Changing Management Cultures and Organisational Performance in the NHS (OC2)

Research Report

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Outline of the Report

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1 Introduction

The rhetoric surrounding policy changes in the NHS has, in recent years, extended beyond consideration of structural arrangements and incentive regimes, to encompass suggestions that NHS organisations also need to undergo significant cultural renewal if the desired improvements in quality and performance are to be secured (Department of Health, 2001; Mannion et al. 2005).

Since the election of the New Labour government in 1997, clinical quality, safety and performance have all been the focus of purposeful management intervention alongside broader systemic changes. From 2002 onwards, broader system reform has included a whole raft of pro-market policies, programmes and supporting tactics designed to introduce new incentives for purchasers and providers, including the promotion of a more diversified delivery environment - with an expanded role for independent sector providers and private capital; a new hospital prospective payment system (Payment by Results); and enhanced patient choice. The implementation of such changes is likely to have major cultural consequences, (both intended and unintended) not least because they challenge many deeply held managerial assumptions and professional values that have been affirmed over decades and woven into the fabric of health care delivery (Scott et al. 2003b).

This report details the findings of a three year National Institute of Health Research Service Delivery and Organisation programme funded project into changing cultures, relationships and performance in the NHS undertaken by an interdisciplinary consortium of researchers based at the Universities of Birmingham, York, St Andrews, Manchester, Durham and King's College, London. It builds upon (and should be read alongside) the associated SDO report – *Measuring and Assessing Organisational Cultures in the NHS* – also available on the SDO website (Mannion et al. 2008b).

1.1 Aims and objectives of the study

The overall aim of the project was to understand the nature of changing management cultures in the NHS and explore their relationships with changing organisational performance.

Specifically we sought to:

- identify and classify the extant cultures in key NHS organisations;

- explore how these cultures evolve and transform over time, both in response to external policies and as a result of internal or cross-boundary drivers;

- analyse the (longitudinal) relationships between changes in culture and performance at both an organisational and a local health economy level.

1.2 Research design and project overview

Although appeals for culture change in health systems draw on an assumption that culture is related to organisational performance, studying the culture/performance link in and across health care organisations poses substantial theoretical and methodological difficulties: not least in terms of conceptualising and operationalising both 'culture' and 'performance' as well as in inferring the nature of any causality in relationships uncovered. Even given definitions of culture and performance, and associations between the two, it is still difficult to disentangle the nature of any causal linkages.

Given the diversity of views and approaches to understanding and assessing organisational culture and organisational performance, and the intrinsic complexity of any relationships, we adopted a multi-method approach, integrating both qualitative and quantitative approaches in order to examine these relationships in both *breadth* and *depth*.

In order to capture the breadth of any associations between cultural dynamics, inter-organisational relationships and health care performance we conducted national quantitative surveys of management cultures in hospital Trusts and PCTs using a validated culture-rating instrument. We also conducted culture assessments at GP level in a sample of 10 PCT areas. These cultural data were linked to a pre-existing comprehensive and robust national performance data set. The combined data set was used to explore culture/performance associations at organisational level, as well as to investigate the inter-organisational contingencies for performance in local health care economies.

In addition, to contribute *depth* and richness to our understandings of organisational change and performance relationships, we conducted in depth case studies in *three local health economies* with the aim of exploring how organisational change impacts on organisational cultures and whole-system performance. Each case study had as its centre of investigation a *sentinel* organisation with a reasonable 'cultural gradient' (or likelihood of one); that is, an organisation where there was a reasonable expectation of significant ongoing cultural shifts both planned and emergent.

The case studies included different health economies with:

- an acute hospital Trust that has recently transitioned to Foundation Trust status;

- a Primary Care Trust (PCT) pursuing a strategy of integration between health and social services, as well as implementing a division between commissioning and provider functions;

- and an acute hospital Trust with high profile and long standing failings in clinical governance.

It is important to note that identification of the organisation undergoing significant change was simply the way in to our case studies. Each 'case' for study actually comprised the *local health care economy* surrounding the single organisation – i.e. the key acute and primary care organisations and local Social Services Department(s) which acting together and separately deliver care to a community. The overarching philosophy underpinning the design of the case studies was one of Realistic Evaluation in which we assume that particular organisational outcomes are not simply a product of mechanisms within the organisation, but are intimately connected to the context in which they are exercised (Pawson and Tilley, 1997).

1.3 Structure of the report

This report is arranged as follows.

Section Two charts the key changes in policy, culture and relationships in the NHS since its inception in 1948 until the present day.

Section Three constitutes the theoretical core of the project and outlines a range of theoretical frameworks and conceptual models for understanding cultural change in health care organisations.

Section Four presents the methods and findings of the national quantitative surveys of organisational culture in the NHS.

Sections Five to Seven present the methods and findings from the three case studies examining changing cultures, relationships and performance across three sentinel organisations health economies.

Section Eight integrates across the empirical work and provides an overview and assessment of the contribution of our research evidence by drawing out the common patterning and divergence in our sources of data and interpreting our findings within the context of the broader theoretical and empirical literature.

Section Nine details the policy and managerial implications of the study and looks forward at the emerging research issues arising from the project.   We conclude by setting out a strategy for promoting the uptake and utilisation of our findings throughout the NHS.

2 Policy and Organisational Culture in the NHS: An Overview

The language of 'culture' in relation to organisations and to organisational change has become increasingly commonplace since the publication of a number of popular management books in the 1980s (Peters and Waterman 1982; Deal and Kennedy 1982; Handy 1985). The NHS has been no exception to this (e.g. Kennedy 2001). As we note in greater detail in the companion SDO report (Mannion et al., 2008b) and discuss briefly in Section Three of this report, academic understandings of exactly what is signified by the term vary widely (Meek 1988; Scott et al. 2003), whilst policy is often vague in relation to expected effects (Davies 2002; Mannion et al. 2005). However, broadly speaking, the study of organisational culture focuses on that which is shared between organisational members and sub-groups, for example:

- beliefs, values, attitudes and norms of behaviour;

- routines, traditions, ceremonies and rewards;

- meanings, narratives and sense-making.

Such shared ways of thinking and behaving both define and reflect what is socially legitimate and acceptable within given organisation; in colloquial terms *'the way things are done around here'*. Culture is thus a lens through which an organisation can be understood or interpreted both by its members and by interested external parties through an appreciation of an organisation's symbolic codes of behaviour, rituals, myths, stories, beliefs, shared ideology and unspoken assumptions. I

In this chapter, we aim to provide an overview of NHS organisational culture, in relation to its formal organisational structures, over the life of the NHS up to the present day. In fact few studies of NHS management and organisation prior to 2000 employed the term 'culture' explicitly (exceptions are Pettigrew et al. 1992; Harrison et al. 1992). Nevertheless, much of the qualitative empirical literature on NHS management and organisation can quite reasonably be interpreted as providing a basis for a general characterisation of changing culture, and especially the relationship between management and medical professional subcultures. The chapter is organised chronologically into three sections.

2.1 From the beginning: 1948-1983

The original NHS of 1948 in England took the so-called 'tripartite' form, with separate organisational arrangements for hospitals, GP and other primary care services, and community services. These and other aspects of organisation can perhaps be seen as a reflection of the political challenges involved in creating the Service. GPs remained self-employed

subcontractors to the NHS. Medical consultants were employed at regional level, their contracts thereby somewhat insulated from the management of the hospitals in which they worked, were allowed to use NHS facilities for private practice, and were officially granted professional autonomy in their clinical practice. The various governing Boards and Committees which governed the NHS had heavy medical representation (Ham 1981). Hospitals were in practice often managed by a 'triumvirate' of Administrator, Chief Nurse/ Matron and senior medical consultant, none with overall responsibility.

Questions about the adequacy of these organisational and management arrangements occurred and recurred during the 1950s, increasing in intensity by the late 1960s (Harrison 1988 pp12-13). The roots of inspection and regulation by agencies not in a line management relationship to the NHS can be traced to this period, most notably in the government's response to a report into the scandal of mistreatment of long-stay patients at Ely Hospital in South Wales (Watkin 1978 pp78-81; see also Walshe 2003). The outcome was the creation of a Hospital Advisory Service (later Health Advisory Service) which, though not strictly an independent inspectorate, undertook visits to hospitals to assess the quality of care provided. Long-running discussions about a precise form for a unified NHS to supersede the old tripartite arrangement culminated in the reorganisation of 1974, which ostensibly brought together hospitals, primary care and community services under a single organisation in each locality. Yet consultants remained regionally employed and GPs remained self-employed. The former 'triumvirate' arrangement was extended and formalised into consensus decision-making teams at all levels of the Service. The precise arrangements varied at each level, but membership always included Administrator, Chief Nurse, Treasurer and a public health physician; at operational levels, the team was extended to include a practising consultant and practising GP, elected by their colleagues. (For a detailed discussion of these decision-making arrangements, see Harrison, 1982.)

Although no academic social scientific research into NHS organisation and management appears to have been published until the mid-1960s, some 25 studies were subsequently conducted in the hospital sector up to 1983, and were systematically reviewed by Harrison (1988). Although the scale and methods of these studies varied considerably, their findings were highly consonant both amongst themselves and with the formal organisational arrangements outlined above. The overall pattern was summarised by Harrison (1988 ch3) in the following terms. First, the most influential actors in the system were consultants and GPs collectively, in the sense that the unmanaged aggregate of their clinical decisions *constituted* the shape of the NHS's services. Managerial decisions, formal plans and capital expenditure decisions tended to reflect and sustain this pattern, rather than determine it. Second, and very much as a consequence, change tended to be incremental, based on 'shopping lists' of deficiencies rather than on explicit plans or priorities, with little or no systematic evaluation of services in

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terms of efficiency or effectiveness. Third, and again in consequence, the style of management was highly reactive, with administrators/ managers performing the role of problem-solvers and resource-gatherers in order to maintain their organisations and satisfy their medical staff. Fourth, the orientation of management was internal, rather than external, focused on professional demands from within the organisation rather than on demands from patients or even the NHS hierarchy. Administration or management in this picture departed radically from the rationalistic objective-driven manager as depicted in classic texts such as Stewart (1979 pp66-7). In contrast, the approach to NHS management represented in the research was characterised as 'diplomacy':

> .....a process concerned to conciliate, in as co-ordinated a fashion as possible, all the sub-groups within an organisation... In the context of diplomacy, there is rarely a meaningful overall objective; more often, there is a set of partially, or sometimes completely contradictory objectives held by groups or individuals (Harrison 1988 p51).

In terms of the wider conceptual literature, the above provides a picture of hospital structures and organisational practice that matches Mintzberg's (1991) description of 'professional bureaucracy'. In relation to the clinical activities of hospitals, individual physicians enjoyed considerable influence and autonomy, though non-clinical activities were governed by administrators in a more bureaucratic manner. In the modern jargon of organisational culture (explored more fully elsewhere in this report), NHS hospitals at this time can be regarded as an amalgam of professional 'clan' culture and administrative 'hierarchical' culture. Although little parallel research was undertaken in the primary care, it seems clear that little had changed by way of professional/ managerial relationships since 1948, with the work of the relevant authorities largely confined to administering the technicalities of the GP contract. Although the size of general practices in terms of numbers of GP partners had tended to grow, practices remained 'clans' in the jargon of organisational culture.

2.2 General management and a new performance regime: 1984-1990

In the early 1980s, the government found itself under a range of economic and political pressures in relation to the apparently declining productivity and inadequate management of the NHS (Harrison 1994 ch3). In response, two groups of management innovations were introduced: a system of annual top-down reviews of performance together with a set of 'performance indicators'; and a series of changes to organisation and management following an Inquiry commissioned under the chairmanship of Mr (later Sir) Roy Griffiths, chairman of a prominent supermarket chain.

The period also saw the beginnings of attempts to look more critically at general medical practice.

In early 1982, the Secretary of State for Social Services announced arrangements to 'improve accountability' in the NHS. One aspect of these arrangements was the so-called 'regional review process' in which ministers and their officials examined the 'long-term plans, objectives and effectiveness of each Region' along with regional chairpersons and their chief officers. The process began immediately, and was subsequently extended to region-district and to district-unit relationships. The reviews were, in due course, to be accompanied by a set of paper-based quantitative performance indicators, a first set of which (some 70 in number) were issued in late 1983. These included indicators relating to the use of clinical facilities, finance and the workforce, and allowed comparison between the performance of local health authorities. A more extensive and sophisticated set of some 450 indicators was published in computerised form in mid-1985, and an even larger set of about 2,500 in 1987 as part of the government's implementation of plans to improve NHS information provision more generally. (For accounts of relevant events in this period, see Carter et al. 1992 ch4; Harrison 1994 ch2.) Published evidence about the effect of these new arrangements is scanty; some insiders have concluded that the review process had little impact in practice (Smee 2003 p60) and it is notable that numerous official and managerial statements were made to the effect that performance indicators were intended to be treated as intimations of where organisational problems might be found, rather than as definitive of performance itself (Fairey 1985 p9). Again, the implication is of little immediate impact.

The establishment of the Griffiths Inquiry was announced in early 1983, and its report was published later in the same year. Though the Inquiry made no attempt to synthesise earlier research, its 'diagnosis' of the situation (NHS Management Inquiry 1983), derived largely from discussions within the Service bore a remarkable similarity to the 'diplomat' picture sketched above. The Inquiry's recommendations led to the abolition of consensus teams and the development of 'general management' (that is, chief executives, though not so termed until later) in hospitals and elsewhere in the NHS structure, along with attempts to promote the greater involvement of physicians in budgeting and financial matters (DHSS, 1984).

In the seven years following the Griffiths Inquiry, some 24 empirical studies of NHS management and organisation were conducted, varying in size, scope and methods. They were systematically reviewed by Harrison et al. 1992. The findings were perhaps somewhat less homogeneous than those of the pre-Griffiths research, but generally indicated that, although the new general managers were (in acute hospitals at least) initially only marginally more influential than their administrative predecessors, the *office* of general manager was widely regarded as legitimate by other staff, NHS including physicians. As noted above, central government had at the same time decided upon a more interventionist approach to NHS performance

management, manifest in such developments as national performance indicators and fixed-term manager contracts. In consequence, the new general managers also became more responsive to central government demands than their predecessors had needed to be, though there is little evidence that they became any more responsive to patients or patient groups than before. In modern jargon, the consequences of the Griffiths report can perhaps be seen as a modest shift in the balance of NHS organisational culture from 'clan' to 'hierarchy'. Whilst it is important not to overstate the degree of change, it is worth noting that such matters as the perceived legitimacy of general managers is likely to have been a necessary, though not sufficient condition for subsequent organisational reforms. It seems similarly likely that the continued publication of publication indicators during the 1980s may have contributed to the legitimation of quantitative concepts of organisational performance.

Finally, the 1980s marked the beginnings of a more proactive approach to general medical practice. A consultation document was published in 1986, suggesting that greater use of incentives, greater competition and greater accountability were required, followed by a White Paper (Secretaries of State 1987) which sought to extend the role of the statutory NHS bodies in controlling GPs through the introduction of discretionary funds for GPs' staff and premises. The new NHS contract imposed on GPs in 1990 included incentive payments for meeting targets in relation to screening and immunisation.

2.3 The quasi-market: 1991-97

In the late 1980s, the government once again became subjected to political pressure in relation to the alleged inadequacy of NHS resources. In the course of a somewhat unfocused prime ministerial review of the Service, proposals for the introduction of an internal (quasi-) market emerged, in which hospitals were supposed to compete for contracts to treat NHS patients, and where GPs could elect to hold budgets to purchase elective secondary care for their patients (Ham 2004 pp36-7). These changes can be seen as extending the logic of earlier reforms insofar as they represented attempts to strengthen managerial control and accountability in the NHS, but they also sought to nurture a competitive 'business culture' throughout the organisation (Davies and Mannion, 2000; Le Grand et al., 1998). The reforms gave rise to potential political embarrassment (for instance, if an NHS hospital were to be driven out of business), professional resistance and resilience to these changes was more evident than a wholesale transformation of values and behaviour (Jones and Dewing, 1997; Broadbent et al., 1992), and research is more suggestive of collusion than market competition (Flynn and Williams 1997). However, the brief review of empirical studies of organisation and management conducted in relation to this period (Harrison and Lim 2003 pp16-17) suggests that a consolidation of both central government ability to define required performance and of managerial legitimacy and influence more generally had occurred. Thus the beginning of what has subsequently been represented as a 'target culture' in the NHS can be dated to this period, for instance in

the *Patient's Charter* (Department of Health 1991a), *The Health of the Nation* (Department of Health 1991b), and the GP contract of 1990. But managers still found it very difficult to control the acute sector or to successfully implement radical organisational change, and again there was little evidence of any increase in responsiveness to the public or to patient groups, despite the ostensible ambition of *The Patient's Charter.* However, research does suggest that those GPs who elected to be 'fundholders' with budgets to purchase elective secondary care were able to use their powers in the market to secure preferential treatment for their patients (Glennerster et al. 1994).

In modern jargon, this period probably represents only the most modest of cultural adjustments towards a 'rational' or 'market' culture, and hierarchy was still strong, though the impact of fundholding showed that determined small-scale purchasers could create change through the market. Although, as we note below, notions of NHS competition were initially abandoned by the incoming Labour government of 1997, it seems likely that the emergence of a *language* of markets and competition during the mid-1990s helped to legitimate subsequent changes.

2.4 Investment and reform: 1997-2008

When the Labour government came to power in 1997, it had little by way of detailed and coherently formed and expressed health policy, and although its campaign for office had turned in part on the urgent need to "save the NHS", it had made few pre-election commitments beyond promising, perhaps unwisely, to reduce the number of people waiting for elective surgery, and announcing its intention to reverse the previous government's quasi-market reforms. Once in government, however, it showed a growing enthusiasm and ideological commitment to public services reform (Cabinet Office 2006). As a result, the last decade has been a period of perhaps unprecedented change in NHS resourcing, organisational structures and systems, governance and accountability arrangements and public and political expectations. The NHS has been subjected to a rapid succession of organisational reforms, and a host of often piecemeal, ad hoc and emergent policy initiatives (Coote and Appleby 2002). When problems or difficulties have emerged, their solution has often been sought not in the better management or direction of existing systems, but in further policy initiatives and institutional change. Indeed, after almost a decade in charge, the Labour government has most recently concluded that more radical change is still required and has turned once again to a wholesale review and reform of the NHS, with expectations that culture change will follow from structural and procedural reform (Darzi 2008).

Amid this turbulence, three key themes can be discerned. The first concerns the government's evolving views on how it seeks to influence or shape the performance of the NHS, and what governance mechanisms and accountability arrangements are needed to secure and sustain performance improvements. The second concerns the costs of the NHS, and the shifting

political and social consensus about the share of national resources allocated to healthcare spending and the way those resources are gathered and distributed. The third concerns, in perhaps less tangible but equally important terms, the nature of the relationship between government, the NHS and the medical profession, and the way that changing attitudes and ideas about those relationships have been played out, often through the language of organisational culture and cultural change.

Our first theme concerns the structures or management arrangements of the NHS. From 1997 to 2000, the Labour government first dismantled some of the quasi-market reforms of its predecessor (such as the internal market, and GP fundholding) and put much of its faith in the more effective centralised management of the NHS, as one organisation. A series of nationally driven initiatives were established – such as a national framework for performance assessment, National Service Frameworks as templates or models for care in major service areas, and a new national agency, the National Institute for Clinical Excellence, to assess and advise on the adoption of new drugs and other technologies in the NHS. In response to an initial deterioration in NHS performance and growing waiting lists, it established an apparatus of performance targets and monitoring particularly aimed at improving access to acute services by driving down waiting times and lists (Bevan and Hood 2006). These reforms were initially successful, at least in their own terms, but the dysfunctional and perverse behaviours which resulted from ever tighter central direction and performance management led to a gradual but ultimately profound change of direction. In 2001 Labour re-embraced market based reforms and began to espouse a new enthusiasm for devolving power from the Department of Health to the NHS, and promoting patient choice, provider competition, diversity and plurality of supply, and a shift from central bureaucratic direction towards a more networked or multilateral form of accountability and performance management, drawing on competition and contestability, national standards and regulatory oversight, and user voice and choice (Cabinet Office 2006).

Since 2002 the government has pressed much further than any of its predecessors in introducing pro market reforms. Key structural changes on the demand side include the extension of patient choice of service provider, intended to empower patients to put pressure on hospital providers to improve the quality of elective services; and the development of practice based commissioning with the aim of providing GPs with incentives to reduce inappropriate hospital referrals (Mannion and Street, 2009). These changes have been matched by reforms on the supply side, including an expanded role for independent and voluntary sector providers and the introduction of a new type of organisation – NHS Foundation Trusts – that have a number of operating freedoms not available to other hospitals and a statutory form and governance structure modelled on mutual or not for profit organisations and which puts them outside the statutory powers of direction of the Department of Health (Mannion et al. 2007).

Underpinning and binding these structural reforms was a new prospective funding system termed Payment by Results (PbR) under which hospitals were paid on the basis of the type and amount of work (conceptualised in casemix measures similar to Diagnosis Related Groups) they undertook.

PbR replaced block contracting arrangements, according to which hospitals received a fixed annual sum in order to provide a pre-specified level of activity. The stated aims of PbR were to stimulate hospital activity (thereby reducing waiting lists), reward efficiency, facilitate patient choice and encourage a mixed economy of provision by allowing 'money to follow the patient'. By design, the new financial arrangements created strong incentives for NHS organisations to behave more entrepreneurially and had the potential to drive major changes in the management cultures of NHS organisations (Mannion et al., 2008b). The extent to which this complex set of changes – and the return to pro-market reform strategies they represent – have brought about cultural or attitudinal changes in NHS organisations remains to be seen (Mannion et al., 2008b).

Our second theme concerns the scale of national investment in the NHS. While the Labour government began by promising to follow its predecessors spending plans, it quickly realised that decades of parsimonious underinvestment in healthcare in the UK had produced healthcare performance and health outcome statistics which were woeful by western European standards. Changing the performance of the NHS required a substantial increase in resourcing. In January 2000, Tony Blair promised publicly to raise NHS spending to European levels by 2006 – which health economists calculated meant an increase in healthcare spending from £57.6 billion (6.6% of GDP) in 1999/2000 to £87.6 billion (9% of GDP) by 2005/06 (Appleby and Boyle 2001). As part of the process of securing both political and public support for what would be the largest deliberate increase in healthcare spending introduced by any government in recent times, the Treasury (rather than the Department of Health) tasked Derek Wanless with reviewing the long term healthcare needs and funding options for the NHS. His final report, in 2002, recommended that NHS spending should continue to rise over the next two decades at a rate well above the historic average of healthcare spending increases. Real terms increases of 7.1% pa initially were needed, and by 2022 healthcare spending should be between 10.6 and 11.1% of GDP (with NHS spending having gone from £68 billion to £154 billion in 2002/03 prices) (Wanless 2002). He also examined, somewhat cursorily, alternative models for funding NHS spending and concluded that the fairest and most efficient approach was to continue to fund the NHS largely from general taxation.

With the benefit of hindsight, this large dose of additional resources, which took NHS spending in the UK to £113 billion in 2007/08, was not particularly well spent (Wanless, Appleby and Harrison 2007). Pay and price inflation accounted for about 43% of the increased spending. A large proportion went on poorly negotiated NHS staff pay settlements, which for consultants, GPs and some other staff resulted in increased pay levels with

little or no productivity gain and even some reductions in work intensity. Some was invested in grand national projects, like the £6 billion NHS IT programme, Connecting for Health, which then failed to deliver their intended benefits. The additional resources did produce increasing levels of hospital and other clinical activity, and a welcome increase in NHS infrastructure and equipment spending, resulting in the renewal of buildings and facilities, but most observers have concluded that the increased spending has not been invested wisely, and has certainly not brought with it the deeper organisational and cultural changes that some anticipated might result from investment-led reforms.

Our third theme, and perhaps that most closely connected with the subject matter of this report, concerns the changing relationships between government, the NHS, the public and the clinical (particularly the medical) profession. From the outset, the Labour government showed itself willing to reach out and control areas of practice and decision making which had for decades been largely ceded to the medical profession. Following a widely praised White Paper on quality in the NHS (Department of Health 1998), it established new requirements for clinical governance in NHS organisations and legislated to create a Commission for Health Improvement and to create a statutory duty of quality on NHS organisations. Through the establishment of the National Institute for Clinical Excellence it began to control the adoption of new technologies, and the processes for creating and promulgating clinical guidelines.

But the turning point came with two public inquiries into major failures in NHS care (reminiscent in some respects of the Ely Hospital inquiry in the 1960s referred to earlier). The first resulted from a scandal concerning failures in paediatric cardiac surgery at the Bristol Royal Infirmary between 1985 and 1995, which resulted in around 35 avoidable neonatal deaths. In 2001, the highly influential report published by the resulting public inquiry (Kennedy, 2001) concluded that the culture of healthcare in the NHS *'which so critically affects all other aspects of the service which patients receive, must develop and change'*. It described the prevailing culture at the Bristol Royal Infirmary at the time of the tragic events as a 'club culture', a term previously employed in organisational contexts by Handy (1985) and as a description of the style of UK government by Marquand (1988). In both cases, the 'club' notion implies excessive power and influence amongst a core group elite, whose members are mutually uncritical of each other. The Kennedy Report concluded *'the inadequacies in management were an underlying factor which adversely affected the quality and adequacy of care which children received'* (Kennedy, 2001, p203). Kennedy argued that while some problems were specific to Bristol, other aspects were more typical of the NHS. In particular, he suggested that the cultural characteristics of the NHS that had colluded to fostering a climate where dysfunctional professional behaviour and malpractice were not effectively challenged. As a consequence, a number of cultural shifts were seen as necessary to transform the NHS into a high quality, safety-focused institution, that would be sensitive and responsive to the needs of patients.

The government largely accepted the findings and recommendations of the Bristol Inquiry, and in its published response the Department of Health announced a range of new measures and supporting tactics aimed at tackling the systemic problems identified in the report (Department of Health, 2001). These included: the establishment of a National Patient Safety Agency; a new Council for Healthcare Regulatory Excellence to strengthen and co-ordinate the piecemeal system of professional self-regulation; and further release to the public of clinical outcome data (aggregate outcomes data were already publicly available, but this was now extended to individual level data, starting with risk-adjusted mortality rates for all cardiac surgeons in England).

The second inquiry resulted from the case of Dr Harold Shipman, a GP who over a period of about two decades murdered over 200 patients by administering lethal doses of morphine, and whose actions went almost wholly unchallenged until he attempted a crude forgery of one patient's will. The subsequent inquiry produced a series of six reports which in part reiterated and strengthened the findings from the Bristol inquiry about the clinical and organisational culture which had permitted Dr Shipman to harm patients for so long, and recommended in particular the wholesale reform of the General Medical Council (Smith 2004). Following two Department of Health led reviews, a major legislative reform of the systems for regulating all healthcare professions was initiated and passed into law in 2008.

At the same time, the processes of reform outlined earlier continued. The powers, remit and resourcing of NICE were extended, and NHS organisations were essentially directed to adhere to its advice. The Commission for Health Improvement was replaced first by the Healthcare Commission and, in 2008, by the Care Quality Commission, each in turn enjoying broader and stronger powers of regulatory oversight and intervention in NHS organisations.

Between them, the Shipman and Bristol cases (along with a number of other high profile instances of failures in care during this period – (see Walshe and Higgins 2002) have been important components of a new narrative of clinical professionalism in the NHS, which emphasises openness, accountability, the management of clinical performance and the importance of teams and organisations – in place of the "club culture" which could be argued to prefer secrecy, clinical autonomy, clinical freedom, and the sovereign importance of clinical professionals as individuals. The institutional architecture of the NHS as a system and of NHS organisations now embeds a degree of oversight and control which would have been unthinkable or unacceptable to most doctors and to some other clinical professionals ten or twenty years ago. The progressive corporatisation of clinical practice in the NHS might be expected to have brought about or been accompanied by consequential or concomitant changes in attitudes, beliefs and values among both managers and clinicians.

2.5 Concluding remarks

In this section we have reviewed the key national reforms and structural changes that have impacted on the formation and transformation of professional and organisational cultures in the NHS since its inception in 1948 up to the present day. This review therefore provides a broad historical backdrop and policy context against which our empirical work exploring the dynamics of culture change since 2001 can be interpreted and analysed. The next section briefly explores the concept of organisational culture, before outlining the key conceptual models and theoretical frameworks for understanding how organisational cultures may change – both through their own dynamic and through planned management action.

3 Theories of Culture and Culture Change

3.1 Conceptualising organisational culture

Organisational culture is a highly-contested concept. Our companion Report (Mannion et al., 2008b) discussed the origins of contemporary conceptualisations and reviewed the relevant literatures at length, so that it is necessary only to summarise some of the themes from this material here before drawing out its implications for the present study.

The original literal meaning of 'culture' is something that is cultivated, such as crops. When used in relation to *social* phenomena, 'culture' is therefore a metaphor originally applied by social anthropologists a century ago to signify processes of human socialisation through institutions such as family, community, religion and education (Williams 1983). The germ of the notion that formal organisations should be seen as social (rather than mechanistic) phenomena can perhaps be traced back to the beginnings of 'human relations' thinking in the 1930s, for which the famous Hawthorne 'experiments' (Roethlisberger and Dixon 1947) are a convenient starting point. Although post-war scholarship in a range of academic disciplines emphasised the importance of culture in shaping behaviour in organisations (for instance in the US, Cyert and March 1963 and Selznick 1947; and in the UK Jaques 1951), it was not until 1979 that the phrase 'organisational culture' (Pettigrew 1979) was coined, and until the 1980s that the topic emerged as a distinct element in mainstream management thought. This new prominence occurred partly in response to then success of Japanese industry in comparison to that of the US and Europe (Ouchi 1981), but also via the influence of several popular management texts, especially Peters and Waterman (1982) and Deal and Kennedy (1982), on the notion that organisational culture was an important influence on employee motivation and organisational performance. Whilst at least some of this emerging material can be criticised for drawing over-hasty conclusions from poorly-designed research, the topic has remained on managerial and scholarly agendas for the last 25 years, generating a substantial literature from a number of disciplinary perspectives (for overviews, see Martin 2002; Alvesson 2002).

Perhaps the most critical cleavage amongst contemporary conceptualisations of organisation culture is that identified by Smircich (1983; see also Meek 1988); in brief, culture may be treated as a property of an organisation (something it 'has') or as something that the organisation 'is'[1]. The former approach variously defines culture as the

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[1] For completeness, it should be added that there is also a branch of the literature that treats culture as a metaphor, to be used alongside other metaphors in order to generate a range of 'ways of seeing' organisations. The most prominent account in this vein is perhaps Morgan (2006).

beliefs and/ or values that organisation members have in common (for example, Peters and Waterman 1982), 'the way things get done around here' (Deal and Kennedy 1982), or the patterns of shared assumptions that have been reinforced by their apparent success in solving organisational problems (Schein 1985). Thus, this approach treats culture as a variable or attribute, alongside others such as the organisation's technology, business strategy and so on. An implication of this approach is that culture can in principle be treated instrumentally, as something to be taught, and perhaps otherwise manipulated or 're-engineered' for management purposes, particularly in order to 'fit' the organisation's external environment. In contrast, the latter approach implies the existence of fewer levers by which management might secure change, since the entire organisation is seen as a cultural system in itself, with analytical interest focusing primarily on how it is accomplished and reproduced.

Significant as this cleavage in conceptions of organisational culture has been, the distinction between the two polarised approaches often cannot be maintained, and many authors employ elements of both (Alvesson 2002). The distinction therefore risks sustaining parodies: as the case may be, culture can (or simply cannot) be manipulated for managerial purposes. Organisational culture can be seen as indeed *emergent* (Selznick 1957), not straightforwardly manipulable by a *single* group of members (such as managers) but rather constantly re-made in the context of interactions between members and of reframings of perceptions of the organisation's external environment. Moreover, it is possible to envisage some elements of culture as 'deeper' and therefore more resistant to change than others. An important work in this vein is that of Schein (1985), who distinguishes between *artefacts*, *values* and *basic assumptions.* Artefacts form the most visible 'surface' level of an organisation's culture, including the physical environment, products, technology, overt behaviour and the use of language and other symbolic forms. Values underlie and influence behaviour; they signify espoused normative positions, 'what ought to be' rather than 'what is', and therefore include ethical and ideological positions. Finally, basic assumptions are the deepest level of an organisation's culture, including causal and normative beliefs that have become so internalised by members as to have dropped out of their active consciousness.[2]

A further problem generated by the prominence of the conceptual cleavage described above is that it diverts attention from the implausibility of assuming that a given formal organisation is likely to be characterised by a single 'unitary' culture. Divergences in culture within an organisation are likely to arise from at least two sources. First, if as Schein (1985) suggests, cultures are in part the products of organisational members' experience of solving problems of internal integration, then there is no reason to assume

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[2] As noted in our companion Report (Mannion et al., 2008b), numerous modifications of Schein's framework have been suggested in the subsequent literature. It is also worth noting that similar ideas occur in other disciplinary literatures, for instance Young's (1977) concept of 'assumptive worlds' in the policy process.

that different groups within the organisation will have had the same experiences or arrived at the same solutions. It follows that organisations of any size are likely to be characterised by a number of *subcultures*, some of which will be found at particular levels of the hierarchy.[3] Second, it is not necessarily the case that organisational members have membership of only that institution, and it is implausible to assume that they leave one culture behind and enter another as they move between different parts of their life. This is of particular and obvious significance in the context of the present research, since membership of NHS organisations is held by a number of self-consciously identified occupations (professions), many of whose histories long pre-date that of the NHS itself, and many of which have formal institutions that significantly influence education and other aspects of socialisation and which promulgate their own codes of ethics and behaviour. It cannot therefore be simply taken for granted that such members are not influenced by such professional cultures whilst working in NHS organisations.

Researchers have adopted two broad approaches to studying organisational subcultures. One such approach examines subcultures in relation to an organisation's overall pattern of culture, especially seeking to identify those that support, oppose or simply coexist alongside the presumed 'dominant' culture (see, for instance, Martin and Seihl 1983). To employ NHS examples, it might for instance be suggested that a hospital 'centre of excellence' might exhibit cultural values that cohere with, but a stronger than the dominant NHS culture. Alternatively, a culture might be *orthogonal* in the sense of being different but not counter to dominant organisational culture; the cultures of health professional institutions are sometimes portrayed in these terms. There may, however, be genuine *counter-cultures* that oppose either the dominant culture, or at least its perceived direction of travel; for example, there exists opposition within the UK medical profession to the increasing marketisation of NHS health care (need a ref, ideally. BMA must have said something). The other approach to organisational subcultures is more complex in that it recognises the numerous dimensions beyond organisational and occupational roles on which organisational members have cultural affiliations, including ethnic, religious, class and gender identities (Scott et al. 2003).

Having briefly discussed the origins and nature of organisational culture we now turn to discussions of how culture may change-both through its own dynamic and through planned management action.

3.2 Theories of culture change

A diverse range of models for understanding organisational culture change have been developed, usefully reviewed by Brown, (1995). This diversity

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[3] There are also theoretical grounds for doubting that the members of an organisation of any size can completely share culture or even the same technical language. See Dunsire's (1978) characterisation of organisations as 'Towers of Babel'.

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reflects a lack of theoretical consensus surrounding both definitions of organisational culture (outlined above) and the processes of organisational change. Broadly the literature can be classified into three perspectives (Alvesson and Sveningsson, 2008).

In popular writings it is often assumed that organisational culture through the use of the right skills, strategies and resources can be changed, managed and manipulated by senior management to beneficial organisational ends.

A second approach is that members do not always respond predictably to 'top down' managerial efforts to change values, assumptions and beliefs; although culture change can take place with management one of the organisational sub-groups able to exercise at least some moderate influence over the formation of meanings.

A third perspective emphasises that although culture is always in a state of flux it is beyond conscious manipulation and control. Members create meaning in organisational contexts which is dependent upon educational backgrounds, work tasks, group belonging and interpersonal relations etc. The implication is that managers may have little influence over the formation of desired cultures and that intended and received meanings may not overlap.

In this section we explore some of the key theoretical models and frameworks for understanding culture change drawn from the literature. The intention is to provide a conceptual backdrop for the exploration and interpretation of the cultural changes (and continuities) identified within the national quantitative surveys (Section 4) and the in-depth case studies (Sections 5-8). The following is based closely on the review by Brown (1995) and should be read alongside the conceptual discussion set out in the companion report Mannion et al. 2008b.

In a wide ranging review of theories of organisational culture Brown identifies five key models of culture change drawn from the theoretical literature, although he empathises that none of these have achieved the status of the definitive means of modelling culture change (Box 3.1)

Box 3.1 Five Models of Organisational Culture Change

- *Lundberg's model, based on earlier learning-cycle models of organisational change; emphasises external environmental factors as well as internal characteristics of organisations.*
- *Dyer's model, posits that the perception of crisis in conjunction with a leadership change are required for culture change to occur.*
- *Schein's model, based on a simple life-cycle framework; posits that different culture change mechanisms are associated with different stages in an organisation's development.*
- *Gagliardi's model, suggests that only incremental culture change can properly be described as a form of organisational change.*
- *A composite model, based on the ideas of Lewin, Beyer and Trice, and Isabella; provides some insights into the microprocesses of culture.*

Box 3.1: Five Models of Organisational Culture Change (Scott et al., 2003, adapted and derived from Brown 1995).

3.2.1 Lundberg's model
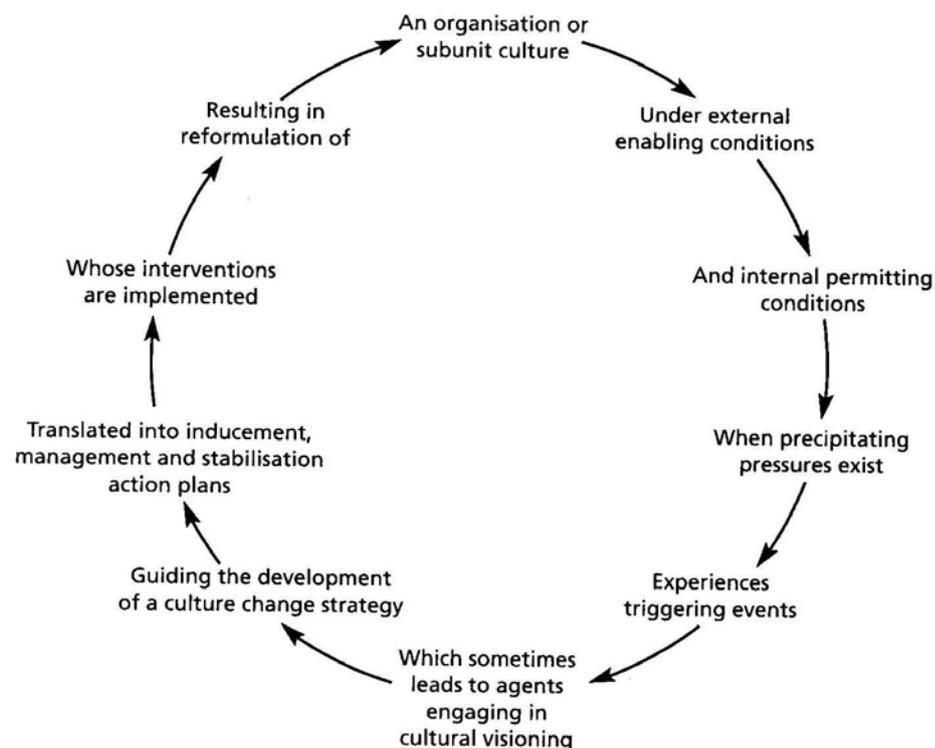
Figure 3.1 Lundberg's organisational learning cycle of culture change (Lundberg, 1985) and reproduced in Brown (1995).

