

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

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prepared by

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Section 1: Studying culture change and acute hospital care of older people

1.1 Introduction

Organisational culture is seen as key to health care quality and performance in the National Health Service (NHS) and consequently a continuing aim of NHS policy is to promote quality of care and performance improvements through culture change. The basic assumptions, beliefs and values shared by staff are central to understanding their patterns of behaviour. However, there is little evidence to underpin suppositions underlying the importance of culture for health care delivery and the dynamics of culture change programmes. Whilst advice about culture change is abundant, there are very few robust studies of cultural change initiatives. Frequently, studies are short term and conducted on a superficial level, insufficient to draw conclusions about whether change has occurred (Alvesson, 2002).

Much research and practitioner interest has been given to effects on performance of the 'right' (e.g. flexible/adaptive) or strong culture, but the relatively few robust studies on the culture-performance link have provided little empirical support (e.g., Siehl and Martin, 1990). Some recent progress has been made with Mannion, Davies, and Marshall's (2003) work on cultures for performance in health care funded by the Department of Health's Policy Research Program. However these findings are limited by their reliance on senior managers' views of the values held by their organisation and their cross-sectional design. There remains a clear need to gain a better understanding of culture-performance links in the health sector.

1.1.1 Culture and care for older people in acute hospitals

This report details the findings of a three-year study funded by the National Institute of Health Research Service Delivery and Organisation (NIHR SDO) programme. The project focuses on one area of the NHS where the importance of culture and the need for cultural change has already been identified as central to the delivery of improved care: Acute health services for older people.

Ensuring high quality, dignified care for vulnerable groups of service users, such as frail older people, has been an enduring challenge for nearly 50 years (Norton *et al.*, 1962; Townsend, 1966; Robb, 1967). Widespread concerns about the poor standards of acute health care for older people (HAS, 2000 1998) precipitated the introduction of the National Service Framework (NSF) for Older People (DH, 2001), a 10 year programme of reform intended to enhance independence and good health for older people by promoting 'culture change so that all older people and their carers' are always treated with respect, dignity and fairness' (Milburn, 2001). Evidence at the time the present study began suggested that considerable progress had been made towards achieving such change (Philp, 2004) but at the same time

it was evident that the envisaged cultural change had not yet permeated through all organisations with the same degree of success (Young *et al.*, 2003). The NSF for older people has subsequently been followed by a series of initiatives such the Dignity Challenge (SCIE, 2006) and the Dignity on the Ward Campaign (Help the Aged, 2007), which are intended to ensure that older people receive the quality of care they deserve. Indeed 'dignity' is seen to lie at the heart of the 'New Ambition for Old Age' (Philp, 2006).

1.1.2 Aims of the study

Within the context outlined above, the quality of acute health care for older people therefore provides an excellent vehicle for exploring applied cultural change and performance outcomes. The study was designed both to provide new theoretical insights and to address important practical questions in relation to four of the SDO objectives, namely:

- impacts of structural change on culture in acute hospital care delivery for older people, primarily in terms of patient and carer experiences
- links between culture and care delivery for older people in acute hospitals
- tracking impacts of purposive cultural change in acute hospital environments on key stakeholder groups (staff, patients, carers) and at differing organisational levels
- patient and carer impacts on culture in acute hospitals.

1.1.3 Structure of the report

The remainder of this section highlights methodological considerations in culture research and the theoretical approaches adopted here. It then describes the broader societal and NHS context within which the care of older people is embedded. *Section 2* explores the concepts of organisational culture and climate, the Senses Framework, and other analytic dimensions, such as transactional and transformational change, employed in this study. *Section 3* describes the methods used. *Section 4* presents a systematic narrative review of the literature on organisational culture, culture change and care of older people. *Section 5* describes the development of the scales that were part of the multivariate analyses and form part of the toolkit, *Section 6, 7, 8 and 9* report on four case studies that longitudinally explored links between culture and care of older people and the impact of culture change. *Section 10* presents the findings of the questionnaire-based study examining the relationships between climate for care and patients and carers' experiences of care. *Section 11* concludes the report by bringing together the different strands of the study, explores the policy implications of our work, and outlines the toolkit together with a potential means of application.

1.1.4 Methodological considerations in culture research

Our approach recognizes that studying culture change in a large organisation such as the NHS results in a rather broad brush approach. For example exploring the effects of interventions by top management in isolation may say very little about how, and if, such ideas are translated into practice at a ward or unit level.

Therefore, many accounts of culture change describe changes in practices, procedures, and symbols and their supposed impact on organisational culture, but we often learn little about how people reacted to or interpreted these changes (e.g., Brown, 1998). A culture change is not just management's attempt to impose new behaviours, but requires changes in the ideas, values and meanings of groups of people. A useful approach must have more depth and precision than most of the extant literature.

A further, broader, issue in the study of culture is the popular, if contentious, view that self report questionnaires can be used to measure culture (e.g., Ashkanasay, 2000) whereas others would argue that such approaches measure organisational climate and can be seen as a surface level indicator of underlying culture (eg Schein, 2000). We endorse the latter view; the two concepts are not interchangeable. Organisational climate is defined as individuals' perceptions of organisational policies, practices and procedures, both formal and informal, such as quality of communication or supervisory support (Reichers & Schneiders, 1990). As such climate is a branch of the broader area of organisational culture. We believe that questionnaire measures of climate are a valuable tool to be used in addition to qualitative research. Characterising cultural elements in terms of generalisable climate dimensions allows us to investigate, across multiple sites, the characteristics of organisational climate that potentially promote good patient care. Qualitative research can explore the deeper layers of culture, describing the meanings behind the patterns and associations (Rousseau, 1991; Schneider, 2000). Both concepts are described in greater detail in *Section 2*.

These issues had implications for the study's research methodology. First, the research employed in-depth qualitative studies of cultural dynamics in a limited number of settings, generating insights that could be recontextualised to broader settings (Morse, 1994). Second, exploring climates for care through self-report questionnaires allowed the testing of statistical inferences about the relationship between the climate experienced by staff and the quality of care experienced by patients and carers.

1.1.5 Previous work by the authors and theoretical underpinning to the study

This study focuses on cultural dynamics in relation to improving care for older people and their carers in acute hospital settings. It was given further strategic focus by employing a theoretical framework, the Senses Framework and relationship-centred care, to explore culture. This framework, described in detail in *Section 2.2*, has been generated from extensive prior empirical work with older people and their carers by members of the research team in a wide range of care settings (see for example Davies, Nolan, Brown & Wilson, 1999; Nolan, Davies and Grant 2001; Nolan, Davies, Brown, Keady & Nolan, 2004; Nolan, Brown, Davies, Nolan and Keady, 2006). Central to the Senses Framework is the belief that an understanding of the dynamics of care requires a detailed exploration of the complex set of interdependent relationships that characterise health care environments. As a result of this prior work the characteristics of *enriched* as opposed to 'impoverished' environments of care and learning have been identified, together with a theoretical framework that helps to explain the dynamics of such

environments. The Senses Framework and relationship-centred care (Davies *et al.*, 1999; Nolan *et al.*, 2001; Nolan *et al.*, 2004; Nolan *et al.*, 2006) provide important insights into the nature of interdependent relationships and the differing factors that create and sustain the positive interactions that characterise good care for older people and their carers whilst also heightening job satisfaction and motivation for staff.

The Senses Framework was therefore identified a-priori in our proposal as one theoretical 'lens' that would be used to explore cultural change in the selected units. This approach has already been used to explicitly promote positive change in the care of older people in a number of contexts (see for example Davies *et al.*, 2007 and www.myhomelife.org.uk). However the narrative synthesis has identified other theoretical and policy frameworks that have also influenced our analysis. These are described later in *Section 2.3* and *Section 4*.

1.2 Policy context

1.2.1 Societal, historical and policy contexts

The primary aim of the present study is to explore change initiatives within acute health care settings using services for older people as a proxy for change. More generally it became apparent at a very early stage that to consider such changes without reference to a range of broader societal, historical and policy-related factors would be to provide an incomplete understanding of the complexities involved. This section therefore presents a necessarily brief account of: The relatively marginalised position that older people, and especially frail older people, occupy in society as a whole; the historical development of health services for older people; the current policy context; and the views of our reference group and opinion leaders. These various strands are used to set the scene for what follows.

1.2.2 Broader social context

Based on figures from the European Commission, average life expectancy at birth in the UK is currently 77.56. In 1997 it was 74.65. At present Healthy Life Years (HLY - life expectancy with no disability) at birth in the EU is, on average, 14 years shorter than overall life expectancy for men and close to 20 years shorter for women. Data from 2006 indicate that men could expect to live 80.7% of their life free from disability, women 75.4% (source <http://ec.europa.eu/health/indicators/echi>).

The percentage of the population aged 65 and over started to rise sharply in the second half of the 20th century. Initially this was due to the prevention of premature death. However, this continued increase in the proportion of the population aged 65 and over is now due to better survival rates amongst this age group. In 2008, 17% of the European population were aged 65 and over (countries ranging from 11% to 20%), and this is likely to rise to around 24% by 2030 (source <http://ec.europa.eu/health/indicators/echi>). If the current trend of life expectancy increasing by 2.5 years per decade persists, the average lifespan may be 100 years by 2070.

Although older people within contemporary Britain largely retain their image as a social group worthy of support, they continue to occupy an ambiguous position in our society (Victor, 2005). Wider society is very much preoccupied with independence and youth, with young role models being idealised and population as a whole being increasingly focussed on remaining ever youthful (Fahey, 2003). As a society we do not seem able to face the degeneration and indignities that are often perceived to accompany extreme old age and nothing in our wider culture prepares us for them. Therefore, we tend not to question current underlying beliefs and assumptions about what it means to be old (Gibson and Barsade, 2003) but resort to ageist stereotypes, the prevalence of which indicates our lack of willingness to recognize older people as a diverse group.

Even though the experience of ageing within contemporary society might be richly diverse, society consistently displays ageist attitudes that demonstrate a marked lack of concern about its older members (Victor, 2005). Ageist stereotyping leads to older people often being described as stupid, decrepit, feeble, or unusually eccentric, wise or sweet natured, and in any event a group of people to be patronised. They are derogatorily labeled as geriatric, despite the obvious semantic inappropriateness of this (who would call a child a paediatric?), a burden or a problem and our language is littered with negative assumptions, for example describing someone as *'60 but still fighting fit'*. In addition, the term *'older people'* is often taken to mean anyone over the age of 65 thereby placing someone 65 years old in the same age group as a person 90 years or older. As Baroness Mary Warnock puts it, writing in *The Observer* on the role of older people in society "It's an insult to treat everyone above a certain age as if they are the same. Have some respect for my wishes" (*The Observer*, 17th May 2009). In fact to treat such a large and rapidly growing number of people as a homogenous group almost inevitably means lessening their sense of human agency, personal identity and dignity to some degree, and in some contexts such as acute care environments the prevailing culture can sometimes lead to the total absence of these important aspects of human existence.

The major sources of care for older people derive from their family and wider social networks: It is mainly within the domain of health care that professional contributions and cultures assume dominance. The research covered in this report focuses on one area of the NHS where the importance of culture has already been identified as central to the delivery of improved care. As noted earlier, widespread concerns about the poor standards of acute health care for older people (Health Advisory Service 2000, 1998) precipitated the introduction of the NSF for Older People intended to root out age discrimination in health care (DH, 2001). However, notwithstanding the considerable effort that has been expended, recent evidence suggests that the above aims have not been achieved and that the envisaged cultural change has not permeated all organisations with the same degree of success (Young *et al.*, 2003). Indeed a consideration of how modern day health services for older people have evolved would suggest that they have been inherently ageist since their inception, as the following section illustrates.

1.2.3 The evolution of modern day health services for older people

In their seminal consideration of the evolution of modern day health services for older people Wilkin and Hughes (1986) argue that it is necessary to consider the ways in which both old age and health are socially constructed if a full understanding of the complex factors that shape health care is to emerge.

We have already noted the social stereotyping that older people are subjected to and Wilkin and Hughes (1986) contend that this results in an overwhelming tendency for society as a whole both to view older people as a homogeneous group and to think of old age as a period of inevitable decline. The negative impact such stereotypes have on the health care older people receive is compounded by the continued application of either a medical/curative model or a functional model of health, rather than a more holistic approach, to the needs of older people. Consequently acute health services often fail to take full account of the complex array of social, psychological and cultural factors that shape health and instead focus primarily on curing a disease state or restoring physical function. Whilst these are entirely appropriate aims in many cases there is a large section of the older population for who neither cure or rehabilitation are relevant goals.

In their penetrating historical analysis Wilkin and Hughes (1986) trace the influence of the medical and functional models of health and the emergence of modern medicine during the nineteenth century on the way in which health services in general, and those for older people in particular, have developed. During the mid-nineteenth century there were three primary ways of obtaining health care:

- from poor law institutions
- from voluntary hospitals
- fee-for-service.

The wealthy paid for their health care privately: Fee-for-service. Those with acute illnesses turned to the voluntary hospitals which were emerging as centres for '*scientific medicine*' and the training of doctors. Those individuals who, because of disability or old age, could not be cured (termed the *incurables*) were left to the ministrations of the poor law institutions: Workhouses.

Here we see the antecedents of the current pejorative terms that are often applied to those individuals who fall outside the remit of medicine (the *incurables*) who became increasingly marginalised as advances in medicine gained pace and the prestige and status of the medical profession grew. The situation was exacerbated over the next 100 years and whilst the pioneers of Geriatric Medicine such as Marjorie Warren began to demonstrate what could be achieved with the right care, however, negative attitudes towards older people with 'chronic conditions' continued to manifest themselves in numerous ways.

Even the Beveridge Report, the bedrock of the NHS, cautioned about the dangers of being *lavish* to old age and questioned the value of expending resources on *unproductive* members of society (Wilkin and Hughes, 1986). Moreover, due to the failure of the Report to provide specific goals for the nascent NHS the dominant acute medical model, based on a hospital elite, was adopted uncritically (Wilkin and

Hughes, 1986). Consequently, as the success of the NHS was implicitly predicated on cure and the discharge of patients, older people with chronic conditions presented problems from the outset and were seen increasingly as a drain on resources. Over time the *incurables* became the *bed-blockers*, and more latterly *frequent flyers*. During the 1950-60's the emerging specialty of Geriatric Medicine was struggling for recognition and status in the face of stiff opposition from its more prestigious peers, medicine and surgery, who could see no value in '*spending time, money, energy and bed space on redundant senior members of society*' (Felstien, 1969). Eventually Geriatric Medicine was accorded specialty status for largely pragmatic reasons, the desire to free up beds. The existence of Geriatric Medicine provided medicine and surgery with a way of getting frail older people '*out of their beds*' (Wilkin and Hughes, 1986).

However as an emergent discipline Geriatric Medicine was faced with a dilemma: In the absence of cure for many of its patients how could it demonstrate success? According to Wilkin and Hughes (1986) this was achieved by replacing the medical/curative model of health with a functional one in which rehabilitation and the restoration of function became the goals of geriatric care and improved scores on measures such as the Barthel Index became key indicators of success.

Paradoxically the emergence of Geriatric Medicine, whilst legitimising the needs of those who would benefit from rehabilitation, had the effect of further denigrating people with long term needs who rapidly became an embarrassment to the system and were subject to '*aimless residual care*' (Evers, 1981). Essentially modern medicine has always valued cure more than care (Evers, 1991) and such tensions are escalating, as evidenced by the need for recent initiatives such as the '*Dignity Challenge*' (Social Care Institute for Excellence, 2006). Interestingly, concerns about the quality of acute care for frail older people are not new, indeed the desire to improve standards was what motivated the early pioneers of Geriatric Medicine and Gerontological Nursing. However even the committed have struggled to initiate and sustain change. For example over 20 years ago a joint report of the Royal College of Nursing (RCN), the British Geriatric Society (BSG) and the Royal College of Psychiatrists (RCP) (1987) lamented the poor standards of care for older people in acute hospitals. Their concerns related less to the quality of '*technical care*', which was generally considered good, and instead reflected the failure to attend to the *personal, social and psychological implications* of illness. Far from things improving, events over the last two decades indicate that these areas remain a major cause for concern.

This is in large part a product of the deep-seated and often unspoken beliefs that drive acute health services, as reflected by the continual push for greater efficiency and the various targets that provide one of the key measures of success. Of course limited resources have to be used wisely but as we will argue later there remain fundamental tensions between a curative model of health on the one hand and the needs of an increasingly large section of the older population on the other hand that require further consideration. This was highlighted by Wilkin and Hughes (1986) who concluded their analysis by noting that:

"Fundamental change is only likely to be achieved as part of a wider social and political movement...which challenges society's attitudes towards old age and seeks

to win the power to formulate objectives for health care and manage resources accordingly”

This is something to which we will return later. Having briefly considered the historical and professional antecedents of health services for older people we now look at more recent policy developments.

1.2.4 Older people and the NHS: The need for culture change

When considering the prediction that the number of over 75 year olds in Britain will rise from 4.7 million in 2007 to 8.2 million by 2013 (Office of National Statistics, 2007) it becomes clear that caring for older people will continue to be the core business of the NHS. Currently older people, i.e., those over 75 years old (and increasingly those over 85 years old) constitute the highest proportion of health care users; indeed the average 85 year old is 14 times more likely to be admitted to hospital than the average 15-39 year old (Hospital Statistics Data, 2005/2006). Moreover, whilst just 17 per cent of people under 40 have a long-term condition, 60 per cent of people over 65 years old suffer from one or more complex co-morbidities and long-term conditions that require regular inpatient stays and continuing NHS care in the community (DH, 2008b).

The last 15 years has witnessed a series of initiatives designed to improve the experience of older people within the acute health care setting. Prompted by initiatives such as the *Not Because They Are Old* report (HAS2000, 1998) and Help the Aged *Dignity on the Ward* campaign (Davies *et al.*, 1999) the Government launched the NSF for Older People (DH, 2001). Based upon the principles of the NHS Plan (DH, 2000) the NSF outlined a ten year comprehensive government strategy designed to ensure the provision of fair, high-quality, integrated health and social care services and specialist interventions for key conditions aimed at meeting the needs of an ageing population (Askham, 2008).

By applying key principles of rooting out age discrimination and promoting *person centred care* the NSF aimed to ensure that care would be delivered on an individual basis which enhances the independence and wellbeing of older people, whilst also ensuring that all older people and their carers are treated with respect, fairness and dignity (DH, 2001). An ambitious project, which demanded effective and consistent application of evidence based care, the NSF had major implications for the way in which health care services were organised and delivered. It required a better trained workforce, the development and strengthening of partnerships between health and social care providers and also between the providers and the recipients of care, and their carers.

Since the initial publication of the NSF in 2001, there have been subsequent reports published in 2004 *Better Health in Old Age* (DH, 2004) and in 2006 *A New Ambition for Old Age* (DH, 2006a) which together with a review (Commission for Healthcare Audit and Inspection, 2006) have highlighted a number of improvements that have been made to the care of older people. Overall these paint a favourable picture of the impact of the NSF, suggesting that age discrimination has diminished and that as a result: More older people than ever are in receipt of appropriate health care services (DH, 2004); there are more specialist services and specialist staff for older people (DH, 2006a); that increasing numbers

of older people are taking advantage of health promotion opportunities (Commission for Healthcare Audit and Inspection, 2006); and, that person centred care is more evident in practice, for example, by a greater number of carer assessments and more older people in receipt of direct payments (Commission for Healthcare Audit and Inspection, 2006). In addition, while better intermediate care services have provided greater support for independent living, there is evidence of a continuing decline in the rates of complex discharges (DH, 2004). Health services also now provide more intensive home care services thereby reducing the need for people to enter care homes prematurely. Whilst some of these improvements might have occurred without the NSF, recent developments provide some promise of enhanced health care for older people (Askham, 2008).

However, all is not well and despite the above there is still evidence of deep-rooted negative attitudes and behaviours towards older people (DH, 2006). Such attitudes inevitably impact on the care of older people, and a sustained focus by the national media on the standards of care older people were receiving in acute hospitals in England and Wales (for example Panorama's *Undercover Nurse* in 2005) resulted in a national campaign to promote dignified care for older people in hospital; in response the Government promised *Dignity Nurses* in each hospital in England and Wales. These nurses were to be employed at a senior grade and would be responsible and held accountable for dignity issues within each hospital. It was envisaged that larger Trusts would have teams of Dignity Nurses (Daily Telegraph, 20th July 2005). Such a focus on dignity reflects the increasing concern worldwide about dignity in healthcare (Brundtland, 2003). It was at this point that the current project was being developed and the focus on promoting dignified care for older people provided an ideal opportunity to explore change initiatives within the acute hospital setting.

Since we submitted the proposal for this study the focus on dignity has been sustained with the launch of further reports centred on this issue, including *Dignity in Care* (Social Care Institute for Excellence, 2006) which set the *Dignity Challenge*: An explicit set of statements which clearly laid out what people could expect from a service which '*respects dignity*'. This '*challenge*' was backed up by a series of *tests* which could be used by providers, commissioners and service users as a means of assessing the performance of their service with regard to the provision of dignified care. More recently the Royal College of Nursing launched its own *Dignity: At the heart of everything we do* campaign (RCN 2008) which focused on providing direction and support to the UK's nursing workforce during the delivery of care for patients. This was followed in 2009 by the Nursing and Midwifery Council (NMC, 2009) publishing its *Guidance for the care of older people* in which dignity was a key element. Despite such initiatives however, care of older people in acute hospitals continues to attract negative attention with, for example, the publication of *Patients not numbers, people not statistics* by the Patients Association (Mullan, 2009) which highlights sixteen accounts of very poor care in the NHS.

Against this background the future of the NHS itself has been the subject of review. *The Next Stage Review* (DH, 2008) outlined the future of the NHS and indicated what is needed to ensure the delivery of a world class health service. Despite containing very few specific references to the care of older people, the Next Stage Review aims to drive up standards of care for all those who use the

NHS. Unsurprisingly there is a strong emphasis on the delivery of dignified care with respect to quality of care, long-term conditions, and the delivery of personal care. Moreover, as we will highlight later, the review enshrines compassion as one of the core values lying at the heart of the NHS. In achieving its goals the report proposes the introduction of standard quality measures, and performance metrics which are likely to become ever more predominant features of the healthcare system, with performance data being made available to the public. Such an emphasis builds upon existing initiatives such as *Essence of Care* (DH, 2001b), *NHS Productivity Metrics* (DH, 2006b), *Saving Lives* (DH, 2007a) and *Releasing Time to Care* (DH, 2007b). Whilst these initiatives and others aim to improve quality in terms of patient safety and effectiveness of care, commentators have warned that other issues, such as dignity, which cannot be captured through the measurement of technical caring practices, may not be seen as being of equal importance by health service managers with an eye on monthly performance measures (Reed and McCormack, 2007). Concerns over such issues have led to the Kings Fund to launch their recent *Point of Care* (Goodrich and Cornwell, 2008) campaign, which is considered in greater detail in *Section 4*.

This section has briefly highlighted a number of issues which impact on the current project, these include: The growing population of older people in society; the historical tensions that addressing the needs of older people and those with long-term conditions have posed for acute health services; recent concerns over the quality of health care for older people, and attempts to address these; and, the potential tensions between the focus on dignified care and meeting standardised targets.

We conclude this context setting section with the views and experiences obtained from our reference group and opinion leaders.

1.2.5 Reflections of users, carers and national opinion leaders

As part of establishing the context and setting the scene for the larger study we wished to augment the above brief consideration of the relevant societal, historical and policy factors by obtaining the views and opinions of a small group of users of health services and their carers' and of national opinion leaders drawn from the worlds of policy, practice and academia who might be expected to have an informed view on health services for older people.

To explore the views of users and carers we recruited a reference group of six older people from an already existing group of trained volunteers. All of the participants had recent experience of an acute health care setting, either as patients, carers, or both. We asked the group to reflect upon their experiences using a critical incident technique to identify significant events, the way that they were managed and their perceived outcomes. We met the group on five occasions of 2 to 3 hours each, mainly prior to the start of the main period of data collection. The reference group data was treated in an iterative manner with members asked to comment on the study as it progressed. We also consulted with them to seek their advice, for example, in relation to the survey. Audio recordings from the meetings of the reference groups were transcribed and subjected to content analysis (see *Section Five*). Here we focus on their thoughts about their recent

experiences of acute health care and briefly consider some of the main themes that emerged.

With regard to opinion leaders we identified 11 individuals who occupied very senior, nationally important. Roles in the policy/practice arena, the third sector or academia. We conducted in-depth individual interviews with them, either face-to-face or over the telephone and asked them their views on a number of key issues.

In these interviews with '*opinion leaders*' we asked them to adopt a strategic view and to reflect on several central concerns, in particular:

- factors that they felt impacted on the culture of care within acute hospitals
- the challenges of providing high quality care to frail older people
- the perceived impact of the NSF
- factors that might facilitate or inhibit culture change in acute services for older people

A largely open interview style was used but as the interviews progressed and data were collected and analysed we introduced themes from earlier interviews into late ones on order that they could be further explored and elaborated upon.

Below we provide a brief overview of these reflections, beginning with the views of the reference group.

As noted all the members of the reference group had recent experience of acute health care and all voiced similar concerns whilst also being able to identify often seemingly '*little things*' that nevertheless often made a real difference to their experiences. As we asked them to think in particular about issues relating to dignity and quality of care we focus primarily on these issues.

Many of their reflections centred round factors that shaped the nature and quality of the physical and interpersonal environment of care. The quality of the physical environment was clearly important and people talked of their concerns about issues such as cleanliness, the lack of space between beds and how these impacted on privacy and personal dignity. However, of far greater concern were the attitudes and care practices of staff, primarily, but not exclusively, nursing and direct care staff; a perceived absence of nursing staff, who often did not seem to '*be there*', was remarked upon several times. The lack of a visible nursing presence was seen as a cause of anxiety, not only in terms of providing reassurance that help was available if needed but also in helping patients to feel confident that support would be provided promptly if the call bell was used. The relative failure of nurses to respond quickly to a summons for assistance or a failure to return '*in a tick*' as promised caused much unnecessary anxiety.

Paradoxically sometimes the presence of a nurse was itself a cause for concern, especially when they demonstrated what was seen as unprofessional behaviour. This often involved either attending to the patient's needs but talking over them as if they were not there; or possibly worse sitting at the nurses' station and talking about personal, and occasionally intimate, details of their life within earshot of patients. Some nurses gave the impression that often small requests from patients were '*just too much bother*'. Worse still some nurses were perceived as being '*sharp*' or '*nasty*'. Other nurses were described as demonstrating '*ageist*' attitudes

and of indicating by their behaviours that older people were '*past it*', '*stupid*' or '*not worth the effort*'. Particular concerns were voiced about the care of older people with cognitive difficulties. Interestingly the majority of the comments about nurses' attitudes came from family carers who, as the literature attests, often become skilled observers of care and make highly insightful and subtle judgements about whether nurses are '*up to the job*' of providing good care for their carer (Brereton and Nolan, 2003). The carers we spoke to often felt the need to be assertive and to raise concerns about the care their relative was receiving, despite feeling in a relatively vulnerable position. Furthermore, carers did not base such judgements solely on their observations of the care their relative received but also on their observations of the care given to all patients within their sight.

Nutritional care figured prominently in the comments and related not only to a lack of attention to patient preference for type of food or portion size but in particular to food being placed beyond a patient's reach and/or being taken away without the patient having touched it, this linking, once again, to the absence of staff from patient care areas at significant points, such as meal times.

On a more interpersonal level the quality and nature of communication with patients and carers received considerable comment, both positive and negative. A lack of information and failure to communicate were major bones of contention, but on the other hand, sensitive attention to these areas prompted much praise. Carers in particular wanted staff to listen to both the patient and themselves. Nurses who were seen to do this and to: '*Go the extra mile*'; '*keep their promises*'; and '*really get to know the patient*', were highly valued but were often seen to do this '*in spite of*' rather than '*because of*' the system of which they were part.

The group left no doubt as to the value that they accorded to good leadership from the senior nurse on the unit, and the characteristics of a good leader were not hard to identify. She/he was:

- highly visible on the unit, for staff, patients and carers
- had clear expectations and communicated these to staff
- made it clear who was in charge and what they expected them to do when she/he was off-duty
- created a feeling of teamwork on the unit
- mediated between potential interdisciplinary disputes.

The above is consistent with previous work on dignified care (Davies *et al.*, 1999) and as will become apparent was substantiated both in the opinion leader interviews and in our narrative review.

Although the above reflections were obtained from a small group, the participants were well informed and had recent experience of multiple hospital admissions either as a patient, carer or both. Importantly the themes described above mirror closely those identified by numerous reports of patients'/carers' experiences that prompted the NSF. Significantly the views of the reference group were obtained several years after the NSF had been introduced and it might be assumed that the above issues had been largely resolved. Therefore whilst we make no claims for the representativeness of the above views they reinforced the importance of the

study exploring a number of key areas that we had suggested in our original proposal. Further support was provided from the interviews with opinion leaders and these are considered next.

Much of the power of the data from the reference group came from the immediacy of their experiences and their skill in recounting them in a reflective way. The interviews with the opinion leaders provided a more strategic and global account.

For the opinion leaders the roots of many of the problems that older people face when requiring acute care were seen to lie in the deeply embedded cultural antipathy towards older age that society was seen to hold. A number of people believed that an aversion to old age was based on a widespread fear of ageing, and the negative consequences that were associated with it. Such fear and lack of understanding was believed to affect practitioners as much as anyone else, with such individuals not being immune to the ageist attitudes of society. Interestingly, given our consideration above of the historical antecedents of the NHS, one of the opinion leaders noted the following:

"Ageism is built into the system, which is often inappropriate to the needs of older people. The acute hospital system was designed in the 19th century and the care homes came out of the workhouses so the traditions are longstanding and not geared to the needs of older people today. The whole system needs radical reform and modernisation"

Whilst one of the main goals of the NSF was to eliminate ageism in health care there was a view that the NSF in isolation was insufficient and that addressing the above deeply held beliefs, both about the nature of ageing and the implicit assumptions underpinning acute health care, required a root and branch reform of the NHS. The parallels between this view and the analysis of Wilkin and Hughes (1986) are striking. Therefore whilst the NSF might tackle the more overt manifestations of ageism it did little to address the far more deep-seated and latent cultural issues, both within the professions servicing the NHS and society more generally. One opinion leader believed that action was needed at several levels:

- societal
- institutional across the NHS as a whole
- professional
- organisational
- unit
- individual.

There was recognition that the above represented a considerable challenge and that the types of change needed required the investment of time and energy. One of the opinion leaders from the third sector felt that possibly the most useful approach to achieve change that would directly impact on the patient's experience was to target initiatives at the unit level. He noted that from the comments his organisation received the quality of care not only varied from ward to ward within the same hospital but sometimes from shift to shift within the same ward.

Mirroring the thoughts of the reference group he highlighted the pivotal role of the ward leader:

"I think that at the ward level and hospital level there is the issue of role models and leadership. I guess one of the things that strike us is how random quality of care can be within the same hospital from ward to ward and even sometimes from shift to shift on a ward. I think particularly at the ward level then the role that is played by the ward leader is crucial in setting the cultural standards and the relationships that happen there."

The acute hospital context was seen to provide a particularly challenging environment due to a variety of factors, particularly the pressures and expectations to deliver that acute Trusts had to operate under. This was often seen to compromise the formation of relationships with patients, as was the use of casual staff:

"There's a particular challenge in acute settings due to the everyday pressures, such as the lack of time to build relationships with patients. Time pressures hit home and having an acutely ill 80 year old doesn't help. Neither does the use of bank and agency staff".

The target driven culture of the NHS was the subject of frequent comment with it being noted that the emphasis now seemed to be placed on the metrics of care rather than the meaning of care.

The challenges of attracting staff to work with older people due to the poor 'image' and status of such work, despite the skills required, was also raised a number of times:

"Work with older people generally tends to attract a certain type of person who doesn't mind the image which is generally unsexy, not interesting and in fact terribly dull. People who work with older people generally have specialist knowledge and skills of the ageing process and have worked through their own fears and prejudices about ageing".

The net result was an over-reliance on agency or bank staff which was seen to impact negatively on the quality and continuity of care.

As noted above feelings about the impact of the NSF were mixed. There was general agreement that the initiative had helped to raise the profile of age discrimination. Beyond this, some thought that it had helped to address issues of access but not dignity, others the reverse. Again, as highlighted above, deeper seated issues were seen to lie at the heart of the problem:

"It's (NSF) had a direct impact in terms of raising the issue of discrimination, but I'm not convinced that it has driven forward the culture change. I don't think that hospital care is much better than it was 5 or 6 years ago, it hasn't addressed the underlying ageism".

There was recognition of the considerable investment of time and money in the NSF but a general feeling that its impact was not as wide ranging as it might have been and that overall awareness amongst staff on the ground was limited.

Informants were asked to reflect upon the factors that they thought might promote or conversely inhibit the sort of culture change needed to improve the care of older

people in acute settings. They identified several factors with, as noted above, the most frequently mentioned being the influence of leaders both at ward and a more strategic level. However genuine 'buy-in' at all levels was seen as essential.

"I think it's entirely possible (to bring about culture change) especially with an inspirational leader to drive forward change, for example a nurse consultant, not just in acute settings but at the interface. There's a need to get 'buy in' from senior managers and the nurse consultant is potentially pivotal here".

"There's a need to create a commonly understood purpose, we need sufficient critical mass. This was the secret behind major cultural change in the past, such as the civil rights movement in the US".

Improvements in communication, efforts to more fully involve older people and the importance of establishing a commonly understood sense of purpose were also stressed, especially around key transitions such a discharge:

"The top issue is around communication, that's the key thing. I'd include the need to provide support and advocacy for older people, more engagement between staff, older people and their families. This is one of the biggest issues, especially around discharge".

However, it was also recognised that there were potentially significant barriers to culture change, not least the unrelenting pace of change in the NHS, leading to a short term agenda:

"My biggest concern is that there is so much change, so many new initiatives that it stifles any long-term strategic vision for planning and investment. It results in a short term mentality. There's so much effort put into each new thing and then all that work goes when the next policy comes out. It's all a desperate waste".

Having in this section provided a context and background to the study we now go on to consider some key concepts that informed the way that the study was conducted. We begin with a brief overview of notions of organisational culture and climate.

Section 2: Key concepts informing the study

2.1 Organisational culture and climate

This section describes three key analytic frameworks that are used throughout the study to help interpret and analyse our data and shape our conclusions – the Senses Framework, Transformational and Transactional models of change, and the tension between Pace and Complexity running through health care. We first provide brief overviews of the concepts of organisational culture and organisational climate.

2.1.1 Organisational culture

Although the role of culture in the achievement of performance in general, and safety and quality of care in particular, in the NHS has received considerable attention from managers, policy makers and researchers, there remains considerable confusion over what is meant by organisational culture. For example, Ott (1989), in a survey of published sources, identified over 70 different words or phrases used to define organisational culture. The conceptual confusion surrounding culture has also been reflected in fundamental disagreements about how culture should be studied, if it can be controlled by management, and whether particular types of culture result in better performance (Martin, 2002).

Nevertheless, organisational theorists repeatedly employ terms that bear a family resemblance (Barley, 1983), with understandings of culture being underpinned by notions of shared values, beliefs and meanings. These ideas are reflected in manifestations of culture including formal practices (such as pay levels, structure or hierarchy, organisational policies and procedures), informal practices (such as the norms), rituals, language, and the physical environment.

To help focus culture research and organise its different elements, culture is often approached as existing at several levels. The most influential of these approaches was developed by Edgar Schein (1985). In Schein's theory, culture exists on three levels which range from the very visible, which are readily accessible to observers, to the tacit and largely invisible that are very difficult to access.

Level One: Artefacts

Level Two: Values and beliefs

Level Three: Basic assumptions

The easiest level to observe is that of artefacts. They include everything from the physical layout of the building, the language people use, the way they dress, to behavioural routines and norms, including structures that reflect these patterns of activity, for example, decision making, coordination, communication and reward that are observable to outsiders.

Values and beliefs exist at the next level of visibility. They consist of reasons or justifications for people behaving as they do (Sathe, 1985), and influence behaviour. They are moral and ethical codes, ideologies and philosophies that serve as guidelines for action in an organisation. Whereas artefacts can be interpreted as what is, values represent what should be. However, it is important to distinguish between espoused values and values in use. For example, the NHS states officially that it gives equality of care irrespective of patient age, but in practice may still prioritise care to younger patients.

Basic assumptions lie at the deepest level of culture and are taken-for-granted, underlying and usually unconscious beliefs and values that determine perceptions, thought processes, feelings and behaviours. Assumptions differ from values at level two which are mostly espoused, in that they have become so ingrained that people subscribe to them in a largely unconscious and unquestioning way.

According to Schein's model, the essence of culture is its core of basic assumptions and beliefs that reach outward through values to culturally guided action and other artefacts. So as we discussed in the prior section the basic, and largely tacit, assumptions that underpin modern medicine have acted in powerful ways to shape the nature of the health care older people receive.

While some cultural elements may be shared across an organisation or professions, there will be some elements that differ across sections of the organisation or amongst and between professional groups. Culture is not simply the espoused values of one group, (for example managers) that are supposedly shared by all or most employees. Sub-cultural differentiation is an essential feature of any organisation's culture and the more complex the organisation the greater the differentiation. This is especially true in the NHS where the culture of management often competes with strong professional subgroups in defining what is *correct* (Parker, 2000). Subcultures exist within different occupational or professional groups and are associated with different levels of power and influence within the organisation, such as the primacy of the medical culture in the NHS for example (Davies, Nutley & Mannion, 2000). The potentially pernicious effects of this have already been discussed in relation to services for older people.

It is very unlikely any culture, studied in depth, would exhibit organisation-wide consensus as employees have different interests, tasks, responsibilities, backgrounds, experiences and expertise, and are subject to varying leadership styles. The material conditions of their work, the pay they receive for it, and the status it is accorded, differ. In addition, individuals bring different group identities (e.g. class, ethnicity, gender) to the workplace (Alvesson & Berg, 1992; Martin, 1992; Van Maanen & Barley, 1985). The NHS is particularly complex because of the way that teams are assembled to perform particular tasks or networked to perform sequences of tasks but are also cross-cut by other sources of cultural differentiation such as professional identities. Organisational culture is therefore inherently complex, comprising a nexus where environmental and organisational influences intersect, creating a nested, overlapping set of subcultures (Martin, 1992).

An important point in relation to this study is that subcultures are likely to emerge where any subset of an organisation's members interact regularly with one another, and identify themselves as a distinct group within the organisation.

Consequently the subdivision of hospitals into different wards provides a perfect setting for the emergence of subcultures based on ward, and/or professional, membership (Lok *et al.*, 2005). Indeed a central assumption of this study is that cultural variation will exist on different wards that in turn will influence the quality of care provided for older patients.

Although organisational culture can be segmented into subcultures, it is important to acknowledge that the culture of an organisation is bound up with larger cultural processes associated with the organisations' environment. Every organisation expresses aspects of the national, regional and industrial cultures in and through which it operates. The NHS is a uniquely British institution that is influenced by British culture and no doubt the value accorded to older people in our society does, as we highlighted in *Section 1.2*, influence the value placed on older people within the health care system.

Organisational culture is seen as key to quality of care and performance improvement in the NHS, however there is actually little evidence to support a causal relationship between culture and performance. Much research and practitioner interest has been given to effects on performance of the 'right' (e.g., flexible/adaptive) or strong culture, but the relatively few systematic empirical studies on the culture-performance link have not provided convincing empirical support (Brown, 1995; Calori and Sarnin, 1991; Siehl and Martin, 1990). Some recent progress has been made with Mannion, Davies', and Marshall's (2003) work on cultures for performance in health care funded by the Department of Health's Policy Research Program. However these findings are limited by their reliance on senior managers' views of the values held by their organisation and their cross-sectional design. Likewise, managed cultural change has been continually advocated as a route towards improving health care, as we describe earlier has been the case in older people care, but little is known about how best to enact such a strategy of change successfully.

The layering of culture into artefacts, values and assumptions highlights the difficulty of changing culture, especially in such a richly diverse organisation as the NHS. While it may be relatively unproblematic to change and introduce new artefacts and espoused values, changing deeply ingrained beliefs and assumptions is a considerably more challenging proposition (Davies *et al.*, 2000), especially across different subcultures with sometimes conflicting interests and different levels of power. For example, our research suggests that while some of the older person initiatives described in *Section 1.2* have brought life to debates around the care of older people, they have failed to transform deeper values and beliefs that drive clinical practice.

In this study we aim to shed light both on the implications of culture for health care performance, and on the processes that facilitate and support cultural change by giving the research a strong strategic focus. Culture research can be problematic, being almost anything depending on who is conducting the research (Martin, 2000); and culture research needs a strategic focus if it is to be more than a description of one organisation at a time. Understanding culture in relation to the experiences of health care for older people, rather than a generalised notion of *performance*, will, we hope, bring about a deeper and more nuanced understanding of the complex factors that operate to sustain the current culture of care within

acute health care settings and how efforts to initiate and maintain change may be successful.

2.1.2 Organisational Climate

Culture is a highly complex phenomenon that particularly lends itself to the in-depth qualitative methods that we employ in the case studies presented in this report. However we believe a multi-method approach can help reveal different levels of culture. Survey methods are suitable for exploring the more overt aspects of culture as perceived by employees, labelled organisational climate (Schein, 2000). At more practical level, considering the diagnostic purposes of the toolkit, survey methods facilitate the collection of data from a large number of individuals across many units. Climate can be understood as a surface manifestation of culture (Schein, 1985; Schneider, 1990). Climate reflects staff perceptions of their organisation and work unit, in terms of organisational policies, practices, and procedures, both formal and informal. Aspects of organisational climate are easier to measure because they are tangible. So, a multidimensional climate questionnaire measure may focus on the beliefs held by individuals regarding such organisational properties as communication quality or managerial trust.

Climate perceptions are seen as critical determinants of individual behaviours, attitudes and well-being in organisations, thought to mediate the relationship between characteristics of the work environment and individual responses (Carr, Schmidt, Ford, & Deshon, 2003). That is, individuals do not respond directly to the work environment, but how they perceive and interpret it. Climate research seeks to assess this interpretation, on the premise that employees' behaviour is an outcome of this process.

At the individual-level of analysis, studies have reported relationships between employees' perceptions of their work environment and outcomes such as job satisfaction (Mathieu, Hoffman & Farr, 1993; James & Tetrick, 1986) psychological well-being (Cummings & DeCotiis, 1973), absenteeism and turnover (Steel, Shane, & Kennedy, 1990), and job performance (Brown & Leigh, 1996). Many empirical studies have used an aggregate unit of analysis, such as the work group or team, department or organisation. Such climates are constructed by grouping individual employee scores from climate questionnaires to the appropriate level and using the mean score to represent climate at that level. The rationale behind aggregating individual data to a unit level is the assumption that organisational collectives, whether it be a team or an organisation, have their own distinct climate and that this will impact on important outcomes such as team or organisational performance. The majority of theory and research is now focused on aggregate rather than on individual climate (Schneider, Bowen, Ehrhart, & Holcombe, 2000).

It is when individual level climate perceptions are aggregated to the group or organisational level to represent, like culture, a group phenomenon, that climate can be seen as a surface-level indicator of organisational culture (Schein, 2000). Indeed, Reichers and Schneider (1990) define organisational climate as *'..the shared perceptions of the way things are done around here'*, indicating the common ground shared by culture and climate. There is no doubt that climate and culture are similar concepts since both describe employees' experiences of their organisations, and both are linked to organisational outcomes. Organisational

climate, according to Schneider (2000), represents the descriptions of the things that happen to employees in an organisation. Organisational culture, in contrast, comes to light when employees are asked why these things occur. The question of why is answered in relation to shared values, common assumptions, and patterns of beliefs held by organisational members and it is these that define organisational culture. That is, members' cultural assumptions, values and beliefs are translated into practices, processes and procedures that guide collective action, such as care giving, and that are measured as climate perceptions (Parker *et al.*, 2003).

As with culture research, we advocate, that the climate concept is most usefully employed when it has a strategic focus. Early climate research did not have a specific focus but considered employees' experience of broad organisational issues in relation to broad organisational outcomes such as company performance, mostly with limited success. More recent work, using strategically focused climate measures has produced much more consistent relationships with specific organisational outcomes. For example, in health care settings, research has demonstrated that employee perceptions of safety climate are strongly related to safety outcomes such as medication errors (e.g., Hoffman & Mark, 2006). In service settings, employees' experience of a climate for service is reflected in customers' experience of service quality (e.g., Schneider 1980, 1998, 2000). Likewise, in this study we aimed to develop an instrument that assesses staff's work climate perceptions with a specific focus, namely the practices and procedures that support care giving.

In order to understand the role of organisational culture and climate within acute health care settings we will also draw on a range of prior theoretical frameworks that have strong support from existing work and were reinforced by our narrative synthesis. We consider these below beginning with the 'Senses Framework'.

2.2 The Senses Framework

As already noted the last decade has witnessed considerable concern about the quality of care frail older people receive in acute health care settings. Such concerns originally achieved prominence following the *Not Because They Are Old* report (HAS 2000, 1998), which highlighted the failure of acute hospitals to attend to fundamental aspects of care such as adequate nutrition and hydration. Subsequent to this, Help the Aged launched their *Dignity on the Ward* campaign which resulted in a major report identifying the characteristics of an environment that promotes dignity for older people, and those who work with them (Davies *et al.*, 1999). Contrary to studies that attempted to discover what was not working in the care of older people, Davies *et al.*, (1999) set out to identify acute care areas where older people and their carers considered that they had received good or excellent care. Following a literature review on dignity and a series of detailed empirical case studies Davies *et al.*, (1999) sought to distil the characteristics that the areas providing good care shared. They found that each area focussed on four key principles and that they all had a culture that:

- valued fundamental practice and accorded value and status to so called 'basic care' such as attention to adequate hygiene, nutrition and continence

- had a stable ward team that was encouraged to innovate and question practice
- had a commitment to an explicit and clear set of values with a philosophy of care that was shared by staff of all disciplines
- established clear and equitable goals of care so that older people received the same standard of care as younger individuals.

Further analysis of the extensive data indicated that it was the actions of the ward manager or managers that were key to ensuring that this culture was sustained. In seeking to identify the factors that promoted such a culture Davies *et al.*, (1999) drew upon the Senses Framework originally developed by Nolan (1997) for use in long-term care settings. Concerned with the continued poor standards of care in such environments and the lack of a clear therapeutic rationale for staff Nolan (1997) argued that the goals of care should be to create a culture in which residents experienced six senses. These were:

- a sense of security: To feel safe physically, emotionally and psychologically
- a sense of belonging: To feel part of a valued group, to be able to continue or initiate valued relationships
- a sense of continuity: Not only in the care received but also to experience care that made meaningful links between the past, present and future
- a sense of purpose: To have clear and valued goals to aspire to, something to give life meaning and purpose
- a sense of achievement: To be able to make progress towards such goals and to feel pleased with your efforts
- a sense of significance: To feel that you and what you do in some way matter.

In proposing the senses Nolan (1997) also argued that if staff were to create these senses for residents then they also had to experience the senses themselves in their day to day work. So for example staff needed to: Feel safe to question practice; feel part of a team with a valued contribution to make; experience continuity of goals; have a clear sense of purpose and know the goals of their care; be able to achieve their goals and have recognition for their efforts; feel that what they do is important and accorded worth and status.

In using this approach as a framework to interpret their data Davies *et al.*, (1999) found that the same principles, albeit with different manifestations, applied equally well to acute care settings and they were able to identify how the senses were created for older people, their carers and the staff who worked on the unit. Subsequently the senses have been further refined and tested in a range of settings to include care homes and the community (see for example Nolan *et al.*, 2001, 2006; Brown, 2006; Faulkner *et al.*, 2006; Davies *et al.*, 2007; www.myhomelife.org.uk) The term an *enriched environment* (Nolan *et al.*, 2001) has been coined to describe care settings in which all stakeholders experience the senses and an *impoverished environment* for one in which the senses are lacking for some or all the stakeholders.

In our proposal we argued that the senses would be used as an analytic lens to try and capture the sort of environment in which culture change was more likely to succeed. For example would change be more likely to be initiated and sustained in an enriched environment in which staff felt safe to innovate and in which a questioning approach was promoted? The senses, therefore provide one of the key theoretical approaches underpinning the study.

2.3 Other analytic frameworks

As will be seen shortly, the narrative review and synthesis (see *Section 4*) identified a number of other frameworks that we have used to help interpret our data and shape our analysis and conclusions. Our intention here is to make explicit those frameworks that influenced our thinking from an early stage in the study. The major one, the Senses Framework has been described above. Here we briefly consider two more, the transactional and transformational model of change and the theoretical framework of Pace /Complexity.

We have already noted the widespread concerns about the quality of care for frail older people in acute health care settings manifest at the time the study started. However such concerns were not confined to health care and in response to similar issues in the social care arena the Government introduced the Modernising Adult Social Care (MASC) programme comprising a series of linked initiatives intended to transform the delivery of social care for frail and vulnerable people. After the programme had been completed a review of all the initiatives was commissioned in an attempt to identify any shared lessons that seemed to apply across contexts and settings. In reflecting on the success of the various projects Newman and Hughes (2007) concluded that, whilst there had been some progress, there was still scope for considerable improvement. They argued that too much emphasis was given to achieving change using transactional mechanisms, and too little to the use of transformational approaches. In the former instance change is introduced because sanctions are applied, and people therefore comply with the necessary conditions. In other words, people change their behaviour because they feel they have to, not because they want to. In marked contrast, transformational models seek to promote change by helping people to reappraise the values that underpin their practice. If successful, peoples behaviour changes because they believe it is the right thing to do. Newman and Hughes (2007) concluded that the more complex the change initiative the more the need for a transformational approach. This logic appeared to us to be entirely consistent with the senses approach where the goal is to transform the environment of care from an 'impoverished' to an 'enriched' one. We therefore have also considered change initiatives in terms of a transactional or transformational model.

The final *a-priori* theoretical framework that influenced our initial thinking addresses the tensions between the acute orientation of modern day health care and the ongoing needs of older people with long-term conditions. Such tensions are currently exemplified in the focus on dignity in care and, as will become apparent in the narrative synthesis, also lie behind recent initiatives such as the RCN *Dignity campaign* (RCN 2008), the *Nursing and Midwifery Council (NMC)* statements on *Care for Older People* (NMC 2009) and the King's Fund *Point of Care*

Campaign (Goodrich and Cornwell, 2008). Such tensions are often brought to a head when discharge planning is considered.

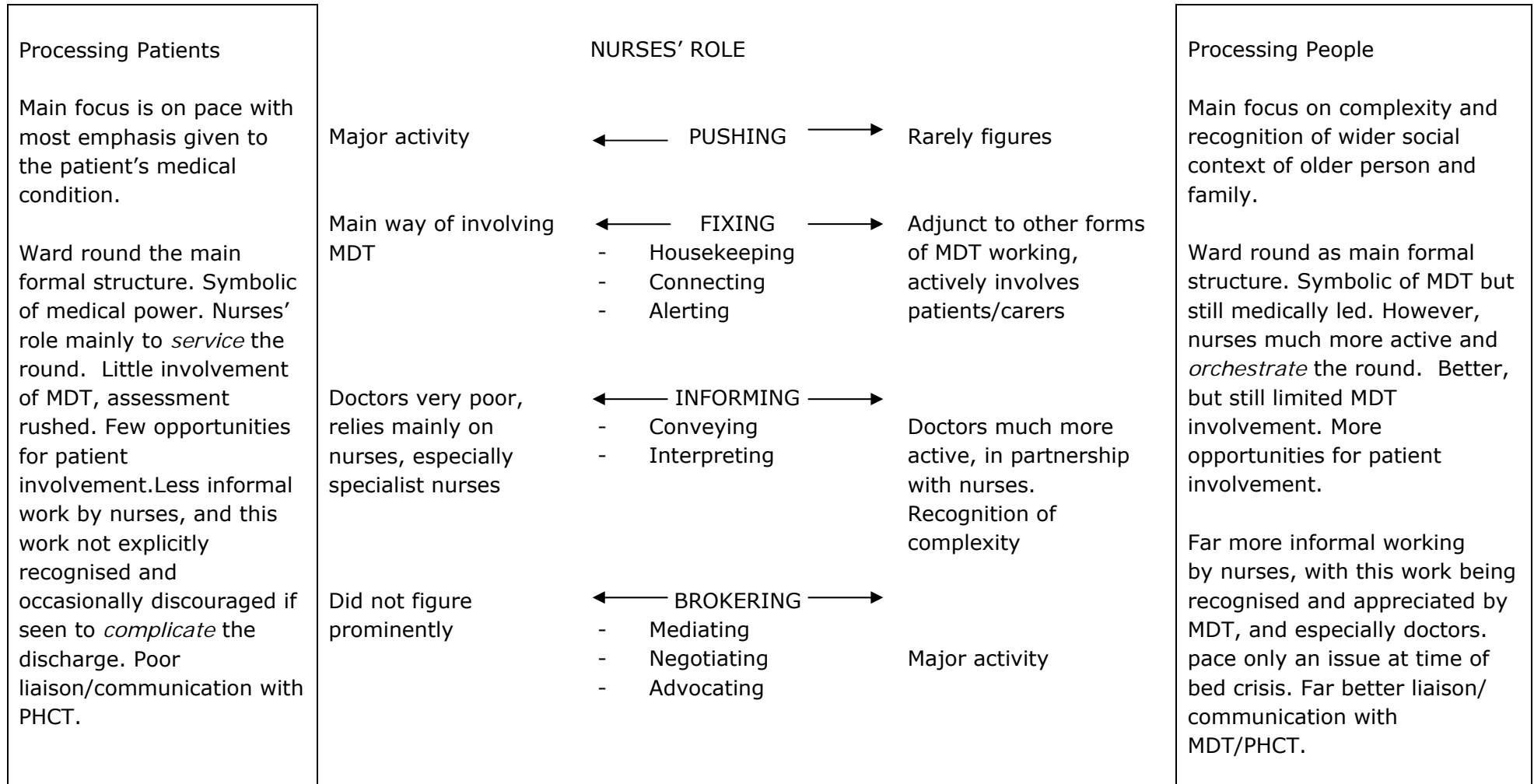
The challenges of discharging frail older people from acute hospital settings when they may be medically fit but do not have the necessary support to safely manage at home has been an enduring issue for some forty years. Early studies (Brocklehurst and Shergold, 1968; Skeet, 1970) identified several concerns that appear to have been undiminished despite the passage of time and numerous policy initiatives in the UK and further afield (Connolly *et al.*, 2009; Hickman *et al.*, 2007; Petersson *et al.*, 2009). Indeed the situation has been exacerbated by the increasing frailty of older people, the complexity of their needs, and the evermore rapid throughput and reduced length of stay in acute hospitals. This issue was explored in a study by Williams (2001) which sought to understand the differing discharge experiences, and the reasons underlying them, for older people on acute surgical, medical and specialist units. His conclusions suggest that two differing *modus operandi* underpin the discharge planning process. The ultimate aim of both is the same, that is, to move older people through the hospital system and out again, ideally into the community as quickly and safely as possible. However the quality of the discharge experience for older people and their families varied considerably dependent upon whether individuals were treated mainly as *patients* or recognised as *people* during the discharge *process*. This distinction hinged crucially on where the main efforts of the Multidisciplinary Team (MDT) were directed. At one extreme the team focussed almost exclusively on pace and their main goal was to ensure that the *patient* was moved through the system as quickly as possible. All other considerations were secondary, and indeed likely to be seen as an impediment to the ultimate goal. This was the main way of functioning on the medical and particularly the surgical unit. Conversely on the specialist care of older persons unit there was far greater recognition of the complexity of older peoples' needs and an appreciation of the importance of taking into account a range of social and other factors. The MDT therefore adopted a far wider and more holistic focus. The only consideration of complexity on the medical and surgical units was with regard to the patients medical condition. Detailed analysis of the data revealed that the ways in which Pace and Complexity were enacted, in terms of the perceived success of the MDT; and the extent to which older people and their carers were actively involved in the discharge process, turned on the role of the nurse as the orchestrator of the formal and informal work that was undertaken.

When the discharge planning process was concerned mainly with pace, *pushing* became the focus of staffs' efforts, and *fixing* became one of the main ways of achieving their goals (see Figure 2.1). In this way patients were processed as quickly as possible with little involvement and limited attention to anything other than their medical needs.

Conversely, where efforts were directed at *processing people*, complexity rather than pace became the prime concern based on an acknowledgement that older people present with a mix of illness-based issues and important social factors. As a consequence, the discharge planning process reflected a broader and differing pattern of working and included a significant range of interpersonal activities described as brokering. On the specialist care of older persons unit the key to treating older people more as *people* than as *patients* was the *brokering* activities engaged in by nurses, which consisted of *mediating*, *negotiating* and *advocating*'.

Such activities were largely absent in areas such as medicine and surgery where pace predominated.

Figure 2.1: The discharge experience: A theoretical account (Williams 2001)



These activities, their relationships and their impact on MDT working and the patient/carer experience are summarised in *Figure 2.1* and *Table 2.1* below.

The activities of *fixing* and *informing* were common across the differing clinical areas, but with considerable variation in terms of emphasis. How *fixing* and *informing* were structured provided a litmus paper test for the pattern of MDT working in clinical areas. In areas dominated by pace and *pushing*, such as medicine and surgery, the activities of *housekeeping*, *connecting* and *alerting* were the main ways of working, whereas on the specialist unit with its focus on complexity, these activities were an adjunct to more diverse ways of working that more fully involved patients and their carers as active participants.

In those clinical areas where pace and processing patients was the dominant model, the activities of *conveying* and *interpreting* relied primarily on the efforts of a few specialist nurses, for example the stroke nurse, who were not members of the ward team but rather provided a service to the hospital as a whole. Such individuals ensured that older people and their carers had the information they needed. Consequently, *conveying* and *interpreting* were not a routine part of the ward nurses role. Furthermore, the involvement of doctors was limited and *ad hoc*. Such ways of working were in direct contrast to the specialist unit for older people where *informing* was a major activity that involved multidisciplinary working and a partnership approach between nurses and the medical staff at all levels.

However, it was when brokering is considered that the real complexity of interactions and their skilled and dynamic nature becomes apparent. The three dimensions of brokering [mediating, negotiating and advocating, see Table 2.1] represent important forms of *relational knowledge and practice* (See *Section 2.3* narrative synthesis) that nurses drew upon in order to ensure that the complexity of discharging older people from hospital gets the attention it deserves.

We believe that the Pace-Complexity continuum and the related activities have potential explanatory power that extend beyond the discharge experience and might shed light onto the wider tensions within older people's services. We therefore use them as a lens to help interpret our case study data.

Having provided a background and context for the study and made explicit those initial theoretical frameworks that informed our thinking, *Section 3* provides a brief overview of the study methodology.

