From Metrics to Meaning: Culture Change and Quality of Acute Hospital Care for Older People

Executive summary for the National Institute for Health Research Service Delivery and Organisation programme

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prepared by

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Executive Summary

Background

Organisational culture is seen as key to health care quality and performance in the National Health Service (NHS). A continuing aim of NHS policy is to promote quality of care and performance improvements through culture change. However, there is little evidence to underpin suppositions underlying the importance of culture for health care delivery and the dynamics of culture change programmes.

Care provided for older people in acute hospitals provided an excellent way in which to address this issue because:

- the majority of patients in hospital are older and if the care provided is good for older people then it is likely to be good for everyone;
- there are a number of well-documented concerns about the standard of acute hospital care for older patients, especially relating to dignity.

Aims

The study had two primary aims:

- to understand those factors that either facilitate or inhibit culture change in acute hospital care for older people, carers and staff.

- to generate a potential 'toolkit' for change that might be used to apply the findings in other contexts and settings.

We explicitly predicated our proposal on a relational model of care delivery underpinned by the Senses Framework (Nolan et al 2006). This essentially argues that an *enriched* environment of care is one in which all stakeholders experience six Senses: security, belonging, continuity, purpose, achievement, and significance. If staff are to create an enriched environment for patients

and their carers then they too must enjoy an enriched work environment in which they experience the Senses.

About this study

In order to address these aims we adopted a multi-method longitudinal design involving both qualitative and quantitative elements that comprised:

- context setting working with a user reference group and key opinion leaders

- a review and narrative synthesis of the literature on culture change and dignity for older people

- longitudinal case studies in four Trusts purposively sampled to provide differing contexts for change

- the development of measures of work environment important for the delivery of good quality care and associated patient, carer and staff ratings of care quality

- the use of these measures to test the links between climate for care factors and associated patient and carer outcomes in participating Trusts

Key findings

Evidence from the user reference group, expert opinion leaders and the literature all underlined the challenges and complexities inherent in providing high quality care for older people in a health service where pace predominates. Survey findings further confirmed the rationale for basing the research in this area, identifying that whilst at an individual level older people tended to be more positive in their ratings of care, on wards with a higher average patient age significantly poorer care experiences were reported both by patients and their carers.

Different strands of the research demonstrated the difficulty of achieving culture change and the Pace-Complexity dynamic (Williams, 2009) emerged as an important explanatory framework in two ways

1. Culture change: Building on the data from the study it is clear that the NHS in general, and a variety of change initiatives in particular, are too driven by a pace agenda that looks for a 'quick fix' solution and tends to overlook both the complexity of the issues involved and the amount of time it takes for real and enduring change to occur.

2. Delivery of care for older people with complex health needs: The results support arguments made consistently through the report that older peoples wards are perceived to be challenging in terms of meeting complex patient needs in a target driven culture. Yet there were also many examples of the way pace was prioritised and reinforced by the value placed on meeting targets rather than doing the 'little things' that help maintain dignity and build a relationship with the patient. As one opinion leader put it the focus is on *'the metrics rather than the meaning of care'*

Findings from the survey confirmed the theorised link between climate for care (staff experiences of their work environment) and quality of care as reported by patients and carers. Survey data from 70 wards (incorporating responses from 929 nursing staff, 985 patients and 507 carers) showed that nursing teams, and their patients and carers experienced distinct climates for care. In particular, nursing teams reporting a shared philosophy of care and higher levels of task and emotional support among team members were also rated by patients and carers as providing higher quality care. In understanding the drivers of shared philosophy of care and team support, the survey identified the importance of the ward manager in developing and sustaining an enriched environment critical for enabling a positive climate for care amongst the team,

In line with this emphasis on the importance of the ward manager role, our results suggest that local culture change is much more realistic. Rather than thinking about managing an entire culture it is better to think of managing within cultures and affect the values and action of subordinates, peers or immediate supervisors. Whilst change at this level can succeed there will always be constraint from a broader (Trust, NHS) pace driven culture.