Lundberg's model is based on the assumption that for culture change to occur several internal and external conditions must obtain (Figure 3.1). The two *external enabling conditions* are *domain forgiveness*, which is associated with the perceived threat faced by an organisation (e.g., degree of competition turbulence in the environmental). According to the model the more forgiving the external environment the more likely change will occur. The second external factor is *organisational-domain* congruence. In situations where there is a degree of congruence between the organisation and domain is too low or too high, then change may not occur as it is perceived to be too threatening. Change is more likely when there is a moderate degree of congruence.

Lundberg also distinguishes between four *internal permitting conditions* that facilitate culture change Brown, 1995). In brief:

- sufficient change resources (e.g., finance, managerial time and commitment);

- system readiness (a shared assumption that organisation members support change);

- co-ordinative (sic) and integrative mechanisms that allow communication and control

- a stable leadership group with the awareness, vision, power and communication skills to lead the desired culture change

Four types of *precipitating pressures* that influence the likeliness of change are also identified:

- atypical performance demands (e.g incentives to improve performance)

- stakeholder pressures (including the public, pressure groups, external regulators, etc.)

- pressures arising from rapid organisational growth or contraction

- a perception of crisis (e.g., financial losses or large debts)

Lundberg's model proposes one further condition needs to obtain before cultural change can be initiated: a *triggering event* and he distinguishes between five different classes of triggering event:

- environmental disasters (e.g., economic downturn)

- environmental opportunities (e.g., technological advances)

- internal revolutions (e.g., a change in senior management)

- external revolutions (e.g., a new regulatory regime)

- and managerial crisis (e.g., criminal wrongdoing by senior executives)

When the trigger event catches organisational leaders by surprise they may respond by initiating a process of enquiry. This will involve clarifying the existing culture and envisioning alternatives. Lundberg terms this *culture visioning*.

Success in establishing a new culture depends on the new vision being transformed into a *culture change strategy* implemented through action plans. Such a change strategy should contain three important factors:

- the *pace of change* (will change be quick or slow paced?)

- the *scope of change* (how radical will the change be?)

- the *time span* (over what period will change be managed?)

Three particular forms of action planning are needed to prompt cultural shifts:

- *inducement action plans* that strengthen organisational preparedness for change and engaged with resistance to change

- *management action plans* that enable members to reimagine the extant culture in line with the culture change strategy

- *stabilisation action plans* reinforce the changes and ensure their longevity.

These plans might include criticising dominant myths and legends, rewriting the organisation's history and introducing new metaphors. They may also involve the use of external consultants in helping to refashion the organisation's identity, redesign training programmes and revise recruitment and selection criteria.

Although Lundberg's model acknowledges the complexity of organisational change and recognises the multiple layers of culture that exist and need to be tackled by a change strategy, and the presence of multiple subcultures.

All of which makes planned culture change extremely difficult to effect. However, the model is rather mechanistic, failing to fully acknowledge the dynamism and uncertainty between cause and effect in organisational life (Scott et al., 2003b). It also fails to address the political forces (doctor-managerial tensions) within organisations, or recognise the influence of key individuals and groups in facilitating and resisting culture change.

3.22 Dyer's cycle of cultural evolution

Dyer's (Dyer, 1985) framework is premised on a definition of culture comprising of four levels: artefacts, perspectives (rules and norms):
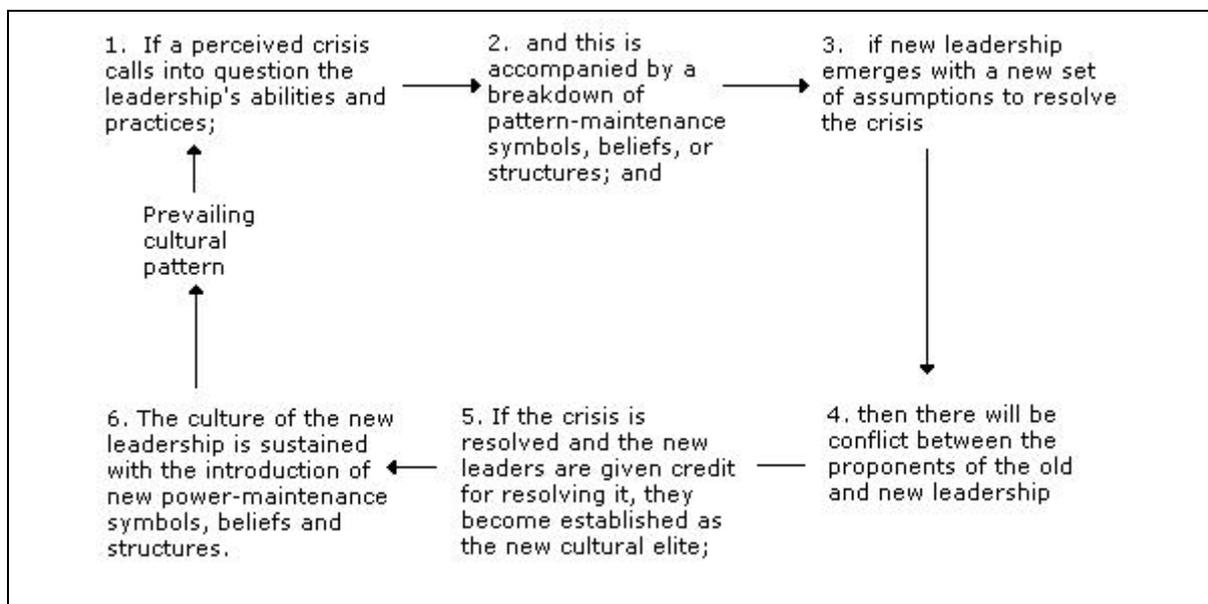
Figure 3.2 The cycle of cultural evolution in organisations (Dyer 1985) and reproduced in Brown, 1995.

Although presented as a sequential cycle (Figure 3.2), Dyer acknowledges that the stages can overlap or occur simultaneously.

During the first stage the leader's abilities styles of management and systems put in place are subject to critique. Within this model it is assumed that this is initiated by an adverse event, which creates a perception of crisis that organisational members believe cannot be resolved through the use of existing strategies and practices. In health care organisations, examples of such crises could arise from public confidence caused by high profile failures in professional and clinical practice. The perception of crisis

causes a breakdown in what Dyer terms the pattern-maintenance symbols, beliefs and structures, which are the means by which a culture is reproduced. This breakdown is necessary to make way for a new culture. The pattern-maintenance symbols, beliefs and structures can include dominant leaders, and reward structures.

The erosion of the culture's supportive symbols, beliefs and structures is not, however, a sufficient condition for culture change. The promotion of an alternative set of artefacts, approaches, and assumptions is also required. The arrival of the new leadership sparks conflict between supporters of the old and new cultures. Those unable to accept the new order may have to leave the organisation, voluntarily or otherwise, or be transferred to powerless positions. This might provoke a counter-attack by the old order, which the new should anticipate and swiftly quash. Conflict resolution is the next stage of Dyer's cycle of cultural evolution. The new leadership elite must deal with resentment and resistance caused by their new practices. The new leader must be credited with successfully solving these crises, which increases that individual's power's and reduces the power of reactionary rivals.

In order to embed the new culture in the organisation the new leadership must then begin to establish new pattern-maintenance symbols, beliefs and structures. In addition to recruiting people supportive of the new order and challenging nonconformists, the past history of the organisation is typically reinterpreted. According to Dyer's model, organisational cultural change comes out of a crisis affecting the old leadership and the effectiveness of a new leadership to take cultural control. According to the model, the most important decision in culture change concerns the selection of a new leader inasmuch as a new leader who enters an organisation during a period of crisis has unique opportunities to transform the organisation's culture by bringing and embedding new artefacts, perspectives, values, and assumptions into the organization. Leaders do indeed appear to be the creators and transmitters of culture (Dyer 1985: 223).

One advantage of Dyer's model over many other theoretical models is that its two essential conditions for cultural transformation – crisis and new leadership – are relatively easy to identify and test in organisational settings. It also usefully emphasises the importance of leadership in organisational culture and change. The framework can be criticised, however, for its simplistic view of culture change processes (Scott at al, 2003). The roles of the majority of individuals in an organisational culture are de-emphasised in favour of a focus on innovative leadership. Dyer's model also fails to ask a crucial and rather obvious question about the *causes* of crises in organisations. In answering that question it may be found that culture is a factor, but possibly only in the sense of its mediation of other more easily manipulable variables, such as finance, remuneration and career structures.

3.2.3 Schein's life-cycle model

Schein's (Schein, 1985) life-cycle model of organisational culture change suggests that organisations undergo distinct stages of development, each associated with a different culture serving different functions and susceptible to change in different ways. These stages are *birth and early growth*, *organisational midlife*, and *organisational maturity* (Figure 3.3).

Figure 3.3 Schein's Life Cycle Model

Growth stage	Function of culture	Mechanism of change
I. Birth and early growth Founder domination, Possibly family Domination *Succession phase:*	• Culture is a distinctive competence and source of identity • Culture is the 'glue' that holds Organisation together • Organisation strives towards more Integration and clarity • Heavy emphasis on socialisation as evidence of commitment • Culture becomes battleground between conservatives and liberals • Potential successors are judged on whether they will preserve or change cultural elements	1. Natural evolution 2. Self-guided evolution through therapy 3. Managed evolution through hybrids 4. Managed 'revolution' through outsiders
II. Organisational midlife • New product development • Vertical integration • Geographic expansion • Acquisitions, mergers	• Cultural integration declines as new subcultures are spawned • Crisis of identity, loss of key goals, values, and assumptions • Opportunity to manage direction of cultural change	5. Planned change and organisational development 6. Technological seduction 7. Change through scandal, explosion of myth 8. incrementalism
III. Organisational maturity • Maturity of markets • Internal stability or stagnation • Lack of motivation to change *Transformation option* *Destruction option* • Bankruptcy and reorganisation • Takeover and reorganisation • Merger and assimilation	• Culture becomes a constraint on innovation • Culture preserves the glories of the past, hence is values as a source of self-esteem, defence • Culture change necessary and inevitable, but not all elements of culture can or must change • Essential elements of culture must be identified, preserved • Culture change can be managed or simply be allowed to evolve • Culture changes at basic levels • Culture changes through massive replacement of key people	9. Coercive persuasion 10. Turnaround 11. Reorganisation, destruction and rebirth

Figure 3.3 Growth stages, functions of culture, and mechanisms of change. Reproduced from Schein (1985) and reproduced in Brown, 1995.

Birth and early growth

During this stage the cultural emphasis is on socialisation and cohesion. Mechanisms of change include natural evolution, the involvement of outside consultants in 'clinical' therapy to guide change, recruiting specific individuals to engineer change (evolution through hybrids), and revolutionary change by recruiting new leaders to steer the young organisation through crises. Managed revolution entails conflict with the older culture and scepticism, resistance and sabotage are all likely. Eventually a dominant view forms about whether the new regime has been successful, or has not. In the latter case the outsiders are likely to be forced out.

Organisational midlife

In this phase the organisation is well established and the developmental instabilities are replaced by strategic choices concerning growth diversification, and acquisitions. The culture of the organisation are fully formed and embedded in its strategies and structures. Strong subcultures may have developed, making a deep understanding of the organisational culture both difficult and necessary to change. Mechanisms of change in organisational midlife include planned change and organisational development, technological seduction, scandal and explosion of myths, and incrementalism.

- Planned change and organisational development

Schein (Schein, 1985) defines organisational culture by three levels: artefacts, values, and assumptions. Briefly, artefacts are the material aspects that we can see, hear or otherwise sense when we enter the organisation: its distinctive architecture, behaviour, symbols, etc. Values are the espoused rationale for how the organisation does what it does. And assumptions are values that have become so embedded in the culture as to be taken for granted or as Schein often puts it: 'dropped out of consciousness'. According to Schein, the basic methodology for assisting with organisational culture change is to look for discrepancies between observed artefacts and espoused values. These, he states, are usually explicable in terms of the underlying assumptions that provide the basic substrate on which more observable aspects of the culture are built.

According to Schein, we should try to uncover the underlying assumptions that explain this discrepancy. We might find for example, deeply held though largely unconscious assumptions about professional status and personal income; about fraternity and solidarity within occupational groups; about contempt for patients who appear unwilling to preserve their own health.

Planned change and organisational development involves facilitating culture change by analysing and bringing to the surface the values and assumptions of the dominant culture and subcultures. This process is seen as a way of 'unfreezing' the culture by providing mutual insight and developing commitment to superordinate organisational goals. It assumes that conflict between the dominant culture and subcultures within the organisations are a decisive spur to change.

- Technological seduction

The introduction of new technology can be another spur to culture change by causing new patterns of social interaction to arise, changing the nature of tasks and whole jobs and by threatening the power bases of people affected by new technologies.

- Change through scandal, explosion of myths

These are extreme cases of the artefact-value discrepancies mentioned above. The Bristol paediatric heart surgery tragedy is the most outstanding of these scandals in the NHS in recent years. Discrepancies between artefacts (inadequate surgical skills, high mortality rates, group-think among surgeons, 'whistle-blowing' taboo) and values (high moral commitment to the care of sick children) of this severity have led to the examination of underlying assumptions and cultural change in the NHS.

- *Incrementalism*

This refers to Quinn's (Quinn, 1978) description of how leaders actually hope to implement their strategies. Incrementalism refers to a gradual process whereby one's daily decisions will, if informed by a long-term desire for change, steer the organisation in that direction in the long-term.

- *Organisational maturity*

Other aspects of NHS culture fit into the maturity phase, where the distinctive change mechanisms are coercive persuasion, turnaround and reorganisation, destruction and rebirth.

- *Coercive persuasion*

Although it appears harsh, there Schein develops a number of arguments in favour of driving cultural change, particularly in situations where employees have no alternative but to accept the new regime because they do not have alternative employment opportunities. Some cultures may be so intransigent that more subtle change processes have little change of succeeding. Here the direct approach is less manipulative that the kind of ideological warfare summoned by Dyer, and could be advantageous in the face of a sceptical, suspicious or cynical workforce. According to Schein sometimes a crisis calls for decisive action and delay could threaten the organisation's existence. In such cases leaders' first duty is to keep the organisation viable by whatever legal means are available.

- *Turnaround*

As the name suggests this category involves transforming the failing organisation into a success story. It requires a grasp of all main aspects of business and organisational culture, though Schein claims that it is the leader's ability to coerce that will make or break a successful turnaround. To be successful in large organisations, culture change by turnaround implies that one person can effectively manipulate the controls of the organisation by implementing clear lines of responsibility and accountability.

3.24 Gagliardi's model

Gagliardi's (Gagliardi, 1986) conception of organisational culture is similar to those of Lundberg, Dyer and Schein in that the essence of culture lies in the unconscious assumptions that are expressed in conscious values and material artefacts. His framework for culture change differs, however, in advocating the view that this change occurs incrementally, not radically. Gagliardi argues that there are four phases in the development of an organisational value:

1. A leader defines objectives and evaluates tasks in accordance with specific beliefs. Whilst these beliefs might not be shared by all members of an organisation, the leader has the influence to shape those under his control in the direction that he or she desires.

2. The belief is supported by experience and becomes shared by all members of the organisation.

3. Employees orient their attention away from the effects of belief, and instead focus dogmatically on the belief as the cause of desirable effects.

4. Finally, the value comes to be shared uncritically and unconsciously by all members. Gagliardi terms this *idealization* in which a belief is *emotionally transfigured*, i.e., held on emotional rather than rational grounds. In Schein's terms the value has become an assumption.

Gagliardi states that the need for large-scale change is rarely perceived by those deeply involved in its culture and more likely to be seen by members of counter-cultures or outsiders. Culture change therefore requires a change of leadership, from outside the dominant culture. Gagliardi distinguishes between cultural revolution, in which the old firm dies to be replaced by a new firm; and an incremental model of culture change (figure3.4)
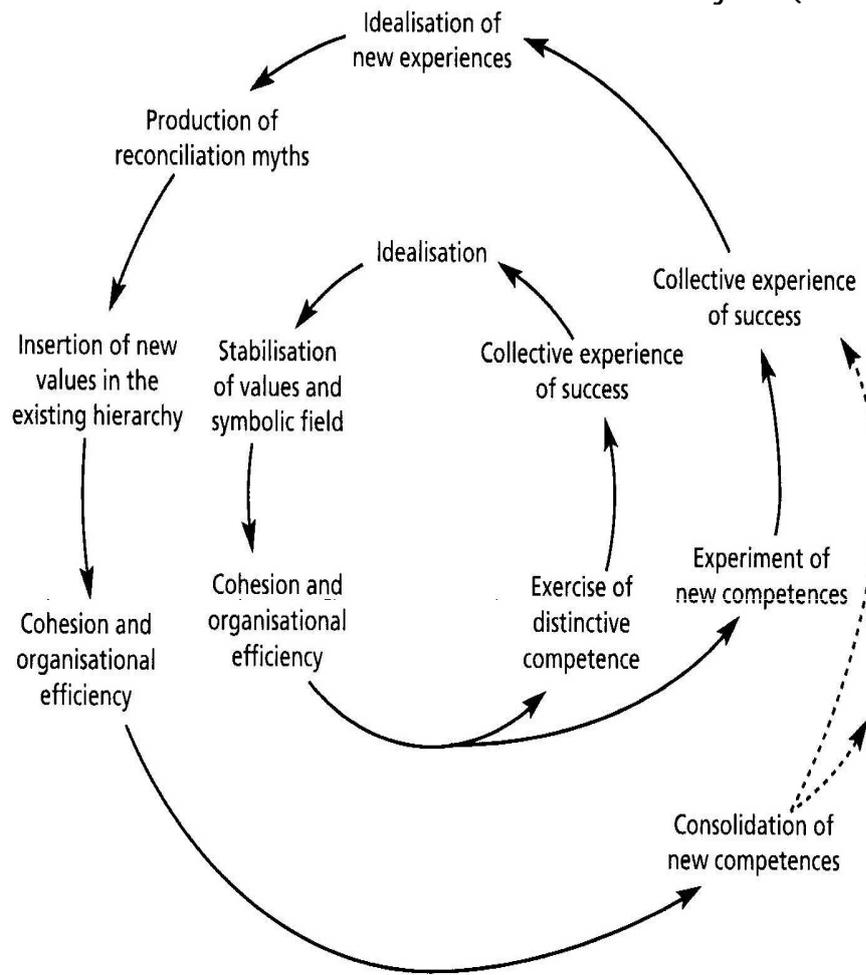
Figure 3.4 Gagliardi's model: Cultural change as an incremental process (Brown 1995: 104)

According to this model the failure of the existing culture to cope with certain problems does not mean that the old culture needs to be destroyed, merely that it has to expand its range of responses by incorporating new values. If the organisation then experiences success, the idealisation process will lead to the new values being ascribed to on emotional grounds and becoming assumptions in their turn. Tensions are resolved by appeals to reconciliation myths promoted by the leadership. These myths convince people that the organisation's success is due to new practices, even though they might really be due to causes unconnected with the new ways of doing things:

'In cultural change, then, the role of the leader is, above all, to create conditions under which success can visibly be achieved, even if only in a limited or partial way, and to rationalize positive events after they have happened, even if accidental... A leader does not reinterpret past history to justify retrospectively his own proposals, nor does he go against existing myths; rather, he reinterprets the recent past and present in such a way that he promotes the insertion of new emergent values into the hierarchy of current operational ones and encourages the birth of new myths which are superimposed on the old ones and reconcile new contradictions' (Gagliardi 1986: 132)

Gagliardi's model of cultural change is interesting for several reasons. First it affirms the possibility of gradual change without the wholesale upset and cost of revolutionary change. Second, it provides insights into the pragmatic and often intuitive methods by which successful leaders convert the inherent ambiguity of meaning of organisational events into clear (though possibly specious) attributions of cause and effect. They do this by shaping events into arguments to promote values and expand the competencies of the organisation.

3.25 Lewin, Beyer and Trice, and Isabella

The final model of organisational change discussed by Brown (Brown, 1995) is a compilation model based on the ideas of Lewin (Lewin, 1952) as modified by Schein (Schein, 1964), Beyer and Trice (Beyer and Trice, 1988) and Isabella (Isabella, 1990). The framework examines the cultural processes associated with organisational culture change and adaptation in more detail than do the previous models. The framework (Figure 3.5) adopts Lewin's division of change into three phases: unfreezing, change, and refreezing.

Contextual	Social	Cognitive
Unfreezing mechanisms	Rites of questioning and destruction	Anticipation
	Rites of rationalisation and legitimation	
Experimentation	Rites of degradation and conflict	Confirmation
	Rites of passage and enhancement	Culmination
Refreezing mechanisms	Rites of integration and conflict reduction	Aftermath

Figure 3.5 Understanding organisation culture change: three related domains (reproduced from Roberts and Brown (Roberts and Brown, 1992))

Unfreezing

The process of unfreezing begins when some leaders develop a perceived need to change, typically in response to adverse events such as declining profitability. This information induces guilt anxiety, encouraging individuals to be more receptive to ideas of change. The felt need to change might be a localised phenomenon, however, unless it is cascaded down and across the organisation.

The unfreezing rites are *rites of questioning and destruction*, and *rites of rationalisation and legitimation*. Rites of questioning and destruction formally challenge the established regime by presenting the information that individuals or systems are failing to perform satisfactorily. These rites take the form of presentations designed both to inform and to persuade, usually as part of an 'advertising campaign'. Other rites of questioning and destruction include bringing in a team of external consultants,whom act as catalysts of change by stimulating debate and questioning of basic organisational assumptions.

Rites of rationalisation and legitimation socialise people to the importance of the desired changes by providing explanations of why they are needed. Sensitising explanations legitimate the new thinking, making it appear necessary and acceptable. They also promote commitment to the proposed change programme. Rites of rationalisation and legitimation usually begin at senior management level, after which internal advocates of change are trained as trainers and this pattern is repeated down and across the organisation.

Change

In this phase, where the actual culture change takes place, there are two further associated rites, rites of degradation and conflict and rites of passage and enhancement.

Rites of degradation and conflict constitute attacks on the old order. Rites of degradation include replacing staff who do not acknowledge the need for change with new staff who support the new order. Constructive conflict situations may be deliberately set up. For example a powerful task force may be appointed to overcome resistance and sweep changes through, challenging the authority of reactionaries. Other rites of degradation and conflict include the introduction of new targets, milestones and performance indicators. These serve to legitimate the new order, by instilling new objectives and values, thereby eroding the objectives, values and the relevance of the old order.

Rites of passage and enhancement are designed to instil a sense of identification and belonging to the new order. This helps to reduce resistance to change (by providing a social psychological motive to join the in-group), broaden the base of support for the new order and encourage ownership of the process of change. Education and training plays a prominent role in this, along with promotions and job titles that reflect the new order. During this phase, individuals progress through two further cognitive states that Isabella terms confirmation and culmination. Once individuals have adequate information they will try to make sense of events using traditional explanations and previous experiences. This tendency to understand the new order using old heuristics is termed the confirmation period. It helps to explain why some individuals and groups are unable to understand fully the changes being sought by the programme, by locating conflicting assumptions or paradigms upon which the changes are interpreted. Only when the deficiencies of the old assumptions are clarified can participants progress to the culmination stage, wherein the changes required are fully understood in their proper context.

Refreezing

During the refreezing phase, individuals seek to reduce the uncertainty and instability in their work tasks and relationships engendered by the change programme and settle into a more predictable modus operandi. This involves individuals in redefining the role and functions required of them and learning to work efficiently with new systems and groups of colleagues. In this phase the new cultural values become embedded as underlying assumptions.

Refreezing also has its associated rites, rites of integration and conflict reduction. These rites bring coherence to the organisation and reduce conflicts and rivalry between groups and departments. Rites of integration and conflict reduction consolidate the new order and raise morale. Praise from senior leaders, refresher training courses, group rituals and other rites contribute to this phase. They also encourage a cognitive shift to a state that Isabella terms aftermath. In the aftermath period, the changes are evaluated and interpreted, conclusions drawn about the new organisation's strengths and weaknesses, and winners and losers identified.

The framework draws upon the social psychological paradigm to understand how culture change is initiated and the behavioural and cognitive experiences of those involved. It pays attention to the ritualised behaviour associated with organisational change, and it usefully couches culture change as a problem of adaptation, both to the external and internal environments, by the organisation and its members. It is very general and applicable to any type of organisation and to any level within an organisation. However the model paints a linear picture of change and appears to expect adaptation to occur without serious upset or bitter

conflict, which is not the fate of most change programmes. It does not tell the change agent what to do, being more descriptive than prescriptive.

Whether a change programme is advisable or successful are questions that this framework does not seek to address.

3.3 Summary of the five culture change models

Despite some key differences between the five models they each share common foci on a *crisis* as the trigger for culture change; on the role of *leaders* to detect a need for and to shape and implement change; on *success* to consolidate the new order and counter resistance; and on *relearning* and *re-education* to explain the efficient assimilation of cultural change (Box 3.2).

Key ingredients of culture change

- Triggered by a perception of *crisis*

- Initiated and shaped by strong *leaders*

- Consolidated by perceived *success*

- Mediated by *relearning/re-education*

Figure 3.2 Key ingredients of culture change

The models illustrate that organisational culture change can be interpreted in a variety of ways. No overall conclusions can be drawn concerning which is the best model to apply. Individually and collectively, the models show that understanding cultural change is difficult owing to the complexity of both organisational culture and organisational change. This review therefore recaps on thinking around culture change as a means of providing some structure against which the empirical work could be devised, analysed and interpreted. The next section reports the findings of national quantitative surveys designed to explore the dynamics of culture change in primary and hospital organisations in the English NHS.

4 Quantitative explorations of culture and performance relationships

4.1 Introduction

This part of the study explored quantitative cross-sectional relationships between health care organisational culture (largely as assessed at senior management team level) and various measures of organisational characteristics and performance. This work took a national perspective focused on English NHS acute hospitals and Primary Care Trusts (PCTs).

Notwithstanding recent and ongoing structural change, especially merger activity (Fulop et al. 2002), NHS Trusts have clear organisational boundaries and (relatively) established identities, and there is also a wide variety of performance data available on these entities.

Our aims were, first, to assess changes in cultural profile across health care organisations over the period 2001-2008 through analysis of repeated observations; and second to look for associations between cultural patterning and patterns of performance at organisational level. The data presented here represent the initial analysis of the complex and linked data sets so constructed: ongoing work will continue to explore more sophisticated analyses (including lags) as more performance data become available and are added to the dataset. In that sense the project funding has seeded the establishment of an ongoing data resource which is being maintained and enhanced as a means of addressing culture/performance questions.

4.2 Assessing organisational culture using the Competing Values Framework

Culture assessment was accomplished through use of an established tool – the Competing Values Framework (CVF, see e.g. Cameron and Freeman 1991; Gerowitz et al. 1996; Gerowitz 1998; Shortell et al. 2000). Using two main dimensions – the first describing how processes are carried out within the organisation, and the second describing the orientation of the organisation to the outside world – the CVF thus articulates four basic organisational cultural 'types' (see Box 4.1 'Competing Values Framework'). Crucially, organisations (or subgroups within them) are not deemed to be simply one or other of these four types; instead, they are seen to have competing values while nonetheless having a more-or-less stronger pull to one particular quadrant.

Box 4.1: 'The Competing Values Framework' for modelling organisational culture

Relationship-based processes
Focus on: flexibility, individuality and spontaneity

Clan Culture	Developmental Culture
cohesive, participative	creative, adaptive
leader as mentor	leader as risk-taker, innovator
bonded by loyalty, tradition	bonded by entrepreneurship
emphasis on morale	emphasis on innovation

Internal focus
Focus on: internal smoothing and integration

External focus
Focus on: competition and differentiation

Hierarchical Culture	Rational Culture
ordered, uniform	competitive, acquisitive
leader as administrator	leader as goal-oriented
bonded by rules, policies	bonded by competition
emphasis on predictability	emphasis on winning

Mechanistic-type processes
Focus on: control, order and stability

Assessment of the dominant culture orientation for any particular organisation was accomplished through use of a postal questionnaire. (See Appendices 1-3 for the questionnaires used in hospital, PCT and GP practice settings.) This was sent to the senior management team (i.e. members of the Executive Board). The CVF questionnaire offers respondents a series of descriptions of a hospital, arranged in five groups of four (copy available from the authors). Within each group of four descriptions, the respondent is asked to 'share 100 points' between them 'according to which description best fits your current organisation'. The five groups represent descriptions of hospital characteristics, leadership, emphasis, cohesion and rewards. Collating these 'points allocations' provides a score (in the range 0-100) for each individual on each of four cultural subtypes: clan, developmental, hierarchical, or rational (see Box 4.1).

The largest score on each cultural subtype defines that individual's dominant culture type; the actual value of this score represents the 'strength' of that dominant cultural type. The dominant culture type, strength, focus and orientation for an organisation are calculated by aggregating across the individual scores of the senior management team.

The analysis focuses especially on dominant cultural types (the quadrant towards which there is strongest pull). However, we also calculated how well the scores for the different types of culture were in balance, using the Blau index (Blau, 1977). Higher scores on this index indicate a more even distribution of pull across the four culture types. Practices that have a

perfect balance across the four culture types will have an index of 1, and the smaller the index the greater the degree of imbalance across the four categories (and hence a greater likelihood of dominance from one cultural quadrant indicating a 'stronger' cultural orientation).

As with all culture measurement instruments, the CVF has a number of limitations (Mannion et al. 2008b). First, it can only provide a snapshot of culture at a particular moment in time. Second, it needs to clarify culture in one of only four categories, which cannot reflect the richness and complexity of cultures in organisation contexts. Finally, it can only capture surface level or 'exposed' cultures rather than 'culture in practice'. Nevertheless, the CVF has good face validity and of all the available quantitative instruments, we believe that it is the most suitable for capturing the breadth of organisational cultures in the NHS.

4.3 Assessing performance

Various routinely collected measures of organisational characteristics and performance have been collated at the Centre for Health Economics (University of York, UK) over a number of years. The database consists of well over 1000 variables and includes measures of expenditure, income, activity, patient characteristics, Trust characteristics, staffing variables, access measures, various quality variables and performance indicators, all measured at the Trust level. Data sources include the Department of Health, CIPFA, NHS Information Authority, Hospital Episodes Statistics, Dr Foster, and Commission for Healthcare Improvement and these are updated on an annual basis.

4.4 Hypothesised relationships between cultural types and aspects of performance

If a contingency view of the organisational culture/performance relationship is correct, then those aspects of performance valued within a given culture should be those aspects of performance that are enhanced in hospitals that exhibit strong congruence with that culture. To test this first-level hypothesis, we have previously drawn on an understanding of the values, beliefs and assumptions that underpin the CVF and developed a number of *a priori* second-level hypotheses about possible relationships between dominant cultures and specific aspects of performance. These second-level hypotheses are shown in the Table below and are based on the key 'competing values' as set out in the earlier Box. The general pattern of these second-level hypotheses was upheld through earlier work (Davies et al. 2007) providing considerable support for our first-level hypothesis on contingency.

Table 4.1: Contingent performance: second-level hypothesised relationships

Dominant culture types:	Valued aspects:	Expected performance variables favoured:
Clan	Tradition, cohesion, commitment, morale ~ Internal/Relational	Better staffing levels, staff opinions/morale; higher degree of specialisation; higher level of cancelled operations; high levels of trust; however, may have poorer star ratings.
Developmental	Innovation, dynamism, growth, entrepreneurship ~ External/Relational	Better waiting times, Better star ratings
Hierarchical	Order, procedures, stability, predictability ~ Internal/Mechanistic	Better data quality and financial balance – but perhaps higher costs associated with bureaucracy.
Rational	External competitiveness, achievement ~ External/Mechanistic	Higher research revenue, costs; Better star ratings.
Cultural orientation:		
Mechanistic	Rationality, rules, ordered decision making	Measures of conformity
Relational	Interpersonal, bonded, shared experience	Staff morale
Culture focus:		
Internal	Maintaining the internal organisational integrity	Staff morale, staffing levels
External	Engaging with the external environment	Waiting times, star ratings, and other formal performance indicators, low level complaints, rapidly dealt with

4.5 Analytic approaches used

Cultural data (aggregated within each hospital Trust) were analysed alongside the extensive data on organisational performance. Multivariate econometric analyses using regressions, ANOVA, multinomial logit, ordered probit and others were used to explore the associations between measures of culture and measures of performance. The key findings from these analyses are presented and explained below. The complete analysis, with full model specifications and detailed outputs, is available from the authors on request.

Each model was calculated using both unweighted values and values (weighted for job type of respondent and for number of responses from a given organisation). Since there was little difference between weighted and unweighted analyses, the unweighted data are presented in each case.

Data are presented in sequence below as follows: first we display the data at individual level for the Acute Trusts, PCT sample and sub-sampled GP Practices. These data demonstrate shifts in cultural orientation aggregated across all individual respondents within each of these three groups at each of the time points for which there are data available. Subsequently, we aggregate up from the individual data to identify the dominant cultural orientation at organisation level (i.e. grouping and aggregating respondents by their Acute Trust, PCT of General Practice). It is these *organisational* level measures of culture that are then used in the subsequent modelling for relationships between culture and performance.

4.6 Data returns

For the Acute Trusts, data are therefore available at three temporally spaced observations at Board level, with the latter two time points also yielding some data at sub-Board level. At PCT level we have senior manager data for the two time points T2 and T3, and then for the sub-sampled GP practice populations (all sampled practices from 10 PCTs), we again have data at time points T2 and T3.

Data returns from Acute Trusts and PCTs at each time point

Respondents	T1 – 2001/02	T2 – 2006/07	T3 – 2007/08	
Acute Trusts				
Board	899	826	739	
Full sample	899	1214	1116	
PCTs	n/a	557	645	
GP Practice level	n/a	348	384	

4.7 Culture scores at individual level in the Acute Trusts

The Tables below show the raw scores for culture calculated by individuals (across the whole sample) for the each of the three time points (T1, T2, T3). The mean scores for Clan orientation can be seen to have declined over the three periods (from 31 down to less than 27) with a corresponding rise in Hierarchical orientation (from a mean of 19 to 22) and a slight rise in Rational (27 to 29). Restricting the analysis to Board-level only individuals tells a very similar story (data not shown).

Average culture scores for individuals: Acute Trusts at time T1

	Mean	Std. Dev	Min	Max
Group / Clan	30.96	14.06	0	86
Developmental / Open	23.04	10.92	0	100
Hierarchical	18.88	12.18	0	80
Rational	27.11	10.69	0	72
Internal	49.84	13.37	0	100
Relational	54.01	16.63	0	100
Mechanistic	45.99	16.63	0	100
External	50.16	13.37	0	100
Culture strength	40.91	10.03	26	100
Dominant culture	2.13	1.23	1	4
Blau index	0.684	0.071	0	0.750

Average culture scores for individuals: Acute Trusts at time T2

	Mean	Std. Dev	Min	Max
Group / Clan	27.46	14.22	0	80
Developmental / Open	22.05	10.88	0	66
Hierarchical	22.54	13.45	0	88
Rational	27.94	11.12	0	80
Internal	50.00	13.17	0	95
Relational	49.51	17.91	0	100
Mechanistic	50.49	17.91	0	100
External	50.00	13.17	5	100
Culture strength	41.08	9.68	26	88
Dominant culture	2.45	1.24	1	4
Blau index	0.685	0.065	0.215	0.750

Average culture scores for individuals: Acute Trusts at time T3

	Mean	Std. Dev	Min	Max
Group / Clan	26.81	13.89	0	88
Developmental / Open	22.43	10.95	0	68
Hierarchical	22.45	13.16	0	80
Rational	28.31	10.71	0	76
Internal	49.26	12.69	4	90
Relational	49.24	17.63	0	100
Mechanistic	50.76	17.63	0	100
External	50.74	12.69	10	96
Culture strength	40.57	9.61	25	88
Dominant culture	2.46	1.23	1	4
Blau index	0.687	0.065	0.219	0.750

Presenting these data graphically (below) illustrates the drift away from Clan orientation to more Hierarchical and Rational orientations (Figure 4.1):

Firgure 4.1 Frequency distribution (individual responses; all Acute Trust sample; unweighted)
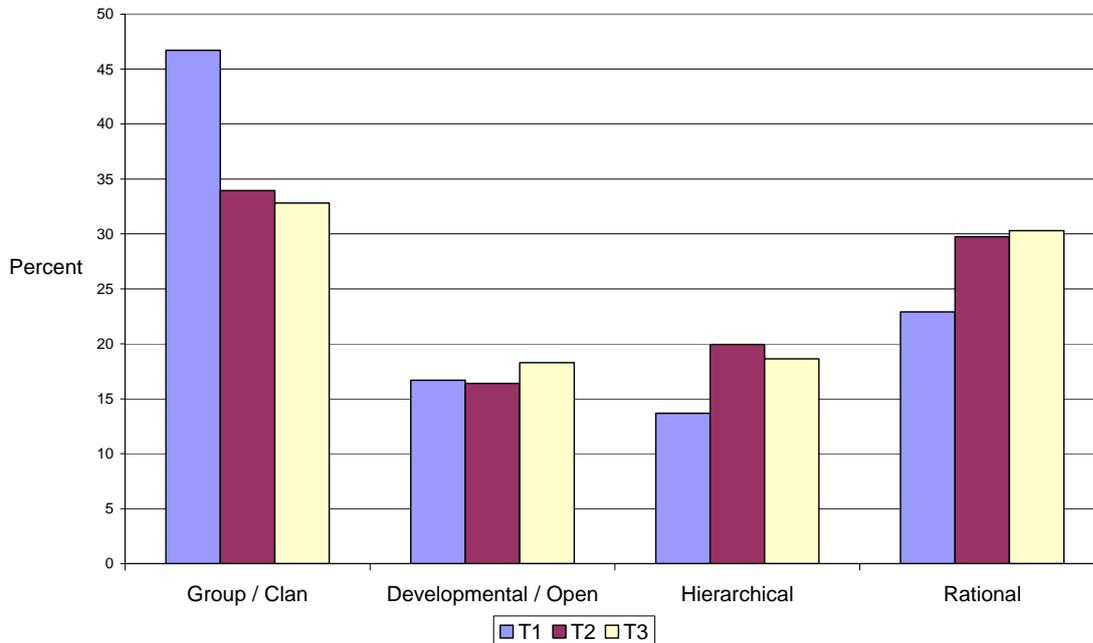
4.8 Culture scores at individual level in the PCTs

For the PCT sample we had data at two time points (T2 and T3). The aggregated data for individual responses are shown below in separate tables for these two time points, and then graphically. Again, over even this short period, we see a marked shift from Clan orientation to Rational (means core for Clan declined from 27 to less than 23; that for Rational increased from 28.5 to nearly 31).