Table 2.1: Activities for *processing patients* and *processing people*

Nursing activities	Nurses Role	Multidisciplinary Team perspective	Patients and carers perspective
Pushing Main focus of <i>processing patients</i>	Involves nurses in a number of activities to get people to accept the discharge decision and complete discharge as soon as possible.	Focus on bio-medical issues and the dominance of the nursing-medical partnership in shaping the discharge process. The ward round was the main mechanism for <i>pushing</i> and nurses were the fulcrum of this process.	Patients and carers were not actively involved in the decision making process.
Fixing Housekeeping Connecting Alerting	Procedural work outside the formal structures which ensured necessary elements were in place for discharge <i>Keeping the books</i> and ensuring paperwork, transport and medication was completed. The relaying of information via most other team members in the hospital, community and with patients/carers. This was a passive role by nurses. Bringing issues of concern likely to delay discharge to the attention of other disciplines.	Medical staff and the MDT constructed these activities as a key nursing role and this was the <i>formal</i> part of the nurses' contribution to discharge planning. Medical staff and the MDT also constructed the activities of <i>connecting</i> and <i>alerting</i> as valuable.	
Informing Conveying	This related to <i>fixing</i> but involved relaying information that was not procedural. The nurses' role was one of being a 'messenger' to relay information from one source to another. Usually from the doctor to the	The roles of <i>conveying</i> and <i>interpreting</i> were seen as important by members of	These nursing activities were a significant part of

Interpreting	<p>patient or carer.</p> <p>This related to providing explanations for patients and carers and linked to <i>conveying</i>, as the information conveyed was often technical or sensitive in nature and required interpretation.</p>	<p>the MDT, in particular the partnership between medical and nursing staff. This nursing role was an important informal mechanism that supported the formal mechanism of the ward round. The skills of nurses in 'interpreting' varied.</p>	<p>the patient and carer experience. They relied on these nursing activities, given the limitations of the formal mechanisms of involvement and information giving.</p>
<p>Brokering</p> <p>Main focus of processing people</p> <p>Mediating</p> <p>Negotiating</p> <p>Advocating</p>	<p>A skilled interpersonal process comprising differing activities that are progressively more proactive.</p> <p>This involved bringing together two parties so as to resolve differences in opinion. The skill was to get the parties <i>to the table</i> and to remain neutral. This focused largely on issues between patients and carers.</p> <p>In <i>negotiating</i> the nurse took a more active role in interacting with the parties involved, and focused on resolving communication difficulties and often 'buying time' to resolve issues.</p> <p><i>Advocacy</i> was even more proactive and involved issues between patients and carers but also the MDT and patients and/or carers. A high level of skill was required to take the opportunity to 'broker' the discharge in this way and do so tactfully.</p>	<p><i>Brokering</i> was the main focus on the care of the Elderly Unit where complexity was recognised, whereas in other areas there were only isolated, individual examples of <i>brokering</i>.</p> <p>The care of the Elderly Unit represented the main arena for 'brokering' and this required a recognition of <i>complexity</i> and <i>brokering</i> activities were important in addressing the effects of balancing-off the demands of <i>Complexity</i> and <i>Pace</i>.</p>	<p>It was clear that some nurses were more skilled than others at <i>brokering</i>.</p> <p>These activities were described as key aspects of the discharge experience and emerged as the informal liaison that occurred between nurses, the MDT, patients and carers.</p>

Section 3: Methodology

This section describes the overall research design and methods that were used to conduct the study. It begins by reiterating the aims and objectives of the study and this is followed by a discussion of the ethical issues and amendments to the original study design. It concludes with a description of the research design and the methods, with a particular focus on the case studies. The more detailed description of the quantitative analysis is contained in the relevant sections (see *Sections 5 and 10*).

3.1 Aims and objectives

As noted earlier the study was designed both to provide new theoretical insights and answer important practical questions in relation to four of the SDO objectives namely:

- the impact of structural change on culture in acute hospital care delivery for older people, primarily in terms of patient and carer experiences
- the links between culture and care delivery for older people in acute hospitals
- tackling the impacts on quality of care for older people of purposive cultural change in acute hospital environments
- patient and carer impacts on culture in acute hospitals.

Out of these broad aims the more specific aims emerged, specifically to:

- update existing literature reviews with a systematic narrative synthesis of recent relevant publications
- conduct interviews with opinion leaders to understand current issues and developments in care for older people, in particular in relation to culture change initiatives
- establish a reference group of older patients and their carers to identify factors influencing user perceptions of quality of care
- conduct organisation wide surveys within participating Trusts to identify organisational climates in a range of care settings and, where possible, measure climate change as a result of purposive organisational change strategies
- conduct detailed case study research in a small number of units within participating Trusts to examine how and with what success culture change programmes are enacted
- provide evidence about whether and how culture change initiatives impact on quality of care and produce a toolkit which enables Trusts to assess cultures within their own setting.

The way in which the study aims and objectives were addressed within this study are now discussed, beginning with a consideration of the ethics related to this study.

3.2 Ethical approval

It is a requirement of all research involving NHS patients or staff that ethics approval is granted through the appropriate research ethics committee. National multi-site ethical approval for this study was granted, and subsequently approval from the Research and Development departments of each participating Trust was obtained and honorary contracts issued for the research team. There were two ethical issues of particular importance – informed consent and confidentiality. Each interviewee signed a consent form acknowledging that: They were sufficiently informed about the nature of the research and the interview specifically; they consented to being audio-recorded; and that they had been informed that they could withdraw from the study at any time. Consent with regards to the survey was assumed upon its completion and return. Secondly, the confidentiality of all research material gathered was assured. Each transcript was assigned with a code that related to the case study site, researcher, transcript number and date of interview. Digital recordings and electronic files were password protected, and their transcripts and paper copies of surveys were stored in a locked filing cabinet at the University of Sheffield. Questionnaires were given individual identification codes and details of older people and carers who completed a reply slip at the end of the survey indicating a wish to participate in telephone interviews were separated from the survey on arrival and entered into a separate unconnected password protected spread sheet. Direct observation of meetings and discussions in the field was undertaken by research staff, however, no direct patient care was observed, e.g. at bedside, field notes were taken but no audio recordings were made.

3.3 Amendments to the original study design

The research project was led both by the study questions but was cognizant of the pragmatics of conducting large scale national research. Participating Trusts were invited to comment on the practicalities of the project design in relation to their own involvement. In addition a site visit was made by members of the research team to each of the case study sites. Patient representatives were made aware of the study and had the opportunity to raise questions and make further suggestions which were taken into consideration.

As a result an application to make changes to the design of the project were made to, and accepted by, the funders, the NHS SDO. The changes allowed for a more focused, in depth and nuanced understanding of the change in the Trusts under consideration and are summarized in Table 3.1 below. These changes were presented to the ethics committee as an amendment to the study and approved.

In order to facilitate a more concentrated approach to data collection, particularly in relation to the survey (see *Section 5*), two research associates were employed to complete data collection.

Table 3.1: Amendments to the original study design

Original Intention	Reason for Change	Amended process
To involve five Trusts as Case Study Sites and include 6-8 case study wards	The type and range of change in each Trust was found to be very complex	To allow for a more in depth exploration of the change initiatives and their impact the number of case study sites was reduced from five to four and the number of case study wards explored in the project was increased from the six to eight outlined in the proposal to 15
Questionnaire packs for patients over the age of 65 and their family carers distributed on discharge by ward staff	Very poor response rate using this method. Despite repeated attempts to invigorate the survey very few questionnaires were handed out to patients, due to time demands on nursing staff. Therefore not all eligible patients or family carers were given the opportunity to take part	Research staff handed out questionnaire packs directly to patients (who were medically fit and expected to be discharged home within the following 24 hours (and their family carers)
Use of repertory grid interviews	Some repertory grid interviews were undertaken at one participating Trust, however it was felt that for the investment of time required they were not providing better data than semi-structured interviews and observation	The use of Repertory grid interviews was discontinued in favour of more semi structured interviews and observation
Use of diaries and Network analysis	The ethics committee felt it was unethical to obtain the names of work colleagues required for the diary and network analysis. Moreover it was apparent from the start of data collection that staff were extremely busy and that asking them to maintain diaries or complete network analysis forms would be impracticable	Research staff attended case study wards and undertook observation and semi structured interviews with staff at convenient times agreed with the Ward Manager

These team members focused primarily on the distribution of the patient /carer survey and to a lesser extent the staff survey, as well as undertaking case study observation. Having established the scope of the study the team then focused on data collection. Below we describe the rationale for the use of a case study approach.

3.4 Case study research on culture change

The aims of the study called for a comparison to be made between NHS Trusts (or case study sites) and across multiple wards (or cases) which were undertaking some form of change initiative. Such change is inherently complex and involves the careful consideration of a wide range of issues. Yin (1999) suggests that case studies are particularly suited to unpacking the complex nature of health service systems, which are characterised by continual and rapid change. Comparative case studies have previously been used in analysing organizational change in the NHS, and allow for the analysis of retrospective change, real time analysis and prospective or anticipated change (Pettigrew *et al.*, 1992, Fitzgerald *et al.*, 2006) Following Stakes' (2000) arguments we used a collective, instrumental design that involved both within and between case analysis. The within case analyses are presented sequentially in *Sections 6-9* whilst the cross case analysis can be found in *Section 11*.

In order to address the study aims and objectives, the study employed both quantitative and qualitative methods. Quantitative methods were used to design and test a range of 'measures' that would comprise the change toolkit (see *Section 5*) and also to undertake a multivariate analysis exploring the impact of ward and hospital climate on outcomes for patients, carers and staff (see *Section 10*). Qualitative methods were typically utilized in the longitudinal case study research because of the nature of the 'how' and 'why' questions under consideration and the need to explore concepts in-depth (Yin, 1994). Yin suggests that discovery should occur through the research process, rather than following a rigid design. While this was true for this study the basic methods employed in each case study remained constant and are outlined below.

3.4.1 Case study methodology

The longitudinal data, collected at 3 points in time across up to 15 units over an 18 month period, allowed for both *unique* and *shared* insights to emerge demonstrating links both within and between cases. Transferability was enhanced using a three point model (Eisenhardt, 1988; Robson, 1993) which allowed:

- detailed description of each case as an individual unit (*Sections 6, 7, 8 and 9*)
- cross case analysis – drawing together the emergent cross case themes (*Section 11*)
- recontextualisation - findings generated from study sites were considered in relation to existing theoretical constructions (described in *Section 2*) and extant literature (*Section 4*)

3.4.2 Selection of the case study Trust

The study of culture within the acute hospital setting requires a dynamic approach to research design and as discussed earlier, changes were made in to the study in response to the nature and complexity of change within each case study Trust.

Each of the four Trusts selected were undertaking varying initiatives to promote a cultural change in part in response to the National Service Framework for older people, but also driven by local contextual factors. Selection was also informed by the views gained from the *opinion leader* interviews. The Trusts are briefly described below but for further detail (See *Sections 6, 7, 8 and 9*).

Trust A (see *Section 6*)– a successful three star rated Trust based in the North of England, formed following a merger of two smaller Trusts, was based on two geographically diverse sites that were originally the main hospital bases for the earlier Trusts. The new larger Trust was in the midst of a wide ranging, ongoing reorganisation and rationalisation of services in an effort both to improve efficiency and to create a shared culture across the sites. The Trust had invested heavily in services for older people.

Trust B (see *Section 7*)– situated in the South of England was under 'special measures' for a large financial shortfall and had been in receipt of intense publicity scrutiny relating to standards of care for older people.

Trust C (see *Section 8*) – situated in the North of England, was moving its medical wards, which served older patients, to a new Private Finance Initiative (PFI) funded building, with wards 50% single room occupancy. The incoming wards were from two different areas of the Trust: The first were 'nightingale' style wards of 18-20 beds previously housed in a Victorian wing of the hospital. The second group had moved from a more modern building erected in the 1980's and included large wards of up to 42 beds which were reconfigured into smaller units which involved the breakup of ward teams.

Trust D (see *Section 9*)– a Trust in the South of England was suggested to the research team during the 'opinion leader interviews' and was introducing the 'Productive Ward' scheme (2007b) part of the Releasing time to Care initiative in response to the NSF and the Dignity challenge.

3.4.3 Case study Data Collection

The case studies were conducted in three phases over an 18 month period and adopted a multi-method approach, which involved intensive exploration of a small number of case study wards within each Trust providing a detailed multi-perspective account of experiences and processes within each case site.

Two members of the research team spent up to a week at each case study site during each of three visits. This allowed on-going reflection and discussion on issues emerging during data collection. A planning visit was made in advance of the initial data collection visit to ensure that staff and patient representatives were aware of the study and had the opportunity to raise any concerns or questions. At the beginning of each site visit, events which could provide a focus for data collection were identified with ward managers and other senior staff. The final methods and tools used for data collection within the case studies were agreed

with the reference group (see *Section 1.2.5*) and with key personnel at each site (see amendments to the original study design above) but included

- observation of key events
- semi-structured interviews with staff at all levels in the organisation
- telephone interviews with patients and carers following discharge
- analysis of documents, such as policies, assessment tools, care plans.

Observation

Each research team that attended the participating Trusts had a qualified nurse and an occupational psychologist or a management expert as part of the team. This meant that observation was able to be undertaken from a variety of perspectives bringing together differing forms of expertise to be brought to bear on the data.

Observation at the case study sites variously spanned morning, afternoon and night shifts, focusing on key events involving staff and staff patients/carer interactions such as meetings, patient admission and discharge, case conferences, staff handover, mealtimes and ward rounds. In-depth interviews were conducted with a wide range of staff members, including, senior and junior medical, nursing and therapy staff, and other members of the multi-disciplinary team including qualified, clerical and domestic staff; as well as members of the senior management teams such as directors of nursing and chief executives. Observation was also made at Trust level matrons meetings, bed state meetings and in service training and field notes were taken.

Patients staying on the ward during each site visit and their carers were invited to take part in the study when they were well enough to do so by completing questionnaires (see *Section 8 & 10*) and taking part in telephone interviews once they had returned home.

Semi-structured interviews

Semi-structured interviews were used in order not to limit participants to pre-defined issues or categories of investigation and to allow for flexibility and interpretation. Appendix 1 details the key issues explored with staff, older patients and family carers. Table 3.2 outlines the number of interviews undertaken at each case study site.

Table 3.2: The number of interviews undertaken at each case study site

Case Study Site	Phase 1	Phase 2	Phase 3
A	14	14	6
B	13	9	9
C	28	32	12
D	20	13	5

More detailed table of the interviews conducted in individual case study sites can be seen in Appendix 2.

Telephone Interviews

Telephone interviews were undertaken with older patients (once discharged) and family carers from case study wards who indicated their willingness to be interviewed at the end of their completed questionnaire. The volunteers were contacted, written consent obtained, and the interview arranged for a time and date of their choosing. However, participants were frequently unable to participate in the interview at the arranged time often due to continued ill health on the part of the older person. Furthermore, it became evident to researchers that little new data were being obtained and the telephone interviews were discontinued.

Documentary Analysis

Key organisational documents, such as local, strategic planning documents, discussion papers and job descriptions, were analysed to provide a historical narrative of organisational context and a textual indication of the issues. It was also important to utilise this documentary information to augment the data collected through interview and observational methods.

3.4.4 Case Study Data Analysis

Data were continually transcribed and assessed throughout the course of the case studies. Interview transcripts and field notes were analysed using Framework (Ritchie and Spencer, 1994) as an approach to organising the analysis.

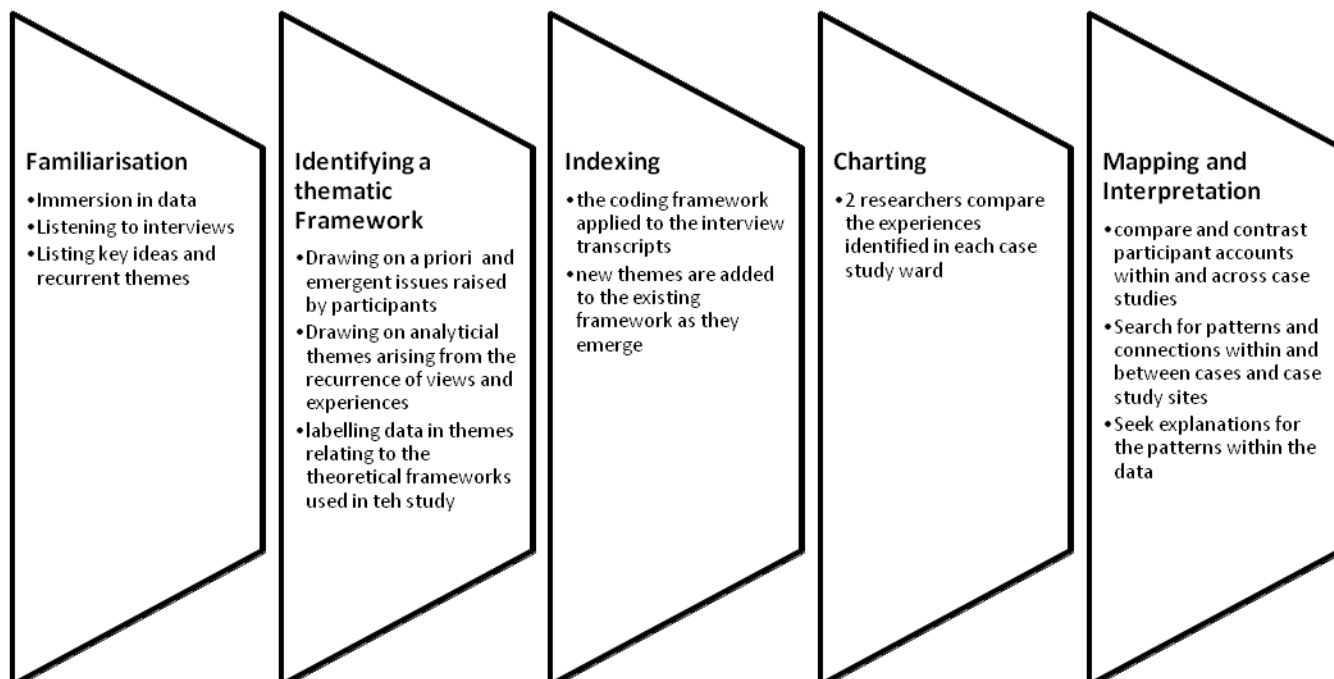
The Framework technique for data analysis

The data analysis package NVivo software package (QSR International) was used to organise the large volume of data for analysis using Framework. Framework (Ritchie & Spencer, 1994) was developed in an applied research context as a systematic procedure for handling qualitative data in order to produce analyses with *potential for actionable outcomes*. (p. 173).

There are five interconnected stages of the Framework technique; familiarisation; identifying a thematic framework; indexing; charting; and mapping and interpretation, which are briefly outlined and in Figure 3.1 below.

Interview elements were analysed thematically for cultural themes with reference to the Senses Framework and the Pace ↔ Complexity dynamic where it was appropriate. Field notes from the observation element of data collection were incorporated into the data analysis.

The final stage in the data analysis process was conclusion drawing and verification. Through an iterative process of data coding, final conclusions were developed and became more explicit. The four individual Trust case study reports were then integrated to provide in-depth, comparative cross case analysis (see *Section 11*).

Figure 3.1: Description of Framework Analysis (Spencer & Ritchie, 1994)

Both qualitative and quantitative data have informed the case conclusions and the multivariate analysis has been drawn upon in the final synthesis. Considerations about the potential use of the toolkit are presented separately. Individual draft case study reports and project synthesis will be returned to key stakeholders.

Although data collection within any active care area is always challenging for all those involved we were greatly assisted in our efforts by the enthusiasm and kindness of all the staff, patients and family carers present in each case study Trust. *Sections 6, 7, 8 and 9* give individual accounts of the case study findings for each participating Trust in which direct quotes are used from interview transcripts. In order to give the reader a sense of the perspective of the 'speaker' while maintaining a level of confidentiality for the individual an identification matrix has been developed (see Table 3.3).

Using this we can see for example that the quote from *Section 6* of the report below is coded as B3 with B representing the case study site and 3 the category of the participant i.e., Ward Managers (G Grade nurses), Junior Sisters / Charge Nurses (F Grades):

We do regular monthly checks. Matron just walks in and just sits about and watches. (B3).

Similarly for a quote from *Section 8* – 'it would be nice if the RADS level of therapy could be carried on for the rehabs but unfortunately it doesn't'. (C4) – the code 'C' represents the case study site and the number '4' indicates that it is a regular member of the 'ward staff' speaking.

Table 3.3: Coding for case study quotes

Code	Case study A, (Section 6)	Case study B, (Section 7)	Case study C, (Section 8)	Case study D, (Section 9)
1. Senior personnel operating at strategic/ board level	Deputy Chief Executive/Director of Nursing Deputy Director of Nursing with main responsibility for Medical/Elderly Services Director of Organisational Development Business Manager for Medical/Elderly Services	Chief Executive Operations Director Director of Nursing Deputy Director of Nursing Associate Director of Nursing	Chief Executive Medical Director Director of Nursing	Deputy Director of Nursing Director of Nursing
2. Senior personnel with a service delivery remit	Consultant Physician Complex Care Unit Acting Consultant Nurse for Older People Matrons	Medical Consultant Operational Patient Flow Manager Matrons Senior practice development nurse	Medical Consultants Matrons	Consultants Head of Nursing for Medicine Head of Nursing for Surgery Practice Development Manager
3. Ward managers	Ward Managers (G Grade Nurses)/ Junior Sisters/ Charge Sisters (F Grades)	Ward Managers (G Grade Nurses)/ Junior Sisters/ Charge Nurses (F Grades)	Ward Managers (G Grade Nurses)/ Junior Sisters/ Charge Nurses (F Grades)	Ward Managers (G Grade Nurses)/ Junior Sisters/ Charge Nurses (F Grades)
4 Other ward staff	Staff Nurses (D and E Grades) Care Assistants	Staff Nurses (D and E Grades) Care Assistants Ward clerks	Staff Nurses (D and E Grades) Care Assistants Student Nurses Housekeeper Ward clerk	Staff Nurses (D and E Grades) Care Assistants
5 Cross ward staff	Therapy Services Coordinator – Acute Therapy Services Coordinator – Community	Social Workers Physiotherapists Student nurses	Junior Medical Staff Physiotherapists, Occupational Therapist and Dietician linked to RADS team	Discharge Facilitator Discharge Liaison Older People Nurse Specialist Physiotherapists Productive Ward Facilitator Psychiatric Liaison Nurse

Having given brief guidance on the reading of the report we now move on to the next section of the report and consider the current evidence in the literature review and narrative synthesis.

Section 4: Literature review and narrative synthesis

4.1 Introduction

The primary aim of this study is to explore the phenomenon of culture change within acute hospital environments in order to identify those factors that either promote or inhibit successful change initiatives. It has been suggested that culture change has become one of the buzzwords of the 21st Century (Stone, 2003) and is a topic of growing political, provider and consumer interest (IFAS, 2008) that is rapidly attaining the status of a social *movement* (Meyer and Owen, 2008, Miller *et al.*, 2008). Despite this there is little clarity as to what *culture* means to differing groups, especially within the increasingly complex world of health care (Morgan and Ogbonna, 2008). Yet if culture is to be *changed* it is essential to appreciate how it is understood by all those within a given organisation (Rytterström *et al.*, 2009). In terms of health care environments this means appreciating the meanings of multiple groups including staff, patients and carers/families. Moreover, the professions often have their own *sub-cultures*, each of which may be underpinned by differing, usually implicit, and sometimes conflicting values and goals. As Youngsen (2007) notes, '*the world of health care is steeped in its own rituals, cultures, language, unspoken assumptions and mental models*' (p76). To compound difficulties the *world views* of clinicians and managers are also underpinned by their own distinct cultures and languages. Attention to the *complex social interactions* that occur in such contexts is therefore seen as a prerequisite to successful change initiatives (Powell *et al.*, 2009).

In order to explore the above complexities we proposed that the study should adopt a specific focus that was relevant across all acute hospital environments and was also likely to be the subject of differing but complementary change initiatives. The quality of care provided to frail older people in acute hospitals has been a topic of great concern for over a decade (HAS, 2000, 1998) and has witnessed a plethora of recent policy initiatives, most notably at the time the tender was submitted, the National Service Framework (NSF) for Older People (DH, 2001). We therefore proposed that the study explore change initiatives that in some way sought to improve the care provided to older people in hospital, arguing that this provides an excellent proxy for other patient groups. If care is good for older people it is likely to be good for everyone.

However, as we will describe in greater detail shortly, the pace of change within health care is rapid and by the time the study started the focus of policy attention had shifted away from the NSF towards the 'Dignity Campaign'. The Dignity Challenge (DH 2006) identified 10 areas of care for older people that acute hospitals (and other care environments) should address in order to ensure good quality care. Exploring the extent to which hospitals were aware of the dignity

challenge, and had acted upon it, provided us with an ideal *entree* to their understanding of the wider needs of frail older people.

However, whilst intuitively appealing, dignity, like culture, is a *slippery* concept (Clark 1995; Davies *et al.*, 1999). As recent commentators have noted, dignity and related ideas such as respect and compassion (Firth-Cozens and Cornwell, 2009) are adopted uncritically and used as *hurrah* words (Levenson 2007), often in a rhetorical and dramatic fashion (Gallagher *et al.*, 2008). Help the Aged (2008) have recently argued that there has been too much emphasis on *slogans* and not enough subsequent action. Policy therefore tends to promote *aspirational visions* (Goodrich and Cornwell, 2008) without fully considering the complex processes that needs to be in place if such visions are to become reality.

There is a growing realisation that if abstract ideas are to be turned into meaningful practice (Help the Aged, 2008) then staff, older people and their families need to be speaking the same language (Magee *et al.*, 2008). Consequently, we need to look closely at the terms, language and concepts that are used by researchers, policy makers and those inhabiting the 'everyday world' of hospitals in order to ensure that ideas are 'ordinary, accessible, jargon free and, most importantly, commonly understood' (Goodrich and Cornwell, 2008). That is the purpose of this section.

Our aim is to briefly consider the various dimensions of culture, culture change and dignity (and related concepts) with a particular emphasis on care environments for older people. Given the nature of the study our primary focus will be on acute hospital settings but, as much of the work on culture change has been undertaken within care home settings, we will also consider this literature and identify lessons that might be of relevance to an acute setting. Whilst we do not seek to provide precise 'definitions' of 'culture' and 'dignity' we will identify their broad parameters and what appear to be their essential characteristics.

We hope to do so in a way that is *ordinary, accessible, jargon free* and will provide a basis for a common understanding.

In essence, we will argue that culture, culture change and dignity are fundamentally *relational* concepts, an appreciation of which requires an understanding of the nature and complexity of social interactions within acute health care settings. In so doing we will explore notions of person (patient)-centred and relationship-centred care and suggest that the Senses Framework described earlier provides a way of unpacking complex dynamics in a way that is readily accessible to staff, patients and families. In highlighting the challenges to implementing *relational practice* in acute care settings we will draw on the ideas of Pace and Complexity (Williams 2001; Williams *et al.*, 2009), again described earlier, to identify the often conflicting and paradoxical demands that policy makes on those delivering care.

Drawing on the literature and recent policy initiatives such as 'Confidence in Care' (DH, 2008), the 'point of care programme' (Firth-Cozens and Cornwell, 2009), and statements from professional bodies (NMC 2009; RCN 2008), we will argue that there is a need to pay far greater attention to the *complex* nature of care in acute settings and that the current emphasis on pace is a fundamental stumbling block to achieving lasting and meaningful change. Such arguments will then be used to

provide a structure for the ensuing case studies. We begin with a discussion of culture and culture change. Before considering this we briefly describe the methodology for the review.

4.2 Review methodology

A systematic search was developed by an information specialist (Chris Carroll) in conjunction with two other members of the project team (Mike Nolan and Malcolm Patterson) to identify relevant literature. The information specialist then structured and ran the searches. The aim was to identify all relevant literature that evaluated the impact of a care organisation's culture, values or norms, and efforts to change such factors, on the dignity, privacy and self-image of older people. The search therefore combined terms describing the population (i.e. older people), the exposure or what was present in the setting that might affect the population (i.e. the organisational culture in the setting, or change initiatives), and the outcome of that exposure (the affect on an older person's dignity, privacy or sense of self).

The search employed a range of terms, both free text and, where available, database thesaurus terms such as Medical Subject Headings (MeSH terms) for each element of the search. For example, for the population, free text terms such as *older* and *elderly* and thesaurus terms such as *Aged* and *Gerontologic care*, were used. Terms for the exposure included *organisational culture*, *affective commitment* and *organisational change*, and, finally, terms to reflect the outcome included thesaurus terms such as *Empathy* and *Human Dignity*, and free text terms like *respect*, *compassion*, *privacy* and *self-image*. An example search, performed in the CINAHL database, is given below (Table 4.1); all of the search strategies performed are provided in Appendix 3.

The databases (Table 4.2) were therefore systematically searched for published and unpublished, or grey literature: The British Nursing Index (BNI), the Cumulative Index of Nursing and Allied Health Literature (CINAHL), MEDLINE, Pre-MEDLINE, PsycINFO, and the Social Science Citation Index (via Web of Science). Two other databases that focused principally on grey literature were also searched: The Health Management Information Consortium (HMIC) database, and Social Care Online, the database of the Social Care Institute for Excellence (SCIE). All of the searches were performed at the end of November 2008. As a similar search had already been completed and a narrative synthesis undertaken on the literature up to 1998 (see Davies *et al.*, 1999; Nolan *et al.*, 2001) the current search was limited to the last ten years (1998-2008). All of the citations were imported into a Reference Manager database and duplicates were deleted. The final list of citations was then screened for inclusion in the review against the stated criteria.

The search of the electronic databases retrieved 1861 unique citations. The number of citations retrieved from each databases is given in Table 4.2.

Once a comprehensive list of references was obtained titles and abstracts were read and decisions made as to the relevance of particular articles. Given that our primary goal was to seek an element of conceptual clarity and to identify key concepts that might inform our study, rather than to conduct a traditional systematic review we did not restrict our inclusion criteria to studies adopting a

specific methodological approach, nor did we confine our interest to only empirical pieces.

Table 4.1: An example search

<p>Database: CINAHL - Cumulative Index to Nursing & Allied Health Literature <1982 to November Week 3 2008></p> <p>Search Strategy:</p>
<p>1 exp Organisational Culture/ 2 culture.tw. 3 organi?ational change.tw. 4 (values or beliefs or norms or ideology or affective commitment).tw. 5 or/1-4 6 exp EMPATHY/ 7 exp "Privacy and Confidentiality"/ 8 exp Human Dignity/ 9 (dignity or dignif\$ or privacy or compassion\$ or empath\$ or sympath\$ or preference\$ or self-image) .tw. 10 respect.ti 11 or/6-10 12 exp Geriatrics/ 13 exp Gerontologic Nursing/ 14 exp Gerontologic Care/ 15 exp "AGED, 80 AND OVER"/ or exp AGED/ or exp AGED, HOSPITALIZED/ 16 (older or elder\$ or geriatr\$ or gerontol\$).tw. 17 or/12-16 18 5 and 11 and 17 19 limit 18 to yr="1998 - 2008"</p>

Table 4.2: Citations retrieved from each database

Database	Number of citations retrieved
British Nursing Index	23
CINAHL	345
MEDLINE	1214
Pre-MEDLINE	31
PsycINFO	300
Social Science Citation Index	300
HMIC	0
Social Care Online	4

*Note: The total number of citations retrieved was 2247, but after the removal of duplicates the number was 1861

Rather an inclusive strategy was adopted and, where appropriate, opinion pieces and editorials were consulted in addition to empirical, theoretical or policy related material. This was considered important in order to provide as comprehensive an overview as possible on the current discourse about culture, culture change and dignity for older people in acute care. Once the reference list was obtained the abstract for each piece (where available) was scrutinised and initial decisions about relevance were made. Numerous sources were omitted at this stage. Sources were excluded according to considerations such as the mere mention of the word dignity in passing without any further consideration of its meaning or application or when the work was primarily focussed on methodological rather than conceptual considerations. Where there was any doubt the full reference was obtained and read and again excluded if not considered relevant. In this way 118 references were identified for further, detailed consideration. Once references were obtained a three stage process of review, analysis and synthesis occurred, in which each piece of literature was treated as if it were a primary data source (see Nolan *et al.*, 1996 for a fuller discussion). An initial reading of each reference was undertaken and detailed notes made identifying the main themes or arguments presented. In this way several hundred sides of 'first order' analysis were compiled.

Subsequently, these notes were re-read and second order analysis undertaken to further refine key themes or concepts, and to identify their differing dimensions. Following this a third level of synthesis was completed in order to identify common or unique aspects and to elaborate upon the themes identified in the level two analysis. The aim here was to provide a comprehensive and in-depth understanding. In this way we hoped to achieve a nuanced appreciation of the implications of culture and culture change initiatives on the dignity and care experiences of older people and their carers that would provide a detailed narrative synthesis of the major factors identified in the literature. The results of this process were then considered alongside the prior reviews (Davies *et al.*, 1999;

Nolan *et al.*, 2001) and a recent narrative synthesis of change within the care home sector (Nolan *et al.*, 2009).

4.3 Culture and culture change in acute environments

The contested nature of culture has already been discussed and we do not intend to rehearse the arguments again here. Rather we will focus on the nature of culture and culture change in acute care environments, highlighting the challenges inherent in providing high quality care for older people. We will also consider the factors that appear necessary to achieve successful culture change. Throughout our arguments will be focussed on the acute setting but informed by literature from care homes.

Much has been written about culture with respect to older people, but in common with the wider literature there is no universally accepted meaning. However, the complexity of the concept is widely acknowledged. With respect to the care home setting Stone (2003), for example, argues that there is a need to consider at least four cultures and their interactions:

- the '*clinical culture*' – concerning the nature of the resident population and the goals of care
- the '*caring culture*' – that to do with the nature and quality of interpersonal relationships, which provide a 'barometer' for the quality of care
- the '*work culture*' – concerning the way that staff are treated, and whether they are nurtured, supported, and treated with dignity
- the '*residential culture*' – reflects the extent to which the home is seen as part of the wider community.

With the exception of the latter, which is less obviously relevant to an acute environment, the others provide a useful framework for considering culture in an acute context.

4.3.1 The *clinical* culture

We have already described the ambiguous position that older people, and especially frail older people, occupy in a health care system that is largely dominated by an acute, medical model approach. Indeed the tensions were captured succinctly by the Pace – Complexity continuum proposed by Williams (2001; Williams *et al.*, 2009 (see page 30)). Several commentators, whilst not using these exact terms, highlight the increasing relevance of this framework (Porter, 2008; RCN, 2008; NMC, 2009). Much recent emphasis has been placed on the nature and quality of the *patient experience* in acute care and, in tracing successive policy initiatives over the last decade, Goodrich and Cornwell (2008) note the paradox between the *aspirational* goals of an enhanced patient experience and the immediate political pressures to reduce waiting times and other notional indicators of success.

They contend that despite the rhetoric behind campaigns such as the Dignity Challenge, what followed was '*an even stronger emphasis on counting numbers*

and measuring activity' p26. They recognise that whilst there is nothing 'wrong per se with technically focussed, rapid treatment, high turnover and short length of hospital stay' p12, these goals are often prioritised at the expense of attention to important values such as compassion, which tend to be seen as an option or add-on. They argue that if this trend continues hospitals will become 'soulless, anonymous, wasteful and inefficient medical factories'.

Whilst some might see this as overstating the case, similar concerns have been expressed from several quarters. The Royal College of Nursing (RCN, 2008) laments the *quick fix* and *target* driven culture of acute hospitals and notes the invidious position in which staff are placed when they are simultaneously exhorted to have *zero tolerance* of undignified care whilst also being expected to meet increasingly stringent targets. This concern was voiced even more strongly by the Nursing and Midwifery Council (NMC) who believe that *'because of the drive for meeting targets and working in a task-centred way there is very little, or no respect for, or recognition of the needs of people they (nurses) are caring for'* (NMC, 2009 p16). It seems that the pace of care is being prioritised at the expense of quality, with an ever increasing focus on tasks and technology (McCabe, 2004; Taylor, 2007; Help the Aged, 2008). Consequently, complex procedures such as discharge planning are driven by the 'administrative requirements' of the organisation rather than reflecting 'the pace of the service user' (Lymbery, 2006). It would seem that little has changed since Williams' study was conducted in the mid 1990s.

Firth-Cozens and Cornwell (2009) argue that the current emphasis on targets (pace) as opposed to the totality of the patient experience (complexity) exerts a profoundly negative effect on the culture of care and staff morale. This is an issue to which we will return later when considering the *work* culture.

What is clear is that new staff, students and patients very quickly become attuned to the dominant culture on a unit and adjust their behaviour accordingly (Alabaster, 2006; Rytterström *et al.*, 2009). So if a pace model predominates, and resources seem to be more important than relationships (Turner and Stokes, 2006), then staff pick up the message that the system does not value the *little* things that promote dignity (Cass *et al.*, 2009). The influence of such a culture on students can be particularly pernicious. Alabaster (2006) argues that if students witness care that is depersonalised they initially respond by providing care that promotes personhood and maintains dignity. However, their efforts rapidly become frustrated by the culture of the ward. Where the emphasis is on speed and tasks, and the priorities are staff centred, then students have to *pretend* to be busy in order to find opportunities to interact with patients. However, when students perceive that staff obviously value older people then they feel free to do so also. But when tasks dominate, the pressure of acute environments and the emphasis on patient throughput is seen as the 'wrong kind of hard work', and students begin to dread their placements with older people:

"Having found it hard to resist the powerful messages which defined older people as unpopular and their care as basic, participants did not look forward to age-specific placements".

(Alabaster, 2006)

It has long been recognised that this can result in the perpetuation of a culture of inhumane care (Gunter, 1983, cited in Koch and Webb, 1996) for older people, addressing which was the main impetus behind the NSF.

Little is likely to change if traditional medical services continue to receive the highest priority, as these produce a system that operates in often subtle ways to ensure that the needs of older people are met (Pedersen *et al.*, 2008), with the emphasis remaining on *technical* rather than *effective* care (Berdes and Eckert, 2007). This then becomes the predominant *culture of care*.

4.3.2 The *culture of care*

For Stone (2003) the caring culture is primarily to do with the nature and quality of interpersonal relationships which act as a '*barometer*' for the quality of care delivered. Understanding the culture of care requires an appreciation of the *how* as well as the *what* of care, with more focus being given to the *richly textured and complex* nature of the patient experience, which is primarily a product of the social processes that occur within the health care system as a whole (Goodrich and Cornwell, 2008).

Rytterström *et al.*, (2009) argue that the caring culture is defined by the *unwritten rules and routines* that become more or less visible symbols of the common value system. To change culture there is a need to understand how these unwritten rules operate and are transmitted. This is a significant undertaking as '*...it means transforming hospital cultures and ordinary practices (the way we do things around here). This is an immensely complex task requiring serious investment at both strategic and operational levels*' (Goodrich and Cornwell, 2008).

A positive caring culture has been defined as:

"One where the ethos of care becomes and remains person/client centred, evidence-based and continually effective within a changing health and social care context".

(Manley *et al.*, 2004, cited in Dewar, 2007)

The concept of person-centred and patient-centred care has become *embedded* in the language of practice (McCormack, 2003), and has recently been the subject of considerable debate (IOM, 2001; Shaller, 2007; Goodrich and Cornwell, 2008). The preferred term in America, as used by the Institute of Medicine (IOM), is *patient-centred care* and the King's Fund argues that this is the term that should be used in the UK. They believe that the IOM definition is clear and that it overcomes the problems created when several disciplines tend to have differing definitions of patient (or person)-centred care that usually reinforce rather than transcend disciplinary divides (Goodrich and Cornwell, 2008). They suggest that for clinically based staff the phrase that best captures the principles implicit in patient-centred care is *seeing the person in the patient*.

The IOM views patient-centred care as comprising six domains:

- compassion/empathy/responsiveness
- coordination and integration
- information/communication/education

- physical comfort
- enhanced support, relief from fear
- involvement of family and friends.

They provide the following definition, patient-centred care is:

"Health care that establishes a partnership among practitioners, patients and their families (when appropriate) to ensure that decisions respect patients' wants, needs and preferences and that patients have the education and support they need to make decisions and participate in their care".

(IOM, 2001)

Recent surveys suggest that over half of NHS patients (51%) believe that they are not as involved in their care as they would like to be and that remedial action is needed (Leatherman and Sutherland, 2007). The recent review of the NHS (DH, 2008) has recognised that there needs to be a shift in focus within the NHS with less emphasis on the quantity of care and more on the quality. To this end the Department of Health (DH, 2008) has launched an initiative designed to *re-instil* confidence in care amongst patients. This is underpinned by certain common themes, which note that:

- care today is more complex than it has ever been
 - patients should be at the centre of care
 - nurses need to care both for (technical care) and about (effective care) their patients
 - care is not just what staff do but is a facet of the environment, culture and history of the unit/organisation. Such factors are interdependent and 'care' is embedded in the whole system
 - staff often know what they should be doing but do not always do it
- patients and visitors constantly monitor the care both they and others receive.

In order to increase confidence in care five things are seen as essential:

- calm, clean, safe environment
- positive friendly culture
- good team-working and relationships
- well managed and effectively delivered care
- personalised care for each and every patient.

However, it would seem that there is still some way to go before these aspirations are realised, with patients describing their experience of acute care as being unpredictable and variable, with the quality largely dependent upon who is on duty, and particularly who is in charge (Goodrich and Cornwell, 2008). All too often patients feel like a *parcel*, moved around the hospital in a reactive rather than a proactive way (Goodrich and Cornwell, 2008). Clearly the *caring culture* is far from right, and later we will argue that the application of a patient or person-

centred model fails fully to capture the dynamic and reciprocal nature of relationships within an acute environment. Key to such relationships are the actions of staff, and the way that staff themselves are treated and this is considered next.

4.3.3 The *work* culture

Although the recent rhetoric places the patient experience at the centre of high quality care, it is widely recognised that such care will not be possible unless staff themselves are empowered and enabled to deliver it (Gilbert and Bridges, 2003; DeCicco *et al.*, 2006; Baker, 2007; Dewar, 2007; IFAS, 2008; Robinson and Gallagher, 2008; Szczepura *et al.*, 2008). In considering how this might be achieved DeCicco *et al.*, (2006) describe several broad types of power. These are:

- formal power – which flows from doing a job that is highly valued and recognised
- informal power – which relates to the nature and quality of relationships
- to experience opportunities to achieve, learn and grow
- access to measures to influence decisions
- psychological empowerment, which itself has several elements:
 - meaning – the ability to achieve congruence between your role and your beliefs
 - competence – having confidence to perform your role
 - autonomy – being able to exercise a degree of personal control
 - a sense of being able to influence things

An alternative model of work empowerment was proposed by Suominen *et al.*, (2008) who define it as '*a process in which individuals feel confident that they can act and successfully execute certain types of action*' (p42). As with DeCicco *et al.*, (2006), Suominen *et al.*, (2008) see empowerment as a multidimensional concept comprising three main elements:

- verbal empowerment – staff have the opportunities to participate and share their views
- behavioural empowerment – staff can:
 - work to solve problems
 - identify the problem to be solved
 - collect data needed to realise solutions
 - learn new skills
- outcome empowerment – staff can determine the course of the problem and how to solve it.

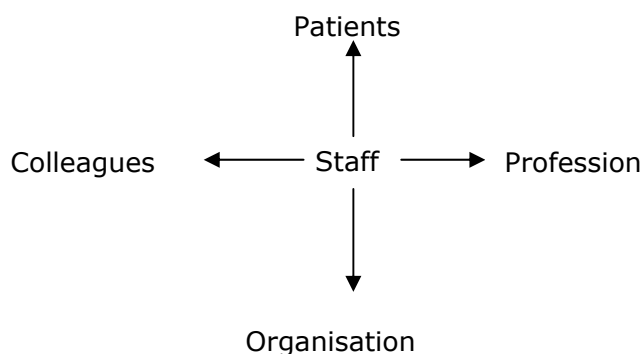
Although the language used in the two models is different many of the ideas are shared.

In empowering staff to play a key role in change initiatives Dewar (2007) promotes three core activities that enable staff to explore their values and beliefs, understand the multidimensional nature of their work, and come to a mutual understanding. These are:

- collaboration – the pooling of knowledge and the creation of an inventory of potential solutions
- narration – the use of 'story' telling to facilitate the exchange of ideas
- improvisation – giving staff the permission and the means to identify and deliver creative responses to challenges.

So how does the current situation in the NHS reflect such a work culture?

Following a large-scale survey of 2900 staff in the NHS it was found that the work culture or environment can be thought of in terms of four sets of relationships (Ipsos/MORI, 2008). These were depicted diagrammatically as follows:



In exploring a range of complex relationships, and following factor analysis, a positive work environment is seen to comprise ten factors which can be captured under four broad themes. These were:

- having the resources to deliver good care
- being supported to do a good job
- feeling your job is worthwhile and provides opportunities to develop
- opportunities to improve the way I work.

When staff considered their current situation they identified four areas in which there was need for improvement: To better understand their role and where they fit into the organisation; opportunities to develop their potential; senior management being interested and involved in their work; and to be treated fairly with respect to pay, benefits and staff facilities. The absence of such factors is likely to compromise staff's ability to relate to patients in a person-centred way.

This is a paradox for it is widely acknowledged that staff-patient relationships are a major source of work satisfaction (Berdes and Eckert, 2007) and yet, as noted earlier, the current emphasis on meeting targets and the technical aspects of care devalues the importance of affective or relational care. This is an issue to which we return when dignity is considered.

Furthermore, if staff are to deliver person-centred care to patients they need to experience feelings of being respected and valued themselves (Youngsen, 2007; Firth-Cozens and Cornwell, 2009; Powell *et al.*, 2009). Essentially staff need to: Gain a *profound sense of purpose* from their work (Secretst *et al.*, 2005); to believe that their work is seen as skilled (Fitzpatrick, 2005); and to be accorded *organisational respect* (Ramarajan *et al.*, 2008). This latter concept is defined as '*an individual's perception regarding the extent to which employees in the organisation are treated with dignity, and care for positive self regard through appreciative and positive valuation*' (Ramarajan *et al.*, 2008).

This is especially important with regard to the *relational* dimensions of staff roles. As we will see shortly, to deliver *compassionate* care it is considered that staff must engage in *real conversations* with patients (Goodrich and Cornwell, 2008). To do this several things need to be in place:

- such work has to be accorded value and status
- there needs to be sufficient resources to engage meaningfully with patients
- staff need to be emotionally supported themselves.

This latter point is particularly important with staff needing to experience *affiliative and support* behaviours from peers and managers (Firth-Cozens and Cornwell, 2009), and to have a safe place to engage in *deep conversations* about their own emotional needs (Youngsen, 2008). Several commentators stress the need for staff support structures such as clinical supervision (Ashburner *et al.*, 2004; Jeong and Keatinge, 2004; Siegel *et al.*, 2008; Youngsen, 2008), yet staff are rarely encouraged to share their own feelings (Youngsen, 2008).

To compound difficulties staff working with older people rarely receive professional and societal respect for the work they do. For example, in the care home sector, feelings of being disrespected and undervalued, even more than low wages and difficult working conditions, are the major cause of staff turnover (Baker, 2007). Work in Sweden indicates that staff feel caught in a double bind in that, on the one hand government and society expect them to deliver high quality care, and yet on the other they fail to value what staff do, nor do they provide them with the resources needed to deliver good care (Häggstrom and Kihlgren, 2007). This has the effect of making staff feel that their work is undermined by a lack of morality and support from the wider society. Therefore, as we will argue shortly, culture change in the care of older people does not just require action at the individual and organisational level, but also in the wider health care system, and indeed society as a whole. As Robinson and Gallaher (2008) note, if staff are to add to quality of life for older people, then the workplace must add to the quality of life for staff.

One of the keys to creating an environment in which staff feel valued is leadership. Davies *et al's* (1999) original study of Dignity in Acute Hospital Wards for Older People, conducted on behalf of Help the Aged and the Order of St John's Trust, identified the presence of a strong and visible ward leader, usually the ward manager, as one of the key requirements for the delivery of dignified care for patients and for creating a positive work experience for staff. Such a leader therefore exerts a major influence on both the *caring* culture and the *work* culture on a given unit. This has been widely recognised in the literature (Webster and

Bryne, 2004; Arnetz and Hasson, 2007; Baker, 2007; Downs, 2007; Dewar, 2007; Elaswarapu, 2007; Miller *et al.*, 2008; Rytterström *et al.*, 2009).

Management commitment to empower staff is essential (Arnetz and Hasson, 2007), and whilst the focus here is on the caring culture and the work culture at a unit level, such considerations also apply organisationally, something we will consider shortly. However, in terms of a direct clinical leadership role Dewar (2007) identifies several characteristics of an effective leader. This is someone who:

- listens and develops an enriched environment for both staff and older people
- establishes values, roles, knowledge and skills, and actively role models these
- empowers staff and realises their creativity.

This requires that (s)he has open communication, encourages participation in decision-making and demonstrates *relationship-centred* leadership behaviours. This notion of relationship-centred care is something that we have already alluded to and it will be considered in greater detail later. There is also a need for a degree of *formalisation*, in other words an element of structure to promote an agreed framework for action. This has been termed the creation of *freedom within boundaries* (Davies *et al.*, 1999). Downs (2007) argues that effective leaders adopt a *servant-leadership* model in which the goal of serving others is their number one priority. The presence of a strong clinical leader who can agree and share a vision and create a culture that empowers, values and respects staff is seen as vital to restoring confidence in care (DH, 2008).

There is a long way to go before such a work culture is the norm for those working with older people. Too often the environment still disempowers staff (Goodrich and Cornwell, 2008) and is frequently grounded in hostility, lack of respect and control (Secrest *et al.*, 2005). Having briefly considered the various dimensions of the clinical, caring and work cultures, attention is now given to various models and approaches to culture change within health care settings.

4.4 Effecting culture change

There is an extensive literature on culture change, much of it emanating from the world of industry and business. However, our emphasis is on models/approaches (many of which may have had their origins in industry) that have been applied specifically in health care settings. As noted earlier, many of the culture change initiatives have been in the care home sector and, whilst our focus is on acute hospital environments, there are distinct similarities in the approaches adopted and both sets of literatures have been used to inform this section.

The importance of certain key factors, such as empowering and motivating staff and the critical role of strong clinical leadership, have already been discussed. Here we consider broader models and approaches and seek to identify the characteristics of what appear to be successful change initiatives. However, it is important to point out from the outset that there is no *magic bullet* (Stone, 2003)

or *quick fix* (Nolan *et al.*, 2008), and that culture change is a long term agenda. It has been described as a '*journey rather than a destination*' (Boyd and Johansen, 2008), requiring a systematic and sustained approach (McCormack and Wright, 1999; Bate *et al.*, 2008; IFAS, 2008; Powell *et al.*, 2009). Indeed in the care home sector change initiatives often take a decade or longer (Boyd, 2003), with the initial *embryonic stage* often lasting up to two years (Gilbert and Bridges, 2003). Chan (2007) notes that there is a need to be '*realistic about the pace of change. Attitudes, practices and cultures are deep-rooted and do not change in response to a one-off campaign or imperative*', p5.

This poses fundamental problems in acute care environments where pace is often the main priority and change initiatives arrive *thick and fast*. This was eloquently and succinctly captured by Goodrich and Cornwell (2008) who, at the time of their clinical visits to acute hospitals, noted that:

"Hospital staff and managers were under immense pressure to achieve the four hour national target for waiting times in A&E; change the pathway for emergency admission; shorten length of stay and limit hospital acquired infection" p8.

All this was taking place against a backcloth of considerable change in junior doctors' hours and the introduction of modern matrons.

A second key point to establish at the outset is that a one size fits all model is inappropriate. In a recent systematic review of Quality Improvement (QI) programmes in the NHS, which explored the success or otherwise of the six dominant approaches, Powell *et al.*, (2009) concluded that no single model stands out above any other and, even more importantly, that it was not advisable to take any given model *off the shelf* and apply it unchanged; rather considerable modification is needed in order to address the local context (Powell *et al.*, 2009). Recognising and addressing the complexity of health care generally, which presents those seeking to introduce change with a '*formidable array of complex generic contextual factors*', as well as attending to '*the contingencies of the local and organisational circumstances*', is therefore essential (Powell *et al.*, 2009).

"What is very clear from the literature is that individual organisations have their own networks, structures and organisational history and challenges which need to be considered in relation to the choice and implementation of QI programmes".

(Powell *et al.*, 2009, p64)

In a similar review of successful QI programmes in the US, Europe and the UK, Bate *et al.*, (2008) stress the need to understand the complex ways that different organisations and human factors influence each other.

Notwithstanding the need to tailor any initiative to individual circumstances, both reviews identified a broad set of *necessary but not sufficient conditions* that need to be in place for successful change. These are summarised over the page:

The two reviews over the page considered the introduction of a particular type of change, Quality Improvement Programmes, within acute hospital settings. There is also a considerable literature specifically on culture change within the care home sector. This again stresses that there is no formulaic path and that change has to be context specific (Deustshman, 2001). However, common factors can again be identified. These are captured in Table 4.4.

Table 4.3: Necessary but not sufficient conditions for change

Powell <i>et al.</i>, 2009	Bate <i>et al.</i>, 2008
<ul style="list-style-type: none"> • Sufficient procedural and clinical Resources 	<ul style="list-style-type: none"> • Structural – planning and coordinating mechanisms
<ul style="list-style-type: none"> • Active engagement of health care professionals, especially doctors 	<ul style="list-style-type: none"> • Political – negotiate change/manage conflict
<ul style="list-style-type: none"> • Multifaceted interventions 	<ul style="list-style-type: none"> • Cultural – shared collective meaning in the organisation
<ul style="list-style-type: none"> • Action at all levels of the system 	<ul style="list-style-type: none"> • Education – create and nurture learning processes
<ul style="list-style-type: none"> • Structural investment in training and development 	<ul style="list-style-type: none"> • Emotional – inspire, energise and mobilise people
<ul style="list-style-type: none"> • Availability of robust data systems 	<ul style="list-style-type: none"> • Physical and technological infrastructures

Whilst the contexts may be different the similarities between the two sets of literatures are clear, and shared essential characteristics revolve around:

- having an agreed vision/goal
- support from the very top of the organisation
- encouraging/involving people at all levels of the organisation including staff, older people and families
- investment of time, resources and education
- empowering people to act, especially those nearest the delivery of care
- fostering positive relationships
- focusing change on the resident/patient experience.

The emphasis on establishing a shared vision/goal is consistent with a transformational approach to change. Whilst something of an over simplification Powell *et al.*, (2009) contend that there are two broad approaches to change, you can inspire or you can mandate. The former is often referred to as a transformational approach, whilst the latter is a transactional one. Far too often a transactional model is applied in care settings for older people, whether in care homes, hospitals or the community. For example, in reviewing the success of the Modernising Adult Social Care (MASC) programme, Newman and Hughes (2007) considered that transactional approaches, which tend to produce compliant behaviour, predominated. People act in a certain way because they feel they have to (or sanctions will follow) rather than because they want to. On the other hand transformational approaches aim to change value systems and beliefs, i.e. cultures and practices and their goal is to generate *committed* behaviour. People act in a certain way because they believe it is the right thing to do. Newman and Hughes

(2007) concluded that the more complex the change initiative the more there is a need for transformational approaches. This has been realised in the care home sector for some time, and as the recent Darzi review (DH, 2008) highlights, there is now recognition of the need to change the focus of the NHS.

Table 4.4: Common factors in successful culture change

Deustshman, 2001	IFAS, 2008/Miller et al., 2008	Robinson and Rosher, 2006	Scalzi et al., 2006
<ul style="list-style-type: none"> •Clear communication •Time and resources •Encourage creativity/risk taking •Participation not control •Recruit staff who share values •Shared values/commitment to change •Multiple strategies •Trust must be earned 	<ul style="list-style-type: none"> •Care recipient at the centre of change •Close relationships with residents and carers •Residents direct the change •Collaboration and group decision-making •Care centred around the residents' needs not the organisations 	<ul style="list-style-type: none"> •Develop a shared vision •Empower those closest to the resident •Education for all and identify leaders •Practice intensive education •Select a positive change •DO NOT GIVE UP! 	<ul style="list-style-type: none"> •Critical mass of staff in favour •Shared values and goals •Resident and family involvement •Empowered to act at a local level

For example, the care home sector has for too long been dominated by the three R's – '*Rules, Routines and Requirements*' (Robinson and Gallagher, 2008). But there are now widespread calls for the identification of new values and relationships (Baker, 2007; Robinson and Gallagher, 2008; Szcypura *et al.*, 2008). As Deustshman (2001) notes, '*attitudes cannot be changed by rules*', while Baker (2007) summarises the situation thus:

"Fundamentally the envisaged change is one of the heart, and the investment that is required is not so much financial as attitudinal".

Transforming the culture is therefore predicated on a new vision which more clearly articulates the goals of care in a way that is easy to communicate and receives widespread support. Whilst this is easier said than done, the road to success is not via an over-reliance on the use of transactional approaches. This has been eloquently captured in both the care home sector (Baker, 2007) and the acute sector (Goodrich and Cornwell, 2008) as follows:

"While we should continue to push for compliance to high standards the path to deep systematic change does not lie in the threat of regulations, but rather is a new vision that is hopeful and realistic".

(Baker, 2007, p3)

Technocratic solutions based on incentives, penalties and regulation have little chance of success – they fundamentally miss the point.

(Goodrich and Cornwell, 2008).

The dignity, and more recently the compassionate care, agendas are promoted as offering one way towards improving the acute care experience, especially for older, but essentially for all, patients. This will require a transformational approach that promotes and supports such values and goals.

4.5 Dignity: A Humpty Dumpty word?

"When I use a word it will mean exactly what I choose it to mean, nothing more or nothing less."

(Humpty Dumpty)

A certain degree of latitude in the definition of terms is advantageous in the right circumstances but in others can be positively inhibiting. Dignity provides a case in point. In academic terms it is viewed as a *slippery* concept (Clark, 1995) but it also has widespread currency in everyday usage. However, exactly what dignity means is far from clear. As a recent review concluded, dignity is difficult to define and is '*never simple but always important*' (Cass *et al.*, 2009). If used uncritically and in an overzealous fashion it takes the form of a *hurrah* word (Levenson, 2007) representing a 'promising but vague ideal' (Coventry, 2006). The recent resurgence in interest in dignity and related concepts has resulted in several reviews of its meaning (Coventry, 2006; Gallagher *et al.*, 2008; Cass *et al.*, 2009) in an attempt to reach a consensus as to its constituents. One concluded that much of the available literature was as likely to confuse as to clarify the situation (Gallagher *et al.*, 2008).