Conclusions

The Pace-Complexity dynamic captures many of the tensions inherent both in the delivery of health care to older people and in culture change initiatives. Concerns about quality of care for older people have led to a raft of policy initiatives and standards over recent years. Many recent initiatives, from the NSF for Older People on have called for large scale change across the NHS. The findings from this research suggest that such approaches are less likely to succeed because they fail to take account of the complexities inherent in providing care for older people. There is a paradox at work here in that the great value placed on new ideas, change and improvement in the NHS undermine the chances of actually accomplishing significant cultural change in the care of older people.

Whilst there is a need for culture change at all levels our results indicate that initiatives most likely to succeed and to derive real benefit for patients, carers and staff are those targeted at the level of the ward or unit. The measures developed as part of this research successfully capture elements of work experience for nursing teams that differentiate between good and poor care experiences for patients and carers. The measures include 12 nursing team scales assessing the climate for care within nursing teams, two scales assessing patients' experiences of care and three scales assessing carers' experiences. The measures have good psychometric properties, are sufficiently sensitive to capture differences between nursing teams, and reliably predict patient and carer experiences. They offer a powerful way of exploring the need for change and, as part of a toolkit, help indicate where, how and on what such efforts should be focused. The rationale emerging from this research avoids a 'one size fits all' approach, instead recognising the importance of local context and organisational history.

Leadership at the top and at the ward/unit level is essential for change, but it is again the ward or unit level where leadership is key to enhancing the care experience for patients, carers and staff. *Leading by example* was fundamental to creating the six Senses for staff, developing an enriched environment at the ward level that in turn promoted good care experiences for older people and their carers.

The concepts used here (the Senses Framework, enriched environments and relationship centred care) meet a need identified in the literature: they speak to older people, their families and to staff in a way that is '*ordinary, accessible, jargon-free and commonly understood*' (Goodrich and Cornwell, 2008). They are consistent with the latest '*best practice statements*' for use with older people in acute care settings (Bridges et al 2009). The toolkit offers a way to apply these concepts in practice. However, success at a broader level will only truly be achieved when there is wider recognition within the NHS of 'relational practice' as important and legitimate work.

This research was ambitious in its aims and scope and has been informed by the extensive insights provided by an in-depth narrative synthesis of the available literature, detailed case studies and large scale surveys across four diverse sites that tapped into the views of staff, older patients and their family carers. However, despite this diversity when synthesising these various elements we were struck more by commonalities than differences. In bringing these commonalities together we identified two opposing models of culture change that we see as operating along a series of continua, each of which represents one or more of the Senses. We referred to these as the Perform or Perish model of culture change and the Relational and Responsive model.

The Perform or Perish model most closely reflects the current culture within the NHS. It is dominated by a pace agenda and seeks to adopt quick fix, short-term solutions to what are often long-term and enduring challenges. The literature and the data collected in this research attest to the limitations of such an approach. In marked contrast the relational and responsive model that we believe is better suited to address the diverse issues surrounding the provision of high quality dignified care explicitly acknowledges the complexities inherent in the delivery of health, and we would add social, care. It recognises the need for a longer term agenda for change and, whilst not ignoring the processes of care, pays greater attention to people and their perceptions, thereby addressing, as Powell et al, (2009) suggest 'the complex social interactions' that shape care delivery. Such a model explicitly values, prioritises and supports relational practices (Parker, 2008).

In summary, the Perform or Perish model is most likely to result in an impoverished change environment where the senses are reduced or even eliminated whereas a Relational and Responsive model will have the opposite effect, in facilitating an enriched environment.

The two models are best seen as ideal types neither of which is likely to exist in its pure form. However, based on our data we would assert that the current situation in the NHS closely approximates to the Perform or Perish model whereas it is the relational and responsive approach that initiatives such as the 'Point of Care' programme (Goodrich and Cornwell, 2008) wish to see become more prominent.

The report concludes with a series of recommendations aimed at assisting policymakers, Trusts, educators and researchers move towards Relational and Responsive models of care delivery.