Average culture scores for individuals: PCTs at time T2

	Mean	Std. Dev	Min	Max
Group / Clan	26.61	13.37	0	84
Developmental / Open	26.14	12.84	0	69
Hierarchical	18.72	12.24	0	81
Rational	28.53	11.46	0	78
Internal	45.33	14.47	0	96
Relational	52.75	17.17	2	100
Mechanistic	47.25	17.17	0	98
External	54.67	14.47	4	100
Culture strength	41.15	9.98	27	84
Dominant culture	2.44	1.22	1	4
Blau index	0.682	0.069	0.283	0.749

Average culture scores for individuals: PCTs at time T3

	Mean	Std. Dev	Min	Max
Group / Clan	22.76	11.91	0	82
Developmental / Open	25.26	12.21	0	74
Hierarchical	21.24	13.79	0	90
Rational	30.74	11.55	0	74
Internal	44.00	14.00	6	90
Relational	48.02	17.28	0	96
Mechanistic	51.98	17.28	4	100
External	56.00	14.00	10	94
Culture strength	40.70	10.33	26	90
Dominant culture	2.80	1.16	1	4
Blau index	0.683	0.073	0.180	0.750

Figure 4.2 Frequency distribution (individual responses; PCT sample; unweighted)
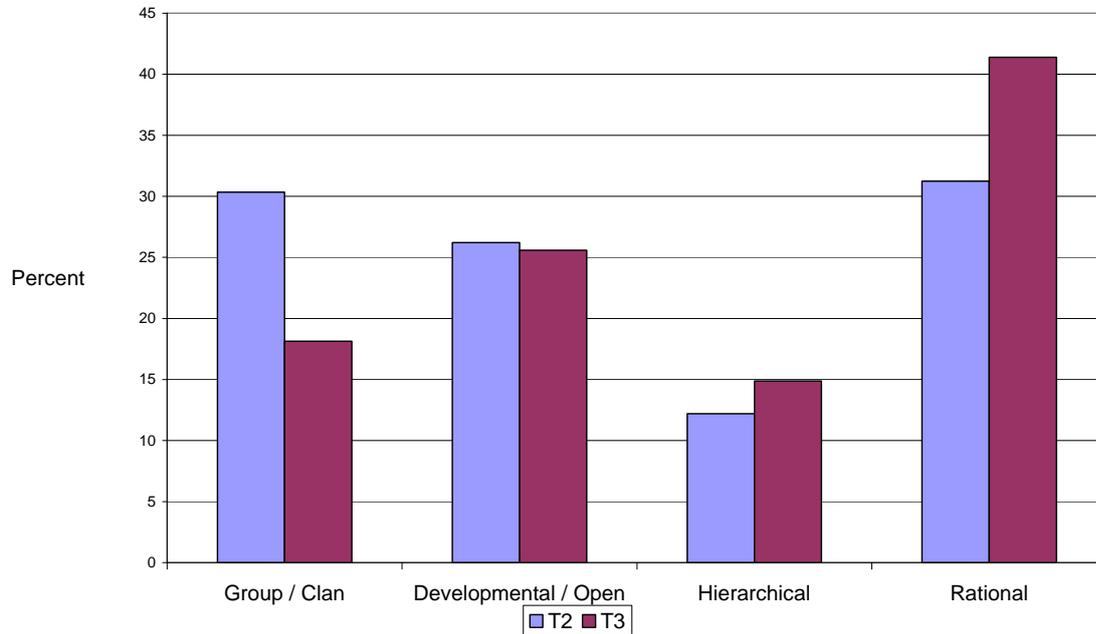
4.9 Culture scores at individual level within the sub-sampled GP practices

Data collected from the sampled GP practices (see below) demonstrated the overwhelmingly Clan orientation at this level, with little change over the two time periods (see Figure 4.3)

Average culture scores for individuals: Practice-level data at time T2

	Mean	Std. Dev	Min	Max
Group / Clan	42.83	21.36	0	100
Developmental / Open	17.17	12.00	0	80
Hierarchical	20.58	13.96	0	78
Rational	19.41	12.89	0	90
Internal	63.42	14.41	10	100
Relational	60.01	22.10	0	100
Mechanistic	40.00	22.10	0	100
External	36.58	15.41	0	90
Culture strength	50.86	15.12	25	100
Dominant culture	1.73	1.10	1	4
Blau index	0.611	0.132	0	0.750

Average culture scores for individuals: Practice-level data at time T3

	Mean	Std. Dev	Min	Max
Group / Clan	43.05	21.91	0	100
Developmental / Open	16.17	10.22	0	62
Hierarchical	21.50	14.37	0	86
Rational	19.27	11.85	0	66
Internal	64.55	15.28	24	100
Relational	59.23	21.53	0	100
Mechanistic	40.77	21.53	0	100
External	35.46	15.28	0	76
Culture strength	50.68	15.19	25	100
Dominant culture	1.68	1.07	1	4
Blau index	0.612	0.130	0	0.750

Figure 4.3 Frequency distribution (individual responses; Practice-level data; unweighted)
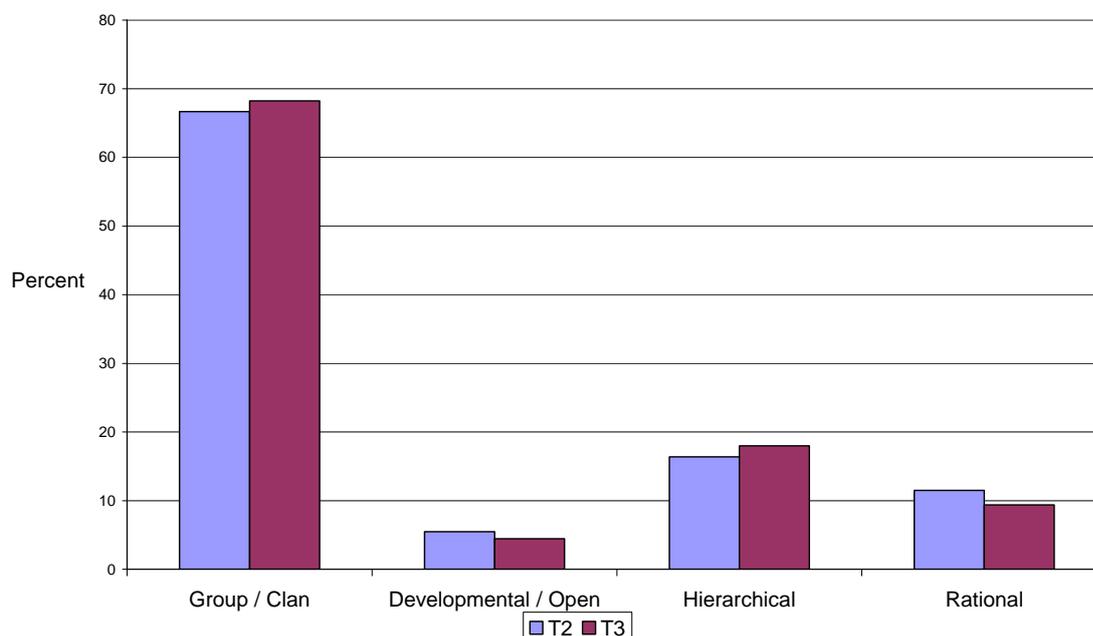
4.10 Aggregating across individuals to get organisational culture: Acute Trusts

The individual-level data were grouped according to organisation to provide an estimate of *organisation* cultural orientation. In assessing the organisations' culture we were seeking robust estimates of senior management views, and previous studies have usually regarded three or four key senior managers' responses as sufficient to define the organisational culture type (Gerowitz et al. 1996; Gerowitz 1998). In this study, and at the first data gathering (T1) at least three senior managers responded from 170 organisations (86%); and four or more replied from 145 (74%). Data from T2 and T3 were considerably better since more respondents were targeted in each Trusts, hence we attained excellent national coverage of the English acute hospital sector.

	T1 – 2001/02	T2 – 2006/07	T3 – 2007/08
Number of Trusts*	187	143	140
3 or more responses	86%	95%	93%
4 or more responses	74%	89%	89%

* NB: the decline in numbers of organisations across the three time periods reflects the mergers and other structural reorganisations that took place over this time period.

The number of respondents per Trust is shown in Figure 4.4 below for each of the three rounds of data collection. The shift of the distribution to the right for periods T2 and T3 reflects the fact that these rounds of data gathering targeted larger numbers of respondents in each organisation compared to the initial round (T1) which focused entirely on senior (Board-level) managers.

Figure 4.4   Percent of Acute Trusts returning one or more individual cultural assessments
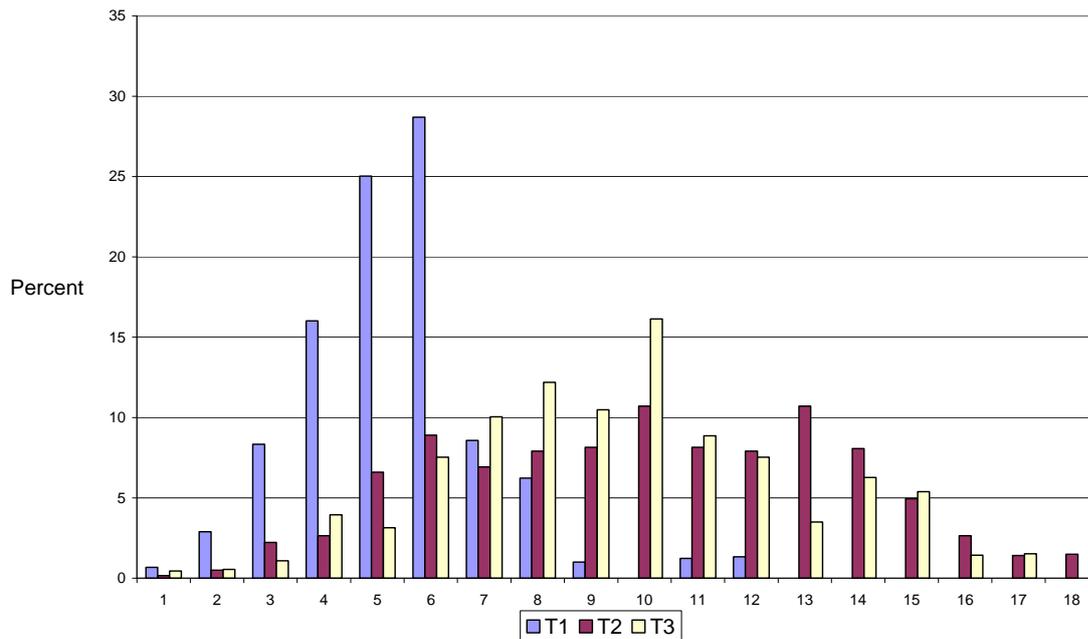
Aggregating data across the individuals from within the same Acute Trust told a similar story to the individual-level data (see Tables below, and Figure following): a decline in Clan orientation and an increase in Hierarchical and Rational orientation. These shifts were seen whether the whole sample was analysed or the analysis was restricted to Board-level respondents, and whether the analysis was carried out weighted or unweighted (only the whole sample, unweighted, data are presented). In effect, these cultural shifts, over just six years or so, have seen the percentage of Acute Trusts exhibiting a Clan-dominant orientation drop from 53% to 35%, while those exhibiting a Rational-dominant orientation have increased from 30% to 42%, with a more than doubling of Hierarchical-dominant organisations from 5% to 13%.

Average culture scores for Acute Trusts at time T1

	Mean	Std. Dev	Min	Max
Group / Clan	31.15	9.69	0	64
Developmental / Open	22.71	7.29	3	49
Hierarchical	18.82	7.94	2	52
Rational	27.33	6.79	13	47
Internal	49.96	9.18	29	80
External	50.04	9.18	20	71
Mechanistic	46.14	11.25	19	97
Relational	53.86	11.25	3	81
Culture strength	36.61	6.11	27	64
Dominant culture	2.11	1.33	1	4
Blau index	0.716	0.033	0.528	0.749

Average culture scores for Acute Trusts at time T2

	Mean	Std. Dev	Min	Max
Group / Clan	27.46	8.39	10	50
Developmental / Open	22.05	5.85	11	44
Hierarchical	22.54	7.23	8	43
Rational	27.94	5.63	14	58
Internal	50.00	7.03	27	74
External	49.51	7.03	26	73
Mechanistic	50.49	10.38	27	76
Relational	50.00	10.38	24	73
Culture strength	34.23	4.71	26	58
Dominant culture	2.37	1.32	1	4
Blau index	0.725	0.022	0.602	0.749

Average culture scores for Acute Trusts at time T3

	Mean	Std. Dev	Min	Max
Group / Clan	26.81	8.38	9	60
Developmental / Open	22.43	6.05	9	42
Hierarchical	22.45	6.83	0	47
Rational	28.31	4.84	2	53
Internal	49.26	6.33	29	64
External	50.74	6.33	37	71
Mechanistic	50.76	10.25	2	80
Relational	49.24	10.25	20	98
Culture strength	33.74	4.54	27	60
Dominant culture	2.62	1.33	1	4
Blau index	0.727	0.028	0.495	0.749

Figure 4.5 Frequency distribution of Acute Trusts by dominant cultural orientation
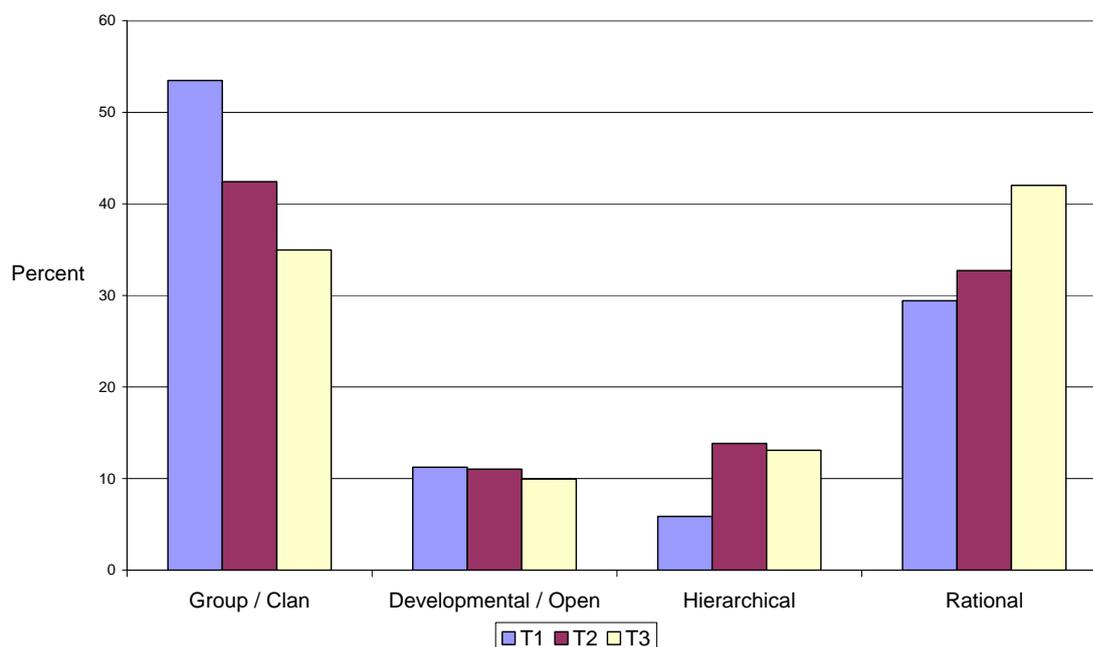
4.11 Aggregating across individuals to get organisational culture: PCTs

PCT organisations numbered 145 at time point T2 and 114 at time point T3. At the first of these data gatherings, we received usable responses from at least 3 respondents for 86% of the PCTs, and in the second round of data

gathering this figure rose to over 95%. The culture scores aggregated within organisations showed a very marked shift away from Clan and (less marked) Developmental cultures to an increase in Hierarchical and Rational culture dominance. (Figure 4.6)

Average culture scores for PCTs, at time T2

	Mean	Std. Dev	Min	Max
Group / Clan	26.61	7.96	0	62
Developmental / Open	26.14	8.86	0	59
Hierarchical	18.72	7.01	2	6
Rational	28.53	6.98	12	7
Internal	45.33	9.15	14	76
External	54.67	9.15	24	86
Mechanistic	47.25	10.66	19	98
Relational	52.75	10.66	2	81
Culture strength	35.56	6.21	27	76
Dominant culture	2.40	1.26	1	4
Blau index	0.709	0.052	0.374	0.748

Average culture scores for PCTs, at time T3

	Mean	Std. Dev	Min	Max
Group / Clan	22.76	6.66	9	43
Developmental / Open	25.26	6.36	12	44
Hierarchical	21.24	7.02	6	46
Rational	30.74	5.83	16	47
Internal	44.00	6.76	29	63
External	56.00	6.76	37	71
Mechanistic	51.98	9.72	22	78
Relational	48.02	9.72	22	78
Culture strength	34.42	4.30	26	47
Dominant culture	3.07	1.13	1	4
Blau index	0.727	0.017	0.662	0.750

Figure 4.6 Frequency distribution of PCTs by dominant cultural orientation
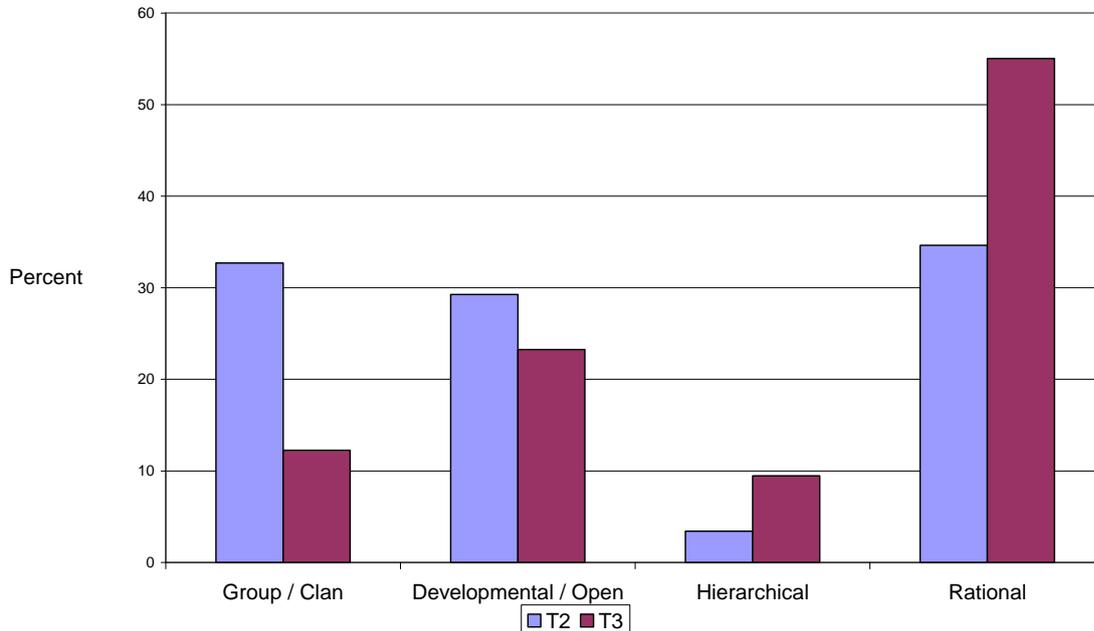
4.12 Cultural congruence in health economies

Having calculated dominant cultural orientations for this national sample of both Acute NHS Trusts and PCTs, it then becomes possible to look for cultural congruence between the Acute Trusts and their main (PCT) purchaser. Acute Trusts and PCTs were matched using the 2002/03 purchaser-provider matrix, with the correlational analysis being run separately at each of the time points T2 and T3. Only low level correlation was observed through this analysis suggesting little shared cultural patterning across major purchaser/provider relationships. (It should be noted, however, that the matching process using the purchaser/provider matrix reduced the effective sample size to 70 pairings at T2 and just 40 at T3 suggesting limited power; moreover, focusing on dominant culture type loses information suggesting that more sophisticated analyses using raw scores may be more fruitful; exploration of the most appropriate analytic technique here is ongoing).

Correlation between culture type for Trusts and their main purchaser

T2			
(n=70)		PCT-Dominant culture	Trust-Dominant culture
	PCT-Dominant culture	1	
	Trust-Dominant culture	0.0988	1
T3 (n=40)			
	PCT-Dominant culture	1	
	Trust-Dominant culture	0.1664	1

4.13 Aggregating across individuals to get organisational culture: Practice sample

Given the dominance of Clan orientations in the individual-level data, unsurprisingly these translated into very numerous Clan-dominant orientations at Practice level. Indeed upwards of 80% of Practices were Clan-dominant at each time point, with less than 10% each for Rational and Hierarchical dominance and almost no Developmental-dominant Practices (data not shown). Given this marked lack of variability in the Practice samples, there was very low correlation between Practice cultural orientation and their host PCT cultural orientation (again, data not shown).

4.14 Modelling culture and performance across the Trusts

While we have access to a substantial data file on year-by-year organisational performance (described earlier), there are significant challenges in using these data longitudinally. First, organisational mergers and dissolutions have led to a constantly changing landscape of NHS organisations thus complicating year-to-year comparisons of 'organisational performance'. Second, changes to data definitions or the actual data that were collected make comparisons across years difficult. Addressing these challenges is an ongoing task, and the analysis below represents the first iteration through the data set.

4.15 Ordered probit models linking culture to star ratings

We ran an ordered probit model on the star ratings. This is derived from a model in which a latent variable y^* (performance) ranging from $-\infty$ to $+\infty$ is mapped to an observed variable y (star rating) which is thought of as providing incomplete information about the underlying y^* according to the equation:

$$y_i = m \text{ if } \tau_{m-1} \le y_i^* < \tau_m \text{ for } m = 1 \text{ to } J$$

The τ's are called cutpoints. Thus for the four star ratings, zero to three, the observed y is mapped to the latent variable y^* according to the measurement model as follows:

$$y_i = \begin{cases} 0 \\ 1 \\ 2 \\ 3 \end{cases} \text{ if } \begin{array}{l} \tau_0 = -\infty \le y_i^* < \tau_1 \\ \tau_1 \le y_i^* < \tau_2 \\ \tau_2 \le y_i^* < \tau_3 \\ \tau_3 \le y_i^* < \tau_4 = \infty \end{array}$$

These can only be done for T1 and T2, since the performance data in 2005/06 (for T3) does not have star ratings – they changed to the annual health check. We also ran the model for T1 and T2 pooled. Results were identical when carried out on the full sample and when restricted to Board-level managers only.

Ordered probit model of culture scores against star ratings, pooled T1 and T2

Ordered probit estimates						
			Number of obs =		325	
			LR chi^2(11) =		17.27	
			Prob > chi^2 =		0.0006	
			Log likelihood =		-388.814	
			Pseudo R^2 =		0.022	
Star ratings	Coefficient	Robust standard error	z	P>|z|	95% confidence interval	
Clan	0.016	0.010	1.590	0.112	-0.004	0.035
Developmental	0.040	0.010	4.130	0.000	0.021	0.059
Rational	0.026	0.015	1.760	0.079	-0.003	0.055
Cut 1	0.435	0.767			-1.068	1.937
Cut 2	1.445	0.767			-0.059	2.949
Cut 3	2.518	0.773			1.003	4.033

The results suggest that higher star ratings are more likely in Developmental cultures (significant at 1%).

Ordered probit model of culture scores against star ratings, T1

Ordered probit estimates						
			Number of obs =		183	
			LR chi^2(11) =		12.02	
			Prob > chi^2 =		0.0073	
			Log likelihood =		-211.156	
			Pseudo R^2 =		0.028	
Star ratings	Coefficient	Robust standard error	z	P>|z|	95% confidence interval	
Clan	0.005	0.013	0.420	0.675	-0.020	0.030
Developmental	0.040	0.012	3.270	0.001	0.016	0.064
Rational	0.021	0.018	1.150	0.250	-0.015	0.057
Cut 1						
Cut 2	-0.021	0.989			-1.958	1.917
Cut 3	0.959	0.985			-0.972	2.889

The results again suggest that higher star ratings are more likely in Developmental cultures (significant at 1%) in T1.

Ordered probit model of culture scores against star ratings, T2

Ordered probit estimates						
			Number of obs =		142	
			LR chi^2(11) =		11.14	
			Prob > chi^2 =		0.011	
			Log likelihood =		-168.221	
			Pseudo R^2 =		0.032	
Star ratings	Coefficient	Robust standard error	z	P>|z|	95% confidence interval	
Clan	-0.003	0.017	-0.190	0.849	-0.037	0.030
Developmental	0.001	0.026	0.060	0.955	-0.050	0.053
Hierarchical	-0.045	0.027	-1.670	0.094	-0.097	0.008
Cut 1	-2.704	1.513			-5.669	0.261
Cut 2	-1.633	1.497			-4.567	1.300
Cut 3	-0.843	1.495			-3.773	2.088

4.17 Multinomial logit model: explaining culture through various organisational variables

In the following model we wish to explain differences in culture type. We are not able to combine the separate culture scores for each Trust into a single dependent variable for the model and therefore use dominant culture type as the dependent variable. This amounts to a loss of information since Trusts proportionally may belong to one culture type more than another, but not exclusively to only one. (We test congruence in the next section). We therefore reduce the information to a discrete measure where it may not necessarily be. Econometrically we do not have a satisfactory way of dealing with this in a single model, since the culture scores are essentially jointly determined and constrained dependent variables. Throughout we used the full sample since results hardly differ when the analysis is restricted to Board-level managers only.

The multinomial logit is the most frequently used model for nominal outcomes. A multinomial logit model performs maximum likelihood estimation of models with discrete dependent variables and is used when the dependent variable takes on more than two outcomes which have no natural ordering as is the case with dominant culture type. We estimate a set of coefficients $\beta^{(1)}, \beta^{(2)}, \beta^{(3)}$, and $\beta^{(4)}$ corresponding to each outcome category (for instance):

$$\Pr(y=1) = \frac{e^{X\beta^{(1)}}}{e^{X\beta^{(1)}} + e^{X\beta^{(2)}} + e^{X\beta^{(3)}} + e^{X\beta^{(4)}}}$$

$$\Pr(y=2) = \frac{e^{X\beta^{(2)}}}{e^{X\beta^{(1)}} + e^{X\beta^{(2)}} + e^{X\beta^{(3)}} + e^{X\beta^{(4)}}} \text{, and so on.}$$

In our case, the categories are 1, 2, 3, and 4 are for each culture type Clan, Developmental, Hierarchical and Rational.

To identify the model, one of $\beta^{(1)}$, $\beta^{(2)}$, $\beta^{(3)}$ or $\beta^{(4)}$ is arbitrarily set to 0, for instance category (y = 1), the most frequently occurring category. Thus the remaining coefficients $\beta^{(2)}$, $\beta^{(3)}$ and $\beta^{(4)}$ measure the change relative to the (y = 1) group. The multinomial logit model can therefore be thought of as simultaneously estimating binary logits for all possible comparisons among outcome categories. Thus setting $\beta^{(1)} = 0$, the equations become (for instance):

$$\Pr(y=1) = \frac{1}{1 + e^{X\beta^{(2)}} + e^{X\beta^{(3)}} + e^{X\beta^{(4)}}}$$

$$\Pr(y=2) = \frac{e^{X\beta^{(2)}}}{1 + e^{X\beta^{(2)}} + e^{X\beta^{(3)}} + e^{X\beta^{(4)}}} \text{, and so on.}$$

The relative probability of (y = 2) to the base category (y = 1) is:

$$\frac{\Pr(y=2)}{\Pr(y=1)} = e^{X\beta^{(2)}}$$

The model is run 3 times using different base categories as comparison groups in order to make all relevant contrasts across the 4 outcomes. Those variables significant at the 5 percent level are highlighted, although some are also significant at the 10% level.

Note the choice of variables is quite constrained by having to find variables that are available in all 3 periods, hence some of the variables we used before in the analysis had to be dropped and other new ones introduced as substitutes. Also some of the performance data was not yet available for 2005/06 at the time of running this analysis.

Multinomial logit model, <u>for time period T1</u>

Multinomial regression			Number of obs =		181	
			LR chi^2 =		54.660	
			Prob > chi^2 =		0.000	
			Log likelihood =		-174.682	
			Pseudo R^2 =		0.135	
Comparison group	A (Group / Clan)		B (Developmental / Open)		C (Hierarchical)	
Dominant culture	Coefficient	P>|z|	Coefficient	P>|z|	Coefficient	P>|z|
B (Developmental / Open)						
Foundation status	0.988	0.154				
Average number of available beds	**0.003**	**0.000**				
Total no. imaging tests per bed	0.009	0.113				
Median waiting time	-0.008	0.608				
No. consultants per bed	**17.829**	**0.026**				
No. admin staff per bed	-3.957	0.055				
Constant	-4.527	0.009				
C (Hierarchical)						
Foundation status	-0.569	0.645	-1.557	0.224		
Average number of available beds	**0.003**	**0.004**	0.000	0.868		
Total no. imaging tests per bed	**0.015**	**0.036**	0.006	0.476		
Median waiting time	-0.043	0.054	-0.035	0.165		
No. consultants per bed	4.581	0.633	-13.248	0.237		
No. admin staff per bed	-2.103	0.365	1.854	0.508		
Constant	-4.120	0.047	0.407	0.869		
D (Rational)						
Foundation status	-0.415	0.536	-1.403	0.065	0.154	0.906
Average number of available beds	**0.003**	**0.000**	0.000	0.805	0.000	0.998
Total no. imaging tests per bed	-0.002	0.715	-0.010	0.092	**-0.016**	**0.032**
Median waiting time	0.010	0.306	0.018	0.266	**0.053**	**0.022**
No. consultants per bed	8.410	0.169	-9.419	0.270	3.829	0.705
No. admin staff per bed	-2.568	0.079	1.389	0.526	-0.465	0.852
Constant	-1.691	0.145	2.836	0.116	2.429	0.260

We can interpret the results from the multinomial logit as for instance available beds being higher in group (y = 2) (Developmental / Open culture) compared to group (y = 1) (Group / Clan) and similarly in group (y = 3) for (Hierarchical) compared to group (y = 1) (Group / Clan) and also (y = 4) (Rational) compared to group (y = 1) (Group / Clan). (And so on for other interpretations of variables.)

In summary, the results suggest that:

- The average number of beds is higher for Developmental, Hierarchical and Rational compared to Clan-dominant cultures.

- Number of consultant staff per bed is higher in Developmental-dominant cultures compared to Clan cultures.

- Number of admin staff per bed is lower in Hierarchical and Rational compared to Clan-dominant cultures.

- Waiting times are lower in lower in Hierarchical compared to Clan cultures and higher in Rational cultures compared to Hierarchical cultures.

- Total number of imaging tests per available bed is lower in Rational compared to Hierarchical cultures.

Taken together, these results reinforce the argument that there is a contingent relationship between organisational culture and performance – that is, organisations appear to perform better on those variables which would be valued more highly according to the dominant culture type.

There are several tests that are commonly used in association with the multinomial logit (Scott Long, 1997). First, we can test that all of the coefficients associated with an independent variable are simultaneously equal to zero (that is a test that a variable has no effect). We use either a likelihood-ratio test or Wald statistic to test whether the x_k variables have any effect on the dependent variable. The null hypothesis is that $H_0: \beta_k = 0$ or that all coefficients associated with given variable(s) are zero. These statistics are distributed as chi-square and results for the likelihood-ratio test shown in the following table. Not all variables reject the hypothesis that they have no effect on culture types in T1, but we chose the variables which best correspond with achieving significance in some or all periods.

Tests of independent variables for multinomial logit

	LR tests		
	chi^2	df	prob > chi^2
Foundation status	3.837	3	0.280
Average number of available beds	28.309	3	0.000
Total no. imaging tests per bed	7.295	3	0.063
Median waiting time	6.576	3	0.087
Number consultants per bed	5.713	3	0.126
Number admin staff per bed	7.085	3	0.069

Second, we can test whether the independent variables differentiate between different pairs of outcomes. This test is commonly used to determine whether any two outcomes can be combined. Again, we can use either a likelihood-ratio test or Wald test and the null hypothesis is that all coefficients (except intercepts) associated with a given pair of outcomes are zero (or that categories can be collapsed). All pairs of outcomes are evaluated. Results for the likelihood-ratio test are shown in the following table and suggest (at the 10 percent significance level) that only two categories are not independent and could potentially be collapsed (Developmental/Hierarchical and Hiererachical/Rational).

Tests for combining dependent categories for multinomial logit

	LR tests		
	chi^2	df	prob > chi^2
A – B	25.257	6	0.000
A – C	13.052	6	0.042
A – D	30.571	6	0.000
B – C	4.652	6	0.589
B – D	10.852	6	0.093
C – D	10.320	6	0.112

Finally, we can assess the assumption of the independence of irrelevant alternatives (IIA) using a Hausman test. The multinomial logit assumes that the odds for any pair of outcomes are determined without reference to the other outcomes that might be available. This is known as the independence of irrelevant alternatives (IIA) property. The Hausman test is computed by estimating the full model and then a restricted model eliminating one or more outcome categories and testing the difference in the coefficients. The null hypothesis is that the difference in coefficients is not systematic. The results in the following table suggest evidence in favour of the null hypothesis in each case. Hausman and McFadden (1984) note that negative test statistics are possible and Freese and Scott Long (2000) suggest it is very common. These authors conclude that a negative result is evidence that IIA has not been violated.

Tests of IIA for multinomial logit

Omitted	chi^2	df	prob > chi^2	evidence
Clan	0.760	12	1.000	for H_0
Developmental	-3.046	11	1.000	for H_0
Hierarchical	-0.846	12	1.000	for H_0
Rational	-2.560	10	1.000	for H_0

The analytic structure as set out above is then repeated for time periods T2 and T3, with the data presented following.

Multinomial logit model, <u>for time period T2</u>

Multinomial regression			Number of obs =		139	
			LR chi^2 =		47.940	
			Prob > chi^2 =		0.000	
			Log likelihood =		-146.239	
			Pseudo R^2 =		0.141	
Comparison group	**A (Group / Clan)**		**B (Developmental / Open)**		**C (Hierarchical)**	
Dominant culture	Coefficient	P>|z|	Coefficient	P>|z|	Coefficient	P>|z|
B (Developmental / Open)						
Foundation status	-0.232	0.776				
Average number of available beds	**0.002**	**0.029**				
Total no. imaging tests per bed	0.007	0.258				
Median waiting time	-0.011	0.545				
No. consultants per bed	2.865	0.460				
No. admin staff per bed	-0.522	0.703				
Constant	-4.210	0.045				
C (Hierarchical)						
Foundation status	-32.811	1.000	-33.578	1.000		
Average number of available beds	**0.003**	**0.000**	0.001	0.280		
Total no. imaging tests per bed	0.004	0.571	-0.003	0.703		
Median waiting time	0.020	0.170	0.031	0.143		
No. consultants per bed	1.122	0.825	-1.743	0.765		
No. admin staff per bed	-0.517	0.702	0.005	0.998		
Constant	-5.062	0.022	-0.852	0.756		
D (Rational)						
Foundation status	-0.626	0.320	-0.394	0.653	21.185	0.000
Average number of available beds	**0.003**	**0.000**	0.001	0.265	0.000	0.907
Total no. imaging tests per bed	**0.013**	**0.018**	0.006	0.444	0.009	0.220
Median waiting time	0.013	0.284	0.023	0.217	-0.008	0.610
No. consultants per bed	-3.462	0.459	-6.327	0.244	-4.584	0.429
No. admin staff per bed	-0.961	0.331	-0.439	0.759	-0.445	0.738
Constant	-4.833	0.004	-0.623	0.788	0.229	0.916

In summary, the results suggest that:

- Average number of beds are higher for the three other dominant culture types compared to Clan-dominant cultures.

- Total number of imaging tests per available bed is higher in Rational-dominat cultures compared to Clan-dominant.

At this second analysis, the few significant effects are again broadly consistent with the contingent theory of culture/performance linkages, but fewer variables appear significant. Again not all variables reject the hypothesis that they have no effect on culture types in T2, but we chose the variables which best correspond with achieving significance in some or all periods.

Tests of independent variables for multinomial logit

	LR tests		
	chi^2	df	prob > chi^2
Foundation status	7.955	3	0.047
Average number of available beds	26.619	3	0.000
Total no. imaging tests per bed	6.512	3	0.089
Median waiting time	3.232	3	0.357
Number consultants per bed	1.574	3	0.665
Number admin staff per bed	0.968	3	0.809

Results for the likelihood-ratio test suggest (at the 10 percent significance level) that four categories are not independent and could potentially be collapsed (A-B, B-C, B-D and C-D).

Tests for combining dependent categories for multinomial logit

	LR tests		
	chi^2	df	prob > chi^2
A − B	5.648	6	0.464
A − C	25.693	6	0.000
A − D	34.000	6	0.000
B − C	9.883	6	0.130
B − D	7.438	6	0.282
C − D	6.455	6	0.374

The results for the IIA test suggest evidence in favour of the null hypothesis in each case.

Tests of IIA for multinomial logit

Omitted	chi^2	df	prob > chi^2	Evidence
Clan	0.000	1	1.000	for H$_0$
Developmental	0.000	1	1.000	for H$_0$
Hierarchical	8.565	12	0.740	for H$_0$
Rational	0.000	1	1.000	for H$_0$

Multinomial logit model, <u>for time period T3</u>

Multinomial regression			Number of obs =		135	
			LR chi^2 =		53.470	
			Prob > chi^2 =		0.000	
			Log likelihood =		-141.199	
			Pseudo R^2 =		0.159	
Comparison group	**A (Group / Clan)**		**B (Developmental / Open)**		**C (Hierarchical)**	
Dominant culture	Coefficient	P>|z|	Coefficient	P>|z|	Coefficient	P>|z|
B (Developmental / Open)						
Foundation status	-0.755	0.309				
Average number of available beds	**0.003**	**0.001**				
Total no. imaging tests per bed	-0.001	0.920				
Median waiting time	-0.050	0.008				
No. consultants per bed	3.943	0.304				
No. admin staff per bed	-0.614	0.625				
Constant	-0.687	0.749				
C (Hierarchical)						
Foundation status	-1.345	0.251	-0.590	0.636		
Average number of available beds	**0.004**	**0.000**	0.001	0.367		
Total no. imaging tests per bed	0.009	0.249	0.010	0.294		
Median waiting time	0.014	0.415	**0.065**	**0.006**		
No. consultants per bed	-0.333	0.961	-4.276	0.549		
No. admin staff per bed	-2.580	0.075	-1.965	0.241		
Constant	-5.147	0.055	-4.460	0.142		
D (Rational)						
Foundation status	-0.628	0.280	0.127	0.857	0.717	0.526
Average number of available beds	**0.004**	**0.000**	0.000	0.509	0.000	0.598
Total no. imaging tests per bed	0.002	0.727	0.002	0.728	-0.008	0.332
Median waiting time	-0.008	0.522	**0.042**	**0.027**	-0.023	0.202
No. consultants per bed	2.064	0.463	-1.879	0.612	2.397	0.716
No. admin staff per bed	-0.260	0.769	0.355	0.766	2.320	0.092
Constant	-2.386	0.169	-1.699	0.438	2.761	0.276

In summary, the results suggest that:

- Average number of beds are higher for cultures other than Clan-dominated.

- Number of admin staff per bed is lower in Hierarchical than Clan and higher in Rational than Hierarchical.

- Waiting time is higher in Hierarchical and Rational compared to Developmental.

Again not all variables reject the hypothesis that they have no effect on culture types in T3, but we chose the variables which best correspond with achieving significance in some or all periods.

Tests of independent variables for multinomial logit

	LR tests		
	chi^2	df	prob > chi^2
Foundation status	2.284	3	0.516
Average number of available beds	31.068	3	0.000
Total no. imaging tests per bed	1.471	3	0.689
Median waiting time	9.377	3	0.025
Number consultants per bed	1.211	3	0.750
Number admin staff per bed	3.881	3	0.275

Results for the likelihood-ratio test suggest (at the 10 percent significance level) that only one pair of categories is not independent and could potentially be collapsed (B-D).

Tests for combining dependent categories for multinomial logit

	LR tests		
	chi^2	df	prob > chi^2
A – B	18.077	6	0.006
A – C	27.745	6	0.000
A – D	30.684	6	0.000
B – C	17.134	6	0.009
B – D	6.521	6	0.367
C – D	10.678	6	0.099

The results for the IIA test suggest evidence in favour of the null hypothesis in each case.

Tests of IIA for multinomial logit

Omitted	chi^2	df	prob > chi^2	evidence
Clan	-0.483	12	1.000	for H_0
Developmental	0.069	12	1.000	for H_0
Hierarchical	-2.444	12	1.000	for H_0
Rational	-0.040	12	1.000	for H_0

The overall picture that emerges is that relatively few variables (structural or performance) appear significantly related to culture in time points T2 and T3, compared to T1 when there were several such relationships. However, those relationships that do appear significant broadly support the idea of a contingent relationship between culture and organisation performance.