In terms of ensuring a *culture* that promotes dignity for frail older people the key challenge is to find a way of turning ideas into meaningful practice (Help the Aged, 2008).

Our aim here is not to provide a comprehensive analysis of dignity, and the several related concepts that are often seen as analogous, such as autonomy and respect (Rodgers and Neville, 2007; Sikorska-Simmons and Wright, 2007; Cass *et al.*, 2009) but rather to distil what appear to be the essential elements of dignity within the context of a care environment. Too often dignity has been reduced to important but relatively easily measurable ideas such as privacy. Whilst privacy is an essential component of dignity, we suggest that the core of dignity in care lies in the nature and quality of interpersonal relationships and the extent to which these provide or detract from a person's sense of personal worth and well being.

Over the last decade or so there has been a renaissance in the concept of dignity. Debate was once primarily confined to dramatic, bioethical issues (Nordenfelt, 2003) but has now widened considerably so that there is a greater focus on the

'ethical in the ordinary' (Powers, 2001). Consequently, dignity has moved from a life and death issue to one that is '*crucial to the everyday experience of older people*' (Alabaster, 2006). Dignity has certainly become a central concern of government health policy (Gallagher *et al.*, 2008) and is seen by both professional (RCN, 2008) and campaigning (Help the Aged, 2008) organisations to be an essential prerequisite of good care. The RCN (2008) view it as being at '*the heart of good nursing*', whilst Help the Aged (2008) see it is the 'backbone' of a quality service. The challenges to achieving dignity should not be underestimated, with Gallagher *et al.*, (2008) concluding that the dignity of older people is now more compromised than it was following Robb's (1967) damning critique of services in *Sans Everything* over 40 years ago. Age Concern (2006) argue that the care system for older people in the UK is '*little short of a national disgrace*' and several commentators have suggested that the acute health care system, despite impressive technical advances, is '*failing at a fundamental level*' (Youngsen, 2007, 2008) and is overlooking the single most important factor – '*how people are treated*' (Dickson, 2008). Peter Townsend (2006), one of the leading academics in the field of ageing has recently called for a '*fresh, more helpful direction*' for the support provided for older people. Dignity, therefore, is increasingly seen as a basic human right (Morgan and David, 2002; Elaswarapu, 2007; Houtepen and Meulen, 2008; Pederson *et al.*, 2008; NMC, 2009) and one that, based on the above, many older people are being denied.

A major European project (see special issues of Quality in Ageing 6(1) and 6(2) 2005 and www.cf.ac/dignity) recently explored the concept of dignity from the perspectives of older people, health and social care workers, and the population at large. It concluded that older people across Europe see dignity as an important and relevant concept, as do health and social care workers. Based on the results of their own review of over 1000 pieces of literature, and extensive consultations with the above groups, the project team identified 4 main *types* of dignity. These are:

- dignity of merit – based on social rank or position in life. This type of dignity is unevenly distributed amongst members of society and varies both from individual to individual, and for the same individual at different times in their life
- dignity of moral stature – based on peoples' actions and whether these are consistent with what is seen as right and proper by their society or group
- dignity of identity – this refers to an individual's self-image and their sense of who they are as a person. This type of dignity is most influenced by our relationships with others and their relationship with us
- menschenwürde – coming from the German, this type of dignity is the most fundamental of all and is the dignity that everyone possesses because they are human. It cannot be lost as long as someone is alive, but can be compromised by inhumane treatment. Dignity must also be preserved after death, with due recognition of cultural and ethnic beliefs.

The study indicated that older people across Europe are particularly concerned about receiving dignified care, with the type of dignity most affected by poor care being the dignity of identity. Older people wanted recognition and respect for their

identity, and to be actively involved in their care in order to reduce feelings of vulnerability. Effective communication is essential to good care (Bayer *et al.*, 2005), and feeling that they have a contribution to make is central to an older person's feeling of worth (Campbell, 2005). Consequently, the attitudes and actions of care staff are the most important factor influencing an older person's dignity (Tadd and Dieppe, 2005). Whilst the NSF has done much to eliminate overt age discrimination, some staff still demonstrate deep-rooted negative attitudes towards older people that reduce their dignity (Philp, 2006).

However, it is reassuring to note that most staff place great value on dignity, which they see as being achieved by:

- promoting autonomy and independence
- providing person-centred holistic care
- maintaining identity and encouraging involvement
- enabling participation
- ensuring respect

(Ariño-Blasco *et al.*, 2005)

As with older people, staff place great store on effective communication. This major European study suggests that there is close agreement between older people and health and social care staff, not only about the importance of dignity, but also what it means in a care setting.

From the above it is clear that it is the *dignity of identity* that is most at risk in care settings, and that this form of dignity is essentially enhanced or diminished during our interactions with others. This is consistent with the conclusions of the review of dignity in care undertaken for the original Help the Aged: Dignity on the Ward Campaign, which noted that '*dignity therefore relates in fundamental ways to being considered a worthy human being*' (Davies *et al.*, 1999).

The inherent subjectivity of this form of dignity, and its essentially relational character, have important implications for the delivery of care.

The need to understand dignity from a patient's perspective and to embed it within the patient experience has been asserted several times recently (Goodrich and Cornwell, 2008; Matiti and Trorey, 2008; Baillie, 2009; NMC, 2009). Baillie (2009) has proposed the concept of '*interpersonal*' dignity which she defines as:

*"Feeling valued and comfortable psychologically with one's physical presentation and behaviour, level of control over the situation and the behaviour of other people in the environment"*p32.

The recent review completed on behalf of the Social Care Institute of Excellence (SCIE) defines dignity in care in the following way:

"Dignity in care therefore means the type of care, in any setting, which supports and respects, and does not undermine a person's self-respect regardless of any difference".

(Cass *et al.*, 2009)

The emerging consensus therefore is that dignity in care is ultimately linked with feelings of well being, personal worth and self-respect (Davies *et al.*, 1999; Nordenfelt, 2003; Coventry, 2006; Gallagher *et al.*, 2008; Baillie, 2009; Cass *et al.*, 2009) and that in the context of care it is enhanced or diminished via interactions with others (Davies *et al.*, 1999; Coventry, 2006; Gallagher *et al.*, 2008; Matiti and Trorey, 2008; Baillie, 2009; Cass *et al.*, 2009). In other words in this context dignity is essentially *relational* and is experienced in the 'small' encounters that characterise the important elements of the patient experience. This is something we will explore in greater detail shortly.

Recently, and potentially adding a further layer of confusion, the King's Fund has launched its *Point of Care* programme (Goodrich and Cornwell 2008, Firth-Cozens and Cornwell 2009), the goal of which is to promote *compassionate care* within the NHS at the *point of care*. It is here, they argue, that the most important encounters occur. This is consistent with the conclusions of Davies *et al.*, (1999) who, following their detailed examination of dignity in acute hospital settings, argued that:

"Care delivery therefore provides both the context and the vehicle for interaction (between staff and patients) and occupies a central position in any analysis of dignity in acute care settings".

(Davies *et al.*, 1999, p52)

The King's Fund note that *compassion* has been established as a core value in the draft NHS constitution and, builds on the work of Youngsen (2007, 2008). Youngsen argues that existing models of health care delivery are too linear and fail to reflect the complexity of the acute hospital setting, where the emphasis is placed on the '*technical fix*' which provides a spurious focus:

"For the overwhelming burden of global health problems, chronic disease, risky lifestyles, mental illness or prolonged dependency, there is no cure or fix".

(Youngsen, 2007, p43)

The reality Youngsen suggests is that the system comprises the people who constitute it, and the real dynamic is the interaction of their thoughts, beliefs, circumstances and behaviours.

The King's Fund (Goodrich and Cornwell, 2008; Firth-Cozens and Cornwell, 2009) elaborate upon these premises, noting that compassion is expressed with and towards others and that it has the capacity both to alleviate pain but, if those providing it are not supported by the system of which they are part, it can also cause pain to them. True compassion requires empathy, respect and recognition of the unique individual and a willingness to forge a relationship with them that acknowledges the limitations, strengths and emotions of other parties. It requires that practitioners engage in a *real* dialogue with patients based on honesty and courage. In other words, a focus on the *little things* that are essential to compassionate care.

However, as they note, the current emphasis on meeting targets (pace) and the devaluing of direct care by delegating it to the least qualified, essentially negates the importance of such relational work. Moreover, the increasing emphasis on technical competence over the interpersonal aspects of care in professional training

is producing a generation of practitioners who both fail to see the value of, and lack the skills necessary for, the delivery of high quality compassionate care.

Whether the introduction of another slippery concept, compassion, further muddies the already cloudy waters remains to be seen. However, we would argue that irrespective of the word used, compassion, dignity or respect, the crux of good care hinges on the relational dynamics that fundamentally influence both the quality of the patient experience, and the job satisfaction that staff gain. It is this area that we next explore.

4.6 Patient-centred care, person-centred care or relationship-centred care?

The current debates about patient and person-centred care have already, in large part, been explored. Moreover the central role played by relationships both in shaping the nature of the patient experience, and as the major source of staff job satisfaction, has similarly been established. Furthermore, the literature review reinforced the essentially relational nature of dignity in the context of an acute care environment and established that it is interactions between patients and staff that provide the vehicle by which dignity is either enhanced or diminished. As Goodrich and Cornwell (2008) contend, it is the *clinical micro-system* that shapes the nature of care in acute settings. However it is also apparent that the current emphasis on pace negates the importance of the relational aspects of care in favour of a 'technological fix' (Youngsen, 2007). As Dickson (2008) notes the NHS is in danger of losing sight of one of its key attributes, concern over how the patient is treated, not as a disease or condition but as a person.

Recently, however, several commentators have asserted the need for culture change initiatives that seek to *transform* the status of relationships at all levels and between all parties, professional, patient/resident and family (Baker, 2007; IFAS, 2008; Parker, 2008; Szczepura *et al.*, 2008). Baker (2007) contends that there is a need for a new way of thinking about relationships in the context of care, with others arguing that the goal of culture change initiatives should be to shift the focus away from tasks and towards relationships (Robinson and Gallagher, 2008). This will require a greater recognition and promotion of 'relational practice' (Parker, 2008), which Parker sees as those activities 'necessary to develop and sustain interpersonal relationships' based on an understanding of individual circumstances and their contexts. Mirroring the arguments previously made about the relative balance between Pace and Complexity, Bate *et al.*, (2008) caution that the *human and organisational* facets of health care must not be neglected in favour of the *clinical and technical*. As Baker (2007) cogently states with regard to care home settings 'The more time I spent in these places the more I learned that culture change is fundamentally about relationships and community'.

However, the paradox remains that whilst on the one hand initiatives such as the new constitution for the NHS explicitly endorse the importance of *compassion* as a core value for health services, providers are at the same time under intense pressure to shorten, routinise and reduce the interactions that constitute such relationships (Parker, 2008).

Williams' (2001; Williams *et al.*, 2009) work which highlighted the tensions between Pace – Complexity inherent in acute care settings also paid explicit attention to the *relational* work undertaken by nurses and the processes that either enhanced or compromised important interactions within the ward context. He noted that on medical, and especially surgical, wards the major focus of staffs' efforts was on 'pace', with the goal of discharging patients as quickly as possible. The organisation and practices of the ward/unit (culture) were predicated on expediting this aim, and consequently the main nursing activities were *pushing* and *fixing*. Pushing involved doing everything necessary to ensure a speedy discharge, and fixing involved ensuring that all the potential procedural impediments to a rapid discharge were dealt with. As a result ensuring that the patient and the family were fully informed about, and understood the implications of discharge (*informing* activities) often suffered as a consequence. Furthermore there was very little *brokering* activity on behalf of the patient or the family. In marked contrast, on the *care of the elderly* unit, there was far greater recognition of the complexity of older peoples' needs and the main activities engaged in by nurses during the discharge process were *informing* the patient, family and members of the multi-disciplinary team of the arrangements and *brokering* as needed. *Brokering* was a largely informal but nonetheless vital *relational* practice that, depending on circumstances, might include:

- mediating between patient and family or members of the MDT
- negotiating on the patient's/families' behalf
- advocating for the patient when they were not able to do so for themselves.

Such informal *relational* work would appear all the more necessary in the current, even more pace orientated, environment. More recently Parker (2008) has argued that relational practice requires a number of factors to be in place and comprises several dimensions. She sees the latter as being:

- accessibility – staff need to be available when they are needed
- boundary management – staff need to make emotional connections with patients, but also avoid being overloaded
- connection – the ability to create engagement/empathy and demonstrate emotional authenticity
- collaboration – all parties need to share information and be involved in relational work
- continuity – the ability to relate past and present experiences.

However, while such *relational* practice often occurs between individuals, Parker (2008) asserts that the nature of the group interactions between staff are also critical, and that such work requires: Inter-group support; informal and formal coordination systems; the management of membership and boundaries; and a clear understanding of interdisciplinary relationships and status. Such conclusions mirror the work of Williams (2001; Williams *et al.*, 2009), which found that on the *Care of the Elderly Unit* the *informal* work of nurses in *informing* and *brokering* was both recognised and promoted by other members of the MDT, especially the doctors.

Parker (2008) sums her findings up thus:

"Relational work in caregiving organisations thus depends, not only on the skills of individual practitioners and care workers, but also on the extent to which the workgroup and the organisation are structured and operated in ways that are supportive of relational work behaviours" (p206).

This position is consistent with the work of Liaschenko and colleagues (Liaschenko, 1997; Liaschenko and Fisher, 1999; Stein-Parbury and Liaschenko, 2007) who argue that successful collaboration in acute settings depends on the appropriate use of three types of knowledge: Case knowledge; patient knowledge and person knowledge. These are defined as follows:

- case knowledge comprises biomedical, scientifically derived knowledge that is independent of a particular individual or context. It is based essentially on objective and standardised measures. This is largely the domain of doctors
- patient knowledge is much more contextual and concerns an individual's reaction/response to a disease and its treatment. It requires an appreciation of case knowledge but also the ability to go beyond this. It represents the *case* in context and requires *knowing the patient*. This would seem consistent with *patient centred* care as discussed earlier and is seen by Liaschenko and colleagues to be the primary form of knowledge used by nurses, needing a better understanding of the *complexity and idiosyncrasies* of the individual
- person knowledge is an appreciation of what it is to live a certain kind of life, to be a person with a unique biography, as Stein-Parbury and Liaschenko (2007) state *'to know a patient as a person is to know what the recipient of care knows, what matters to the recipient and why'* (p 473). This would seem more consistent with the notion of person-centred care. However Liaschenko (1997) argues that such person knowledge is increasingly seen as *fluff* in modern day health care settings.

The importance of creating a supportive environment in which such relational practices and knowledge can flourish is well recognised (McGilton *et al.*, 2003), as is the fact that relationships should be based on an equal partnership between patients and staff (NMC, 2009). Thus an appreciation of the *'complex social interactions'* that constitute the culture operating in acute settings (Powell *et al.*, 2009) has to take full account of the interdependent nature of relationships (Baker, 2007; Davies *et al.*, 2007; Dewar, 2007; Youngsen, 2007). Dewar (2007) summarises this as follows:

"The strong message that unites this piece of work (on culture change) is the interdependence of staff, residents and carers, and any attempt to promote culture change within the care home setting needs to nurture these important relationships"

The literature indicates that the same considerations apply equally in acute care settings. We would therefore suggest that one of the key factors in creating and sustaining culture change, especially that designed to promote dignity and/or compassionate care, is a focus on relationships and relational practices. Therefore,

rather than the current three R's (Rules, Routines and Requirements) that exert an undue influence on care, there should be a far greater emphasis on relationships. As we noted earlier, this study is predicated in large measure on the belief that an enriched environment is far more likely to exist if a relationship-centred model of care is adopted where all parties experience the senses.

4.7 Aligning culture change and dignity – the four 'P's'

If relational practice is to be at the forefront of culture change designed to ensure that dignity and compassionate care become the core values of the NHS, then there will be a need to resolve the tensions between Pace and Complexity and to find a new model for acute health care. As we have argued, this will require a transformational approach as opposed to a largely transactional one. The work of the Pew-Fetzer foundation (1994) that originally coined the term *relationship-centred* care had just such a goal, arguing that the dominant cure model of western health care systems was inadequate to address the major health challenges facing modern society. Recently Youngsen (2007, 2008) has advanced an essentially similar set of arguments in promoting compassion as the key to better health services. He argues that there is a need for a move away from a health service based on *fixing* (the similarities with the language of Williams is striking here), where the goal is to provide a service, to one where the main aim is to be of service in order to create a *healing* environment. He draws on the work of Heifetz (1994) who describes the differing approaches needed to resolve technical and adaptive problems. Technical problems are those where the goal is clear and there is an agreed approach to the solution and its application. This would be consistent with a pace driven, case knowledge based approach. According to Heifetz such problems require management. On the other hand, adaptive or *wicked* problems are those where the definition is unclear and there are multiple stakeholders, often with differing assumptions. This would typify the complexity found in the acute care of older people. Heifetz believes that the solutions to such problems require leadership. Youngsen (2007) argues that this means moving away from the quick or technical fix towards a healing environment. Conceptualising what such an environment looks like is the challenge, but we would assert that it might equally be called an *enriched environment* as reflected by the senses, which capture the interdependency of relationships in health care.

Recently both the Royal College of Nursing (RCN 2008) and the Nursing and Midwifery Council (NMC 2009) have produced two reports that outline a model of care comprising of three elements, which are again interdependent:

In a recent analysis of *interpersonal dignity* in acute care Baillie (2009) identifies a not dissimilar group of inter-related factors that she asserts either promote or diminish such dignity. These are:

- patient factors – the influence of the patient's own characteristics
- staff factors – the way that staff interact with patients, families and colleagues

- hospital environment – the way that the system is structured, especially the culture and leadership that is in operation and the behaviours of other patients in the environment.

Table 4.5: RCN and NMC models of care – the three ‘P’s

RCN 2008	NMC 2009
<p>Place – the physical environment and culture of the organisation.</p> <p>People – attitudes and behaviours of others.</p> <p>Processes – nature and conduct of care activities.</p>	<p>Place – is care managed and resourced effectively, does the environment encourage an element of calculated risk?</p> <p>People – are they competent, assertive, reliable, empathic, compassionate?</p> <p>Processes – is there open communication, and partnerships between patients, colleagues and families?</p>

These recent publications seem to capture important elements of the extant literature and potentially provide a framework to begin to explore the varying dimensions of the case study sites. However, given the essentially subjective nature of relationships and concepts such as dignity and compassion, we would add a fourth ‘P’ to the model, *perceptions* in order to provide a more comprehensive approach.

4.8 Culture change: Widening the context

So far our concern has been with the introduction of culture change within a specific context, that is the acute hospital environment. As important as this is there is widespread recognition that attention to this area alone is unlikely to result in far reaching and lasting change, as this requires addressing a far wider set of factors. Several authors note that interventions need to be targeted at a number of levels ranging from the individual practitioner right through to society as a whole. So, for example, Bate *et al.*, (2008) talk of addressing issues at an inner and outer context, the one to do with the organisation itself, the other with the wider system within which it operates. The RCN (2008) has recently offered a slightly differing approach, suggesting that attention needs to be turned to:

- the micro level – focusing on the individual and ensuring that they challenge poor practice
- the meso level – focussing on the culture of the organisation and the extent to which they invest in their staff
- the macro level – the need to challenge the target driven culture that dominates current health care policy

- Youngsen (2007) takes a similar approach, advocating the need to encompass: The individual/family; health care professionals; health care organisations; wider health care systems.

With regard to the care home sector Fahey (2003) argues that change initiatives pay too much attention to the facility or organisation and fail to adequately consider the need to change not only practitioner behaviour and public policy, but the sort of values that society itself promotes and privileges. Baker (2007) takes up these arguments and believes that it is only by transforming society's values and views of older people that the culture of care environments will change. The logic of such an approach is that the acceptance of poor standards of care for older people is a reflection of the ageist attitudes of society more generally. Whilst the NSF (DH, 2001) had as one of its fundamental goals the eradication of age discrimination in health care, and has made progress in this regard, the fact that there is still a need for campaigns such as the *point of care* (Goodrich and Cornwell, 2008) attests to the work that remains to be done.

Therefore, whilst our focus here will predominantly be on culture change within acute health care settings, we will return to the need for action at several levels in the discussion.

4.9 Structuring the case studies

Although the case studies have been purposively sampled to explore diverse settings and initiatives an element of conceptual ordering and structure is helpful in teasing out similarities and differences. As we have noted above many of the ideas dominating current discourse, such as culture and dignity, are themselves *slippery* but if meaningful change is to occur there is a need to translate such abstract ideas into the reality of practice (Help the Aged, 2008) and to ensure that the language used is jargon free, easy to relate to and commonly understood. That has been the purpose of the literature review. Therefore in structuring the case studies we will follow a format that describes:

- place - providing a description of the case and its settings
- processes - that are enacted using the three R's (Rules, Routines and Regulations)
- people - highlighting their perceptions and the nature of their interpersonal interactions, representing the fourth 'r'; relationships
- perceptions: Peoples' views of the above and their experience of receiving or delivering of care.

The above will be interpreted using the Pace-Complexity continuum and the nature of the environment, whether enriched or impoverished as reflected by the senses.

Section 5: Toolkit development

5.1 Introduction

In this section we report on the development of a number of survey instruments that assess views or experiences of high quality care from four perspectives:

- nursing teams' perceptions of practices that support high quality care giving (climate for care)
- patients' experience of care
- carers' experience of care
- matrons' assessment of the quality of care provided at a ward-level.

The purpose of this work was threefold:

- to provide important survey-based data to support, validate and supplement the case study interview and observation data reported in *Sections 6 to 9*
- to examine, using multivariate statistics, the relationships between nursing teams' perceptions of climate for care with patients' and carers' experience of care across 65 wards using the instruments developed here (see *Section 10*)
- to contribute to the production of a toolkit that helps Trusts, hospitals and wards assess their care giving environments, and stimulate the promotion of change in relation to work with older people.

The intention is that the instruments described in this section, when used as part of a wider change initiative, provide baseline data on key factors that might promote or hinder care giving, and on care outcomes such as patients' and carers' experience of care. The instruments have the potential to be used as diagnostic tools, allowing practitioners and researchers to track the impact of change initiatives over time.

Before describing the development of the instruments, we first discuss the concept of climate for care that, together with the Senses Framework and relationship-centred care, were used to guide this development work.

5.2 Nursing team climate for care

What can hospitals and their staff do to promote the delivery of quality care to older people? An important route is the creation of a climate for care among staff (See *Section 2.1* for a discussion of the concept of organisational climate). Climate for care refers to staff perceptions of the practices, procedures and behaviours that support them in providing good care. This argument is based on the idea that staff will deliver excellent care to patients when staff experience an environment that is supportive of, and promotes, care giving. We would expect that the climate

experienced by staff would be reflected by the experience of patients and carers. This conceptualisation of climate for care closely mirrors the Senses Framework, as both approaches highlight the relational nature of care. Considering the potential importance of creating and maintaining a work environment that supports care giving we sought to develop an accessible and easily administered survey instrument to measure climate for care among nursing teams. We focussed our attention on nurses as it is widely recognised that it is this group that provides 24 hour support to older patients and their families and that it is the ward nursing leader that primarily creates and sustains the philosophy of care (Davies *et al.*, 1999).

We next describe climate factors that support care giving in nursing teams and which underpin the development of the staff instrument.

5.2.1 Identifying climate for care factors

The narrative literature review reported in *Section 4*, together with previous reviews of both the climate and care literature informed the identification of climate factors associated with quality in care. Again here we draw on the Senses Framework which proposes that effective care for older people stems from an enriched ward environment in which staff experience the six senses: Security, belonging, continuity, purpose, achievement and significance. We did not directly seek to assess the senses with the climate instrument, but rather, in line with climate research, we aimed to identify those ward-based practices that create the senses for staff. We identified the following climate factors that theoretically can be expected to engender the senses and consequently be associated with good care:

Shared philosophy of care. An important basis for quality of care is an explicit and shared set of values leading to an agreed philosophy of care that places patient care at the core of nursing activity and clearly identifies the standards of care expected for patients. A sense of purpose and a sense of continuity for staff are enhanced by a shared set of care values.

Resources. In an acute care setting the essential consideration is that the illness episode necessitating admission is treated successfully. This requires a reasonable number of adequately trained, competent staff and sufficient basic supplies in terms of essential equipment.

Team support. Working within a supportive team, both emotionally and in terms of task accomplishment, where the emotional demands of work are recognised are important antecedents of the senses of security, continuity, belonging and significance. Team support is seen to be integral to care giving (Kahn, 1993). Nurses ideally need to be accessible to patients, emotionally, as well as physically and intellectually, thus risk being emotionally drained. If nurses are to continue to give good care, they need to feel cared for themselves and the nursing team can be a powerful source of support.

Psychological safety. Team psychological safety is a shared belief among team members that it is safe to take interpersonal risks and that team members will not embarrass, reject or punish someone for speaking up (Edmondson, 1993). Freedom to challenge without censure is important in enabling team members to

explore difficulties and errors, learn from them and improve practice. There is considerable support for relationships between psychological safety and team learning, behaviours and performance (Edmondson, 1993). Also, in a study of hospital nursing teams, a climate of psychological safety resulted in open reporting and discussion of errors. In teams where psychological safety was low, team members tended to keep information about errors to themselves. It is a strong foundation for a sense of security in staff.

Training and development. A commitment to developing staff is important not just in terms of ensuring a competent and skilled nursing team but also in creating a sense of significance for staff.

Participation in decision-making. The more the nursing team participate in decision making through having influence, interacting, and sharing information, the more likely they are to invest in the outcomes of those decisions and to offer new and improved ways of care giving. Having opinions listened to and valued enhances senses of significance, belonging and purpose in staff. Research on participation in decision making has a long history in social and organisational psychology, and shows that participation enhances effectiveness and commitment, lessens resistance to change and fosters innovation (Bowers & Seashore, 1966; Coch & French, 1948; Lawler & Hackman, 1969; Wall & Lischerson, 1977; West & Anderson, 1996).

Commitment to improving practice. A commitment by the nursing team to monitoring care giving standards, developing practice, and problem solving where deficits in care standards are identified and rectified, help sustain a positive care giving climate, and create a sense of purpose and a sense of achievement for staff.

MDT-working. Considerable attention has been focused on the effectiveness of MDTs and studies have linked team performance to positive patient care outcomes (e.g., Gavett, Drucker, McCrum & Dickinson, 1985). The extent to which interdisciplinary teamworking impacts on patient outcomes depends on how well members work together and coordinate their actions (Temkin-Greener *et al.*, 2004). A cohesive MDT helps to create a sense of significance and sense of achievement and has been integral to the concept of good care for older people since the advent of geriatric medicine (Wilkin and Hughes, 1986).

Work demands. A common discourse among health care workers in the present context of staff shortages and high workloads is that there is too little time to give high levels of care to individual patients. Indeed the purpose of the Productive Ward initiative is to free up nursing time so that staff can spend more time with patients. Unacceptably high work demands can also lead to staff feeling depleted senses of achievement, support and significance, with a consequent lowering of morale (Davies *et al.*, 1999).

In addition to the theoretically derived factors described above, we also sought to develop measures of factors that may enhance and sustain a climate for care. There are many possible factors supporting the development of a climate for care in nursing teams, such as the composition of the nursing team and the organisational context in which wards are embedded. In this study we have concentrated on developing measures of two factors – ward leadership and a hospital climate that supports staff.

Ward leadership. A considerable amount of climate research has emphasised the role of leaders in the creation of climate. For example, Koene, Vogelaar and Soeters (2002) reported the influence of leadership behaviour (charisma, consideration and initiating structure) on organisational climate and financial performance in a chain of supermarkets. Schneider *et al.*, (2005) examined the influence of leadership behaviours on enhancing climate for service, and subsequently on customers perceptions of service, and unit sales in supermarket departments. We take a similar view with regard to the importance of ward managers' leadership behaviours in creating a climate for care and subsequent good patient care. Indeed, Davies *et al.*, (1999) literature review and the narrative literature review undertaken for this study reported that the culture of a ward stemmed largely from the leadership of the ward manager. Our view is that the ward manager's leadership behaviour - e.g., promoting a clear philosophy of care, modelling appropriate care behaviour, supporting and developing staff - is key to fostering and sustaining a climate for care for the nursing team.

Supportive hospital climate. Hospital climate refers to staffs' perceptions of policies, practices and procedures enacted within their hospital, as opposed to within their ward. We propose that a climate for care within nursing teams, rests not only on a ward manager's leadership behaviour, but also on the broader hospital climate that provides support in fundamental ways such as the assistance to perform effectively through resources and training, and that also signifies a concern for staff welfare through, for example, practices that treat staff fairly and encourage staff involvement and participation. This view of climate for care as a figure resting on a general supportive background climate is one that finds support in the customer service literature (e.g., Schneider *et al.*, 1998).

While the above factors are by no means exhaustive, they do represent key practices and processes underpinning the six Senses that capture important elements of the experience of giving care. If the nursing team works in an environment that actively promotes positive care, intertwined with a climate that promotes staff well-being through for example, support, participation and development, then good care is likely to be reinforced.

5.3 Assessment of quality of care and staff well-being

In addition to developing a multi-dimensional measure of climate for care for use with nursing teams we also undertook the development of measures that will allow hospitals to tap important outcomes. We focused on four key groups of informants: patients; carers; nursing teams; and matrons.

5.3.1 Patient experiences of care

The importance of considering the subjective experiences of patients as key indicators of the outcomes of care is central to the current changes in the NHS (DH 2008). In particular the extent to which their dignity is upheld and the degree to which they are enabled to participate in their own care are key dimensions of quality. It was our intention to develop an approach that would *tap* into these domains in a way that was consistent with a relationship centred approach to care. We did not have the time or resources to develop items directly from patients and

so therefore drew on indicators gleaned from the original Dignity on the Ward report (Davies *et al.*, 1999).

5.3.2 Carer experiences of care

The ongoing input of family carers is essential to the support of frail older people within their own homes and the more widespread involvement of carers within an acute setting has been advocated a number of times (see Nolan *et al.*, 2001, 2003). However despite the increased attention given to carers' needs several studies suggest that they are not as involved as they would like to be and that they often feel marginal figures in the support of their relative, with their expertise being overlooked (Brereton and Nolan, 2003; Audit Commission, 2004). The involvement of carers is central to a relationship centred approach to care and our intention was to develop an approach that would tap into their perceptions both about the quality of care that their relative receives and the extent to which the carers themselves had been actively involved. Items for these measures were again underpinned by the original Dignity on the Ward report (Davies *et al.*, 1999) and later work on developing the Senses Framework (Nolan *et al.*, 2006), as well as on-going work with colleagues at La Trobe University, Melbourne.

5.3.3 Nursing team outcomes

If staff work in a supportive environment in which positive care is actively promoted we would expect there to be benefits for their psychological well being. We therefore included a measure of staff well being as well as a measure of the nursing teams' self-assessment of the quality of care they provide.

5.3.4 Matrons assessments of care

Although measures of patients' and carers' subjective experiences of care are key outcomes for this study, some patients and carers might have limited exposure to the care practices of different nursing teams when completing their questionnaires. We therefore also developed a short questionnaire assessing ward-level care quality, designed to be completed by matrons or those in similar management-level positions with an overview of the care practices of multiple wards on which to base their judgements.

5.4 Development of questionnaires

5.4.1 Development of the nursing team questionnaire assessing climate for care factors

Initially, an extensive review of published measures of climate, both in the health and non-health literature, was conducted. These measures were examined for their component sub-dimensions in relation to the posited climate for care scales described above: Shared philosophy of care; resources; team support; psychological safety; training and development; participation in decision-making; developing practice; leadership; and supportive hospital climate. Only subscales or items appropriate to these factors in an acute hospital context were retained. The questionnaire drew upon, for example, Nolan *et al's* (1998) Assessment of Work

Environment Schedule, but overall, many of the items comprising the measure were self-generated. For instance, no comparable measure assessing the philosophy of care factor was identified, so all items were generated by the research team based on their experience and other studies in the area (Davies *et al.*, 1999).

For all scales, respondents were asked to indicate the extent to which each statement was true for the ward on which they worked, except for items targeted at hospital climate. The response format used a 5-point Likert scale ranging from *1=strongly disagree, 3=neither agree nor disagree, 5=strongly agree*.

The questionnaire also contained items addressing two nursing team outcomes; staff psychological well-being; and the nursing teams' perceptions of the quality of care they deliver.

5.4.2 Development of the patient and carer questionnaires

We discussed the source of items for these two questionnaires above. As with staff, patients were asked to respond to each statement in relation to the ward on which they were staying. Carers were asked to respond to statements about their own and their relative's experience of care quality. The response format used a 5-point Likert scale ranging from *1=strongly disagree, 3=neither agree nor disagree, 5=strongly agree*.

5.4.3 Development of the matrons questionnaire

Some of the items were newly developed for the study and some of the items were adapted from a measure by Temper-Greener, Gross, Kunitz & Mukamel (2004). The response format used a 5-point Likert scale ranging from *1=strongly disagree, 3=neither agree nor disagree, 5=strongly agree*.

5.5 Questionnaire distribution and analyses

The staff climate survey was conducted among the nursing wards at the four participating Trusts. Patient and carer questionnaires were distributed on the same wards. In total 70 wards were sampled. All nursing team staff were invited to take part.

Data collection proved extremely problematic necessitating survey distribution on two separate occasions. On the first occasion, responses to the patient and carer survey proved to be very disappointing, precluding the possibility of analysing relationships between care climate and quality of care; one of the key objectives for developing the measures. The patient and carer surveys were distributed by nursing staff to patients over 65 being discharged home as part of their discharge documentation. Distribution by nursing staff rather than researchers was a requirement for ethical approval from a Multi-Centre Research Ethics Committee (MREC).

Exploration, with the participating Trusts, for the reasons behind the low patient and carer response rate revealed that many questionnaires were not handed out, and even when distribution took place, questionnaire returns were extremely low.

Both the Trusts and the research team agreed that the best way to ensure eligible older people were given the opportunity to participate in the research was for members of the research team to visit the ward areas on a regular basis, and, liaising closely with the nurse-in-charge of the ward, hand out the questionnaires directly to patients (and/or their carers) who were deemed medically fit and were expected to be discharged home within the next 24 hours. These are patients who no longer required any further medical treatment, or acute therapy input. A request was submitted to the MREC for a substantial amendment to the protocol to allow such an approach to data collection. The application was successful.

The patient and carer surveys were subsequently repeated over a period of five months. As over six months had elapsed since the first survey round, we also repeated the staff survey to ensure temporal equivalence between staff responses, and patient and carer responses. The new data collection procedure was considerably more successful, but was very resource intensive. Repeated visits to sites were required to identify patients medically fit and ready for discharge and therefore eligible to participate in the patient survey. In addition, it became clear that most patients preferred, or required, researcher assistance to complete the questionnaire. This usually took 30 - 40 minutes per patient. Consequently two research assistants worked full time at sites for five months, supported by other members of the team, to collect patient and carer data. Patients and carers also had the option of returning their questionnaire directly to the researchers in a pre-paid envelope. Questionnaires were completed anonymously.

While the low response rates from patients and carers was the primary reason for repeating the surveys, responses from staff in the first round were low in many wards and often the within-ward response rate, or the percentage of the total number of the nursing team per ward that responded to the survey, was so low as to question whether the nursing team could be included in the sample. As sustaining a reasonable sample size to examine links between nursing team climate for care and care outcomes was vital (the sample size equates to the number of nursing teams not the number of individual respondents) we also adjusted the method of distribution of the staff survey to encourage greater participation. In the first round of data collection, members of the research team delivered the questionnaires to the wards, usually leaving the questionnaires with the ward manager to be distributed to staff. In the second round, we attempted to gain greater *buy-in* from ward managers and their matrons. The researchers attended meetings with ward managers and matrons involved in the study, at which they presented the general research aims, and answered questions about the project. At the meeting, ward managers and matrons were told that the focus of the study was on developing new measures for a tool kit to facilitate change and exploring relationships between staff, patient and carer views across hospital wards. Staff were provided with a pre-paid return envelope and instructed to return their questionnaires direct to the researchers. All questionnaires were completed anonymously and staff were assured of the confidentiality of responses to the questionnaire. Staff returns while considerably improved on the first round still proved problematic and we followed up the initial distribution of questionnaires with visits, emails and telephone calls to ward managers to encourage returns.

5.5.1 Refining the questionnaires

Prior to distribution, the nursing team questionnaire was shown to nursing staff. No direct data were collected as part of this pilot; the purpose was to assess the face validity of the questionnaire. Likewise, the patient and carer reference group provided feedback on the acceptability of the patient and carer questionnaires. However, repeating the survey allowed us to use the first round of data collection to undertake a much larger scale pilot of the questionnaires and use collected data to subsequently refine and shorten each questionnaire. It also provided the opportunity for some longitudinal analyses to track changes in key variables over time (see *Section 9, Case Study four*).

A series of exploratory factor analyses (EFA) on the pilot data were computed using the Varimax procedure on SPSS. As a result a number of items loading highly on two or more factors were removed from the surveys. The questionnaires distributed for the second round of data collection assessed the same factors as before but with fewer items (see Appendix 4 for the survey instruments distributed in the second round of data collection).

5.5.2 Sample for scale development

In the second round of data collection, questionnaires were distributed to 2,127 members of the nursing teams on 70 wards. Overall, completed questionnaires were received from 929 staff, constituting a 44% response rate. Completed questionnaires were received from 985 patients and 507 carers. Due to the nature of the distribution of questionnaires to patients and carers it was not possible to calculate a response rate.

5.5.3 Exploratory factor analysis

The staff data, patient data, and carer data were again subjected to separate EFAs to find how closely the data derived from staff, patient and carer responses were consistent with the hypothesised scales following the initial refinement of the questionnaires using the pilot data. Basically EFA determines whether items "hang together" as groups of items that correspond with the scales. Based on these findings, the scales were refined by examining the internal consistency of scale items.

5.5.4 Internal consistency

More detailed analyses of the factor analytic solutions were undertaken to examine the internal consistency or reliability of the scales using Cronbach's alpha. This statistic measures how strongly the various items comprising a scale are related to each other. Cronbach's alpha ranges from 0 to 1 and values exceeding 0.7 indicate high reliability or confidence that the items in a scale are consistently measuring the same thing (Ghiselli, Campbell & Zedeck, 1981). We removed a number of items on some scales from all the questionnaires on the basis that this improved the reliability of the scales. Cronbach's alpha for all the scales comfortably exceeded 0.7. We next describe the scales which emerged from the EFAs and reliability analyses.

5.6 Measures

The final scales and items described below, are shown in Appendix 5.

5.6.1 Climate for care

Climate for care in nursing teams was assessed by nine scales measuring the dimensions set out earlier in this section. We have sought to name each scale in a way that reflects the scale domain but that is also likely to *speak* to practitioners, patients and carers:

Shared philosophy of care measures the extent to which the team share values that prioritise the importance of patient care using five items. Items include, *We have a culture on this ward about caring for patients and supporting them rather than being about doing tasks and the team share an explicit philosophy of care.*

Having resources measures the extent to which the team had sufficient staff and other resources to complete their tasks using three items. Items include *We have sufficient basic equipment and supplies to deliver good level of care,* and *There are sufficient staff with the knowledge and skills to provide quality patient care.*

Supporting each other assesses the level of trust, task and emotional support between members of the nursing team using six items. Example items are *colleagues show concern and support to help each other deal with stresses at work,* and *the team can really count on each other to help out with any difficult tasks at work.*

Feeling safe uses four items to measure psychological safety. This scale explores the extent to which the team is a safe environment for interpersonal risk taking such as bringing up errors. The scale is adapted from Edmondson's (1993) measure of psychological safety. Two example items are *this is a team where anyone can challenge poor practice without fear of being rejected,* and *people feel safe to be themselves in this team without fear of criticism, censure or feeling foolish.*

Improving practice assesses the degree to which the team members interact to discuss care performance and reflect on ways to improve quality of care using five items. Sample items are *We regularly take time to figure out ways to improve our care delivery,* and *We discuss ways to make our team vision a reality.*

Having a say uses five items to measure the extent to which influence over decision making is shared among team members. Examples of the items are *The team participate in decisions that affect them on this ward* and *We have a say in how work is managed within the ward.*

Developing our skills measures the extent to which there is an emphasis on developing team members' skills and competencies. The measure uses three items, including *We are given time and opportunity to develop new work skills.*

Too much to do assesses the workload of the nursing team and measures the extent to which staff feel the quality of their work is negatively impacted by excessive work demands. The measure comprises four items including *There is too*

much work to do in too little time and We cannot follow best practice in the time available.

MDT working uses three items to measure the level of trust and communication between members of the MDT. An example item is *We work well with other members of the MDT.*

5.6.2 Factors that enable climate for care

The proposed factors that enable climate for care, namely leadership and supportive hospital climate, were assessed by the following measures:

Leading by example assessed the quality of ward leadership with a measure designed to capture elements of both transformational leadership styles and the attributes of effective ward managers identified in the literature. The measure consisted of four core dimensions assessing the extent to which the ward manager:

- promotes confidence among the nursing team (two items)
- provides support and consideration to team members (three items)
- creates a *caring* ward by demonstrating clear expectations of standards of care (three items)
- actively role models and coaches care delivery (three items)

EFA revealed that the four dimensions consisted of one factor (coefficient alpha = .91) and Leading by example was subsequently considered as a single scale. Sample items are *The ward manager instils a sense of pride in our ward by focusing on what we do well, The ward manager acts in a caring and supportive manner towards members of the team, The ward manager takes initiatives to establish strong standards of excellence in care, and The ward manager actively coaches individuals to help them improve their care delivery*

Support from the top used eight items to measure staffs perceptions of policies, practices and procedures enacted within their hospital (i.e, hospital climate) that assist staff to perform effectively through resources and training, and also signifies a concern for staff welfare. Example items are *This hospital has access to the resources it needs to get its work done, Staff's concerns and opinions are listened and responded to by management in this hospital' and There are good career opportunities in this organisation.* EFA revealed one scale (coefficient alpha = .87).

Finally we report the scales used to assess quality of care and staff well-being.

5.6.3 Patient experiences of care

Analysis of the patient questionnaire resulted in two scales.

Feeling significant (p) is a thirteen item scale addressing the extent to which patients reported positive experiences of care. Example items are *Staff made time to get to know me as a person, Staff always explained any treatment or procedure to me and Overall the quality of care I received was very good*

Could do better (p) is a five item scale measuring negative experiences of care with items such as *Staff seemed more concerned with getting the job done than*

caring for me as an individual and Staff did not always respond quickly if I needed help.

5.6.4 Carer experiences of care

Three scales emerged from the carer questionnaire.

Giving my relative the best uses six items to assess carers' perceptions of the level of care their relative received. Example items include *Overall the quality of care my relative received was very good* and *My relative always received the standard of care that I wanted*.

Could do better (c) is a three item scale measuring the extent to which carers felt their relative received negative experiences of care. An example item is *Staff did not treat my relative with dignity and respect*.

Feeling significant (c) measures the extent to which carers felt significant and involved in their relative's treatment using ten items. Items include *Staff always made me feel welcome on the ward* and *Staff always listened to my views and opinions about my relative's care*.

5.6.5 Nursing team well-being and self-rated effectiveness of care delivery

Two scales examined self reported psychological well-being and self assessed team performance in care delivery.

Feeling motivated measures the extent to which members' of the nursing team have positive feelings and attitudes at work. It was measured with a shortened version (using six items) of a 12-item scale developed by Warr (1990). Respondents are asked to indicate how much their work had made them experience each of six feeling states over the past few weeks, such as *motivated* and *enthusiastic*. Answers were recorded on a 5-point response scale ranging from 1 (never) to 5 (all of the time).

Doing our best for patients and carers measures the extent to which members of the nursing team see their team as delivering a high standard of care to their patients and meeting the need of carers, using six items. Example items are *Our team does a good job in meeting family members needs* and *Our patients experience very good individualised care*.

5.6.6 Matrons' assessments of quality of care

EFA and reliability tests on the measure revealed two factors.

Meeting patients' needs measures the matrons' assessments of the level of care received by patients on a particular ward using six items. A sample item is *The ward team almost always meets its patients' care needs*.

Looking to improve measures the extent to which matrons believe that a particular ward is seeking to improve its care practice with four items. An example item is *The ward team is constantly seeking to improve its care practice*.

5.7 Demonstrating that the climate for scales differentiate between nursing teams

One final test of the properties of our measures is the ability of the climate for care scales to identify distinct nursing team climates. That is, do the climate measures identify shared climates within the nursing team (*i.e.*, team members have similar climate perceptions) but also are the measures sufficiently sensitive to capture differences between nursing teams? Analyses of variance (ANOVAs) on all the scales revealed significant between-team differences on all the scale scores ($p < .01$) and that variability within teams was significantly lower than variability across teams *i.e.*, members of teams tended to agree with each other and their responses as a group differed from those of other teams.

5.8 Summary

As we discussed at the beginning of this section, the measures developed here provide data to help illuminate the case study analyses that follow, and, in *Section 10* to examine whether nursing teams' experience of practices that are theorised to support care giving is reflected in the experiences of older patients and their carers. The development of staff, patient and carer questionnaire measures, which demonstrate robust psychometric properties, including the ability to discriminate between wards along important climate for care dimensions, will, we hope, be a valuable and helpful addition to the toolkit developed from this study. The questionnaires hold promise as measures of team climate and patient and carer experiences, and for team building and organisational development interventions.

Section 6: 'Two sites; two cultures'? A Case Study

6.1 Setting the scene

This case study focuses on an organisation with a long history of innovation and excellence, as measured by the various national targets that have been introduced over the last several years. At the time the study started it had been a three star Trust for a number of years and was one of the first to achieve foundation status. For several years there has been significant investment in staff development and training and in the creation of Practice Development Units (PDUs) as a means of promoting and disseminating innovative and excellent practice.

Moreover, in the context of the present study, there was explicit recognition of the complexity of the care required by older people and the need to invest in such services. This was reflected in both symbolic and substantive ways. Symbolically the main ward providing specialised care for older people was called the Complex Care Unit, with the title being deliberately chosen to reflect the fact that the nature of the population within such an environment required attention to a wide range of factors that went far beyond addressing the presenting medical condition. This was captured by the senior medical consultant on the unit who believed that when supporting frail individuals it was essential to focus on both the *urgent* and the *important*. He saw this as being in marked contrast to the usual practice in acute care settings where the focus of efforts was primarily on the urgent, with the consequence that '*the urgent becomes the enemy of the important*'. (A2)

In terms of the Pace ↔ Complexity dynamic the urgent would equate with pace, and the important with complexity. The adoption of the title Complex Care Unit to distinguish the work of the Unit from that of Acute Medicine more generally overtly recognised the qualitative and quantitative differences that exist, not only in terms of patient need, but also in the philosophy and culture of the Unit. This is symbolic of the more holistic approach to care that was seen to be taken.

A more substantive manifestation of the Trusts' commitment to the care of older people was provided when it became one of the first in the country to invest in a Consultant Nurse post and deliberately chose to appoint a consultant nurse for older people. According to the Chief Nurse this decision had arisen out of concerns about the quality of care provided to older people and recognition of the need to do something to improve it that, in her own words, '*recognised the complexity of their [older peoples'] needs*' (A1). Although the Consultant Nurse concerned had retired shortly before the study started, it was apparent that she had had a considerable impact, being a well respected figure both locally and nationally. In making the appointment the Chief Nurse had ensured that the post holder had considerable clinical freedom, in order that she could '*get where she wanted to be*' (A1). The individual appointed was described as having a '*passion*' for the care of older

people and a mission to transform the way that they were viewed and treated, not only by nurses, but by the rest of the hospital. How she went about this will be considered in more detail shortly. Prior to the present study starting the Consultant Nurse had visited members of the project team (MN/JB) at the University of Sheffield and had introduced elements of the Senses Framework into the Trust in conjunction with an academic colleague from the local University.

Based on the above, the Trust was purposively sampled because, on objective criteria, it seemed to reflect most of the characteristics of an 'enriched' environment.

6.2 The place: Trust and unit level

The Trust in question was located in the North of England and had been established in April 2001 following the merger of two adjacent Trusts. It provides 24 hour acute care services to about 425,000 people with some services being delivered to a much wider population. The Trust employs approximately 5,300 staff and has an operating budget of just over £200million, mainly provided by Primary Care Trusts who commission their services. They also manage a number of shared services, including the health informatics service, which operates not only across the Trust, but also serves the Primary Care Trusts and the Mental Health Trust. They deliver their main services in two hospitals which provide about 860 beds between them, one site opened in 1965 but has recently been subject to a major programme of modernisation and the other site opened as a modern centre of excellence in 2001. At the time of our first visit the Trust was in the midst of a significant reconfiguration of services which had initially involved a move of all mother and child services to a single site. This had met with extensive local opposition. As we began data collection a second round of reconfiguration was about to start. This focussed on the orthopaedic services, with all the trauma cases being relocated to a large unit at one of the hospitals, while elective surgery was being placed in a smaller unit at the other major hospital.

In order to fully appreciate the impact of both the merger and the recent service reconfiguration it is important to realise that the two towns in which the original Trusts had been based prior to their merger, although geographically close, had a long history of rivalry and saw themselves as quite distinct in a number of ways, with two markedly differing cultures. As one of the participants diplomatically put it *'both places have a very strong sense of civic pride'*. (A1)

Such a strong sense of identity was also apparent in the way that the hospitals viewed themselves and their culture. While the merged Trust had worked hard to create a *'two-sites, one culture'* (A1) ethos, it was apparent from our data that this had not been entirely successful and that, despite progress, differences remained. Interestingly peoples' opinions seemed to vary depending upon which hospital they had been primarily associated with. In order to help preserve anonymity the differing hospitals and former Trusts will be referred to a site A and site B. Generally speaking site A was described historically in terms like *'more lateral thinking'* (A2), *'more innovative'* (A2) and *'more devolved'* (A2), whereas site B was seen to be *'more by the book'* (A2), *'more hierarchical'* (A2) and *'relying more on structures'* (A2). However one individual who had primarily been associated

with site B took a very different view considering that *'there was always more flexibility at site B, they rely on proformas at site A'* (A2). Whatever stance was taken it seemed that staff who had been in the area for a while and had worked primarily at one site, categorised colleagues as either a site A person or a site B person. This could make a marked difference to their perception of others and their motives. For example the former Consultant Nurse for older people who, as noted above, was held in very high regard by most people was seen as far less effective by one participant who when asked to reflect on her impact noted:

"She didn't make much of a difference, in fact she upset a lot of people over here [site B]. She was always a site A person". (A5)

The Trust had made considerable efforts to integrate staff, and at a senior level there was a belief that this had been largely achieved *'when they first brought us together [senior clinical staff from site A and B] we sat on separate tables, but now we are good friends and colleagues'*. However it seemed that many of those who had trained in one Trust or the other still held on to allegiances and loyalties that had obviously developed over several years, if not decades. Against such deeply held, and often implicit, values and beliefs even the most carefully planned change initiative is likely to experience considerable difficulties.

At a population level the cultural differences had been brought into stark relief during the recent service reconfigurations when the relocation of mother and child services to one site, and therefore one town, had raised strong objections among inhabitants of the other town who did not want their child born *over there*. The furore the move of the maternity services caused was captured by one of our participants in the following way:

"They've had processions, they've had demonstrations in the streets, they've had MPs saying this is wrong, it conjures up emotions....like men don't want their son born in [xxxx]". (A5)

The forthcoming reconfiguration of the orthopaedic services had not caused such a public outcry but nevertheless there was deep disquiet amongst many of the staff, for both patient and personal reasons. Whilst staff could often see the logic of the reconfiguration in purely objective terms, they questioned its worth when the problems it would cause patients and their families, especially older and frailer patients, were considered. Visiting was seen to be a particular problem:

"If you live in [X], then you have to catch a bus from [X to Y]. Following that you then have to catch a bus from [Y to Z]. Even when you get to [Z] you have to catch a bus from the centre to the hospital. So like that's 3 bus journeys and it could take hours. What if you are an 88 year old man and your wife has had a hip fracture and you have got to get three buses to visit her?" (A4)

Many people voiced similar concerns. Furthermore the reconfiguration and the necessary move of personnel were also perceived to cause problems for staff, both personal and cultural. At a personal level many staff had longstanding child care arrangements that often relied on family who lived locally. The fact that staff might now have to travel considerable distances was seen to be highly disruptive. Below a single Mother, who has had no sickness in 10 years, talks of the potential disruption:

"But I've no access to a car, and the drivers on the ward will argue why should we move wards just because we drive? The practicalities are I've proved me child care works but me child care is me 76 year old Mum whom I don't see should be going home at 11 at night just because I'm on a late". (A4)

Others had concerns that were more to do with the disruption to those working relationships that were central to their job satisfaction and morale. These, in large part, can be seen as manifestations of the continued existence of differing cultures at the two sites:

"I don't want to go to [X] because I don't know the staff. It wouldn't have made any difference which service went where as I just wanted to be with the people I know because I'm sad like that. I'm not good at meeting new people". (A4)

Although there had been attempts to offer a choice of future workplace the general view was that this had been a 'Hobsons' choice' and that in reality there was little option but to accept the move or find new employment. This had caused considerable disquiet for many:

"Demoralised, worthless, you can go. People have left because of the way that they've done it and up until now morale has been very low and people are looking for other jobs". (A4)

Such longstanding cultural differences, both in the two communities and the two hospitals that comprise the Trust, together with recent and on-going service re-configurations provide an important part of the backdrop to this case study. Having established this context we now consider data collection.

Although we collected quantitative data from the majority of units in the Trust, the case study focussed on a much smaller number. We initially had discussions with several units, including the Orthopaedic services, the Acute Stroke Unit and the Complex Care Unit. Each had interesting facets. As noted above, the Orthopaedic Unit was undergoing major service reconfiguration, which seemed to present an opportunity to explore the way that this process was handled. However, whilst many of their patients were older, many were not and, furthermore, the duration of the change, and the fact that it was only starting when data collection commenced, meant that we would not be able to capture all the key moments and would be most unlikely to be able to explore the ways in which the newly reconfigured services bedded in. The stroke unit had been set up in direct response to the NSF but by definition focussed its activity on one condition – stroke. As interesting as this was we did not feel that it reflected the range of challenges that older people provide for acute services. The Complex Care Unit on the other hand seemed ideal. As noted earlier, it explicitly recognised, and sought to address, the complex needs of older people and it enjoyed a reputation throughout the Trust for providing high quality care. Moreover Williams' (2001) work cited earlier suggested that such a unit was much more likely to focus on the holistic needs of older people and their families and to pay attention to the relational aspects of care identified in the narrative synthesis as being central to a positive hospital experience. If a specialist unit operating within a Trust with a history of innovation could not provide good quality care for older people then others would certainly struggle. On this basis it was decided to focus our attention on the Trust as a whole and the Complex Care Unit more specifically.

6.3 Shaping culture: The people and the processes

Given our intention to place the Trust as an organisation, and the Complex Care Unit as a part of that organisation, at the centre of this case study, our qualitative data collection focussed primarily on key individuals and their perceptions of the people and processes operating within these two contexts. Interviews were therefore held with a range of senior figures at Executive/senior clinical level, as well as ward staff on the Complex Care Unit, from the consultant, through to the ward manager, senior staff nurses and care assistants. It is these people, and the processes that they enact, that largely shape the culture of the Trust as a whole and the unit in particular.

In interviewing those at Executive /senior clinical level we focussed on a number of issues. After introducing the project and its goals, and obtaining informed consent, the discussion usually began with an overview of how participants would describe the culture of the Trust as a whole. We then moved on to reflect on the challenges that older people present to an acute care environment, before turning attention to participants' views on the dignity challenge, their awareness of it, and how it might be implemented. The interviews were generally minimally structured and informants spoke openly and at length about a range of issues, needing little or no prompting in most instances. Interviews were held with the following individuals:

- Deputy Chief Executive/Director of Nursing
- Deputy Director of Nursing with main responsibility for Medical/Elderly Services
- Director of Organisational Development
- Business Manager for Medical/Elderly Services
- Four matrons across the Trust
- Acting Consultant Nurse for Older People
- Consultant Physician Complex Care Unit
- Therapy Services Coordinator – Acute
- Therapy Services Coordinator – Community

Whilst an interview had been organised with the Chief Executive this had to be cancelled for personal reasons.

Analysis of the data revealed a high degree of consistency and agreement on key features of the Trust with regard to its culture and the people and processes that shaped it.

6.4 Participants' perceptions of the people and processes shaping the culture of the Trust

There was a high degree of consensus about the type of culture that the Executive team at the Trust were working to create. It was clear that the needs of the patient were seen to lie at the centre of the Trusts' mission and in order to ensure

that this remained the case Trusts' ethos was described as very '*clinically driven*' (A1). Given their strong performance with regard to the various 'targets' that they were required to meet there was an obvious awareness of the importance of '*ticking all the boxes*' (A1) but the approach now taken was very instrumental. Following the introduction of targets achieving these had been a major priority in its own right, but the targets were now viewed largely as a means to an end. In other words the targets were met because it was widely recognised that if the Trust '*performed well*' (A1) then they would be given a far higher degree of autonomy and would be largely left to their own devices. As one participant pithily noted '*a three star Trust can get away with different things*': (A1)

Consequently whilst all the necessary targets were achieved, a 'passion' for excellence was seen as the main driver of the Trust's activity:

"We don't focus on the targets, it is part of our culture to focus on the patient rather than the target. To be good isn't good enough, our goal is to delight. We also want people to be proud to work here. Passion drives us not targets". (A1)

The culture was described as highly devolved, empowering and supportive with a flattened structure in which egos and status were seen to play a very small part; '*There are no plush carpets around here*' (A1). Staff were actively encouraged to innovate and to take risks in what was described as a 'no blame' culture, where the ethos was to '*seek forgiveness not permission*' (A1). This was reflected in comments by several of those interviewed:

"It's a very forward thinking culture, we do try to encourage an open culture and take on board anything that's new. There's always a lot of discussion". (A1)

"It's a very democratic organisation, it's not 'top down'....staff are very empowered and we try to empower staff to make decisions without asking permission all the time". (A5)

"In the main I think that the Trust has striven for lots of awards. This may give the impression that we're just 'ticking the boxes' and to a certain extent we are but by getting those awards we've embedded a 'can do' and empowering culture. The organisational support we've had from the Trust means that at every level we encourage people to be empowered". (A1)

This culture was seen to originate from the very top of the organisation, with virtually everyone interviewed mentioning the key role played by the Chief Executive. She was seen to be both inspiring and also very approachable. The message that the Trust was promoting was described as being clearly communicated throughout the organisation and '*owned*' by the staff as a whole:

"There is a clear vision and values, a very visible Chief Exec who is highly respected locally and nationally. You feel safe, you work hard because you know why the organisation is going where it's going". (A1)

The culture was therefore described as having clarity and visibility, which, according to those interviewed, created a belief among staff that they worked for *Their Trust*. The values and goals of the Trust were communicated to new staff, who were encouraged to see themselves and their behaviours as representing the Trust, no matter at what level of the organisation they worked. Consequently the message to them was; *You're the face of the organisation, put a smile on it.*

However despite the Trusts' success in meeting the required performance targets there was considered to be little or no complacency, with there being recognition of the need to constantly strive to do better:

"Interestingly a lot of people are starting to say that we are not getting this quite right. Five or six years ago they wouldn't have said that". (A1)

The prevailing view of creating and sustaining a positive culture was that such an undertaking was an 'on-going journey', requiring within the organisation a *social movement* for change.

