.[16-17] The culture change team need to be prepared for this, and if they feel challenged need to admit they face barriers. Perseverance and focus on the end goal is important, as is a willingness question and rethink their chosen approach, try alternatives, and ask for help from others in the organisation. This is not an admission of failure – but an admission that no one has all the answers. There is a possibility that the culture change may fail, and if it does the organisation needs to learn from this.[28.]

Conclusion

This chapter reviews the different aspects of culture change, and how these link with the preceding chapters of this report. The Berwick, Francis and Keogh reports all emphasise a shift in attitudes and priorities towards one of patient care, quality and safety.[9] Attainment of this state will not be accomplished though individual or piecemeal interventions. Instead, a systematic approach involving a series of planned interventions in the culture within the NHS – including the various subcultures that exist, is needed.

References

[1] Berwick, D. (2013,). *A promise to learn, a commitment to act: the Berwick Review into Patient Safety*. National Advisory Group on the Safety of Patients in England. London: Department of Health. Available from www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

[2] Francis, R. (2013, February 6). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary*. Available from www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

[3] Schein, E.H. (1985). *Organisational culture and leadership*. San Francisco, CA: Jossey-Bass.

[4] Callahan, C. & Ruchlin, H. (2003). The role of nursing leadership in establishing a safety culture. *Nursing Economics, 21*(6), 296–297.

[5] Schein, E.H. (1999). *The corporate culture survival guide*. San Francisco, CA: Jossey-Bass.

[6] Scott, T., Mannion, R., Davies, H.T. & Marshall, M.N. (2003). Implementing culture change in health care: Theory and practice. *International Journal for Quality in Health Care, 15*(2), 111–118.

[7] Lok, P., Rhodes, J. & Westwood, B. (2011). The mediating roles of organisational subcultures in health care organisations. *Journal of Health and Organisation Management, 25*(5), 506–525.

[8] Schein E. (1996). Culture: The missing concept in organisational studies. *Administrative Science Quarterly, 41*(2), 229–240.

[9] Dixon-Woods, M., Baker, R., Charles, K., Dawson, J., Jerzembek, G., Martin, G., McCarthy, I., McKee, L., Minion, J., Ozieranski, P., Willars, J., Wilkie, P. & West, M. (2014). Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. *BMJ Quality and Safety*, published online First, 3 October 2014.

[10] Westrum, R. (2004). A typology of organisational cultures. *Quality and Safety in Health Care, 13*, 22–27.

[11] Wilderom, C.P.M., Glunk, U. & Maslowski, R. (2000). Organisational culture as a predictor of organisational performance. In N.M. Ashkansay & C. Wilderom, M. Peterson, *Handbook of organisational culture and climate*. Thousand Oaks, CA: Sage.

[12] Davies, H., Mannion, R., Jacobs, R., Powell, M. & Marshall, M. (2007). Exploring the relationship between senior management team culture and hospital performance. *Medical Care Research Review, 64*(1), 46–65

[13] Benning, A., Ghaleb, M., Suokas, A., Dixon-Woods, M., Dawson, J., Barber, N., Franklin, B.D., Girling, A., Hemming, K., Carmalt, M., Rudge, G., Naicker, T., Nwulu, U., Choudhury, S. & Lilford, R. (2011). Large scale organisational intervention to improve patient safety in four UK hospitals: mixed method evaluation. *British Medical Journal, 342*, , d195.

[14] Doherty, R., Loughrey, C. & Higgins, P. (2013). *Organisational culture: A review of the literature*. Northern Ireland Department of Health, Social Services and Public Safety. Available from www.dhsspsni.gov.uk/organisational_culture_literature_review.docx

[15] The Change Foundation (2012). *Kingston General Hospital leads patient-centered care reforms.* Available at: www.changefoundation.ca/2012/kingston-general-hospital-leads-patient-centred-care-reforms/

[16] Wellin, M. (2007). *Managing the psychological contract*. Aldershot: Gower.

[17] Cameron, K. (2007). *A process for changing organizational culture. In T.G. Cummings (Ed.), Handbook of organizational development*, pp.429–445. Thousand Oaks, CA: Sage.

[18] Geller, E.S. (2002). Leadership to overcome resistance to change: It takes more than consequence control. *Journal of Organizational Behavior Management, 22*(3), 29–49.

[19] Schein, E. (1985). Organizational culture and leadership. San Francisco, CA: Jossey-Bass.

[20] Bradley, L. & Parker, R. (2006). Do Australian public sector employees have the type of culture they want in the era of new public management? *Australian Journal of Public Administration, 65*(1), 89–99.

[21] Flin, R. & Yule, S. (2004). Leadership for safety: Industrial experience. *Quality and Safety in Health Care, 13*, 45–51.

[22] Rundmo, T. & Hale, A.R. (2003). Managers' attitudes towards safety and accident prevention. *Safety Science, 41*(7), 557–574.

[23] Andriessen, J.H.T.H. (1878). Safe behaviour and safety motivation. *Journal of Occupational Accidents, 1*, 363–376.

[24] Bevan, R. (2011). Keeping change on track. *Journal for Quality and Participation, 34*(1), 4–9.

[25] Allcorn, S. (2005). *Organizational dynamics and intervention: Tools for changing the workplace.* New York: M.E. Sharpe Publications.

[26] Agocs, C. (1997). Institutionalized resistance to organizational change: Denial, inaction, and repression. *Journal of Business Ethics, 16*(9), 917–931.

[27] Gotsill, G. & Natchez, M. (2007). From resistance to acceptance: How to implement change management. *T+D, 61*(11), 24–27.

[28] LaGuardia, D. (2008). Organizational culture. *T+D, 62*(3), 56–61.

The British Psychological Society
St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK
Tel: 0116 254 9568 Fax 0116 247 0787 E-mail: mail@bps.org.uk Website: www.bps.org.uk

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