Multinomial analysis across the three time periods was hampered for two key reasons: first, mergers across organisations effectively reduced the number of organisations in the sample and complicated the process of linking cultures and performance at the same and different time points. Second, performance variables were not always measured (or measured consistently) at each of the three time points, so certain variables had to be discarded from the analysis while others were introduced at latter time

points. As the performance data set is enhanced we intend to revisit these analyses working in particular to develop lagged hypotheses that culture at earlier time points is related (contingently) to performance some years downstream.

4.18 In conclusion

Taken across the analyses to date, a number of key messages emerge:

1. individual perceptions of culture have seen a marked shift across the time periods away from Clan orientations and towards (especially) Hierarchical and (to a lesser extent) Rational orientations;

2. these shifts in individual orientations (away from Clan) are seen both in the Acute Trusts and the PCTs;

3. data from Practice level, however, show that the overwhelming dominance of Clan orientation shows no sign of diminution;

4. shifts in individual values are reflected in marked shifts in the dominant cultural orientation for the Acute sector Trusts – with Clan-dominant Acute Trusts dropping from 53% to 35%, while Rational-dominant organisations have swollen from 30% to 42% alongside a more than doubling of Hierarchical-dominant Trusts (from 5% to 13%);

5. similar shifts were seen (in the short time period from T2 to T3) with a very marked fall-off in Clan-dominant PCTs, some loss of Developmental-dominant PCTs, and sizeable increases in Hierarchical- and Rational- dominant PCTs;

6. there was little evidence of cultural congruence in local health economies, with very low correlations between Acute Trust dominant cultures and that of their main purchaser PCTs;

7. linking culture to performance proved elusive for reasons of structural change in the health system, data inadequacies and methodological challenges, nonetheless, some evidence of a contingent relationship between culture and performance is extant;

8. augmentation of the dataset with additional performance data downstream may enhance our ability to perform lagged analyses.

The following three sections (5-7) present freshly gathered qualitative evidence linking culture and performance in NHS organisations and which in many ways serve to flesh out the dynamic shifts identified by our national quantitative data.

5 Transition to Foundation Trust Status Case Study

SUMMARY

Bigtown Hospital Trust is a teaching hospital trust, located in a large city in the South of England, with a strong espoused commitment to its local, deprived, community.

Over the last fifteen years its performance has improved steadily, so that it has moved from having a reputation for poor performance to high achievement in nationally measured indicators of clinical and financial performance.

The organisation perceives itself as disadvantaged in relation to a neighbouring trust, Uptown Hospital Trust, also a teaching hospital trust with a more established reputation.

Senior management interviewees in the trust credit the application of a "rational approach" through a series of performance management and organisational change programmes for the trust's improving performance. Achieving foundation trust status was seen as a step in this performance improvement, as is a new development of joining with other organisations in a significant partnership.

These developments were valued for the advantages they brought (reduction of control from above for foundation trusts, securing scarce funding in the partnership) but also seen as symbolic of their status as a high-performing trust.

The relationship between those developments (achieving foundation trust status and the partnership) and both cultural change and performance improvement is not a simple one.

Performance management, achieving foundation trust status and forming a partnership all appeared to be both driven by and drivers of the trust's dominant, rational culture.

The dominant culture may well have had an influence on performance improvement. Nonetheless it was one of several cultures which were variously supportive of and orthogonal to the dominant culture. A question arises as to how far a culture has to permeate through an organisation in order to have an impact on performance.

5.1 Aims and objectives of the case

The aim of this case study is to understand how the transition to foundation trust status affected the nature and dynamics of culture in an acute trust, and in particular how organisational culture links to health care performance and relationships across the whole health economy. Transition to foundation trust status was only one of several internal and external factors affecting culture, performance and relationships, including a series of performance improvement and organisational change programmes, a partnership initiative with other organisations in the health economy, and changes to incentives in the wider NHS.

5.2 Policy and managerial context and significance of transition to foundation trust status

Foundation trusts are NHS organisations free from strategic health authority control. They have financial freedoms not given to most NHS organisations, including the freedom to retain financial surpluses, and to borrow. They were first announced in 2002, as a way to extend the principle of earned autonomy within the NHS plan – *"A new model is needed where intervention is in inverse proportion to success"*.[4] Foundation trusts were to improve local accountability and *"... look outwards to the communities they serve not upwards to Whitehall"*.[5] They would also give greater freedom to trust employees at every level to make decisions on services, *"... shift the balance of power genuinely so that people who work in the service have greater control over how the service is delivered"*.[6]

It was hoped that these freedoms would shift values and beliefs in NHS organisations to encourage trusts to innovate, *"... help unleash that spirit of public service enterprise that exists in so many parts of the NHS but for too long has been held back"*.[7] They would provide genuine public involvement, *"bridge the gap between public services and the public who use them"*.[5]

The first wave of NHS organisations began operation as foundation trusts in 2004. At the end of the data collection period, 96 of about 250 acute, specialist, mental health and care trusts entitled to seek authorisation were foundation trusts.

Governance structures are designed to improve connections with local communities and make organisations responsive to local healthcare needs, including:

- a board of governors (in addition to the board of directors) which includes representatives of patients, the local community, employees and local NHS organisations and other stakeholders

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[4] NHS plan, 2000

[5] Speech by the Rt Hon Alan Milburn MP, Secretary of State for Health to the New Health Network and the New Local Government Network 5 February 2003
http://www.dh.gov.uk/en/News/Speeches/Speecheslist/DH_4000784

[6] Speech by the Rt Hon Alan Milburn MP, Secretary of State, to the NHS Chief Executives' Conference, 13 February 2002 http://www.dh.gov.uk/en/News/Speeches/Speecheslist/DH_4000673

[7] From Speech by the Rt Hon Alan Milburn MP, 30th April 2003- Social Market Foundation
http://www.dh.gov.uk/en/News/Speeches/Speecheslist/DH_4031877

- a membership of several thousand drawn from similar constituencies who are kept informed of trust activities and engaged in its development

Standards are inspected by the Healthcare Commission, like those of other NHS organisations. An independent regulator, Monitor, (accountable to Parliament and not to central government) authorises applications for foundation trust status, subject to applicants' meeting rigorous criteria including financial risk management and performance, and the achievement of three stars under the Healthcare Commission's performance ratings. Monitor also ensures that foundation trusts comply with the terms of their authorisation, and can intervene where there are concerns, including those raised in Healthcare Commission reports.

We investigated a teaching trust which applied for foundation trust status with the first wave of trusts in 2004 and achieved authorisation only after some delay. Its first application was deferred because of Monitor's concerns about financial risk, which were addressed in a later application.

The case study trust, Bigtown Hospital Trust, is a teaching hospital trust which has improved its performance steadily over recent years, and some detail is given in Box 5.1.

Bigtown Hospital Trust is a teaching hospital trust with around 950 beds in at the time of the study. (As in most hospitals the number of beds is falling because of changing models of care and shorter hospital stays).

Its performance in recent has been good. It performed well in the Healthcare Commission's Annual Health Check over the period of the study and had improved from previous years. It is one of very few trusts in its region to meet the four-hour A&E wait target, and achieved most of the longer-standing NHS targets. As a foundation trust, its Use of Resources score is based on its Monitor Risk Rating in which it received a satisfactory rating for finance risk, and the best possible rating for both governance and services. The trust achieved moderate surpluses in recent years and was anticipating a surplus in in the year of data collection, following an earlier history of deficits.

Its executive directors have been in the trust at senior level for many years. Its chief executive has recently taken another NHS post having held his post for several years.

Box 5.1: Background to Bigtown Hospital Trust

Bigtown Hospital Trust is part of a financially strong health economy serving a relatively deprived population, described in Box 5.2.

Bigtown Hospital Trust provides nearly all its services from a single site close to the border between two deprived, ethnically diverse local authority areas each served by a single PCT. Both are Spearhead authorities, among the most deprived fifth of authorities in England. Each PCT commissions just under half of its local services from each of two acute teaching trusts, Bigtown Hospital Trust and the neighbouring Uptown Hospital Trust. The two PCTs commission jointly from the two trusts, with one acting as lead commissioner for one trust, and one for the other. The two acute trusts were more important to the local PCTs than the PCTs were to the trusts. Between them, the case study trust and its acute neighbour provided 90% of the acute services of each of the PCTs. However, around 60% of the case study's services, and 30% of its neighbour's services were provided to these two PCTs.

The PCTs collaborate on other work, and both are financially sound. However, some neighbouring PCTs, and district general hospitals (DGHs) within their areas, have been in some difficulties, and a service review for this wider area has recently made recommendations for acute reconfiguration across the area. This review had raised the possibility of Bigtown Hospital Trust replacing some services now provided by DGHs within the wider area, a prospect which was not necessarily a welcome direction for Bigtown Hospital Trust, since it was seeking to develop through its specialist services, and its relationship with the immediate local community.

The neighbouring acute trust, Uptown Hospital Trust, is also a teaching trust and a foundation trust with a medical school shared with Bigtown Hospital Trust. It is equally well located to provide services to the same two PCT populations which commission most of Bigtown Hospital Trust's district general hospital services. Uptown Hospital Trust has a portfolio including a higher proportion of specialist services than Bigtown Hospital Trust, and like Bigtown Hospital Trust, has a national or international reputation for some units. Uptown Hospital Trust is a more established organisation. Like Bigtown Hospital Trust, Uptown Hospital Trust performs well in Healthcare Commission and Monitor assessments.

Box 5.2: Organisations in Bigtown Hospital Trust's health economy

Performance improvement is associated, for trust interviewees, with an organisational threat which marked a turning point, many years before data collection (Box 5.3).

Both Bigtown Hospital Trust and Uptown Hospital Trust were affected by a review of acute provision in the region conducted in the 1990s. Bigtown Hospital Trust was reported to be threatened for closure or merger. Uptown Hospital Trust was formed following the review as the result of a hospital merger.

Bigtown Hospital Trust's response to the review was to initiate a series of performance improvement programmes, the most recent of which involved a performance management framework structured around scorecards, implemented across the organisation, supported by an organisational change programme, introduced division by division. The organisational change programme had not been implemented in every division at the time of data collection.

Box 5.3: Background to performance improvement in Bigtown Hospital Trust

5.3 Research Strategy and Methods

The case study used semi-structured interviews with internal and external stakeholders in two rounds separated by six to nine months to investigate changes in organisational culture, relationships within and between organisations, and the performance of the health economy, during and after the transition to foundation trust status.

We obtained a range of perspectives by including interviews with a wide range of stakeholders. Wherever possible we checked data against documents, and noted inconsistencies carefully. Two rounds of data collection allowed investigation of developments in the transition to foundation status over time. See Appendix Four for background interview materials and Appendix Five for the interview topic guide.

5.31 Sampling strategy

A sample frame of internal interviewees was drawn up by the research team. Three groups within the trust were sought – the senior management team and two clinical settings. The clinical settings were to be chosen as contrasting in the demands of their workload, and interviewees were to consist of a core set (Table 5.1) with other interviewees identified through interviews with the core interviewees as giving insight to organisational cultures. An assumption was made that there was not a homogenous culture within the organisation, and interviewees were chosen to ensure a range of seniorities, professions and specialisms. External interviews were planned with other organisations in the health economy including PCTs and GPs, and other organisations emerging as significant through the course of

the research. Interviewees were identified through a combination of recommendations by the core set of interviewees and use of 'snowballing'. The trust is divided into seven divisions, most including more than one clinical directorate. Initially we planned to look at a division with DGH functions and a division with tertiary functions, and a trade union representative. Twenty interviews with internal interviewees were planned in the first round, and ten in the second, to consist entirely of interviewees from the first round.

Table 5.1. Planned interviewees

Senior management	Divisions	External
Chair of Board Chief Executive Director of Operations Medical Director One further director	Clinical Director General Manager Senior nurse, AHP or scientist At least 3 front line staff identified by core interviewees	Up to 8 in PCTs and other organisations identified through emerging findings

5.32 Data collection and processing

Appendix Four includes the introductory email and information sheet about the project that were sent out to all respondents, and that were supplemented by e-mail and telephone contact with individual respondents.

Twenty-eight interviewees gave thirty-nine interviews, between July and December 2007 (first round) and January and September 2008 (second round). Interviews took place as planned with the senior management team and a 'DGH' division. After prolonged negotiation, the first tertiary division approached declined to take part because of the demands of organisational development work. Instead, interviews took place in the division responsible for scientific and diagnostic services and clinical radiology. The trade union declined to take part without providing a reason. It became evident during the course of interviews that it was important to interview employees of the company providing catering, cleaning and portering services, and interviews were sought. As a result of emerging findings from internal interviews, a neighbouring acute trust was added to the external organisations where interviews took place. Interviewees were grouped for analysis into senior managers, middle managers and clinical, scientific and administrative staff. A summary of interviews undertaken, by setting, broad group, and round is given in Table 5.2.

Table 5.2: Interviews conducted by group and round

	Senior managers	Middle managers	Clinical, scientific and administrative	External	Total
Round 1	4	6	7	2	19
Round 2	5	6	3	6	20
Total	9	12	10	8	39

"Senior managers" include non-executive and executive directors, and non-board directors (regardless of professional background)

"Middle managers" include staff below director level with significant management responsibility (regardless of professional background)

"Clinical, scientific and administrative" includes nurses, scientists and allied health professionals with no management responsibilities, receptionists, administrative staff, porters and cleaners.

Most second round interviewees were drawn from among the first round interviewees, but one senior manager, one middle manager, two clinical, scientific and administrative, and four external interviewees were added at the second round. Interviews were conducted face to face at respondents' places of work, or in one case, on the telephone. Interviews were conducted using topic guides which listed the issues and sub-topics to be explored. Responsive questioning and probing was used to ensure relevant topics were covered in depth. The topic guide from which topics were drawn as appropriate to the interviewee is reproduced in Appendix B. Interviews were recorded, with participants' permission, and transcribed verbatim. In the second round, attention to some topics relating to the process of achieving foundation trust status was reduced in favour of topics relating to impact.

Findings from interviews were compared with each other, and with findings from review of internal and external documents, and observations of the buildings and the daily activity of the hospital, to seek to corroborate emerging accounts of the trust's culture.

5.33 Analysis of qualitative data

The data were analysed using 'Framework', a systematic and comprehensive method for classifying and interpreting qualitative data (Ritchie & Spencer, 1994). The first stage of analysis involved familiarisation with the data and identification of key emergent issues. A series of thematic matrices or charts was then drawn up, each covering one key theme with columns representing sub-topics and rows representing individual interviews. The data from each interview were then summarised in the appropriate cell, with the context retained with a reference to the location of the full text in the transcript. The charts were stored in Microsoft Excel. The charted data from both rounds were reviewed to

explore the range of comments made under each sub-topic, and to explore individual settings in detail. Within the text, quotations are used to illustrate findings from analysis. Numbers following quotations indicate the round from which the quotation comes.

The competing values framework was used to explore the dominant culture of the organisation and findings were compared with the findings of the national survey of NHS trust boards and the internal survey conducted within Bigtown Hospital Trust.

5.4 Cultural Continuity and Change in the Foundation Trust

5.41 Apparent dominant/espoused managerial/corporate culture

Experience with the competing values framework suggests that one of the four types (clan, developmental, hierarchical or rational) tends to dominate in an organisation, although most organisations are a combination of all types. To identify the dominant culture in this acute trust, we paid particular attention to the statements of the senior management team, and sought supporting views expressed elsewhere in the organisation.

Senior managers were likely to describe the trust as capable of delivering, good at implementing and 'can-do'. It put a strong emphasis on performance, and the trust had implemented a performance improvement programme, one of a succession of change programmes in the organisation spanning over a decade. Interviewees described the organisation as patient-centred, and strongly aligned to the local community.

"…with the hospital, the patient comes first, patient focus" (Clinical, scientific or administrative interviewee) [1]

"…a very strong kind of local focus and culture … they have got a culture that is embedded in their local health economy" (External interviewee) [1]

"I think both [the trust and respondent's area of work] is very busy, and … challenging, which for me is a good thing and kind of performance driven and sort of targets, but more so in terms of making it better for the patients I think. I know we've got targets, but that's what, I suppose that's what drives me" (Middle management interviewee) [1]

However, one interviewee who praised most aspects of care was concerned that this did not extend to responding to patient dissatisfaction with food.

"You know, you give them the meal, they said "Oh, I got that at lunchtime." You know? Because some of them they get so confused that they ordered a meal, but they can't remember, but sometimes they remember they have eaten the same thing and then they will say to you the same thing that is on the menu for lunchtime is the same thing for at supper time and you, yourself, you know it is. You feel bad" (Clinical, scientific or administrative interviewee) [1].

It was described as innovative, nimble, and risk-taking in its approach to service delivery.

"… in the main a sort of can-do culture, and also what is quite good is that people take a risk, but they're willing to give it a go quite often. You know, it's not heavily bound in bureaucracy" (Middle management interviewee) [1]

"… it is businesslike and I would say it's young, it's vibrant and exciting to me" (Senior management interviewee) [1]

Interviewees attributed this 'can-do' approach to the history of the trust's place within the health economy. It had been considered, in past years, a poorly-performing underdog compared to neighbouring trusts, and had responded by proving itself, leaving a 'chippy' or even 'paranoid' spirit which drove a need to demonstrate excellence. These events could be seen as a 'narrative' which senior management 'use' to hold the organisation together.

"… in some ways quite a self-critical culture, but very much a sort of a can-do, you know, rally sort of mentality, which I'm sure we discussed before … in a sense it's sort of part of the history of Bigtown Hospital Trust and where it's come from" (Senior management interviewee) [2]

This view of the trust was found most strongly among senior managers, but was also found in other settings in the trust, most commonly in more senior staff.

"Bigtown Hospital Trust has been well-known, I think, for having a bit of a chip on its shoulder, perhaps being, financially being a poor relation, politically being perhaps at somewhat of a disadvantage. So I think, you

know, we've often seen ourselves as the underdog" (Middle management interviewee) [2]

Cultures where performance and delivery dominate are described as rational within the competing values framework. There are also strong elements of the developmental type, in the trust's emphasis on innovation and problem solving. To a lesser extent there are elements of the clan type, in the unifying impact of the 'paranoia' induced by external perceptions of a poorly performing organisation, and the loyalty and long service of many staff at all levels of the organisation.

"The executive team of six or seven have 98 years with the organisation" (Senior management interviewee) [1]

As shown in Section 4, the national CVF survey of trust senior management teams found a shift over time from clan to rational cultures, and the account given of changes within Bigtown Hospital Trust supports a move in this direction within this trust.

The trust did not have a form of words expressing its values widely dispersed among its employees (unlike some organisations which reproduce mission and vision statements on cards given to each employee, or straplines attached to the organisation's name and used on documents and notices). Employees, asked "what values are important here?", responded with a variety of professional codes of practice and policies appropriate to the particular setting.

5.5 Presence and nature of different sub-cultures (including counter cultures) and their values and beliefs within the organisation

We examined the extent to which cultures were shared across professions, divisions and levels of seniority, and whether subcultures enhanced or opposed the dominant culture. These findings are based on a limited number of interviews (see Table 2 and accompanying text), and are particularly limited in examining cultures within professions. Most interviewees expressing the dominant culture believed that the culture was not necessarily shared across the organisation, but that other cultures were orthogonal, and did not undermine the dominant culture.

"...you'd get given a similar view from a lot of senior people that I've articulated .... They would undoubtedly recognise the sort of spirit of Bigtown Hospital Trust, they would certainly recognise the worry of Bigtown Hospital Trust, anxiety of Bigtown Hospital Trust, often referred

to as prudent paranoia. … They would also add, and I haven't said it, but they would add that for the most part Bigtown Hospital Trust is not a 'them and us' organisation, not a big gap between the senior clinicians and the managers." (Senior management interviewee) [2]

"But again, I don't like to attribute, you know, too much of the variance to a corporate explanation, because if we know anything about culture, …you'll know that they're very sub-cultural institutions" (Senior management interviewee) [2]

5.51 Professions

Medical interviewees did not show a uniform cohesive separate culture, and were likely to identify strongly with their division.

"I don't know how, how generic it is. A lot of it may stem from my being involved for a long time in the [department], which is a very discreet geographic entity, we're not spread over the whole hospital, so since, you know, geographically and temporally quite easily identifiable. So I think that generates potential for a very cohesive environment" (Middle management interviewee with clinical element to role) [1]

"… to be honest, for me personally it's, it's the type of work that I do and I really, I love what I do, and it's given, the job has given me an opportunity to create a niche for myself and also I have fantastic work colleagues and that, a lot of that, me staying on had a lot to do with that as well, my other consultant colleagues". "[IS YOUR EXPERIENCE SOMETHING ABOUT THE TRUST OR IS IT SOMETHING ABOUT THE PARTICULAR AREA THAT YOU'RE IN?]" "I think it's more about the particular area that I'm in" (Clinical, scientific or administrative interviewee) [1]

Nurses were reported by other interviewees to be likely to be less engaged in the trust culture, and this was confirmed by some interviewees but not all. Allied health professions and scientists referred strongly to their own professional standards and values, and were less likely than other interviewees to perceive the trust as having a culture distinct from that of other NHS organisations. In none of these professional groups was there evidence of a culture opposed to the dominant culture.

" … from an outside looking in, when I came here, nurses were all downtrodden and going 'Oh poor us, nobody listens to nurses.' And from the senior nurses they will still say nurses don't have a voice, nurses aren't listened to, nurses aren't strong enough. And I actually have a

problem seeing that …" (Middle management interviewee with clinical element to role) [1]

It was argued that there was a lack of nursing leadership, because the director of nursing had another role on the board, which was perceived to take priority.

Those who articulated the dominant culture gave an image of team-working through the organisation, although they were realistic that there would be conflicts between some groups triggered by structures and incentives.

"I mean obviously there are there are always going to be issues where there will be professional differences. I'm just trying to think of an example. For example, if you are thinking about how you reconfigure a service, you know, obviously there may be different views from different health professionals as to what the best model would be for that service, but generally speaking I think the experience here is that that gets worked through in some way" (Senior management interviewee) [1]

"Wherever you find yourself conflicts will never finish, but at the end of the day the only thing that will solve that conflict is communication" "[AND DOES THAT HAPPEN HERE?]" "It does, communication does happen" (Clinical, scientific or administrative interviewee [1]

Interviewees across the organisation gave illustrations of such conflicts, due to different working patterns and entitlements.

"… therapists can come around and assess and make recommendations, which often involve nurses, which then puts the emphasis on the nurse to do, but the nurse may not have the adequate support or resources or staffing on that ward to actually carry out the recommendations properly, which therefore ends up compromising patient safety or level of satisfaction for the actual nurse… " (Clinical, scientific or administrative interviewee) [1]

5.52 Seniority

Senior interviewees predicted that their experience of the organisation would not be shared at all levels, but saw no problem with that. Executive directors had taken steps to experience the trust at the front line, for example working on the help desk or in A&E. Interviewees in ancillary non-clinical roles showed low awareness of important developments within the trust such as its progress to foundation trust status or its performance

management programme, but showed no opposition specific to the senior management team.

> *"Well, to be quite honest with you I think also the director of nursing and the hierarchy I think they are working very hard as well. If you see the success of the hospital I think they are doing their hard work, they are not sitting down because they visit wards is the other thing I've noticed, you know."(Clinical, scientific or administrative interviewee) [1]*

The senior management team stressed their connection to the day-to-day work of the hospital, and this was reinforced in ceremonies.

> *"So things like executive go-sees we have where we can maybe go down to a ward or department and see some of the changes in action. If some of the execs have planned to go and don't what is that saying to the organisation? You know, they're waiting for it, that's their chance to shine, to show. We've got to live the values as well." (Senior management interviewee) [2]*

> *"… we, the executive team, the board all understand the need for that full ceremony, for the fact for the executive directors to be close to their constituencies and bringing their constituencies along. In fact we've developed that. You take the ops director … she pulled together a series of ceremonial events, … to deliver key targets and create a sort of large bring-and-buy sale over an objective of the trust, which is to deliver the eighteen week target. And in this all the [divisions] come together periodically and tell everybody else what they've done, what they're intending, what their bad bits are and then there's a sort of exchange of ideas and breakthrough opportunities" (Senior management interviewee) [2]*

The connection was symbolised by the location of the senior management offices in an area close to and approached through the main hospital entrance. This contrasts with many acute hospital trusts where the executive offices are away from operational areas of the hospital and approached by another entrance.

Relationships between different groups by seniority seemed to be harmonious in most settings, with exceptions in a few cases in relation to particular immediate line managers, and clinical, scientific and administrative interviewees were balanced in their assessment of these conflicts.

"[YOU'RE MAKING IT SOUND A LOVELY PLACE. IS THERE EVER ANY SORT OF CONFLICT?]" "You do sometimes will find maybe one or two, but it's not something that you really keep a grudge of or will hate that person because they say maybe the wrong thing to you at the wrong time. There's not a lot I can remember about that anyway" (Clinical, scientific or administrative interviewee) [1]

However, in the specialist division, some interviewees believed that middle managers expected too much of the front line.

"I mean upper management. I think sometimes they should be, they're implementing rules for us to put in and, you know, sometimes being hard on certain members of staff and certain groups of people where your added pressure is not good for that person… " "[HOW MANY LEVELS ABOVE YOUR BOSS WOULD THAT BE?]" "… we have two above my line manager and those are the two that I think push the hardest when they should really look and see what's really going on" (Clinical, scientific or administrative interviewee) [1]

"… one big thing that I found was when the new management kind of came in, our working day seemed to be a lot more regimented" (Clinical, scientific or administrative interviewee) [1]

5.53 Differences between Divisions

There was a sharp contrast between the divisions. The 'DGH' division presented a culture strongly supportive of the dominant culture. The specialist division did not have as uniform a culture as the DGH one. It consisted of diverse elements – clinical, scientific and diagnostic services, including a separate unit providing testing to other NHS organisations. It had experienced workforce restructuring including significant downgrading of posts as part of an expenditure reduction programme, and had not yet taken part in the organisational development supporting implementation of the trust's performance improvement programme. Interviewees in all groups in this division were likely to express anger and cynicism at the trust's management.

The specialist division was the only group, from seniority groups, professional groups and clinical settings, to express views sharply divergent from the dominant culture. While it did not have united distinct culture of its own, interviewees were more likely to express negative views about their experience of their working life than other interviewees, on a variety of issues.

There were examples of perceiving the trusts performance management as a 'big stick' and the trust as 'rule-bound', not shared elsewhere.

A low awareness of the trust's greater accountability to patients and the public was widespread in levels below middle management across the organisation, but in this division the accountability structures were sometimes viewed with frank cynicism.

"… those members of the public are not here all the time, they will attend for board meetings and, you know, AGMs and things like that, but then there's other times that they're not here and whatever they're finding out is, you know, by reading about it and, you know, other minutes and agendas that are sent to them. That is what they get, but then for people that are here on a daily basis and seeing things that are going on within here it's a different thing altogether, it is a very different thing altogether. I, you know, even, certain things, you know, we've been even the other day we were working in the department and it was absolutely freezing and it was literally, you know, heating wasn't being turned on. You know, you could feel it in the waiting rooms, the patients could feel it, we as staff were there, you know, we could feel it and it's, you know, you're phoning and you're asking 'What's happening with the heating? What's happening with the heating? It's not coming on.'" (Clinical, scientific or administrative interviewee) [1]

They were also likely to mention the poor physical state of parts of the trust's buildings, a challenge to the declared value of being patient-centred. Most negative comments related to impacts of the expenditure reduction experienced in this service, including downgrading of staff, and more demanding work schedules.

"I think it may have been mentioned in one of the staff meetings that there was a surplus. I mean to, how people sort of view that, it's difficult because I think again, it's difficult to say because it's only me talking and I don't want to sort of put words into other people's mouths, but I think the general consensus is why, have we had to do so … much cost-cutting still when, when we've got this?" (Clinical, scientific or administrative interviewee) [2]

However, negative experiences were not necessarily blamed on the trust's corporate management, but sometimes on management within the division. Positive perceptions of the experience of working in the trust were invariably attributed by clinical, scientific or administrative interviewees in this division to individual senior staff within the division, rather than corporately to the trust.

"Senior management [in the division] always, don't always agree on things. Some people want things done one way and the other people want the other. It's invariably the people that want things done a certain way that it can't be done, it's because they haven't actually worked there. You know, theoretical and practical don't always work. They want things done a certain way and sometimes it's just not possible and my boss is constantly fighting all these systems. They just want changes, they're more concerned about the patient care, which is good, but sometimes not always possible." (Clinical, scientific or administrative interviewee) [1]

"You know, your line manager, she will try, you know, to get you along with what you have to do, help you with all your, with all you've got to do" (Clinical, scientific or administrative interviewee) [1]

A planned partnership with neighbouring trusts (Section 3.4) was viewed with more anxiety than in the 'DGH' division.

The lack of a coherent culture in this diverse division contrasted with the consistent experience of the trust reflected in the 'DGH' division and the senior management team. The cost containment, the lack of organisational development implemented elsewhere to support performance improvement (see Section 3.4), and the heterogeneous nature of the division are likely to account for this difference.

It was noted that divisions were distinct from one another in culture, a perception reported by several interviewees in all settings, and observed in our interviews in two divisions. The specialist divisions were perceived as privileged in relationship to other divisions, and there were 'boundary' disputes where specialists resisted transfers from 'DGH' divisions.

"… the conflicts tend to be between specialties in the broader sense, so, for example where it hits us most is the relationship between the emergency department and some of the specialty areas, so if a patient turns up in A&E and is deemed to require admission and has a predominantly neurological condition they will, you know, the tendency would be to say "Right, let's get the neurologists down to review the patients." They will come down and they will say "Well, it's a local patient." We're a tertiary service where if it's a local patient then they need to be admitted under the medics because if they were a local patient turning up in [neighbouring district general hospital] there wouldn't be a neurology service there, we are their neurology service. They would get admitted in [that hospital] to the medics and then if it was deemed to be a specialist neurological problem they would be referred on to Bigtown Hospital, therefore we need to treat our local

patients in the same way as local patients all over [this area]. And that leads to conflict and a batting back of a patient sometimes between specialties. And, but it's not at an individual level because it's, it's whoever is on for those specialties at the time and then the next night it will be different people" (Middle management interviewee) [1]

5.6 Perceived cultural drivers

5.61 Regional review

For those who articulated the dominant 'can-do' performance-driven culture, the strongest driver was a regional NHS service review conducted in the 1990s. The trust had been threatened with closure as a financial and clinical poor performer. It was poorly resourced, and considered ill-equipped to respond to the threat, but had responded to the extent that the threat was lifted. It had implemented a performance improvement and organisational change programme. It was to this that interviewees attributed its "chippy" or "heroic" response to subsequent difficulties, a wish to prove itself which underlay its emphasis on achievement.

"I think at the time of the [regional] review there was question marks being raised about the number of trusts there were or hospitals there were in [region] and I think at that stage Bigtown Hospital Trust took a hard look at itself and came up wanting and I think since the last fifteen years or so it has worked very hard to reinvent itself into the organisation that it is today." (Senior Management interviewee) [1]

5.62 Comparison with Uptown Hospital Trust

Contrasts were made to the neighbouring teaching trust with a longer history, a well-endowed charity and a more significant academic reputation (Uptown Hospital Trust). The desire to 'prove itself' was often presented in relation to Uptown Hospital Trust's performance and reputation.

"Bigtown Hospital has always seen itself as a slightly poorer relation to Uptown Hospital's, size, wealth" (Middle management interviewee) [1]

"There was a recognition, sort of down the strategic lines, so for me their being shocked at how good we are. … They have money and they have resources to pay for it, but it's not delivered world class services" (Senior management interviewee) [1]

5.63 Portfolio of services

The mix of local and tertiary services was considered a driver of the trust's patient-focused and community-focused orientation. Around two thirds of the trust's services were commissioned from the two local PCTs, compared to a third of the neighbouring trust's services. Several interviewees saw this as giving a connection and a stake in the local community, which drove a patient-oriented approach to performance improvement.

Nevertheless, the presence of specialist services in the trust also drove the trust in that it contained examples of units with an international reputation to which other units or the trust as a whole might aspire.

"Bigtown Hospital Trust is a major teaching hospital, it's always been engaged in specialist activity and so on. I think the major push and pull on their performance culture won't be their relationship with commissioners. I think it will be their relationship with other teaching hospitals" (External interviewee) [1]

"… if you think strategically where we want to go, Bigtown Hospital Trust very much has the view that we should be dealing with the sort of difficult sophisticated complex end of the market, that's where we add value, so therefore we should be seeking with our primary care partners and our district general hospitals to push out the work that we don't really add value to and that it should be done as close to home as possible" (Senior management interviewee) [2]

5.64 NHS incentives

Like other NHS organisations, the trust was influenced by policy and organisational changes in the wider NHS. There were expressions of irritation at national performance management.

"And so, and so, you know, the central direction, you know, if the foundation trust is really going to be what it's meant to be, sold as in terms of being able, being able to respond to local needs or our local patients and our specialist patients, then I'd like to see that being able to flourish without the constant change and drivers from the centre" (Middle management interviewee) [1]

External interviewees reported the health economy serving the populations of the two local authorities in the area were well equipped to respond to changing health system incentives.

"All the NHS organisations [in the immediate area] are pretty performance driven, I mean they've all, they're all FTs, they're all, they've all demonstrated they need to perform, or they can perform and, and, you know, kind of turn their kind of … advantages of being in

specialist teaching and all that kind of stuff hospitals into performance as well across the kind of mainstream targets" (External interviewee) [2]

Agenda for Change, the European Working Time Directive and the need for cost containment had been important drivers of the negative perceptions in the specialist division.

"So the proposed system, no-one has actually come up with one yet. This is what we're trying to, trying to sort out, to basically kind of, yeah, take into account the working time directive and to make sure that there's enough staff on site in the evenings and overnight and to make sure that the pay doesn't reduce too much" (Clinical, scientific or administrative interviewee) [2]

However, senior managers argued that Bigtown Hospital Trust was driven more by its own striving for excellence than by external incentives.

No interviewees raised the potential of competition from the private sector as a driver. Senior managers perceived competition from other national centres of excellence, and from international centres, as threats in the longer term.

5.7 Efforts and success of purposive (managerial) attempts at cultural change

5.71 Performance management and organisational change

Interviewees described a history of performance improvement and organisational change programmes dating back to the trust's response to the regional NHS review from the 1990s when the future of the trust had been threatened. The most recent change programme focused on process indicators, particularly length of stay, but including externally-defined indicators such as the four-hour A&E wait target and the 18-week referral-to-treatment target.

Scorecards were drawn up for care groups, and for levels below, down to ward level, with each unit being responsible for improvement in indicators to which they could realistically contribute, hopefully forming a causal chain to the top-line trust level indicators. The indicators included the major external ones on which the trust and the professions and training areas were measured, and also ones developed internally, and were under regular review. There were regular workplace meetings where scorecards and barriers to achievement were discussed, feeding into a monthly meeting between the general manager for each division and the director of operations. That director reported to a committee of the board, which met monthly.

Generally, the programme and its indicators were well-accepted, and there was support for the validity of the indicators from nearly every interviewee. This had been the result of a process of engagement with staff over indicators. The impact of this programme on performance is considered at Section 5, but as a process, its acceptance by staff in different settings and levels was a notable success. It was reported to have allowed staff to understand what was possible, and to have driven changes in models of care.

"… we never got past the point of the debate about whether we were looking at the right things … But we now have a very clear indicator that doesn't reflect the length of stay of every single patient through our bed. But it reflects length of stay of an agreed group of patients that in themselves then reflect the efficiency and the performance of the [division] and everybody buys into that. So we look at patients that are admitted as an emergency through A&E to a medical ward, not to a rehab ward, not to a stroke unit, but the length of those, length of stay of those patients and that really forms a good indicator for us and it allows us to have a target and to know, you know, that our target length of stay for that group of patients is ten." (Middle management interviewee) [1]

"… we have to stop telling the gerbils to run faster. You know, it's about doing something sometimes differently or recognising and rewarding something that's good." (Senior management interviewee) [1]

The development of indicators was accompanied by a programme of organisational change, introduced division by division, to support achievement of performance improvement, reportedly as a response to patient choice. The 'DGH' division had been an early entrant to this work, reportedly because of its urgent need to reduce the level of medical outliers treated on surgical wards. The specialist division had not undergone the programme. The application of the programme could account for the difference in culture observed in the two divisions, where the DGH division had a culture more supportive to the dominant culture, and the specialist one had a more fragmented culture including individuals with more cynicism about the trust hierarchy (3.2.3). At the time of the second round of interviews consideration was being given to not introducing the organisational change programme in every division. At the same time the emphasis of the programme was shifting from indicators such as length of stay to other aspects of the patient experience such as safety.

Simultaneously the trust had been improving its financial management, with activity based costing implemented down to the level of wards or equivalent units. This programme was completed by the second round and the trust had developed an accountancy software package for the job which it was marketing to other trusts.

5.72 Foundation trust status

The achievement of foundation trust status was not regarded, by most interviewees, as an attempt to change the culture in itself, but more as a development compatible with the direction that the trust had decided, independently, to take. There had been a delay in achieving foundation trust status because Monitor had concerns about the trust's financial management processes. These issues were addressed, and foundation trust was achieved just over a year later. Most senior managers asserted that the trust's financial management, performance management and measures to improve public accountability were already progressing in a direction compatible with foundation trust status. Foundation-trust-type governance structures – membership and a board of governors – were implemented at the time that foundation trust status was initially deferred, and already operating in shadow at the time that it was granted. There was one member of the senior management team who argued that the performance improvement programme was prompted by the initial deferral of foundation trust status, but this was an unusual view.

> *"... the performance management improvements were kick-started, if I can describe it like that, by our failure to achieve foundation trust status in the first place, in my view, and I suspect that's shared" (Senior management interviewee) [2]*

Awareness of implications of foundation trust status beyond senior interviewees was low. Few of the clinical, scientific or administrative interviewees were aware of the financial freedoms granted to foundation trusts. Most were not aware of the governance structures to increase the trust's public accountability and thought that the trust was accountable to the public in any case. Most had been aware of the initial deferral and eventual granting of foundation trust status, but beyond that the application process had had no impact on them.

> *"[AND WHAT ABOUT WHEN THEY ACTUALLY GOT FOUNDATION STATUS, HAS THAT MADE ANY DIFFERENCE TO HOW THE WARD WORKS?]"* *"Haven't noticed." "[DO YOU FEEL MORE ACCOUNTABLE TO THE PUBLIC THAN YOU USED TO BE OR DO YOU SEE MORE OF THE PUBLIC THAN...]"* *"Maybe, maybe it is, but I don't notice. I just come in and get on with my work" (Clinical, scientific or administrative interviewee) [1]*

The main perceived impact of foundation trust status was an external one – the trust was viewed as keeping company with high achieving trusts, with consequent improved reputation and ability to attract staff. Foundation trust status was symbolic of the standing of the trust relative to other NHS organisations.

> *"I think the other thing in terms of foundation trust issue was that, well, you know, our neighbour with the big house up the road, Uptown*

Hospital Trust, was going to be one and therefore no other reason than parity." (Middle management interviewee) [1]

There were, in the specialist division, staff who attributed their perception that the trust had become more "rule-bound" in recent years to foundation trust status.

5.73 Partnership

A further development was taking place during the course of the study, which would require management of organisational change for its success. The trust was joining with Uptown Hospital Trust, two other local organisations in a partnership with implications for research and services. The immediate implication of this was close partnership (in a form not yet defined at the time of data collection) with the neighbouring acute trust. For the most part, the areas of specialism of the two trusts were complementary, and the trust's best-esteemed specialist units were not threatened. However, the lack of clarity about the structure for joint working might be expected to create anxiety in some areas, and senior managers were aware that the development of partnership needed management at division and unit level.