In achieving their success to date the Trust had invested heavily in staff development and training, underpinned by the belief that culture was as much about people and their relationships as it was about formal structures and processes; *Culture is relational rather than about committees and structures. We're good at the interpersonal aspects.* In order to sustain momentum it was appreciated that; *A culture of investing in relationships is required.*

However more formal structures and processes were also in place. The Trust's commitment to PDU's has already been alluded to and these units were seen to promote the highest quality patient care and were characterised by good multidisciplinary teamwork. There were regular Trust-wide events to celebrate staff success, such as an annual award day for the most innovative change initiatives in the organisation. There was also widespread recognition amongst those senior staff that we spoke to of the Trust's considerable investment in staff development and education:

"They're very good at developing people around here, they're always looking to support and help. They are very educationally focussed. Even when budgets are tight, courses are not the first thing to be targeted". (A5)

With regard to meeting the needs of frail older people in an acute setting there was acknowledgement of the challenges this posed and that an acute hospital was not necessarily the best place for older people to be for an extended period of time. However the Complex Care Unit was described as having a very good reputation for the quality of care that it provided; *It's an exceptional ward this one, I have to say. The care that the patients get is excellent as the clinical indicators show.*

As with the Trust as a whole the culture on the Complex Care Unit was seen to be the product of several factors, foremost amongst which were the parts played by the former Nurse Consultant and the current Medical lead. It was considered that the Unit set very high standards and that the needs of older people were recognised in the Trust more generally and not just on the Complex Care unit. The high profile the care of older people enjoyed was attributed in large measure to the former Consultant Nurse who was considered to have had a *passion for quality and excellence* and an outstanding reputation both locally and nationally. Her efforts extended beyond the specialist unit with the post holder spending considerable time working with surgeons and other senior medics, accompanying them on their ward rounds when they were considering the needs of older patients. She had set several initiatives in train such as falls clinics, assessment proformas and a series of educational programmes looking at the needs of older people with cognitive frailty. However despite widespread recognition of her contribution, praise was not universal and as already noted some saw her allegiances as being primarily with

one site, whereas some of those from other disciplines considered that her focus had been *too nursing* without enough attention being given to other needs.

The other key individual seen to shape the culture of care for older people was the senior Medical Consultant. As with the former Consultant Nurse he was described as being passionate about the care of older people:

"It's [the culture] about leadership and staff attitudes and the consultants as well, especially [xx] who is a champion for older people". (A1)

The consultant in question saw the role of the unit as being to 'manage rather than fix' the patients problems and believed that success should be judged largely by the extent to which a stay on the Unit had *turned a patient into a person again*. Consequently the main goal of the Unit was to *make a difference* and to reconnect people with who they were and what they did. For the consultant the motivation for a person choosing Geriatric Medicine should be because he/she saw work anywhere else as not being hard, challenging or rewarding enough.

The complexity of older peoples' needs and the need to temper the pace of care was widely acknowledged:

"They [staff] need to take time to sit and chat to the patients, even though they are busy, like on the care of the elderly wards. There they slow the pace, even though they have acute needs, you haven't got the culture where it's only medical needs that take priority. The pace is different on the care of the elderly ward". (A4)

"I think that there is always room for improvement, we need to slow down to the pace of that individual. In hospital things are so fast, there are little things you can do to get a better understanding of the older person's pace. Not just their physical pace but their mental pace. An understanding that they take longer to absorb information for example". (A3)

6.5 Reflections on culture: Place, people, processes and the Senses

Earlier we introduced the concept of an 'enriched' environment and suggested that this could be understood largely in terms of whether key stakeholders experienced six senses: Security; belonging; continuity; purpose; achievement and significance. On the basis of the interview data above it seems that the culture at the Trust could appropriately be described as enriched if these criteria are applied, at least from the perspectives of the Executive team and, given the Trust's strong performance in meeting targets, national standards. Innovation was actively encouraged and structures and processes put in place to facilitate it. The Executive believed that staff should therefore feel *safe* to introduce change in a *no blame, ask forgiveness not permission* culture, which created a sense of security. The Executive team also felt that they had worked hard to create a sense of belonging to *our Trust* and to foster a *'two sites, one Trust'* culture. Continuity of message about the Trusts' mission was readily apparent within the interview data and participants believed that this was clearly communicated to staff at all levels. This should have created a shared sense of purpose, underpinned by a patient

focussed and clinically lead culture with a *passion for excellence* at its core. Certainly, by any national criteria, the Trust as a whole was seen as a high achiever and processes had been put in place to create a similar sense of achievement for staff. The significance that the Executive placed on both patient care and staff development and training should, in theory at least, have ensured that staff feel that who they are and what they do *matter*.

With regard to the care of older people there was explicit and spontaneous recognition of the tensions between Pace and Complexity without these ideas in any way being introduced to participants, further reinforcing their potential usefulness and currency as analytic concepts enhancing an understanding of the real world of practice. Furthermore the data also suggest that the concept of *relational practice* resonated, again without being introduced, with participants' recognising the importance of interpersonal dynamics: '*Culture is relational rather than about committees and processes. We're good at the interpersonal here*'.

If the above data are compared with those factors identified from the literature synthesis as being prerequisites to creating a supportive culture, that is:

- a shared vision and goal
- leadership from the top
- enabling and involving staff at all levels of the organisation, especially clinical staff
- investing sufficient time, resources and education in staff development
- empowering people, especially those closest to the delivery of care
- fostering positive relationships
- a focus on the patient experience

The Trust might be seen to be *ticking all the boxes*.

However, notwithstanding the above, participants recognised the tensions and challenges inherent in providing high quality acute care for frail older people, even in what might be considered as an *enriched* environment. Such tensions were seen to be due to several factors. Some related to the increasingly complex needs of older people and their far greater physical and mental acuity. Others were to do with cultural differences and sometimes poor or underdeveloped relationships between the Trust and other key players, especially social services.

With regard to the increasing complexity of older peoples' needs recent innovations such as the introduction of community matrons meant that older people were kept at home for longer and as a consequence were far more acutely ill when they required admission:

"The community matrons keep people at home longer with long-term conditions but when they do come into hospital they're a lot sicker, a lot more complex. We now tend to get those at the last stage of their illness. A mixture of very complicated patients and EMI (Elderly Mentally Ill) is a real challenge". (A3)

The challenges posed by older people with cognitive frailty were mentioned by many of the senior staff interviewed with dementia being described as the *new*

cancer. Difficulties were exacerbated by the very limited provision of services for such individuals by the Mental Health Trust who were seen to disinvest in facilities for older patients, especially those with dementia.

To compound things primary care commissioning was described as *fairly immature* and relationships with social services varied considerably. To further complicate the situation, the PCT's, social services and other community providers were seen as having a *very territorial culture* with these organisations perceived to have differing visions and priorities. The need to work on creating better relationships with these various organisations was recognised, with it being suggested that; *'nurses are better at brokering these sort of relationships'*.

The similarities between the above quote and the concepts used by Williams (2001, Williams *et al.*, 2009) are striking, and once again, consistent with the literature synthesis, attests to the importance of such relational work.

The impact of these structural and processual differences were often highly significant for patients and their families, especially at the time of discharge. It was acknowledged that sometimes families were not as fully involved as they might like to be, and that on occasions the focus on ensuring a speedy discharge (pace) sometimes resulted in a less than complete understanding (complexity) of the situation:

"We are sometimes too busy doing the technical job, too busy hitting the targets, we've sometimes forgotten that there is a whole person there and also a family going through a massive life change. Sometimes we can lose sight of the fact that we need to help the family adjust and not focus on the technical aspects". (A3)

The need to discharge some patients rapidly could also have other negative effects, especially when difficult decisions were being made, such as admission to care:

"Also discharge to nursing homes is a problem, people need a bit more time and this [hospital] is the best place to assess them. Some are borderline and if they were here for a bit more time they might not need to go into care. There are lots of challenges and I don't always think that we have it all right... we don't always seem to have the patient at the centre and its got to change". (A3)

Clearly even in the best of circumstances difficulties remain. Sometimes these are due to the systems that are in place, sometimes to differing organisational missions and goals. These will be considered further shortly. Attention is now turned to the views of staff on the Complex Care Unit.

6.6 Delivering complex care: Staffs' perceptions

Whilst the Executive/senior clinical staff interviewed acknowledged the challenges of providing high quality care to frail older people in an acute setting they also painted a picture of a Trust with a clear mission, whose prime focus was on the patient experience and who were committed to investing considerable time and resources into developing and empowering staff. The Trust were meeting all their national targets and were widely recognised for their innovation and achievements. The Complex Care Unit was also acknowledged as providing high quality care, but what was the experience of staff at the *coal face*?

What follows are data taken from interviews with the ward manager, senior and junior staff nurses and care assistants on the Unit, those from the Medical Consultant having been included in the interviews with senior personnel. The data suggest that staff on the Unit believe that they are providing high quality care to older people and that this care is qualitatively different from that provided in the rest of the Trust. At the same time they feel that they are struggling to maintain standards and morale in the face of increasing demands, shrinking resources, especially staff, and the negative image that work with older people still has amongst many of their colleagues.

The Unit itself was considered to be a 'nice place' to work, with staff generally being highly supportive of one another:

"I think it is a nice place to work and everybody says that. I think people are very supportive of each other on here, there doesn't seem to be any bitching going on and it is not because I don't hear it because I would hear it because people tell me things. There might be things sometimes when people have a bit of a do but that's it, its forgotten about and if anybody is in crisis or has a personal problem there is support for them, it seems to be that way anyway". (A4)

With regard to their philosophy of care for older people there was explicit recognition of the need to focus on the whole person, but awareness that the wider 'systems' that were in operation did not always recognise or facilitate this. What follows is a lengthy quote but it eloquently captures the importance that the Unit places on 'seeing the person behind the patient' (A4) despite hospital systems that seem to negate such efforts:

"What we do well here is, we always say 'look after a person as a whole' and I think that's what we do well on this ward. We take account of everything, not just the patient's physical step-up. We find the patients we get, the complexity is more the social background and the physical background and on here we deal very well with that aspect of patient care really...and if you can sort them out before they go home you don't see them bouncing back because the package of care and everything you organise is all there... we don't leave a stone unturned really. I don't know if you have seen that across the site we have a new discharge plan. It is like a tick box and they use it on the wards... well when the patients are middle aged they don't have home care or anything and for that sort of patient well the tick box is fine. We also have it here but we find that the tick box is not appropriate for the patients that we have to be honest you tend to miss out a lot and that is when mistakes get made. So that is just an example of one thing that they have brought out that we don't think is appropriate so we don't use it". (A4)

The above closely mirrors the tensions described by Williams(2001) when his study was undertaken well over a decade ago between the *processing patients* model with its emphasis on pace and the consequent activities of *pushing and fixing* at the expense of the more complex and relational activities of *informing and brokering*. Consistent with the above more holistic view of the needs of older people, staff at all levels and grades on the Complex Care Unit recognised the importance of getting to know *patients as people* and also of working closely with carers and family. Below a care assistant describes how it is often staff operating at her level that have the time to get to know patients and can subsequently relay the information they gain to their senior colleagues:

"And just sitting and talking to them [patients] makes such a difference. They can air their views about what's bothering them, because we've got to plan the discharges. You've got to make sure that the family are aware of everything. It's not just a straightforward phone call. You've got to plan whether they are fit to go home, whether the family are supportive, home care, how many times will they need that? If we have time an auxiliary can 'pitter patter' to a person and find out a lot to pass on to a staff nurse who was busy doing the ward round and everything and wasn't aware of it". (A4)

There was also recognition of the importance of taking time to provide care in a way that was consistent with the pace of the older person:

"Yes, I think that you have to have a lot of patience and they [older people] cannot be rushed. You have to take into consideration that they want to do it their way and when they are ready, you can't rush things so you have to learn on their level and go with them". (A4)

Similar sensitivity was in evidence when the needs of family carers were considered:

"It is about the patient but it is not all about the patient. At times some relatives are under so much pressure that they need the support from the ward as well and I would say that 90% of relatives if you asked them now would say that nursing staff are always on hand to answer any questions and if we don't know we find out. I normally find on this ward what I have observed and that is positive. I have never experienced anything negative from relatives at all, it has always been positive that the nursing staff take time to listen and be supportive, they are really good". (A4)

"We spend time talking to them [relatives] and they can be very tearful. The drinks are made for them and food if they haven't managed to have anything. And we can sit and talk to them and explain what's happening and also ask how they are coping at home. If they've got some family support for themselves as well as the patient". (A4)

However despite the obvious awareness of the importance of addressing the needs of both older people and their carers, staff had concerns about the increasing demands made on their time due to the complexity of patient need, the growing level of administrative work and the shortage of staff. The following quotes give an indication of these tensions:

"It is an acute elderly ward and we are treating chest problems, GI bleeds, pneumonias, heart attacks, the lot and most elderly people don't just have 1 diagnosis they will have three or four. They might come in with one and they might end up with four or five and you're treating them for lots of different things". (A3)

"We are getting different complex patients, you've got your Alzheimer's and your dementias and with all the wards shutting that would have taken them they are coming to us. But we are also having to treat all different types of medical conditions, which can be very draining at times". (A4)

Despite the complex needs of older people staff did not think that the skills they had were fully recognised by colleagues on other units, due in part to their out-dated views about what work with older people was really about:

"I think that a lot of people think that the culture of nursing older people is you get all nurses that are hopeless and have no skills to do that.....but I personally think that it is a very skilled job and that many people can't do it because they don't have the right skills, like enough patience.....You only have to see the difference when they have been on the medical assessment unit for a couple of days and they come here and their relatives will say 'Do you know they couldn't manage them down there, you deal with them so much better up here, they're really settled now'. And yes I know they are busy there but I think it's because the nurses up here are skilled at looking after older people". (A3)

Moreover the increased level of acuity was seen to be having a detrimental effect on patient care, compromising the time staff had to attend to the 'little' things that are so central to a positive patient experience:

"Quite a lot of the patients we've been having haven't been able [to help themselves], they've been very poorly and have taken two [people] to do their hygiene needs and all the care. And you are rushing around, you haven't got time to sit and talk with the patient and find out their likes and dislikes, what sort of life they have had, what's upsetting them". (A4)

There was recognition by the staff that very old and frail patients on the Unit could be lonely and bored. Staff wanted to do something about this but once again recognised that it was often not possible within existing staff resources:

"I think that a lot of these older people have got nobody else so they rely on your company and if they sit in a side room, no visitors, can't see to watch telly or read or knit or whatever so they become just isolated. We do bring their chair to the door so they can see what's going on but it is a long day just eating and drinking and not moving, quite boring. A lot would like to talk.....but we don't have time to sit and have a chat, comb their hair and put curlers in, you know the little things that make their day". (A4)

Staff believed that the technical and other care they gave was very good but that the pressures they were under meant that they sometimes had to 'rush' things more than they would have liked:

"I think that the nursing care on here is very good. The only thing I will say is I think we could go that little bit extra if we had more time. They get the care they need but most of the time it has to be very rushed....I think what management doesn't always realise is that we are dealing with very dependent patients and more so recently because we only get the poorest people coming into hospital. You cannot rush them but sometimes you do find yourself saying 'come on, can you move yourself. You need to do it now' and you feel bad doing that but you know what pressures are on you". (A4)

The pressures alluded to above were not always clinical and for qualified staff came increasing from administrative tasks, often to do with meeting the 'targets':

"There is always somebody ringing up and saying 'Have you sent in your audits for this month' and it is not like we haven't done them but there is pressure on you all

the time. You can only ask your staff to do so much and you can't say to them 'Look don't look after the patients today or come in on your day off'. They [management] are only interested in what they want and they don't care what's going on elsewhere. I know its government stuff and I know I have to do it, I'm not stupid and I know it will make us look bad if we don't do it, so what can you do?" (A3)

There were indications that the above pressures were starting to have a potentially negative effect on staff morale and that the low staffing levels were eroding opportunities for even mandatory training, despite the Trusts commitment to a much broader training agenda:

"We don't even get time to get people through mandatory training, this is another thing we are going to bring up is that your moving and handling and things like that it is so difficult to try and fit it all in because we don't have enough staff on the ward.....I think that everybody is fed up. I think that people are just really tired, its not that they don't like their job, it's just that they're worn out and to try and keep morale high is quite difficult at times". (A3)

In addition to the interviews with staff, members of the research team spent periods of time on the Unit simply *hanging around* and making general observations of their impressions of the activity on the Unit. These were recorded as field notes. A brief selection of reflections from a member of the research team who is an experienced clinical nurse paints a picture that in many ways reinforces the impressions gained from the staff interviews: That is of a staff group committed to providing high quality care who are nevertheless struggling to maintain the standards they set, whilst also meeting the needs of increasingly frail older people within limited resources. The three excerpts from the field notes below relate to three separate visits. The first records general impressions, the second looks at the nature of the staff handover and the third describes activity during a lunch-time period:

"Staff appear to be thin on the ground. I have been on the ward for over an hour and there are two qualified staff on shift and three auxiliaries. This is a 28 bedded ward and from what I can see the majority of patients are poorly. There is one patient who is 'going-off' quite rapidly and is having what looks like a rapid infusion of some sort - and of course is taking all the time of one qualified nurse. Later I speak to the other nurse about this and she says that they are quite short staffed as many staff had a lot of holiday to take before a certain date. (NB the ITU outreach team arrives later to provide support. It looks like there is access to high end support when needed)".

"Each patient is addressed in turn. The nurse hands-over from the Kardex (rather than from a hand-over sheet or a personal notebook). There is lots of discussion about what the current diagnosis (diagnoses) is (are). There are clearly lots of multiple pathologies present for most patients. Treatment regimes and options are discussed. There is a two way dialogue between all the staff. The support workers clearly know the patients well, and feel able to contribute to the hand over. I get the feeling that all the staff know the patients well, and care about them, as the main focus of the handover is not just on what has happened that day, but what needs to happen for the patients to move forward".

"At lunchtime there are not quite enough staff to feed all the patients who need assistance, and so one support worker feeds two (or three) patients at any one time. The qualified staff nurse is busy with the medicines. I can see the logic of this, but wonder if she would be better helping to feed too? I think there are issues around dignity here. But then I can see how doing the drugs now is more efficient (as the patients are sat up, and in a good position to drink and swallow medicines). That is one thing I note here-the patients are all in a good position to eat [those who are eating]. It is not something you see on every ward!"

The above quotes provide subtle indicators of high quality, sensitive care and a sense that staff feel valued and able to contribute to the team effort. However staff are *thin on the ground* and are supporting patients who are mostly *poorly* with *multiple pathologies present for most patients*. In the face of these demands there are minor *issues around dignity* that are consistent with the observations made by staff about having to *rush things*.

So far the story has been told using staff data alone. Attention is now turned to patients' and carers' views, and those of the wider staff group that were obtained from the survey data.

6.7 The views of patients, carers and staff: Findings from the survey

As was noted in the methods section the survey data were time consuming and complex to collect and considerable effort was expended to ensure that sufficient questionnaires were distributed and returned to make meaningful analysis possible. The quantitative analysis resulting in the scales for the toolkit was presented in *Section 5* and provided details of the factor analysis and related work. The multivariate modelling that were undertaken are considered in *Section 10*. Here selective data from the patient, carers and staff questionnaires are used in a descriptive manner to provide an overview of their perceptions on the nature and quality of the hospital experience for patients and carers and staffs' views on a range of issues concerning quality of care, teamwork, workload/resources and their work experience and opportunities. These latter data complement the interviews and provide the views of a wider staff group. Importantly the questionnaire data allow detailed insights in to the patient/carers experiences and the views of staff across the differing hospitals that comprise the Trust. We begin with a consideration of the former.

The factor analysis of the measures for the toolkit created two scales capturing the patient experience (*Feeling Significant (p)* and *Could do better (p)*) and three reflecting carers' views, two of which focussed on the care given to their relative (*Giving my relative the best* and *Could do better(c)*) and one reflecting the carer's experience (*Feeling significant (c)*).

Overall the data indicate that patients and carers were very happy with the quality of care that they received on the majority of items on the above scales. Patients appeared highly satisfied with: The level of information they received and explanations about their treatment; staffs' responsiveness to their questions and the extent to which staff listened to patients' views; their access to therapy and

treatment; and the extent to which staff treated them with dignity and respect. They were similarly satisfied with the reception that their carers received and considered that family members were made to feel welcome on the ward and were able to speak to staff about the patient's care and treatment. However there were some concerns about there not being enough staff on the wards, with only just over half of the patients agreeing that staff had enough time to provide good care and less than half thinking that there was enough for patients to do to help them to pass the time. This is consistent with staffs' views on the Complex Care Unit.

Relatives were similarly satisfied with overall patient care and the extent to which their relative was treated with dignity and respect, with staffing taking time to get to know the patient as a person. Overall the ward was seen to be a welcoming place (80%+), with staff seeming happy in their work (75%) and making families feel welcome on the ward (80%). There was somewhat less consensus about the extent to which carers were given enough information about the patient's care (65%), and less than 50% of the carers considered that: They could speak to a doctor about the patient's care; staff seemed to care about their needs as well as their carers; they were fully involved in discussions about patient care; and that staff actively sought information that the family might have about their relatives' needs. This would suggest the need for further attention to be paid to these areas. Concerns re staffing and the potential impact on the patient experience were raised in the staff interview data, and as will be apparent, emerged again in the staff questionnaires.

Given that there was the suggestion that there were two cultures operating at the Trust reflecting the situation that existed prior to the merger, the staff data are considered with respect to site A and site B. As described in *Section 5* the staff questionnaire comprised many more items than the patient/carer questionnaires and these explored multiple dimensions of the ward and Trust climate and of staffs' experiences and perceptions. The scales generated by the statistical analysis have already been described and here they are used to highlight often large differences between site A and site B which suggest that two differing cultures do still potentially exist.

Several of the scales reflected varying and complementary aspects of the patient/carer experience that were to do with staffs' views on: The overall quality of care they provide; person-centred care; patient/carer involvement in care; and staffs' philosophy of care.

With regard to the overall approach to care staff across both of the sites were of the opinion that they provided care of a very high quality, treated patients with dignity and respect and fully met patients' and carers' needs. There were no significant differences between sites on these issues.

A similar pattern emerged for the other scales concerning the patient/carer experience. Staff strongly endorsed the view that they had a consistent philosophy of care that was clearly communicated to new staff and that they focussed on patient need rather than tasks. Psychological care was highly valued and staff promoted the direct involvement of patients and carers in their care. Although such views were endorsed by three quarters or more of staff across the Trust, staff at site B were much more likely to strongly agree with these items and there were

significantly higher total scores at site B. Indeed the scores here were higher than at any other hospital in the whole study.

Staffs' positive views on the experiences of those in their care were also apparent when consideration was turned to the extent to which they provided person-centred care and involved patients and carers. Therefore virtually across the board nine out of 10 staff believed that they: Took time to get to know patients as individuals; took account of their views even if they disagreed with them; showed concern for patients and encouraged them to talk about their worries; and made visitors feel welcome on the ward. High, but somewhat lower support (about 75%), was given to items that related to the involvement of patients/carers in their care. The item with the lowest support of the 21 in this theme was the extent to which carers were actively encouraged to be involved in the patients' care. This was still high (65% at site A and 75% at site B) but the lower rating is consistent with the views from the carers questionnaire that they were not always as engaged as they would like to have been. There were no significant differences in total scores across the two sites on these scales.

Overall therefore staff at both sites felt that they delivered high quality care to patients and their carers. It was when attention was turned to the scales capturing staffs' perceptions of their own experiences that large differences emerged.

Scales explored staffs' views of: Whether the team had the skills needed to provide good care to older people; the quality of teamwork on their unit; the degree of participation within the team; multidisciplinary teamwork; the degree of psychological safety in the team; and whether the team felt that they learned from each other. There was strong support (generally over 70%) across all the items indicating that staff felt they worked within a very supportive team, with high levels of trust and confidence. They also believed that the multidisciplinary team worked well together and that the team worked in a participative and collegiate way. More positive responses were again evident in site B and in some instances these differences were large, but not significant. There were no differences between sites regarding the extent to which staff believed that colleagues supported each other. This was uniformly high across the Trust and higher than any other Trust. Similarly staff felt safe to discuss difficult issues within the team, although support for these items was rather lower (about 55-65%) with no site differences. Both sites felt that the MDT functioned well. However on the other scales the scores were much higher at Site B. Here staff believed that

- they had better skills to care for older people, especially those with dementia
- participation within the team was better, with some large differences being apparent. Staff at site B described a less hierarchical culture in which they felt more able to: Influence activity on the ward (56% site A v 74% site B) participate in decisions (48% v 66%); and have freedom to make important decisions (45% v 69%).
- they learned from each other more effectively and were more likely to discuss issues as a team and to seek solutions. Scores on these scales were significantly higher at Site B

A single scale (*Leading by example*) tapped into staffs' views on the quality of the clinical leadership at the ward or unit level. The original *Dignity on the Ward* report (Davies *et al.*, 1999) concluded that the culture promoted by the ward leader was the most important single factor influencing the creation of an enriched ward environment and the above were seen as key leadership attributes. Overall staffs' views at both sites indicated that they felt that they enjoyed high standards of clinical leadership with the ward leader setting clear standards and goals and promoting excellence. Over three quarters of staff at both sites agreed or strongly agreed with statements to this effect. It was also clear that the ward leader had an on-going presence on the ward and often led by example by being directly involved in care delivery. A more resounding endorsement of some these items was again apparent at Site B, where staff were much more likely to consider that the ward leader:

- inspired confidence (55% v 75%)
- ensured the interests of staff when making decisions (48% v 70%)
- consulted with the team about daily care (57% v 77%)
- acted in a caring and supportive manner (61% v 77%)

If attention is turned to the wider hospital environment (*Support from the top*) the data provide an indication of staffs' views on the overall climate in the hospital and the opportunities that they had for training and development. Responses to these items suggest a mixed picture, with relatively high numbers of staff (about a third on average) providing a neutral (neither agree nor disagree) response. Overall however, staff were more likely to agree than to disagree that: The ward could access resources when they needed to, including expert assistance; there were good training opportunities; they had the authority to make decisions; and that there were good career opportunities. Nevertheless, the percentage agreeing or strongly agreeing with these items was lower than the other items considered so far and was typically about 50-55%. Differences between site A and B were still apparent in these data. Staff held more equivocal views about the extent to which they felt that they were treated with dignity and respect, that their views and opinions were responded to and that they were rewarded fairly for their work. Overall, across both sites, about 40% of staff agreed that they were treated with dignity and respect, a similar number gave a neutral response and some 20% disagreed. The percentage agreeing that their views were listened to by management was 36% at site B but only 24% at site A. Thirty five percent of staff at site B thought they were rewarded fairly for their work but this figure fell to 19% at site A

These differences of opinion between the sites were brought into further sharp relief when staff were asked to consider the training opportunities that were available to them (*Developing our skills*). Once again staff at site B were significantly more likely to agree that:

- there was enough time and opportunity to develop new skills (39% v 74%)
- training and professional development were available to everyone (47% v 71%)
- mentoring and supervision were available (45% v 71%)

Staff generally considered that their morale and job satisfaction were being maintained. However staff at site A were significantly more likely to report feeling depressed and gloomy and less likely to describe work as enthusing or motivating them. Very large differences between the sites emerged when levels of enthusiasm and motivation were considered. Staff at site B were far more likely to agree that they were enthused (50% v 85%) and motivated by their work (52% v 84%) with levels of optimism being lower overall, but still higher at site B (24% v 43%). Staff at site A were more likely to report feeling callous and hardened by their work, with this figure being higher at site A than at any other hospital in the study.

In an effort to further explore the reasons for these differences we noted that there were more PDUs at site B than at site A. We therefore ran analyses controlling for this. This suggested that PDUs generally had higher scores on many of the staff scales than non-PDUs but that these differences were not sufficient to explain the highly significant variations in the data set. PDUs may therefore play a part but they do not offer a complete explanation.

6.8 Case Study: An overview

In many respects this case study reflects a number of the major themes that emerged from the literature synthesis, particularly those relating to Pace and Complexity with respect to both the delivery of high quality care for older people and to the challenges inherent in initiating and sustaining change.

On objective criteria the Trust provided an enriched environment for both patients and staff. It regularly meets and exceeds the nationally set performance targets and as such has a high degree of autonomy. Its culture might be described as having two main characteristics. First and foremost it is patient focussed and clinically driven seeking to deliver *excellence* rather than simply satisfactory care. Secondly it aims to create an empowering and enabling culture for staff that encourages innovation and promotes a *can do* attitude, underpinned by a clear and agreed philosophy of care. There has been considerable and sustained investment in staff development. The culture is seen as *relational*, with an appreciation of the central role played by interpersonal dynamics.

With regard to the care of older people there is a designated Complex Care Unit that explicitly recognises the challenges of providing high quality care to a frail population against a background of increasing acuity and pressure to reduce length of stay. Despite this the emphasis is on '*managing not fixing*' (A2) problems and on '*turning patients into people again*' (A2); all sentiments consistent with a relationship centred approach to care. Staff feel that they are providing high quality care but are struggling to maintain their standards against growing pressures and shrinking resources. Major challenges are posed by the increasing levels of cognitive frailty amongst older people and the relative lack of close understanding between the Trust and other major service providers.

The Trust-wide patient data paint a positive experience on the vast majority of fronts but patients, and especially carers, feel that they could be more involved in patient care. Overall staff also believe that they provide care of a good quality.

What is most striking from the survey data are the large and often highly significant differences that appear between the two hospital sites in staffs' perceptions of a range of work-related factors. As noted earlier the Trust was formed in 2001 from two existing organisations and it was clear from the senior staff interviews that a great deal of effort has been expended in trying to create a *two sites, one Trust* culture and the general view was that this had been successful. However, both the qualitative and quantitative data paint a rather more equivocal picture. There are clear indications that staff continue to characterise themselves and others as either a *site A* or *site B* person and that such a classification is both enduring and real in terms of where perceived loyalties are seen to lie and the type of culture that each site has. The recent service reconfigurations have indicated that differing, and deep seated, cultural differences and loyalties remain.

The reconfiguration of the maternity services suggested that the towns in which the hospitals are located have fractious and possibly antagonistic relationships, underpinned by divisions that go far back in time.

Many of the staffs' perceptions and feelings about their work also go back decades, sometimes to their training, with such tensions possibly being reinforced by their place of birth or domicile. The challenges that change initiatives can face were highlighted by the recent reconfiguration of the orthopaedic services. Differences between the sites were brought into sharp relief by the survey data, with staff at site B painting an altogether more positive picture. Here they considered that there was: A more consistent philosophy of care; better teamwork, with greater trust and confidence between team members; a feeling that staff could exert more influence and participate in decision-making on the ward; a higher standard of clinical leadership. Staff also considered that more attention was paid to their professional development, that they had more opportunities to learn new skills and that they had better mentorship arrangements. These are the very conditions, characteristic of an enriched environment, that the Executive Team were seeking to promote across the Trust as a whole. However they appear far more manifest at site B.

Staff at site B were also more likely to feel that their opinions were listened to by their managers, that they were rewarded fairly for their work and that they enjoyed better access to resources, especially staff.

Perhaps not surprisingly staff at site B were more enthused and motivated by their work, whilst those at site A were more likely to report feeling gloomy and depressed and to consider that they had become hardened by their work. These latter data are characteristic of a relatively impoverished environment for staff. However this did not, as of yet, seem to be impacting negatively staffs' perceptions of the quality of patient care.

We are not in a position to fully explain these site differences and whilst the greater number of PDUs at one site might offer a partial explanation it also seems differences are due in part to the continued existence of long-held cultural beliefs that, despite considerable effort, remain relatively immune to change. This is consistent with the conclusions of the narrative synthesis which concluded that any change initiative must pay attention to a complex array of contextual factors and recognise that achieving change takes a considerable time. The implications of this

will be considered in the concluding section when the other case studies have been presented.

Section 7: An impoverished Trust, an enriched ward and the role of leadership, a case study

7.1 Introduction

This case study tells the story of an acute care Trust in the South of England that at the time the study started was not only failing to meet a raft of financial and performance related targets, but had also been the subject of a major media exposé relating to poor standards of care for older people on some of its wards. On all objective criteria the Trust could be seen as constituting an *impoverished* environment. At the time of our first visit staff morale was very low and in response to the failure to meet national performance targets a highly controlling, top-down and transactional management style was adopted with the focus being placed almost entirely on the next target. The agenda was seen as reactionary and short-term with little attention given to wider strategic aims or the nature of the patient experience. Here we consider three elements of the situation as they unfolded over the 18 months of data collection. The first describes how, despite the overall impoverished environment of the Trust, one unit managed to sustain an *enriched* environment for both staff and patients. This can be attributed almost solely to the efforts of the nurse ward manager. Secondly we consider the highly marginalised position of the specialist wards providing care for older people and how they might be seen as being even more impoverished than the rest of the Trust. Thirdly, we explore how the arrival of a new Executive Team began to turn the Trust around and set it on a pathway to recovery.

7.1.1 The place: Trust level

The Trust had a total of approximately 840 beds over two geographically separate sites which served the population of three adjoining Primary Care Trusts. As noted above it was purposively sampled as an organisation that was undergoing radical changes to its financial and operational management, that affected services provided for the care of older people. Beleaguered by a large financial shortfall of over £20 million in 2006, the Trust was one of 18 in which financial *Turnaround* teams were introduced by the Department of Health in January 2006. *Turnaround* included the assistance of specialist input from Pricewaterhouse Coopers to develop a financial recovery plan which involved measures such as closing beds, reducing the use of bank and agency staff, and more effective purchasing.

The Trust was also failing to meet the Department of Health targets for waiting times for admission for planned surgery and was regularly having patients wait in accident and emergency for more than four hours. In 2005 the Trust was also highlighted for a particularly poor performance in infection control in a Department of Health league table that ranked hospitals according to the number of patients infected by MRSA (methicillin resistant staphylococcus aureus).

Furthermore, a series of events surrounding the care of older patients prompted considerable and sustained adverse publicity and brought significant media attention. All these factors led to the closure of 2 wards and the loss of 38 beds for the care of older people putting a significant strain on the remaining facilities in the speciality. This challenge was met by the swift development of an action plan to improve care of older people across the Trust which was already underway as the research began. This plan included the appointment of a matron for older people (May 2006), identification and training of older peoples' champions, the mapping and monitoring of progress in implementing the National Service Framework (NSF) for older people, and the appointment of a matron responsible for infection control. A new Chief Executive (CEO) was appointed and a new senior management team were established in July 2007.

7.2 Shaping the culture: The people and the processes

Our data collection focussed firstly on interviewing senior personnel to establish the overall culture of the Trust at the time of our first visit. At the same time data were collected from staff on two medical wards specialising in the care of older people and one 58 bedded specialist unit providing a range of services. The former two were selected as sister wards, in the same building and serving the same patients to those which had been the focus of the adverse publicity surrounding the care of older people. The latter was chosen because when all around seemed to be failing here was a unit that not only appeared to be meeting all its performance criteria, but also providing what was perceived to be excellent care delivered by a highly motivated ward team. We were intrigued to find out why this was the case.

We visited the Trust on three occasions over an 18 month period and during that time were also able to witness the early steps towards recovery that followed the introduction of the new CEO and his team. Throughout the data collection period we undertook interviews with senior/executive level staff focused on a number of issues, these were more general at the beginning of data collection exploring the culture of the Trust and their perceptions of the events outlined above. We then moved on to discuss the implementation of the changes and the effects on patients and staff. The interviews had a minimal structure, with participants requiring little prompting. They raised a broad range of topic areas which were either directly related to the case study wards or affecting them as part of wider Trust policy. Interviews were held with the following:

- Chief Executive
- Operations Director
- Director of Nursing
- Deputy Director of Nursing
- Associate Director of Nursing
- Medical Consultant
- Senior Practice Development Nurse
- Operational Patient Flow Manager

- Matrons

In addition to the above a range of staff on the three case study wards were interviewed both before and after the changes were implemented by the new Executive Team. These included interviews with:

- Matrons
- Ward Managers
- Nurses
- Care Assistants
- Social Workers
- Physiotherapists
- Student nurses
- Ward clerks

There was a general feeling among many senior staff that the Trust's problems stemmed from the top. The culture under the Chief Executive and members of the senior management team in place prior to July 2007 was seen to have created an organisation which was *'entirely financially driven'* (B1), and had not *'emphasised nursing practice'* (B1). A culture in which the then Director of Nursing although *'full of ideas'*; failed to carry things through so that *'nothing was ever finished within the organisation; so projects were picked up and dropped which was frustrating'* and there was *'never an expectation to deliver'* (B2). There was also a perception that the Trust strategy was weak; as one senior nurse said:

"If you haven't got a strong strategy that gets right to the bottom when you try to develop anything and that foundation isn't there, then it all tends to go a bit wrong really, and people get disillusioned and then the focus tends to get lost" (B1).

Such difficulties were compounded by the tendency to implement initiative after initiative without waiting to see if the previous efforts had been successful *'when you take your eye off the ball, because you are going to focus on the next initiative, things seem to slip'*.

Measures to address the major issues the Trust faced began at once, with the closure of 38 beds and a Trust wide focus on meeting government targets. This was felt keenly on the wards, with the emphasis very much on the pace in the Pace – Complexity dynamic and the achievement of government targets being a major priority in its own right. This was clearly understood by staff. *'The emphasis is how quickly we get people out of hospital'* and this directly impacted on ward managers who were *'performance managed on length of stay'* (B2).

The Trust's mode of management became ever more transactional and highly centralised with the above emphasis on meeting targets seeming to be the only thing that mattered:

"How many more managers are going to come in and ask the same question about how many delayed discharges there are. It just seems numerous people come in holding clip boards and asking the same questions. They have closed wards down and so the pressure on beds is horrendous we always seem to be on red alert and

no one seems to have the answer...There just seems to be a very heavy management structure" (B5).

Some staff felt that the Executive Team were not open and that their motives lacked clarity. *'The way things are gone about it's like it has been done in secret and we don't really have a say' (B4);* and that there was limited consultation with shop floor staff or recognition of their potential to contribute ideas:

"I think he is one of these Chief Execs who knows his job is on the line, doesn't want to come and face the people and find out what their opinions are and whether they could come up with alternatives (B4)".

Furthermore, there was a feeling that the failure to communicate with staff was affecting morale and the ability of the organisation to meet its objectives:

"We are just treated as second class citizens really. You're just here to do a job, just get on with it. Fine but if your workforce are unhappy you are not going to get the best out of them" (B4).

The frustration experienced by the matrons with the focus on achieving targets at the expense of concentrating on improving patient care was acknowledged by one senior nurse:

"It's really frustrating for the matrons, whilst they completely understand why they need to do the target chasing; actually what they want to do is work with their wards to improve the care of the patients and I think that they feel quite ground down by it" (B1).

The goals of improving practice, especially for older people and meeting government targets seemed to be at odds with one another, and led to matrons having a very directional and interventionist style of management:

"Some of the work that we took forward perhaps wasn't done in a very touchy feely way, it was done in a much more directional way and it was managed more firmly" (B2).

However, there was recognition by some that using this style of management made it difficult to get staff to buy into the changes:

"It's disappointing that when you feel you have convinced people it's a good thing and you hope that would give them the motivation to continue. When you realise that perhaps the reason why they are doing it is that there is some sort of consequence if you don't... at least there doing it, but you want people to do these things because they believe in them" (B2).

Matrons adopted a micro-managing approach and their role was increasingly seen as *policing* the meeting of targets such as infection control rather than providing strategic direction and a management lead:

"We do regular monthly checks. Matron just walks in and just sits about and watches" (B3).

The focus increasingly became the 'procedural' aspects of care rather than the patient experience:

"We look at 3 patients' notes each week and then we have a look, whether they've got name bracelets on, whether they've had their assessments done, you know have they had their temperatures done, have their bowels been sorted? We've got 10 different things that we look at every week" (B3).

It was against this backdrop that data on the case study wards were collected. Here we present accounts of two very contrasting experiences. The first illustrates how, despite the overall impoverished environment, one unit in particular managed to continue to excel. The second considers the markedly different experience on two medical wards focusing on the care of the older people. We begin with the more positive story.

7.3 Maintaining an enriched environment

The ward in question was a 58 bedded specialist unit employing 120 staff (approximately 90 whole time equivalent) containing both medical and surgical beds as well as a high dependency unit. The large ward occupied one floor of a relatively modern high-rise building where all other floors in the building housed two individual wards. The fabric of the building was in good repair. The ward had a clean, tidy and uncluttered appearance with sufficient room for patients to move freely. The decoration and bed curtains were clean and fresh and the bed areas were supplied with appropriate beds, chairs and clinical equipment such as piped oxygen. There was one large central nurses' station and another two smaller desks at either end of the ward. As well as appropriate clinical rooms there were also a staff room and a quiet room. Both the ward manager and the Consultant had an office on the ward. It was noticeable that even when the ward was busy all visitors to the ward were greeted promptly and their needs addressed.

Notwithstanding the relatively impoverished environment within the Trust as a whole, the unit had always had maintained an excellent reputation for delivering outstanding care, as the quotes below amply demonstrates:

"I have heard on more occasions than I can possibly think of, people saying that if they were sick or one of theirs was sick, her ward is where they would want them to be nursed. And I've heard that said from consultants who have actually asked, specifically asked for either their patients to be moved to this ward because they realise that the level of care is very good. Or my relative is a patient somewhere, could they come to your ward, and I've heard that over the years" (B4).

"And just the general opinion was everyone holds this ward in a very high regard. Oh you're going to (xxxx) and you just kind of get the feel around this hospital that (xxxx) - I don't know what it is about it. But it's a weird feeling about it but it's good, I like it" (B5).

The reputation for excellence was not confined to the quality of patient care as the unit was also seen as an excellent place to work. As a consequence staff actively sought out work on the unit, and the ward manager recruited the vast majority of her staff from the locality:

"A good ward, high standards and I felt that it would be a good experience for me to have my first job here and learn how to do things properly. So that's why I chose it and luckily I was offered the post" (B4).

"People also know that it's a good place to come and work. Well, I say people know, people who train in [xxxxx], the people who train here do and I probably get 80% of my staff come through [xxxxx]. So it's a popular place for newly-qualified nurses to come to" (B3).

The unit was seen to have several major strengths which, when taken together, demonstrate all the characteristics of an enriched environment. These included the following:

The focus was very much on patient care, which was seen as the main purpose of the unit:

"We all know that her raison d'être here is patient care and whilst she [ward manager] can be perhaps quite exacting at times, we all have no shadow of a doubt that the reason for that is because she wants the best for the patients. So from that point of view its fantastic, the support she gives the staff is wonderful. She does her best for us and for the patients, there's no question about that, she's incredibly dedicated in the hours she puts in and so forth" (B3).

"I think from the top that the most important priority is the patients, and how they're looked after and that is just disseminated through the whole team. And I think if you look here, that's how it is, that's the priority. And if we pick up that perhaps someone isn't doing that as well as we think they should be, then we will talk to them and tell them" (B3).

Whilst the technical care was of the highest quality, fundamental aspects of care, such as attention to nutrition and continence were also described as high priority:

"Protected meal times is when we wear our pink apron and we're not allowed to be disturbed by the nurses, they're not allowed to do any jobs. So if there is a patient that can't feed themselves, then that is our time to sit down, we get at least 30 minutes. It's at least half an hour and that's our one on one where we're not allowed to be called away, we're not allowed to do anything. And it's to feed purely, our attention is on the patient that we need to feed" (B4).

The staff knew exactly what was expected of them, the ward manager had clear and explicit standards, and these were endorsed by staff:

"Strong leadership and that filters down through my level at band 6, deputies as it were, and she expects us when she isn't here to run a very tight ship and that standards be kept the same. Part of my role on a day to day job as coordinator of the ward is that I have to see, [the ward manager] expects me to see every single patient, every single 58 patients. Are their wounds Ok, have their dressings been done, have their cannulas been looked at, are they in date, are they still needed? Have their discharge plans been sorted out?" (B3)

The ward manager was a visible presence on the unit for patients and acted as a role model for staff, providing expert advice when needed:

"But actually she's always out on the ward, she sees all the patients, she'll help out if there's, if we're short staffed or whatever. If there are complicated patients, because we get some very complex patients sometimes, she's always involved in that" (B4).

"And [the ward manager] is really really good and really proactive. You see her on the ward a lot, she goes around and meets all the patients, which that gives the patients better experience as well because they've met the ward manager and know that she's there if they need her" (B4).

Whilst the primary focus was on patient care, staff's development needs were also accorded a high status and staff knew that the ward manager would 'fight' their corner if needed. This encouraged staff to perform to their best:

"If there's anything that you want to do, you only have to speak to [the ward manager] or your mentor and they'll try their hardest to at least get you on the list for the course. And then the next slot you do get. And then we work up like, because I just look after patients but I've just started being in charge, on the less acute sides. And then you work your way up to be in charge of south, the high dependency bit. So you know that you've always got another step" (B4).

"I think the management style here is good. It's very supportive but it's also, I guess it's a little bit authoritarian but that makes people work harder and try and meet standards that they need to be meeting. And I think that encourages staff to try their best and not become a bit passive in their care" (B4).

"And she fights for her staff, we're well staffed, we're probably the best staffed area of the general wards in the hospital I would have thought" (B3).

The ward was very well organised so that issues of both Pace and Complexity could be addressed:

"This ward's really well organised, I don't know about the rest of the Trust. But here it's really well organised and you've got your set teams and you've always got somebody that you know is in charge. So instead of all working individually you've got somebody overall who you always know is there to turn to. It's really well supported so if you've got any questions you haven't got to fumble about and try and sort it out yourself when you don't really know where you're supposed to go for it. You've always got somebody who knows that little bit more or has got different experiences and you can all help each other out" (B4).

Whilst the ward met all the *necessary targets*, the ward manager would not compromise on quality, and if staff or other resources were seen to be too low then she would refuse to take more patients:

"I've worked for this Trust for nearly 20 years and while sometimes you may hear people say that she can be perhaps perceived as a little bit difficult or argumentative perhaps, or confrontational. All of those things would be because she - arguing about not opening beds or not taking such and such an admission because the ward is not staffed. 'Unless you get me the correct numbers of staff, no, I won't be taking that patient'. Whereas perhaps other people may say oh there's nothing I can do about it and we're just going to have to manage as best we can. [The ward manager] won't allow for that to happen. So that I am sure doesn't make for friends in high places all the time" (B3).

Despite the already high quality of care the ward manager was in no way complacent and looked for ways of constantly improving the way the unit ran:

"I mean, [xxxx] and I you know, one of my band sixes we always have a joke about this because there's never a minute where there isn't something you can make better for people, you know. We do the wound care plan. Or we redo the documentation or you know you do essence of care of privacy so you redo the documentation to fit in with it, do you know what I mean? There's never a second where you can't make something better for people" (B3).

Given the efficiency of the unit and the perceived strength of character of the ward manager the unit was left largely to itself and was not subject to such close scrutiny as the rest of the Trust, especially the care of older people unit. Despite this the staff on the unit still felt the impact of the predominant focus on pace. An excellent example of this was the *golden discharge*. This meant that patients who were to be discharged that day had to be in the discharge lounge by 10am, even if their transport was not arranged until 4pm. Freeing up the bed early meant that new patients could be admitted more quickly, and the Trust were less likely to break the four hour A&E target. Whilst staff on the unit invariably achieved the *golden discharge* they also recognised its potentially negative effects, especially on older patients:

"Getting our discharge process, getting patients out by 10 o'clock in the morning, our real time bed state. Having to hour by hour have a real bed state rolling on. But actually, whilst I can see that getting patients out by 10 o'clock in the morning stops the build up of patients in A&E, and stops the breaches, I can fully appreciate that. But actually for some of the elderly patients when you say well, you can have your breakfast and then you will be on your way. That can be quite daunting for them. And we have the discharge lounge but that facility is only there Monday-Friday it's not a weekend facility" (B4).

"But some of the pressures on discharging patients to get your golden patient if your discharge is before 10 o'clock in the morning, it's a golden patient. And you get points if you have so many golden patients. We think well - not sure that's perhaps the right forward. I can see sometimes the patients' sort of being slightly puzzled that we're rushing them out of the door, porters coming to take them to the discharge lounge because their ambulance can't pick them up until 4 o'clock in the afternoon or whatever. And they don't understand why that has had to happen" (B4).

Therefore, despite the units' emphasis on the quality of the patient experience, the overriding emphasis on pace could occasionally compromise this. Notwithstanding such challenges there is no doubt that the unit could be described as creating an enriched enclave in an otherwise largely impoverished environment.

The essence of a relationship-centred approach to care, where an enriched environment is one in which the senses are created for all parties is eloquently captured in the quote below, which succinctly 'sums up' the success of the unit:

"But I think a good ward manager does make a hell of a lot of difference because if you're happy in your job, you're happy in the care that you're giving to others. No matter what their age or gender or anything like that" (B4).

The quantitative analysis reinforced the data from the interviews and observations. The staff measures indicated that the unit scored more positively than the Trust as a whole, or any other unit in the Trust, on all the scales and significantly higher on:

- *having resources*
- *supporting each other*
- *improving practice*
- *developing our skills*
- *leading by example*
- *feeling motivated*

Perhaps not surprisingly the most significant difference was in respect of *Leading by example*, confirming the interview data about the quality of the leadership. In contrast to this enriched environment the situation on the care of older people wards, could not have been starker.

7.4 "The crapiest old building; crapiest old nurses"

"Most of our older people in medicine are cared for in the crapiest oldest building and I think it makes you feel like one of the oldest, crapiest nurses and the value that is placed on your service is not high because this is the environment you've got to work in" (B2).

The above quote, from one of the senior nurses we interviewed, brings into sharp relief the difference between the unit described above and the situation on the care of the older people units. As already noted, these units had been the subject of a recent media exposé and not surprisingly staff morale and overall patient experience were not high. When we arrived the units were probably one of the most impoverished environments in an already 'impoverished' Trust. Here we present their story.

In order to capture the views of staff on the two units, interviews were undertaken with a variety of members of the multidisciplinary team and other 'visitors' such as student nurses for example. These included:

- Matrons
- Ward Managers
- Nurses
- Care Assistants
- Social Workers
- Physiotherapists
- Student nurses
- Ward clerks

7.4.1 The place: Ward level

The building in which the wards were housed was over 150 years old and essentially gave the impression of being busy, cramped and run down; a confusing arena full of equipment and people, where patients struggled to walk from one end

of the ward to the other. Nursing staff were aware of the poor environment in which they worked:

"The first thing you notice when you come here is the state of the place with paint coming off the walls...The difference between this building and the newer block is very physical. There are old wards in this building and space issue is a big thing. Sometimes we really struggle to get a hoist into because of the pillars and things like that" (B4).

The hardships caused by the environment for both patients and staff were evident to members of the multidisciplinary team:

"The heat, in the summer it is unbearable, the windows are only allowed to be open 2 inches. It must be awful for the nurses, how they manage to work in that heat but for the patients it is just, the whole environment is pretty rotten really."

And to staff from other areas and visitors to the wards:

"We had a nurse that came over from [the medical admissions unit] to bring a patient ... and she walked in and said "oh the smell", she could smell urine. We get relatives that come in here and its "look at the state of the place" type thing, and I think that produces a negative image for us (B5)."

The effects of the environment were compounded by a perception that the wards lacked the resources to care for older patients, and to make matters worse, other areas were seen to get an obvious priority:

"You don't get all the new equipment, you get second hand equipment, we haven't got enough chairs but you have to go and look at everybody else's cast-offs so you have enough chairs to sit people in. So it's not a case of you getting new chairs, it's like cardiac will get the new chairs and you can have their leftovers so I sometimes feel like second hand Rose" (B3).

Resources were obviously an issue in a Trust with such a financial deficit and the ward managers were keen to ensure waste was avoided 'my team is quite aware of how much a sheet is, etc down to a syringe so they try not to waste'. But the ward manager felt penalized for their efforts;

"See I manage a budget and the turnaround project takes £3,000 from my budget to help regenerate the Trust financially because I am one of the ward managers that is under spent". (B3)

7.4.2 The people

Not surprisingly providing adequate care for frail older people was difficult on both wards, and this was compounded by a lack of staff. For example, on one visit the research team went on a doctor's round to find that there was only one person who was a regular member of staff on the ward in either the nursing or medical team. This lack of continuity, although perhaps an extreme example, necessarily affected the ability of the team to provide high quality care. Furthermore, although ward managers were supposed to have supervisory status, as described in the previous unit this was often impossible and they often had to take a full patient load as well as undertaking their management duties. This meant that

junior staff had to take on more senior levels of responsibility; an issue that impacted on ward manager stress:

"Yesterday I had to have a junior nurse who's only been qualified two months in charge. She was on with an agency nurse and one auxiliary because the other auxiliary had been moved again. I said you've got my home phone number, if there's any issues just give me a ring. I'd rather they phone me at home than spend all shift or all night worrying about it". (B3)

Ward managers were acutely aware of the consequences of staff shortages, and the impact of the use of agency staff:

"They've now taken my F grade away to run next door, so that leaves me short of one. Back filling with agency staff, who a) don't know the patients; there's no continuity of one person being booked for the whole week to cover that shift, which would be better. So we're just having anybody coming and they're all expensive agencies that are coming. They b) can't do IV drugs, so therefore the site manager is having to come, bleep holders are having to come, putting extra pressure on the bleep holder because they're having to go around more". (B3)

As senior ward staff left the unit ward managers had difficulty in recruiting experienced replacements, in sharp contrast to the previous unit. For example following two staff leaving, one ward had only part time staff nurses remaining which caused problems in providing continuity of care. Ward managers were replete with examples of how staff were often unable to provide the care they wished. A very poignant example was given by a ward manager:

"We had a patient who was transferred in to us yesterday. She had no next of kin whatsoever and was dying. And the poor staff nurse felt so, so demoralised because she didn't have time to go and sit with that patient. And she couldn't sit there for the final few minutes when the patient was dying... She just felt terrible because she had to leave that person and of course by the time she got back, the person had died, and they were alone when they died; and I think that's, for any nurse it's quite hard to take really.... I think that's awful. That's affected a junior member who's only just been qualified 3-4 months and she said she found that really hard, very hard". (B3)

This tragic incident may have been an extreme example, however, there was general agreement that older patients were not receiving the care they needed and that with a larger than normal cohort of inexperienced doctors and nurses the complex needs of patients were not being appreciated:

"Well I don't think they're getting the care they need. They're not, because the patients are not being assessed properly, therefore they're not applying the care. There is this sort of vision that you've got to get the patients well, get them out again. But they're not actually planning, not even thinking about these patients. They're old, they're frail, they're elderly, vulnerable...I think that half the time people are staying in longer because things are missed, whether it's junior doctors doing the ward round with the SHO's [senior house officers] or junior nurses. They miss things if I'm not on the ward round to tell them...It's like the auxiliaries doing the observations unless they are taught what to refer to trained nurse things can get missed". (B3)

There was also a shortage of doctors so that patients were only being seen every other day by a doctor more senior than a house officer. This meant that discharges were delayed because there were no doctors to discharge patients or write discharge prescriptions.

With high numbers of less experienced nurses and agency staff there was a perceived lack of nursing skill on the wards and with low staff numbers and financial strictures were more problems in the staff accessing appropriate clinical courses.

Both the lack of appropriately trained staff and resources was seen by one member of the multidisciplinary team as contributing to patients' loss of mobility and independence during their stay; increasing the complexity of the care required and jeopardising their ability to return home:

"I suppose the culture of the ward is that's your bed area and that's where you stay. There's no day room for the patients so they can't socialise, and the ward is so cluttered, there's no storage. Now because of that we quite often have people whose mobility deteriorates.... the nature of the ward it's dependency, people come in and they might be fairly independent but they are actually made dependent... But if there were a nurse who could encourage that person to walk or they had a day room to walk to that would be enough to keep their mobility. I think there is one maybe two loos...people are taking commodes to the bedside. The nurses just don't have enough time to encourage people to get up and do things for themselves...people lose their mobility then have to go to rehab, some people don't regain that mobility and the impact is huge". (B5)

Lack of resources both in terms of people and equipment was having a potentially significant effect on patient recovery and their future lives. The staff under such intense pressure felt unappreciated by senior management:

"Once in a while if someone in management actually came down and saw you face-to-face to tell you that you are doing a good job [that] would make a hell of a lot of difference; they are quick enough to tell you what you are not doing right". (B5)

Some people felt senior management was oppressive:

"You just feel that big brother is watching you...there is so much pressure on staff to deliver and the attitude is that if you don't like it you know where the door is and it doesn't matter how many years you have put in. It doesn't pay to be loyal anymore." (B5)

Keeping up staff morale under these circumstances was a real challenge and ward managers spoke of the ways in which they tried to support their staff. Role modelling care for junior staff was seen as important, as was the use of humour, meeting as a group socially outside work, and listening to staff.

"If patients look really well presented I'll say to the auxiliaries "you've made her look really comfortable well done". And I try to take one person to lunch with me, somebody different each time and we have a little chat over lunch and I can give them time to express their views." (B3)

The above account highlights the stark differences between the situation on the care of the older persons ward and that on the large 58 bed unit described

previously. However such differences are more indicative of the outstanding abilities of one ward leader than they are an indictment of care on the older persons unit. It is apparent that in the latter, at least prior to the arrival of the new Executive Team, that caring staff are struggling to maintain standards in the face of both poor resources and a culture in the Trust that prioritised targets above all else. The *golden discharge* even impacted on the patient experience in the enriched ward. For the Trust as a whole, pace predominated.

7.4.3 Processes: The impact of pace

As already indicated the Trust's imperative was to address the government target for patients to be waiting no more than four hours in the accident and emergency department and this patient flow issue affected every ward and department, with doctors being required to give patients expected dates of discharge on admission and ward managers being performance managed on length of stay. However, there was a feeling on the wards that patients were being moved around the hospital in a way that was not benefitting their care

"If you do patient mapping you'll find that one patient will have experienced about six places....It doesn't actually mean that they leave hospital quicker they are just shuffled from one inappropriate place to another". (B3)

There was an appreciation that meeting waiting time targets compromised the inability to provide 'gold standard care', as another senior nurse noted.