"… as you would imagine, that sort of thing is not a straightforward dialogue, it's a very very complex dialogue because there's so many different constituents in it, from people who fear, maybe, that their service might be overrun or taken off this site and moved to another site or, you know, from people who are used to a certain way of working in one organisation who don't want to adopt to a different way of working, etc, etc" (Senior management interviewee) [1]

The importance of this development was greatest at the second round of interviews, when an announcement of the intention to proceed with the centre had been made. At this stage, most senior interviewees declared themselves as positive about the prospect, although in some cases they were concerned about the impact that the chief executive's departure would have on the momentum of its development.

"… I think [the chief executive's departure]'s more significant because it's at a time when we're moving into partnership … as part of the [partnership with Uptown Hospital Trust and other organisations] and, you know, were he not going and we were moving into that partnership we would be just steaming ahead and with full confidence. I mean I think we are going to just steam ahead anyway, but there's a, in my mind there's a slight anxiety that, you know, that the timing is not great in that respect" (Middle management interviewee) [2]

A few clinical, scientific or administrative interviewees in the second round showed low awareness of the development. There were areas of the trust where no interviews were conducted, which were reported to be threatened by partnership, and senior interviewees reflected on how the partnership would deal with the differing styles of the two organisations.

"You know, I would say we're probably, as an organisation, more open than perhaps the other partners involved. Certainly more than some of them, I wouldn't know that I would know enough to judge all of them, but I think, you know, and I think that is an issue because, you know, clearly, you know, we will want to be giving the same messages to the same audiences at the same time and, you know, the difficulty where nuances of meaning creep in which, you know, are not, are not agreed or intended is a, is an interesting one" (Senior management interviewee) [2]

"Culturally the two organisations of Bigtown Hospital Trust and Uptown Hospital Trust, who initially we were sort of aware initially I suppose from the majority of discussions taking place, very very different organisations, as I'm sure you're aware. … one very much larger and sort of pre-existing merger of two other trusts and so having been through sort of a merger process already obviously that in a sense sort of also informs opinion at their end I think when one starts to talk about how we might work more closely together, whatever that model might be" (Senior management interviewee) [2]

"As far as Bigtown Hospital Trust is concerned the biggest problem at the end of the day it's still poor. It happens to find itself swimming in the same pool as someone rich so I think Bigtown Hospital Trust's future is not as an independent organisation. For the safety of this campus, for the benefit of the people of [this area], it is important that we do go into a marriage. On the one hand that will change Bigtown Hospital Trust forever and in a way destroy it as an independent organisation, but Bigtown Hospital Trust as a part of that is what I would expect to be a highly successful health care organisation" (Senior management interviewee) [2]

5.8 Relationships within the health economy

5.81 Uptown Hospital Trust

The external relationship most frequently mentioned by interviewees was that with its neighbouring acute teaching trust, Uptown Hospital Trust, which was both a rival and a partner. The two trusts were about to embark on an important partnership, (Section 3.4) and were putting work into

developing that partnership. They were responding to two important policy documents jointly, had mutual representation on governance structures, and had taken the opportunity of timely vacancies to appoint a joint director of strategy. The chief executive of Uptown Hospital Trust was making a significant input to the appointment of the new chief executive Bigtown Hospital Trust. The trusts were already working together in some services in advance of the partnership.

At the same time it was acknowledged that they were competitors, although the extent of competition for provision of services was not great.

Bigtown Hospital Trust was not seeking to greatly expand its local provision, and their provision to the local PCTs was not a source of conflict. There were specialist areas where one or other of the trusts was a clear national or international leader, but there remained specialist areas where there was scope for rivalry. Being geographically very close, they shared a labour market and a medical school, a potential source of conflict where there were scarce skills. This shared labour pool also led to close knowledge – several interviewees had formerly worked in Uptown Hospital Trust or had family members who currently did so.

The impression was gained from many interviews that the competition was in relation to reputation as well as for resources. In attempting to describe the organisational culture, interviewees, especially the more senior ones, characterised the organisation in relationship to its neighbour. Bigtown Hospital Trust was seen as a poorly resourced, innovative, upstart organisation rooted in the community and with something to prove, incomparison to its rich, established and influential neighbour, Uptown Hospital Trust.

> *"… when people ask me about Bigtown Hospital, it's a kind of working class organisation by which I mean working class are characterised by work and that they don't expect, nor do they receive, any favours. They don't have any savings, they live from week to week, they are restlessly anxious and they believe that any moment that what little they have might be taken from them and they're right. They are to be contrasted with the middle classes, who of course are not restlessly anxious.*

> *Complacent, rich, they don't live from week to week … and Uptown Hospital, for example, are a middle-class organisation … Uptown Hospital … is immensely wealthy … and good things happen to it"* (Senior management interviewee) [2]

An Uptown Hospital Trust interviewee recognised the cultural differences, without seeing it as a barrier.

"… one of the things that … we talk about openly with colleagues at Bigtown Hospital Trust is, you know, their paranoia that, cos we're bigger … are we any better? … if you talk about that and make people not feel threatened then there's a chance of the cultures coming together cos you realise it's not, you know, them out there, that you can actually be genuinely partners and, and try and make the best use of the resources" (External interviewee) [2]

In fact statements about the culture of the two organisations could be interchangeable – this comment refers to Uptown Hospital Trust but could easily refer to Bigtown Hospital Trust.

"…it's probably articulated as striving for excellence in everything you do, you know .. and certainly at induction we try and get people, if they find a problem to, you know, address it, to tell us about it, to not blame people if things have gone wrong cos, you know, hospitals are stressful environments, but to come up with the ideas to constantly improve things to try and make it better" (External interviewee) [2]

It is possible that the idea of difference between the trusts was important to the identity of Bigtown Hospital Trust.

However, the contrast between the trusts in the level of their relationship to the local community was perceived by all stakeholders, and reflected in Bigtown Hospital Trust's greater proportion of provision to local PCTs.

"… anything that can be done to keep that whole population focused and particularly where you are serving such a deprived population. I think maybe that there is any way a cultural difference between Bigtown Hospital Trust and Uptown Hospital Trust which might help them, achieve that" (External interviewee) [1]

"I would say that Bigtown Hospital Trust on the whole is less, less arrogant and less ivory tower-ish. That implies that Uptown Hospital Trust still have that and, and I think Bigtown Hospital Trust are very committed to the DGH part of their function whilst absolutely wanting to develop the specialist areas" (External interviewee) [2]

5.82 PCTs

Relations are reported as good with both PCTs, and the trust and the PCTs are collaborating on demand management and care pathways. The trust

was not perceived by one of the PCTs to be 'gaming' in its use of Payment by Result tariffs.

"We work very well with Bigtown Hospital Trust over the past. We have very good relationship at director level" (External interviewee) [1]

"It was much more locally engaged, than its competitors in local communities, than [the hospitals that merged to form Uptown Hospital Trust] or a combination of [those organisations]. It had a reputation for being, more sort of almost a district general hospital in its feeling and that was a good thing, of course, certainly from the primary care point of view" (External interviewee) [2]

Bigtown Hospital Trust interviewees expected that the PCTs would see it as good at delivering, and this impression was confirmed by PCT interviewees.

The good relationships, and the growing partnership between the two acute trusts was seen by PCT interviewees as helpful to the health economy.

"Well, they're extremely positive about the relationship with Bigtown Hospital, but I can't answer for Uptown Hospital, but I suspect they're positive about them as well because of course we assure them of a damn good service. Locally the feedback is people are very happy with the acute services that they get, which is a significant change from fifteen years ago" (Senior management interviewee) [2]

Within the trust, acute trusts were seen as more powerful and mature organisations within the health economy than PCTs, and spontaneous references to PCTs were uncommon relative to references to the neighbouring trust. Asked how the PCTs would describe them, senior internal interviewees used terms such as predatory and anticipated that the PCTs might be frustrated by the trust's low capacity, although PCT interviews did not confirm these impressions. Senior trust interviewees reported having convinced PCTs that continuing provision by the trust was preferable to PCT or commissioning group provision of some services.

The local general practices were reported by the trust as being supportive of the trust.

5.83 Local community

Internal interviewees, particularly senior interviewees, reported strong relationships with the local community. They were proud of a high uptake of membership, and had engaged the members in a successful campaign to advocate for improved accessibility for a local station. They had closed a community hospital site with, reportedly, minimal local protest, and attributed this success to careful engagement. However, a series of local meetings had been poorly attended, though lively. Senior interviewees saw patients and the public becoming more important to the trust, and more influential in its development, in the years to come, partly as a result of the foundation trust governance structures.

"You consult, you know, what's historically been a fairly crude process when we want to do major change and we now have some accountability for doing that properly for local authority overview and scrutiny committees, which increases, if you like, the scrutiny of consultation. But what that doesn't do is give you the steady flow of input from your consuming population in the way that over time the governance arrangements for foundation trusts should do as people get more confident. So there's, over time, an opportunity to rebalance the relationship between the professional and the consumer… " (Senior management interviewee) [2]

"Now, most people are happy, which is why we put the comment box, and don't want to make complaints about the service, but would want to help us go from good safe services to excellence and we've always been in pursuit of excellence at Bigtown Hospital Trust. So we're driving that philosophy forward and taking on any information base that we can, so when there was that recent argument about, the government shouldn't direct you or Monitor shouldn't direct you, we're here to gather information from anybody who can help contribute to more effective decision-making, which is evidence-based, that enables us to improve the quality of services that we provide. So, to tell you the truth, if there was a talking dog that could articulate how to improve services I would not say that you're not a constituent of the organisation, I would say I will have to take the, I'm glad to take the information in, transfer it and see how we can best utilise it." (Senior management interviewee) [2]

As noted (Section 3.4.2) the perception of interviewees was that good relationships with the community and patients predated foundation trust status, and a perception that the relationship would develop as a result of foundation trust status was limited to more senior interviewees. However, there was growing awareness of the foundation trust public accountability structures from clinical, scientific or administrative interviewees between the two rounds of interviews.

5.9 Facilitators and barriers to planned cultural change

The more senior interviewees reflected on what supported change, but a question of cause and effect arises, in that they also claimed characteristics such as retention of staff and effective leadership were results of the culture.

5.91 Retention of senior staff

The long serving board was mentioned as both an outcome of the trust's culture and important to its ability to implement change.

> "I must think it's a good organisation, otherwise I wouldn't have been here for fifteen years, but it's not unusual to find people who've worked here for some time. I mean obviously, you know, there's a healthy mix of those long-stayers, like myself, and others who come and go, but I think it's an organisation that's relatively unusual from that point of view, certainly in health" (Senior Management interviewee) [1]

5.92 Leadership

There was an opportunity during the course of the case study to assess the impact of the chief executive's leadership on its culture. Between the first and second rounds of interviews the chief executive resigned and second round interviewees could reflect on the impact of his departure. During the first round, he was seldom mentioned by interviewees, and their experience of what the trust was like was not attributed to his leadership. Asked specifically about the impact of his departure, the second round interviewees (most of whom were senior) paid tribute to his competence and vision, but did not envisage great changes to what sort of place the trust was. They trusted the appointment process to select an appropriately skilled successor to carry forward their shared vision. Their main concern was for a loss of momentum in the development of a significant partnership with other organisations (Section 3.4).

A previous, long standing chief executive was also mentioned as being a significant influence in the trust's progress from poor performer to heroic achiever.

Nursing leadership was seen by some as having been neglected because the director of nursing had other onerous and high profile roles. Several senior interviewees described nursing morale as low, due to factors affecting all nurses in the NHS, and those who were concerned about leadership saw strengthening leadership as a way to counter the negative nursing experience.

"…nursing, it's a bit of a mess. The silo mentality has suffered along with all other hospitals" (Senior management interviewee) [2]

"… obviously outside looking in the logical thing, if that that person is not functioning as director of nursing, you should just remove that post from them and create a proper director of nursing" (Middle management interviewee) [1]

The leadership within divisions (clinical director and general manager) was given considerable autonomy in addressing scorecard indicators, but interviewees did not give an impression of dispersed leadership where staff at all levels of the organisation were encouraged to take initiatives.

"I'd say some things are very much top down, but there has been…trying to get service improvement at a lower level and getting people to try and take responsibility for that. That's something I try, but obviously, you know, the time commitments, that obviously takes a lot longer. If you haven't got the time to facilitate that then it does tend then to become top down, so I suppose it's that balance between I think idealistically you'd like that involvement, but you've got to do it this way" (Middle management interviewee) [1]

There was acknowledgement that their performance management could be associated with a *"big stick"* [8-1] approach. This finding coincides with a quantitative finding from the internal competing values framework that hierarchical type of culture dominates in Bigtown Hospital Trust both overall and within most separate dimensions, among both health professionals and administrative and support staff. However the response rate in this survey is low, and it is hard to know what stratum this finding reflects (Appendix XX).

5.93 Strength of health economy

The organisations in the immediate area of Bigtown Hospital Trust (Bigtown Hospital Trust, Uptown Hospital Trust, a mental health trust and two PCTs) were all economically healthy, and had a history of collaboration and mutual trust. However, NHS organisations in the surrounding four PCTs were less healthy.

"If you took [the two closest] PCTs, Uptown Hospital Trust, Bigtown Hospital Trust, [another local trust], all healthy, all FTs, are all in a pretty good position. If you look wider in terms of the health economy of the whole sector, you know [four neighbouring PCTs], probably 50:50 for big deficits and break even" (External interviewee) [1]

Across the region, several areas had experienced severe financial failure meaning that PCTs without deficits such as Bigtown Hospital Trust's main commissioners would be top-sliced to support failing organisations. While there was a knock-on impact on resources to commission Bigtown Hospital Trust's local services, the strength of organisations in Bigtown Hospital Trust's immediate area was made more significant by the contrast.

5.94 Local community

The local community was reported to be loyal to and supportive of Bigtown Hospital Trust, a factor attributed partly to Bigtown Hospital Trust's commitment to serving its community despite its cultivation of specialist services.

"We're here for the community and that speaks back to the outcomes of their satisfaction. The whole problem then, because we had problems about facilities, quality of care and hospital care. Most of our complaints now are about things like transportation, access, it's not about the care that we provide and my first object is to make sure we provide safe care, that it's the best care and then the, you know, the environment which we do it in" (Senior management interviewee)[1]

"Yeah, people like it. There are some that would never go to another hospital but Bigtown Hospital Trust". ["AND HAS THAT ALWAYS BEEN TRUE, ALL THE TWENTY-FIVE YEARS?"] You can hear one or two people said 'No, I would not go to Bigtown Hospital Trust' because maybe their mum was there and she died. For some reasons they, and then there's another, then there is, there will be others that said 'Oh, that's the only place I will ever go, I was born there.' And they may be eighty, they're saying 'I was born there.' They won't go nowhere [else]. Just like myself, but now I've got to change hospital. Because I had all my kids born here, all my five kids. It's just that, it's just that the care was really really excellent" (Clinical, scientific or administrative interviewee) [1]

"Bigtown Hospital has not got problems in recruiting midwives, whereas Uptown Hospital have, and I think part of that is because although it is not that much further out of [metropolitan area], it does actually have a sort of catchment area or a hinterland that it can recruit from more local people than maybe Uptown Hospital Trust does and it's a problem for us as a PCT in terms of recruitment, but I am just saying that" (External interviewee) [1]

The strong local support could, as interviewees argue, be attributable to the trust's actions to build its relationship with the community. However other factors are likely to support a strong relationship. The trust had not been through merger with accompanying closure of sites or withdrawal of

services, unlike many hospitals in the region, and delivered nearly all its services from a single site familiar to the community.

5.10 Unintended and dysfunctional consequences of culture change

The performance management initiative, although generally well-supported, seemed to have some unintended adverse consequences. Some senior interviewees acknowledged that the trust was "lean" and running "close to capacity". For interviewees in the specialist division, there were negative impacts on both the working experience and the patient experience (although it was hard to separate the impact of the performance management programme from other pressures). These interviewees were irritated at forecasts of the trust's improved financial performance (Section 5.1) given the impact on services that they believed its achievement had cost.

There was, particularly in the early interviews, a perception that performance management had induced a rivalry between senior managers in different divisions, and a structure which did not support sharing of solutions between divisions, so that the divisions became 'silos' in their implementation of the programme. The rivalry was perceived to have diminished by the second round of interviews.

5.11 Changing Relationships Within and Between Organisations

Emphasis of performance management

At the second interviews, a change of emphasis had been made to the organisational change programme supporting performance management, to emphasise patient safety and subjective aspects of the patient experience, rather than the achievement of clinical performance and financial targets. There was also an acknowledgement that it might not be essential for every division to undergo the organisational change programme in order for the organisation as a whole to achieve benefit.

"And to some extent we're feeling that … it's a bit of the law diminishing returns on occasions about keeping on going. You know, do you have to step on the lily pad in the pond, you know, to get where you got to? And how do we, one of the things I think with change management and the change programme is all about is constantly refreshing itself because if it becomes just a bit of me too, you know, it loses its excitement almost for people" (Senior management interviewee) [2]

Departure of chief executive

Section 3.6.2 reported that the imminent departure of the chief executive had raised concerns about the momentum of development of the partnership with Uptown Hospital Trust and other local organisations, and also about his particular strengths in developing influence with decision-makers at national level. There less concern about loss of continuity within the trust or across the health economy.

"… there's been a change of personnel at chief exec level of the Trust. We always had a very strong relationship, kind of personal relationships across. That .. and, and when you get a change of senior personnel, obviously that brings change with it. But we have good .. relationships with the new incoming senior management as well. .. So I think there's a good degree of continuity in that, so that's a kind of change but unchanged, if you like" (External interviewee) [2]

Response to improved performance

Some interviewees observed that improvement in performance (see section 5) had brought about a reduction in the 'chip on the shoulder' which was believed to drive the trust to excel.

"… we call, used to call it the Bigtown Hospital Trust paranoia, but to my mind that is changing because Bigtown Hospital Trust is a more self-confident institution" (Senior management interviewee) [2]

"… we've often seen ourselves as the underdog, but I think, I think that, you know, it's not a question of complacency or cockiness, I just think that, people are more prone to talk about the strength of Bigtown Hospital Trust now than they are about the weaknesses of Bigtown Hospital Trust. So I think, I think there's been a tremendous cultural shift in saying, you know 'Gosh, you know, we're pretty good at this.' Or 'We can be good at this if we do this.' Rather than 'Oh, I don't know if we can do this.' You know?" (Middle management interviewee) [2]

Awareness of foundation trust status

Generally, the low level of awareness of change due to foundation status at the first round of interviews among clinical, scientific or administrative interviewees had not changed by the second round.

["… AND I JUST WONDERED … WHETHER, YOU KNOW, THE FACT THAT YOU'VE GOT GOVERNORS AND MEMBERS IS SOMETHING THAT, YOU

KNOW, THAT"] "It hasn't made any change at all still." ["NO?"] Not that, not that I personally noticed. In my working day-to-day life I've not noticed any difference at all" [laughing] Clinical, scientific or administrative interviewee) [2]

However there were examples of staff who were unaware of any impact of foundation trust status at the first interview being more aware of it by the second interview

"I think that since then I've increased my understanding of the foundation trust. I would also say that being a foundation trust is now filtering out there as being a good thing because this year we have an under-spend, which means that we have ……money to take forward into the new year. I can't think of the word. And I think that that is a big recognition in people's head of actually now we're a foundation we can keep this under-spend and use it next year, whereas if you're not a foundation you have an under-spend and it's gone. So I would say that, that it is beginning to filter down as a positive thing. I think I'd say that's most probably the only bit so far, but that's, you know, a good start. (Middle management interviewee) [2]

External interviewees perceived the dominant culture permeating further through the organisation:

"… they've really grown and matured as an organisation so that the top level rhetoric is beginning to be much more a core part of the organisation. So I suppose we're talking about a sort of historical change, which, you know, top level rhetoric starts off and, of course, that's often where it does begin, doesn't it, in leadership terms? But actually what you're now getting is departments and consultants much more on message. That sounds terribly jargon-y but, but much you get a much more of a sense that they feel part of a corporate organisation rather than lots of individual teams" (External interviewee) [2]

5.12 Changing Performance Within the Organisation

National performance measures

There was widespread awareness that the trust had made a surplus in its first year as a financial trust and was projected to exceed its target surplus in the next year, and had generally performed well. These achievements were listed with pride by senior staff. Two responses to this have already mentioned – a greater degree of confidence (Section 4.3) and some resentment within the specialist division which had had to make savings including some downgrading in a year when they felt expected to share in pride at the surplus (Section 3.7).

Senior staff in both divisions were aware of surpluses within their own divisions, and within the specialist division the purchase of new expensive equipment was attributed to overall good performance in advance of the availability of detailed activity based costing data to justify it.

"… we've had a lot of business cases accepted, it certainly feels better off. … It changed the language around finance, getting that message to staff and still getting that message to staff is quite difficult, whereas previously we'd been talking like 'Oh, we've got to break even, we've got this [size] deficit.' And now we're talking surpluses" (Middle management interviewee, round 1) [1]

"… what we are seeing is … needs for data tightening up, so we are seeing the impacts of having that. We have also seen the impact of having more investment as well" "[REALLY?"] "Certainly in [this specialism]. Now whether we'd have got that investment anyway I don't know or whether that's the fact that we've been really successful this year in terms of achieving our activity to income in surplus, but we have seen more investments. I'm about to tender for four pieces of bit kit" ["BUT YOU DON'T KNOW WHETHER YOUR PARTICULAR FINANCIAL PERFORMANCE HAS INFLUENCED THAT SPENDING DECISION ABOUT THE BITS OF BIG KIT?"] "Not directly, but I would imagine if I was way off pace then there would be questions asked". (Middle management interviewee, Round 2) [2]

There was little cynicism about the validity of performance measures or the possibility of 'gaming'. A notable exception to this perception was an interviewee from the contractor.

"Well it's obviously in the papers, they've got different types of infections. … That's been highlighted, so, and that's the reason why the standards are so high and I find Bigtown Hospital Trust are very good at monitoring the standard. (Middle management interviewee) [2]

There was also one example of a cynical perspective on the surplus – a senior interviewee who pointed to the continuing poverty of Bigtown Hospital Trust relative to Uptown Hospital Trust and the small significance of the surplus in that context.

["YOU DON'T GET YOUR SURPLUS TAKEN AWAY?"]. "Well, that's very true. So what? We don't get as much opportunity to plan investment in our estate, do we? Our surplus is piddling" (Senior management interviewee) [2]

Softer measures of performance

No interviewees mentioned staff surveys. There were mentions of patient experience surveys as an important tool in achieving excellence, but overall the strong focus of this trust on hard measures of clinical excellence, financial performance, and national process targets gave less significance to softer measures than they might have in other NHS organisations.

Linkage to changes in culture and relationships in the organisation to performance outcomes (hard and soft).

Reflection on the link of performance management and foundation trust status to performance outcomes was common.

Several interviewees believed that the level of monitoring involved in their performance management programme did improve performance, though not directly. They believed it enabled them to identify and to some extent to 'unpack' a barrier to improvement, so that they could come up with solutions.

"Eighty-five to ninety percent of our work is based on what comes through the emergency room door, so we're very responsive. So for years people have felt a bit passive about that when you have to deal with what comes in, but we began to realise we didn't have to deal inefficiently with what comes in. … the currency of medicine used to be outliers, how many outliers, how many patients were spilling into other people's beds, that was kind of a marker of our efficiency or the lack of it and the average length of stay was not a concept that was really appreciated, and gradually as we analysed the data people began to understand that this was really a very very key indicator of performance and that by working on average length of stay they'd have a lot more flexibility and therefore a lot more efficiency" Middle management interviewee) [1]

Activity-based costing was singled out as a process that would increasingly give information leading to improved performance.

"… we're not at the stage just now that we can just say to the [divisions] 'You can keep all the money you make' because the organisation still does, needs to stabilise itself a bit more, but the plan is at the end of the day that that's what will happen is that if they can be really, you know, good about it then they can have that money and they can reinvest, not just as reinvesting as a trust, but they can reinvest in their service" (Senior management interviewee) [1]

Specifically in the area of financial achievement, some interviewees argued that compliance with the requirements of foundation trust status had led directly to improved performance by promoting efficiency and financial risk management. The requirements for approval for and maintenance of foundation trust status were believed to be well chosen as ones which led to improved financial performance.

"I think it's possible to draw the conclusion that foundation trust status, because of the compliance requirements, the financial regime, they taught us to manage money much better, they've given, helped everybody understand the possibilities of managing money much better" (Senior management interviewee) [2]

"They're much more efficient now, better run because they had to jump through hoops, and took a long time to achieve foundation trust status.

They were better able to describe their performance to themselves, and so to the PCT. They've done a huge amount of work on the patient experience. FT is not necessarily the only driver, but it was an important driver. Individuals and organisations are on a sounder footing if finances are on track, FT status was a very significant driver" (External interviewee) [2]

"To get to foundation trust you have to demonstrate that you're delivering on x, y and z and I suppose it's about the fact that actually somebody did make the right decision and x, y and z are the things that do move you on, and in delivering on those you, in effect everything else begins to fall into place" (Middle management interviewee) [2]

Some interviewees made a direct connection between the culture of Bigtown Hospital Trust and its improving performance. The 'can-do' (developmental) and performance-driven (rational) culture had an impact beyond the application of performance management processes.

"[an outcome of] the culture of Bigtown Hospital Trust, its energy, the anxiety of Bigtown Hospital Trust, the wish to do well". (Senior management interviewee) [2]

"I think the idea of setting up key performance indicators and scorecards, you know, that was discussed at Uptown Hospital Trust as well and they've been going along that journey, but I think a model doesn't work unless you can implement, unless there are people there to drive it. I think it's intrinsically …the sort of organisation Bigtown Hospital Trust is that's driving it. And again, organisations are made up of individuals"

(Clinical, scientific or administrative interviewee, with some management in role). [1]

"When I came here you first had to assess the culture and the organisation, basically what resources do I have to move the agenda forward? And so part of that was the fact that it had to be more reactive and responsive than Uptown Hospital Trust in order to survive. So I was building upon the aspects of the culture that was already here and exploiting that … If you were at Uptown Hospital Trust you would build upon the financial strength, you would build upon the historical situation, critical influence, you would use a different strategy to enhance the … culture and resources that you have there" (Senior Management interviewee) [1]

5.13 Changing Cultures, Relationships and Performance Across the Local Health Authority

Foundation trust status was not believed either by the trust or by the PCT interviewed to have had an impact on how the trust operated in the health economy. It had not changed the good relationships between the trust and the PCTs, and PCT interviewees reported their confidence in the judgement of the trust in taking independent action.

There were some reports from trust interviewees of the PCTs making unreasonable demands for information to support commissioning, but a PCT account of how financial trust status had affected the relationship suggested that it might be influenced by the Department of Health attempting to make PCT monitoring substitute for direct management of foundation trusts by the department.

"It is not uncommon for [strategic health authority] to ask the PCT to get information from the foundation trust in order to feed it back up the system Department of Health, and presumably therefore to ministers, because they themselves cannot go directly to the foundation trusts. so they've put foundation trusts on one side and .. can't hold them to account directly, so we have this rather bizarre situation where, you know, they have to come to us to ask us, and really the foundation trust only have to report to Monitor … Department of Health or [strategic health authority] can't ask directly from them, you know, it's, you know, you feel like you're just yapping around at the heels of the foundation trust, you know, who are the big players in all of this." (External interviewee) [2]

PCTs, while stressing good relationships with the trust, could be frustrated by the financial relationship into which both foundation trust status and changes in the payments system for hospital services had put them.

"They've got a … role in making sure that healthcare works and I do believe that a lot of them do do that but actually they're also a business and Monitor is making sure that they're in the business of being in a business so, you know, it's very difficult" ?" (External interviewee)[2]

"I say well you must code your data, they say yes we must code our data but they don't do it cos it's in their interest. Eventually we have a showdown and for instance I've, I said to them 'Well how is it that you've doubled your critical care costs in three years?' 'Oh yeah, we'll have a look at that'. .. so. But where's the power? Do I send in a team to look at it and where am I going to get that team from? Or do I say to them 'I need you to look at this cos this is a problem'? They'll look at it and they can up with a thousand answers as to why. Wouldn't you?" (External interviewee)[2]

An external interviewee, who stressed that relationships with Bigtown Hospital Trust remained good, expressed concerns that the PCT had had about foundation trust status when the proposal was first announced. The PCT had been apprehensive about foundation trust status. They feared it would be a barrier to mutual trust between organisations in the health economy, and specifically to the provision of information to the PCT by the trust, and also that they would compete for scarce skills within the local labour market, and for the provision of services.

"We were aware that they were obviously pushing hard for that and they were, they were sort of doing quite a lot of interesting innovative things to sort of dress the window and look impressive on that, which, and which they genuinely, you know, were doing and were impressive in many ways. … I think one of the things we thought might be a problem would be that foundation trust would be even more cagey about its internal data and it might be harder to get information out. Because foundation trust, the foundation trust movement also coincided with the whole opening up of the market in healthcare and the contestability and all that sort of stuff and the independent sector coming in and therefore people were sort of guarding their information because, you know, the business opportunities or competition. So I think we felt a little bit concerned about that. The other slight negative we felt about the whole notion of foundation trusts was that they would basically become a law unto themselves, they would have, they would distort the labour market because they'd be able to offer higher salaries, that they would poach people from the primary community sector, particularly from the nursing side of things. We thought it might, you know, that might distort the local labour market, health professionals. And also we were a little bit concerned that the foundation trusts might actually sort of move in on

primary care and actually start running some of the practices and that there again that could be a distorting factor. Some, some very long-term, medium to long-term concerns about the whole thing about them, foundation trusts, nothing specific to Bigtown Hospital Trust" (External interviewee) [2]

However, foundation trust status was also seen as generally beneficial, because improved performance meant better services for the local population.

"you know, we all moan about whatever, and there are bits of course that aren't as good, but actually when you, when I certainly talk to other colleagues and you hear what goes on in other places in the country you think 'Oh my goodness, gosh, we've got, we've got excellence.' So I think we feel quite privileged, but certainly we're really conscious of the fact without being, we're not overawed by it, but I think very conscious of the fact that because we have three foundation trusts that serve our population, you know, Uptown Hospital Trust, Bigtown Hospital Trust and [another organisation], that that is good for our population because of the quality stuff" (External interviewee) [2]

The progress towards partnership with other local organisations was affecting external relationships. Both internal and external interviewees though it would be helpful in the relationship with PCTs in reducing unproductive competition between trusts, promoting service quality including the chance of single agreed care pathways for common conditions, and improving recruitment.

"Of course the [partnership] has settled down any local feuding that might have taken place five, six years ago, so that makes [the PCTs'] lives easier, and they are involved in the [partnership] development" (Senior management interviewee) [2]

"We are potentially excited about the [partnership] in the sense that I think having our local population able to access, hospitals that are part of cutting edge research is good. I think the challenge for us is around how we influence that in a way that it isn't just esoteric research that doesn't address some of the, some of the needs of our local populations and so that we actually try and influence some of the research programmes so that it's actually dealing with both applied science and the real population issues in [this area]" (External interviewee) [2]

"It would bring … real benefits to the local population, you know, in many ways. As, as employers it'll bring, you know, it'll make them more attractive to the workforce. In terms of service planning and research,

it'll be really good, and in, and in terms of bringing together providers, it'll be helpful for us" (External interviewee) [2]

However, as noted in Section 3.4.3, there was a lack of clarity on what form the partnership would take overlaid on a history of competition which was affecting both trusts internally. Bigtown Hospital Trust's senior management team was having to manage some internal anxiety, and apparently this was also true within Uptown Hospital Trust.

"There are a few people who I keep asking the question of, are you actually taking business from each other, cos you're both growing, and yet personalities say that they just can't get together and agree how to take things forward. Even though, you know, they're both doing well, they're both expanding, they, they just feel like, you know, it's, this is my hospital and I am the top dog here, and pulling all that together takes time." (External interviewee) [2]

External interviewees were careful to emphasise that the change of chief executive would not have a large impact on relationships or performance within the local economy, for example in the quotation from the external interviewee at Section 4.2, and the one below.

"And [Uptown Hospital Trust and Bigtown Hospital Trust chief executives] were able to talk and agree actions to take the thing forward. As long as [chief executive of Uptown Hospital Trust] and whoever … replaces [chief executive of Bigtown Hospital Trust] can do that … then I don't see an issue" (External interviewee) [2]

5.14 Summary and Conclusions

Key themes and issues arising from the case study and implications for policy and management

Evidence from interviews suggests that the senior management team at Bigtown Hospital Trust has an open, performance driven, rational culture, with elements of a developmental culture in its fostering of to innovation in the achievement of excellence.

There is evidence that this culture was shared in at least one division, where interviewees at al levels shared an espoused commitment to excellence, and an expectation that problems and conflicts would be resolved rationally, openly and in the interest of service quality. Elsewhere in the trust, however, interviews suggested a more fragmented culture, and some evidence of a hierarchical culture, with conditions being imposed on reluctant front-line employees. A hierarchical culture was also found among

those trust employees who returned the quantitative competing values framework questionnaire (Appendix Six).

A national survey of trust boards at three time points shows a trend over time away from clan and towards rational culture. The account given within this trust, particularly by more senior interviewees, supports a growth in rational culture, and possibly that the culture that it replaced was of the clan type. Senior interviewees spoke of a "useful paranoia" in the face of external perceptions of a poorly performing organisation, which motivated the trust's progress, a perception which diminished as performance improved.

Elements of all culture types are commonly found in all organisations, and organisations of any size will contain a number of co-existing cultures. In considering the relationship between culture and performance, it is convenient to look at the legal entity for which performance is measured by the Healthcare Commission. The many cultures within an organisation raise the question of which culture is linked to performance. Other researchers examining the interaction between culture and performance (for example Gerowitz et al. 1996) have chosen to focus on the culture of senior management teams, making for an easier correspondence between the legal entity and the organisation for which information on culture is available. This study has allowed investigation of how cultures within an organisation can confound or support the link between the culture of the senior management team and performance.

Bigtown Hospital Trust's externally measured performance had improved over the years preceding this study, and the improvement coincided with performance management and organisational change programmes. It is credible that the senior management team's rational culture and the efforts that they had made to intervene in the culture across the organisation contributed to its improved performance. However, as reported above, culture was not uniformly rational across the trust, and was evidently hierarchical in parts. The trust had made a decision not to roll its organisational change programme to every division. How far, therefore, does a culture conducive to performance improvement have to permeate for performance to improve. Is it sufficient (as appears to be the case in Bigtown Hospital Trust) for the senior management team to show a cohesive culture, and for values such as 'patient centred' and pursuing excellence' to be widely espoused in cultures which differ from, but do not conflict with, the culture of senior management? More practically, do organisations need to implement organisational change programmes throughout an organisation, or just in some key parts (and if so which parts)?

Sustaining culture

Bigtown Hospital Trust has sustained improvement in performance over more than a decade, through two long-serving chief executives, and now hopes to maintain and build on that improvement. What has contributed to this maintenance of a culture conducive to performance improvement, and what will it take to continue to maintain it?

The account given by senior management interviewees stressed two related external factors as motivating the trust's employees. firstly, the external perception of the trust as a poorly performing organisation, particularly under threat of merger from a regional review, induced a kind of constructive paranoia bringing about heroic recovery. Related to this was the presence of a wealthy, academically renowned trust providing services to the same population (Uptown Hospital Trust), providing a challenging example of high performance and reputation. These two factors served as myths or parables to influence the coherence of culture within Bigtown Hospital Trust over a long period.

At the time of data collection, the trust had sustained good performance. It was about to engage in a close partnership with Uptown Hospital Trust, and too great an emphasis on differing from Uptown Hospital Trust might interfere with the achievement of management goals. So the power of both of these 'myths' was at risk of diminishing or being unproductive. At the same time, a long serving chief executive was leaving. Bigtown Hospital Trust interviewees were confident of the ability of senior management to sustain leadership through the transition from one chief executive to the next (and had successfully sustained performance improvements at the departure of a previous long-serving leader). There was, however, no evidence of the development of a new myth which accounted for a trust which was not overshadowed by its neighbour, and whose good performance was a surprise to no-one.

A sustained culture conducive to performance improvement may not, in any case, be entirely the result of intervention by senior management. Unlike many other hospital trusts, Bigtown Hospital Trust operated from a single site, had not experienced a merger in recent decades, and existed in a financially sound health economy. These supportive external factors were seldom referred to by internal interviewees.

Foundation Trust status

Foundation trusts were intended to give NHS organisations incentives for improved financial performance, by rewarding them with greater autonomy. This in turn would be expected to shift values and beliefs to produce more innovative organisations. They were also intended to make trusts more accountable to, and connected to their local communities.

The rhetoric in Bigtown Hospital Trust suggested that foundation trust status was a consequence of the trust's culture rather than a driver of it.

However, there were also indications that both financial management and connection with the community had improved as a result of processes related to foundation trust status. Several interviewees linked improved financial performance to compliance with the requirements of foundation trust status. There was an acknowledgement among senior interviewees that the membership and governors' board gave them a resource to guide quality improvement not available through usual patient and public involvement processes. So without necessarily influencing culture, the foundation trust processes had influenced, or were likely to influence performance improvement. To that extent experience at Bigtown Hospital Trust suggests that foundation trusts have provided benefits to the NHS.

However, the perception from within the trust was that the main drivers for improved clinical performance and financial stability were internal, and that the trust was, in any case, well connected to its local community. For internal interviewees the main importance of foundation trust status was symbolic. It indicated that the trust was a member of an elite group of NHS organisations. At present, foundation trusts are such an elite. Whether the good performance of foundation trusts will still be sustained over years when to have that status is not to be a member of an elite is open to question. For this trust, and perhaps for other early foundation trusts, it was one of a range of indicators of their membership of an elite group of NHS organisations, and associated with other measures to improve performance and standing.

Relationships in the health economy

There was concern across the health economy that the system of payment for hospital services was serving to frustrate integrated primary and secondary care, and to damage relationships between NHS organisations. Foundation trust status was seen by some external interviewees as contributing to this by giving those organisations more of a business focus and making them more reluctant to share information. Good relationships were seen by some as persisting despite, rather than because of, recent structural changes in the NHS.

5.15 Implications for future research and theoretical generalisation/development

Models of cultural change

Some elements from models of cultural change outlined in Section 3 can give partial accounts of Bigtown Hospital Trust's trajectory of change.

Dyer's (1985) model assumes a perceived crisis leading to a loss of confidence in leadership and a breakdown of the organisational elements which support current patterns, leading to resolution. If these circumstances applied to Bigtown Hospital Trust, they would have applied many years before the case study began, at the time when the organisation's independent existence was jeopardised by an acute services review. Interviewees did not report the conflict preceding organisational change predicted by this mode. However, the importance of leadership in the model is supported in Bigtown Hospital Trust where two long-serving leaders were reported to have been important in introducing and sustaining positive change. Dyer's model does not offer an account of the sustained positive change in Bigtown Hospital Trust over a long period.

In terms of Schein's (1985) life cycle model, Bigtown Hospital Trust is in organisational midlife, and engaged in planned change and organisational development. The process of accepting the validity of indicators used in performance management could provide an example of "unfreezing" of older cultures. Interviewees gave reports of initial concerns about the validity of indicators uovercome through processes of exploring facilitators and barriers to achieving shared objectives. Most of the characteristics of mature organisations in Schein's model, where organisations are less flexible, and planned change requires coercion, are not applicable to Bigtown Hospital Trust.

The stages of "unfreezing" and "change" from the model compiled from the works of Lewin (1952) as modified by Schein (1964), Beyer and Trice (1988) and Isabella (1990) provide a good account of the planned change executed by Bigtown Hospital Trust's senior management team. "Rites of questioning and destruction", "rites of rationalisation and legitimation" and "rites of passage and enhancement" could all be recognised from the content of interviews. The model is also compatible with our findings from Bigtown Hospital Trust in the importance of leadership and the lower emphasis given to crisis and conflict than is found in some models. However, following planned changes, the senior management was not engaged in "refreezing" – rites which reinforce changes into a more predictable way of working. Rather, they were turning their attention and that of the organisation to new challenges while doing what was necessary to sustain earlier change.

Lundberg's (1985) model provides a language with which to describe changes in Bigtown Hospital Trust taking account of the external environment ("domain") and precipitating pressures, and allows for the possibility of strong internal drivers, and the complexity and change.

The incremental model of change proposed by Gagliardi (1986) reflects particularly closely the circumstances in Bigtown Hospital Trust, where a leader is able to work within a culture to achieve changes which are not a radical threat to existing beliefs and practices. This model allows for a series of smaller changes, rather than the radical change which in its turn becomes entrenched and then overthrown (described by Dyer's and Schein's models and the "unfreezing-change-refreezing" model)

Bigtown Hospital Trust presents a challenge to many models of organisational change which give accounts of external and internal crisis. Only Lundberg's model allows for a multiplicity of cultures within an organisation. Many models assume single organisation-wide changes which are sustained until overthrown. What happened at Bigtown Hospital Trust was a series of more gradual but eventually far-reaching positive changes and the closest account of the incremental process is offered by Gagliardi's model. The changes did not happen uniformly across the organisation but accumulated and were sustained over a long period. Theoretical development is needed to go beyond description and make predictions which account for the complexity of circumstances such as those in Bigtown Hospital Trust.

Performance, structural change and environmental pressure

Bigtown Hospital Trust sustained improvement over a period of years, and progressed from a poorly performing to a high-performing organisation. A credible account from trust interviewees attributes these achievements to planned organisational and cultural change implemented by committed and competent leaders. However, over this period many of the acute trusts with which Bigtown Hospital Trust is compared have experienced unavoidable changes and pressures which Bigtown Hospital Trust has been spared, including merger, service reconfiguration and financial failure of other organisations in the health economy. To understand the connections between performance improvement and the interventions in culture and organisation undertaken by management would require a study which looked at similarly high-performing trusts with a range of external pressures, or conversely looked at several trusts with a range of performance levels which were similarly advantaged or disadvantaged by the pressures of their environment.

6 Clinical Governance Failure in a hospital Trust

SUMMARY

Metrotown Hospital Trust, located in the North of England, is the result of two mergers between three hospitals, all of which serve areas with relatively high levels of deprivation.

There is a history of clinical governance problems at the Trust site that was investigated in this study, with one particularly problems having difficulties that have been widely reported in the media, and which go back over ten years. The hospital Trust was investigated, as a result of clinical governance failures, by what was then CHI, whose reported suggested that the failures were systemic rather than being located in the one Department they were originally brought in to investigate.

The hospital Trust has had significant financial difficulties, but has improved over the last year (2008) in terms of both its quality of care and resource utilisation.

Relationships with both the SHA and most local PCT have been historically very difficult, with the Trust perceiving itself to have been financially disadvantaged in reforms post 2000, claiming that a decision was made to locate deficits in the local health economy at the hospital Trust, and as a result, the hospital having to make significant organisational changes to try and deal with the deficit. More recently, relationships have improved with the appointment of a new Chief Executive of the hospital in 2007.

The hospital has gone through a significant programme of turnaround that resulted in a number of staff being redeployed, as well as having to improve its financial situation considerably in order to successfully apply for a new PFI build on the existing hospital site which is due to be completed in 2010.

Culture within the hospital trust varies considerably according to the level of the organisation examined, the committee of the organisation staff are being asked to describe, and whether or not managers and clinicians regard themselves as supporting the changes (including an extensive turnaround programme and a PFI build) put in place by the hospital. Cultures range from a very clannish view of the world where the hospital is being assailed on all sides by healthcare inspectorates and an unfair performance management system, to service managers who believe that the

> The new Chief Executive is trying to lead cultural change, and to bridge the perceived gap between the administrative centre of the hospital, and wards and clinics, through the use of new communication strategies involving rewarding good work, as well as getting around the hospital more to meet staff and try and form personal relationships.

6.1 Background

Metrotown Hospital Trust is the result of recent mergers between hospitals in three relatively deprived areas. Services often appear fragmented between the three hospitals, with some passing to single sites and others attempting to rotate between all three. Despite the difficulties experienced at the main Trust site investigated here, local people appear to have remained 'loyal' to the site, at least so far.

Metrotown has had significant financial deficits since 2003, and was ranked in the bottom 50 of all health organisations in within the last couple of years. A Healthcare Commission Report investigating governance failure at one of the Trust sites, the one examined in depth in the following Report, suggested managers were preoccupied with the financial state of the Trust at the expense of care, and that clinical governance was not adequately implemented. In 2007 Metrotown was one of the hospital trusts identified as no longer sufficiently creditworthy to be to be lent money from government funds to cover their accumulated deficits.

Metrotown was placed in special measures as a result of the Healthcare Commission Report, and is presently undergoing major development having secured, despite concerns over its finances, a PFI build to replace buildings in two of its locations. It was chosen as a case site specifically to investigate how a site labelled as experiencing clinical governance failure was managing its culture in order to improve its (clinical) performance.

The hospital site that experienced governance failures routinely receives very poor press coverage in the local area, although divisions with good clinical practice in the hospital claim that their reputations remain intact, and indeed are receiving referrals from outside of the local health economy.

The merger between the three Trusts initially appeared to be going reasonably well, with the Trust on track to achieve Foundation status. However, a rather catastrophic collapse of finances, the governance failure leading to the CHI/Healthcare commission inspection, and the subsequent poor publicity and turnover of Chief Executives, has led to significant governance concerns.

The Trust has difficulty retaining its Chief Executives. A new CE has been in post since Easter 2007. Other members of staff show greater continuity, particularly the Chief Nurse.

6.2 Aims and objectives of the case study

The case study at Metrotown aimed to explore a case of governance failure with a NHS hospital Trust in order to understand the interactions between organisational culture and performance in such an environment. In practise, these relationships were difficult to track given other organisational changes taking place at the site, including two successive mergers, a substantial financial deficit, a turnaround programme, and a successful PFI application that required a radical change in planning for the future of the Trust.

6.3 Policy and managerial context and significance of particular culture change under study

Organisational failure remains a significant area of discussion in policy. If markets are to be used on a more widespread basis in health, as in other welfare areas, then consideration is needed of how organisations labelled as 'failing' are to be treated.

In the case of the NHS, the introduction of the performance management system trailed in the NHS Plan (Secretary of State for Health, 2000), suggested that where Trusts were regarded as being the worst performers in the country their Boards might be removed wholesale and be replaced by those from more successful organisations. A key part of the process by which the changes necessary to take organisations from being regarded as failing to (at least) an average level of attainment has been that of achieving 'cultural change' (Mannion et al., 2005). This requires reorienting the organisation so that its values and goals allow it to achieve far higher levels of performance, and typically that it becomes more externally focused towards its external environment, particularly with respect to its patients. Alongside this, there may or may not be an element of decentralization in which staff are given more space to be creative and entrepreneurial.

Within the competing values framework, a cultural change like that described in the previous paragraph represents something of an anti-clockwise movement around the graphical representation shown in figure 4.1 in Section Four.

Starting with the clan culture, which is typically associated with a health site dominated by a professional, internally-oriented group such as the medical profession, an assertion of greater control leads to a movement toward the hierarchy ideal-type, with the aim of perhaps bringing clinicians under greater control in order to assert managerial values over the

organisation. In the event of a significant clinical incident, as occurred at the case-study site, systems of clinical governance were criticised in the subsequent Healthcare Commission inspect, and resulted in the top-down imposition of a number of new control mechanisms that resulted in the organisation having a strong inward focus in order to address the clinical problems highlighted in the report.

After a movement towards a hierarchy-form, a next movement, in response to initiatives such as Payment by Results and patient choice, might suggest that the organisation needs to take greater account of its external environment, and so become more externally-oriented again. This would suggest the organisation move more towards the 'rational' type organisation in which control is still exerted, but it become more externally focused and begin a process not simply of managing the present, but also planning for the future.

Finally, where the organisation becomes externally focused and governance mechanisms are routinely incorporated into practice, a more open-systems model might be allowed where flexibility is reintroduced and managers are encouraged to become more entrepreneurial than control-focused. Central to much public management theory of the last twenty years has been the demand for public organisations to become more entrepreneurial (Moore, 1997 ; Osborne & Gaebler, 1993), and when cultural change towards this goal is successful, an organisation moves towards this organisational type.

Considering cultural change through the CVF in this form shows a pathway towards the presently desired form of public organisation away from the internally-oriented, producer-centred archetype that is regarded as preventing significant public reform (Barber, 2007), as well as giving an indicator of how an organisation, such as Metrotown, might respond to a clinical incident that requires significant cultural change.

6.4 Research Strategy and Methods

6.41 Sampling strategy

An initial strategy was conducted of starting with the particular site within the organization where organisational failure had occurred. Clinicians, administrators and nurses were interviewed, observations of clinics conducted, and access to the considerable evidence presented to the Healthcare Commission in relation to its investigation were examined. Interviews were conducted in both a formal basis, within the particular specialty at Metrotown, as well as less formally via telephone where interviewees wished to remain anonymous but still agreed to participate in the study.

At the same time as research was being carried out at the specific site of the clinical incident, interviews with senior board members were organised to get an overview of the wider governance problems identified in the Healthcare Commission Report, and which brought to light promising locations (both high and low performing) for in-depth study in the rest of the organisation. Once these sites has been located, senior consultants, nurses and administrators were approached to attain their approval (or not) for studies in those areas and staff who were prepared to be interviewed were approached to find mutually suitable times. Many members of staff, in addition to this, wished to speak confidentially so rang the researcher at specific times to speak confidentiality.

In addition to interviews, observational work took place where the researcher spent a more extended period of time on a ward or clinic watching how staff interacted with one another and with patients. Sometimes the researcher was invited to observe meetings or talk to staff in larger groupings.

Other groups within the organisation were also asked to contribute towards the research in various ways. Representatives of the trade union (UNISON) were particularly interested and were prepared to be interviewed, but administrative functions tended to be less likely to give consent for involved.

In addition, the researcher spent large amounts of time in informal discussions with staff in the hospital canteen, trying to engage staff (once the role of the researcher had been explained) in off the record discussions about what it was like to work in the Trust. These were sometimes followed-up by more formal interviews where both the researcher and staff member wished to talk more.

Interviews at the Trust were in the following pattern

External stakeholders	8
Front line staff	23
Middle managers	20
Senior managers	15
Total	66

6.42 Data collection and processing

Extensive notes were taken after interviews and observations, and where interviewees agreed to be recorded, interviews were taped and transcribed.

In terms of secondary data, reports on the governance failure at the institution were analysed, and the institution's submission to the Healthcare

Commission were read through with notes being taken and key passages recorded onto tape. This material, however, cannot be quoted in the final report as a condition upon seeing material submitted to the Healthcare Commission was a guarantee it would not be recorded here.

Data was also collected by the researcher being given access to meetings at ward level, and observation of board meetings. As well as the researcher conducted informal discussions in the Hospital canteen, where staff were approached, and on guarantees of anonymity, asked for their thoughts on the trust and what was happening there. Again, extensive notes were taken after such discussions. The method followed relied extensively upon these notes not only because they offered a means of extensively documenting events, but also offered a common thread amongst the very many types of data examined (as suggested by Latour, 2005)

6.43 Analysis of qualitative data

From the extensive notes taken during interviews, observations and discussions, material was coded thematically, and where transcripts were available, they were cross-referenced against notes. The themes emerging from inductive analysis were then cross-referenced against one another, as well as compared to analysis derived from the competing values framework to try and achieve some comparability both with other case study sites, but also with the quantitative aspect of the study. This involved examining data in a more deductive way, but is justified on the grounds of achieving additional theoretical sensitivity (Glaser, 1978) for the study.

Findings from the project have been fed back to members of staff within the organisation to check their validity, and concerns of staff in relation to findings taken into account in the final version of the report.

6.44 Description of any specific conceptual framework used to collect, analyse interpret data

Data was coded inductively, looking for opportunities to cross reference findings against the competing values framework where relevant, but also seeking substantive links to other literature on cultural change.

6.5 Cultural Continuity and Change in Sentinel Organisation

6.51 Apparent dominant/espoused managerial/corporate culture

There was no dominant culture at the site. There were significant differences in espoused culture at every level of the organisation, and between specialties and wards. As such, the Trust could perhaps be best regarded as a collection of clans rather than having a single, clannish culture. One theme was that the organisation had come to regard itself as being a victim of NHS reform, and that it urgently needed to overcome this if it was to improve.

Culturally as well….the organisation as a whole I think, if it does have a single culture, has, has a view that it is the victim, that it is done to, that it's out of control, that is doesn't own or share an agenda with any of its stakeholder organisation (Board level manager)

At the same times as this, however, despite its problems, there were still areas of the organisation that regarded themselves, perhaps unjustifiably at times, as being leaders in their field:

I'd say it's an organisation that's by no means as bad as its external reputation is painted, and bits of it are by no means as good as some people internally think it is. (Board level manager)

Early in the study references were made to a split in the organisation between clinical and non-clinical managers, with a separation between the two being in place that created substantial communication problems, and there were allegations being made that this split was deliberately utilised in order to minimise clinical involvement in senior decision-making processes:

I think there's still a, a big divide between clinicians and managers even though our chief exec, who's just left, restructured our management in order to involve clinicians much more in management, and on paper he put a clinical management committee as the key structure before the Board. In practice .. that didn't happen because that committee was large, it took it months to become anything like a committee that actually works and operates, and then more recently .. decisions appeared to be bypassing that committee and power was again being reserved by the exec director team. (Middle manager/clinician)

There was some evidence to support this view. In the pre-history of the case of clinical governance failure in the Trust, several reports had been commissioned that attempted to address the competence of the consultant in the specialty under investigation, but it seemed that not all members of

the Board had seen all the reports, and that the content of the reports had seen an extremely limited circulation. This is understandable as the contents of the reports was sensitive, but needs to be put in a context where it also appeared that the reports had been leaked to the local media, with sections of them being reproduced there.

In terms of the specific clinical incident that began the Healthcare Commission investigation into the site, concerns were expressed that senior clinical and non-clinical managers were not communicating effectively, particularly with regard to the external reports that had been conducted into the already-identified clinical problems at the site, but appeared not to always have been shared by the entire hospital board:

> *I think that, that from the top there was .. a clear message that things should not be shared unless they have to be, to the extent that major committees often, and even after the investigation, did not see full copies of reports, but they might be summarised by an individual for a committee and that's .. I think risky, a risky behaviour for an organisation. .. So I think from the top of the organisation that led a culture of failure to share. I think there are pockets around the organisation who have a different culture and are more likely to discuss things as teams and share things, but I think from the top, from the Board, that was the message that was coming down. (Middle manager/clinician)*

The result of this was that there was evidence of two senior clans at senior management level at the time of the clinical incident, divided between managers of a clinical, and non-clinical background.

The Head of Nursing at the Trust was put in charge of collecting materials upon which the Healthcare Commission Report was to be based, and was regarded universally as being extremely committed and organised. She subsequently took on the role of instigating clinical governance reform at the Trust, effectively overseeing patient safety and putting in place systems for its safeguarding. However, there were concerns that patient safety was still regarded as a peripheral concern by many clinicians at the Trust, and there appeared to be challenges to the Chief Nurse as to who should be responsible for Clinical Governance at the Trust.

> *It can all get very political – not about trying to improve things but instead turn quickly into turf wars. So xxxx is trying to extend his range of responsibilities to include governance, but yyyyy wants to hold onto that when it's really the Chief Nurse's job. (Board level clinician)*

Even though the hospital had come through the process of special measures, concerns were still expressed that it had not really learned from the experience of governance failure as well as it might have done:

> *…this does seem to remain and organisation without a memory- because…various little things come up which were, which are similar to those that were flagged up in the Healthcare Commission report, and one would think that if the Trust were an organisation with a memory and if the Trust were committed to making the changes….recommended by the Healthcare Commission…then there would actually be demonstratable change. I'm not convinced that this has happened, but that's just my opinion (Clinical service lead)*

Given the problem of a perceived lack of progress at dealing with the clinical governance problems of the past, what seemed to be the barriers to learning? As the research continued, two additional clans appeared to be described as existing at board level. The board appeared split between those who wanted to have a more incremental approach to improvement ('traditionalists') and those who wanted to try and achieve more radical, quick change ('challengers'). The Chairman was identified by several members of the Board as being the most radical member of the latter camp:

> *So we have a commercially minded Chairman who comes from, well, you know, if you've got thirty-six subsidiaries and twelve aren't making any money .. close them, sell them, get rid of them. Well it's not quite as simple as that Chairman, you know, we have, we have to deliver coherent services and some of those could become, you know, profitable or whatever. So we're going through that kind of debate at the minute. (Board level manager)*

But views of this type were also expressed by reforming clinicians:

> *if this place ran Ikea, Ikea would be bankrupt. Whereas if Ikea ran the NHS it would be a much better place, thank you very much. (Clinical service lead)*

The tension between the traditionalists and the challengers at board level manifest itself in some staff appearing to regard discussions over who was 'in charge' of particular programmes as a political battle, and not helped by a high turnover of chief executives (the phrase 'ten chief executives in ten years' is much-used). Staff described a need to jockey one another for the Chief Executive's attention, especially in the early months after the appointment of a new one in 2007:

The appointment of the new Chief Executive led to everyone thinking about their position again. She had to quickly learn who she could listen to because they were trying to improve things, and who was just trying to impress her and get more power. Some people around here would walk over anyone to get her attention (Middle manager/clinician)

At the senior management level, the difficulties of the turnaround process were openly acknowledged to varying degrees, with newer board members expressing a desire to leave the past behind as much as possible in order to improve things in the future. They wished to get rid of words that had become labels for bad experiences in order to look to a better future:

But I wanted to eliminate the word 'turnaround' from the language and start to look forward and put ourselves back in control in a more .. in a more stable way than perhaps would be in the future…………… So the words professionalism and pride .. are the two words that I want to replace, you know, turnaround and deficit (Board level manager)

At middle-management level, there appeared to be a split between those factions wanting to try and 'shield' as many of those working beneath them was very present in one discourse, but there was also a cadre of, typically younger clinician/managers, who wanted to try and make the desired changes more quickly. The first group expressed frustration and anger at those in the centre of the organisations for staff cutbacks, especially as a part of the turnaround programme, and stressed that they believed their services were in danger of becoming unsafe as a result, with at least a lower standard of patient service being offered as a result of the changes.

Since the merger we've had to take on patients from xxxx, but we've actually got less staff now than we had then. We're pretty much cutting-edge in terms of what we do, but there's a limit on how efficient you can be before you offer a bad service. And I think we've now cut services to the bone so much that if someone goes off sick we can't work, and that can't be right (Ward clinician)

The second group of middle managers (whom might be termed 'reformers') were impatient of those they regarded as slow to service their needs at the centre of the organisation, with a far more commercial language being predominant and organisational relationships being viewed as inter-connected contracts rather than a unified organisational form. They wanted to move forward with changes that they believed to be necessary to secure both their specialty, and the hospital's future, but were receiving a poor level of service from the centre of the organization

At the 'coal face' or front-line of the organization, on the wards and clinics, views differed widely. Staff directly affected by the programme had experienced considerable disruptions in their career narratives (Sennett, 1999) and often expressed extreme sadness and bitterness. They felt that they were doing a good job, but had been forced to reapply for their own post or be moved on to another area of the hospital, often after a period of considerable anxiety, without any good reason being given:

I remember it quite .. vividly actually. I, the message came from .. I believe, xxxxx, who was the, the manager, was called to a meeting on, one day, was informed that there would be drastic changes to our staffing but not to inform anybody for twenty-four hours. The following day, the matron and two other colleagues came, I don't remember who they were precisely, somebody from finance, I believe, and somebody else, came, and the staff that were on duty that day were asked to go to a meeting in our coffee room. So there wasn't a lot of staff there, by all, any stretch of the imagination, and they were told that there would be a review of the staffing. Our staffing would be cut significantly, somewhere in the region of seven trained nurses, and there was no consultation. It was not a fin, not a financially driven decision .. and that was it. I was on annual leave and I came back to find out my job was under threat. (Ward clinician)

These problems seemed to stretch the support mechanisms of the hospital to their limits:

So it's, it went on, you know, and seeing people who were quite, ward sisters who were used to coping with stresses and strains suddenly turning to nervous wrecks because they'd lost their job after twenty years, you know what I mean, it's not nice to see, ...So they were doing their own job and having to console people who knew them who were being, what they thought were thrown on scrap heap. And whole wards and departments shut that they'd worked together as teams for, in some cases, ten/twenty, longer, then the ward closed and they were just, went all, some might go to one ward some to another, all those teams were broken up. But some people couldn't handle that because it's too big a change to, to put up with. (Ancillary worker)

The PFI build at the site, rising up from a car park on one side of the estate, became increasingly visible to staff as the study went on. It was blamed by many of them for the Trust's problems. The logic of this argument was that the hospital had been forced to make significant financial cutbacks in order to meet the criteria for being granted a PFI, and that the turnaround process was an integral part of cost-saving. However, an alternative narrative had also emerged where the PFI was regarded as being a game between political parties in order to deliberately cause problems for one another:

Anyhow, given that PFIs are a disaster and everyone knows that they're a disaster, given that no hospital is future proof .. given that the .. costs of maintaining a PFI are absolutely astronomical, there is no way that we are going to be able to fund the requisite clinical services because all of our money is going to be going into paying off the mortgage. So Labour says, here you go, we sign on the dotted line, you've got your shiny shiny new hospital, Labour loses the election, Tories come into power, PFI goes belly up, Labour says, we were wonderful, we gave you the new hospital, the Conservatives have just demonstrated that they simply can't manage the healthcare system because we gave them all these shiny new hospitals and they've completely buggered them up. (Clinical service lead)

This seemed to suggest that staff were not engaged in the planning or building of the new hospital, and so were prepared to speculate about its politics rather than looking forward to its completion.

Staff who had not been directly affected by the turnaround process expressed a more generous view, but were still concerned about being asked to take on more work on reduced staffing levels. They expressed the view that the organisation was required to become more parsimonious at the cost of providing good patient service as a result.

Discussions around culture in the hospital seemed to regard it very much as a local phenomenon. Staff were often very familiar with particular areas of the hospital, but not at all with the Trust as a whole. Part of this was down to the rather dispersed hospital site, but also down to people associating cultures with committees as much as departments or clinics. Particular committees were labelled as having particular cultures that were hostile to either increased managerial intervention, or to clinicians, and that these committees had a collective existence independent of the individual people who operated on them, who were often completely different when not in the committee context.

I once went to a, a directorate clinical governance committee ….. Probably about twenty consultants and it was probably a difficult directorate with the characters that are in there, and they'd invited a number of us to go and get them rolling on clinical governance, so there was a series of presentations to make them sort of aware of things like risk management and things like that. .. They just shot people down. .. Really, really rude, and like the general manager, clinical director never said a thing, and presenters really struggled and nobody challenged that behaviour. You know we were there to support them and to help them along and we were just like made to be, to feel like that big….. My exposure to the m, majority of who I work with are very, very supportive of what we're trying to do. It's just culture of a couple of directorates,

you know, they don't learn, they just want to be anti-management. (Middle manager)

The lack of sense of there being an organisational culture of the hospital as a whole could be down to a number of factors. Staff throughout the organisation appeared to struggle with the organisation's name, which did not reflect any of the partners of the mergers, and which referred to a geographical area that did not exist outside of the Trust. Because the new Trust was the result of a merger between three formerly separate hospital Trusts, the new name was an attempt to try and find a new name around which staff could rally and which would demonstrate a new beginning and an attempt to bring together staff from all three partners. However, the new name seemed to upset staff who did not feel sense of ownership with their own Trust as result:

It, oh well we'll lump it together and call it xxxxx. You know xxxxx was a new name, it doesn't exist in any of the history of, the geography or Local Government or anything. So, so I think there was a bit of that. (Board level manager)

The view outside the organisation from those prepared to talk to the researcher in the PCT and SHA expressed a view of the organisation as a 'dinosaur', that it was slow-moving and continually in crisis. They claimed that they were always 'waiting for the next crisis' to happen.

Having said that .. local mythology, and certainly mythology in the health system as a whole, the sort of xxxx health system there's always been a sort of corporate sigh where (Metrotown's) concerned and I, I actually found people doing it in my induction period. Where are you from? Metrotown. Oh yeah (sighs)….. (Board level manager)

Relationships between the hospital and its immediate organisational external stakeholders appeared very poor in the past, but were beginning to improve as relationships between the new hospital chief executive and senior figures outside the hospital improved. However, that relationships appeared to depend so much on individuals seemed to demonstrate a relative immaturity in organisational terms, and was subject to considerable fragility should key staff leave. As Metrotown experienced a considerable turnover of staff at senior level ('Ten chief executives in ten years' was a much heard quote in interviews) the difficulty of establishing trust with senior figures from other organisations, particularly in the PCT and SHA was very apparent.

And so our relationships with PCTs were nonexistent or dreadful .. relationships with the .. Strategic Health Authority lacked any level of trust (Board level manager)

Finally, the culture of the area of the hospital itself was frequently alluded to, with local people regarding the trust as being 'their' hospital, due to it being the largest local employer and so the long-standing relationship manylocal people had with the institution. That the area was not the most affluent in the region added to the strong links with local people.

More of our people live very lo, more of our employees live very locally .. and that has upsides and downsides. When they're our ambassadors it's positive, but clearly when we're putting a lot of people through change, it can be a downside and it can create something of a hot-house environment .. and I think that was a challenge. You know most of the public engagements, and I do a lot, the, the, a lot of public engagement then as now .. around some of these difficulties .. was based on, actually I met a member of staff in the pub and they say this is what's happening, and you, it's very difficult isn't it to say well yeah, but they're wrong .. (Board level manager)

6.6 Nature of culture changes/continuity at different levels/professional groups in the organisation

Both managers and professionals appeared split between the 'guardian' and 'challenger' discourses, but the nearer staff were to patient care, the more 'guardians' were found (although there were certainly challengers at this level as well). Professionals were attempting to find ways of squaring their clinical identities with the changes required of them, but many instead argued for resistance and claimed that senior managers did not understand the situation 'on the ground' that they were having to deal with.

Q: Right. How do you think the service you can offer patients has changed as a result of all of this?

A: I think it's .. it's suffered, we do very well with what we've got, but I feel very angry sometimes that basic things are .. not done, not for the want of not wanting to do them, but we've got so much to do that quite often they get forgotten.

Q: Right. Is it getting better or…?

A: No.

Q: Oh OK. Are there any signs that things may change in the future to, to, to make things better or is…?

A: No. (Ward clinician)

Many nursing staff spoke approvingly of managers above them in the organisational hierarchy who had been able to 'defend' them from changes, and there was a clear sense in the Trust about areas that had been 'most affected' by change. In the latter areas, there was a sense that managers were perceived as being 'weaker' than those where defence had been more successfully organised. There was general support amongst nursing staff for managers who held responsibilities for their general areas though, with an acknowledgement that they were 'doing their best'.

A considerable amount of blame was attached to senior managers for changes to workloads, especially in relation to staffing reductions. Staff appeared to have a complex discourse that acknowledged that significant NHS reform was occurring, but also blamed senior managers at the Trust for the way that they had responded to these changes, especially around the turnaround process that had caused real fear for many staff, and in relation to the PFI, which was the cause of considerable uncertainty in the future. Staff feared that the PFI might be used to further cut-back services, and as a means of attempting further organisational change. As well as this, they often appeared unconvinced that the model as a whole was financially viable for the Trust:

Well we are stuck with it and we'll do us best….but that don't mean to say that we can't show people. I mean if there were all community services provided and in ten year's time they only need half of beds, we'll still be paying for beds for thirty years, that is bloody crazy, absolutely insane (Ancillary worker)

Medical staff at the ward level articulated discourses that were primarily driven by the need to improve patient care – they regarded themselves as speaking for their patients. This discourse, however, led to two different diagnoses that linked to the guardian and reformer positions. In the former version, changes to the organisational had to be resisted because they reduced staffing levels and reduced the standard of service to patients. Doctors expressing this view often became extremely animated and angry in discussions and wanted to 'put the record straight' and 'say what was really going on'.

Well I hope you don't mind confrontation young man because that's what I'm prepared to show over this issue. Those people making decisions have no idea what we have to deal with, and then they come down here asking us to cut back services because their silly reports tell them we have too many staff. Well let them come down here and try and manage with what we have. (Clinical service lead)

These doctors often blamed senior managers for the problems of the Trust, suggesting that they had to work more with doctors in order for the Trust as a whole to get better. Only by working together, and understanding doctors' agendas, could things improve:

Unless they make some attempt to understand what it is we do, and what we need, can we make progress. We do a damned good job and some acknowledgement of that sometimes would be gratefully received, but no, it's always change this, and change that, when they don't even understand what it is we do in the first place (Clinical service lead)

Doctors presenting the reformer view, however, claimed that in order to improve services, significant changes were necessary. These clinicians, who were often (but not always) younger than those presenting themselves as guardians and often (but not always) newer appointments at the Trust, suggested that some of their colleagues had a view of the organisation's past that a little too 'rosy' and that the problems experienced by the organisation demonstrated a deep-rooted need for change that they were disappointed that their colleagues did not always share:

Again it's a generational difference, I think that probably .. anyone that was appointed to a consultant post after the turn of the Millennium probably realised that it wasn't going to be what it is, what it was in the movies, whereas anyone that was appointed before the turn of the Millennium may have carried with them the attitude that I have slogged my guts out for fifteen years and that's it, I'm a consultant now, now I coast. .. So there's probably a slightly different .. understanding of what it means to be a consultant between the .. new kids on the block and the old school …. (Clinical service lead)

6.7 Perceived cultural drivers

A significant criticism of the organisation made in the Healthcare Commission Report on the hospital was that it focused overly upon finance to the detriment of care, but as the hospital had continued to run at a significant deficit, a great deal of board energy had been invested in trying reduce the deficit, especially as the age of the capital inheritance upon the site meant that a new hospital was necessary by everyone interviewed on

the site, and in the contemporary NHS, this means that a PFI was applied for successfully. The PFI application placed an additional stress upon producing a financial turnaround plan that involved significant staff reductions, in many cases through 'natural' wastage, but also through a great deal of redeployment. This created a large amount of uncertainty, particularly amongst nursing staff, and made it clear that significant change was occurring in the hospital.

The PFI initiative has been a strong totemic driver of cultural change in the hospital over the last year, as it physically appears in the car park, and staff are reminded on a daily basis that beds will be reduced upon the move in 2010, and that a higher turnover of beds will be necessary, driving changes throughout the hospital to try and achieve a higher level of efficiency.

The Healthcare Commission investigation was reported extensively in the local media, and its final report communicated widely within the organisation. The impact of the HC report was most felt by senior managers, and provided a means of creating change in some surgical specialties where it was harnessed as creating legitimacy for change.

Past mergers between the hospital site and two other sites have caused significant organisational problems and often an environment of suspicion on the part of all three organisations within the trust, all of whom appear to feel 'hard done by' by the mergers.

> *Well the, the organisation's had a very turbulent past. I guess .. I've described it to staff here as .. as kind of two failed mergers .. in lots of senses, combined with .. failures clinically, financially and from a performance point of view, which obviously led to special measures, but, you know, effectively special measures related to all three aspects of service .. service provision and delivery. ..(Board level manager)*

Attempts to reconfigure the organisational 'centre' as a service department have tried to begin the recast relationships to make senior managers more in touch with the concerns of those as the 'coal face' and to position them more responsively.

The most significant external agendas at the hospital were those that were a part of the performance management system in the NHS, with it being regarded as being important to improve ratings, especially in relation to utilisation of resources, because of the considerable financial problems the Trust had faced. Agendas around patient choice and practice-based commissioning were regarded as being relatively unimportant, with it being suggested that there was as yet little local competition for services, and

that local people continued to return to the Trust regardless of how bad their experience:

> *I mean I've got, I had a ward that was infested with ants .. here, and the fact that it showed no peak in complaints I'm sure is a tribute to the staff, but it's also frankly a poverty of expectation problem that's, you know, genuinely slightly eye-watering.. (Board level manager)*

6.8 Efforts and success of purposive (managerial) attempts at cultural change

The turnaround process has been successful in that it has allowed the hospital to move closer to financial balance, but has created a great deal of tension and uncertainty for those that had to go through the process of redeployment. Many staff are extremely concerned that services have become 'cut to the bone' and that motivation amongst staff is now extremely low, and is leading to a 'silo' mentality

> *you know, we, we are just stripped down to the bare bones at the moment in all services. (Pause) But what moves people into silos? .. It could be that, you know, people have some type of dissonance around what's going on. It's easier to .. not lift the head and look round because it's too hard and they, they are aware that there's some issues, but it's easier not to challenge than to challenge. Cos, you know, it's all around culture isn't it? And if, if they had a very closed culture, and I don't know them particularly, then I can understand why people, you know, maybe don't come out of that silo and sort of take supervision around what's going on or report concerns. (Middle level clinician/manager)*

Cultural change through reconfiguring of central/service departments appears to create uncertainty on both sides at present, with some central departments being regarded as producing poor service by the 'challengers' at middle management level, whereas those in the more 'guardian' roles seem let down that they are not receiving support in all the changes taking place at the trust.

Performance management was a particular concern with the Trust because of the very low ratings it had experienced in the past, and of the negative media coverage they had led to. The most obvious rating that was a problem was in terms of management of resources because of the very significant deficit it had inherited.

The most recent Chief Executive's reaction to these problems has been to try and improve relationships within the Trust and to try and make management more personal and immediate. This had resulted in a change in the way the senior team worked:

And we're all do, we're all doing at the moment .. infection control walkabouts because we've got a problem with MRSA and it's important to be, so, you know, we're, we're, we're kind of leading it from the front and we're setting the direction and we've got the partnership working right and we've secured a bit of money and support for various things from others and there is a sense of confidence now. It's only a little sense of confidence .. a green shoot, if you like, although I .. I'm not sure I want to use that expression. .. But, you know, some people are smiling and the wonderful people that are, are in the organisation will start to pull .. the kind of less motivated with it. .. But there's also been a view for example that if you're not involved in management you've got no power. It's nonsense, a jobbing doc is just as powerful or a, a jobbing midwife as, as I am, you know, in many ways. I mean I carry the accountability, of course I do, but .. they can make a difference, and .. I'll give you an example. I sat in, I did an, an open staff meeting in xxxx last Friday and .. and actually it was, it was one of the more positive ones that .. that I'd done but the, the midwives over there deeply unhappy and .. and they said, well we don't, we don't have staff meetings any more, you know, we don't know what's going on. So well why don't you? She said "Well what are you going to do about it?" I said "I'm not going to do anything about it. What are you going to do about it?" You know this is your responsibility. So the words professionalism and pride .. are the two words that I want to replace, you know, turnaround and deficit or, you know... (Board level manager)

Another change is that the Chief Executive has put in place is of giving publicity to those achieving high standards within the Trust by placing them on the front page of the in-house magazine and highlighting them as 'heroes'. This is still in its early stages of roll-out, but is clearly an extension of the approach outlined in the quote above.

In addition to these changes from the Chief Executive, the Hospital had also gone from having very little internal staff appraisal to nearly a hundred per cent of staff being involved. This was seen as demonstrating that big changes could occur quickly, and that change was possible:

…and there were three things that were…very important about that. One that it was an organisation-wide thing. The second was that we have set ourselves the goal of doing better than we'd be told to do, and I think that was very important, and the third was that we, particularly my team, learned something about change and what works in the organisation to achieve change (Board level manager)

6.9 Facilitators and barriers to planned culture change

Managers described in 'Guardian' roles above believed that the changes to the hospital have been poorly handed and un-necessary and express considerable anger towards them. They were concerned about the effects of

the turnaround process on the clinical professionals that they worked with, and believed that this was damaging the care offered by the Trust. The danger of this is that it resulted in a disengagement from management processes, and a preference for looking to the past as a time when things were better. This reaction was described by a senior Trust manager in the following terms:

I guess we've got some .. not extremes, but, you know, there, there are, it seems to me that .. we are very traditional. So traditional will be a factor that, you know, inhibits, I don't know, inhibits change maybe, we probably display that quite strongly. .. As I say, I think things like a lack of, you know, effective clinical involvement and engagement in management probably means that the medical profession, in particular, still .. still has and certainly perceives that it's, it is the power base, the world, you know, is orientated around them rather than their part of something bigger. Talked, you know, mentioned sort of Trade Unions and I think, you know, they're .. they're very strong and extremely traditional in their views. .. Years and years of fixes and fudges rather than dealing with the fundamental issues, you know, we, we've probably gone through ten years of change in two years and that's been an incredible shock (Board level manager)

The internal focus on the Trust was also a factor of the perceived lack of internal pressures coming from initiatives such as Payment By Results and Extending Patient choice. One senior manager suggested:

Equally, at the minute, to be completely frank, we're so flush with demand that more of our conversations are about how we can .. constructively decline .. patients than anything else. (Board level manager)

6.10 Unintended and dysfunctional consequences of culture change.

The biggest danger that appears to have resulted from the changes at Metrotown is that of cynicism amongst the staff, who believe that they have now been through so much change that they no longer wish to co-operate. This symptom has been presented in the literature as a reaction to too-much reform or 'redisorganisation' (Smith et al., 2001). This view was summarised by senior manager:

But there was a, a staff survey done I think last winter, just before I arrived, possibly February/March time, and one of the questions,.. I think something like fifty-eight or sixty percent of staff or even more in some

parts of the Trust said that they wouldn't recommend their service to their family and friends. Well you can't have that ..., this lack, lack of control over your own destiny, this lack of professional pride, so what I'm trying to do with staff is not make them feel valued by telling them we value them cos, you know, they kind of (laughter) they kind of sit at you, look at you, shake their heads and walk away, you know, sort of another load of NHS management bollocks, they're just not interested. But actually demonstrate .. that we do by listening to their concerns, taking their advice about the future and, and thinking it through carefully, and that takes quite a lot of time. (Board level manager)

A more systemic concern that came from the Trust's need to develop a financial plan to address is deficit is that it tended to lead to a strong internal focus, and to criticisms (not least from the Healthcare Commission) that it was becoming too concerned with finance at the expense of other areas of Trust operation. There was a danger of self-perpetuating cycle of deficit leading to cut-backs leading to disaffection and potentially further governance problems coming from working with a reduced staffing base. This is further expanded upon in the conclusion to the report.

6.11 Changing relationships within and between organisations

Between different levels of the hierarchy

At Metrotown, the senior management are located in a building that is physically separate from the rest of the Trust, giving a sense to many working within the hospital that this geographical separation also leads to a lack of communication and understanding. Access to the administrative building is via a telecom system, instigated after a stabbing there a few years ago, but which adds to the remoteness, for many staff, of those residing at the 'top' of the organisation. The Chief Executive's attempts to get 'out and about' more often were received generally well by staff, but also with a little concern as they were not used to being in contact with those in senior management positions. They also suggested that it was 'easy for her' to come and talk to them, but that they were subsequently 'left to deal with the problems anyway' when she left (Sister, Cardiology).