"You look at gold standard dementia care for example, you want them moving from A&E straight here really, that would be the ideal move, but as long as they are in A&E for less than four hours it's like who cares where they go as long as they don't breach the target [maximum four hour wait in A&E]". (B2)

Discharge of patients was another area that caused concern for the wards, especially for older patients.

"From the minute the patient arrives the focus is on how quick they can get out. I think sometimes it is not considered that this person is very old and their recovery rate is a lot slower than younger people. They might be physically able but emotionally, when someone of that age is unwell it does take time. They may have lost their confidence, there is so much to consider but care is very concentrated on what they have come in with, that problem rectified they are out the door". (B4)

Shortage of beds had increased the pressure for patients to be taken promptly to the discharge lounge. When the research team first visited the Trust the target for a *golden discharge* was for a patient to be in the discharge lounge by 10 am and the bed ready to receive another patient within one hour. On a subsequent visit, older patients with complex needs had to be in the discharge lounge before 9am to meet the target.

Ward managers felt hampered in meeting targets by factors outside their control; the lack of communication between health and social care in the community held up discharges and the lack of available portering staff to facilitate *golden discharges* for example. It was evident that many of the problems needed a *whole systems* approach in order to make sustained improvements.

7.5 Instituting change

In July 2007 a new Chief Executive and Senior Management Team (SMT) were brought in and on the return of the research team the Trust was four months into the new regime. Although the new team were clearly having an impact it appeared that the new vision for the future of the Trust simply mirrored the old. Therefore, the achievement of Government targets remained a priority and, if anything, the focus on pace had increased.

Morale within the Trust with the arrival of the new senior management team was at an all time low and this was especially evident among matrons. The problems of low staffing and a poor environment, in a target driven culture persisted. However, greater emphasis on increasing the flow of information coming from the wards to the centre on a range of topics, such as infection, cleanliness, and discharges, put additional pressure on some staff. Meetings between the matrons and the operational manager, observed by the research team and documented in field notes at the time highlighted some of the issues.

"The operational manager wanted to know how many beds were closed due to an outbreak of clostridium-difficile and how many admissions and discharges each unit could expect that day. The matrons sat looking at each other and tried to avoid making eye contact with the operations manager. When asked directly one replied "it could be three, maybe four I'm not sure I haven't been round the wards this morning". Another when asked what targets would be breached said "I'm not really sure what target you're talking about". In response he explained in some detail what figures he was wanting and that they were the same ones he had wanted the week before. The reply to this was that the matron still did not know. At the end of the meeting a matron explained that it was the same every day, the same ground gone over, the same questions asked". (Research field notes)

It was evident that these demands met with considerable resistance and caused resentment among the matrons, some of whom considered the new senior management team as 'ball breakers' (B2) and 'henchmen to do the dirty work' (B2) of the Chief Executive. Some matrons comforted themselves by suggesting that the new senior management team were 'just passing through' (B2), and were, unlike themselves, soon to move on. However, it was evident that the pressure was having a significant effect on the matrons, with some taking time off work with stress.

In turn the pressure to meet targets and produce the information required by the centre of the Trust was passed down from the matrons to the ward managers.

"I say to my ward managers this is what you have to achieve, and if you don't achieve I will get the sack. Actually I'm not going to get the sack; you are. So, you need to make sure that this actually happens; and if your staff nurses aren't doing this you need to address it with them, because it needs to be the same they need to get the sack before you do. You have got to make sure you are managing the staff really hard". (B2)

This downward pressure was felt by ward managers, one of whom was told:

"If you don't want to do what is asked of you, you need to think what else you can do to earn a living because this is how it's going to be, no lets offs and people will be on your back about this". (B3)

Overall ward managers were left in no doubt of what they had to do and of the consequences if they failed:

"It's do it or get out. More paper work new paper work and more policing so that it is evidenced on paper". (B3)

Given the above we were surprised on our final visit to see how much change had been achieved.

At this point it was evident that the new Chief Executive and the SMT were moving toward a more transformational style of management and leadership. The Chief Executive had certainly made a significant impact on the culture of the Trust in terms of creating and sharing a vision of what it was possible to achieve once the Trust was seen to be meeting it's national targets.

"The Chief Exec is a fabulous communicator, he does leader days when he stands up and talks giving the state of the nation address, and you think, yes, I'll follow, I'll do that, that's great. Very, very good at motivating and you know making you feel it". (B2)

The Trust objectives were now clearly articulated to staff at all levels; as one matron explained:

"The Trust objectives are now very clear and I think understandable for anyone working here. It's very explicit where the organisation needs to go, what it needs to achieve". (B2)

Ward managers too were aware of the implications of the objectives for themselves and their staff and that the old culture of not delivering was becoming a thing of the past:

"In some ways people are now much clearer about who has to deliver. There is much more accountability...the wards now have set objectives, and they have had to sign up to those". (B3)

There was also a keen understanding of what was being required of staff and a clear expectation that they would deliver at every level:

"You know we have a new Chief Exec and he has made different demands from people within the Trust all the way up and down to shop floor level". (B4)

The importance of gathering good information at shop floor level was understood:

"We had a tough time in providing the information for the senior managers because we didn't have the evidence. You went onto the wards wanting to know this or that and they couldn't put their hands on it, but they can now. We have had to be very directive this is the information you will keep and this is the way in which you will keep it". (B3)

The key to this new understanding seemed to be the quality of communication by the Chief Executive who had a policy of ensuring that staff at all levels were well informed:

"Communication is the key...the Chief Executive sends out weekly emails the 'Friday message'. We have re-looked at our staff magazine which has been revamped to make sure that it contains material that is important for staff to know about. We have looked at our staff survey results very closely this year, and we have had a much better response this year....The Chair of the staff side of our Trust council comes to our Executive Team meeting on a weekly basis, and there are open door meetings where staff can come and meet the Chief Executive. All staff meet the Chief Executive or one of the directors on the corporate induction that we do on the first day for new staff... and I do weekly walkabouts with the Chief Executive as well as walkabouts on my own and with other specific people". (B1)

This improvement in communication was achieved in large part by the Chief Executive and the SMT being highly visible, approachable to staff and delivering a clear and consistent message through the SMT down to the matrons and ward managers:

"I meet with the matrons weekly to see if we can identify hot spots and trends and share good practice...I meet with associate directors of nursing on a monthly basis in terms of nursing and midwifery leadership....I have a quarterly meeting with the ward managers where I brief them on what's new and what is coming over the horizon". (B1)

To further aid integration and visibility the SMT moved from offices off-site to pre-fabricated open plan accommodation within the hospital grounds:

"There is something about being visible, being available, we now have an open plan office so anyone can just walk in and talk to you, people can find you, they know where you are. When I first came here if I wanted to see the director of finance I had go and find him and make an appointment. Whereas now I sit two chairs away from him and we sit and talk about things and get them done". (B1)

This emphasis on being visible and accessible was further highlighted by senior personnel appearing as a *real person* to staff at all levels, as one senior manager notes below:

"The important thing for me is visibility so people getting out there so the ward staff know who the senior management team are. It pleases me when I go away on holiday and one of the porters asks if I have had a nice time, because they know you have been away, and they have missed seeing me. Consultants and other staff ring you up directly on your mobile and that's the way it should be not lazy bureaucracy". (B1)

This personal touch seemed to be appreciated by staff as one of the matrons who happened to meet the Chief Executive explained:

"I bumped into him in the corridor, and he says "it's good to see you back from sick", and I was like wow you know! And my boss said "yes he knows and he saw that you were gone and asked where you were" and that's very good, very skilled". (B2)

At this stage it was evident that the new senior management team believed that building trust and positive relationships throughout the organisation was a key to getting the staff on side, as one of the team explained:

"For me it's about fostering those relationships with the divisions, building trust. I think that if people have been brow beaten over a period of years they bring the shutters down and you can only get through that by building relationships". (B1)

Therefore, whilst there was still an emphasis on meeting targets, the reasons for, and benefits of this were now much clearer. Moreover, there was a far greater emphasis on the relational aspects of change, with recognition of the importance of relational practises in getting people on board.

It was apparent that the Chief Executive and the new SMT had a management style based on openness, clarity and accessibility, giving out consistent messages with an emphasis on good communication, expectations to deliver and recognition of the relational aspects of work within the organisation. There were also indications that the reins of control were being loosened but in a carefully controlled way.

"Because the organisation has worked in crisis mode for so long there is panic and mayhem, lots of people have become totally controlling and somehow we have to teach people to let go...when organisations bring all the control to the centre and hold it there until all the panic is over and then they let go and say "off you go then"; and that's no good. There has to be a way in which while control is being held centrally people are being shown what to do when they get it back... I'm not sure we always get it right but that's what we have aimed to do". (B1)

As a consequence the data suggested that front line staff were becoming more proactive and empowered.

"Us 'G' grades set up our own meeting group called 'sisters with attitude' and we've met a couple of times. We had concerns about finance and so we got the finance director to come and see us". (B3)

Although the full empowerment of front line staff still had a way to go it was evident that they were developing a sense of belonging, not only to the ward or hospital in which they were based, but to the wider Trust as a whole. The following quote is from one of the senior staff on the care of older person's unit:

*"We **are** [participant emphasis] the Trust. When somebody bad mouths the Trust, they are badmouthing me, my staff, and my team, because we are the Trust and we have to make it work".*

It was also apparent that staff were beginning to see the advantages of achieving the Government targets

"I think that a lot of our external reputation is built through our staff speaking well of the organisation... It's about trying to give pride back, for people to believe that it's a good place to work...and it's good to feel that you are working in an organisation that is achieving its national standards, because with that comes a lighter touch in terms of external monitoring; and it enables you to have more control over the things that you do and go forward with". (B2)

This rediscovery of pride in being part of the Trust was partly rekindled by the ward teams feeling that they were valued by senior management. This was evidenced by investment in both staff and the environment, which enhanced feelings of significance amongst staff. For example, on our final visit to the wards,

whilst the old buildings remained, they had been *de-cluttered*, creating an impression of space, surfaces were clean and non essential equipment had been moved into a central storage area. Furthermore, the walls had been painted, bed curtains and window blinds replaced, with new chairs and beds completing the look. There had been negotiations with agencies providing bank staff to promote continuity of staff working on each ward; and there was a recruitment drive in place to improve ward staffing levels. There was also greater appreciation of the need to develop staff, especially with respect to care for older people:

"There are two things a bit about will, and a bit about skill. And originally we had different sections of the workforce that were a little short of both. If you have a workforce with masses of skill but no will, it's always going to be a difficult one. But if you have not quite got the skill but you have the will it's easier...and that's where we are now with regards to caring for older people across the Trust. So we are investing in developing courses such as the new one for care assistants highlighting what is needed in the care of older people". (B1)

The SMT had worked hard to develop the *will* among staff by addressing their needs to have the senses to be created.

It was evident that the SMT, in addition to the improving the ward environment, felt that a whole systems approach was the bedrock to an improved patient experience.

"If you get the systems right at the clinical level, and you get good systems in place; you save money; you have good quality care and high patient satisfaction with a good patient experience. You can't divorce one from the other, they all interrelate". (B1)

In an attempt to improve patient experience performance indicators designed to monitor patient movement were introduced.

"We have agreed to key performance indicators that will enhance patient experience. What we have agreed to monitor are: Movements of patients after 10 o'clock at night, that's inappropriate, a patients rest is important to their recovery; mixed sex wards, how many times because of capacity do we have to think about throwing an 80 year old women in with a group of men?;....patient moves, so how many times does a patient move from one ward to another". (B1)

Although this was a move in the right direction, the focus remained at the organisational level rather than that of the individual patient. However, there was an understanding that there was a person behind the figures and some managers helped staff to see targets from a patient experience perspective.

"Let's not start with the four hour target; let's sit in the waiting room for an hour and a half, let's stay on a trolley in a room with no communication. If you look at it from a quality and patient experience point of view perspective then you have got to get the patient out in four hours, it makes sense, its humane". (B2)

Moreover, there now appeared to be a much stronger focus on the care of older people across the Trust:

"We don't believe that older people's care should just be allocated to those clinical areas that have got a label of being an older peoples' ward. If you look at the

demographics of our patient profile, then many of our patients in all specialities are older patients. So we want to have a Trust wide emphasis on older people". (B1)

And many found this to be an exciting opportunity, with people beginning to see signs of improvement:

"Out of that came an opportunity... for the work I have been trying to get done around older people... suddenly issues around older people whizzed up the Trust's agenda at a great speed". (B2)

"It was hard, and it is hard, but I think that there's a bit of a spring in everybody's step now. You start achieving, you get more of a positive perspective and you can do things". (B3)

Importantly there seemed to be a new realisation that the old regime of instituting one change after another was unlikely to be successful and that a more strategic and considered approach was needed if progress was to be sustained:

"When change initiatives are in place you have to ask yourself why this is not becoming ingrained in what people do; and it might be that it just takes more time to change things in a real way than we actually thought". (B2)

"I think that the real challenge for the Trust is maintaining those and sustaining the changes". (B3)

Furthermore, as the quotes above attest, change initiatives also need to allow space for reflection on the process and the longer term outcomes.

7.6 Conclusions

Once again this case study highlights several themes that have recurred throughout both the narrative synthesis and the empirical work that capture the importance of leadership and clarity in any change initiative, as well as recognising the need to introduce change in an incremental and coordinated way. Another central message to emerge is the role of interpersonal dynamics and the relational aspects of managing the change process.

Whilst our initial interest in the Trust was sparked by the media attention to the poor standards of care for older people it was apparent from the outset that this was symptomatic of far wider and more systemic problems in the organisation as a whole. One imagines that these must have been developing over a long period of time. At the start of the case study the Trust might therefore reasonably be described as being impoverished. However despite this one unit stood out as being able to maintain both a reputation for excellent care and for creating a very positive work environment for staff. This was confirmed by both the extensive qualitative data and the quantitative analysis. This seemed to turn almost exclusively on the leadership skills of the ward manager who was able to ensure that the ward met all its targets whilst maintaining standards. It was also clear that the wards for older people were in the poorest accommodation and were relatively starved of resources, hence the media outcry. However, rather than seek to change the fundamental approach to care, the immediate reaction of the Trust was to focus almost entirely on meeting the next target. This merely exacerbated the situation.

Things began to change when a new Chief Executive and SMT were put in place. Initially it seemed that the perceived solution was just more of the same 'perform or perish' mentality but later it emerged that meeting the targets was a largely instrumental approach that allowed some 'breathing space' to address the deeper-seated issues. Through a strategy of greater transparency and good communication the new regime was beginning to see its message filter down and the data suggest the emergence of a more enriched environment at Trust level with a much clearer sense of belonging, purpose and achievement. Continuity, by definition takes time and trust, as to a degree does security. However these were starting to flourish and the care of older people was being accorded far greater significance than it had previously, not just in terms of the fabric of the environment but also the values that underpinned it. This again was largely the product of the leadership and direction from the top. It is to these and other issues that we will return in the final section.

Section 8: The Rapid Assessment and Discharge Scheme (RADS): Pace Exemplified

8.1 Introduction

The original aim of this case study was to explore the impact on the culture of care of the large-scale movement of several wards/units to a newly built facility that provided a markedly improved physical environment. Along with this move a number of services were also being reconfigured and this seemed to provide an ideal opportunity to explore both the impact of relocation to superior premises and service reconfiguration on culture and the delivery of care to older people. As with the other case study sites the intention was to collect data during multiple visits over an 18-month period in an effort to track change longitudinally. However, during the first period of data collection one unit emerged that encapsulated perfectly several of the potential dilemmas of delivering high quality care for older people in an acute setting, in particular the tensions inherent in the Pace-Complexity dynamic. This unit operated a Rapid Assessment and Discharge Scheme (RADS), the sole purpose of which was to ensure the safe, timely and effective discharge of older people within a maximum seven day period. The scheme itself had been running for several years when the study started and many of the staff had remained the same throughout this period. On the first round of data collection it was apparent that, at least in so far as staff were concerned, the RADS offered an environment in which all the senses were clearly met. There was a core multidisciplinary (MDT) team, many of whom had been together for several years. Because of this there was excellent teamwork, good interpersonal relationships, and first rate communication. Staff felt valued and believed that their opinions were listened to. All these factors served to create strong feelings of security, continuity and belonging. Furthermore the service had a very specific remit and was well resourced to meet its target of a seven day discharge. Consequently it was highly regarded within the hospital. Senses of purpose, achievement and significance were therefore in-built as an integral part of the RADS. However, only half of the unit offered a RADS service, the other half providing rehabilitation on a longer term basis. This afforded the opportunity to explore potential differences between the two groups of patients in terms of their experiences of care. Furthermore, as noted, RADS was relocating from a relatively impoverished physical environment to one that promised, at least aesthetically, far more enriched surroundings. A decision was therefore made to focus the case study on the RADS initiative, and this section is structured to reflect this. It begins with a brief overview of the Trust as a whole, and the rationale behind the relocation of units. We then focus in particular on the RADS, providing a brief description of its evolution and way of functioning before exploring a number of tensions between Pace and Complexity, as well as considering the impact of the move on the way in which the relationships between the RADS and the rehabilitation functions of the unit unfolded.

8.2 The Place at Trust level

The Trust in question became a Foundation Trust in the first wave of applications in 2004 and was formed following the amalgamation of two large Trusts which, when combined, provided over 2000 beds, employed some 12,500 staff and had a budget of over £600 million. The RADS was located on the largest hospital site within the Trust with over 1,100 beds and 5000 staff.

Like many NHS Trusts the site still utilized a number of old-style nightingale Wards. These are 'large, open-plan wards which offer dormitory-style accommodation for hospital inpatients' (DH, 2007). These particular wards dated back to Victorian times being built in 1878 but were still used for acute medical care when the study commenced. Since the increased concern about dignity for older people, nightingale wards have been criticized for inhibiting the delivery of high quality care for patients, especially around issues of privacy. In particular, the DH stated that 'their now-outdated design offers patients very little personal privacy or peace, and [they] do not meet patients' expectations of a modern NHS' (DH, 2007). The NSF for older people called for nightingale wards to be scrapped or upgraded in order to provide multi-bedded single sex bays or single rooms. The policy had forced the Trust to consider providing healthcare in a different, more up-to-date environment. The solution was to build a new state of the art facility designed with the needs of the older patient in mind. The new wing aimed to provide a cutting edge NHS environment for delivering care for older patients. The oval shaped wing had four floors built around a central atrium. The medical directorate had administrative and medical staff offices on the ground floor level of the atrium, and the three remaining floors provided six new wards with a total of 168 beds replacing the same number of beds from the older nightingale wards. There were two wards on each of the 3 floors leading off from the central atrium. Each floor was themed with a different colour representing the seasons, echoing the artwork in the foyer of the atrium. Each of the wards had exactly the same layout. Following industry best practice for new hospital builds, the 28 beds on each ward comprised of 50% single, en-suite rooms and 50% single sex bays, each containing three or four beds and bathroom facilities. This brought the Trust in line with government policy to reduce the number of mixed sex wards in order to improve patient dignity and reduce increasing infection levels. Each of the wards also contained three nurses' stations, a small one at the entrance and another at the far end of the ward, with a larger one in the centre. In addition to the three ward areas, each level had a shared accommodation block that provided offices, seminar rooms, and carers overnight accommodation rooms, as well as staff rest/changing facilities. As part of the construction of the new hospital wing, the Trust took the opportunity to restructure its care services by:

- reorganizing the staff teams on each ward to offer a better skill mix
- changing the number of beds on the wards
- changing the delivery of certain aspects of care such as meals and rehabilitation services

As indicated above, the unit containing the RADS was subjected to these changes and this offered the opportunity to see if both the new environment and the above

reconfiguration of services would have an impact on care delivery. However, in order to fully appreciate any potential effects it is necessary to understand both the way that the RADS functions and a little of its history to date. It is to this that we now turn.

8.3 The evolution and functioning of the RADS

In order to gain insights into the way in which the RADS functioned and to explore the potential impact of the move we collected data mainly from interviews and periods of observation at three points in time: Shortly prior to the move; shortly after the move and about 12 months later. As with all the case study sites survey data were collected from a much larger number of units and this included the ward providing the RADS.

Due to the multidisciplinary nature of the RADS we collected data from a wide-range of individuals which included:

- consultant medical staff
- junior medical staff
- the matron responsible for the RADS ward
- senior nursing staff at G and F grades
- more junior nursing staff, care assistants and student nurses
- the full range of therapy disciplines, including physiotherapy, occupational therapy and dieticians

The data collected were very rich and provided fascinating insights into the ways in which the RADS operated, its interactions with the rehabilitation patients on the unit, and the tensions it encapsulated between Pace and Complexity. We outline these below beginning with a brief history of the RADS team and the way it functions.

The RADS was a high profile service within the Trust. It had begun some years previously, primarily as a research project whose aim was to identify patients suitable for rapid discharge within 72 hours of admission to hospital. It had been allowed to continue after the initial period because it achieved markedly quicker discharge than other units, and enabled a good 'flow' of patients, as reflected below in a quote from one of the consultants for the scheme:

"And from the hospital purely business side of things, it's all about flow of patients. Obviously from our point of view as well as keeping the flow of the patients, we're hoping that we're giving them a good service, we're giving them a comprehensive targeted assessment as well. But the idea is that we get them moving through the system, which keeps the bed stock flowing. Hence every day there are often two or three going home, and two or three new ones coming in. New patients coming in. So there's quite a flow through. And we need to do that, because at the moment we start not doing that, people will start... people as in the Business Managers will start looking at them and say 'you've got quite an expensive service what are you actually doing?' And unfortunately what they look at is bed dates, length of stay". (C2)

Potential RADS patients usually had relatively minor and easily treatable ailments, such as infections or falls, that could be rectified quickly through medical treatment or intensive therapy. A fast turnaround was further facilitated by a well staffed multi-disciplinary team (MDT) who provided an integrated service of medical, therapy, social and community support. The RADS team consisted of:

- a consultant geriatrician who also worked in the community and with rehabilitation patients on the ward
- support from SHOs on rotation
- a dedicated occupational therapist and physiotherapist
- a ward manager in charge who coordinated the scheme, and crucially, liaised with the family and those staff in the community who organized support post-discharge
- nurse support from other nurses on the ward
- rapid access to speech and language therapists and dietician
- preferential access to specialist community care schemes such as the community assessment rehabilitation team and the short term intervention team for home care. A social worker and district liaison nurse often attended the MDT meetings

Whilst the team was highly multi-disciplinary all the members felt comfortable in expressing their views openly and honestly. Our data show that meetings were genuinely co-operative, every ones' opinion was listened to and consensus decision making prevailed

The way in which the team runs is described below by one of the consultants:

"Obviously what we try to do is look at the patient as a whole as well. So they may have come in with a fracture from a fall. Which I would obviously look at medical reasons why they're falling. At the same time, the therapist will be looking at the reason they've fallen. The occupational therapist will be looking at their environment, their home environment. We will speak to the family, [xxxxx], our coordinator, often speaks to families. And we will try and speak to anyone else who are medically involved with them, be it district nurse or something, to get that bigger picture. If there are concerns highlighted about nutrition or diet or something, we'll get the dieticians to see and advise as well. So we try, as well as target that as much as you can, in five or six days, give as much of a comprehensive assessment as you can". (C2)

In order to ensure that patients met the seven day discharge target, strict selection criteria were adopted and staff, usually therapy staff, or senior nurses went *shopping for* and *cherry picked* the *right* type of patient. The focus was very much on pace, and staff would select out at the start any patients who had *complex* medical or social needs:

"Yes, less complex medical cases, yes. We take people that have got simple medical needs".

"If there are beds available the therapist will go shopping for the patients. I think we've got a good understanding of how the wards work we are trying to find the appropriate patients for the wards". (C5)

"I would also perhaps look at their mobility, if they are taking 2 people to stand then they would not be appropriate as it would take too long. I also look at their social background to see if it is a complex social problem because the social workers also go up and a lot of the time they don't feel they can turn patients round because they've got really complex needs". (C5)

"Because obviously we hand pick our patients, those that hopefully aren't that ill". (C3)

A failure to select the *right* type of patient compromised the seven day target and was seen to reflect badly on the teams' performance, especially given the privileged access they had, not only to the whole hospital system, but also to support in the community:

"There is a thing about being medically fit and getting the appropriate patients to justify our service and make sure that we're not getting a bad deal which makes our staff look bad if we can't get them home because we are supposed to get them home because we have luxuries like homecare". (C5)

As the following quote shows, the RADS was extremely well resourced and run with great efficiency:

"RADS has a model where there is a daily, Monday to Friday, daily ward round. And a daily senior ward round. Which is a consultant led ward round. And a daily multi-disciplinary meeting. And then as part of that, we have our own designated physiotherapist and occupational therapists. So they're not spread out all over the hospital. And then we also have access to other multi disciplinary members. Including dieticians. Speech and language therapy. So as part of the multi disciplinary team, we have the various therapists. We have consultant. We have the nurses obviously the nursing staff on the ward. And usually that's xxxxx, the sister. Who is also the RADS coordinator. Who coordinates. So although there's other nurses on the ward, looking after the patient, [xxxxx] coordinates everything, and gathers all the information, as well as coordinating the care". (C5)

So the scheme was focused on identifying those patients who could respond positively to an integrated treatment regime over the crucial seven day time period. If a patient did not fit into this category then they could not be considered for the intensive and rapid delivery of RADS treatments. This meant that paradoxically those patients with more complex needs received less medical, therapy and social input whilst in hospital, thereby all but ensuring that they would be in hospital longer than if they had received more intensive support.

This, as we will see, raises questions concerning the appropriateness and equity of a scheme such as the RADS, of which the RADS team were acutely aware. However, before going on to consider such issues it is important to appreciate the way in which the RADS evolved if a complete understanding of its significance is to emerge.

When the RADS first began, about a decade ago, it was initially introduced as a research led initiative to improve discharge and was subsequently maintained as

part of the Trust's response to the NSF. What is interesting, however, is that from the outset the new RADS initiative was actively *head-hunted* by a ward manager on an existing long-stay rehabilitation ward as a means of improving the *image* of her unit and the job satisfaction and morale of staff. She describes this below:

"It was really, really, really hard work [on the old rehabilitation ward]. We had one of the lowest staffing levels in the whole Trust really. And we were really busy. We run the RADS scheme, which you're familiar with, on the ward. Now that's been running for ten years, and properly in an acute ward setting for about seven years I think. And I like head hunted the scheme. They were going to put it on another ward. And I said 'No. No. We'll have it on this ward. It sounds a really good scheme. Very positive, and it's what we need.' Because we were very...we were totally rehab.....This was a new thing that was coming in to increase, shorten patient's stay, particularly elderly people. So it was a completely different thing. But I just can see that it was just going to be such a good thing for the ward. This is what we need, something to brighten us up, make us seem more acute. So people would feel better about coming to work". (C3)

The sentiments reflected in the above quotes attest to the perceived significance, or rather lack of significance, accorded to rehabilitation as opposed to the more attractive and high status acute care. Rehabilitation was seen as *'really, really, really hard work... because we totally rehab'*, conversely something more acute would *'brighten us up... people would feel better about coming to work'*.

This image of rehabilitation being *heavy* work was expressed by a number of people and many saw work in such a setting as 'de-skilling' them, whereas the RADS were seen to provide a very different work experience:

"In the olden days, ten years ago, you weren't thought of as a proper nurse if you worked on rehab. It was very historically steeped in long term patient care. You'd be looking after these patients for months and months. And they would all be disabled, heavy. So it's changed, very, very much. And the RADS scheme was really good because it gave us a real boost, that we were taking acute patients; and that was a huge change, and one that we've, the whole ward managed really well". (C3)

The type of patients accepted on to the RADS were not only seen as *lighter* but also requiring *real* nursing skills such as giving IV antibiotics. The combination of the two was seen to create a *nice ward to work on*, that also demonstrated a good *throughput* of patients.

"The throughput, you're not stuck with long stay patients, so it makes it interesting. Yep, yeah, the workload on here is what I would call lighter as well. Yes definitely, because patients who go on RADS have to be fairly fit". (C3)

"Because then you're not de-skilling anybody. And we're actually keeping up with the skills that we've got. Because if you've got somebody who's in, who needs IV antibiotics. Then you give those IV antibiotics; whereas if you're just looking after rehab patients, you might not need to give IV antibiotics". (C4)

"I think generally it is a nice ward to work on. Our client group isn't absolutely really heavy and like some of the other medical wards because our patients are assessed to come down here because obviously we don't want really ill patients

because we want to get them out quicker. So we're looking at the weller end of the market so to speak". (C4)

The RADS was seen to define the *identity* of the unit and its presence was central to the job satisfaction and morale of staff. The significance accorded to the RADS could not be higher, because what it did really mattered and its success was readily observable to all. Such sentiments are summed up eloquently below:

"It (RADS) is absolutely fundamental to what we are, definitely, yes, that is our whole personality, it would be very, very bad for morale and everybody would feel a great impact if that wasn't on".(C5)

"There is more satisfaction to the job because you are actually making somebody better because they haven't got mega medical problems and you are getting them home and you have the resources like social work team and a therapist team and a consultant ward round Monday to Friday generally so that just makes an incredible difference to discharge and you've got a nurse-led coordinator doing the discharging so the whole ethos of the ward is that it's busy but it it's not bogged down with chronic problems that you can't do anything about that's really frustrating, you haven't got terribly sick patients – you do absolutely hours and hours on and that maybe don't get better generally in an older age group. We don't have many deaths on here – we might have one a month if that and certainly if you went to another medical ward that they would generally have a much higher percentage, you know, comparable to our age group so generally we are going to get people better, we are going to get them out, we're going to get them back to their own home nearly always so very positive, satisfying type of nursing". (C3)

The staff who were based on the RADS clearly saw their work as important, exciting and interesting and, in the early days, as raising the status of the unit. In terms of the senses the RADS ticked all the boxes; it had an obvious sense of purpose and achievement and the work it was doing was seen as highly significant by the Trust and those staff working in RADS. Such feelings related to therapy and medical staff just as much as the nurses: *"I like the pace, I like the quick turnaround. And the challenge because we also cover A&E to prevent hospital admission so we have a bleep cover to that as well as doing the quick turnaround rehab on the ward. It's the variety that was appealing". (C5)*

"This is much more team based but it has, the results speak for themselves, the patients go home quicker. They get a better quality care, they don't sit around waiting for therapy, etc for days on end. I probably do have a preference for the RADS way of doing things". (C5)

"Yes but equally you can say the RADS patients probably are more interesting In terms of because they are moving quickly you feel you can actually achieve something". (C5)

"I just like that initial meeting a patient, seeing them treated and then discharged home and move on to somewhere else. And then, because that's how you gain your experience, you're seeing more and more problems, rather than somebody on an elderly rehabilitation ward that's gonna be in for 6 months because they haven't got funding. Same thing every day and it's like you don't see any progress. You do a lot of the time obviously, you get people back up on their feet, which as a rehab ward you're going to. But some it's just like groundhog day". (C5)

Perhaps the shortest quote of all summed up the general feeling of the RADS team members most appropriately:

"I really love RADS, and I love the team, and I love working up here". (C4)

The experience of the RADS team, and that of the patients under their care, is therefore qualitatively and quantitatively different from that of any other unit in the Trust. There is a clear sense of purpose and high levels of achievement, and a real sense that you, and what you are doing, 'matters', that is, you feel significant. The patients are *lighter* rather than *heavy* and actually get better. There are very few deaths, the ultimate sign of medical failure.

Furthermore, because many of the RADS team had been together for a number of years, and they knew, trusted and respected each other, there was a very high standard of teamwork, which clearly reinforced feelings of security, belonging and continuity. The quality of the interpersonal relationships within the RADS team were central to its success and highly valued by team members.

"Your opinions are asked. What do you think? The consultants will say 'come and have a look at this, what do you think about this?' It's not 'oh I'm the boss, this is what I say, it doesn't matter what you say'. Everyone's opinion counts and it's just such a nice place". (C5)

"I really like it as well because we work closely with the OTs, the nursing staff, the medical staff. You really feel a part of a team". (C5)

"I've worked on other wards where the doctors don't talk to the therapists and they don't listen to what we say and the nursing staff don't handover and it's a nightmare trying to find out what stage a patient is actually at to get them out so the fact that we can all talk to each other. Like I can go to the consultant and say I'm wondering if this patient has maybe got something else going on do you want to have a look and see what you think or they will ask us to go and look at things as well". (C5)

The fact that the senior medical staff obviously not only valued, but also acted on the opinions, of other team members was also a very important consideration. This was confirmed by the consultant below:

"And absolutely valuing it. So, when therapists say something's not right here, you take note. Sometimes we then go look, reassess, reassure and then it's a case of discussing well what do you think, well what do you think but its taking that on board". (C2)

The reputation for good team working was seen to be the *envy* of other units, further raising the status and significance of the RADS team:

"It's a fantastic team, I think everybody that has ever watched us is really envious of our MDT, because we're all sort of very respectful of each other, we all recognise each other's roles". (C5)

Furthermore students, who as transient members of a ward are often an excellent barometer of the dynamics of a unit, also picked up the positive atmosphere quickly:

"It's a really good ward to come on, the staff work together so well and they also make you feel really welcome" (C4)

The RADS therefore provides as an excellent example of how a pace driven initiative can, on its own terms, be seen as highly successful. However, in many respects it was set up to succeed, in that it:

- had a clearly defined target to address
- *cherry picked* the *right* type of patients who did not have highly complex medical or social needs
- was very well staffed with a core team of highly experienced people
- had privileged access to the full range of resources, including priority for community care packages

The RADS offered a very comprehensive assessment, intensive treatment and, if needed, a coordinated community support package. On such criteria it can certainly be seen as providing a high level of holistic care that clearly went well beyond a consideration of medical needs alone. In this respect it was treating older patients as *people* rather than simply as *patients*, and at face value might be seen to reconcile some of the tensions in the Pace-Complexity continuum (Williams 2001; Williams *et al.*, 2009). However, as it deliberately excluded those patients with really complex needs, such a perception does not stand up to close scrutiny. Moreover, the ward in question had both RADS and rehabilitation patients and there were some potentially stark differences between the experiences of these two groups which suggest that those with complex needs were still experiencing differing levels of care. This is explored more fully in the next section.

8.4 What about the 'rehab's'?

As was noted earlier, one of the initial motivations in seeking to attract the RADS to its eventual home was the desire to raise the perceived status of the unit and to improve the job satisfaction and morale of staff. It is quite clear from the above that this had been successfully achieved. However, the RADS only occupied half the beds on the unit and this begs the question as to what was the quality of the experience for the other patients who were undergoing rehabilitation?

This section explores the experiences of patients receiving rehabilitation on the unit, beginning with the regime on the old ward prior to the move to the new accommodation. Subsequently we reflect on the perceived impact of the move to the new unit and the way in which care is delivered, especially for the rehabilitation patients.

Prior to the move the RADS and the rehabilitation patients were housed in separate sections of the ward and nursed in distinct bays or areas. Nursing staff tended to work primarily with one group or the other and the two groups of patients had separate therapy input from different individuals. Whilst RADS patients obviously had much more intensive therapy input most staff believed that every effort was made to provide the same quality of other care. However some of those we interviewed were not so certain.

There was recognition that the amount of intensive therapy input that the RADS patients received was far higher than the rehabilitation patients and that there was therefore an element of inequality in-built into the system. To compound matters even other systems, such as referrals for investigations or assessment, seemed to become 'slower' on the rehabilitation side:

"But it is noticed that they, because it's all the high inputs into the RADS. I wouldn't say the other stuff gets neglected. But I would like to see some of the practices that we do on RADS, to be done on the rehab side. So on the RADS, if we ask for something, we often say 'we need it today, so we can make a decision on it tomorrow.' So let's get this referral done today. Let's not wait until tomorrow to do the referral. Because the sooner we refer the better. Whereas sometimes on the rehab side, I find that you ask for referral and a couple of days later it's not always been done. And there's the sort of mentality that everything is a bit slower. And just because certain things are slower, I don't think everything should be slower". (C5)

However, whilst there was recognition that the RADS patients got an improved therapy service and enhanced access to community rehabilitation facilities, most staff generally thought that their nursing care was of a comparable quality:

"A lottery service really...a two tier service that depends on where you happen to be allocated when you come in...no, no, it's not really a fair service...it's more about managing the beds really...but I always try to treat the patients the same whether they're RADS or rehab". (C4)

As noted above student nurses are often good barometers of the quality of care as they change wards frequently, have experience of differing wards and regimes and are therefore able to make judgements about the relative quality of their experience and that of the patients. The interview data below collected from a student prior to the move to the new unit suggest, in her opinion at least, that the quality of care was better for the RADS patients than those on the *rehab* side:

"Just things get left and overlooked. It's difficult. It's just things on a day to day basis. Like sometimes you know somebody has not been checked. If you know somebody is incontinent, and you know they won't have been checked. Or toe nails don't get cut, and feet don't get washed. Just the little things, it's nothing major. Nobody gets left on the toilet for days or anything like that. But, it's sort of things like, you could improve". (C5)

Moreover, other, more subtle, indicators of differentiation existed, particularly in the language that was used. We have already seen that non-RADS patients were seen as *heavy* or *really, really hard* and there was a tendency to classify them as the *rehab*s:

"It would be nice if the RADS level of therapy could be carried on for the rehab but unfortunately it doesn't". (C4)

Whilst we didn't form the impression that the term '*rehab*' was deliberately intended to be pejorative, there is no doubt that for many staff work with such patients was far less glamorous, exciting and interesting than work with the RADS patients. However, not all staff felt this way and some saw the greater opportunity to get to know the rehabilitation patients as a positive thing, which added to their

job satisfaction and morale. Such sentiments recognise the complex nature of rehabilitation:

"I think when we mention it to somebody that I work on [xxxxx] ward which has the RADS and the rehab patients most of your colleagues go 'ooh, that must be boring', and you are like no, not really, because you are finding out about their lives and what you can do to make their lives better and in the future I know what I can do for my parents". (C4)

"Caring for an older person in a sense obviously takes a lot more of your time, more complicated obviously than caring for your average person. Each and every one of us have individual needs, there's no 2 people alike. In a sense your work feels more rewarding because most of the time they are totally dependent for everything, you need to feed them, clothe them, wash them, change them, everything. Possibly on a ward where it is average people you do very little for them really when you think about it, you're not doing an awful lot for them. So what you are doing on this area feels a lot more worthwhile because you are really getting involved with the patient". (C5)

On the whole, however, it was clear that for most of the staff it was work with the RADS patients that provided the highest levels of job satisfaction. Indeed staff frequently voiced their frustration that *all* older patients could not be accorded the same level of service and support, whether they were the non-RADS patients on the unit, or older patients across the hospital as a whole. This frustration was felt by both staff on the unit and more generally:

"The RADS... I think its great for older people and I think its an enhanced service that looks after quite a small group of older people, when you think that I've got three other wards that have all got 28 patients on, they don't get a look at the service. So its a good quality service for those patients that hit it (the admission criteria)". (C2)

"For a while there has always been... I don't like the word tension but not tension, but difficulties with therapy and I think obviously RADS is set up to be a very high input, high output service and I think one of the things that frustrates us on the ward but that also frustrates other physicians is why does that group of patients get all of that when the patient sat in the next bed doesn't. In the ideal world they would all get what RADS get, not get the minimum and I think RADS sets the higher standard". (C2)

Many thought that the RADS level of service should be introduced to all older patients who, whilst not necessarily being discharged within seven days, would definitely be able to go home earlier than they currently did:

"It is quite frustrating. Some of them make progress with physio and OT and they just need longer. But it is quite frustrating because you know if a patient had come to you into a RADS bed you'd have got them home. And it's often because you've got to wait for care and I do find that very frustrating. Partly because of the fact they can't go home, its rubbish for the patient and whilst they're here, they potentially fall, they get more confused and disorientated. And they lose some of their social support because they're not in the community". (C5)

"What again frustrates me sometimes when is we get a medical outlier into the rehab bed who is virtually identical to the patient in a RADS bed.... for every one person on here there's probably another fifteen people dotted around the hospital and I think in the ideal world all the geriatric wards would have dedicated therapists and therapists medical staff". (C2)

"Certainly RADS works. But there is an imbalance for what RADS gives for the 14 patients on the ward, to the rest of the elderly people around the hospital... And there shouldn't be a differential between RADS and non-RADS". (C5)

Things were seen to be particularly difficult for a patient who might be admitted under the RADS but who was not making sufficiently rapid progress and then had to be transferred to the non-RADS group:

"It it quite frustrating – when a patient comes in on RADS and then they switch over to rehab it is going to cause kind of a gridlock for that patient like they can't access services as fast as the RADS do because obviously the condition changes, their circumstances change at home, you know relatives will come in and say we no longer get them up in the mornings and things so then we are like right, okay, so they are going to need how many calls a day, two calls, three calls, they're going to need meals, so that takes a lot of setting up because obviously in the community they are quite, they must have a massive workload". (C4)

Interestingly the move to the new ward was seen to have had some benefit for the non-RADS patients because of how patients were distributed within the unit. Prior to the move the RADS and non-RADS had been treated quite separately both in terms of their access to therapy and also the part of the ward in which they were based. Now, however, the unit comprised of three *teams* of nurses, each of whom looked after a mixed group of RADS and non-RADS patients. This was seen to improve the *skills* of the nursing staff and to increase the *variety* of their work:

"And they're de-skilling the nursing staff. And there's no cross over. The ones who do the rehab won't go across to the acute; and the ones on the acute won't do the rehab; whereas here, we're doing everything. So we're keeping the skills that we've got". (C4)

Secondly, following the move those RADS patients who were transferred to a non-RADS category often continued to receive high level medical input, especially if the reason for their transfer off the RADS was due to an exacerbation of their medical condition. In the terminology of the unit such people got to '*stay on the RADS trolley*':

"And it's one thing that we noted, that a lot of the reasons people come off RADS is because they sometimes are medically unwell. Now we make a point on the RADS ward round that if someone is unwell on the rehab side we will pick them up on the consultant. Because we sat here and discussed that it's ironic that if someone comes off of RADS because they are unwell medically, they then go from a daily ward round to a week ward round. If they come off for rehabilitation because of social work reasons that's somewhat different. You could still argue it's ironic because they probably get less social work and physio. So, as a result of that we do pick up, so if we take someone off, we may have picked it up, its not been so bad this week, we keep them on the RADS trolley so from a medical point of view, they will still get the regular medical input". (C2)

Notwithstanding the continued high level medical input, patients transferring from RADS to non-RADS immediately get less therapy and social worker input and lost their priority access to community support services. This could sometimes result in further unintended consequences; a student nurse below explains what happened to an older patient who did not get her 'frame' (walking aid) over the weekend due to a mix-up in her perceived status:

"I didn't realise that (there was a difference between RADS and non-RADS patients) until the other day when a lady last week, one of the ladies who came in, her daughter had a frame in the car and she asked if she could bring the frame in and the staff nurse that was on at the time said we will leave it until the physio, the physio will probably see her tomorrow but the staff nurse had made a mistake thinking she was a RADS patient but she was actually a rehab patient so she went all weekend without her frame and when I asked about it on Monday I came in and I said she has still not get her frame and they said it is because she's rehab". (C4)

Interestingly in the last round of interview data it was noted that over recent times the pressure on the RADS was increasing and they were getting marginally more complex patients as the 'lighter' ones were being picked up by other units before they could get to the RADS. Consequently the length of stay for the RADS patients was gradually increasing;

"I've been in post for about 2½ years and even those last 2½ years we've noticed it and its something that we've again discussed about how to manage it and how to sort of manage the expectations and the pressures. There are certain sort of pressures on targets with regards to social work, but then again I think everyone, there is a push to get people out quickly but its also getting the person out at the appropriate time and I am not going to send someone out at day 7 if its not safe and they need to go out at day 8 or day 9 and to be honest we do take that into account. Although we use the day 6 and 7, I think our average length of stay on RADS recently has been about 8 or 9 days so it does push things up. And I guess like you say, the really good people – I don't like that – the less complex people who can be turned around quickly, are beginning to be turned around before they get to us". (C5)

The implications of this will be considered later in the discussion.

The extensive qualitative data drawn on above paint a picture of a RADS team who are highly motivated and for whom all the senses appear to have been met. Although we did not collect qualitative data from patients the same is likely to be true for them. The impression of an enriched environment for staff was reinforced by the quantitative data from the staff survey with the RADS unit scoring higher on all the staff measures than other units in the Trust and the Trust as a whole. Whilst these differences did not always reach significance the RADS unit had a significantly higher score on job satisfaction and were significantly more motivated and enthused by their work. Moreover there was a large, but not quite significant difference in the perceived quality of the MDT on RADS. The RADS team were also far more likely to feel that they had adequate resources for the work they had to do. Given their access to resources this is hardly surprising.

Having discussed the functioning of the RADS unit, and the impact of the recent move in some detail, attention is now briefly turned to the prime reason for the new build, the desire to create a better quality physical environment.

8.5 More space, but less contact?

As was discussed in the narrative synthesis, the issue of dignity in care for older people now has a very high profile in debates about the quality of health and social care. Whilst dignity is a complex concept it is often closely equated with privacy and this has resulted in considerable attention being turned to the quality and nature of the physical environment of care. Nightingale and mixed sex wards have fallen out of favour and the trend is towards single en-suite rooms or large, spacious, single sex bays. The new unit to which the RADS team moved was designed with such considerations in mind. As noted earlier, it was large, spacious and light. Many of the staff were surprised at how poor their previous ward looked in comparison, even though they were quite happy with it at the time. The far *smarter* new ward was seen to send out a more positive message that the people cared for there were seen as important and therefore 'mattered'.

"The better facilities; yes. The better facilities I think that is why I think I care for people is better. And because they're nicer environments, it's a cleaner environment. It's not like an old ward, because there's no doubt about it, the ward was shabby and dirty, and chunks off the wall. If you are put in that situation, it's not going to make you feel good because this place is old, and I am old. Now lots of people have commented 'Isn't this gorgeous.' It's bright and new. And you can tell that they feel privileged to be here, that they're worth this new building; caring for them; that they are worth it. Yes". (C3)

Indeed the high quality of the new space was greatly admired but it was not without a number of drawbacks, for both staff and patients. For staff more space meant far greater distances and a lot more walking. However the perceived difficulties for patients were seen as being a much greater concern. These related to feelings of loneliness, a greater risk of falls and a potential to increase confusion. Furthermore, the design of the ward, for example, the fact that the bathroom doors swung outwards rather than inwards made them very difficult for a frail older patient to open. The quotes below give an indication of the wide range of comments that the move to the new ward provoked:

"It's nice and airy and open, plenty of space. When we first moved, I moved from [xxxxx] and I saw this as relatively new and modern. But I've since gone back, to transfer patients and I thought 'oh how did we work in this cramped environment?' So it's nice to have the space. However I don't think that when they designed the building they were really thinking about looking after elderly patients. Elderly patients don't like to be isolated in their own room. People our age like to have their own rooms and I think when they surveyed everybody they probably asked my generation or my parents' generation rather than my grandparents' generation. So I think some of - patients can be at risk of falls, they're more at risk of falling if they're in their own room because you can't see them". (C4)

"Up here is lovely and we've got the space and you can do a lot more with them. But some of the elderly, it's not their traditional idea of a hospital and you put

them in some of these whacking great big cubicles with en suite and actually I don't think that helps with their orientation. Because you say they're in hospital and those that are a bit more confused actually it doesn't look like a hospital, it doesn't look like what they think a hospital looks like. There's not rows of beds, there are all these posh electric beds, they've got an en suite room, they've got lots of space". (C5)

"There's less interaction between the patients now we've moved wards. And it's one of those things, from our point of view it's nice to have the space, you can be treating someone behind a curtain and the bay's being cleaned but you're not getting nudged in the back all the time. The mop's not appearing underneath the curtain. So from that point of view, it's great. But it just seems much more isolating for the patients, especially those in the single rooms. Whether that motivates them to get going, get out quicker I don't know. But even in the bays, because they're so far apart, for anyone with visual problems who can't see that distance, it seems to be much quieter. And now they don't have the televisions in the bays any more, you haven't got that". (C5)

In addition to potential isolation for patients some staff considered that the division of the units into three teams also made it difficult to maintain a feeling of collegiality across the unit as a whole;

"I liked it because I think it were a better environment for the patients, for the privacy and the dignity and everything about it. There were a lot more privacy for them, but like I said, a few of the patients didn't like that, they felt a bit isolated. Even on the wards, I mean there were only 4 or 3 beds but that aspect I like because I think well, it's a lovely building. Everybody, visitors used to come out 'oh isn't it lovely'. But they don't have to work on here. Just because of the layout and everything. I liked it for that, but as far as getting back into a team, I don't think it's very good at all. But then I've spoken to everybody else who works on the other [units in the new facility], they've all said the same. They don't feel part of a team". (C4)

Because of the restrictions on interviewing older people placed on the project by the research ethics committee we were not able to gain their views on the new facilities and as the move was fairly recent it was too soon to tell whether the above issues were just teething problems that would iron out as people settled in. However, it seems that enhancing the quality of the physical environment is not necessarily a panacea and that it may have unintended consequences on the social and interpersonal dynamics for patients and staff. This is again something we will return to in the discussion.

8.6 Conclusions

The RADS is in many ways a paradox. It was born out of pace with the main aim of enhancing *patient flow*. It is very well staffed and resourced and is clearly highly successful in meeting its primary goal; it *does as what it says on the tin* and provides a rapid assessment and discharge service for the select few. And whilst by definition it eschews complexity staff genuinely provide holistic care to their patients, who get an enviable service when compared to virtually everyone else. It might reasonably be likened to specialist palliative care which has been described

as providing *five star dying for the few*. The staff of RADS are highly motivated by their work and clearly experience an enriched environment, yet they can see the inequity that is in-built in the service and believe that its facilities should be extended to all older patients who might benefit.

Herein lies the rub, for the type of patient who might benefit, even if the target for success was increased to say 14 days instead of seven is still not the older and frailer patient of the future, whose needs are likely to be ever more complex. Any system predicated on increasing pace, no matter how well resourced or how holistic the care, will never address the complex needs of a large and growing section of the older population. More invidious still is the impact that the success of initiatives such as the RADS has on the perceived status and prestige of work in the field of rehabilitation. The language used to describe *the rehabs* when compared with that used to characterise RADS patients could hardly be more of a contrast:

- *heavy as opposed to light*
- *really, really hard work as opposed to brighten us up, make us feel more acute*
- *de-skilling as opposed to using real skills*
- *bogged down by chronic problems as opposed to more job satisfaction*

However the sense of relative futility that rehabilitation evoked for many was tellingly captured in the phrase *Just like Groundhog day*. The ultimate irony of course is that rehabilitation was one of the founding principles of Geriatric Medicine and now seems to have become, for some, almost an embarrassment. This is an issue to which we will return in the discussion. We now move on to the final case study where, in a further twist, rehabilitation was seen as a means of raising the status of work with older people.

Section 9: An enriched Trust, an impoverished ward and the importance of leadership, a case study

9.1 Introduction

This case study was originally suggested to us by a member of the opinion leaders' group and at or about the time that data collection started it was implementing two change initiatives, one was the introduction of the *Productive Ward* (see later) and the second was a reconfiguration of its services for older people. This latter initiative was intended to move from a situation where the main wards for older people provided a long-term service to one with a more rehabilitative focus. Both of these initiatives afforded an opportunity to study the implementation of change from its initial stages and to explore any early impact. That is the purpose of this case study. It begins with a description of the Trust as a whole before moving on to consider the above two developments.

9.2 The Trust

Built around 35 years ago to provide a full range of district general hospital services for a population of originally 170,000 people, today the Trust serves 400,000 people and is the biggest employer in the locality with an annual turnover of £190million.

In 2005 it became a foundation Trust enabling greater investment in patient services, expanded critical care facilities and extended consultant cover in front-line services. Foundation Trust status has also enabled formalisation of its strong links with the local community through its foundation Trust membership of 10,000 patients, potential patients, stakeholders and staff. Membership is aimed at increasing social ownership of services and offers members of the public, patients or their carers the opportunity to become more involved in the way in which the Trust is run. The Trust is committed to involving members more and more in its future.

This is a high performing Trust which has, for example, consistently been rated amongst the top 40 hospitals for safety by CHKS (Caspé Healthcare Knowledge Systems - data driven performance awards), underlining its consistent quality of service.

The Trust also scores highly in terms of patient satisfaction. The most recent (2009) national inpatient survey (published by the Care Quality Commission (CQC) for all 165 hospital Trusts and specialist providers in England) places the Trust top regionally on key indicators such as: The overall care received; being treated with respect and dignity; having confidence in doctors and nurses; and cleanliness.

Patients also rated their hospital highly for privacy during examination and treatment in A&E and for the way staff explained procedures and answered their questions.

9.3 Shaping culture: The people and the processes

As for the other case studies, quantitative data were collected on a Trust wide basis, providing information for the overall climate analyses. For the more in-depth case study work we initially identified five wards as being potentially of interest to the study. These were a general medical ward, the stroke unit, an orthopaedic ward and two wards previously dedicated to elderly medicine which had recently undergone development into a rehabilitation and assessment unit for older people. At the first visit qualitative work was conducted on all five wards. However, as indicated above, over the course of the case study and as the research developed, specific initiatives on two wards were identified as being of particular interest and relevance, hence research efforts were focused here.

9.3.1 Productive Ward

The first initiative, 'Productive Ward: Releasing time to care' is a programme developed by the NHS Institute for Innovation and Improvement in response to concerns about the amount of time that nurses were spending with patients and the impact this has on patient care and staff satisfaction. Based on the principles of *lean production*, the initiative takes practices that were developed in manufacturing to improve efficiency and adapts them for use in a healthcare environment. The aim of the Productive Ward initiative is to enable staff to release time to care through efficiencies in ward processes (for a full description of Productive Ward see Appendix 6).

The Productive Ward initiative was of particular interest to the current study for a number of reasons:

- the overall aim of the initiative, to increase time for direct patient care, is of particular relevance to the Pace-Complexity tensions identified earlier in the report (*Section 2.3*) common in relation to older care
- the specific approach of productive ward – initiating change 'from the ground up' – is a potential mechanism for increasing staff engagement, theoretically increasing the extent to which staff experience the six senses (*Section 2.2*) necessary for creating an enriched care environment (namely security, belonging, continuity, purpose, significance and achievement)
- placing emphasis on direct patient care, increasing engagement and experience of the six senses can be seen in the context of changing culture – values and norms, and we were keen to see the extent to which this approach could or would impact on the extant ward norms and values and ultimately patient and carer perceptions of care

The Productive Ward initiative was being considered as a Trust wide venture and was initially piloted on three wards:

- an orthopaedic ward – a 47 bed ward incorporating an admissions unit. Eighty per cent of the patients on this ward were older people (i.e. over 65), many of whom lived alone, and were admitted suffering from fractures. These people were frequently perceived to 'get stuck' in hospital because appropriate support in the community was often unavailable. The challenges on this ward were felt to epitomise some of the Pace-Complexity tensions relevant to many Trusts
- two wards, previously elderly medicine which had recently been transformed in to the Older Peoples Rehabilitation and Assessment unit (OPRA).

9.3.2 Older peoples' rehabilitation and assessment (OPRA)

The OPRA unit also provided the focus for the second initiative of interest to this study. At the time of our first visit to the Trust a new ward manager had been in post for three months and the ward was undergoing considerable change from what was described as '*old fashioned elderly care*' to a '*more modern rehabilitation*' unit. This reorientation of the units' primary function involved considerable changes to ways of working and was supported by a change in style of management. The timing of this organisational change provided an excellent opportunity to study how service development was initiated and its potential impact on culture.

9.3.3 Data collection

Qualitative interviews were conducted with senior Trust personnel, staff on case study wards and staff working on cross-Trust roles including:

- Consultants
- Deputy Director of Nursing
- Director of Nursing
- Discharge Facilitator
- Discharge Liaison
- Head of Nursing for Medicine
- Head of Nursing for Surgery
- Health Care Assistants
- Older People Nurse Specialist
- Physiotherapists
- Practice Development Manager
- Productive Ward Facilitator
- Psychiatric Liaison Nurse
- Staff Nurses
- Support to Head of Nursing

- Ward Managers
- Ward Sisters

Interviews were conducted at three time points over an 18 month period. Key figures were interviewed at multiple time points.

This case study first describes the overall Trust culture, then focuses on the two initiatives, Productive Ward and OPRA. Finally data from patients and carers are used descriptively to reflect on the impact of the changes that had taken place.

9.4 Staff perspectives on The Place: Trust level

The Trust had an extremely stable work force; turnover was low and the majority of staff very long serving. This in turn contributed to a strong culture – ‘*the [Trust] way*’ - shared expectations about the way things are done and clear recognition of the relational nature of culture as the following quotes illustrate. The first two are from members of the senior management team, the third from a ward manager:

“...really [culture is] about values and standards, attitudes, anything to do with what makes up the ethos of the organisation and that can be based not just on professional values, but on local values. Probably a lot is to do with the leadership at the top of the organisation and how people feel, value themselves...it comes out in terms of the service that they deliver”.(D1).

“If you say ‘good customer care’ culture, it’s that view that everybody looks after everybody and treats somebody as they would like to be treated themselves”(D1).

“If staff aren’t happy, then they are not going to care about the patients and the patients relatives are going to pick up on that”.(D2).

The Trust prides itself on being an organisation with a *can do* culture. This is reflected repeatedly throughout the data:

“It’s the way we do it more than what we do...there is the idea that [the Trust] is a ‘can do’ Trust...I think a lot of people would say that they believe it”(D2).

The culture is very much driven from the top of the organisation. However, the importance placed on good working relationships, a *can do* approach and supportive environment was evidenced though repeated comments about friendliness, co-operation and support from staff at all levels in the Trust indicating that these values are shared throughout the organisation:

“I feel quite strongly that we should offer a supportive environment rather than disciplining nurses for errors” (D2)

“The support that is available from the board members and at director level is extremely good” (D3).

“It is much easier to gain access to senior members in the Trust for support or advice or whatever” (D3).

“Our ward manager is brilliant, she just supports everyone...And she walks on the ward, she’s not a manager who sits in the office, she comes out and talks to us and comes out and works with us, she is very good” (D4).

"[our manager] appreciates good [ideas] and she doesn't tell you off when you do something wrong. I think that has motivated our junior staff and that has motivated everyone else as well." (D3).

"Right from the director of nursing down, I think we have a very supportive environment" (D2).

These aspects of communications within the Trust are in turn valued and fostered, with recognition of the importance of hearing from those delivering frontline care:

"When you start talking to your junior staff, it opens the gate doesn't it? And then they can talk freely. I think it is nice to hear the voices of whoever is always with the patients". (D3).

"I would like to think that the ward staff think [the Trust] is a friendly place to work". (D3)

The Trust prides itself on doing things well *'basically if we decide to take something on we do it to the best of our ability'*. This combined with a relatively stable workforce and shared values, means that there is a strong ethos about the Trust way of doing things. However, there is also recognition of the challenges of a static workforce and the need for new ideas:

"...I am aware of many things embedded in our culture to do with privacy and dignity that I have been trying to change...and it's the way things are, the way things are always done and sometimes it is difficult to change the culture". (D2).