Between different professional groups

Doctors are more likely to be guardians at the Trust, but they also made up a considerable entrepreneurial presence at middle management level, albeit

one that was becoming increasingly frustrated by the lack of ability of the 'centre' to respond to their needs. This was most often expressed in terms of the lack of support the Centre was prepared to give to them when they were attempting to create change:

.. I'm, I'm very much aware of my place within the organisation, I'm also very much aware of how much the organisation is prepared to support me, I'm also very much aware of how much I'm prepared to tolerate the organisation either supporting me or not supporting me because ultimately it's my life as well, you know. (Clinical service lead)

Staff at the Centre did seem to recognise that they were being cast increasingly in a role to 'service' clinical directorates, but were still struggling to work out the implications of that change:

So the discussions I'm having with my team are, you know, we have, everything we do we have to start to demonstrate what's our value, what is our added value, cos if we can't demonstrate that then, you know, clinical directorates are going to be saying, well don't want you, thank you very much. (Board level manager)

Across inter-organisational relationships

There has been a poor relationship between the Trust, the PCT and the SHA in the past. This was expressed in terms of difficulties with personal relationships (not least because of the continual change of Trust Chief Executive) but also because of the poor way that the Trust was regarded locally. This was exacerbated by the (apparent) decision to place the deficits within the local health economy all within the Metrotown budget:

So you can see why the decisions were made, because of the reflection on that, although I know the individuals that were involved in those times and I suspect they made what they thought was the right decision for the right reasons at the right time. So that, that, that has set up the relationship badly .. and because I think the PCTs were perceived to have .. been complicit in that .. that that set us up in terms of a failure of trust. But I think, you know, that Metrotown didn't help either because it then disappeared down a, down its own dark hole (Board level manager)

This was not helped by the perceived emergence of 'macho management' at the SHA:

I recall a, a wonderful meeting with SHA which .. they said "Do you know you're turnaround programme is just not going .. far enough or fast enough" I sort of said "Right, OK. Happy to hear that. Show, show us the numbers from other organisations and we'll work out which ones to go and talk to. We're always keen." "We haven't got any numbers from other, any other organisations" (…). "How do you know where?".. and, and you realise that the Emperor's got no clothes, and actually it's, it's a shambles, and, and that sort of, I, I mean I would regard that as unprofessional, and we, we would have regarded our turnaround programme as extremely professional in the way in which it was conducted. ….. (Board level manager)

Relationship did seem to have improved since the appointment of the Chief Executive in 2007, although all sides acknowledged that there was still some way to go.

Outside of the immediate health economy, a similar problem of 'macho' management also seemed to be coming from the Department of Health:

someone from the Department of Health said "Shut the xxx tomorrow". I said "What do you mean, shut it tomorrow?" "Yeah, shut it tomorrow" and I just thought that, that's not actually intelligent remark, that's just kind of silly, male .. testosterone type stuff that's not helpful, and is actually what I'm trying to protect the organisation from, not because I don't think the organisation needs a lot of change. I think the organisation needs phenomenal change, but because you're gonna lose all credibility if this process becomes a sort of .. idiots head-banging boys' club type things as opposed to something else. (Board level manager)

All of this, perhaps understandably, had a tendency to encourage the Trust to focus inwardly rather than attempting to deal with this kind of message from external stakeholders.

6.12 Changing performance within the organisation

National performance measures

The Hospital has been graded poorly in national performance measures for the last few years, but this doesn't appear to matter in the local health economy because of the loyalty of local people, and the perception that demand for the Trust's services remains high:

> *I think, my understanding is that the actual impact of that and payment by results is on financial mechanism, choice, patient choice really being the, the consumerism bit, my understanding is that we, we and the NHS hasn't seen a great impact on patient, of patient choice, it's at the margins at best. So people still want to go to their local hospital and.. you know, there weren't, despite increasing availability of statistics on mortality and all those things, people still went, it wasn't a discerning factor. So, in that sense, I think we, we've kept our customer base, if you like. .. (Board level manager)*

The most recent performance indicators for the Trust (October 2008) do show an improvement, with services rated as 'good' and use of resources as 'adequate'. The Trust does appear to be turning a corner, but how fragile this improvement is remains to be seen.

Softer measures of performance

There is a sense of which units within the Trust are the best performing, and which are not.

> *I, I think there are examples of really good practice probably across most areas, but what they're not necessarily, they're not necessarily consistent and, and embedded in terms of the way they naturally make culture of that part of the service. I think it's still too dependent on the charisma of individuals that may be around to, to apply that, that kind of approach. .. But yeah, those, there are examples right across the Trust but it isn't yet an innate, innate response. (Board level manager)*

As such, despite having a clear idea of who were the good practice areas, it appeared difficult to institutionalise such behaviour, it was regarded as being dependent upon 'charismatic' individuals. As the Trust slowly improves as a whole though, there is a sense that newer members of staff are beginning to make their present felt, and that that 'guardians' within the hospital are losing out to them.

6.13 Changing cultures, relationships and performance across the local health economy

As noted above, relationships in the local health economy in the past have not often been very positive. The local media have published a number of extremely negative stories about the hospital over the last ten years, the PCT is perceived as being content to run a surplus while the hospital

struggles for funds, and the SHA as having little idea what is going on. The Trust has been viewed in the past, because of its clinical governance problems, as something of a 'basket case'. However, things do seem to be improving as personal relationships between the leaders of the various organisations become closer (helped by several figures who did not get on with one another retiring or leaving). This does raise the question of whether relationships between the hospital, the PCT and the SHA can continue to improve on a sustained basis should the leadership of these organisations change again – something that is a strong possibility with the average tenure of NHS Chief Executives as being only three years.

6.14 Summary and Conclusions

Charisma versus control

Interviewees stress successful governance strategies being based on the need have strong and robust control systems in place. Improvement, however, often comes from charismatic clinicians taking a lead and developing services. This sometimes results in unorthodox behaviours (taking over buildings and finding money to renovate them, for example). The tension here was in considering when entrepreneurial behaviour (challenging the status quo, embracing the new) could be considered dynamic and exciting, and when it is instead it was eccentric and subversive.

The failure of clinical governance at the site was often directly attributed to an eccentric clinician who challenged the hospital hierarchy. From there, interpretations differ. Sympathetic views suggest the clinician was right; the service needed capital investment and although his methods may have been unorthodox in raising them, time has shown him to be correct (the charismatic prophet). Unsympathetic views suggest his behaviour was unreasonable and un-self critical, and his lack of ability to engage with hospital managers, particularly the clinical director, created a downward spiral of trust until there was no alternative but to suspend him (the outsider, or scapegoat, out of control).

The organisational hierarchy and the clinical hierarchy

For over forty years healthcare as been described as a 'negotiated order, where both clinicians and managers have organisational hierarchies (Strauss et al., 1963). This was very apparent at the Trust. Managers appeared to have attempted to utilise the separate clinical hierarchy by creating a clinical executive team that have their own meetings and their own representation, but which does not link into the organisational hierarchy in any meaningful way. Clinicians were given their own executive body, but one with no executive powers. In contrast the hospital boards was described as being separate and rather secretive. It was a closed body

that isolated itself from the rest of the organisation and, with a couple of exceptions in its membership, was largely insulated from it.

The main problem this tension led to is that, when a dispute appeared, reports were often separately commissioned by different bodies within the organisation which appeared not to know about each other's existence. Major clinical incidents were investigated several times, often with different conclusions, and no one single account allowed to dominate. This might be regarded positively in terms of multivocality and diversity, but represented a real problem as those managers who knew about the differing accounts did not know what to believe, especially where clinicians had a very different account of events compared to the board.

Guardians versus reformers

The clinical/non-clinical split did not apply in all situations however – some clinicians appeared happy to be cast in the more traditional role of 'guardian', but others wanted to reform services and expressed frustrations that the pace of change was so slow, and that they were not getting what they believed was adequate support from the centre for trying to change their services.

The importance of good communication

There were accusations that the hospital board was a rather secretive body (refuted by a couple of its members), and made closed decisions without sufficient consultation. This led to many members of the trust expressing understanding of those that chose to leak details of the trust's difficulties to the media. Even though leaking was not regarded positively, it was, according to some interviewees, legitimate to make the 'truth' known, and to allow 'ignored' figures the right to speak.

This sense that the Trust was secretive, and that various members of the organisation were briefing against it in the local media, led to a break down in trust. Negative feedback loops appeared to be established so that messages from the board were not trusted, or negative spins placed upon them, and only 'bad' stories carried any credibility within the trust. A lose-lose situation.

Many staff within the Trust hoped that, when the HC report was finally presented, it would solve this situation by giving the 'true' events, but were disappointed to find that ambiguity persisted and that no single series of events was endorsed. This seemed to leave trust employees dissatisfied and unable to 'draw a line' under the past.

The new Chief Executive was trying to overcome concerns that the Board are isolated from the impacts of their decision by 'getting about' and by using the hospital magazine to communication more openly.

Continuity and change

The biggest area of change within the Trust remains staff turnover. The organisation particularly struggled to retain its Chief Executives. My 'temporary' employee badge carries the signature of the CE two before the current one. This CE was replaced by an interim figure (a former clinical director), who has now been replaced by another manager. This occurred at a time where the Trust has been singled out as one of the worst performing financially in the country (after coming close to being encouraged to apply for FT status in 2002/3) but has also managed to attract one of the largest PFI builds in order to consolidate its two mergers around a new site.

At the same time as all of this change, many figures in managerial roles remain still in post. There is a sense of resignation and 'brittleness' at times. Resignation in that the constant turnover of CEs has not made strategic planning possible, especially as the organisation's persistent financial problems have put the organisation onto the back foot. Ever since the Trust was allowed out of special measures, it had significant financial problems, and a story of 'cutting services to the bone' predominated. There was a sense of reactivity rather than looking to the future. 'Brittleness' came about because many managers didn't believe they have done much wrong – the problems came from the merger and the inheritance of under-performing organisations from it, along with government-imposed budgetary systems that work against the Trust. Managers often felt that they had inherited problems that are not of their doing, but now had to bear the consequences.

Culture as changeable and local versus organisational culture

Culture is often described as being very locally constituted. Committees had cultures, especially where they have long-standing members who expect to be able to behave, in that forum, in a particular way. Managers described wanting to avoid some clinician-dominated committees where clinical behaviour was described in an animalistic fashion ('wolves'). There is a strong sense of collectivity amongst some board members ('us'), especially those that had worked through the Healthcare Commission investigation and came out the other side. This collectivity is perhaps the flip-side of the secrecy others seem to associate with some board activity.

Culture was local in the sense that it was the charisma (or lack of it) that drove the clinical team process and makes improvement possible.

Organisational culture at the site was an amalgam of the high and low performing clinical teams, the various committees and the other associational and service groups within the Trust. Many within the Trust reported the culture of their own part of the organisation as being representative of the whole, even when it differed significantly from what the next service down the corridor is doing. There is a sense of shared destiny with 'there but the grace of God goes us' being a sentiment in relation to clinical incidents, but at the same time a belief that some individual services were genuinely of very high standard.

The single unifying cultural factor was that of the Trust as 'victim', and it was taking a considerable amount of energy to refocus the Trust into a more positive frame of mind.

Performance management versus persecution

Performance management can be very instrumental when it is entirely based on the meeting of externally-set targets. At Metrotown these targets were regarded increasingly resentfully by managers at the Trust who suggest they are being 'singled-out' by inspections because of the reputation of the site. Managers who were not a part of the difficulties leading to the Healthcare Commission inspection are particularly resentful of this, believing that their organisation was not being fairly treated. There is a sense that the organisation is sometimes being 'persecuted'; it had been through special measures and come out the other side, and now should be left alone to regroup a little rather than being subject to continued external harassment. Performance was gradually becoming a little more progressive in some areas with talk of 'raising our eyes' to deal with new challenges such as patient choice and the new healthcare economy.

Clinical leaders are not clear how performance is to be communicated to the commissioning world. They believe that their services are good, but are concerned about negative press coverage. They believe however, that 'their' patients have good stories to tell in the local community, and that referrals will keep coming. There have been recent attempts at 'good news' stories from the trust to try and turn the tide in marketing, with celebrity launches of new facilities. Media coverage, however, remains rather schizophrenic with very negative stories being followed by very positive ones (around, for example, the launch of the new service) with little attempt at coherence.

Culture and performance

The most predominant form of culture at the Trust in terms of the CVF is perhaps that of the clan, but this metaphor still doesn't really work as well as Handy's 'power' culture. In this treatment a strong central figure directs all around him or her. The Trust often feels like a series of power cultures (the board, the service directors, individual committees), organised around strong individuals, but with less communication or communication between those individuals than is needed. The clan metaphor was appropriate in that the professional background of the central figure is often central (although it is not always the case), but does not really capture the importance of particularly figures in the governance problems in the trust. Individual seem to have supporters who work around them, but with individual 'webs' not really communicating to one another as smoothly as it seems can be achieved in other organisations. The hospital infrastructure does not help with this – the Trust is a very odd, flat, diffused building, and the continued existence of separate sites after merger means that, unless previous practices are consciously changed, then pre-existing power relationship have often remained. This factor, however, will clearly change when the new PFI hospital opens.

In terms of the CVF, the Trust appeared to be trying to move from a clan formation to a hierarchy, but there was little evidence of the external focus that would lead it on to a rational-type organisation. The move from clan to bureaucracy had come about by a concerted attempt by senior level managers to exert greater control over the organisation both as a result of the clinical governance failure, but also because of the significant financial problems the Trust had experienced. Clinical governance, especially in terms of patient safety, had become a higher priority as a result of the Healthcare Commission's investigation, but still appeared to be implemented rather unevenly because of the persistence of strong feelings against the process in some clinical-dominated committees, wards and clinics. The main instrument for trying to address the financial deficit was the turnaround process, which had been successful in getting the organisations onto a sounder financial footing (with it moving towards a break-even position), but at the possible expense of alienating the large numbers of staff who had been through the redeployment process.

Performance remained a problem at the Trust because of a lack of co-ordination between the various power cultures. Some managers have crossed boundaries to try and drive up standards and improve performance, challenging existing power relationships and low performance at the same time. However, they expressed frustration at the slow pace of change and the lack of support from HR in dealing with individuals (especially doctors) who were not willing to embrace the changes they believed necessary. Clinical leads often talked about their colleagues in a way that is far ruder than managers talk about clinicians.

Culture is linked to performance in that, where performance has been driven up, it is often due to managers and clinical leads being able to successfully challenge working practices that appear to be based more on habit than evidence. Rotating clinics (between the three merger sites) had been used to break up old working practices, but clinical leads suggested that colleagues not willing to come 'on-board' now need to face disciplinary action where persuasion has not worked. Performance improvement, in that last instance, appears to depend on the threat of disciplinary action – where cultural change is not possible through embracing new ideas and services taking greater collective responsibility, the threat of clinicians losing their job is deemed necessary, but at present not forthcoming. One progressive clinical lead became so frustrated at this lack of support he resigned, believing it was not possible to take the changes he was working on any further. He was dismayed at the lack of the support 'from the centre' – he wanted to behave as an entrepreneur but was unable to because of the lack of some of his colleagues to embrace change. This clinical lead put this lack of willingness to change down to the personal self-interest of his colleagues, and their lack of concern for service improvement.

Culture for improvement is therefore equated with freedom of local managers to achieve organisational goals in new ways, but expecting support from the centre to get rid of those not willing to go along with new agendas. Performance is defined in terms of service improvement, which in turn is linked to getting contracts from increasingly further afield. However, clinicians were unclear as to how PBCs or PCTs outside of their immediate area got to hear about how good their services were except through 'reputation', with no clear idea of how reputation was spread except through individual patients going back to their GPs with good experiences.

6.15 Policy implications from the case study

Downward spirals and how they might be reversed

A metaphor for the problems the Trust appears to have experienced might be that of a 'downward spiral', in which clinical governance and financial problems have led to managers having to impose very transactional systems upon the organisation, increase the amount of internal controls, and attempting to overcome problems by being far more interventionist. This has led to middle-level managers expressing resentment of central interference in their jobs, and nurses and doctors often being extremely angry at staff reductions and programmes of redeployment that they believe have been handled badly. This might be thought of the move of a clan-based organisation to one that is more hierarchical, but which reduces trust within the organisation as it becomes more rule-based instead – or moves from what Klein described as from a system based on trust, to one based instead on contract (Klein, 1993). This leads to greater resistance from disaffected staff, and potentially for the centre to want to get more

involved at operational levels of the organisation again – a potentially destructive spiral downward in which performance suffers as managers have less space to manage, and where staff feel increasingly demotivated.

The new Chief Executive is attempting to break this downward spiral by forming closer relationships within the Trust by visiting wards and clinics more than has often been the case at the past, as well as rewarding good work done the hospital by awarding it publicity in the hospital magazine and awarding prizes for it. The Chief Executive is trying to restore trust between the administrative centre of the organisation and its wards and clinics by spending more time with staff in their places of work, and by trying to get staff to take responsibility for the delivery of their own services and backing them with the authority to be able to change things there if necessary. This means she is trying to make the organisation more externally focussed and create an environment where improvement is self-sustaining rather than having to be driven by the centre.

The difficulties of considering organisational culture and performance at an NHS Trust

A clear link between culture and performance at Metrotown is difficult to establish as culture appears so fragmented and performance such a contested topic within the Trust. There is a sense that the financial problems of the Trust have been the result of strategic decisions that the Trust had little control over, and an interesting area of future research would be examine whether it is the case that particular health economies in particular areas did, in fact, attempt to consolidate their deficits in the early 2000s by placing them in hospital Trusts. Several board members have, in informal conversations with the researcher, suggested that this might well have been the case.

It is hard not to imagine that the considerable instability at the Trust coming from its clinical governance and financial problems have led to a sense of fragmentation, a more insular outlook at the organisation, and to a belief that culture remains a very local phenomenon. The organisation's victim mentality will take a considerable amount of time to overcome, but its year-on-year improvements in measured performance are going some way to dealing with this. This raises the question of whether, when organisations are labelled as 'failing' in some way, whether insularity leads to culture becoming more fragmented, and to the danger of downward spirals discussed in the section above. How this spiral can be broken is of even greater importance.

The lack of continuity of leadership at Metrotown is another significant factor in its problems. If the present Chief Executive stays at the Trust, this may begin to address this problem as a consistent and coherent message can be communicated in a way that has not been possible in the past. Future research that addressed the link between the length of tenure of organisational leadership and performance seems to be appropriate – is it the case that long-standing leaders are more credible?

In the local health economy, relationship still seem very fragile and based on the efforts of leaders of the organisations to cooperate more than has been the case in the past. However, this does raise the concern that, should the leadership of organisations change, then there is potential for the problems of the past to re-emerge. Research considering the dynamics of local health economies in terms of the relationships between senior managers could therefore be fruitful – do health economies function better as a whole when local managers have good relations, and are able to openly discuss problems and share strategies?

7 Managing Organisational Change in a PCT

SUMMARY

Smalltown Primary Care Trust was established in 2002 in the North West of England. It serves a community with high levels of deprivation. The PCT is pursuing a strategy of integration of health and social services. This is credited by the PCT with saving money and improving performance.

The PCT and the local council have improved performance on nationally measured indicators of quality and resource use in recent years. Unlike many PCTs Smalltown was not merged with another PCT as part of the reconfiguration of PCTs in 2006. Interviewees credit the PCT's progress on integrated working with the local council as an important factor in helping maintain their original boundary.

Maintaining the PCT boundary was seen by PCT staff at various levels as important in taking forward the integration agenda but was also seen as a recognition of their progress on joint working and performance improvement.

Alongside the pursuit of integration, in response to national policy directives, the PCT has been required to create a clear split between its commissioning and provider functions.

The relationship between these developments (maintaining the PCT boundary, closer working with the local council and splitting the PCT between commissioning and provider functions) and both cultural change and performance improvement is complex.

- The 'can do' developmental culture is credited as contributing to the success of the integration (of health and social care services) agenda
- Over time there appears to have been a shift from this developmental culture towards a more rational cultural context, particularly within the provider arm of the organization
- This shift appears to be have been driven by the need for provider arm services to compete with other providers and a greater focus on performance targets across the organization more generally.
- A question arises concerning the extent to which it is possible to harness the benefits of both 'rational' and 'developmental' cultures particularly when performance is measured in different ways by different parts of the same organization and policy drivers to 'split' the organization and standardise services make it difficult to sustain traditional narratives of unity and spontaneity.

7.1 Introduction

Aims and objectives of the case study

- The aim of this case study is to understand how the integration of health and social care and the split between commissioner and provider arms of an organization affected the nature and dynamics of culture in a Primary Care Trust (PCT). It also explores the relationship between organisational culture and health care performance across the whole health economy.

  Investigating changes which create pressures both to integrate (with regard to health and social care - a long term local policy) and to split (commissioning and provider arms - a relatively recent national policy) provides a way of exploring the PCT's culture and its relationship to performance across the health economy. Whilst joint working between health organisations and local government partners has been a long standing policy, the extent to which it has been actively embraced by PCTs varies. The ambitious approach of moving towards integration in Smalltown means that the challenges it faces and organisational responses to them, may have less resonance in PCTs where joint working is much less developed.

7.2 Policy and managerial context and significance of integration and separation

PCT functions are:

- To commission a wide range of health services for their local populations

- To engage with partners, patients and the public over the planning and delivery of local health services

- To provide high quality and effective health services.

  Performance is assessed in a variety of ways. The PCT is subject to an annual health check by the Healthcare Commission. In addition to national targets, there are also local priorities and performance measures. For example, Local Area Agreements area agreed between central government and a local area (the local authority and Local Strategic Partnership) and other key partners at the local level. These national and local indicators are intended to make organisations responsive to local healthcare needs.

We investigated a PCT which is at the same time integrating (health and social care) services and splitting itself into commissioner and provider functions. Some background information is provided in Box 7.1.

Smalltown PCT serves a district in England that is highly deprived according to the Index of Multiple Deprivation. Historical under-funding and health inequalities were being addressed by the injection of considerable investment.

As part of the CPLNHS process, a 'fitness for purpose' review was undertaken which drew attention to the need to create a clear split between the PCT's commissioning and provision functions. This process had commenced at the time of the 2007 interviews, with staff taking on changed roles and accountabilities. It has performed well on Healthcare Commission Annual Health Checks.

Most of the PCT's executive directors and its chief executive have been in the organization at senior level for many years.

Box 7.1: Background to Smalltown PCT

Smalltown PCT's health economy is described in Box 7.2.

Primary care services are provided through a wide range of routes including walk-in centres, GP surgeries, dentist surgeries and mental health and acute hospital services.

In addition, the integration agenda means that the PCT works closely with the local authority to provide and commission services. Services are provided across Smalltown and beyond.

In addition, local GPs are involved in commissioning care as part of the Practice Based Commissioning arrangements.

The PCT is not the lead commissioner for any acute trust but works with a number of acute providers across the health economy.

A key partner is the local authority whose boundary is coterminous with that of the PCT.

Box 7.2: Organisations in Smalltown's health economy

Performance improvement has been given greater attention following recent changes as described below (Box 7.3).

Performance for PCTs is measured in a number of ways. PCTs are judged on measures which relate to services they provide and commission as well as broader indicators which relate to wider determinants of health.

For PCT senior managers, integration was viewed in itself as a key measure of success. However, the CPLNHS 'fitness for purpose' review identified a need to pay greater attention to external performance indicators such as those included in the Healthcare Commission's annual health check.

Historically, measures of performance and contract currencies for 'community' services (e.g. district nursing, health visiting) have been slower to develop than those in acute service settings. However, due to the policy of market testing greater attention is being paid by staff employed in these settings to quantitative measures of performance.

Box 7. 3: Background to performance measurement in Smalltown

7.3 Research Strategy and Methods

This case study uses semi-structured interviews with internal and external stakeholders in two rounds separated by twelve to fourteen months to investigate changes in organisational culture, relationships within and between organisations, and the performance of the health economy, during the process of integration and splitting.

We obtained a range of perspectives by including interviews with a wide range of stakeholders. Two rounds of data collection were intended to allow investigation of developments over time.

7.31 Sampling strategy

First round interviews were carried out in 2007. Second round interviews were conducted a year later, purposely selected to ensure that a diverse range of participants were followed up. A disproportionate number of senior managers were followed up, reflecting the importance of a relatively small cadre of people (Executive Leadership Team) in defining and implementing both the organisational goals and its wider approach to work. External stakeholders came from a variety of organisations, including the local hospital trusts and third sector representatives. In both years, very few front line staff were recruited to the study and difficulties recruiting front line nursing staff meant that though accounting for large numbers of PCT employees, very few of these staff were interviewed.

Table 7.1. Interviewees

	April/May 2007	April/May 2008
External stakeholders	5	1
Front line staff[8]	12	5
Middle managers[9]	27	7
Senior Managers[10]	13	8
TOTAL	57	21

7.32 Data collection and processing

Interviews were conducted face to face at respondents' places of work, or at PCT HQ. For the first round of interviews, staff were asked to describe their role and the organization. They were also asked about changes impacting on them, how their PCT compared with their experiences of working elsewhere and key challenges they faced. These interviews were relatively loosely structured since the intention was to elicit a wide range of information and to avoid imposing a prior framework (e.g. specific views about or definitions of 'culture') on the participants. For the second round of interviews, a set of questions was identified with the intention of using it in a reasonably structured fashion [see Appendix 1]. All first round interviews were read carefully and a summary of the issues was noted on each participant's sheet. Each second-round interview began with a reminder to participants of the main contents of their interview a year earlier. Initial questions focussed on the extent to which any major change had occurred since then and then specific issues were explored using the interview guide as a prompt. It was immediately apparent that it would be inappropriate to ask all the participants all of the questions, so an attempt was made to focus on the areas most appropriate and of most interest to each participant. Although scheduled to last an hour, interviews varied in length from 45 minutes to an hour and a half. Interviews were audio-recorded and transcribed in full. Transcripts were checked for accuracy and completeness.

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[8] nurses and other clinicians

[9] staff below director level with significant management responsibility

[10] non-executive and executive and other directors

7.33 Analysis of qualitative data

Data were analysed thematically. Atlas.ti software was used to code data, with codes created using the project case study template. To preserve some anonymity quotations are labelled as external stakeholder, front line staff, middle management or senior management (Executive Leadership Team). Participant ID number is given first, then interview round.

The competing values framework was used as part of the process of exploring organizational culture once data had been collected. As outlined in Section 4, this framework conceptualises the organization's internal processes, and its relationships to the outside world.

The case study was drafted and discussed extensively within the local project team. Case studies were regularly shared and actively reviewed across the wider research team, leading to fruitful insights, extensive amendments and widespread improvements to the text.

7.4 Cultural Continuity and Change in the PCT

7.41 Apparent espoused culture(s)

The competing values framework questionnaire offers respondents a series of descriptions of an organization arranged in five groups of four. Within each group respondents are asked to 'share 100 points' points between them according to 'which description best fits your organization'. Collating these points provides a score for each individual on each of four cultural subtypes (clan, developmental, hierarchical or rational). The largest score on each cultural subtype defines that individual's *dominant* culture type. (See Section 4)

From our qualitative data we sought to identify statements made by PCT staff and other participants in terms of these four cultural subtypes (clan, developmental, hierarchical and rational).

In the first round of interviews many participants described the PCT in terms compatible with the 'developmental' quadrant of the competing values framework (creative, adaptive, leader as risk-taker, emphasis on innovation etc). For example, Smalltown was described as having a 'can do' culture

> *I'd say it's a forward looking service. I'd say the approach is to use a cliché, it's a 'can do' service (Middle Manager) [41-1]*

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there is very much a can do culture and we do find ways around things. … staff on the whole can feel quite empowered so people are given the opportunity to innovate. And I think that does cut across both aspects of the organisation, as a health and a social care provider. (Middle Manager) [19-1] a can do culture … nothing's impossible ….this commissioning provision split .. we're walking through fog and all I know is we're holding hands together and we'll come out the other side, so I still feel a bit fuzzy but I don't feel on my own… we do foster a culture of, 'We will, we will do it' (Middle Manager) [18-1]

The comments above about walking through fog may reflect the sort of fluid structures which the PCT appears keen to promote.

lots of ambiguity around here, we thrive on ambiguity. (laughs) …the kind of people we attract to work here are people who relish that kind of ambiguity, you know, they're not seeking certainty, they'll be very very unhappy and we have lost people along the way. … the PCT and Health and Social Care in its broadest terms, are creative and imaginative and innovative and, and that we reward innovation. (Senior Manager) [45-1]

However, despite losing 'people along the way' most of the interview participants reported feeling comfortable with this state of affairs and described the PCT as a supportive organisation. It is also (according to participants) a place where risk taking is encouraged and innovation flourishes.

the PCT care about the staff … they put a lot of time and effort in making it easy for people. You know, they give things to help people who are caring for relatives as, you know, they give money to help for respite care. There's lots of things that they do to help staff which I don't hear about, you know, from people in other trusts….we don't have a huge movement of staff, so they must like something . (Front Line Staff) [16-1]

I think it's a lovely place …I've never felt as supported as by an organisation as what I have when I've come here really. .. it's very relaxed and it is family friendly. I lost my mum last year, she was quite ill beforehand and they were absolutely fantastic, it was sort of 'don't worry about work, go and look after your mum, don't even let this worry you,' you know? And that was fantastic (Middle Manager) [44-1]

In addition to the integration agenda generally, examples were provided to illustrate Smalltown's openness to innovation and willingness to test out new ideas.

not that necessarily that we're perceived as, the trust that are getting it right all the time but as a trust that are trying different things. (Middle Manager) [19-1]

the chief executive, both here and in borough council think it's a great idea and want to run with it [idea for service development]....that's quite challenging for any organisation to adopt any idea like that. Which at the moment isn't really formulated and needs a lot of work. But they can see it and they want to put energy and resources into developing it. And I think that says a lot for an organisation if they've got the confidence to do that, and they've got the systems in place that will allow it to happen. (Middle Manager) [39-1]

However, the willingness to let staff run with initiatives or roll out ideas which as the quote above has it 'at the moment isn't really formulated and needs a lot of work' may be interpreted in a negative light by some people as an example of knee jerk policies whose impacts are never evaluated that a small number of critics highlight.

In the second round of interviews this innovative, developmental approach was still strongly espoused, although the need to attend to external performance criteria and demands was fully acknowledged and increasingly important. The challenging local health and economic characteristics and a positive history of distinct local solutions provided both a rationale and support for the organisation's strongly and distinctive self image. Collective solutions were sought for local challenges, but there was no sense that these solutions were either to be found elsewhere or could be exported to other contexts.

In a context where national policy directives may encourage the adoption of mechanistic and standardised processes of the sort associated with rational cultural types, Smalltown attempted to maintain its emphasis on spontaneity and flexibility.

as long as we can 'Smalltown'-ify it I think … as long as we don't have to follow this very, very set formula then I think that's a good way forward and we are working on that. (Senior Manager) [48-2]

these so called Darzi practices …. Smalltown decided at the very early stages of that, that the procurement route that they were proposing would not work in Smalltown … they've now accepted that we can do things differently… procure it more effectively, more efficiently and importantly, quicker, but still maintain the quality of the whole process. (Senior Manager) [50-2]

7.5 Presence and nature of different sub-cultures (including counter cultures) and their values and beliefs within the organisation

Despite the positive descriptions of the PCT given by most participants, there were a small number of dissenting voices in the first round of interviews.

they just get to sign a piece of paper and a post's created.. there's no scrutiny of what goes on, and I'm not saying everything should be governed by committee, but there's no rhyme or reason… it doesn't feel like there's clarity of purpose here… it almost feels like that, you know, "Stop doing that, we all need to do this, all run to the front of the ship, now all run to the back of the ship" (Middle Manager) [22-1]

During the first round of interviews, there was some evidence that people working in the provider arm viewed themselves as having specific needs and challenges with regard to the contestability agenda. By the second round of interviews, there was some evidence that the provider arm were beginning to see themselves as in need of special or different training or support from that traditionally provided within the organisation. They had independently commissioned some management development from an external provider, bypassing their own HR department.

Some participants distinguished between social and medical models of care and these differences were also seen as reflected in people speaking different languages.

it's just very, very different perspectives on how we, how we come at it in terms of our patients, or they call them service users. (Middle Manager) [43-1]

Some interviewees in health roles thought that social services had taken over, while some with a social services background saw the organisational changes as a health take over. Both nurses and social workers perceived themselves as flexible and service-user/patient centred (in contrast to the 'other lot'). Health was characterised as unhelpfully hierarchical, in contrast to the more adaptable social service approach.

The competing values framework classifies cultural types according to the extent to which organizations adopt mechanistic as opposed to organic processes and the way the organization positions itself with regard to the

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outside world. Several people identified a difference between 'health' and 'social care' cultures in both sets of interviews. (Similar distinctions have been reported in other studies[11]). Whilst on the surface this distinction may not lend itself to neat categorisation according to the CVF quadrants, one interpretation is that clinical risks and responsibilities may limit the extent to which flexible and spontaneous (developmental) approaches can be adopted wholeheartedly by staff delivering health services. Instead, more mechanistic and standardised approaches might be adopted.

'Protectionist', 'isolationist', 'reactive', 'stifling' and 'controlling' were terms used to describe PCT culture.

> *… people in the senior management team haven't got to the stage where they can let go .. people on the senior management team who are immature …I mean their experience of managing people, managing change and the type of things we are working with is limited and until you've had that kind of experience and you've got the confidence in yourself, you won't let go. (Middle Manager) [42a-2]*

In the second round of interviews, staff in the provider arm of the PCT seemed to have been most affected by changes towards more business-like approaches following on from the pursuit of the contestability agenda. Various elements of the provider arm of the PCT had tendered for service provision, not only within the PCT but in neighbouring trusts and these tenders had been unsuccessful ('although we've been very close to being successful' Middle Manager 19-2). There was some evidence of differences of opinion with regard to the contestability process. Integration is seen as a central plank of service delivery, but pressure for contestability had brought about some perceived separation. It is likely that senior managers would

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[11] Richardson, S. and S. Asthana (2006). "Inter-agency information sharing in health and social care services: The role of professional culture." British Journal of Social Work **36**(4): 657-669.

Peck, E., Towell, D. and Gulliver, P. (2001) 'The meanings of "culture" in health and social care: a case study of the combined Trust in Somerset', *Journal of Interprofessional Care*, **15** (4), pp. 319–327.

Hiscock, J. and Pearson, M. (1999) 'Looking inwards, looking outwards: dismantling the "Berlin Wall" between health and social services?', *Social Policy and Administration*, **33** (2), pp. 10–163.

Johnson, P., Wistow, G, Schulz, R. and Hardy, B. (2003) 'Interagency and interprofessional collaboration in community care: the interdependence of structures and values', *Journal of Interprofessional Care*, **17** (1), pp. 69–83.

Mackay, L., Soothill, K. and Webb, C. (1995) 'Troubled times: the context for interprofessional collaboration?', in Soothill, K., Mackay L. and Webb C. (eds), *Interprofessional Relations in Health Care*, London, Edward Arnold, pp. 5–10.

characterise this as integrated separation, but those closer to it felt it more as separated integration.

> *it's actually, three organisations, effectively…we've got social care and PCT and the provider. I see it as three aspects of a related organisation, but the relationships are changing. There is no doubt about that now. (Middle Manager) [19-2]*

Nurses, district nurse in particular, were seen as a group who felt particularly challenged by the organisational changes, with some cultural differences within the organization reported as being problematic and deep seated.

> *Social Services and Social Workers have different criteria as to what's urgent as what we see as urgent. They have different sets of, we have a code of conduct, … theirs is different from ours and what they would see as a duty of care might not necessarily be the same as ours. So it is difficult …it's completely different cultures .. we are trying to work together more closely, being integrated just in offices has helped .. but there's still that culture there, there's still a different culture. (Front Line Staff) [07-2]*

Therapists were aware of changes occurring around them, not only in their own organisation but in the neighbouring Trusts (both PCTs and Acute).

> *the main kind of concern is …contesting for business … more demands to prove that you are doing what you say you are doing and reaching targets set by people to kind of prove that you are doing the job and that you're value for money basically. …. that still is a big area of concern for everybody within our department. (Front Line Staff) [14-2]*

7.6 Perceived cultural drivers

7.61 Commitment to the local community

Health inequalities and public service values were uppermost in most senior and middle management accounts. Rather than drawing attention to the barriers to health improvement, the senior management team insist that aspirations for Smalltown residents should not be reduced to take account of the low base from which the PCT is starting.

I feel about being set targets, well you have to be measured … in what you do and, and I don't object to … to targets at all and we want to be very ambitious for the people of, of Smalltown and we want them to have life expectancy and quality of life … which is as good as the rest, the rest of the country. That's what we exist for. (Senior Manager) [54-1]

In addition to motivating staff to 'aim high', this line of argument can also be seen as part of a process of deliberately downplaying narratives of deprivation, which may hamper the PCT's attempts to transform Smalltown.

we don't celebrate deprivation in the way that, that Smalltown used to … that was the way of attracting resource … we try to reposition Smalltown to be a place where people do want to come and live and work and do business and … unfortunately by celebrating that you're the most deprived area, you know, in the country, if not the whole world, just to attract resource is pretty short sighted strategy but we've all done it… It becomes a story. (Senior Manager) [45-1]

Although many people reported a commitment to work-life balance this at times appeared at odds with the long hours worked by staff at middle and senior manager levels. These onerous work schedules were reported as driven by the need to improve local services and outcomes.

7.62 Partnership and integration

The emphasis on partnership, with external organisations was also recognised by external stakeholders and espoused by PCT staff.

their top team is a kind of can do team…. very flexible and the chief executive… the leadership there sets that whole scene. .. we consider Smalltown as a key partner to us and it's a partnership rather than a stakeholder… there's no airs and graces, there's no sort of attitude struck… the culture, I think, is, is top rate…. when it says it's going to do something it does it. (External Stakeholder) [5-1]

[Resistance to partnerships?] Not within Smalltown you never encounter that because of the leadership [Chief Exec], but also from the Chair of the PCT and the leader of the Council, they all speak the same language, "Partnership matters in Smalltown." We've delivered great things; we want more things from it (Senior Manager) [56-2]

7.63 Contestability and competition

The contestability agenda was changing relationships and structures as well as attitudes to service provision within the PCT during the research. Clarity and unity of purpose amongst the 'senior leadership team' was noted and appreciated, not just by senior managers but by staff at all levels. However, amongst staff in the provider arm, the emphasis on performance measurement and contestability contrasted with the policy of integration and unity espoused by senior managers.

> *I don't think there's any harm in having one single provider, if that provider can deliver a multitude of outcomes to suit need, and can work effectively with commissioners. Separating them at arm's length, taking your PCT provider arm and putting it separate, is artificial for me… You don't have to be separated; you don't have to be competitive, entrepreneurial. So we're even shifting into expecting providers to become entrepreneurs. Sorry, that's a model that doesn't sit well with me; it doesn't sit well in social care or health care. (Senior Manager) [56-1]*

Whereas previous research links 'rational' cultural types to senior management approaches and performance[12] the irony is that at Smalltown, moves towards more 'rational' approaches were being driven by staff lower down in the PCT. In turn, the responses of these staff were driven by the external national policy drivers for in-house providers to compete in the evolving healthcare marketplace. At the same time moves by provider arm staff which involved increased performance measurement and control *within* the provider arm, were combined with a language which emphasised flexibility and spontaneity compared to the rest of the PCT and with regard to the external environment.

One interpretation is that the contestability agenda and a culture where staff have felt able to innovate and take risks have enabled these participants to feel comfortable with setting the pace for change. In the first round staff reported feeling empowered due to the clarity, unity and support provided by the executive team, though some tensions were evident between the unity and integration narrative of senior managers and the requirement for in-house providers to compete for services. The line taken by PCT directors that contestability involved in-house providers demonstrating value for money (a 'weak' version of contestability) was at odds with national policy directives which emphasised competitive tendering in the marketplace. In some second round interviews, there was further evidence of tension. In some cases staff appeared to see their executive

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[12] Davies, HTO. et al. (2007) Exploring the relationship between senior management team culture and hospital performance *Medical Care Research And Review* 64; 46-65.

team less as providing leadership and support than as potentially holding back changes seen as essential for survival.