"Just because it's our way doesn't mean it's the right way – tell us your way, bring in the research and we'll change our way"(D2).

"I always think it is important to have new ideas from other places. It's good when people come in from outside". (D1).

In addition to annual NHS surveys, the Trust conducts its own surveys of 200 patients every month. This helps the Trust to react quickly in the areas that matter most to patients – such as dignity, cleanliness, communication, and having confidence in hospital staff.

The Trust has put in place a number of specific initiatives in relation to the care of older people. Some are in part in direct response to the NSF for older people. These include facilities such as a stroke unit, cross Trust action groups with specific remits e.g. a falls assessment group, and policy review and development including a new privacy and dignity policy.

These activities are further supported through a number of key appointments with one of the senior nursing staff taking on the role of privacy and dignity champion, charged with supporting implementation of the new policy, a dedicated older people nurse specialist, a specialist older person's psychiatric liaison nurse and a small team dedicated to discharge facilitation.

Other practical and innovative changes have included introducing a red tray system (not just for older patients), now extended to a red cup system. The system is designed to indicate which patients need assistance with feeding. It helps with monitoring of food and liquid intake and avoids a situation where food trays are removed from patients before they have had the opportunity to eat. Currently one

idea being tested is the use of fluorescent denture pots. Existing white/cream pots are hard to see against pale tables and walls. Loss of dentures is a continuing problem, as is damage or hygiene risk to the patient through incorrect storage. Fluorescent pots are being tested to see if they encourage safe storage, minimise loss of/damage to dentures and improve hygiene.

The last few years have seen a strong investment in training and staff development within the Trust and a drive to increase senior managers' clinical presence, including getting ward managers on to the wards working clinical shifts. The commitment to and quality of training available within the Trust was reflected in many interviews:

"The training here is absolutely phenomenal..."(D3).

"I was a healthcare assistant here and [the Trust] sponsored me through my [nurse] training"(D4).

"everyone is so supportive, study days are available, it's just fantastic, that's all I can say, I can't praise it enough"(D3).

Training in support of specific initiatives has been provided and special seminars set up to cover policies such as the implementation of the Essence of Care (DH 2001b) (including issues around privacy & dignity) and Dementia Awareness. At the time of the first visit the Trust was in the process of setting up an in-house course provided by a dementia consultant with the aim of raising awareness of staff caring for patients with dementia. In response to a complaint from a relative of a patient with dementia the Trust has also undertaken a training needs analysis, conducted with all staff, checking *grade, date of qualification and date of last training in areas such as Alzheimers, learning disability, learning difficulty, adult issues, mental health, mental capacity act etc.*

Training is a significant resource commitment, and emphasises the importance the Trust places on skills training and high quality practice.

"I don't think practice development is a cheap resource. The hospital does recognise that actually you get out what you put in and there is an awful lot of investment" (D2).

"Because there are so many changes [in nursing practice] it's nice for the staff because they say to us 'I need more of this' and we set up learning lunches for staff". (D5).

9.4.1 Reflections on culture: Trust level

The concept of an enriched environment was introduced earlier in this report (*Section 2.2*). Whether or not an enriched environment exists within a Trust or Ward can be assessed in terms of whether key stakeholders experienced six senses: Security; belonging; continuity; purpose; achievement and significance. On the basis of the interview data above the culture at this Trust could appropriately be described as enriched when judged by these criteria.

The strong no-blame culture described both by senior management and junior staff and the emphasis on learning at the Trust helps to engender a sense of security for staff. The friendly and supportive working atmosphere and the importance placed

on relationships coupled with very low staff turnover contribute to a sense both of belonging and continuity. This is further exemplified through several references in interview to *'the [Trust] family'*.

A strong sense of purpose was apparent both from the ethos of *the [Trust] way – if we take something on or decide to do something we always do it to the best of our ability* and clear, consistent messages and actions throughout the Trust in support of specific objectives or initiatives. It was clear from interviews that if an activity or initiative was taken on appropriate communication, resources and support would also be in place to support it.

A sense of significance was fostered through the Trust's perceived responsiveness to staff requests/needs/ideas. This was evidenced through comments from staff at all levels. One aim of the Productive Ward initiative was to enhance engagement and significance amongst junior staff, a way of devolving responsibility to staff for improving their environment and the way they work.

A strong message from the interview data was the importance placed on what can be described as relational practice. Interviews displayed an implicit understanding of the need for staff to feel valued/fulfilled and to pass that on to patients.

Factors were identified from the literature synthesis as being prerequisites to creating a supportive culture (*Section 4*), data from the interviews in relation to both the senses and the criteria for generating a supportive culture would indicate that this Trust could rightly be considered as creating an enriched environment for staff and patients. Despite this however, tensions and challenges in providing high quality acute care for frail older people were apparent. These tensions arose from a number of different factors, some of which are discussed in relation to each of the specific initiatives examined here. One consistent theme however was recognition of the complexity and increasing frailty of a lot of the older patient population within the Trust:

"I think dependence levels over the last five years [amongst older patients] have increased" (D3).

"[We are dealing with] the more acutely ill" (D2).

9.5 Staff perspectives on processes: 'The Productive Ward'

The second case study visit was timed just after the Productive ward initiative had just been launched in two areas of the Trust. The following data are drawn from both OPRA and the orthopaedics ward.

By the time of the visit initial assessments had been made and work was starting on the first modules of Productive Ward which focus on e.g. *the well organised ward*. Junior members of staff were encouraged to lead on different strands of the work, supported by a senior colleague acting as *Productive Ward* facilitator across the Trust. Comments from ward managers and senior staff fully recognised the need to achieve support and buy in from across the grades.

"There's lots of good ideas, but you've got to push it from the bottom otherwise it doesn't sustain...the time to do this work is given to the band 6s...[the Productive Ward facilitator] has taken two care assistants out one day this week...and they're going to literally just walk the corridor with a fresh pair of eyes. What can we change, where can we keep things? But you've got to give them the time to do it, but if it comes from the bottom we'll sustain it better than if it's just me saying 'this is the way [were going to do it]'...(D3).

"...and the good thing about it is really developing the staff. It's developing the band 6s and empowering them to make changes within their own working environment. Service improvement change - empowering them to do it, and giving them the tools and techniques and knowledge to be able to do that." (D3).

The initiative is supported from the top and the Trust has made a significant investment in ensuring that the junior staff members working on each strand of productive ward have direct access to the help they need to achieve their objectives as demonstrated by this quote from a Sister working in a cross Trust role:

"Since January I have a new role now as surgical project nurse, leading on two projects at the moment. One is the implementation of the productive ward programme and the other one is to develop a high performing pre operative assessment service within the organisation as well. So I've split my time between the two." (D5).

"She's [One of the nursing senior management team] really supportive, really keen...I've been waiting four weeks now for that radiator to be moved, I told her about it last week and it will be moved this week – she'll make the right phone call. Because that is what she has said to me, anything like that, 'you come and see me if it is for productive ward'". (D3).

By the time of the final visit Productive Ward had been in place for over a year and the case study wards had moved from initial modules (such as the well organised ward) to other areas such as handover.

Overall the initiative has been well received and the messages from the pilot wards were very positive in terms of the impact of productive ward on a range of outcomes:

"It has had an impact, yes definitely. It is definitely a much better ward, much tidier so it has been much to the benefit of the staff". (D3).

"I do think my time is used more efficiently and I think that the ward works a lot better." (D4).

In particular the initiative has been successful in giving staff a greater sense of significance and developing the sense of security, particularly amongst junior staff, to feel they can question the way things are done and suggest improvements.

"I've been at [the Trust] for six years and this is the only time that I have not felt incidental." (D4).

"It's been an absolute success productive ward, ...to discover the talents, people that we didn't realise had talents and who have helped". (D2).

However, it was also recognised that this success was the result of a lot of hard work from staff *a lot of extra hours from the nurses*.

9.5.1 Reflections on culture: The 'Productive Ward'

The *Productive Ward* initiative had been in place on two pilot wards for over a year by the time the case study ended and such was its success, it had been rolled out to other wards within the Trust.

Examples of the success of productive ward were many and varied from tidier environments, improved storage and better processes and practices. However, by the time of the third visit some of the initial benefits had been lost:

"We have had some hiccups in our well-organised ward...we lost our hoist cupboard...we lost another storage cupboard, so that means [staff] have to walk all the way to the top end of the ward to collect stores and supplies...part of productive ward was about releasing time to care, so it's a shame, but they wanted to create more beds. We will re-visit well-organised ward when the building work has finished...we'll just have to get really clever with our storage again." (D3).

As the quote indicates, there was recognition that productive ward was an ongoing process rather than a one off activity and suggests that it has the flexibility to fit around other priorities and demands on the ward. However, the quote also illustrates the tension between efforts to create a better environment through engaging staff, enhancing their experience and pace of work through increased bed numbers. There was recognition that sustaining change is the hard part, although here again, the *bottom up* ethos of productive ward was seen to be critical:

"That's the hard part isn't it, sustaining things...But because the changes you make are generated by staff and not by the management, because the ideas come right from the very bottom and you walk up through the process with them...because staff have to do the work, they sustain it. Because it's what they want, it makes their job better". (D3).

A key aim of productive ward was to release time for direct patient care and there was some debate as to how well it had succeeded in this outcome as the following quote illustrates:

"It depends on what you call direct patient care – it [time released through productive ward] is spent on patients, now whether that is because I or other members of staff spend a lot of time creating beds, trying to get people up from A&E, it's still being done for the patient, it's still patient care, but it's not sitting down and having a chat with you as a patient, or brushing your hair...you know, real physical time spent with the patient". (D3).

"When I think about direct patient care I think about time spent by the bedside and that time I don't feel I've got any more of". (D3).

"I'm not sure [if it has released time to care], it's helped give a nicer working environment, but I'm not sure that the [additional] time to care has not been taken up by [other tasks]. There's always something else isn't there to take the nurse away from the side of the bed". (D4).

Overall then it seems unclear at present whether the objective of increasing time spent on direct patient care had been fully successful. The quotes here suggest that whilst more time has been made, it has been taken up with more pace driven work rather than providing time for more complex or relational care to take place. The other demands placed on nurses and care assistants displace direct care and raise the question of how competing priorities should be managed and whether staff feel that additional direct patient care is a legitimate use of their time.

This suggests is that while the productive ward may have been successful in changing some of the processes of care and thereby freeing up time this is no guarantee that such time will be used to enhance direct patient care. This is something to which we will return shortly after we consider the changes to services for older people.

9.6 Staff perspectives on processes: Developing care for older people (OPRA)

As discussed at 9.3.2, at the time of this study the Trust had started the process of reorganising and restructuring care for older people. The Elderly Medicine department had been transformed into the Older Peoples' Rehabilitation and Assessment Unit (OPRA) and a new ward manager had been in place for three months. The change coincided with the increase in services in the community and intermediate care schemes. Longer term rehabilitation beds were available at local hospitals so there was felt to be less need for long term elderly care beds in the Trust.

Prior to the change, elderly medicine was managed by a head of nursing who was office rather than ward based. The absence of a senior, up to date clinical presence on the ward meant that Elderly Medicine was '*very, very old fashioned in lots of practice out there*'. Additionally the wards were very cluttered and poorly organised with for example no proper drug storage facilities '*drugs were scattered all over the place... no one could find anything*'.

With the increase in local care provision it was recognised that the Trust could get people through the system more quickly and back to their own homes. The change was described by staff as moving from *slower stream* to a more *dynamic environment* with a strong emphasis on rehabilitation.

As care of the elderly, the ward had arguably lacked a clear, shared vision:

"The place was a mess... it was a dumping ground for people, it wasn't working with rehab, people weren't moving through". (D3).

The change in name and focus has clarified the purpose of the unit and challenged some existing pre-conceptions within the Trust:

"A lot of people working in the Trust have always had the view that they would not want to work on a geriatric area because it is full of people who should be in a nursing home, so they tend to send us people who they think should be in a nursing home. Now that view changes, but it changes slowly". (D2).

At a Trust level the change has been supported through communicating the aims of the unit to staff and applying stricter criteria for referral to the unit:

"[We] referee who come in [to OPRA] a bit better...so we are getting patients who we think are appropriate for rehabilitation...We are giving [colleagues] explicit statements of what we are trying to do and by not taking those patients we don't think we can help, hoping to get the message across..." (D2).

These changes have also had implications for staff working on the wards. At the time of our first visit the unit consisted of several teams working across two wards. Teams were insular and there was evidence of poor working practices and low co-operation on the ward, with small teams working in isolation:

"...even just trying to say to someone, well your over your numbers on your early that day so you are moving team – well, they'd take annual leave rather than move two teams up the ward." (D3).

Practice was variable as the following two field observations illustrate:

Observation 1 takes place during a busy drugs round, the nurse discharging drugs hands medication to a patient and turns back to trolley:

Patient: *What's this?*

Nurse: [still working at trolley] *Your medication*

Patient: *What is it?*

Nurse: [continues working] *Your usual medication*

Patient: [sounding anxious] *What are the pills?*

Nurse: [sounding irritated] *There's no paracetamol in them*

Patient: [sounding uncertain] *I suppose I'll have to trust you then?*

Nurse moves on to next patient

In observation 2, a care assistant is supporting a patient walking down the ward. The patient sees another staff member (ward manager) and tries to approach, the care assistant appears to try and steer him away

Ward manager: [becomes aware of patient, breaks off conversation and turns towards him] *How can I help?*

Patient: [Distressed - *describes strange/unusual symptoms*] - It is unclear whether the patient is confused,

Ward Manager: *That sounds very painful, will you come with me?*

Patient: [still distressed] *Oh you're going to tell me to get back in to bed like the other one.*

Ward Manager: *No, I want you to come with me because I am the ward manager and we will report this to the sister in charge of your section and make sure it is followed up with the doctor*

Patient: [Relieved] *Oh, you'll get it followed up? Thank you very much...*

Ward manager accompanies patient back to his section and reports symptoms to the sister in charge. Subsequent observations of shift handovers showed that the monitoring of the patient's symptoms was picked up and was followed up the next day by the ward manager.

In the first observation it can be seen how the exchange could contribute to the patient's sense of (in)significance and (in)security. Conversely, the second observation illustrates both modelling of good practice by a senior practitioner and how a patient's sense of significance and security is enhanced.

At the ward level, the complexity of caring for older people, in particular the shift to a more rehabilitative approach, had implications for the way staff on the ward worked. The ward manager had the remit of improving ward practices and bringing them in line with the aims of the new OPRA unit. The types of change needed in terms of skills were recognised within the unit:

"it's quite different here [from work in other areas] in that it's much more closer multi-disciplinary working...OT, physio, pharmacist, dieticians... are required to discharge these patients, you know, the much more acutely unwell." (D3).

Change was achieved through a number of formal and informal approaches. On the formal side training has been a key factor, as has the introduction of a new computer based discharge planning procedure:

"Their [ward staff] care for the patients is second to none, they are fantastic carers. What they perhaps weren't so good at... was the rehab of patients...the pushing people that little bit more. Which is why we are putting together these rehab study days...it's to keep the rehab going when the therapists aren't here, like after five o'clock and the weekends... Just so [the care assistants] can see the bigger picture, they can feed that back into the team, not just take over and do it for the patient..." (D3).

"It's a software system that just keeps everyone focussed...it does [give much more structure] you know someone is accountable, it does seem to have worked." (D3).

However, the leadership role of the ward manager cannot be overemphasised and the way in which changes were introduced was as, if not more, important than the changes themselves.

Formal change occurred alongside the more informal work of the ward manager to develop cooperation and support across the unit. The ward manager has a highly visible presence on the unit, working three clinical shifts. And as the observations make clear she acts as a role model for staff in delivery of care. The rehabilitation vision for the ward is clearly communicated and formal procedures such as the training described above, support the message consistently given and modelled about how care should be delivered to support rehabilitation objectives.

Additionally the ward manager has encouraged staff to work together, facilitating the sharing of good practice between nursing teams and standardising procedures across the unit, nurturing responsibility in junior staff. This has in turn enhanced practices and reduced concerns about working across different teams. The formal structure of the Productive Ward initiative (which was also ongoing on the unit at

this time) has been used as an opportunity to encourage staff from different teams to work together in this way.

One of the significant achievements of the OPRA unit during the course of the case study was the shift to truly MDT working. Previously this area of the Trust had been characterised as having little movement of patients through the rehabilitation process to successful discharge. Work started to encourage clearer goal setting for patients and co-ordination of efforts across the team towards an expected discharge date (EDD). Observations at MDT meetings in the early stages of the case study revealed a lack of clarity about the discharge planning process and reluctance to commit to discharge dates. Work to encourage staff in this area, led by the ward manager and supported by the introduction of a new computerised discharge planning system have helped to bring about real change in this area of the unit's work. The structure of communications within the ward has been changed from the old handover meeting to a *more informal meeting* in the mornings where the computerised discharge system is updated. There is also a PC in the MDT room which is updated during the MDT meeting. This helps to give all staff a clear overview about progress with each patient and shared goals.

It can be seen how the work of the ward manager on this unit accords with the characteristics of a good leader identified by the user, carer and national opinion leader interviews (*Section 1.2.4*), specifically:

- highly visible on the unit, for staff, patients and carers
- had clear expectations and communicated these to staff
- made it clear who was in charge and what they expected them to do when she/he was off-duty
- created a feeling of teamwork on the unit
- mediated between potential interdisciplinary disputes

This has helped to create a far more supportive working environment as evidenced by data from the staff and patient surveys and clinical data from the Trust. A pilot survey conducted during the early stages of our case study, and soon after OPRA had been established, indicated that the perceptions of staff on OPRA differed from staff in the rest of the Trust on a number of important factors associated with providing good quality care (see *Section 5* for a full description of the scales used). Staff working in OPRA were significantly less likely to report that they experienced the following in their work:

- *sharing a philosophy of care*
- *supporting each other*
- *feeling safe*
- *improving practice*
- *developing skills*
- *feeling motivated*

Additionally, they were also less likely to report that they had the resources required to do the job, had a say in how work was done or were supported from the Trust.

By the time of the full survey, all differences between staff working in OPRA and other staff in the Trust had disappeared, with survey results indicating that OPRA staff perceptions of the work environment had, with one exception, risen to match those of staff on the other wards surveyed.

The one area where staff perceptions on OPRA continue to differ from staff in the rest of the Trust is with regard to the demands made on the team resource (Too much to do) with staff on OPRA significantly more likely to report experiencing this in their work.

9.6.1 Reflections on culture: OPRA

There was clear recognition within OPRA of the implications for pace of work when delivering high quality care to an older population:

"To give these patients the real care they deserve... it all takes more time. Time is what these patients need, time. You have to be prepared to do the ten minute walk to the toilet. Yes it takes you two minutes to stick them on the commode. That's not helping their rehab". (D3).

The perceived level of demand in OPRA poses an interesting question about the extent to which the levels of resource required to provide rehabilitation are recognised and points to some of the Pace-Complexity tensions highlighted throughout this report.

In addition, changing nursing and care assistant behaviour on OPRA to align with rehabilitation objectives and encouraging shared objectives across the MDT, particularly with regard to expected discharge dates, has been an ongoing process. The role played by the ward manager in achieving these changes should not be underestimated. The leadership of the ward manager has helped clarify what is important on the unit and define objectives. Her approach has helped to instil confidence in staff, provide a sense of significance and achievement and imbue staff values about caring for and supporting each other. The case study serves as a clear demonstration of what can be achieved in terms of changing culture at the ward level.

There is a real sense of success in the way care for older people has developed over the 18 month period of the case study:

"It is changing the care of older people, we really are MDT led and we're talking much frailer people and still looking at [their own] home as the first option" (D4).

This is also having an impact in staff attitudes to working with older patients:

"...the people that are coming to work in here are not seeing it as the sort of thing they do at the end of their career...it used to be where nurses went when everything else got too busy for them. Now that's changing, that's really changing. You know the bank area are calling and telling me that [bank staff] are asking for elderly care first whereas it always used to be that they wanted the acute areas." (D3).

Similar preferences were also being expressed by new junior staff on placement, and reflected in the numbers of applicants to work on, or transfer to OPRA. The Ward Manager attributed this change to better understanding of the different skills needed in nursing older people and the strong emphasis on MDT working.

Notwithstanding this success, there were still challenges in the wider Trust in communicating the purpose and value of OPRA. These tensions highlight the points made earlier in relation to Pace and Complexity:

"I sometimes think we are seen as the quiet part of the hospital. Yes, I don't have 10 IVs, but 14 out of 15 patients need help with everything – so it's just different skills and the skill of stepping back and promoting that independence as opposed to just stepping in and doing it" (D3).

"There could be more recognition of the rehab side of things after major surgery for older patients...it's not just getting over a hernia operation or bowel surgery, it's everything attached to their pathology. I do think that's not always recognised and I think the chance isn't always given to rehabilitation really. And it can be a long slow process and everyone's got targets to meet and I do think... it's not always recognised that you need to give a bit more time and input on the rehab side of things" (D4).

"I do think that there is a preconceived idea that, because someone is over 80...they're not actually going to recover and get back home". (D2).

These quotes not only epitomise some of the Pace-Complexity tensions inherent within care for older people, but also demonstrate the relatively slow pace of change in attitudes and beliefs about older people even within a Trust where there is an enriched environment and the support of a proactive management team.

Another major tension was identified with discharge procedures. Many older patients were felt to be more acutely ill and have higher levels of dependency meaning discharge processes and getting appropriate support at home were more complex. This was compounded by the fact that the Trust straddles a number of social service areas each with different processes, priorities and levels of provision.

There were stark contrasts between the pace at which social service and Trust processes worked. For example, if someone with a care package is admitted to hospital, that care package is deployed to someone else in the community that needs it and there is generally a 48 hour wait to reinstate existing care packages, if increased levels of support are needed the case need to be made to a social services panel for increased funding. This contrasts sharply with a Trust process where a patient is referred with the aim that they can be discharged the next morning.

The complexities of discharge for older, more dependent patients and the need to get the package right were emphasised in this quote from a staff member answering a question about the most challenging aspects of discharge:

"...other people don't actually have a concept of what discharge entails and are always hassling to sort of speed everything up. But there is a process that has to be followed and...with the best will in the world you have got to do a thorough job otherwise it is just a pointless exercise ...and I think others don't always understand that". (D5).

It is evident from these quotes that even in an enriched, supportive environment challenges and tensions remain. Some are within the remit of the Trust, however others are arguably more difficult to surmount, involving as they do inter-organisational working.

9.7 The views of patients, relatives and staff: Findings from the survey

This section presents findings from the patients, relatives and staff survey in relation to this Trust. Details of the scales used and their development are provided in *Section 5*. The main quantitative analysis across all Trusts is presented in *Section 10* and provides details of the multivariate modelling that was undertaken. Here selective data from the patients and relatives questionnaires are used in a descriptive manner to provide an overview of stakeholders' perceptions on the nature and quality of the hospital experience for patients and relatives.

Overall the data indicate that patients and carers were very happy with the quality of care that they received, with over nine out of 10 patients describing their care as *very good* and over eight out of 10 family members describing their relative's care in similar terms.

Patients were also asked a series of questions about their access to therapy and treatment, and the extent to which staff treated them with dignity and respect. Seventy eight per cent of patients reported that they had regular access to therapy staff with 87 per cent of patients agreeing or strongly agreeing that they were always treated with dignity and respect.

With regard to the way relatives and carers were treated by ward staff, 88 per cent of patients agreed or strongly agreed that their visitors were always made to feel welcome and the same proportion felt that their family members were able to talk to staff about their relative's care when they wanted to. Whilst the vast majority of relatives/carers agreed that staff always made them feel welcome on the ward (over three quarters of respondents) fewer (54 per cent) felt that they knew who to speak to if they had any questions about their relative's care and treatment, with only 40 per cent saying that they could speak to a doctor about their relative if they wanted to. This suggests that, from a relatives/carers perspective there is some difficulty in gaining access to staff.

Additionally, whilst 90 per cent of patients felt that staff always seemed happy in their work, 56 per cent felt that staff did not always have enough time to give good patient care and 42 per cent felt that there was not enough to do to help patients pass the time. This strongly reflects some of the issues raised in interviews about the amount of time spent on direct patient care. Despite this, 72 per cent of patients felt that staff took the time to get to know them as an individual.

Relatives seemed similarly satisfied with 73 per cent reporting that staff seemed happy in their work and 67 per cent indicating that they felt the ward was a happy and welcoming place. A good proportion (70 per cent) felt that staff always listened to their views about their relatives care and 64 per cent agreed or strongly agreed

that their relative always received the standard of care they would like. However, In line with patient views, a far lower proportion of the relatives and carers taking part in the survey (54 per cent) felt that staff always had enough time to give good quality care with the same proportion reporting that staff took time to get to know the patient as an individual.

Whether this is due to real or perceived lack of staff presence on the ward or perceived workload of staff by both patients and relatives/carers is unclear, but it suggests scope for improvement in these areas.

9.8 Case study overview

The data from this case study are illustrative of many of the themes highlighted in the literature synthesis, including those of enriched environments, the tension between Pace and Complexity, particularly in relation to care for older people and the importance of leadership in developing services and sustaining change.

The Trust performs well on national measures of patient satisfaction and conducts its own monthly patient satisfaction surveys. The Trust has a strong *can do* approach and prides itself on doing things well. The environment is friendly and supportive, with a strong ethos about *the Trust way* of doing things which is to do things *to the best of our ability*. A high premium is placed on quality of care and there is considerable investment in training and development to support this end. This case study focuses on two specific initiatives within the Trust: The re-organisation of services for older people and the *Productive Ward*. Taking the latter first, Productive Ward was perceived by staff and management to have been an extremely worthwhile investment of time and resource in two pilot areas and by the end of the case study had been rolled out Trust wide. There were many examples of successes achieved through Productive Ward, increasing efficiencies in practice and creating a better environment for staff and patients. However, whilst time was freed up and spent on patient care there was debate about the extent to which it permitted staff to spend more time at the bedside or in developing relational care, reflecting some of the Pace-Complexity tensions identified earlier in the report. To some extent Productive Ward appeared to free up time for more pace driven work such as getting patients up from A&E faster or actioning discharge related tasks, raising the question of what was seen as *legitimate* activity in relation to care. In other words the primary focus of the change initiative was on the people, processes and routines of care in the place/people/process/perceptions model. Whilst Productive Ward succeeded in changing people in terms of eg engagement with their work, ownership and improvement of the way their work is managed, (the productive ward element) it seems far less attention was given to the need to change the way people think about direct care (perceptions) and the relationships they create (the 'releasing time to care' element of the programme). If more significant culture change is to occur, it is this latter part of the process that needs to be given further consideration. This is something to which we will return in the concluding section.

The other strand to this case study focused on the Older Peoples' Rehabilitation and Assessment Unit (OPRA) which during the course of the case study was

undergoing considerable change in the way that services for older people were organised and delivered.

Changes in intermediate care arrangements meant that the Trust no longer needed long stay beds for older people and the newly created unit has a strong emphasis on rehabilitation and multi-disciplinary team working.

The leadership style of the ward manager (with support from the senior management team) was found to be integral to the successful transformation of this unit. Responses on the staff survey taken soon after the arrival of the new ward manager and eighteen months later show positive improvements on many of the aspects of ward climate believed to be important in providing high quality care. It is an indication of what can be achieved at a ward level with regard to culture and ward environment.

There was clear recognition of the skills needed to provide high quality care to older people with complex health issues, although the tensions between Pace and Complexity were again apparent with the sense that OPRA was sometimes viewed as the *quieter* part of the Trust and could be for example, the first place to lose staff if shortages meant they were needed elsewhere. Once again this highlights the fact that whilst change initiatives can influence the perceptions people hold at the ward level (e.g. that care of older people is *quieter* or *less skilled*) if these perceptual changes do not extend to the wider Trust level then enduring change in underlying beliefs or values, that is, culture will remain elusive. Again we will return to this in the concluding section.

Patient and carer/relative data for the Trust as a whole paint a positive picture, with high levels of overall satisfaction reported. Perhaps the most noteworthy findings from the survey relate to the perceptions of carers/relatives and patients on access to staff. Just over half of carers/relative feel that they knew who to speak to if they had any questions about their relatives care. Both patients and carers/relatives expressed concern about whether staff always have time to give good patient care. Fewer than half the patients and just over half the carers/relatives felt that staff had enough time in this respect. The patient and relative/carer survey results then appear to confirm the qualitative messages from the case study about the extent to which the increasing demands of pace driven work act to the detriment of high quality care, although these findings need to be understood in the context of high levels of patient and carer satisfaction overall.

Section 10: Linking nursing team climate for care to care outcomes: A ward-level investigation

10.1 Introduction

A key aim of this study was to examine distinct climates for care across wards in the NHS Trusts taking part in the research and their impact on a range of care outcomes. Climate for care describes staff experiences of the practices, procedures and behaviours that support them in providing good care. In *Section 5* we made the case that care will be enhanced when staff experience a positive climate for care. That is, when staff experience a work environment that supports care giving and that fosters the senses for staff, then this will be reflected in the experiences of patients and carers.

This section describes how we have assessed and tested the relationship between the climate of care experienced and reported by nursing teams and the associated quality of care reported by patients, relatives/carers and matrons. We also examined the impact of climate for care on staff well being.

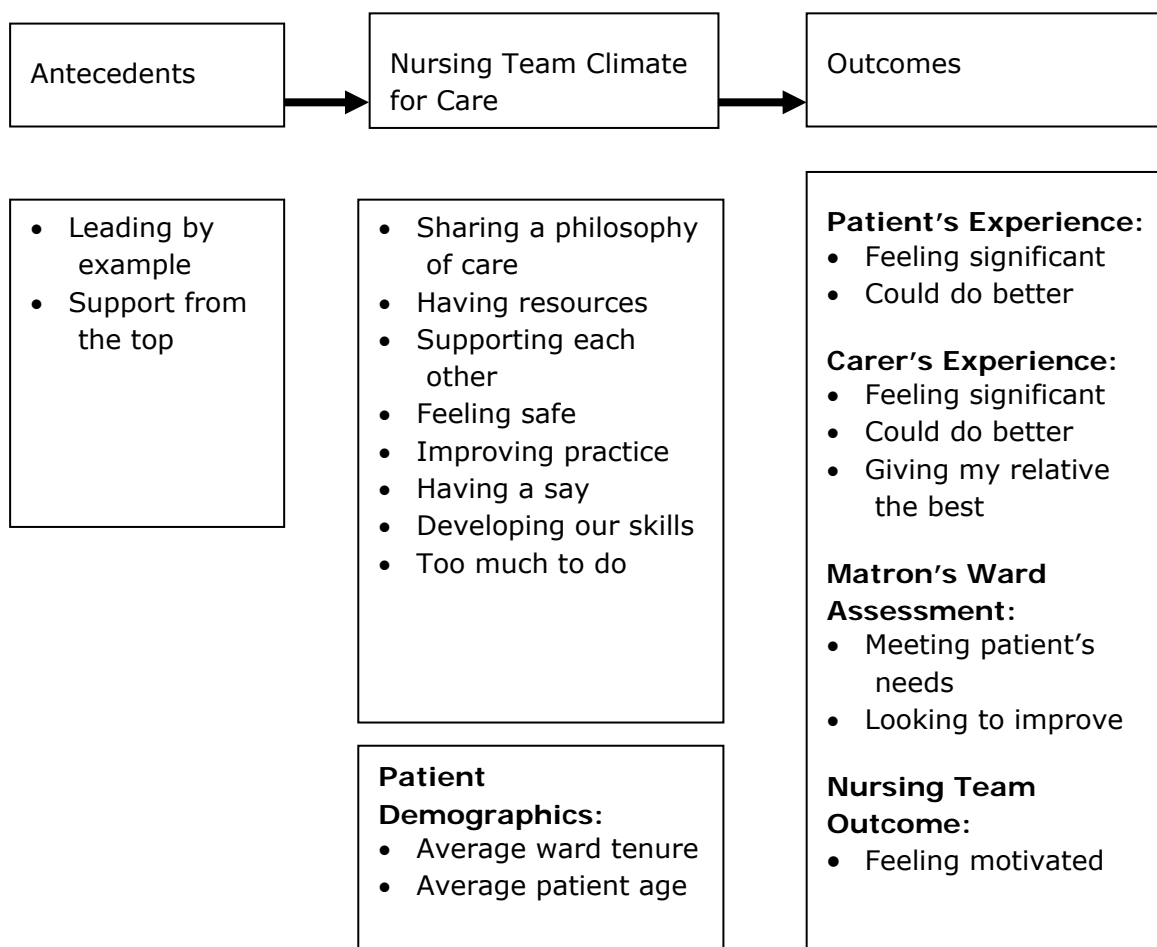
10.2 Climate for care and patient outcomes

The aim was to understand which aspects of nursing team experience are particularly important for positive patient and relative/carer experiences and positive outcomes for staff. The overall model we used to guide our research design and analyses in this section is presented in Figure 10.1 below (see *Section 5* for a fuller account of its development).

The model describes three broad categories that are important for understanding quality of care. On the left hand side are the antecedents or pre-requisites for creating a climate for care within nursing teams. In *Section 5* we established that these two factors had an important role in shaping the way the nursing team operates, determining the overall values, goals and capabilities of the team.

In the middle are the climate for care scales, i.e., the measures of how staff perceive those aspects of their work environment which are important for the care outcomes on the right, that is: Patient and carer experiences; matrons' ratings of wards; and nursing team well-being. Staff well-being is considered an important outcome alongside quality of care ratings for two reasons:

- from a relational perspective, staff well-being is an important indicator of an enriched care environment (see *Section 2.2*)
- when staff work in an environment in which positive care is actively promoted and the senses engendered, one would expect staff morale and well-being to be similarly enhanced

Figure 10.1: Model for climate for care and care outcomes

In these analyses we focus on the experience of nurses as they are the staff group who provide 24 hour support to older patients and their relatives or carers. The ward nursing leader is the person who primarily creates and sustains the philosophy of care (Davies *et al.*, 1999). In addition there is strong evidence that nursing teams develop distinct cultures and climates that impact on the quality of care experienced by patients and carers, both from previous research and reviews (e.g., Davies *et al.*, 1999; Larrabee, Ostrow, Withrow, Janney, Obbs, & Burant, 2004) and from the work in this study. The nursing team largely shape the 'practice milieu' (Ellis and Nolan, 2005) or 'clinical micro-climate' (Goodrich and Cornwell, 2008) through which shared climates will evolve through leadership, relatively intense interaction with patients and active social constructions and relational processes. As leadership and related factors will vary by ward, it makes sense to try and capture these variations in the analyses. The point is that shared patterns of understanding and norms of behaviour are more likely to develop at the level of the ward than at the level of the organisation.

A further rationale is that patients' experiences of care will largely be based on their interactions with staff, especially nursing staff, and consequently it makes greater theoretical sense to examine relationships at ward level.

The data presented in this section are drawn from patients, carers and staff across 65 wards. The development of the scales used and their reliability and validity are reported fully in *Section 5*. The research design required that the climate perceptions of nursing teams *and* the patients and carers be obtained.

Before describing the sample and analyses it is important to reiterate that as the study focuses on climate in nursing teams all staff data are aggregated to the ward-level and we use the mean score for each scale to represent team climate. Patient and carer data were collected concurrently from the same wards as the sample of nursing teams, and aggregated to the ward level providing a mean ward-level score for the patient and carer scales.

10.3 Sample description

Data were collected from 70 wards, although a number of wards had to be dropped from the analyses for varying reasons: From two wards, no staff responses were received; on another ward, no questionnaires were returned by carers; and two wards became infection control wards during the course of the data collection period: We were able to match data for nursing teams, patients and carers for 65 of the original 70 wards.

On average, 13 nurses per ward responded to the survey and the response rate for staff was 43 percent. We also achieved an average of 14 patient and carer responses per ward, however different distribution methods make it impossible to calculate a meaningful response rate. The majority of questionnaires from patients and carers were researcher administrated.

Returned questionnaires from matrons covered 51 of the 65 wards, therefore the sample size for any associations involving matrons assessment of ward care quality was 51.

10.4 Measures

All the measures shown in Figure 10.1 and used in the subsequent analyses are described in *Section 5* with the exception of two variables represented by personal characteristics of respondents, one patient-based and one staff-based. The first variable included was that of ward tenure which represented the average length of time members of the nursing team had worked on that ward. Having a stable team of core staff is important for the delivery of high quality, consistent care (Davies *et al.*, 1999,). *Average ward tenure* of staff was therefore included as a proxy indicator of team stability.

The second variable included was labelled *average patient age* - this represented the age of patients averaged for the ward. We included average patient age to examine whether it was related to quality of care outcomes reported by patients, carers and matrons. Considering the primary driver of the project, concern over poor quality care for older patients, we were interested in establishing whether there is a significant association between patient age and care outcomes.

10.5 Checking the data prior to analyses

In these analyses we are using mean scores from groups of nurses to represent nursing team climate. In order to ensure that the data are suitable to be used in this way they must undergo a number of checks and meet certain statistical criteria. For example it must be demonstrated that the mean scores for a group accurately reflect a consistent view within the group and accurately distinguish between different views across groups. These checks are important to establish that the data and subsequent analyses are robust and meaningful. These data were found to be suitable for aggregation. Details of the tests used are to be found in Appendix 7.

10.6 Results

This section reports the results of the modelling work undertaken on the data to test the relationships proposed in Figure 10.1. We first describe the initial relationship between the scales, followed by the modelling process, and then present four models predicting the outcome variables. An initial idea of the important variables and the relationships between the scales can be gleaned from their means and correlations (see Appendix 8 for the correlation table which also gives means and standard deviations for all aggregated study variables).

Looking at mean scores for the scales, the first point of note is that for both patients (*feeling significant (p)*) and carers/relatives (*feeling significant (c)*) scales mean scores are high, indicating that both groups tend to report positive experiences of care overall, although relatives were slightly less positive than patients in their ratings of care.

When looking at the nursing team data, *shared philosophy of care* was, on average the most positively rated scale, indicating that nursing teams generally agreed that they experienced a shared commitment to prioritising care.

10.7 Initial relationships between scales

10.7.1 Nursing team scales

Looking at the correlations between the scales helps us to understand which of the measured aspects of nursing teams' experiences of work (boxes 1 and 2 in Figure 10.1) are related to each other and to our outcomes measures of quality of care.

All the nursing team scales were moderately or strongly correlated with each. The highest correlation was between *philosophy of care* and *supporting each other*. In other words, nursing teams that report a high level of shared expectations about the way care is delivered are also highly likely to report experiencing (and giving) a high level of support amongst the team.

10.7.2 Patient, relative/carers and matron scales

Many of the correlations between the scales from these three groups of respondents were significant. This is reassuring as it indicates a consistent pattern

of response across patients, relatives/carers and matrons – there is a degree of consistency in the way all three are assessing care.

10.7.3 Relationships between nursing team scales and patient, relative/carer and matrons quality of care scales

The strongest relationships with high quality of care as rated by patients, relatives/carers and matrons were clustered around three climate for care (nursing team) measures – *shared philosophy of care*, *supporting each other*, and *having resources*. For example, the nursing team measure *supporting each other* was significantly and positively correlated with *giving my relative the best (c)*, *feeling significant (c)*, and the matrons' assessment of *looking to improve*. *Supporting each other* was also negatively correlated with *could do better (c)* which measures the extent to which carers feel their relative experienced negative care (i.e., higher levels of team support reported by nurses is associated with lower levels of negative care experiences reported by carers).

Interestingly, average ward tenure of the nursing team was positively correlated with *giving my relative the best (c)* and *feeling significant (c)*. So, the longer a nursing team has been in place, the more likely the relative/carer is to report that their relative receives good care and that they themselves are recognised by staff and involved in their relatives treatment.

One of the most interesting relationships to emerge when looking at the relationships between single scales is that between the average age of patients on a ward and patient and relative/carer ratings of care on that ward. The older the average age of patients on a ward, the more likely that patients and relatives/carers report negative experiences of care, higher average age correlating most strongly with *could do better (p)* and *could do better (c)*.

So the higher the average age on a ward, the more likely the ward is to be rated as providing poor care by patients and their relatives/carers.

Many associations of interest can be identified between individual measures, however the purpose of this analysis is to identify which aspects of climate for care as experienced by nursing teams are most important in determining positive ratings of quality of care by patients, relatives/carers and matrons. The next section describes the modelling work undertaken on the data.

10.8 Modelling the relationships

The next stage of the analysis was to examine the overall model linking climate for care to care outcomes shown in Figure 10.1. Path analysis was conducted using the Structural Equation Modelling (SEM) package MPLUS to explore the utility of this model in explaining relationships in the data. SEM is a statistical technique using data to test models. It is particularly helpful in interpreting data where, as is the case here, complex inter-relationships exist between several measures. It does not establish cause and effect between measures, but does confirm whether or not the data are consistent with a causal model.

10.8.1 Identifying measures for inclusion in the models

This type of modelling requires the researcher to propose theoretically based models of how measures relate to each other then uses the data to test whether the proposed model is plausible. This procedure highlights the difficulty of conducting analysis at the team and ward level. We immersed a considerable research effort into collecting questionnaire data from large samples of individual staff, patients, relatives/carers and matrons across the four Trusts. As described previously, this data from individuals was then aggregated to the ward level giving a final sample of 65 teams and wards (effectively an N of 65 for analysis purposes). Preliminary analysis of the data confirmed 18 distinct scales (see Figure 10.1). Although the overall sample is reasonably large for analysing data at the ward level, it is small for analytic purposes when using a number of scales with structural equation modelling. For this reason it was necessary to restrict the number of scales considered in the models.

Both the scales proposed as antecedents to a climate for care (*leading by example* and *Support from the top* – see Figure 10.1) were felt to be theoretically important and distinct concepts, and had prior empirical support, so both were retained for use in the modelling.

The Climate for Care scales (Figure 10.1, central box) were strongly inter-correlated, meaning it is unlikely that they all have unique effects on the quality of care outcome measures. Sometimes a climate for care scale can display an overall relationship with an outcome (i.e., a significant correlation) but this relationship is shared with more important climate for care scales.

Preliminary analyses had already shown that two of the nursing team measures - *shared philosophy of care* and *supporting each other*- were the most strongly associated with quality of care outcomes, accounting for associations between the other climate dimensions and the patient, carer and matron data.

In addition, the relationship between *shared philosophy of care* and *supporting each other* was so strong as to justify treating them as a composite construct. They overlap highly and we therefore combined the scales to create a single measure. This is appropriate not only empirically but also, we believe conceptually. We discuss this further in the conclusion to this section.

Based on preliminary findings the other measures included in the modelling were nursing teams' ratings of workload - *too much to do*, and the demographic measures: *Average ward tenure* of the nursing team; and *average ward age* of patients.

10.9 The modelling process

We produced four models covering four groups of outcomes – patient experience of care, the carer experience of care, the matron's assessment of care, and finally a model for nursing team well-being. In each model, *leading by example* and *support from the top* were included as the proposed antecedents of a climate for care. *Shared philosophy of care* and *supporting each other* were included as a composite measure representing the core constituent of climate for care. Other important

variables were identified as *too much to do*, and the demographic measures: *Average ward tenure* of the nursing team; and *average ward age* of patients and these were included alongside the climate for care measures.

10.9.1 Climate for care and patients assessments of quality of care

The first analysis modelled patients' assessments of care. The measures used in this model are highlighted in Figure 10.2 below.

Figure 10.2: Proposed model of patient's assessment of care

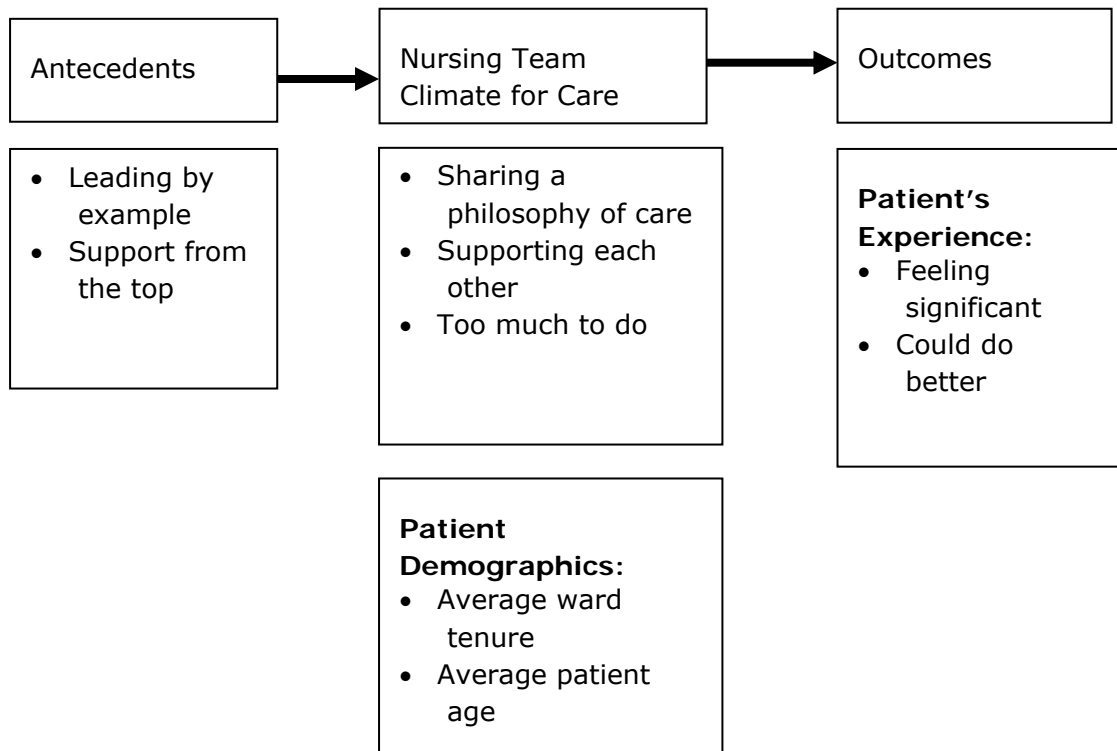
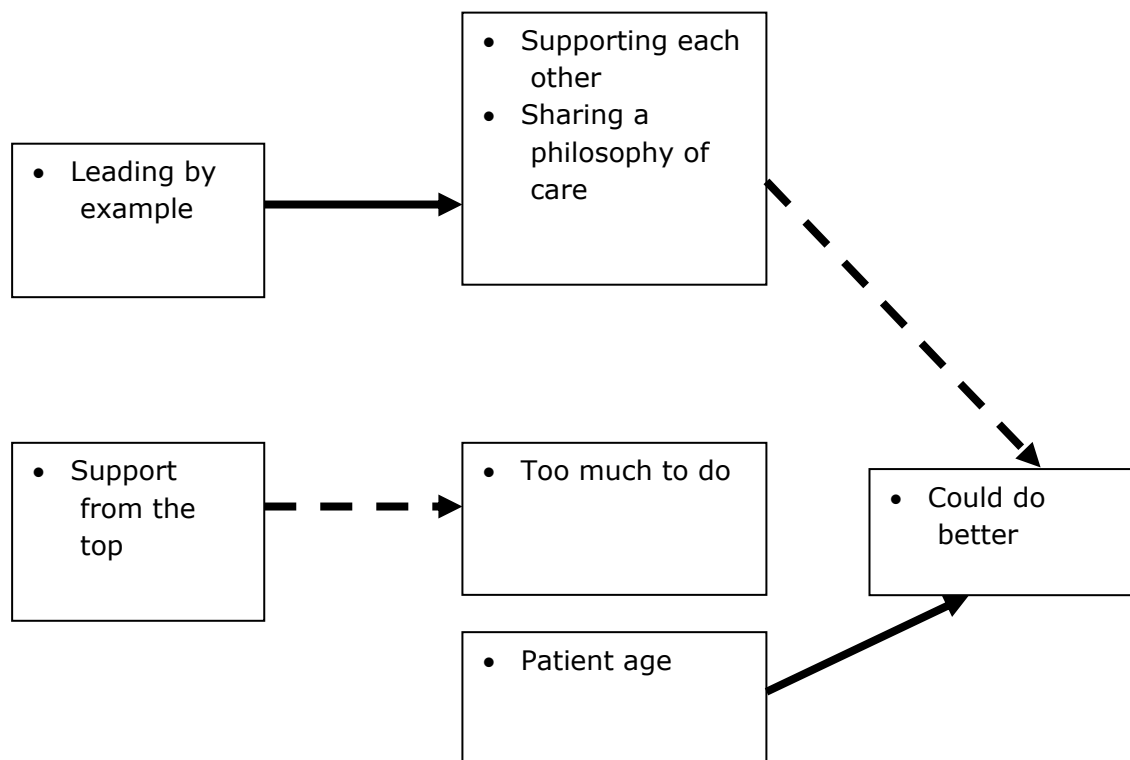


Figure 10.3 below shows the pattern of relationships in the data underpinning the model of patient care. Only relationships that are statistically significant at the .05 probability level or less are shown. The relationships can be positive or negative. For example, a positive relationship between *shared philosophy of care and supporting each other* and an outcome shows that *shared philosophy of care and supporting each other* increases the level of the relevant outcome, and a negative relationship shows that it decreases the level of the outcome.

Overall, SEM results for this model show that two important factors impact on patients' reporting negative experiences of care - *shared philosophy of care and supporting each other* and *average patient age* per ward.

Figure 10.3: Actual predictors of patient's assessment of care

$N = 65$, only associations significant at $p < 0.05$ are shown

—————> +ve, positive association

- - - - -> -ve, negative association

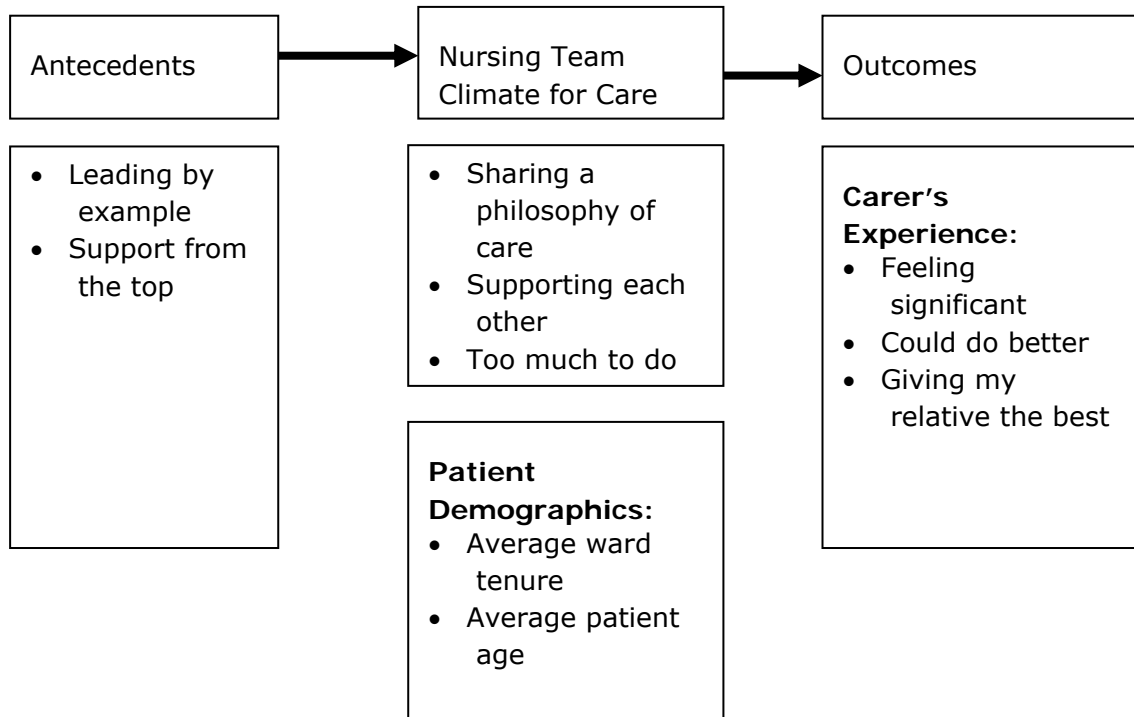
Shared philosophy of care and supporting each other was negatively linked to lower scores on *could do better* (p). So the more the nursing team reported a shared philosophy of care and support from team members the less patients reported negative care experiences (*could do better* (p)). In other words if staff shared a philosophy of care and supported each other then patients were less likely to consider that:

- staff did not respond quickly if they needed help
- staff were more concerned with getting the work done than treating patients as individuals
- staff did not have enough time to give good care
- that patients did not feel that staff had the right knowledge or skills
- that staff spoke sharply to themselves or their relatives

Average patient age per ward was strongly positively linked with *could do better* (p). In other words, patients reported poorer experiences on the above items when they average age of patients on that ward was higher. No age-related effects were found for patients' experience of *feeling significant*, suggesting that capturing patients' negative care experiences maybe a more powerful way of identifying variations in care practices.

Looking at which factors shaped the climate for care, as predicted, *leading by example* was strongly positively linked to *shared philosophy of care and supporting each other*. In other words, the better the ward leadership the more likely were staff to share a philosophy of care and to feel high levels of team support. This result further supports the findings of the narrative review and once again highlights the importance of the ward manager in creating and maintaining a positive care climate. *Support from the top* had no effect on *shared philosophy of care and supporting each other* but did negatively impact on *too much to do*. So, the greater (lower) the perceived *support from the top* the lower (higher) the level of work demands and feeling of 'too much to do', reported by the nursing team. This result suggests that a positive team climate for care, represented by *shared philosophy of care and supporting each other*, is shaped on the ward by the manager, but that a supportive hospital climate is important in determining whether the team feel they are faced with excessive work demands.

Figure 10.4: Carer's assessment of care

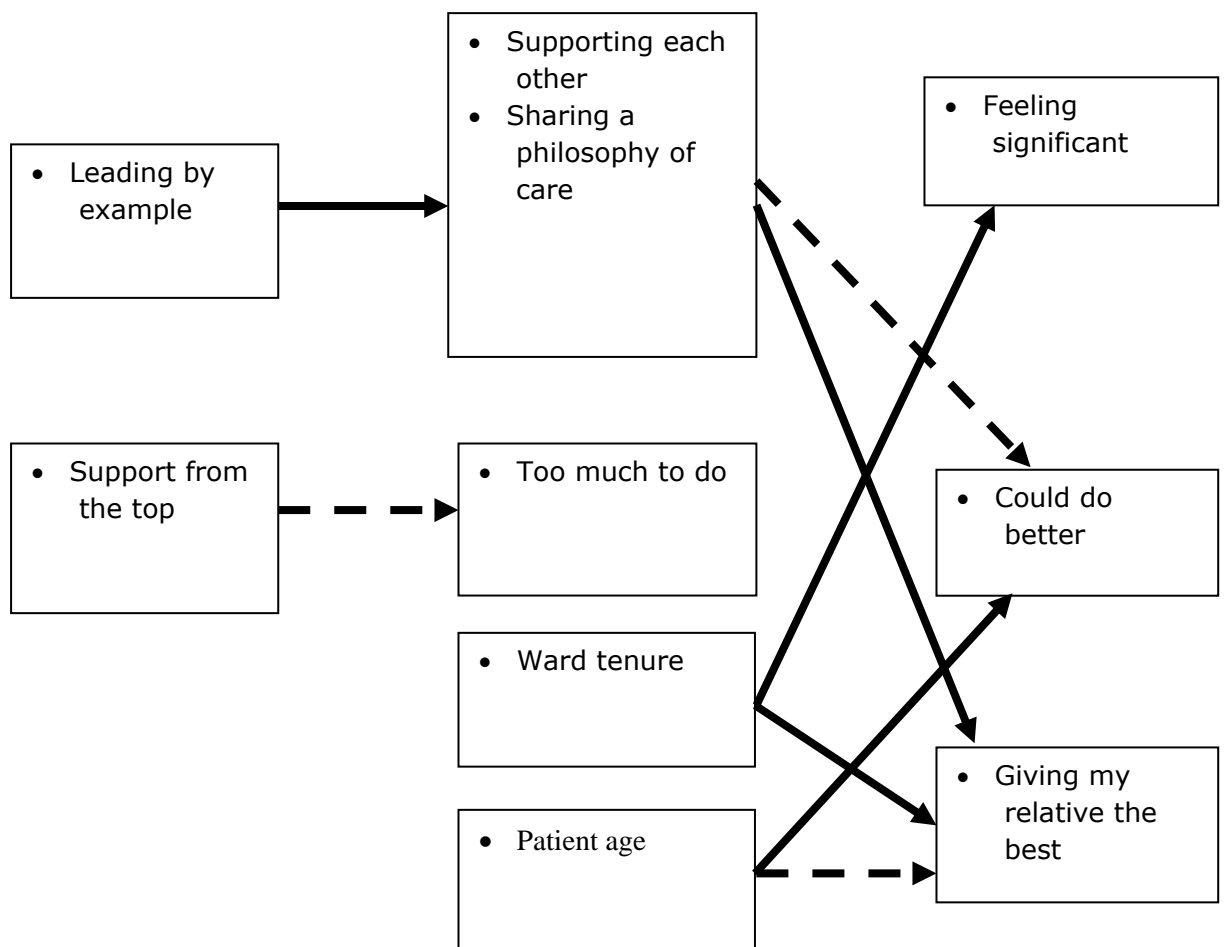


10.9.2 Relative/carer assessment of care

The next model analysed the pattern of relationships in the data underlying relative/carer assessments of care. Figure 10.4 shows the measures used in the model of which measures shape carers assessments of care.

Figure 10.5 shows the results of the modelling procedure. Once again, only relationships that are statistically significant at the .05 probability level or less are shown.

Figure 10.5: Predictors of carer's assessment of care



$N = 65$, only associations significant at $p < 0.05$ are shown

—————→ +ve, positive association

- - - - -→ -ve, negative association

Shared philosophy of care and supporting each other was found to be an important factor for two aspects of carer experiences. It was negatively related to carers' reports of negative care received by their relative, *could do better (c)*, and positively predicted carers viewing their relative's care in a positive light, *giving my relative the best*. So the carer data corroborated the patient results in

demonstrating the importance of a shared team climate for care amongst the nursing team in maintaining standards of care (shown by the negative relationship with *could do better (c)*), but the results also pointed to the importance of team climate for promoting good care (a positive association with *giving my relative the best*).

Average patient age per ward was also a powerful predictor of carer reports of the quality of care received by their relative. On wards with older patients, carers reported more negative experiences for their relative (i.e., a positive association with *could do better (c)*) and lower delivery of good care for their relative (i.e. negative relationship with *giving my relative the best*). The results indicate that poorer care outcomes are experienced on wards with, on average, older patients.

Average ward tenure of the nursing team was the only factor that significantly predicted *feeling significant (c)*, the extent to which carers felt welcome on the ward, listened to and involved in their relative's care. *Average ward tenure* of the nursing team also predicted *giving my relative the best (c)*. In both cases the associations were positive. The longer, on average, team members had worked on the ward, the more carers reported positive experiences on the two care outcomes. If we take *average ward tenure* to indicate the degree of stability in the nursing team then the results suggest that a stable team of core staff supports the delivery of high quality care, as perceived by carers, and meeting the needs of carers themselves.

10.9.3 Matrons' assessment of care on the ward

The next analysis evaluated the factors that could have an impact on matrons' assessment of care on each ward, along two dimensions, *looking to improve* and *meeting patients' needs*. Figure 10.6 illustrates the measures used in this model.

Figure 10.6: Matron's assessment of care

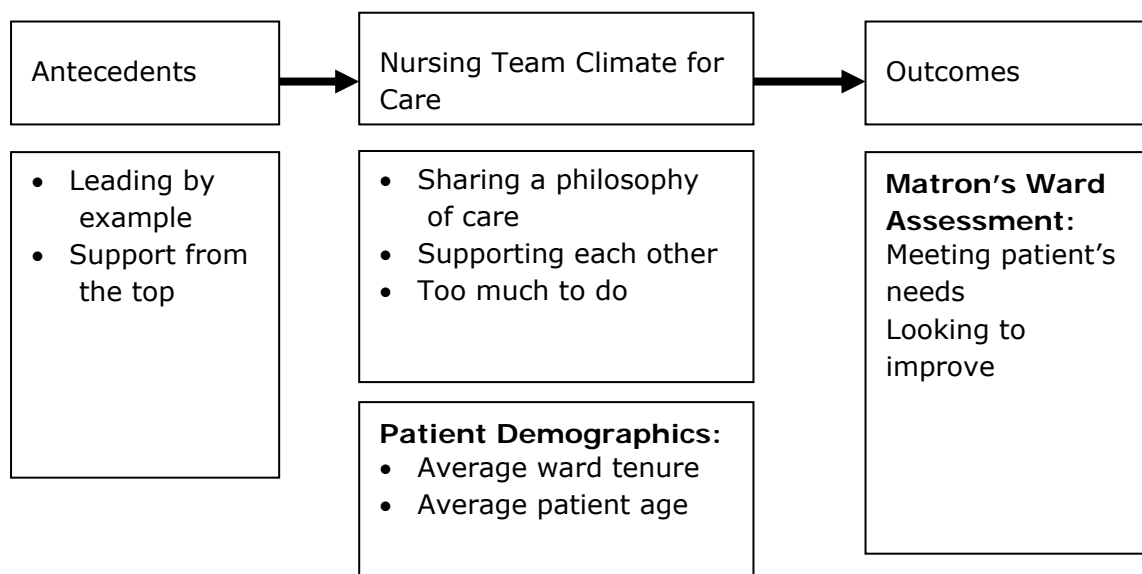
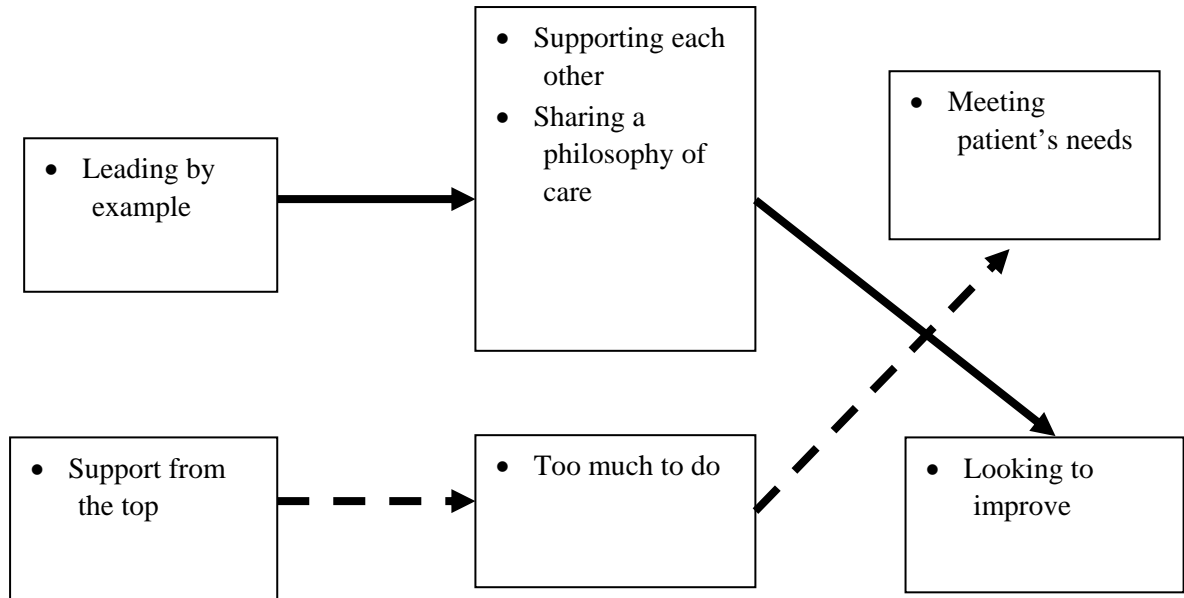


Figure 10.7 presents the pattern of relationships in the data. Once again, only relationships between measures at the .05 level or lower are shown.

Figure 10.7: Predictors of matron's assessment of care



$N = 51$, only associations significant at $p < .05$ are shown

————— → +ve, positive association

- - - - - → -ve, negative association

Shared philosophy of care and supporting each other positively predicted *looking to improve* (the extent to which ward practices were focused on improving care practices). Thus, a positive climate for care increased matrons' ratings of *looking to improve*.

Figure 10.7 shows *too much to do* negatively predicts *meeting patients' needs*. The results indicate that excessive work demands was detrimental for *meeting patients' needs* when assessed by matrons' observations.

10.9.4 Nursing team well-being

The final model explored how the ward environment drives nursing team well being assessed by *feeling motivated*. Figure 10.8 highlights the measures used in this analysis.

Higher responses on this scale indicate that the team experience more positive feelings in relation to their work, such as motivation and enthusiasm. Clearly the well being of staff is an important outcome in its own right but it is also important in sustaining staff commitment and care giving. Figure 10.9 illustrates the patterns of association in this data:

Figure 10.8: Assessment of nurse well-being

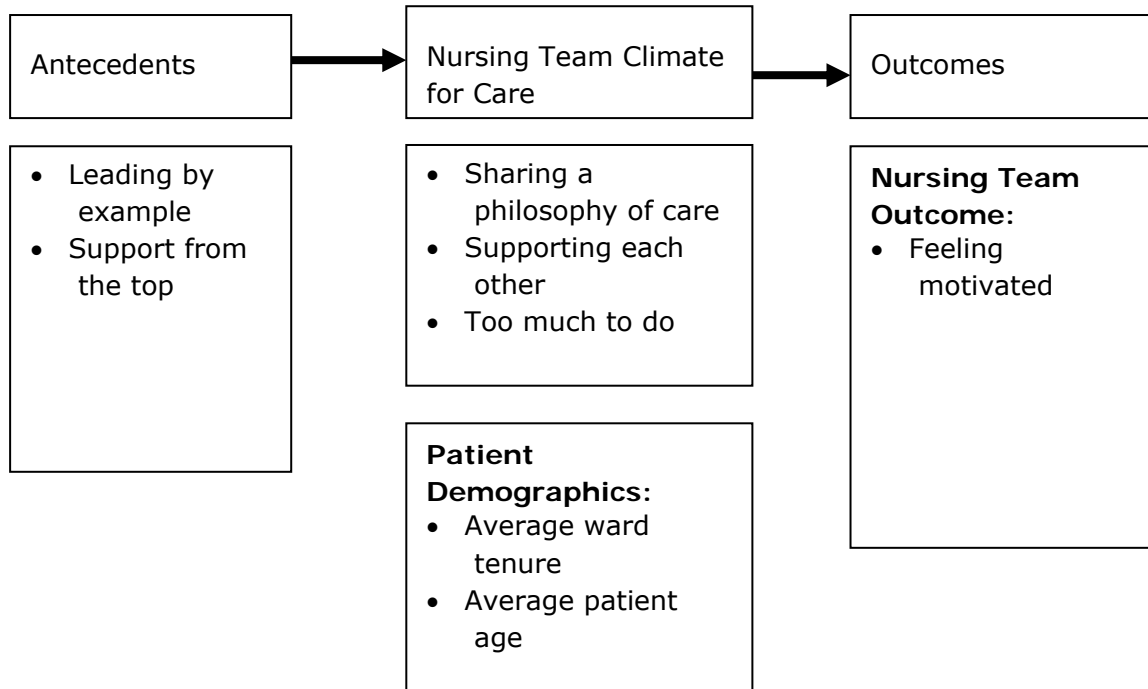
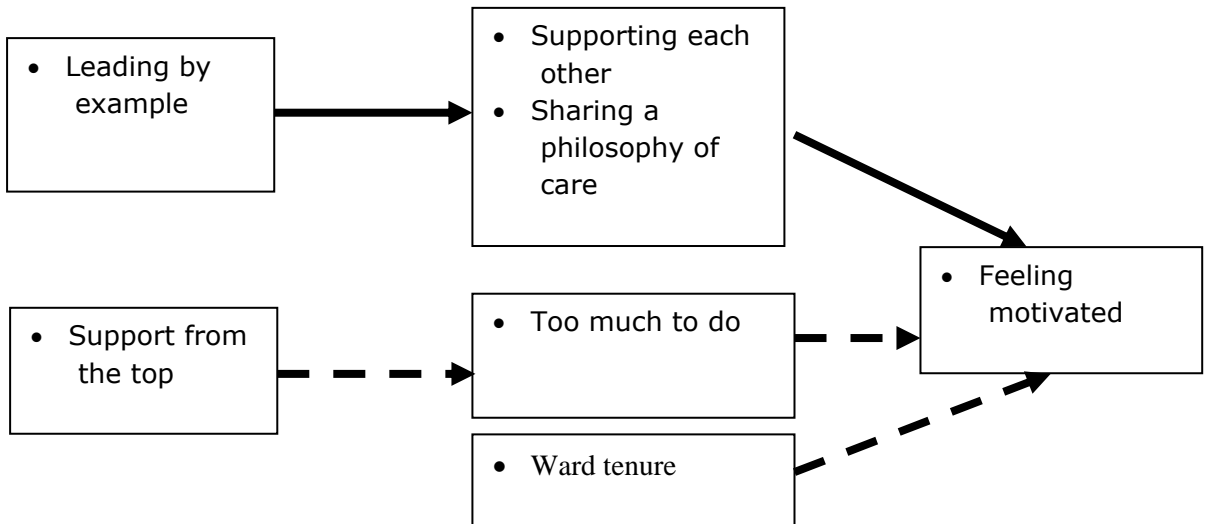


Figure 10.9: Predictors of nurse well-being



N = 65, only associations significant at *p*<05 are shown

—————> +ve, positive association
 - - - - -> -ve, negative association

Shared philosophy of care and supporting each other positively impacted on feeling motivated. This result indicates that where staff work in a team which works well together and which shares and promotes positive care then staff morale and well being is likely to be enhanced.

There is a long history of empirical research both in the health and non-health literature demonstrating that excessive work demands leads to poorer well being. The significant association between *too much to do* and *feeling motivated* is therefore not surprising. Nursing teams who report excessive demands which compromise their care giving also report fewer positive and more negative feelings about work.

The final association links *average ward tenure* to poorer well being. However further analysis showed the association could be accounted for by the average age of the nursing team. That is, nursing team members who had been on the ward longer were also, on average, older in age. Well being was actually predicted by average age. The older the average age of the team then the poorer team well being.

10.10 Summary

The analyses described above highlight a number of interrelations between variables in our overall model and we now pick out some of the key results to discuss further. We begin with the role of the ward leader.

The importance of good leadership from the senior nurse is a theme that runs consistently through the findings in this report, from the narrative synthesis, the data from the reference and opinion leader groups, and the case studies. This has been reinforced in the multivariate analysis. Here we found that *leading by example* was a significant driver of *shared philosophy of care and supporting each other*. In our model we also proposed that a supportive hospital climate, *support from the top*, would also impact positively on the climate for care experienced by nursing teams. However, although *support from the top* decreases reports of excessive work demands (*too much to do*) by nursing teams, it was not related to *shared philosophy of care and supporting each other*. These findings are significant in indicating that a positive team climate is shaped by the immediate team environment, particularly by leadership on the ward. Moreover having a shared philosophy and good teamworking were the main factors predicting not only patient and carer outcomes but also staff motivation and their likelihood of '*looking to improve*'. This suggests that resources alone are unlikely to lead to improved care and that greater attention needs to be turned to the importance of the ward manager, the value of an explicit philosophy of care and good teamworking.

The survey data therefore point to a *shared philosophy of care and supporting each other* as core components of a climate for care. From the Senses Framework perspective, developing a commitment to shared values, prioritising care and caring and supportive team relations, all promote the senses of security, significance, belonging, and purpose for staff.

Our decision to create one construct for the shared philosophy of care scale and the supporting each other scale was supported empirically but also, to a degree, conceptually. There is a considerable literature (e.g., Kahn, 1993, Nolan *et al.*, 2001, Parker, 2002) advocating that care giving over any extended period requires social support. The most likely and potent source of support is one's team members. Our data suggest that a nursing team's shared philosophy of care, its emphasis on prioritising patient care, goes hand in hand with being embedded in a

network of caring and supportive relationships within one's team. The results also emphasise the importance of a relational approach to care. The care received by patients is wrapped up in the quality of relationships between team members

Shapiro and Carr (1991) articulate the concept of a "shared interpretative stance" through which team member can process their experiences, as important in creating a context that effectively supports interactions between team members and patients. The *shared philosophy of care* dimension is just such a shared interpretative stance within our nursing teams that appears to support group cohesion and patient care. Furthermore, as we noted in the narrative synthesis, Parker's (2008) recent work on relational practice stresses the importance of all members of the team valuing and supporting such work and Youngsen (2008, 2009) highlights the need for staff to experience such a supportive environment if they are to deliver compassionate care

In terms of making judgements about the quality of care our results suggest that carers' views may provide a better barometer than those of patients, especially very frail older patients with complex needs, who in an acute setting may be too ill to provide their views. Previous research has tended to treat carer responses as proxies for patient data. However, in the research reported in this section, it was the carer data, more than the patient data, which were the most powerful in discriminating between the care provided by different ward environments. We are not suggesting that carer data should take precedence over patient data, but that each should be seen as valid measures of quality of care in their own right. The results indicate, as do other studies (see for example Brereton and Nolan, 2003) that carers are often keen and knowledgeable observers of the quality of care received by their relatives and this can be especially important in the case of older and frail patients. They are able to provide a voice for the relative's experiences as well as their own.

A final important finding in the analyses reported in this section was that *average patient age* per ward was significantly associated with poorer care on that ward as reported by patients and carers, and lower reports by carers of positive care experiences for their relatives. *Average patient age* showed the strongest relationship with patient and carer data than any other variable. The associations were striking, with the correlation between, for example, *average patient age* and *could do better (p)* showing that they shared 20% of variance in common. These results are telling in light of the context and impetus for the overall study – concerns about the quality of care that older people receive in hospital.

The negative association between patient age and care were not repeated when we look at individual patient data rather than averaged across the ward. Indeed the dimension *feeling significant (p)* was significantly positively correlated with patient age. So if we look within wards we find a tendency for older people to report better care (this might partly be explained by the reluctance of older people to complain about standards of care) but if we look across wards, then wards with greater concentrations of older patients tend to produce experiences of poorer care for both patients and carers.

The results support arguments made consistently throughout this report that older people wards are often perceived to be challenging environments for care giving in terms of meeting complex patient needs in a target driven culture and also the

frequently poor image and status among staff of such work and the view that it is 'heavy' and 'deskilling'. Compounding the situation examining the correlations in our data between *average patient age* and nursing teams' perceptions of climate for care (see Appendix 8), shows that average patient age is significantly negatively associated with *having resources*. This means that nursing teams working on wards with older patients report having fewer resources to meet the care needs of their patients. This was reinforced in the case studies when it was often the older peoples' wards who were the first to have staff moved to other areas at times of shortage or were more likely to have to draw upon bank and agency staff. This again is often linked to the perception that work requires less staff than more acute wards. The other climate for care dimensions, and staff well-being, while not significantly correlated with age, all show the same negative direction in the relationship.

These are all issues to which we will return in the next, and concluding, section.

11.0 Reflections

11.1 Introduction

The original proposal on which this study is based was submitted in response to a call from the SDO to explore the impact of culture change in acute hospital settings on key stakeholder groups (staff, patients and carers) at differing organisational levels, with a particular emphasis on the patient and carer experience. In responding to this tender we argued that the care provided for older people in acute hospitals provided an excellent way in which to explore the above issues 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
- at the time the proposal was submitted there were a number of concerns about the standard of acute hospital care for older patients, especially relating to dignity. This had resulted in a flurry of change initiatives, most notably the NSF for older people and associated developments

We also 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, significance. Therefore, the model argues that 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.

We had two primary aims for the study. Firstly, to try and better understand those factors that either facilitate or inhibit culture change in acute hospital care for older people, carers and staff. Secondly, to use the insights gained to generate a potential 'toolkit' for change that might be used to apply the findings in other contexts and settings.

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

- a context setting phase in which we sought the views of a reference group and key opinion leaders. The reference group was also used at various points throughout the study to advise on methodological aspects
- a systematic narrative synthesis of the literature on both culture change and dignity for older people in acute hospital settings that was also informed by a prior view undertaken by some of the applicants (Nolan *et al.*, 2001) and a recent similar review of culture change for older people in care home settings (Nolan *et al.*, 2008)

- detailed longitudinal case studies in four Trusts purposively sampled to provide differing contexts for change. Two of these case studies focussed initially on change at a Trust level, before later focussing on changes occurring on various wards. Two others looked primarily at changes at the ward or unit level, but with reference to the wider Trust context
- the development of a number of indices or measures that tapped into staffs' perspectives of their work environment and patient, carer and staff outcomes
- the use of these indices in large-scale surveys across numerous units at all the above Trusts, both to explore variation within and between units at the individual case study sites and to undertake a multi-variate path analysis to explore a number of conceptual models on the potential linkages between climate for care factors and patient, carer and staff outcomes.

As we described, the study provided a number of challenges and involved considerable effort in order to achieve the above aims. In particular, ethical considerations and the acuity of older patients prohibited us from gaining detailed qualitative data from patients and carers. Therefore their perceptions are mainly reflected in the quantitative data. Nevertheless, we feel that the project has successfully met its aims and provided valuable insights into the challenge of culture change in acute settings, and also generated a number of conceptually and statistically well grounded instruments that can be incorporated into a potential 'toolkit' for change. Below we reflect upon the main issues raised during the study.

11.2 Culture change: A journey not a destination

The decision to focus attention on acute hospital care for older people proved to be highly appropriate. Since the study started, and indeed up until the writing of the report, concerns regarding the nature of the acute hospital experience for older people have retained a very high profile. The last three years have seen several initiatives and reports on such issues both from government and a range of third sector organisations, including the:

- Confidence in Care Initiative (DH, 2008)
- the Point of Care Campaign by the King's Fund (Goodrich and Cornwell, 2008; Firth-Cozens and Cornwell, 2009)
- the RCN Dignity Campaign (RCN, 2008)
- the NMC standards on work with older people (NMC, 2009)

Despite the above developments, recent publications such as the report 'Patients not numbers, people not statistics' (Mullen, 2009) by the Patients' Association have maintained a high level of public concern about quality care for frail older people in hospitals and there has, within the last few weeks, been the publication of a new set of best practice statements for the acute care of older people that explicitly endorses a relational model of care (Bridges *et al.*, 2009). We will return to this latter issue shortly.

We feel that there are two main sets of messages that emerge from the study, one that relates to culture change initiatives in general (including those aimed at older people) and one that relates to older people in particular. We will consider both of these below in the light of the main conceptual frameworks that have informed our thinking. We briefly outline these frameworks again below, and then present our thoughts on those issues relating to culture change in general.

The key role of relationship-centred care and the Senses Framework in both the conceptualisation of the study and its conduct has already been referred to. However, during the narrative synthesis, a number of other frameworks emerged as being of potential relevance and these proved highly influential in the conduct of the study, our analysis and interpretation of the data, and in shaping our conclusions. Probably the most influential of these additional frameworks was the Pace-Complexity dynamic originally proposed by Williams (2001; Williams *et al.*, 2009) as a means of better understanding the diverse discharge experience of older patients in hospital. As we will discuss shortly, this framework provided many useful insights and we believe that its relevance extends well beyond discharge and that it captures many of the tensions inherent both in the delivery of health care to older people and in culture change initiatives.

Another approach that we drew upon was the transactional/transformational approach to change that was used to explicate the success or otherwise of the MASC initiative (Newman and Hughes, 2007). This also proved very relevant for our study.

The final two influences on the study arose from differing contexts. One came from the literature on in change home settings and the other from professional organisations concerned about the standards of care for older people.

The former relates to the writings of Robinson and Gallagher (2008) who concluded that change initiatives in care home settings focussed too much attention on the influence of rules/routines/regulations and gave insufficient to the nature and quality of relationships in such settings. This seemed to us to be entirely consistent with a relationship-centred approach and the Senses Framework. Furthermore, it chimed with the transactional and transformational model of change with the 'rules' aspect reflecting a transactional approach and 'relationships' more a transformational model.

The last set of influences came from the recent publications from the RCN (2008) and the NMC (2009) who, when reflecting on the factors that shape the experience of older people in acute care, suggest that there is a dynamic between Place-Process-People. This was supported by the narrative review but we argued that a fourth 'P' needed to be added and that was 'Perceptions', the way people view things.

Building on the above and 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. To compound difficulties pace is often reinforced by the use of targets in a largely punitive sense, and the continued application of an

essentially transactional approach to change. We might characterise this as a *perform or perish* model of service delivery

As the recent systematic review of QI programmes in health care by Powell *et al.* (2009) argues, there are broadly speaking two main approaches to change; you can either mandate or you can persuade. They concluded that persuasion is the best route to success but that mandatory change still remains the predominant modus operandi in the NHS. As a result too little attention is paid to the relational dimensions of change (Bate *et al.*, 2008; Powell *et al.*, 2009) and we believe that recent initiatives, for example, the *Productive Ward* still focus primarily on the *processes* of care. Therefore whilst the main goal of this initiative is to *free up time to care*, as case study four demonstrated such time is not necessarily used in direct patient contact but rather to improve the pace driven agenda and smooth patient flow.

Greater attention to the more subtle and relational aspects of change is needed, especially the '*complex human factors*' (Bate *et al.*, 2008) if future change initiatives of any type are to have an optimum chance of success. The situation in relation to care for older people is even more complex, as the roots of the current problems often lie in deep-seated professional and societal images of ageing. Changing these will require on-going and systematic efforts at various levels ranging from the individual through to the societal. Whilst we can offer no definitive solutions to such challenges we will briefly reflect upon them later.

Firstly, we turn attention to the key messages emerging from the study with respect to change initiatives in general.

11.3 'The urgent is the enemy of the important'

The above quote, from a consultant physician for older people in one of the case study sites, eloquently captures many of the dilemmas both in the delivery of health care and in attempting to constitute change. That is the tension between what Williams (2001; Williams *et al.*, 2009) termed Pace and Complexity. Such issues figured prominently in the study, with pace being exemplified by the quick fix and target driven mentality that is seen to dominate the acute health care setting (RCN 2008, NMC 2009). This manifests itself in many ways and has a number of both intended and unintended consequences. For example, in their consideration of the ongoing failure to deliver '*compassionate care*,' Goodrich and Cornwell (2008) point to the current emphasis on *counting* numbers and *measuring* activity which tends to turn attention away from the *little things* that are so important to the quality of the patient experience. The NMC (2009) conclude that a target driven culture leads to a regime of task-centred care which is at odds with the policy rhetoric of the primacy of the patient experience. Dickson (2008) argues that the NHS is in danger of losing one of its core values; the way in which patients are treated, not as conditions, but as people, with Youngsen (2007) suggesting that this is indicative of the whole ethos of modern day health care with its focus on the *technological* fix. This has led commentators to suggest that such an emphasis has a *profoundly negative effect on culture* (within acute settings) (Firth-Cozens and Cornwell, 2009).

Our own data support such conclusions, with the opinion leaders talking about their concerns with the current focus on the *'metrics rather than the meaning of care'*. There are several other examples of the emphasis on pace such as the *golden discharge*, and indeed the RADS initiative itself, which was predicated entirely on pace. The latter provided a highly efficient, and indeed holistic, service but achieved this by explicitly *filtering out* complexity in its various forms.

But pace does not just impact on the delivery of direct care and the patient experience of it; pace also drives most change initiatives. Over recent years one set of initiatives has followed another with almost relentless momentum. Indeed several initiatives often occur simultaneously, with some implicitly taking priority over others. In such circumstances the 10 year agenda of the NSF has little chance of success if more pressing *targets*, which are often linked to punitive action, also need to be addressed.

Paradoxically the change literature is quite clear that there are no magic bullets, or quick fixes and that there is a need to be realistic about the pace with which change can be introduced, especially when the issue concerns long-held and often deep-rooted beliefs (Chan, 2007). This has been re-affirmed time after time in the literature from the care home sector and Powell *et al's* (2009) systemic review of QI programmes in the NHS. This highlights the need to adopt a *systematic and sustained approach* to change. However this is simply not possible in the face of multiple change initiatives, all seemingly requiring immediate action.

The introduction of frequent initiatives can lead to half-serious attempts to carry them out. In the case of culture and the care of older people, this may lead to some success in bringing about change and signalling to NHS staff and external audiences that the issue is taken seriously, but often leads to inattention from staff. Indeed, our case studies showed, that at the stage of our research, the Dignity Campaign had left little imprint at our case study sites.

It is here that complexity comes in. The recent DH (2008) Confidence in Care initiative recognises that care has never been more complex and moreover it acknowledges that care and culture are interdependent. Moreover as the narrative synthesis highlighted culture, dignity and related concepts are inherently complex and all the more so in health care settings that involve the relationships between different professions that are often underpinned by implicit and sometimes antagonistic, assumptive worlds.

Culture in such settings therefore comprises for example: *Clinical* cultures – to do with the goals of care; *caring* cultures – concerned with the quality of interpersonal dynamics that act as a barometer for care; and *work* cultures – relating to the way in which staff are treated (Stone, 2003). All of these figured prominently in our study.

Furthermore, one goal of the SDO in commissioning the projects in this call was to explore the influence of culture at differing organisational levels. However, whilst organisational culture is important, it is only a small part of the overall picture and it is quite clear that, especially in respect of older people, there is a need for longer-term action at multiple levels that extend well beyond the organisation. These would include:

- individuals

- ward/unit
- organisation, i.e. Trust
- profession
- institution, i.e. NHS, Government
- society

Our main concern here is focussed on the ward/unit and organisational level, but later we will briefly allude to other more fundamental changes that are required at higher levels of abstraction.

Returning to the world of health care Powell *et al.*, (2009) concluded that any change or quality improvement initiative has to take full account of the '*complex social interactions*' that occur, and this conclusion is again consistent with a relationship-centred model.

The results of our study point quite clearly to the limitations of a pace-driven agenda; culture change takes time. There is a need to pay far closer attention to the complexity of the processes involved, especially the interpersonal dynamics; relationships are central to successful culture change. Whilst such relationships are essential at all levels, those that unfold at the level of the '*clinical micro-system*' (Goodrich and Cornwell, 2008) – that is the arena for the delivery of care – are especially significant. It is to here that we now turn.

11.4 Place, processes, people and perceptions: The role of leadership

The recent publications by the professional and statutory bodies in nursing (RCN 2008, NMC 2009) suggest that the delivery of care to older people is shaped by a combination of three factors:

- the place – the culture, the environment and the resources
- the processes – the way that care is delivered
- the people – their attitudes, beliefs, values and behaviours

To this we added the importance of perceptions and the way such perceptions shape the above factors. The study results indicate that the 'P's' interact in subtle and manifold ways to create either an enriched or impoverished environment. Many of the recent change initiatives tend to focus primarily on the *processes* of care, such as care pathways, or the Productive Ward. This emphasis on processes is also manifest in the way that organisations shape their service, for example, the notion of the golden discharge. However, as in case study two, when you *take your eye off the ball* and focus primarily on targets and processes at the expense of care then the risk is that standards will drop, often to unacceptable levels. None the less, even in the overall impoverished environment that characterised case study two at the start of the study, one unit in particular maintained a standard of excellence for both patients and staff and ensured that an enriched environment continued. This was attributable in large measure to the ward leader. Similarly, towards the end of data collection, it was apparent that the Trust was *turning a*

corner, and again this was due mainly to leadership – this time at the top of the organisation. This involved the new CE and his team communicating the mission of the Trust, clearly but in a way that recognised the needs of the people involved – the leadership became real and took on a human face. Of course attention to process is important but only if attention is also given to the people involved and their perception of what matters.

This was quite clear at case study four where the Productive Ward initiative did focus on people and processes and did free up more time. However, this was not necessarily time to care but rather was used to smooth out the patient journey and expedite effective discharge. A pace driven agenda still predominated.

The current focus primarily on the processes of care is unlikely to be successful in instigating longer term change in complex situations unless far greater attention is given to the relational dynamics that underlie such processes. As Bate *et al.*, (2008) contend, you cannot ignore the '*human and organisational*' in favour of the '*clinical and technical*'. Human and organisational factors impact at several levels, as the case studies illustrate. However, the narrative synthesis, and our own data, indicate that perhaps the most crucial level at which to consider such human factors is at the level of the ward or unit. Here the role of the ward leader is paramount.

The original *Dignity on the Ward* study (Davies *et al.*, 1999) highlighted the key role played by the ward leader in establishing the overall quality of care on the unit. This has since been reaffirmed in numerous other studies in care environments (Baker, 2007; Dewar, 2007; Downs, 2007; Miller *et al.*, 2008) and by the DH in its *Confidence in Care* programme (DH, 2008).

The pivotal role of the ward leader was raised by both our reference groups and opinion leaders. The reference group identified several key attributes of the ward leader from a patient/carer perspective and these included:

- being a visible presence on the unit
- having clear expectations and standards that were communicated to staff
- letting it be known who was in charge when she/he was not on duty
- encouraging good teamwork
- mediating in potential disputes

These attributes reflect those found in the literature and they were also apparent numerous times in our own data. The ward leader in case study two provides an outstanding example. Her influence was reaffirmed in the quantitative data so that staff on her unit felt that they:

- had better resources
- supported one another
- improved practice
- developed their own skills
- felt motivated

All of these were significantly higher than on other units in the Trust.

However, the largest and by far the most significant difference between this unit and the others were the extent to which staff believed that the ward leader '*led by example*'.

The importance of this was brought to the fore in the multivariate analysis. This demonstrated that whilst the influence of activity at a Trust level (Support from the top) did impact on staff and matrons outcomes, it did not seem to do so on patient and carer outcomes. Furthermore, this influence was mediated via staff perceptions. So in the absence of perceived *Support from the top* staff were more likely to believe that they had *Too much to do*. If they believed that they had too much to do, and had to compromise on the quality of the care they delivered, this had a negative impact on their feelings of motivation and matrons were less likely to feel that staff were able to meet patients' needs. These are important outcomes and clearly attest to the need for sufficient resources and perceived *Support from the top* in order for staff to get the most from their work.

However, it was staffs' perceptions of whether they felt that they Shared a philosophy of care, and that they worked closely to support each other, that had a far greater impact on patient and carer outcomes. So when staff believed that they did work well together and Shared a philosophy, then patients were far less likely to report poor care and carers were more likely to feel that their relative was receiving the best care and less likely to report that they had not been treated with dignity and respect, or that staff were more concerned with getting the job done than caring for their relative. These are essential outcomes with respect to the patient and carer experience and are clearly linked to staffs' perceptions of their work climate. The crucial determinant of staffs' perceptions was whether or not they felt that the ward leader was '*Leading by example*'. Therefore it becomes clear that the ward leader is key to establishing the *climate for care*, or in terms of the senses, of creating an *enriched* environment. In order to achieve this, the quantitative data indicate that she/he:

- instils a sense of pride on the ward by focussing on what we do well
- inspires confidence by saying positive things about the ward
- ensures that the teams' interests are considered when decisions are made
- consults the team closely about problems and procedures
- acts in a caring and supportive manner towards the team
- is clear and explicit about what standards of care are expected
- takes initiatives to establish strong standards of excellence in care
- sets clear goals and objectives
- is an 'on-going' presence on the ward, someone who is readily available
- actively encourages individuals and helps them improve their care delivery
- sets an example by involving herself/himself in hands-on patient care

It is easy to see how someone who acts in the above way would establish all the senses for the staff group and the climate that enables staff to create the senses for patients and carers.

Interestingly the first two items on the leading by example scale, and those with the highest factor loadings – are that the leader '*focuses on what we do well*' and *says 'positive things about the ward'*. This is consistent with an appreciative inquiry approach to instituting change and this is something that we will return to later when we consider the change toolkit.

Our results show that local culture change is more realistic in the short-term. Rather than thinking about managing entire cultures it is productive to think of managing *within* cultures and affecting the values and actions of, for example, team members (Alvesson, 2002). For most managers and practitioners in the NHS everyday cultural re-framing (Alvesson, 2002) is a more relevant form of culture change than larger scale projects. That is the way, for example, ward managers, '*lead by example*', draw attention to, and underscore values and practices supporting care by their own words and actions. The value of the toolkit developed from this study and discussed later in this section, is that it provides ideas and tools for change at this more micro-level. Clearly, however, individuals are not always free to emphasise certain values and downplay other values and local initiatives can be constrained by broader organisational culture, such as the emphasis on pace in the NHS.

11.5 Culture change – broadening the agenda

So far we have identified several key messages that emerge from both the narrative synthesis and the empirical findings of our study. These include:

- the current overriding emphasis on pace in the NHS, and the seemingly never ending stream of initiatives, fails to acknowledge adequately the time and effort that sustained culture change requires
- there is too little recognition of the complexity of introducing change, and the action that is needed at multiple levels and with differing professional groups
- whilst a focus on process is a necessary, it is not a sufficient condition for change, and far more attention needs to be given to the complex interpersonal dynamics of change processes and the relationships and perceptions that underpin these
- leadership both at the top and at the unit level is essential, but that the key to enhancing the experience for patients, carers and staff seems to be at the ward or unit level
- large-scale culture change appears to be an extremely long-term undertaking as visibly demonstrated in case study A where, despite a considerable investment over time in creating a *two site, one culture Trust*, there appear to be two quite different cultures in operation which, whilst they do not appear to impact negatively on patient care, do have several potentially negative impacts for staff outcomes

- On the other hand change initiatives targeted at the local or unit level seem far more likely to recoup real benefits.

The literature synthesis suggested several attributes of a successful change initiative, which include:

- support from the top
- clear vision and goals well communicated
- encourages and values people at all levels, especially those nearest to the delivery of care
- fosters positive relationships
- focuses on the patient experience

Our findings reinforce these, but as many of the studies informing the review focussed on the organisational level we would add the centrality of unit/ward leadership to this list as this is essential if change is to directly improve the patient, carer and staff experience. Furthermore, our data clearly highlight the importance of paying greater attention to the carers' perceptions of the quality of care, both for themselves and their relative. This is a key consideration that is often overlooked.

We would suggest that the above considerations are equally relevant to all change initiatives irrespective of the age of the patient. However, our specific focus was on the delivery of care to older people and this raises additional and even more complex issues.

11.6 Culture, care and older people: 'Just like Groundhog day'

'Just like Groundhog day'. This was the phrase used by a junior doctor to describe his experience of some longer stay rehabilitation patients in one of the acute hospitals that formed part of our case studies. Most people will be familiar with the premise of Groundhog day: a cautionary tale of a cynical reporter who finally finds something or somebody he can believe in but cannot attain it until he has lived the same day over and over again and finally achieves a 'perfect' day. The use of the phrase by the junior doctor reflects the former part of the story, living the same day over and over again, but without the promise of finding what you really want at the end. It succinctly captures the futility with which the care of older people with long term needs is perceived by many who work in acute care.

'Just like Groundhog day' seems a very appropriate metaphor here as in many ways it reflects the seemingly endless conundrum of how to value and provide appropriate care for older people with longer term care needs.

We have already referred to the marginalised position that frail older people occupy in society and the negative attitudes, or at least unacknowledged fears, that younger people have about ageing. This was described by one of the opinion leaders as demonstrating a *deep-rooted cultural antipathy to ageing*, with culture here referring to a societal rather than a professional phenomenon.

As we also pointed out, the emergence (and subsequent virtual disappearance) of geriatric medicine illustrates such antipathy. The goals of the modern NHS and its acute orientation lie in the mid 19th century and stem from the creation of the voluntary hospitals as centres for the care of the acutely ill and the training of doctors. At such times the old and frail who were seen not to benefit from such a service were called the *'incurables'*, the beginning of a long history of pejorative terms that have been through various manifestations including *'bed blockers'* and *'frequent flyers'*. Is the latest version of this *'rehabs'*? As we noted, this was applied to the patients that were not deemed suitable for the RADS team. Whilst we believed that this was not intended to be a deliberately derogatory term it nevertheless classes such individuals as different from those in receipt of RADS, they are the *'rehabs'*. This illustrates the marginalised position that rehabilitation now seems to occupy in a pace dominated health service.

The irony is that, as Wilkin and Hughes (1986) note, when geriatric medicine was struggling for recognition it turned to the concept of rehabilitation to provide itself with a sense of purpose and achievement. Successful rehabilitation defined what geriatric medicine did and when it did it well. Yet 50 years later rehabilitation has become almost an impediment in some acute contexts. To add a further layer of irony, the introduction of the OPRA unit at case study four was intended to have the opposite effect and to raise the status, image and perceived significance of the ward from an *'old fashioned care of the elderly unit'* to a *'modern rehabilitation unit'*.

Clearly this is all about perception and as our data amply attest work with frail older people who have complex needs is often seen as *'heavy'*, *'de-skilling'*, and *'really really hard'*. Work with such people provides little prospect of progress and there is little to be gained in the way of job satisfaction: Groundhog day indeed. Yet at OPRA the opposing view was taken and rehabilitation was seen to be far better alternative than *'an old fashioned care of the elderly unit'*. What exactly is meant by the latter term is unclear but in their differing ways both OPRA and RADS, inadvertently cast negative aspirations on the value and significance of the oldest and frailest members of society. This is the very section of the population that is the most rapidly growing and is the most prolific user of health services. Where does the future lie for such individuals when they need acute health care?

We do not have the space, nor indeed the data, to suggest solutions but the question clearly signals the need for an on-going debate at a societal level both about the place of very frail older people and how we address their health care needs. This is particularly important in view of our findings, that the wards with the highest average patient age were, from a patient's perspective, those most likely to deliver poor care in terms of staff:

- staff not responding quickly when help was needed
- staff being more concerned with getting the job done than treating patients as individuals
- staff not having enough time to deliver good care
- patients not feeling confident in staffs ability to deliver good care
- staff speaking sharply to patients

Carers, often a better overall barometer of the quality of care, also reported that on wards with the highest average patient age staff were least likely to give the best care for their relative and more likely to 'need to do better'.

There is clearly a need for culture change at all levels. However our findings suggest that the initiatives most likely to be successful and to result in direct benefit for patients, carers and staff are those targeted at the level of the ward or unit, We conclude with a brief consideration of how a potential toolkit for culture change might impact in such a setting.

11.7 A toolkit for culture change: Rearranging the deckchairs on the titanic?

The two main aims of this study were to explore the range of factors that might either facilitate or inhibit culture change in acute care for older people and to use such insights to inform the development of a potential culture change toolkit for use in such settings. We believe that the first aim has in large part been achieved and that the study has generated some important messages that can be incorporated into future change initiatives. Here we focus our attention on those initiatives targeting change at the unit level. We do this for several reasons:

- firstly we believe that this is the level at which change can be most successfully achieved if the initiative is to be of direct benefit for patients, carers and staff
- secondly our data, both qualitative and quantitative, provide the most telling insights at this level, especially concerning the role of the ward leader in creating an enriched environment
- thirdly during the study we have developed a conceptually and statistically robust set of 'tools' to go in the kit, that have been empirically demonstrated to differentiate between enriched environments for patients, carers and staff at a unit level
- finally we have extensive practical experience of using a relationship centred model of change underpinned by the Senses Framework to successfully introduce change in both care home settings (Davies *et al.*, 2007) and a range of acute environments for older people (Nolan and Nolan, 2009).

Taken together we feel that these factors meet two essential, but often missing criteria identified from the literature: They use concepts that speak to older people, their families and staff in a language that they can understand (Magee *et al.*, 2008); and they do so in a way that is 'ordinary, accessible, jargon-free, and commonly understood' (Goodrich and Cornwell, 2008). Of equal importance the approach we are advocating is relational (being underpinned by the Senses Framework and relationship centred care) and this is consistent with the latest best practice statements for use with older people in acute care settings (Bridges *et al.*, 2009). These statements have been developed following a systematic review of the literature on patient and carer preferences in acute care and are intended to replace those guidelines generated in support of the NSF.

Bridges and colleagues (2009) explicitly promote a relation approach to care and on the basis of their work suggest that the statements that they have generated represent the *'Most current and comprehensive evidence-based practice guidelines available'*. They promote a model which focuses on three dimensions of care which *'highlight the importance of relationships, however transient, that older people and their relatives have with acute care staff'*.

These three dimensions are:

- *See who I am*; which is about maintaining the identity of the older person
- *Connect with me*; which is about creating a two way relationship
- *Involve me*: Which is about engaging the older person and their carers as partners in care.

We believe that key aspects of these three dimensions are captured in the patient and carer outcome measures we have developed (*Feeling significant (p)*, *Could do better (p)* and *Feeling significant (c)*, *Could do better (c)* and *Giving my relative the best*)

For the above practice guidelines to be successful relational practice has to be seen as important and accorded significance. Cultural change requires the use of words, actions and practices that are coherent and back up each other (Alvesson, 2002). The narrative synthesis, the findings of our study and our prior experience of change in care settings for older people suggest that if such practices are to be introduced then certain things need to be in place. These include:

- relational practice needs to be seen as important and legitimate work
- staff have to believe that they have sufficient resources to deliver high quality technical and fundamental care
- staff need training to develop the skills necessary to deliver such relational care
- staff need to be prepared to give something of themselves and to have emotional support mechanisms in place if required.

Several of the main elements above are captured in the various indices that we have developed and that reflect the *climate for care*. For example: Having a shared philosophy to include valuing psychological care and involving patients and carers; staff who support each other emotionally and have a climate of trust and who acknowledge the emotional demands of work; feeling safe to voice issues and concerns; believing that you can have a say; striving to improve practice; and believing that you have sufficient resources and do not have to compromise on *best practice*. The presence of such factors is typical of an enriched environment where staff experience all the senses. In the presence of the factors above relational practices are much more likely to flourish. In the absence of these factors such practices are extremely unlikely. Perhaps most importantly of all the indices offer a way for staff to reflect on the extent to which the ward leader *leads by example*.

Based on the above we believe that the various indices that we have developed can potentially form the core elements of a toolkit for change. Of course having

such tools is one thing, using them appropriately is quite another. However we believe that there are some key lessons that might be applied here also.

Firstly, as with Powell *et al.*, (2009), we believe that you cannot take any approach to change off the shelf and apply it in a uniform and prescriptive way. Rather any model should be sufficiently flexible to be modified according to the local context and organisational history and in so doing recognise the '*complex mix of organisational and human factors*' that operate (Bate, 2008).

Secondly, and taking a leaf from the top items on the *leading by example* scale it is important, at least initially to *focus on what our ward does well* and to *say positive things about the ward* in order to instil some pride and a sense of confidence. This is consistent with an appreciative inquiry approach to change that has been used with such good effect in care environments for older people by Professor Julienne Meyer and colleagues at City University in major national campaigns such as My Home Life (www.myhomelife.org.uk).

Thirdly, if staff are to change their attitudes and approaches to care, an essential element of our model, then there is a need to start with where staff are 'at' and to explore their existing values and beliefs. Use of the Senses Framework has proved extremely effective in this respect both in agreeing core values for the whole of Gerontological nursing (See Tolson *et al.*, 2005) and in initiating local change in care homes (Davies *et al.*, 2007) and acute settings for older people (Nolan and Nolan, 2009).

Finally, as we have demonstrated, whilst the scales themselves can be 'scored' and entered into complex statistical models we would not recommend their use in this way in a unit based change initiative. Rather, as we have done in a care home setting (Faulkner *et al.*, 2006) we would suggest that they are used to create a 'profile' that is used as a basis for: Identifying the need for change; planning a way forward; and evaluating the results. This could be done for staff, patients, carers, or all three groups depending upon local circumstances and needs.

We are not suggesting that the toolkit comprise the scales alone and feel that other additional resources could be added drawing on the lessons learned from elsewhere (Davies *et al.*, 2007; Nolan and Nolan, 2009) and local initiatives and concerns. Nevertheless we believe that the scales offer a powerful way of exploring the need for change and that if implemented as suggested above they have a high likelihood of success. Therefore, in addition to the new theoretical insights this study adds they constitute an important outcome of the project.

12.0 From metrics to meaning: Some conclusions and recommendations

12.1 Introduction

Complexity has been one of the main conceptual underpinnings of this report and this seems entirely appropriate as the study upon which it is based addressed a broad range of complex issues and utilised a number of differing methodological approaches. We feel that this has resulted in rich and detailed insights that have helped to illuminate, and hopefully to provide the means to begin to address, several vexing problems. However, in-depth understandings do not necessarily provide readily applied solutions and there is much work to be done before the lessons we have learned can fully inform, even transform, future change initiatives. It is our belief that the nascent toolkit that is emerging from the study provides a potentially useful way of empowering practitioners not only to better understand, but also to begin to change, the '*clinical micro-system*' (Goodrich and Cornwell, 2008) of which they are part. But to do so will require more than just a toolkit, this is simply a means to an end. What is required in addition is an approach to culture change that translates our key findings from the complexities of a final report into a form that *speaks to* practitioners in a language that they can relate to and thereby see the potential of applying to their own situation. That is our aim here, where we will distil the key messages emerging from the study and in so doing will propose two contrasting models of culture change, one of which we believe reflects the currently dominant approach operating within the NHS, with the other being a model that we feel needs to be introduced more widely if some of the seemingly intractable challenges of providing dignified or compassionate care are to be addressed. Subsequent to this we will briefly reflect on the recommendations arising from the study for policy makers, practitioners and future research.

12.2 Models of culture change

Two main conceptual frameworks have informed this study: The Senses Framework (Nolan *et al.*, 2002, 2006); and the Pace-Complexity continuum (Williams 2001; Williams *et al.*, 2009). These have proved highly informative and we draw upon them again to frame the models of culture change that we propose. As noted above the present study 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, a series of 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 have created 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 have referred to these as the *Perform or Perish* model of culture change and the *Relational and Responsive* model. Their various dimensions and their characteristics are captured in Figure 12.1 below.

Figure 12.1: Models of culture change

• Perform or perish	• Relational and responsive
Pace: Quick fix, short term, process driven, pushing and fixing	Complexity: Longer term, focus on people and perceptions, brokering
External: Top down agenda, local context largely overlooked, off-the-shelf, one-size fits all approaches applied	Locally contextual factors fully acknowledged and addressed, solutions tailored to situation, existing models modified accordingly
Select few determine goals and direction of change	All groups including users/carers involved in deciding goals and direction of change
Punitive and transactional leadership style from top, little unit level leadership	Empowering, inspiring and transformational leadership style at all levels, especially unit
Metrics matter: Superficial, often quantitative targets for success, e.g. patient flow	Meaning matters, relational, dynamic qualitative 'indicators' of success, peoples' experiences
Scored	Profiled
Impoverished change environment results and the 'senses' are reduced	Enriched change environment results and the 'senses' are enhanced

However before going on to explore these models in greater depth it is important to state that although our study focussed on the experiences of older people we strongly believe that the models presented in Figure 12.1 have relevance to all those who use or deliver health care. Moreover, as much of the literature we considered emerged from the care home sector we also feel that similar considerations apply there, and indeed to the wider social care agenda, and public services more generally where the interactions between people, both providing and receiving services, are a key factor.

The *Perform or Perish* model on the left, for us, 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 our own data attest to the limitations of such an approach. The primary emphasis is on changes to the processes of care, as reflected in initiatives such as the Productive Ward. As our case study showed even if this is successful in freeing up time the broader NHS pace driven culture predominates and this time consequently tends to be used in attending to yet more process oriented issues and is not directed to hands-on patient care as was envisaged. Moreover the fact that one change initiative follows another with unrelenting pace further

exacerbates the limitations of this approach. In terms of Williams' model such activities are best captured using the pushing and fixing metaphor, whereby one initiative is pushed through without adequate thought or planning and staff, therefore have to engage in fire fighting and fixing activities to limit the disruption caused. In terms of the senses this is highly destructive as there is little or no time to establish a sense of continuity.

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) such as the brokering activities that Williams (2001, Williams *et al.*, 2009) suggests are needed to orchestrate care delivery. The adoption of this longer term and relational view of change creates and sustains a sense of continuity.

Moving to the second dimension within the perform or perish model, that concerning who *calls the shots*, here a largely top down, centrally driven agenda predominates with the local circumstances being largely overlooked. This is typical of the way in which policy edicts that are delivered from *on high* currently dictate the direction, and hence the primary activity of the NHS. Change initiatives tend to come as pre-packaged entities adopting a one size fits all approach. Once again the literature attests to the limitations of such a directive model. In terms of the senses, what is seen as significant and gives organisations, if not practitioners, their sense of purpose is largely externally imposed. Following logically from this it is clear that a select few individuals determine the goals for and direction of change, which further reinforces an externally driven sense of purpose and also undermines peoples' sense of belonging and the belief that they have a contribution to make to the team effort.

At the opposite end of the spectrum the relational and responsive approach to change fully acknowledges the importance of the local context and seeks solutions that are sensitive to this. It adapts existing approaches to change to suit the local circumstances and, importantly, ensures the full engagement of all groups in shaping the goals and direction for change. Once again both the literature and our own data reinforce the importance of this. In terms of the senses, what counts as significant and defines a shared sense of purpose are negotiated rather than imposed. Moreover, as everyone has the chance to contribute, a sense of belonging is much more likely to be successfully created and sustained.

12.2.1 Leadership and culture change

Leadership, especially at the level of the ward/unit, emerged as a major factor enabling successful change from both the literature synthesis and our empirical work. Within the *Perform or Perish* model leadership operates largely from the top and adopts a punitive and transactional approach to change with there generally being limited opportunities for leaders to be effective at the ward level. Change is therefore largely mandated (Powell *et al.*, 2009). In terms of the senses this type

of environment actively undermines a sense of security, as staff do not feel safe or enabled to innovate. The types of power identified in the narrative synthesis as being essential to staff motivation and commitment to change is denied them. Conversely the literature and our own data strongly endorse the potential for strong and clear leadership at the unit level to transform the experiences of giving and receiving care. Indeed the scale *Leading by example* succinctly captures the attributes of such a leader and it is clear that he/she enhances staffs' sense of security and creates the conditions in which innovation and improvisation are actively encouraged.

A sense of achievement refers largely to how success is judged and celebrated. How do people know, and how are they told that they are doing well? Within the perform or perish model achievement is largely judged using metrics and measures that are often, but not inevitably, superficial and frequently not only fail to reflect peoples' true experiences of care but actually serve to fragment it. For example in order to meet the patient flow targets that had been set centrally one of the case study sites introduced the notion of the *golden discharge*. This gave the largely spurious impression that a target had been met but in actuality fragmented the patient's experience of discharge and resulted in frail older people potentially spending several hours isolated in the discharge lounge. Achievement in such circumstances is typically *scored* in some way to provide a numerical value, allowing putative comparison with others areas. When using a relational and responsive model meanings take precedence over metrics and achievement is judged far more in terms of peoples', not only patients' but also carers' and staffs' experiences of giving and receiving care. In other words achievement is judged by the extent to which an *enriched* environment is created for all parties. Here success is profiled rather than scored and with the profile being used to both identify what is being done well and what could be improved. Work in the care home sector suggests that such an approach is far more likely to result in successful change. (Davies, *et al.*, 2007)

In summary therefore 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.

Of course the two models outlined above 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.

Whilst we believe that the above models provide a useful heuristic, capturing a number of complex ideas in a succinct and readily accessible form, if things are to change, and the *Relational and Responsive* model is to be widely adopted, there is still a need for concerted action at several levels.

12.3 Balancing metrics into relational care

In the preceding chapter we indicated that if enduring and meaningful change is to occur then society itself needs to engage in more focussed debates about the type of health and social care that it values and is willing to fund. This is increasingly important for, as technology advances and the seductive allure of cure is potentially available to more and more people, there is a growing risk that the most frail and vulnerable members of society (many but not all of whom will be older) will either be excluded, or their seemingly more prosaic but nevertheless important needs will be simply seen as less worthy of attention. The results of such a debate need to be communicated clearly to government the limitations of the current *Perform or Perish* model made transparent and meaning replace metrics in the value system.

Undoubtedly metrics must always have a place in a service where resources are finite, demands potentially infinite, and multiple departments are competing for a slice of the cake, each with their own legitimate demands. Furthermore whilst the local context figures prominently in the *Relational and Responsive* model it is essential to consider how a National Health Service can operate in order to ensure equity of care. However this should not mean reducing care to the lowest common denominator, nor should it stifle local innovation and the ability to tailor services to local need. Furthermore there will always be times when rapid and widespread change is needed in order to respond to unforeseen events and therefore pace is not inherently bad. Rather it seems to us that the balance has swung too far in one direction and there is a need for a significant realignment of the processes of health care delivery in order that they pay greater attention to the people giving and receiving care and their perception of what is significant. This may well require re-examining the *taken for granted* values and beliefs underpinning health care. But such fundamental culture change is a long-term and ongoing endeavour: '*A journey rather than a destination*' (Boyd and Johnson, 2008).

Whilst this needs be recognised, realisation of the enormity of such an undertaking is as likely to stultify as to stimulate action. Fortunately our results suggest that more local and focussed action can result in significant change even, as case study 2 showed, in the most impoverished of environments. Such action seems most successful at the level of the unit and is closely tied to peoples' perceptions of the processes of care that they experience. Conceptually this might be better thought of as climate change rather than culture change, with the former being more readily accessible and amenable to intervention. But whilst we feel we could make a convincing case for such a change in emphasis, the resulting semantics of 'climate change' seem a recipe for confusion in view of other debates about the worlds' weather.

However we believe that the emerging tool kit developed as part of the study can provide a potentially powerful stimulus for action as well as a means to begin to introduce change. The various scales comprising the toolkit were underpinned by the Senses Framework and represent a conceptually and statistically robust set of instruments with which both to explore and introduce changes to practice.

The climate for care subscales map very clearly on to the Senses Framework as below:

- *feeling safe* equates with security
- *supporting each other* and *MDT working* with belonging
- *improving practice* with continuity and achievement
- *sharing a philosophy* with purpose
- *having a say* and *developing your skills* with significance

The remaining two factors, *resources* and *too much to do*, highlight the potentially inhibiting influences that need to be addressed.

If all of the above are attended to then an enriched environment (at least for staff) can be said to exist. But as this study and others using the senses (Davies *et al.*, 1999) clearly demonstrate creating such an environment turns on the quality of the leadership at unit level. The key attributes of such a leader are fully captured in the scale *leading by example* which illustrates the range of behaviours that the ward manager needs to exhibit in order for staff to be able to co-create an enriched environment.

However the views and experiences of patients and family carers are also central to the Senses Framework and an enriched environment can only be said to exist when they experience such senses too. The toolkit again addresses this issue with two scales for patients (*Feeling significant* (p) and *Could do better* (p)) and three for carers (*Giving my relative the best* (c), *Could do better* (c) and *Feeling significant* (c)). These latter scales are particularly important for whilst of late considerable attention has rightly been turned to the needs of patients, carers have needs of their own which are often not fully addressed. As importantly, our data suggests that patients, especially older and frail patients, may not necessarily provide a comprehensive assessment of the quality of their care experience and in such circumstances the views of carers offer a most useful complimentary source of information.

The toolkit also provides a brief assessment as to the matrons' views on the ward environment in terms of the extent to which the ward is meeting patients' needs and whether or not they are looking to improve the care they offer.

In our view therefore the toolkit offers a comprehensive and theoretically well grounded means of exploring the caring dynamics within a ward environment. Importantly the content is likely to *speak* to staff and be readily accepted by them. the Senses Framework has been developed over the last decade or more for, with and by staff, older people and their family carers. Consistent with the *meanings* and not the *metrics* of care we are not suggesting that the scales in the toolkit be scored, although they have the statistical properties that would enable this. Rather we believe that they can be used to create profiles within units that can act as the basis for indentifying what works well and what could be changed and thereby initiate important dialogue about the need for action. As we indicated in the preceding chapter, work with the CARE profiles in the care home sector has demonstrated how useful this approach can be (Faulkner *et al.*, 2006), especially if aligned with an appreciative enquiry model (see www.myhomelife.org.uk). Therefore whilst we hope that the conceptual, methodological and theoretical contribution of this study will further thinking in the area of culture/climate change

we believe that it is the toolkit and its further development and application that has the greatest potential to shift the balance from metrics to meaning.

However for changes such as the above to have any realistic chance of success an enriched environment, not only of care, but also within the wider health and social care system needs to be created that more closely reflects the relational and responsive model outlined above. In reflecting upon the extent to which compassionate care might be achieved within current health and social care services Nolan (2010) suggested that society as a whole needs to consider a series of fundamental questions about the type of services that it wants, values and is willing to support and subsequently to pose these questions to government and those charged with designing and delivering policy on societies' behalf. Taking a relational view of an enriched environment Nolan (2010) used the senses to help frame these questions, which were:

- is relational practice seen as **significant**? That is does it matter and is it accorded value and status, not as an added extra but as one of the core values underpinning service delivery?
- is relational practice one of the primary goals of service delivery? In other words is it seen as one of the fundamental **purposes** of care?
- is relational practice central to the way that **achievement** (success) is conceptualised and celebrated?
- do practitioners experience **continuity** in their exposure to positive role models for relational practice? In other words does relational practice figure prominently in their basic training and are they subsequently enabled and facilitated to develop and refine the skills need to practice in a relational way?
- do practitioners from diverse disciplines, with often implicit and potentially conflicting values and beliefs, feel that they **belong** to a practice community that subscribes to relational practice?
- do practitioners feel safe and **secure** to provide care based on relational principles? Are the potential vulnerabilities of such a way of working acknowledged and appropriate support provided?

The answer to many of these questions was unlikely to be an unequivocal yes. Such questions are rarely explicitly posed and yet they capture many of the current concerns about the quality of care delivered to the frailest and most vulnerable members of society. Taking these arguments a stage further, Nolan posed a second set of questions, again framed by the senses, this time focussing on current policy for the delivery of health and social care. These were:

- does current government policy create an '**enriched environment**' for the delivery of health and social care?
- does a pace driven agenda create the necessary condition of **continuity** for change to be successfully achieved?
- does a target driven and largely punitive culture create the necessary conditions of **security** for organisations and individuals to feel safe to take risks and innovate?

- does current government health and social care policy promote a common sense of **purpose**, and is this sense of purpose shared by the institutions, professions and practitioners that deliver health and social care thereby creating a sense of **belonging**?
- does the way that **achievement** is currently conceptualised, measured and rewarded promote and sustain the type of care/services that meet the needs of frail and vulnerable people with compassion and dignity?
- fundamentally, what are the core values lying at the heart of health and social care, what is seen to matter and count as **significant**? How explicit are these values and are they promoted by the existing target driven culture that dominates the service delivery system?

We believe that these questions capture many of the tensions emerging from this study and that they raise several challenges for multiple audiences including those devising policy, those institutions charged with its delivery and the practitioners who ultimately have to provide the direct care/service itself. Such questions also feed into the potential recommendations arising from this study.

Of course the recent change of government, combined with the inevitable financial constraints that will apply, have thrown many of the above issues into the melting pot and we do not currently know with any certainty exactly what future government policy will be. The following recommendations arising from the study should therefore be viewed in light of the above.

12.4 Recommendations from the research

12.4.1 Policy recommendations

As we have shown, a key requisite for cultural change is stamina and time. The models presented in Fig 12.1 offer a way of conceptualising the tensions between the type of culture that we see as currently dominating policy and practice (perform or perish) and what we believe is a culture more likely to result in the delivery of compassionate and dignified care (responsive and relational).

The ideal of quick fixes evident in the NHS, reinforced by target setting, transactional approaches, and short-term perspectives run directly against successful culture change as this takes time and persistence. Planned organisational cultural change is in general recognised as a difficult project. All the evidence from the literature and this study points to the complexity of culture change and the need for consistent re-iteration of *the message* over the long term, with many change initiatives taking years if not decades to realise. Based on this we would suggest that:

1. Large scale culture change in care for older people requires the adoption of a shared, coherent, intellectually well-grounded position on what care for older people should look like, and what is required to achieve this. The perform or perish model, emphasising pace and top-down, target led change is more conducive to creating impoverished as opposed enriched environments of care. Policy makers

should recognise that a relational and responsive model of care and culture change provides a much more realistic chance of creating an enriched environment for the delivery of care to older people and ensure that these principals are central to policy developments.

2. There is a clear need for a move away from the political imperative *to be seen to be doing something* typified by the quick fix, short term, Pace driven models of culture change, towards longer term interventions with a focus on people (staff, patients and carers) and perceptions and meanings i.e., a relational and responsive model of change. At a policy level this means a more strategic, longer term, overarching initiative, clearly and consistently articulated.
3. Tied into this is the issue of the plethora of policy initiatives, which are often not seriously implemented and/or have high mortality rates. Successful introduction of new practices requires a systematic approach, underpinned by an overarching vision that supports implementation. However the NHS places a cultural premium on constant improvement, or at least new promises of improvement, and this often results in a succession of new initiatives, rather than a focus on a smaller number of more fundamental but longer term policies. At a policy level there needs to be a more co-ordinated approach between agencies, with fewer initiatives fitting within an overarching strategy.
4. Methods of culture change are of relevance here, in particular, recognition that checklist approaches (such as that used in The Dignity Challenge) whilst advocating entirely positive aspirations, are relatively limited in terms of achieving enduring culture change and/or high quality care – such approaches are unlikely to impact in cultural terms as they do not address beliefs, values or norms, but simply provide another set of *things to make sure you do*. At a policy level there has to be acknowledgement of the need for different approaches to change which focus on the meanings, values and aspirations behind such checklists. This means developing training/support around tools and leadership materials that can help effect change, such as the components of the *toolkit* identified in this study.
5. Culture change in care for older people needs to be backed up by material changes in policy, structure, processes, and reward systems.
6. Patient care and culture change need to be conceptualised in ways that have meaning for front line staff, patients and carers. This means replacing or complementing existing targets/standards with activities or interventions that focus on patient, staff and carer outcomes and experiences. The Senses Framework offers a way of conceptualising what needs to be achieved and the toolkit developed as part of this research can be used to identify what is currently working well and where further work is needed.
7. Approaches to change need to take account of the roles of all parties (ie staff, carers and patients) and policy initiatives need to make this explicit.

8. Approaches to culture change need to recognise the importance of local context, and policy initiatives need to avoid a 'one size fits all' approach and incorporate scope for local adaptation.
9. Finally, at a policy level and consistent with our results, any initiative, as well as fitting in to an overarching strategy, needs to have a realistic timeframe for action and meaningful assessments of follow up or outcome. We have already discussed the potential of profiles rather than scores. Equally such indicators of change in the desired direction could include qualitative measures, or measures of staff, patient and carer perceptions and experiences such as those included in the tool kit based on the Senses Framework.

12.4.2 Recommendations for practice

As well as requiring coherence and a longer term agenda the type of culture change we are suggesting here will also require a clear will from senior managers and receptiveness among NHS staff to take on board new ways of working and delivering care. Indeed many of these changes may well challenge accepted, but often implicit and long standing professional values and beliefs. There are clearly potentially formidable cultural constraints in the NHS working against wholesale change. However, on a more optimistic note, we know that many front-line staff are receptive to the ideas presented here. Our results suggest that local culture change is much more achievable. In making recommendations with regard to local culture change, we are not ignoring the challenges of attempting this within a wider NHS culture that is predominantly pace driven, but clearly our results indicate that, with the right combination of factors, real culture change can happen at this level. A lot of managing culture talk at the macro level is vague and does not go beyond espoused intentions. Rather than a formula for a good overall culture and a set of rules for how to create it and modify it, it is more practically valuable for change agents, managers and practitioners to use the ideas and tools presented here (i.e. the Senses Framework, our survey measures) to support change at a more micro level. The survey measures developed in this research (see Chapter 5 and Appendix 4) include 12 scales assessing climate for care within nursing teams, two scales assessing patients' experiences of care and 3 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. Managers and staff may well find the questionnaire measures a useful tool for practice development.

10. Local culture change is often driven by strong leadership, and the characteristics of such a leader have been amply demonstrated in the 'Leading by example' scale developed in this study. The survey work shows how a culture of care can be shaped locally by a leader and the impact this has on quality of care. At a Trust level, the importance of identifying and supporting the development of ward leaders is paramount. In particular, our work demonstrates the significant impact of leading by example and developing a shared philosophy of care on staff, patient and carer outcomes and it is these skills that Trusts should be seeking to promote in ward managers. As demonstrated by the ward leader in case study 2 this requires a strategic approach to the development of individuals over time.

11. Leaders at all levels must be aware of the importance of underscoring care values and practices through their own talk and actions. Leaders can help shape local culture change through what leaders pay attention to, and what they control, reward, and coach.
12. In support of this, Trusts need to recognise and promote a system that allows wards leaders to maintain a visible presence on the ward in order to role model the type of care/leadership required.
13. The findings of this research, in line with much previous research in the area identifies the importance of senior level support for the implementation of initiatives and in turn encouragement for more junior managers to embark on initiatives to change local thinking and practice.
14. Both culture change and quality of care require that the relational practices referred to earlier are recognised as a key skill that needs to be valued, promoted and supported. In particular the potential emotional vulnerability of this type of work must be acknowledged and appropriate support systems put in place.
15. Culture change requires the use of talk, actions, practices and processes that are coherent and back each other, including the use of symbols of recognition and reward which point to the importance of, for example, relational practices. Attempts to re-orientate values and beliefs incoherent with organisational processes and procedures are likely to fail.
16. Values, beliefs and meanings, the bedrock of culture, can be difficult to adjust. Changes in behaviour can eventually lead to changes in culture, and therefore a strategy to change climate (staffs' perceptions of formal and informal practices, policies and procedures in the workplace) is a useful way of prompting changes in behaviour that can lead to lasting change in values. Managers need to introduce material changes in workplace processes that impact on the climate for care experienced by staff, as a starting point for more fundamental culture change.
17. Leaders and managers need to concentrate on developing an enriched care environment that emphasises the values encapsulated by the Senses.
18. Trusts need to develop more locally contextual and responsive ways of 'measuring success' and highlighting a sense of achievement for all parties. The toolkit provides a number of potential means. A regular form of 'profiling' could be introduced, linked to an appreciative inquiry model of instituting change. In particular the perspectives and involvement of family carers should be sought more regularly and systematically.

12.4.3 Recommendations for research

19. There is a need for more applied research on methods of implementing and sustaining culture change at local level and the further development and refinement of the toolkit presented here is a potentially interesting option. Such research should build in a systematic way on the insights provided by this study and actively involve staff, patients and family carers in any further work aimed at further developing and testing the toolkit and associated change methodologies. This would lend itself to a programme of research culminating in a large scale trial of an intervention based on the principles identified in this study.
20. There is a need for further exploration of greater understanding of how/why enriched environments can flourish in otherwise impoverished settings – are there other minimum requirements (in addition to those for the Senses).
21. There is a need for further empirical and conceptual work on the type of 'relational practices' that have been identified in this report together with research on effective training to develop and sustain such skills in all those involved in care delivery.
22. The proposed dimensions of the two contrasting cultures of care need to be further explored and elaborated upon. Are they adequate? Are important dimensions missing? Do the contents of the current toolkit capture the key dimensions of the models.
23. Given the time it takes for genuine culture change to be achieved there is a need for more longitudinal studies that explore the dynamics and the factors necessary to create and sustain such change overtime.
24. We need to understand more about the pace and complexity tension existing in older people care and the available strategies to resolve it or at least achieve a greater balance between the needs for 'pace' versus 'complexity' in both strategic and practical management terms. What would an effective balance look like? Cross-cultural comparisons might be useful here.
25. We describe the evolution of modern day health services for older people in this report, however perhaps a further study is needed to examine, in greater detail, older people care from a historical perspective, i.e., how did older people health services come to reach the state they are in currently.¹

¹ We are grateful to an anonymous reviewer for suggesting this recommendation.

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Appendix 1: Staff, patient and carer interview schedules

Culture Change and Care for Older People Project Manager/Senior Staff Interview Schedule

General Introduction

- ◇ Explain the project to the participant.
- ◇ Gain consent – fill in and sign consent form.
- ◇ Anything you say will be confidential and anonymity is guaranteed. You or the ward will not be identified in any reports that result from this study.

General Questions to establish relationship with interviewee

1) Can you tell me a bit about your current job...

How long have you been working here?

What other jobs have you done?

(If relevant) how long is it since you qualified?

Why do you do this job?

Dignity Challenge:

There has been a big initiative launched recently by the government to try and address the challenges of providing dignified care for older people (*The Dignity Challenge*):

1. What is your opinion of the 'dignity challenge'?
2. What are the implications of the dignity challenge for your trust?
3. What sort of challenges have you had to address to be able to implement the changes recommended by this initiative?
4. Thinking terms of local policy, what sort of changes have you had make to accommodate these new government guidelines?
5. Have any support structures been put in place to assist staff in meeting these challenges? (**Prompt: What, how, staff reaction**)
6. How well do you think the needs of frail older people are met in acute care settings in this Trust?
- 7.

General Issues:

Patients

1. How well do you think this trust provides good care for older people?
2. What do you think this trust does well in terms of providing such care?
3. What helps you do these things well?
4. What are the challenges that this trust face in caring for older people?
5. Do you think you could improve the way care for older people is provided? (*Prompt for each challenge*)
6. What sort of resources would you need to introduce such changes?

Relatives

7. What do you think this trust does well in terms of providing care for the families of older people?
8. What helps you do these things well?
9. What are the challenges that the trust faces in trying to meet the needs of families of older people?
10. Do you think this trust could improve the way the needs of the families of older people are met? (*Prompt for each challenge*)
11. What sort of resources would you need to introduce such changes?

Concluding Remarks

Thank the participant for taking part.

Ask:

- ◇ Have they anything further they wish to add?

Culture Change and Care for Older People Project

Staff Interview Schedule

General Introduction

- ◇ Explain the project to the participant.
- ◇ Gain consent – fill in and sign consent form.
- ◇ Anything you say will be confidential and anonymity is guaranteed. You or the ward will not be identified in any reports that result from this study.

General Questions to establish relationship with interviewee

1) Can you tell me a bit about your current job...

How long have you been working here?

What other jobs have you done?

(If relevant) how long is it since you qualified?

Why do you do this job?

Now we want to explore with you your experiences of caring for older people in your department.

General Issues

Patients

12. How well do you think this unit provides good care for frail older people?
13. What do you think you do well in terms of providing such care?
14. What helps you do these things well?
15. What are the challenges in caring for older people?
16. Given such challenges, do you think you could improve the way care for frail older people is provided? (*Prompt for each challenge*)
17. What sort of resources would you need to introduce such changes?

Relatives

18. Overall how well do you provide support to the families of older people?
19. What do you think you do well in terms of providing care for the families of older people?
20. What helps you do these things well?
21. What sort of challenges do you come across when you are trying meet the needs of patients relatives?
22. Do you think you could improve the way needs of the families of frail older people are met? (*Prompt for each challenge*)
23. What sort of resources would you need to introduce such changes?
24. How about yourself? How do you find working with older people?

25. Have you heard about the 'dignity challenge'?

26. *If so*: How did you here about it? (*Prompt: from whom, Trust/Ward Manager etc*)
27. Have you noticed any changes as a result of the 'dignity challenge'?

Events that have happened in the ward

1) Tell us about a time or an event related to caring for older patients that **made you feel happy** about a care situation that you were involved in.

Prompts: What was it that made you feel happy?

Feedback from colleagues

Appreciation from patients / carers

2) Tell us about a time or event related to caring for older patients that **made you feel disappointed or upset** about a care situation that you were involved in.

3) Tell us about a time or event related to caring for older patients that **made you feel supported** about a care situation that you were involved in.

4) Tell us about a time or event related to caring for older patients that **made you feel let down** about a care situation that you were involved in **Concluding Questions**

1) Having talked about the previous issues, what do you think are the most important issues in care for older, frail people?

2) Who do you think are the most important or significant people in this process?

Concluding Remarks

Thank the participant for taking part.

Ask:

- ◇ Have they anything further they wish to add?

Patient and carer interview schedule: Instructions for interviewer

This schedule has been designed to reflect the domains of the survey questionnaire, and should be used in conjunction with the questionnaire.

At the beginning of interview it is important make it clear to the respondent that they don't have to talk about sensitive issues or issues which might upset them. Our aim is to try and find out what it was about their care which prompted their responses to the questions in the survey.

If you find that the respondent becomes very upset, or feel that they need more support than they are receiving then consider offering the following advice:

a) give them the contact details of the PALS team for that particular trust and advise them that they would help them resolve any issues they have about the care that they received;

b) if they are struggling with the role of being a carer give them the contact details of the local carers centre and advise them that they are there to provide support to both new and experienced carers; or

c) if they feel concerned about ongoing health issues, or issues related to another persons health (i.e. their carer / relative) then advise them to contact their GP practice.

If you do advise any of these actions, please record them on the interview schedule and file this in the site file for the appropriate site.

Reassure the participant and inform them that if they have changed their minds about participating in the research then we will discard any information they have given us to that point

This interview schedule is designed to act as purely as a guide. However, there are a series of prompts if the interviewer feels that the respondent is struggling to tell their story. These are designed to remind the interviewer of the content of the questionnaire.

Introduction (Along the lines of...):

Firstly, I would just like to say thank you for filling in and returning our questionnaire, and also for taking the time to talk to me now. It really is great that you can help us with our work. Before we start is there anything you would like to ask me about the project?

I understand that you (or your relative) were (was/is) a patient on.....ward? Could you tell me a bit about that? Firstly, why were you (they) admitted to hospital? Was (the named ward) the ward you (they) were admitted to in the first place?

I would like to talk to you about (the named ward) the ward you (they) were on just before you were discharged.

During the Interview (Think about addressing the following issues: These **may** also act as prompts if the need arises. These **are not** intended as structured interview questions):

Questions about the ward

Did the ward look clean and tidy? Did the ward feel welcoming, and like a happy place? Did you feel like you were treated with dignity and respect? What was the food like?

Questions about the nurses

Did the staff get to know you? Did they know your likes and dislikes? Did they help you quickly when you asked for it? Were you always looked after by the same group of nurses? Did you feel the nurses had enough knowledge and skills to care for you?

Questions about the doctors

How easy was it to talk to the doctor's?

Questions about treatment

Were you told much about your treatment? Were you told how you were progressing? Did you feel that you had a say in your treatment? Could you discuss it with the doctors and nurses? Did you have regular access to therapy staff (occupational therapists, physiotherapists)? Did other patients appear to get the same amount of treatment?

Questions about discharge

Were you given information about your discharge? Were you told when you were going home?

Questions about relatives

Were your visitors always made to feel welcome? Were they encouraged to help with your care, or were they asked to leave when the nurses wanted to do something with you? Could your relatives ask questions about your care?

Conclusion (Something along the lines of...):

Summing up, you feel that overall I you had a experience. You think that was (very) good, and that..... could have been better. Is there anything else you would like to say that we haven't covered?

Thank you very much for helping us with our research. If you have any further questions we can be contacted on the details on the information sheet that you received with the questionnaire.

Close

Appendix 2: Detailed table of interviews conducted in individual case study sites

Case Study A

Interviewee	Phase 1	Phase 2	Phase 3
Ward Manager 1	✓	✓	✓
Ward Manager 2	✓		✓
Ward Manager 3	✓		✓
F Grade Sister 1	✓		
F Grade Sister 2	✓		✓
Staff Nurse 1			
Staff Nurse 2		✓	
Staff Nurse 3	✓		
Staff Nurse 4		✓	
Staff Nurse 5		✓	
Staff Nurse 6		✓	
Staff Nurse 7	✓		
Staff Nurse 8	✓		
Staff Nurse 9		✓	
Staff Nurse 10		✓	
Staff Nurse 11		✓	
Staff Nurse 12		✓	
Matron 1		✓	
Matron 2			✓
Matron 3			✓
Matron 4	✓		
Acting Nurse Consultant		✓	
Deputy Chief Executive		✓	
Director of Nursing	✓		
Deputy Director of Nursing	✓		
Director of Organisational Development	✓		
Consultant Physician		✓	
Business Manager	✓		
Therapy Services Coordinator – Acute	✓		
Therapy Services Coordinator – Community		✓	

Case Study B

Interviewee	Phase 1	Phase 2	Phase 3
Matron – Older People	✓	✓	✓
Sister 1	✓	✓	✓
Sister 2	✓		✓
Sister 3	✓	✓	✓
F Grade Sister 1		✓	
F Grade Sister 2		✓	
Nursing auxiliary	✓		
Staff Nurse 1	✓		
Staff nurse 2		✓	
Student Nurse 1		✓	
Student Nurse 2	✓		
Ward Clerk	✓		
Chief Executive			
Senior Nurse for Practice Development	✓		✓
Director of Nursing			✓
Deputy Director of Nursing	✓		
Associate Director of Nursing			✓
Matron - Infection Control			✓
Operations Director		✓	
Consultant	✓		
Operational patient flow manager			✓
Senior practice development nurse	✓		
Social Worker	✓		
Physiotherapist		✓	

Case Study C

Interviewee	Phase 1	Phase 2	Phase 3
Nurse Director	✓		
Matron 1	✓	✓	
Matron 2 (RADS Team)	✓		✓
Matron 3	✓	✓	
Ward Manager 1	✓	✓	
Ward Manager 2 (RADS Team)		✓	✓
Ward Manager 3		✓	
Sister 1 (RADS Team)	✓	✓	

Sister 2	✓	✓	
Sister 3	✓		
Staff Nurse 1 (RADS Team)	✓		
Staff Nurse 2 (RADS Team)	✓		
Staff Nurse 3	✓	✓	
Staff Nurse 4	✓	✓	
Staff Nurse 5	✓		
Staff Nurse 6	✓		
Staff Nurse 7	✓	✓	
Staff Nurse 8	✓	✓	
Staff Nurse 9 (RADS Team)	✓		
Staff Nurse 10	✓	✓	
Staff Nurse 11		✓	
Staff Nurse 12		✓	
Staff Nurse 13		✓	
Staff Nurse 14		✓	
Staff Nurse 15 (RADS Team)		✓	✓
Staff Nurse 16 (RADS Team)		✓	✓
Staff Nurse 17		✓	
Staff Nurse 18		✓	
Staff Nurse 19		✓	
Staff Nurse 20 (RADS Team)			✓
Staff Nurse 21 (RADS Team)			✓
HCA 1 (RADS Team)	✓		
HCA 2	✓	✓	
HCA 3		✓	
HCA 4		✓	
HCA 5		✓	
Student Nurse 1 (RADS Team)	✓		
Student Nurse 2	✓		
Student Nurse 3	✓		
Student Nurse 4	✓		
Student Nurse 5		✓	
Student Nurse 6		✓	
Student Nurse 7 (RADS Team)			✓
Housekeeper	✓		
Ward Clerk	✓		
Consultant 1 (RADS Team)	✓		✓
Consultant 2 (RADS Team)		✓	✓
Chief Executive		✓	
Medical Director		✓	

Physiotherapist		✓	
Occupational Therapist (RADS Team)	✓		
Senior Physiotherapist 1 (RADS Team)			✓
Senior Physiotherapist 2 (RADS Team)			✓
SHO		✓	
Dietician (RADS Team)			✓

Case Study D

Interviewee	Phase 1	Phase 2	Phase 3
Director of Nursing	✓	✓	✓
Deputy Director of Nursing	✓	✓	✓
Ward Manager 1	✓	✓	✓
Ward Manager 2	✓	✓	✓
Ward Manager 3	✓	✓	
Ward Manager 4	✓	✓	
Director of Nursing – Medical	✓		
Discharge Liaison	✓		
Discharge Facilitator	✓	✓	
Older Peoples Nurse Specialist	✓	✓	
Psychiatric Liaison	✓		
Head of Nursing Support	✓		
Practice Development Manager	✓		
Consultant 1	✓		
Consultant 2		✓	
Healthcare Assistant 1	✓		
Healthcare Assistant 2	✓		
Staff Nurse 1	✓		
Staff Nurse 2		✓	
Staff Nurse 3			✓
Sister	✓	✓	
Matron 1	✓	✓	
Matron 2	✓	✓	

Appendix 3: Search strategies for the narrative literature review

Electronic database searches

British Nursing Index:

Database: British Nursing Index <1994 to November 2008>

Search Strategy:

-
- 1 (organi?ational change or culture or values or beliefs or norms or ideology or affective commitment).tw. (2273)
 - 2 exp nurse patient relations/ or exp patients rights/ or exp "patients attitudes and perceptions"/ or exp Patients Empowerment/ (7763)
 - 3 (dignity or dignif\$ or privacy or compassion\$ or empath\$ or sympath\$ or preference\$ or self-image).tw. (1258)
 - 4 exp elderly nursing/ (1473)
 - 5 (older or elder\$ or geriatr\$ or gerontol\$).tw. (8660)
 - 6 2 or 3 (8553)
 - 7 4 or 5 (8660)
 - 8 1 and 6 and 7 (23)
 - 9 limit 8 to yr="1998 - 2008" (23)
 - 10 from 9 keep 1-23 (23)

CINAHL:

Database: CINAHL - Cumulative Index to Nursing & Allied Health Literature <1982 to November Week 3 2008>

Search Strategy:

-
- 1 exp Organizational Culture/ (6031)

- 2 culture.tw. (13147)
- 3 organi?ational change.tw. (533)
- 4 (values or beliefs or norms or ideology or affective commitment).tw. (35143)
- 5 or/1-4 (51461)
- 6 exp EMPATHY/ (1733)
- 7 exp "Privacy and Confidentiality"/ (8594)
- 8 exp Human Dignity/ (787)
- 9 (dignity or dignif\$ or privacy or compassion\$ or empath\$ or sympath\$ or preference\$ or self-image).tw. (16801)
- 10 respect.ti. (855)
- 11 or/6-10 (25547)
- 12 exp Geriatrics/ (1332)
- 13 exp Gerontologic Nursing/ (7952)
- 14 exp Gerontologic Care/ (8778)
- 15 exp "AGED, 80 AND OVER"/ or exp AGED/ or exp AGED, HOSPITALIZED/ (189493)
- 16 (older or elder\$ or geriatr\$ or gerontol\$).tw. (69239)
- 17 or/12-16 (210171)
- 18 5 and 11 and 17 (389)
- 19 limit 18 to yr="1998 - 2008" (345)

MEDLINE:

Database: Ovid MEDLINE(R) <1996 to November Week 2 2008>

Search Strategy:

-
- 1 exp Organizational Culture/ (7333)
 - 2 culture.tw. (157350)
 - 3 organi?ational change.tw. (545)
 - 4 (values or beliefs or norms or ideology or affective commitment).tw. (287920)
 - 5 or/1-4 (443971)
 - 6 exp EMPATHY/ (5650)
 - 7 exp "Privacy and Confidentiality"/ (0)

- 8 exp Human Dignity/ (0)
- 9 (dignity or dignif\$ or privacy or compassion\$ or empath\$ or sympath\$ or preference\$ or self-image).tw. (71586)
- 10 respect.ti. (1646)
- 11 or/6-10 (77152)
- 12 exp Geriatrics/ (3949)
- 13 exp Gerontologic Nursing/ (0)
- 14 exp Gerontologic Care/ (0)
- 15 exp "AGED, 80 AND OVER"/ or exp AGED/ or exp AGED, HOSPITALIZED/ (851159)
- 16 (older or elder\$ or geriatr\$ or gerontol\$).tw. (164392)
- 17 or/12-16 (908165)
- 18 5 and 11 and 17 (1132)
- 19 limit 18 to yr="1998 - 2008" (1002)
- 20 from 19 keep 1-345 (345)
- 21 exp Privacy/ (5159)
- 22 exp Human Rights/ (50265)
- 23 6 or 9 or 10 or 21 or 22 (123117)
- 24 exp Geriatric Nursing/ (4687)
- 25 12 or 15 or 16 or 24 (908369)
- 26 5 and 23 and 25 (1369)
- 27 limit 26 to yr="1998 - 2009" (1214)

Pre-MEDLINE

Database: Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations <November 19, 2008>

Search Strategy:

-
- 1 exp Organizational Culture/ (0)
 - 2 culture.tw. (21823)
 - 3 organi?ational change.tw. (70)
 - 4 (values or beliefs or norms or ideology or affective commitment).tw. (49719)
 - 5 or/1-4 (70621)
 - 6 exp EMPATHY/ (0)

- 7 exp "Privacy and Confidentiality"/ (0)
- 8 exp Human Dignity/ (0)
- 9 (dignity or dignif\$ or privacy or compassion\$ or empath\$ or sympath\$ or preference\$ or self-image).tw. (9897)
- 10 respect.ti. (266)
- 11 or/6-10 (10150)
- 12 exp Geriatrics/ (0)
- 13 exp Gerontologic Nursing/ (0)
- 14 exp Gerontologic Care/ (0)
- 15 exp "AGED, 80 AND OVER"/ or exp AGED/ or exp AGED, HOSPITALIZED/ (0)
- 16 (older or elder\$ or geriatr\$ or gerontol\$).tw. (22166)
- 17 or/12-16 (22166)
- 18 5 and 11 and 17 (36)
- 19 limit 18 to yr="1998 - 2008" (31)
- 20 [from 19 keep 1-345] (0)
- 21 exp Privacy/ (0)
- 22 exp Human Rights/ (4)
- 23 6 or 9 or 10 or 21 or 22 (10154)
- 24 exp Geriatric Nursing/ (0)
- 25 12 or 15 or 16 or 24 (22166)
- 26 5 and 23 and 25 (36)
- 27 limit 26 to yr="1998 - 2009" (31)

PsycINFO:

Database: PsycINFO <1987 to November Week 3 2008>

Search Strategy:

-
- 1 exp Organizational Culture/ (4834)
 - 2 culture.tw. (43044)
 - 3 organi?ational change.tw. (2595)
 - 4 (values or beliefs or norms or ideology or affective commitment).tw. (91599)
 - 5 or/1-4 (131553)
 - 6 exp EMPATHY/ (4044)

- 7 exp Privacy/ (798)
- 8 exp Self Esteem/ or exp Pride/ or exp Human Rights/ (17290)
- 9 (dignity or dignif\$ or privacy or compassion\$ or empath\$ or sympath\$ or preference\$ or self-image).tw. (55919)
- 10 respect.ti. (604)
- 11 or/6-10 (72919)
- 12 exp Geriatrics/ (2828)
- 13 exp "AGED, 80 AND OVER"/ or exp AGED/ or exp AGED, HOSPITALIZED/ (1056)
- 14 (older or elder\$ or geriatr\$ or gerontol\$).tw. (83640)
- 15 exp Gerontology/ (3601)
- 16 or/12-15 (84256)
- 17 limit 16 to yr="1998 - 2009" (300)

Social Science Citation Index

Topic=((values or beliefs or norms or ideology or affective commitment or culture or organizational change) and (older or elder*) and (dignity or empath* or compassion* or privacy or dignif* or preference* or self-image))

Timespan=1998-2008. Databases=SSCI.

HMIC (Health Management Information Consortium)

(culture and (older or elder*) and dignity).mp

Social Care Online

Topics: Empathy and Older people

Appendix 4: Staff, patient and carer questionnaires



Quality of Care for Older People Survey of Staff Experience



How to complete the questionnaire

For the purposes of this questionnaire we are interested in the ward on which you work including the nursing team, by which we mean nurses and auxiliary staff. In order to respond to the questions, please tick the box or circle the number which best represents your view. For example, this question below is about the levels of training on the ward.

These questions are about the ward:		Strongly Disagree	Neither Agree or Disagree		Strongly Agree	
1.	We receive enough training on this ward to provide good quality care for patients	1	2	3	4	5

Now you have read the instructions, please begin the survey below. Please read every question carefully before responding and answer every question. Thank you.

Section 1: Your ward

1. The following questions refer to your <u>nursing team (including auxiliary staff)</u> and <u>the ward where you work</u> .						
How much do you agree with each of the following about your ward?		Strongly Disagree	Neither Agree or Disagree		Strongly Agree	
a.	The team share an explicit philosophy of care	1	2	3	4	5
b.	The psychological aspects of care are highly valued on this ward.	1	2	3	4	5
c.	Values and expectations for care are communicated to new members of the team	1	2	3	4	5
d.	We have a culture on this ward about caring for patients and supporting them rather than being about 'doing tasks'	1	2	3	4	5
e.	Involving patients and their carers is considered very important on this ward	1	2	3	4	5
f.	Staff receive praise, thanks or other recognition when they show outstanding care	1	2	3	4	5

	for patients					
g.	We have sufficient basic equipment and supplies to deliver good levels of care	1	2	3	4	5
h.	There are adequate support services to allow us to spend time with our patients.....	1	2	3	4	5
i.	Training supports the quality of care on this ward	1	2	3	4	5
j.	Team members receive regular feedback on the appropriateness of their care	1	2	3	4	5
k.	The nursing team are involved in making important decisions about patient care	1	2	3	4	5
l.	There are sufficient staff with the knowledge and skills to provide quality patient care	1	2	3	4	5
m.	There are members of the team with specific training to meet the needs of very frail, older patients	1	2	3	4	5
n.	We have team members with the skills to provide dynamic care for patients with dementia	1	2	3	4	5
o.	Membership of the team is, on the whole, clear and stable	1	2	3	4	5
p.	All members of the team identify with the same goals and objectives	1	2	3	4	5
q.	We operate as a real team	1	2	3	4	5
r.	We regularly take time to figure out ways to improve our care delivery	1	2	3	4	5
s.	There is support on this ward for new and innovative ideas about patient care	1	2	3	4	5
t.	The team is constantly seeking to improve its care practice	1	2	3	4	5
2. These questions are about <u>support</u> within your nursing team.		Strongly Disagree		Neither Agree or Disagree		Strongly Agree
a.	Colleagues show concern and support to help each other deal with stresses at work	1	2	3	4	5
b.	Colleagues provide each other with emotional support.	1	2	3	4	5
c.	The emotional demands of care giving are acknowledged in this team	1	2	3	4	5
d.	Members of this ward team feel confident about the competence and abilities of other team members.	1	2	3	4	5
e.	There is a great deal of trust among members of the team	1	2	3	4	5
f.	The team can really count on each other to help out with any difficult tasks at work	1	2	3	4	5
g.	Some people are afraid to express their opinion at work for fear of criticism	1	2	3	4	5
h.	If you make a mistake on this team it is often held against you	1	2	3	4	5
i.	People feel safe to be themselves in this team without fear of criticism, censure or feeling foolish	1	2	3	4	5
j.	This is a ward where it is safe to bring up problems and tough issues	1	2	3	4	5
k.	This is a team where anyone can challenge poor practice without fear of being rejected	1	2	3	4	5

3. These questions are about <u>roles and decision making</u> within your nursing team.		Strongly Disagree	2	3	4	5
			Neither Agree or Disagree			Strongly Agree
a.	Everyone knows what is expected of them on this team	1	2	3	4	5
b.	Everyone understands their responsibilities within the ward team	1	2	3	4	5
c.	Our team discusses performance objectives	1	2	3	4	5
d.	We discuss ways to make our team vision a reality	1	2	3	4	5
e.	Our team takes the time to share task related information	1	2	3	4	5
f.	When mistakes or errors happen we discuss how we could have prevented them	1	2	3	4	5
g.	The team takes the time to reflect on its performance	1	2	3	4	5
h.	We can influence what goes on in the ward	1	2	3	4	5
i.	We have a say in how work is managed within the ward	1	2	3	4	5
j.	The team participate in decisions that affect them on this ward	1	2	3	4	5
k.	Team members have the freedom to make important work decisions	1	2	3	4	5
l.	We can determine how we do our work	1	2	3	4	5
m.	We can carry out our work in the way we think best	1	2	3	4	5
4. These questions concern the <u>relationships and confidence</u> within your nursing team.		Strongly Disagree	2	3	4	5
			Neither Agree or Disagree			Strongly Agree
a.	Conflicts tend to remain unresolved in this team	1	2	3	4	5
b.	There is a lot of conflict within this team	1	2	3	4	5
c.	We handle differences of opinion between staff well here	1	2	3	4	5
d.	Our team feels it can solve any problem it encounters	1	2	3	4	5
e.	Our team has confidence in itself	1	2	3	4	5
5. These questions are about the <u>resources and demands</u> in your nursing team.		Strongly Disagree	2	3	4	5
			Neither Agree or Disagree			Strongly Agree
a.	There is too much work to do in too little time	1	2	3	4	5
b.	We are asked to do work without adequate resources to complete it	1	2	3	4	5
c.	We cannot follow best practice in the time available	1	2	3	4	5
d.	We have to make trade-offs between the quality of work and cost savings	1	2	3	4	5
e.	The work here is emotionally demanding	1	2	3	4	5
f.	We have to deal with distrustful, aggressive or uncooperative patients	1	2	3	4	5
g.	We often have to comfort upset patients and families	1	2	3	4	5
h.	We are given time and opportunity to develop new work skills	1	2	3	4	5

i.	Training and professional development is readily available for everyone	1	2	3	4	5
j.	Staff development is supported by an active programme of mentoring and clinical supervision where appropriate	1	2	3	4	5
6. The following questions are concerned with the <u>leadership and management</u> on your ward.						
The ward manager...		Strongly Disagree	Neither Agree or Disagree		Strongly Agree	
a.	Instils a sense of pride in our ward by focusing on what we do well	1	2	3	4	5
b.	Inspires confidence by saying positive things about the ward	1	2	3	4	5
c.	Ensures the interests of team members are considered when making decisions	1	2	3	4	5
d.	Consults with the team about daily problems and procedures	1	2	3	4	5
e.	Acts in a caring and supportive manner towards members of the team	1	2	3	4	5
f.	Is clear and explicit about the standards of care expected	1	2	3	4	5
g.	Takes initiatives to establish strong standards of excellence in care	1	2	3	4	5
h.	Sets clear care goals and objectives for this team	1	2	3	4	5
i.	Is an on-going "presence" on the ward – someone who is readily available	1	2	3	4	5
j.	Actively coaches individuals to help them improve their care delivery	1	2	3	4	5
k.	Sets an example by involving herself/himself in hands-on patient care	1	2	3	4	5

Section 2: About you and how you feel at work

7. The following words describe different <u>feelings and emotions</u>. Thinking of the <u>past week</u>, how much of the time has your job made you feel each of the following: I have felt...		Never	Occasionally	Some of the time	Most of the time	All of the time
a.	Tense	1	2	3	4	5
b.	Miserable	1	2	3	4	5
c.	Depressed	1	2	3	4	5
d.	Optimistic	1	2	3	4	5
e.	Calm	1	2	3	4	5
f.	Relaxed	1	2	3	4	5
g.	Worried	1	2	3	4	5
h.	Enthusiastic	1	2	3	4	5
i.	Anxious	1	2	3	4	5
j.	Comfortable	1	2	3	4	5
k.	Gloomy	1	2	3	4	5

I. Motivated	1	2	3	4	5		
8. Thinking about the colleagues you have dealt with over the last two weeks, please estimate approximately how many:							
a. You have interacted with i.e. spoken to about work and non-work issues	_____ colleagues						
b. You have gone to for emotional support	_____ colleagues						
c. You have asked for advice on carrying out your work tasks	_____ colleagues						
d. Have made you feel anxious	_____ colleagues						
e. Have made you feel enthusiastic	_____ colleagues						
9. The following questions ask about feelings at work.							
At work, how often do you feel...	Never	Few times a year	Monthly	Few times a month	Every week	Few times a	Daily
a. Emotionally drained from your work	1	2	3	4	5	6	7
b. Used up at the end of the workday	1	2	3	4	5	6	7
c. Tired when you get up in the morning and have to face another day on the job	1	2	3	4	5	6	7
d. Burned out from your work	1	2	3	4	5	6	7
e. You've become more callous towards people since you took the job	1	2	3	4	5	6	7
f. Worried that the job is hardening you emotionally	1	2	3	4	5	6	7
g. That you don't care what happens to patients	1	2	3	4	5	6	7
10. These questions are about your <u>satisfaction</u> with your work.							
	Strongly Disagree		Neither Agree or Disagree		Strongly Agree		
a. Overall, I am satisfied with the kind of work I do	1	2	3	4	5		
b. Overall, I am satisfied with the organisation in which I work	1	2	3	4	5		
c. Overall, I am satisfied with my job	1	2	3	4	5		
d. I am immersed in my work	1	2	3	4	5		
e. I am very aware of the ways in which my work is benefiting patients	1	2	3	4	5		
f. I am very conscious of the positive impact that my work has on patients	1	2	3	4	5		
g. I have confidence in my ability to provide effective patient care across a range of situations	1	2	3	4	5		
h. I feel I can solve any care-giving problem I encounter	1	2	3	4	5		
i. I have mastered the skills to provide appropriate care to all my patients	1	2	3	4	5		
j. It is important for me to make a positive difference in patients' lives	1	2	3	4	5		
k. My main objective at work is to make a real difference to patients' well-being.	1	2	3	4	5		

11. These questions concern how <u>you</u> are able to do your job.		Strongly Disagree	Neither Agree or Disagree			Strongly Agree
a.	I consult patients about changes to their treatment	1	2	3	4	5
b.	I take time to get know patients as individuals	1	2	3	4	5
c.	I regularly discuss patients' progress with them	1	2	3	4	5
d.	I provide continuity of care for patients	1	2	3	4	5
e.	I encourage patients to get to know one another	1	2	3	4	5
f.	I actively encourage relatives to become involved in the patient's care and treatment	1	2	3	4	5
g.	I encourage patients' opinions about their care and treatment	1	2	3	4	5
h.	I encourage patients to talk about things that might be worrying them	1	2	3	4	5
i.	I show genuine concern and courtesy toward patients, even under the most trying situation	1	2	3	4	5
j.	I always make visitors feel welcome	1	2	3	4	5
k.	I try hard to see things from the patient's perspective, even if I don't really agree with them or like them	1	2	3	4	5
l.	When a patient has views that contrast with my own, I try to understand why they think as they do	1	2	3	4	5

12. These questions are about how <u>your ward team</u> is able to do its job.		A little of the time	Some of the time			All of the time
a.	Our team treat patients with dignity and respect on this ward	1	2	3	4	5
b.	Our team put in extra effort to improve the quality of care that patients receive	1	2	3	4	5
c.	Our team does a good job in meeting family member needs	1	2	3	4	5
d.	Our team meets its patients' care needs	1	2	3	4	5
e.	Although there are a variety of patients, our team's outcomes are very good.	1	2	3	4	5
f.	Our patients experience very good individualised care	1	2	3	4	5
g.	We work well with other members of the MDT	1	2	3	4	5
h.	There is good communication among people on the MDT	1	2	3	4	5

Section 3: About the hospital

13. These questions are concerned with your views of your <u>hospital</u> .		Strongly Disagree	Neither Agree or Disagree	Strongly Agree		
a.	This hospital has access to the resources it needs to get its work done	1	2	3	4	5
b.	This hospital provides good training opportunities	1	2	3	4	5
c.	It is easy for our ward to obtain expert assistance when called for	1	2	3	4	5
e.	Staff's concerns and opinions are listened and responded to by management in this hospital	1	2	3	4	5
d.	Staff in this hospital are treated with dignity and respect	1	2	3	4	5
e.	Employees are given authority to act and make decisions about their work	1	2	3	4	5
f.	People in the hospital are rewarded fairly for the work they do	1	2	3	4	5
g.	There are good career opportunities in this organisation	1	2	3	4	5

Section 4: Background Details

About you:	
14. How old are you? _____ years	15. Are you male or female? <i>Male</i> <input type="checkbox"/> <i>Female</i> <input type="checkbox"/>
16. What is your ethnic background?	
<u>White</u>	<u>Mixed</u>
British <input type="checkbox"/>	White & Black British <input type="checkbox"/>
Irish <input type="checkbox"/>	White & Black Caribbean <input type="checkbox"/>
Other <input type="checkbox"/>	White & Black African <input type="checkbox"/>
	White & Asian <input type="checkbox"/>
	Any other mixed background <input type="checkbox"/>
	<u>Asian or Asian British</u>
	British <input type="checkbox"/>
	Chinese <input type="checkbox"/>
	Indian <input type="checkbox"/>
	Pakistani <input type="checkbox"/>
	Bangladeshi <input type="checkbox"/>
	Any other Asian background <input type="checkbox"/>
<u>Black or Black British</u>	
British <input type="checkbox"/>	
Caribbean <input type="checkbox"/>	
African <input type="checkbox"/>	
Any other black background <input type="checkbox"/>	
	<u>Any other ethnic group</u>
	Please specify:

About your Job:

17. What is your current job title? _____

18. What is your current grade?

A B C D E F G H

OR 1 2 3 4 5 6 7 8

19. Do you work: Full time Part time In a job share

20. Do you usually work days or shifts? Days Shifts (days only) Shifts (nights only)

21. How long have you worked on this ward? _____years _____months

22. How long have you worked in this hospital? _____years _____months

Many thanks for completing this questionnaire. If you have any further thoughts or comments for the research team, please use the space below and continue on a separate sheet if required.

Please place the questionnaire in the pre-paid envelope provided, seal it and post it back to the research team as soon as possible. Thank you for your co-operation. The research team

Thinking about my recent stay in hospital I feel that:		Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Does not Apply
1	I was given enough information about my condition and its treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	I always understood the information I was given about my condition and its treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Staff did not always respond quickly if I needed help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Staff made time to get to know me as a person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	My visitors were always made to feel welcome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	The ward was always clean and tidy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	I was provided with appetizing food and drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Staff seemed more concerned with getting the job done than caring for me as an individual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	My relative was usually asked to leave when care was being provided to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	My family were able to talk to staff about my care when they wanted to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	I was given the assistance I needed to help me eat and drink	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	I had regular access to therapy staff (for example physiotherapy, occupational therapy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	I could always talk to a doctor if I wanted to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	If I had any questions staff always answered these promptly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	I felt that I had some control over my care and treatment whilst in hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Staff did not always have enough time to give patients good care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17	Staff did not always treat patients with dignity and respect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	Staff always introduced themselves so I knew who I was talking to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	I did not feel confident that staff had the right knowledge and skills to give good care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	Staff often spoke sharply to me or my relative(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	Staff always explained any treatment or procedure to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	There was always enough to do to help me pass the time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23	Staff always listened to my views and opinions about my care and treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24	The date and time of my discharge were discussed fully with me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25	I did not have sufficient time to prepare myself for discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26	I had enough information about my future treatment prior to discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27	Overall the quality of care I received was very good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Below are a number of statements about your recent stay in hospital. Please indicate how much you agree with each statement by placing a tick in the box that best reflects your opinion:

EXAMPLE QUESTION: This may not be the way you would answer the first question, but this is an example of how to complete the questionnaire:

Thinking about my recent stay in hospital I feel that:	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Does not Apply
1 I was given enough information about my condition and its treatment	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

We are very grateful for your help in answering these questions. If there is anything else you would like to add in connection with any of the questions - or if you would like to make any further comments, please use the space provided below

Quality of Care for Older People Matron's Assessment of Care Questionnaire

Name of Ward:																		
	Strongly Disagree	Disagree	Neither	Agree or Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Neither	Agree or Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Neither	Agree or Disagree	Agree	Strongly Agree
The ward team is constantly seeking to improve its care practice	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5			
The ward team does a good job in meeting family member needs	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5			
The ward team almost always meets its patients' care needs	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5			
Although there are a variety of patients on the ward, the team's outcomes are very good.	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5			
Patients experience very good individualised care on	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5			

this ward															
The ward does a good job of retaining nurses	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
The ward has a superior reputation for its quality of care	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Patients or their relatives often complain about the standard of care on this ward	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Doctors working on this ward often complain about how this ward functions	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
The individual needs of older patients are always met on this ward	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
The continuity of care which older people receive on this ward is of a very high standard	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
The team gives skilled attention to the physiological and psychological needs of older people	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Older people receive the very best in care on this ward	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5

Appendix 5: Final set of scales and items developed for the toolkit

Items marked with an asterisk (*) are reversed scored before the scale is calculated. All items use a 5 point response scale ranging from *1=strongly disagree*, *3=neither agree nor disagree*, *5=strongly agree*, except where indicated.

Climate for Care (completed by nursing staff)

Shared Philosophy of Care

1. The team share an explicit philosophy of care
2. The psychological aspects of care are highly valued on this ward
3. Values and expectations for care are communicated to new members of the team
4. Involving patients and their carers is considered very important on this ward
5. We have a culture on this ward about caring for patients and supporting them rather than being about 'doing tasks'

Having Resources

1. We have sufficient basic equipment and supplies to deliver good level of care
2. There are adequate support services to allow us to spend time with our patients
3. There are sufficient staff with the knowledge and skills to provide quality patient care

Supporting Each Other

1. Colleagues show concern and support to help each other deal with stresses at work
2. Colleagues provide each other with emotional support
3. The emotional demands of care giving are acknowledged in this team
4. Members of this ward team feel confident about the competence and abilities of other team members
5. There is a great deal of trust among members of the team
6. The team can really count on each other to help out with any difficult tasks at work

Feeling Safe

1. People feel safe to be themselves in this team without fear of criticism, censure or feeling foolish
2. This is a ward where it is safe to bring up problems and tough issues
3. This is a team where anyone can challenge poor practice without fear of being rejected
4. We handle differences of opinion between staff well here

Improving Practice

1. Our team discusses performance objectives
2. We discuss ways to make our team vision a reality
3. Our team makes the time to share task related information
4. When mistakes or errors happen we discuss how we could have prevented them
5. The team takes the time to reflect on its performance
6. We regularly take time to figure out ways to improve our care delivery

Having a Say

1. We can influence what goes on in the ward
2. We have a say in how work is managed within the ward
3. The team participate in decisions that affect them on this ward
4. Team members have the freedom to make important work decisions
5. We can determine how we do our work
6. We can carry out our work in the way we think best

Developing our Skills

1. We are given time and opportunity to develop new work skills
2. Training and professional development is readily available for everyone
3. Staff development is supported by an active programme of mentoring and clinical supervision where appropriate

Too Much To Do

1. There is too much work to do in too little time
2. We are asked to do work without adequate resources to complete it
3. We cannot follow best practice in the time available
4. We have to make trade-offs between the quality of work and cost savings

MDT Working

1. We work well with other members of the MDT
2. There is good communication among people on the MDT

Factors that Enable Climate for Care (completed by nursing staff)

Leading by Example

1. The Ward Manager instils a sense of pride in our ward by focusing on what we do well
2. The Ward Manager inspires confidence by saying positive things about the ward
3. The Ward Manager ensures the interests of team members are considered when making decisions
4. The Ward Manager consults with the team about daily problems and procedures
5. The Ward Manager acts in a caring and supportive manner towards members of the team

6. The Ward Manager is clear and explicit about the standards of care expected
7. The Ward Manager takes initiatives to establish strong standards of excellence in care
8. The Ward Manager sets clear care goals and objectives for this team
9. The Ward Manager is an on-going “presence” on the ward – someone who is readily available
10. The Ward Manager actively coaches individuals to help them improve their care delivery
11. The Ward Manager sets an example by involving herself/himself in hands-on patient care

Support From the Top

1. This hospital has access to the resources it needs to get its work done
2. This hospital provides good training opportunities
3. It is easy for our ward to obtain expert assistance when called for
4. Staff’s concerns and opinions are listened and responded to by management in this hospital
5. Staff in this hospital are treated with dignity and respect
6. Employees are given authority to act and make decisions about their work
7. People in the hospital are awarded fairly for the work they do
8. There are good career opportunities in this organisation

Patient Experiences of Care (completed by patients)

Feeling Significant

1. I was given enough information about my condition and its treatment
2. I always understood the information I was given about my condition and its treatment
3. Staff made time to get to know me as a person
4. My visitors were always made to feel welcome
5. The ward was always clean and tidy
6. My family were able to talk to staff about my care when they wanted to
7. I could always talk to a doctor if I wanted to
8. If I had any questions staff always answered these promptly
9. I felt that I had some control over my care and treatment whilst in hospital
10. Staff always introduced themselves so I knew who I was talking to
11. Staff always explained any treatment or procedure to me
12. Staff always listened to my views and opinions about my care and treatment
13. Overall the quality of care I received was very good

Could do Better

1. Staff did not always respond quickly if I needed help
2. Staff seemed more concerned with getting the job done than caring for me as an individual
3. Staff did not always have enough time to give patients good care
4. I did not feel confident that staff had the right knowledge and skills to give good care
5. Staff often spoke sharply to me or my relative(s)

Carer Experiences of Care (completed by carers)

Giving my Relative the Best

1. Staff took time to get to know my relative as a person
2. Staff always had enough time to give good quality care
3. My relative always received the standard of care that I wanted
4. Overall the ward was a happy and welcoming place
5. Staff always seemed happy in their work
6. Overall the quality of care my relative received was very good'

Could do Better

1. Staff often spoke sharply to me or my relative
2. Staff seemed more concerned with getting the job done than caring for my relative as an individual
3. Staff did not treat me relative with dignity and respect

Feeling Significant

1. Staff always made me feel welcome on the ward
2. Staff asked me for any information I might have about my relative's needs/wishes
3. Staff provided me with enough information about my relative's care and treatment
4. I felt fully involved in discussions about my relative's care and treatment
5. Staff always seemed knowledgeable about my relative's care and treatment
6. Staff seemed to care about my needs as well as those of my relative
7. I could always speak to a doctor about my relative's care if I wanted to
8. I would like to have been more involved in my relative's care and treatment *
9. Staff always listened to my views and opinions about my relative's care
10. I always knew who to speak to if I had questions about my relative's care and treatment

Nursing Team Well-Being and Self-Rated Effectiveness of Care Delivery (completed by nursing staff)

Feeling Motivated

(Source Warr's, 1990, measure of job-related strain)

1. How much of the time has your job made you feel tense*
2. How much of the time has your job made you feel miserable*
3. How much of the time has your job made you feel depressed*
4. How much of the time has your job made you feel optimistic
5. How much of the time has your job made you feel calm
6. How much of the time has your job made you feel relaxed
7. How much of the time has your job made you feel worried*
8. How much of the time has your job made you feel enthusiastic
9. How much of the time has your job made you feel anxious*
10. How much of the time has your job made you feel comfortable
11. How much of the time has your job made you feel gloomy*
12. How much of the time has your job made you feel motivated

The above items use a 5 point response scale ranging from 1=*never*, 2=*occasionally*, 3=*some of the time*, 4=*most of the time* and 5=*all of the time*.

Doing our Best for Patients and Carers

1. Our team treat patients with dignity and respect on this ward
2. Our team put in extra effort to improve the quality of care that patients receive
3. Our team does a good job in meeting family members needs
4. Our team meets its patients' care need
5. Although there are a variety of patients, our team's outcomes are very good
6. Our patients experience very good individualised care

Matrons' Assessment of Quality of Care (completed by matrons)

Meeting Patients' Needs

1. The ward team almost always meets its patients' care needs ^a
2. Patients experience very good individualised care on this ward
3. The individual needs of older patients are always met on this ward
4. The continuity of care which older people receive on this ward is of a very high standard
5. The team gives skilled attention to the physiological and psychological needs of older people
6. Older people receive the very best in care on this ward

Looking to Improve

1. The ward team is constantly seeking to improve its care practice
2. The ward team does a good job in meeting family member needs ^a
3. The ward has a superior reputation for its quality of care
4. Patients or their relatives often complain about the standard of care on this ward*

Taken or adapted from:

^a Tempkin-Greener, Gross, Kunitz & Mukamel (2004).

Appendix 6: The Productive Ward: Releasing time to care

The Productive Ward is part of the Productive Series, developed and promoted by the NHS Institute for Innovation and Improvement. The series aims to support NHS teams to assess and improve their work environment from physical changes to process and managerial ones. The NHS Institute for Innovation and Improvement suggest that this helps achieve significant and lasting improvements – predominately in the extra time staff can give to patients, as well as improving the quality of care delivered whilst reducing costs.

The Institute's website describes Productive Ward in the following way:

The Productive Series has adopted efficiency techniques previously used in car manufacturing and safety techniques learned in the aviation industry. By working with NHS teams we have adapted them for the NHS in a practical and innovative way.

The key to the success of The Productive Series is that improvements are driven by staff themselves, by empowering them to ask difficult questions about practice and to make positive changes to the way they work. The process promotes a continuous improvement culture leading to real savings in materials, reducing waste and vastly improving staff morale.

http://www.institute.nhs.uk/quality_and_value/productivity_series/the_productive_series.html

Appendix 7: Aggregating climate measures to the team level.

When we aggregate individual nurses scores to the team level and use the mean to represent nursing team climate, it is important that some statistical criteria are met. The rationale behind aggregating individual data to a team level is the assumption that the nursing teams have their own climate which is shared among team members, and that these can be identified through the demonstration of significant differences in climate between teams and significant agreement in perceptions within team (James, 1982). Perceptual agreement and difference across teams assures that team climate is viewed consistently within each team while at the same time is sufficiently sensitive to capture differences between teams.

Analyses of variance (ANOVAs) on all the scales revealed that there was a significant team effect on climate (i.e., significant differences between teams in their climate scores). The results showed significant between-team differences on all the scale scores ($p < .01$) and that variability within in teams was significantly lower than variability across teams. We also calculated various other indicators of within-team agreement between team members to justify aggregation. We calculated interrater agreement and reliability using the interrater statistic, rwg (James, Demaree & Wolf, 1984), intra-class correlation (ICC(1)) (Shrout & Fleiss, 1979) which also indicated sufficient agreement for aggregation in our sample. Details of these analyses are available from the research team.

Appendix 8: Means, Standard Deviations and Intercorrelations for all Study Variables

	M	SD	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
1 Shared philosophy of care	4.03	.38	1																		
2 Having resources	3.28	.52	.68**	1																	
3 Supporting each other	3.77	.43	.84**	.64**	1																
4 Feeling safe	3.52	.41	.81**	.59**	.83**	1															
5 Improving practice	3.55	.56	.59**	.62**	.62**	.60**	1														
6 Having a say	3.51	.45	.79**	.76**	.74**	.81**	.73**	1													
7 Developing our skills	3.46	.48	.78**	.79**	.74**	.78**	.76**	.87**	1												
8 Leading by example	3.86	.50	.71**	.63**	.65**	.69**	.78**	.80**	.81**	1											
9 Support from the top	3.39	.44	.49**	.78**	.47**	.50**	.66**	.69**	.70**	.63**	1										
10 Average ward tenure	4.48	2.23	-.03	-.09	.04	-.04	-.10	-.14	-.07	-.16	-.24*	1									
11 Average patient age	70.87	10.11	-.05	-.27*	-.14	-.07	-.18	-.11	-.11	-.06	-.08	-.03	1								
12 Feeling significant (p)	4.11	.31	-.03	-.03	-.04	-.13	-.23*	-.08	-.07	-.20	-.14	.08	-.00	1							

13	Could do better (p)	2.11	.38	-.18	-.18	-.18	-.15	-.08	-.20	-.16	-.10	-.04	.05	.45**	-.51**	1						
14	Feeling significant (c)	3.40	.38	.15	.16	.23*	.16	-.03	.11	.06	.10	-.04	.25*	-.21*	.18	.20	1					
15	Giving my relative the best (c)	3.72	.35	.19	.21*	.34**	.17	.04	.13	.13	.09	-.01	.25*	-.39**	.19	.36**	.81**	1				
16	Could do better (c)	2.11	.38	-.32**	-.28*	-.34**	-.21*	-.16	-.14	-.17	-.15	-.11	-.07	.42**	-.05	-.37**	-.35**	-.49**	1			
17	Meeting patients needs (matron)	4.03	.46	.04	.20	.04	.07	.08	.18	.10	.18	.14	-.03	-.01	-.06	.21	-.06	.05	-.09	1		
18	Looking to improve (matron)	4.04	.51	.25*	.27*	.34**	.07	.25*	.25*	.17	.28*	.09	-.05	-.22	.03	.28*	.32*	.44**	.19	.56**	1	
19	Feeling motivated (nursing team)	3.78	.32	.59**	.68**	.60**	.67**	.60**	.68**	.67**	.60**	.56**	-.26*	-.14	-.14	.11	.05	.09	.24*	.20	.25*	1

N=65, except for matrons' correlations where N=51

*=p<.05

**=p<.01

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme whilst it was managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) at the London School of Hygiene & Tropical Medicine. The NIHR SDO programme is now managed by the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton. Although NETSCC, SDO has managed the project and conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact sdo@southampton.ac.uk