> *we're automatically becoming more entrepreneurial … we are pushing on doors to see if they're open at all times as a provider now and challenging our execs and our commissioners and our social care senior colleagues to say, "You need to allow us to do this. You need to allow us to tender for this outside service or enter into this partnership with another organisation" … challenging our execs to say, "You need to give us the freedom to be completely entrepreneurial. If we grow and flourish and survive, so do you" (Middle Manager) [19-2]*

The Human Resources department saw themselves as working in partnership with managers, trade unions and directly with the staff themselves. Though there was also evidence of moving towards more formal, less spontaneous ways of working in recognition of the demands of the contestability agenda.

> *we're investing some time in developing guidance or protocols to support managers … building some HR capacity amongst management colleagues, because we have got challenges around the sickness and absence levels across health and social care .. our managers . have had to respond to either external tender applications … or loss of in-house provision to other organisations …we've developed guidance and worked with managers and developed their awareness about things - developed checklists (Senior Manager) [51-2]*

The growing centrality of commissioning to some aspects of work was perceived as creating a business focus where none had previously existed. Whilst competing for services and a greater emphasis on demonstrating performance placed provider arm staff under greater pressures, some pleasant surprises had emerged from reviewing services, such as acknowledgment of the value of existing service (by GPs of district nurses).

> *It's [commissioning] talked about all the time. I think that's why we're looking now at the business processes now, we are actually collecting data… to show that we are providing the service that the commissioners want us to provide. (Front Line Staff) [07-2]*

7.64 Survival and recognition from external stakeholders

As part of the CPLNHS reforms Smalltown's ability to preserve its original boundary was seen as recognition of its success in integrating services across health and social care. However, the feedback given to the PCT as

part of this process was that rather than resting on its laurels, or claiming the success of Smalltown's 'unique' way of working as self-evident the PCT needed to make more rapid progress to justify its status. Future survival was not taken for granted. Instead the integration agenda was pursued with vigour. However, there is a risk that discussion of problems related to integration is taboo and constructive criticism, which may help tackle such problems, is suppressed. In other words, the open and innovative culture may only be open and innovative with regard to certain proscribed policies and ways of working.

7.65 Smalltown as 'lucky'

The issue of survival not being taken for granted and the need to demonstrate progress in order to maintain control of one's destiny is also linked to specific benefits enjoyed by the PCT compared to neighbouring PCTs. The fact that Smalltown's boundary was unchanged following the CPLNHS reforms appears to have helped in avoiding the turbulence experienced at other PCTs as part of the CPLNHS process. Furthermore, the PCT has benefited from increased resources in recent years. Due to historic underfunding the PCT has been a financial gainer, which means that it has enjoyed a healthy, balanced financial position and avoided some of the problems experienced by other NHS organisations, arising from the need to tackle financial deficits. These factors mean that motivating staff may be easier, since staff compare themselves favourably to other organizations characterised by turbulent change. However, in a context of organisational and financial stability, PCT staff are aware that the requirement to demonstrate progress may be greater in the short term because of these added advantages compared with neighbouring PCTs. Additionally, there is a recognition that people in other PCTs may be watching enviously and waiting for Smalltown to fail that may motivate staff at Smalltown to succeed.

> they're very jealous in lots of respects… I mean my impression is we have a good reputation out there as an organisation. As I say like with that come people are always possibly waiting for you to fall then aren't they? (Middle Manager) [30-1]

During the second round of interviews, there was much greater stability in local PCTs, as well as generous financial allocations which may mean that PCT staff may not continue to feel lucky compared with their counterparts elsewhere.

7.7 Purposive (managerial) attempts at cultural change

There was a constant emphasis on integration and closer working between health and social care throughout the research period. In the second round of interviews, continuity with the past was emphasised, particularly by senior managers, although change was a consistent feature of that past. As outlined above, staff within the provider arm were keen to drive change in response to the contestability agenda, in some cases challenging what they saw as the slow pace of change adopted by senior managers.

The increase in momentum in relation to commissioning was apparent in the second round of interviews, with structures and processes being developed to engage with professional groups and to address service delivery issues. At the same time, some senior managers did not see this as a deliberate policy aimed at changing culture.

> *have we in the past year deliberately set out had a maybe a strategy around changing culture? not any different to how we envisaged this should be some time ago, although we've reviewed our approach as I say, at our executive leadership timeout, at our management conferences and our staff communications events and board time out, then there's always the opportunity for people to comment and therefore for you know, us to make changes, so I hope it's been a dynamic process as opposed to 'and this year we will do this' (Senior Manager) [45-2]*

However, the denial of a structured 'and this year we will do this' approach is at odds with the PCT strategy which specifies the progress to be achieved in each year for the period 2005/06 to 2009/10. Additionally, other senior managers reported changes which might be interpreted as attempting to change culture. So that although managers espouse commitment to spontaneity and flexibility, the freedom to act flexibly is confined to acting in a way which is consistent with the aims of the senior management team.

> *it's shifting and each individual's perception of where they are and where they're going, and then making sure that you shift another individual's perception into the same direction, and gradually you'll get all the individuals with a shift of perception. … if somebody consistently says, "No, that's not for me," they have to leave and I'm more than happy to find an alternative for them, because you can't be held back, the job is far too challenging too demanding to have one or two people in a team who say, "Oh no sorry I can't be bothered with that." (Senior Manager) [56-2]*

Furthermore, whilst senior managers emphasise processes and structures, amongst provider arm staff there was a focus on performance and

outcomes. This performance and contestability environment was seen as being more of a challenge for some services than others.

> *I'm fortunate to have inherited a portfolio of services who… have always understood the paramount importance of high performance. If I take the allied health professional services, the majority of those services were transferred into the PCT in 2003 and have operated within a service level agreement and a performance framework since then, so a lot of the language that is very new to community providers has been in our vocabulary since 2003… that's not to say that there aren't some of those aspects of those services that are further behind than others, but I think all my managers recognise that things have to change. (Middle Manager) [19-2]*

Following service review, district nursing was seen as specifically in need of a more 'managerial culture', with the change in emphasis for team leaders away from clinical work. This was not necessarily attractive but it was perceived to be having an impact.

> *Yes. I think we are having to be more businesslike and be a bit more business managers, and that is having to be, I'm having to pass it on to my team you know, and say, "You have to collect these figures. We need to do this a certain way because we are a business". And it's getting your junior members of staff on board with that. They are slowly coming on board, whereas I think eighteen months ago, two years ago they thought it would never affect them. (Front Line Staff) [07-2]*

At the PCT various actions could be interpreted as attempts to both create and sustain cultural change, using a wide variety of mechanisms including 'thank you sessions', improving working lives, investors in people, active engagement. There was also investment in communications, not only within the organisation. However, the emphasis here was often on unity and integration rather than the splitting of provider and commissioner functions.

The view that the provider arm was running ahead of commissioners was reflected in the language of the different groups of staff. Borrowing market vocabulary, therapists talked about having a service to 'sell' but perceived that PBC had not yet developed sufficiently to actively buy it yet. Active steps were being taken, using a website, to 'market' the service. A mixture of premises were used (schools, primary care resource centres, children's' centres, hospitals) and the main customers or purchasers for some services weren't necessarily within primary care or even health, but could be in education, for example. Whilst rational approaches which emphasise control and standardisation may characterise this new more formal approach to service delivery, there is also a need to respond flexibly to tailor approaches

to different customers and service locations, which is more characteristic of the developmental CVF culture type.

Management training had been undertaken by participants in the provider arm of the PCT and it was perceived as beneficial. Providers had worked with both internal allies and an outside organisation to enhance their business culture (business planning, marketing, tender development, financial development and other issues). (Middle Manager) [19]

Yes. I did. It was really good, and I suppose it has, I suppose, if I look back and reflect on the things I said twelve months ago, I think I am a step further now, thinking about the business processes now and how important it is. (Front Line Staff) [07-2]

New 'health and social care' workers had been created to discharge a more combined duty – integrating previously separate organisational responsibilities. This was causing problems for workers with a social care background but very positively viewed by older auxiliary nurses who paradoxically perceived it as a return to earlier ways of working, before nursing became more specialised and medicalised.

a lot of our older auxiliary nurses are actually quite keen to take on those roles again, because they're the type of things they like to do. Because, whereas, over the last five years we've been taking bloods and blood sugars and they might do monitoring of chronic disease and that wasn't what they were used to doing. Now we're going back a little bit or doing a bit of both. Most of our health workers are loving the role, but we seem to have a problem when we recruit from social because they don't like the health part of it. (Front Line Staff) [07-2]

7.8 Facilitators and barriers to planned culture change

Although the PCT is undergoing considerable change, various factors have contributed to stability, which appears to have provided a receptive context for other changes.

7.81 PCT Configuration

Unlike most other PCTs, Smalltown's boundary was unchanged following the CPLNHS reforms. This appears to have helped in avoiding the turbulence experienced at other PCTs as part of the CPLNHS process. The decision to

leave the PCT boundary unchanged appears to have been interpreted within the PCT as an acknowledgment of its success, giving morale a boost. It may also encourage staff to work harder since results may be expected sooner rather than later, for PCTs which have not experienced decision paralysis due to the disruption caused by reconfiguration.

> *the fitness for purpose exercise .. we thought we came out of that fairly well, not smug, but again endorsed in what we were trying to do. But what it did demonstrate to us ….was go further, go faster. You've got resources, you're, you're well set up now, be even more ambitious. So we on the Board and in leadership roles, have tried to convey that to staff and the Chief Executive [calls Chief Exec by first name] in the staff communication events "I'm asking you now to go the extra mile, we're doing well, you're doing well, you are all great, let, let, let's, you know, stretch ourselves, put, push it a bit more" …It's absolutely the opposite of being smug and complacent because the needs here are huge and we have by no means solved the health problems. .. we want everybody, including ourselves, to be, to be stretched. (Senior Manager) [54-1]*

7.82 Financial Position

The PCT has benefited from increased resources in recent years. Due to historic underfunding the PCT has been a financial gainer, which means that it has enjoyed a healthy, balanced financial position and avoided some of the problems experienced by other NHS organisations, arising from the need to tackle financial deficits.

> *it's certainly meant that the organisation's had the opportunity to invest, and clearly in that situation it's been much easier to get things changed and sorted than if we'd had no money whatsoever, like some PCTs have had (Senior Manager) [47-1]*

> *I think that's helped because if you've got that sound financial basis you can stop spending all your time worrying about the money and balancing the books and get on with, with delivering services (Senior Manager) [54-1]*

7.83 Commissioning Role

The PCT is not a lead commissioner for any of the acute trusts which are the main providers of hospital services to Smalltown residents. This, coupled with its healthy financial position, means that it may be cushioned from the difficult negotiations which characterise relationships between some commissioners and providers.

The financial position also appears to have helped in terms of working with local Acute Trusts on the national move to shift services out of hospital and closer to patients.

They're very pragmatic, again that's another word I would use in terms of the sort of the way they do business. What they've said to us and what we've agreed is in principle, if we have either our practitioners out there at their primary care resource centres or we train their practice nurses and develop skills for GPs and as long as the governance arrangements are secure so the parents do believe they're getting a [names acute hospital] level of service, even if it's not delivered by our own people here, then they've said "You keep the activity, you keep the income".. Now some PCTs ….are saying if, if you want to come and work in our facilities, fine, but we keep the income. And it's quite a perverse incentive then. (External Stakeholder) [5-1]

Whilst such an approach might help provide stability of income for local trusts, whether paying for hospital services which are delivered at further cost to the PCT represents good value for money is another matter.

7.84 Collaboration

Interviews were conducted with representatives of one local acute services trust, one children's hospital trust and a local foundation trust. In addition a provider from the voluntary sector was interviewed. All reported cordial relationships with the PCT and tended to describe it as innovative and friendly

I'm sure if we went with a problem they'd be as helpful …Well they've been really, really great, really enthusiastic… they've put money in to different bits so that you get an overall service. I mean, and they, they've also listened to what we've said about what our experience has been and they, they have, they, they've put in, investing money into finding out more (External Stakeholder) [4-1]

Generally speaking relationships have always been very good with Smalltown PCT. … In terms of other impressions they're always competent. If they say they're going to do something it generally happens. So you know from a trust point of view we've never really had any major problems. [Foundation Trust] (External Stakeholder) [3-1]

7.85 Changes to pay structures

Agenda for Change (AFC) has impacted on pay scales and performance measurement for almost all PCT staff. The first round of interviews was

conducted in April and May 2007. A report published in 2006 found that the implementation of AFC had created uncertainty and contributed to a lowering of staff morale across the NHS.[13.] However, in Smalltown, members of staff interviewed appeared relatively happy with the outcome of AFC.

I think as a Trust we did well from talking to friends and colleagues in other areas I think we did well out of it (Front Line Staff) [15-1]

I think, that people have actually come out of it quite well in terms of their previous gradings. (Front Line Staff) [11-1]

I think we've, we tackled Agenda for Change very well and national staff survey that's just come out seems to evidence that our staff are broadly quite happy with the outcome. And that's not by accident, there was an awful lot of hard work and our staff side have been amazing, staff side Chair, and all of her team, have moved mountains and I think because we had a very … participative hands on staff side and they've been very open to work with us, that's made a real difference. (Senior Manager) [50-1]

Some staff suggest that this is because the healthy financial position enabled the PCT to be generous with staff salaries. If this is the case, then demonstrating value for money or competing for service provision contracts (depending on how contestability unfolds) may be more difficult.

having to compete with other non-NHS providers who are not bound by agenda for change, who can pay what is locally acceptable… that is going to cause us problems (Middle Manager) [19-1]

7.86 Openness to innovation

As outlined earlier, participants' descriptions of the PCT resonated with the concept of a 'developmental' culture (creative, adaptive, leader as risk-taker, emphasis on innovation). The willingness of senior management to embrace innovative approaches to delivering services (from whatever source or philosophical approach), accompanied by a stubbornness when they believed outcomes would be threatened by the rigid implementation of (usually central government) initiatives appeared to be an important

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[13] MORI Agenda for Change Research Study Conducted for the NHS Trade Unions 2006.

http://www.rcn.org.uk/__data/assets/pdf_file/0008/78722/003096.pdf

facilitator of change. This willingness to innovate and adopt flexible approaches on the part of senior management also appeared to filter down the organisation.

I'd say it's flexible, and it's a very positive environment to work in. I think one of the areas I've been very fortunate in developing the service has been from the outset it's attracted people who want to make a difference. And are willing to work in flexible ways and to test boundaries, to try and develop services that are more service user focussed (Middle Manager) [41-1]

7.87 Size of the PCT

Being a small PCT appeared to be both a facilitator and a barrier with regard to change. Being small enabled the PCT to be 'faster moving' but at the same time placed limits on its capacity to deal with some issues.

it gives them [larger PCTs] that flexibility in that capacity we don't have here. And that's our single most difficult issue at the moment is capacity, everybody is working flat out to do what we're doing here and something new comes along, an opportunity, we can't go there. (Senior Manager) [56-2]

[Moving from a large acute trust to the PCT] has positives and negatives .. those teams came over into the organisation … we didn't always have the answers for things. Everything tended to be covered with a policy or a procedure within the hospital..[The PCT] didn't have the level of sort of vertical infrastructure. And because it's a smaller faster moving organisation things like its human resources, and finance, and training, and clinical governance facilities are smaller. … I think it has imposed a degree of rigour within some of those support services that perhaps wouldn't have developed as quickly if those teams hadn't come over … in the converse it has actually improved the sort of local empowerment, self-management and skills development for local team leaders quite considerably. (Middle Manager) [19-1]

7.88 Infrastructure and capacity to support contestability and integration

Whilst the split between commissioning and provision in terms of job titles and accountabilities had been achieved, on paper at least, by the second round of interviews, concerns were expressed about the infrastructure to support these changes and the delivery of the integration agenda.

I come back here [PCT] for computer access because at the [Local Council base] I've got no access because it's on the Council system and I can't get a password... I mean I've been at [council base] for two years now and nothing's happened and it's not just me, the Physiotherapists are obviously the same and the Nurses so they know it's a big issue (Front Line Staff) [15-1]

IT systems that were discrete for health and social care respectively were seen as serious and persistent obstacles to seamless assessment and care. These were causing particular problems for the provider part of the organisation. In some cases staff perceived that these were issues that needed to be resolved by the PCT. In others, barriers were seen as beyond the PCT's control.

the PCT and Social Care released some significant project resource …to develop our specification for that and to look at whether we could take that out to the market place. I think at the moment there is still ongoing work around basically persuading the Strategic Health Authority to allow us to do that … that's been really about trying to get some definitive answers from the Strategic Health Authority in order for us to move ahead. (Middle Manager) [19-2]

A lack of administrative support and the non-computerisation of records were perceived as serious practical barriers to more business process approaches. There were issues raised about the capacity (staff and skills) of the provider arm to address the new more competitive situation they were in. Finance staff involved themselves very deeply in long term service planning decisions. This was viewed as giving some clarity for all concerned. Operational managers and finance managers were aware of each other's constraints and timescales, which suggested a degree of 'joined up' communication. Logistical problems were identified as an obstacle to integrated working – buildings were planned but as yet had not materialised, causing some temporary service location issues.

7.89 Staff perceptions of and attitudes to change

The novelty of scrutiny and the need of the service to demonstrate its worth (as part of the contestability agenda) were identified as being very different from the preceding culture. Whilst they were not necessarily resented, resistance to change by some long standing, nominally senior supervisory staff were identified as barriers to change. In some cases, staff simply refused to consider different ways of working.

although they were senior members of the team, they never saw their role as a supervisory role. They never looked at monitoring quality or getting involved in PDPs or supervision….I don't think we were ever businesslike. I think you just went out there, you just did it, and nobody ever asked you to justify what you were doing. ..this is public money. .. they pay a lot of money for that service and it needs to be fit for purpose... I don't have a problem with that, but nurses have never had to think of business processes before and we weren't trained to, I wasn't trained to be a manager or a business manager. (Front Line Staff) [07-2]

Senior managers perceived that some staff were defensive and negative (qualities that were perceived to have no place in the 'can do' organisation) and the view was expressed that such people would not be tolerated in the long term.

7.9 Unintended and dysfunctional consequences of culture change.

The perceived success of the organisation had attracted other sections of the local authority to lobby to join in the more closely integrated style of working. This may not have been intended, but was not necessarily dysfunctional either.

But it just shows the benefits of how we've worked and I think the staff themselves both at managerial level and relatively junior level in leisure and culture wanted to come to Health and Social Care. That's the clear message we've picked up, it wasn't just a, "Oh well, we'll move them over there," there was a very positive lobbying to be part of what we've got here. (Senior Manager) [50-2]

There appeared to be several unhappy outcomes of the current changes towards more business-like structures and processes. It was clear that not all changes were perceived positively. In the second round of interviews, some people were unsettled and expressed resentment, suspicion and cynicism, very little of which had appeared in the interviews a year earlier. A lack of understanding of management processes and decisions was also reported. Specific criticisms were levelled at recently changed (newly commissioned) services. The process of commissioning and the outcome (impact on service delivery) were both questioned. The simple speed and number of changes led one manager to point out the frequent need to emphasise the importance of new policies and procedures, to the detriment of his relationship with his team.

Yeah, you have to escalate things; you know it's funny escalating things always leaves a bad taste. (Middle Manager) [43-2]

So I just wonder who makes these decisions and there must be a hidden agenda, it just seems, it just feels not right…… I mean they do 'involve' us in inverted comma's, but it feels like the decision has been made and they're not really consulting us they're telling us. .. in this new world of commissioning, if things are put out to tender and our team doesn't have the expertise to put together a really good bid you know, and fight hard to keep it that, somebody else could get it. (Front Line Staff) [06-2]

Staff described being hampered by the scale and pace of change, which prevented optimum service delivery and led to some tokenistic actions. Whilst PCT directors are seeking to promote unity and collaborative working, some staff were perceived as seeking to pass responsibilities on to others, rather than work together.

Yeah. I've not had enough time to consult and discuss as I previously would have liked, and maybe morally I feel like I owe a duty to the user at the end of the service, and trying to undertake negotiations sometimes with organisations who don't consult and having to keep coming back and setting up some sorts of mechanism to consult, I feel like I've paid a bit of lip service to it sometimes instead of doing it properly. (Middle Manager) [18-2]

I think it's for us to drive sometimes and sometimes I don't think we have enough time to be able to sit down and work with them to drive forward what it is we want to do. Because one of the things I find is that everywhere wants to do less of what they are doing and transfer some of what they used to do onto somebody else. …we are all looking to somebody else, Health look to us, we look to the voluntary sector, I don't know who the voluntary sector will be looking to. (Middle Manager) [42b-2]

A representative of one of the bigger professional groups identified the anxiety levels within the smaller teams following the unsuccessful internal bid for a particular service.

..the [names] service.. why did we lose it? Did we not tender it properly? and I think they have learnt some lessons from that. So it is quite an anxious time for staff (Front Line Staff) [08-2]

Middle management was aware of the challenges associated with managing change in an environment where staff were anxious and defensive.

we have attempted to make this a very inclusive process. We've tried to … adhere to good change management principles around this in terms of recognising the shock and awe that will hit in the first instance. .. the sort of mourning and grieving which we need to get through and there is some of the denial phrases and then work with champions to take things forward …. there is a slightly bleaker feel to things and I think that has had an impact. … the senior and first line management teams are now very clear about how they have to squeeze performance out of their teams and where they are not willing to do that, that's where we've hit on problems (Middle Manager) [19-2]

7.10 Changing Relationships Within and Between Organisations

Between different levels of the hierarchy

Since the first round interviews a big change had been the development of clearer relationships between the provider arm and the commissioning structure and processes. The PCT senior management wanted to offer integrated services but also wanted the best services, and found these two issues in conflict here. Whilst managers in the commissioner arm were relatively phlegmatic about this, staff in the provider arm were not unaffected. An example was given of a clear gap between the PCT senior management team's perception of staff involvement and the staff's actual experience of consultation, which suggested a gulf between senior PCT managers and front line provider arm staff. Perceptions of pettiness were reported, with attendant consequences for morale in some professional groups and implied worsening of staff/management relations.

I'm a bit wary of saying anything, you know because people are being disciplined for really daft things and you know it's affecting morale. (Front Line Staff) [06-2]…

New recording systems had been introduced, providing clearer management information, but at a cost to staff in terms of time and work priorities. One person characterised the old system as taking 'two minutes' and the new one perhaps an hour or more a day. There may have been

some exaggeration, but there was felt to be a different approach to doing and recording work, with staff further up the hierarchy perceived as having little appreciation of the effort involved in new ways of working.

Between different professional groups

There were various changes to service location and delivery during the study. Many of these involved the co-location of health and social care staff, in line with the process of integrating health and social care provision in the borough. Arrangements for integrated teams across PCT provider services and social services reflect this joint approach with managers drawn from health and social care respectively managing teams of staff from health and social care aspects of the service. This is an ongoing process which will see further co-location of services. A team working with older people in the community is seen as one of the most advanced services, in terms of integration.

Most PCT employees were highly supportive of the integration agenda.

People who work here generally I think find it fulfilling, because they're working across professional boundaries. If you were to go out there, you know, you'd only have to take ten steps and we're from a social worker to a therapist to a GP to a pharmacist (Middle Manager) [41-2]

Although many recognise that the reality may fall somewhat short of the rhetoric.

we're an integrated team and I find it frustrating, purely from an operational point of view, that we, we don't even have one system of managing information, of sharing information, so here we are, on the one hand fantastic vision, yeah, brilliant, but then on a day to day basis … sometimes you're just bashing your head against a brick wall. (Middle Manager) [34-1]

Things like supervision processes are much more about, 'these are the things that I am asking you to do and have you done them, and why haven't you done them?' Whereas, within the PCT supervision is much more of a supervisee led process. It's not that it can't involve performance management if you're identifying problems but it's.. seen to be much more of a supportive… helping them to become more reflective practitioners … those sort of cultural elements are quite different (Middle Manager) [19-1]

Whilst problems with information systems and premises were seen as issues that could be resolved over time, tensions concerning risk management and a duty of care, were less amenable to resolution, although staff reported progress in terms of a greater shared understanding of these issues.

a difference in view about clinical treatment.. sort of medical model of care as against a support and long-term support sort of model.... there is a certain amount of history that's being carried forward from various people, from the different backgrounds. And clearly that has an impact. (Senior Manager) [47-1]

In Social Services … the ethos and the culture's really difficult. … … say somebody's got an older person who's maybe partially housebound, who's got a leg ulcer, so it's tiny but otherwise she's relatively okay and she's diabetic, they would say that she would need maybe a bit of shopping… take her to the day centre once a week. Health would say, "If that leg ulcer deteriorates, she's diabetic, she's gonna end up with an amputation, she's gonna lose a foot," it's very different, treatments needs and in some ways they'll never agree on the package but we have come a long way I think in trying to understand (Middle Manager) [18-1]

However, a small number of staff were sceptical about the integration and even amongst supporters of integration there was some recognition that two cultures, a social care or council culture and a PCT culture were in existence.

integration is an interesting concept. But I'm not quite sure it can actually work, inasmuch as, how can I put it, two very different cultures, social services, and the PCT, two very different cultures. If you're trained in, in health, and you think like a healthcare professional, that's the way you are. To learn about a new, a new culture, and adapt to it, and incorporate it, sometimes it's not as straightforward as you think. (Middle Manager) [43-1] the integration has been patchy ….. it's only Social Care making the running, it's only Social Care being motivated and, you know, dragging other people along with them (Middle Manager) [42-1]

Between commissioners and providers

The contestability agenda creates the potential for a 'them and us' relationship which may jeopardise the apparent high morale and good working relationships identified in the first round of interviews within the PCT and health economy more generally. Furthermore since commissioners need to cooperate with in-house providers in order to develop service specifications for tendering services, but provider involvement may bar them from tendering, the potential for tension is increasing. In the absence of such inside knowledge and in an environment of rigid arms length contractual arrangements, the PCT may face financial risk, resulting in further payments for service elements omitted from the original contract.

I think the commissioners' knowledge about the evidence base and the need and the cost in the system and I don't know whether you can do it in isolation. I think there needs to be some joined up thinking around it

and, and I think they're trying with the contestability issue here to have that information from all partners but if you've been involved in developing that tender, then you cannot be involved in the bidding process (Middle Manager) [18-1]

before commissioning provider service came in, they've obviously all had very, very good healthy relationships. But their roles will have to change … all of a sudden they, it's like, "Can I have this data" or "We don't know if we can give you that data" that kind of thing starting to pitch in (Middle Manager) [43-1]

it is likely that will become a bigger split, and the danger with it of course is your provider arm, instead of doing what the PCT needs to do spontan…', well flexibly, actually says "Our contract, our thing says we only do this, so that's all we're going to do" sort of thing. So there are some risks around it definitely. PCTs will have less opportunity to control that group of staff, to deliver say in an emergency, or to move things forward very swiftly I think. (Senior Manager) [47-1]

The contestability agenda was seen as leading to mixed messages within the PCT (which may in part reflect confusion at DH about the future direction of travel) concerning the extent to which in-house services will be subject to market testing and the pace of change during the first phase fieldwork. During the first phase of interviews, amongst some PCT directors, the view was expressed that contestability may merely involve in-house providers demonstrating value for money.

I think the plurality of providers is fine, I'm absolutely clear that people need to have some choice in providers. But I don't think that's what should drive us. I think what the people who receive our services should have is, the choice of the outcome that they want to have delivered.

Generally they don't care who delivers it actually. It's of no consequence to them…So I don't think there's any harm in having one single provider, if that provider can deliver a multitude of outcomes to suit need, and can work effectively with commissioners. Separating them at arm's lengthtaking your PCT provider arm and putting it separate, is artificial for me (Senior Manager) [56-1]

Understanding of contestability had moved on by the second phase of interviews. Various mechanisms for achieving it had been considered. The need to develop processes which were locally defensible (within and outside the organisation) as well as nationally adequate had created a lot of work in the organisation. Various new structures had been created and services were beginning to be put out to tender. Failure of in-house providers to win the first sizeable contract had caused some ripples. Management saw it as

a 'valuable learning experience' while staff anxiety appeared to have greatly increased.

Between managers and front line staff within the provider arm

Within the provider arm managers reported that front line staff were responding to the challenge created by the contestability agenda. Whilst managers sought to drive change, front line staff felt anxious and threatened by such changes.

we are now firmly a provider and no longer a commissioner. But we're now having to be involved in bidding for services…we're having to start the first time at looking at our unit costs and things like that. So we're starting to do work on that.…. we've made them aware that it's a possibility, without scaring them. And saying "Come back and talk to us." … So that they know where we're up to, what's going out to tender, what's happening. And they can see it emerging but slowly. (Middle Manager) [33-1]

I don't feel that they've got their heads fully around it. … We've got to start evidencing what we do and getting better lines of communication open (Middle Manager) [44-1]

private firms could want to come in and provide a service… So there's all those sorts of worries really around (Front Line Staff) [16-1]

7.11 Changing Performance Within the Organisation

National performance measures

Against key national targets, Smalltown has markedly improved its performance over the period of the research. Although there was some impressive success, senior management were not at all complacent.

because of the work that we've done with the [voluntary sector smoking cessation provider], so we have had some really big success stories. But clearly .. we've still got people who die young compared to the national average…although we've got signs that we are going in the right direction in our health and equality gap is reducing, nevertheless there is still a long way to go, we still have loads of issues around poor health generally in the borough. (Senior Manager) [47-2]

Staff knowledge of national targets was variable. Some were well understood by relevant staff but in some cases their achievement was perceived as unlikely, due to factors beyond local control. Other national targets had overarching priority and this was perceived to have a potentially detrimental effect on other work.

Oh no, not off the top of my head, but actually we don't do very well. … Smalltown is an area of high deprivation and we know the breast feeding rates are low…we do as much as we can to promote it .. but you know it's about free choice … it's not going to make them breast feed if that's what they don't want to do. … where there's a lot more affluence, yeah the rates are much higher…the flu targets .. the Government says that you've got to achieve seventy percent of the target group and yeah and you get a big pat on the back because you do it, but you are expected to put everything else on hold, because the PCT is judged on that. (Front Line Staff) [08-2]

Therapists identified the presence of national targets for access/assessments but a lack of specificity in terms of throughput. This was far from a complaint, as patient-centredness and uncertainty were central features of everyday work.

it's really difficult because you could have two or three children who essentially have the same diagnosis, but you don't know how they're going to respond to the therapy until you actually try really, and there are so many different factors that could affect how they perform. (Front Line Staff) [14-2]

The wider issues relating to expected changes in regulatory regime were seen as important, although there was not much optimism for positive development. Whilst PCT senior managers indicated support for a flexible, enabling approach to performance improvement (which might be seen as characteristic of a developmental cultural environment), improving performance was seen as a top-down, 'command and control' process.

it's still unfortunately couched in the 'we are here to performance manage you'…instead of saying Primary Care Trust, you have to go and do your job, you have to deliver better improvements, we want to help you. So there's little enabling, still a lot of command and control. … I suspect that there's going to be a drift still to a more directive approach. (Senior Manager) [56-2]

Results from the employee attitude survey are consistent with comments made by staff in interviews with regard to feeling satisfied and supported in the working environment. The 2006 response rate was above average, although the rate was below average in 2007. Senior managers clearly paid

attention to the positive staff survey and were keen to refer to its contents. However, as was pointed out, the staff survey would only answer the questions which were asked, should other factors dissuade participants from using the opportunities offered by the free text sections. The comment by Front Line Staff [06-2] 'Yeah, but they don't ask the questions' implied that the organisation either deliberately or accidentally failed to pinpoint the critical issues.

Softer measures of performance

There are many ways in which PCT performance is measured. Although progress on integration was viewed as something which had contributed to the success of the PCT, measuring the impact of this is difficult. Amongst external stakeholders there was a range of views concerning the impact of the PCT's integration strategy.

I think what's sometimes difficult is to understand what does that actually mean on the ground. … .. it is very rare for us to have a delayed discharge from Smalltown. ..we have high numbers of delayed discharges from [names 2 neighbouring PCTs]. And whether that's a direct result, or whether it's an artefact, is something that you can measure. Because some of these things are very hard to quantify. (External Stakeholder) [3-1]

I wanna know where the evidence is that this joined up care actually makes a bigger difference than either non-joined up care, or another model of care.. I think that the care is often fragmented because no one is truly managing these people.. I'm not convinced. (External Stakeholder) [1-1]

Staff highlighted the attention which the PCT's success has attracted from other NHS organisations and from overseas visitors alike.

we are constantly being asked to either speak at conferences or go to meetings or colleagues come to visit us from other parts of the country.. they're interested to learn, .. there's umpteen authorities now have been to see us to talk about our arrangements… they've seen you know, the art of the possible. (Senior Manager) [45-1]

For PCTs, service provision involves mostly community based services, many of which do not directly contribute to key performance targets or where they do, these reflect a minor aspect of the role (e.g. district nursing, speech and language therapists, community podiatrists). Additionally, unlike in hospital inpatient settings, where patients are more seriously ill,

service shortcomings may be less likely to have the immediate impact they may have in acute settings or attract the same level of media interest. These factors may cushion PCT employees from negative aspects of a performance which place undue emphasis on controlling staff in order to meet targets. However, in a context where community services may be market tested in the future, the lack of good data to measure performance, as we outline above, is a cause for concern for some staff employed in these services.

Linkage of changes in culture and relationships in the organisation to performance outcomes (hard and soft).

The targets faced by staff in acute settings may mean that staff in those settings feel under greater pressure and that mangers in those settings feel the need to increase control over staff. Comments by the acute trust manager interviewed conveyed frustrations associated with a lack of direct control over allied health professionals working in the hospital who are employed by the PCT. However, for PCT staff who used to work in acute settings, or who remain there but on PCT contracts, having the PCT, as opposed to the acute trust, as an employer the difference appeared to be appreciated.

You feel in the [acute] trust, it's like everything's a lot more crisis management sort of thing … Whereas on the PCT side you feel there's a bit more.. structure … .. It's doable. (Middle Manager) [20-1]

it's a completely different culture. 'Cos here all the staff are employed by the acute trust, apart from the AHPs, and people are very aware of the differences in the support. …. the acute trust, it tends to have like a blame type of culture, and staff are very negative. Whereas in the PCT it's very supportive (Front Line Staff) [11-1]

However, the contestability agenda with its emphasis on performance measurement and management appeared to be changing staff perceptions so that, as discussed earlier, front line staff reported feeling anxious about tendering and competing with other providers.

There appeared to be an increasing focus on performance during the second phase of interviews. Several managers reported more active scrutiny (greater review and monitoring of services) and less tolerance of shortcomings was seen as more prevalent, along with challenging rates of sickness. A trend towards explicitness was evident. A general sharpening up of practice and more outcome focussed working was reported.

I take a harder line with services than I would have done a year or two years ago and that is motivated by concern that those services are seen to perform well .. we had to become more performance-focused than we have in the past. … we are noticing that there is a higher level of staff sickness…relating to work related stress and there is also a higher number of grievances and disciplinaries and I think this is indicative of that change …we are having to become a lot tougher (Middle Manager) [19-2]

I think it was a wakeup call for both managers ..[and] staff. I think across the NHS there's been somewhat perhaps a state of almost denial, "Well actually it'll never happen. This contestability's…. actually to do with somebody else," but I can see just around the staff side table a bit of a reality check where, "Oh it has happened… we now realise that we collectively need to sharpen our act." (Senior Manager) [50-2]

7.12 Changing Cultures, Relationships and Performance Across the Local Health Economy

As discussed above, the increasing emphasis on performance measurement and management as part of the contestability agenda was starting to change relationships within the PCT. The tensions created by conflicting central policy directives were exacerbated in a context where the PCT was actively pursuing a policy of integration with local council social care services and attempting to sustain a narrative of unity, whilst at the same time splitting the PCT into provider and commissioner functions.

7.13 Summary and Conclusions

Key themes and issues arising from the case study

- Smalltown PCT senior management team prides itself on its 'can do' flexible approach.

- Senior interviewees in the PCT attributed progress on the integration agenda to this flexible, spontaneous culture. However, the contestability agenda appears to have created pressures to adopt a more formal, mechanistic approach to commissioning and providing services.

- Whilst senior staff continued to espouse a narrative of unity, which may reflect a desire to protect staff, the failure to acknowledge the need for change, created by the contestability agenda, was perceived by provider arm employees as holding them back.

- An increasing emphasis on performance measurement and management creates pressures to adopt formal and mechanistic approaches, yet these need to be combined with flexible approaches to respond to a changing healthcare marketplace. This suggests that rather than attempting to pursue a dominant cultural type, elements of both developmental and rational cultures are desirable. However, combining flexible and mechanistic approaches appears to be creating significant challenges in the PCT.

- Factors such as stability and clear leadership all appear to contribute to a positive perception of the organisation amongst staff within the PCT and the local health economy. However, the uncertainty and tensions created by centrally driven national reforms highlights the important role of national policies (e.g. contestability) which impact on relationship, culture and performance within PCTs and local health economies more generally.

7.14 Implications for policy and management

Stability and change

Whilst the PCT's geographical boundary was not reconfigured following the CPLNHS reforms, the environment in which it is operating is one in which the pace of change is hectic. Some level of stability is necessary therefore, if PCTs are to pursue change and maintain staff engagement. In addition, the requirement and ability to take responsibility locally and to work more closely with the local authority is undermined by central reforms which take no account of local contexts, accountability arrangements and change agendas. In summary, successful change in Smalltown appeared to rely on a high level of stability. Despite some stability, the organisational change which has occurred in the PCT included service redesign, relocation and redeployment of staff and even wholesale annexation of other services. Delineating the relationships between cultural change and large scale organisational change is difficult. Few organisations in the constantly redisorganised NHS[14] are likely to be immune from a degree of organisational change, which may mean that attention is focused on structural rather than cultural change.

Communication

During the first round of interviews many staff reported being kept informed via formal and informal channels. In part this reflected the PCT's communication strategy. Additionally, being a small organisation was seen as helping in this process. However, if bad news travels fast in organisations, then it is likely to travel even faster in smaller organisations. Uncertainty around the contestability agenda, which in part appeared to stem from uncertainty at the Department of Health, created unease amongst front line staff and threatened to damage the trust and goodwill required to maintain good working relationships. The message here appears to be that clear, consistent and honest communication is important in the process of change and in ensuring commitment to organisational values and strategies. However, this may not always be possible when central policy is characterised by a lack of clarity and inconsistent messages.

Leadership

Many people throughout the PCT referred to the Chief Executive and members of the senior management team more generally using their first name. PCT directors were reported in the first round of interviews as

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[14] Smith, J; Walshe, K; Hunter, DJ. The "redisorganisation" of the NHS. *BMJ*. 2001;323:1262–1263. . (1 December.).

providing a clear sense of direction as well as supporting staff to take opportunities to develop PCT services and collaborations. However, the mixed messages and uncertainty surrounding contestability raise questions about the extent to which it possible to maintain the same leadership style in a changing policy context. Whilst a glib comment might be that leaders further down the PCT structure need to give messages which are consistent with leaders at the top of the organisation, as outlined above under communication, this may not always be possible in a context where central policy is characterised by a lack of clarity and inconsistent (integrate and split) messages.

Information technology

Whilst the PCT has developed new structures and clearer lines of accountability in response to the contestability agenda, there is a need to develop robust information systems to support these structures. In the context of community based services the challenges are likely to be greater than those faced by acute providers. These challenges are exacerbated in the context of joint working across health and social care.

Internal and external influences

National policies create conflicting demands (i.e. to integrate and split) which impede the ability of organizations to make progress. Securing alignment across national and local reform initiatives is important if culture change is not to be blocked or negated.

Harmony and conflict

The fact that Smalltown has improved its Healthcare Commission ratings over the period of the study suggests that it is achieving success in many areas.

Some of the tensions apparent in Smalltown appear to arise because it is pursuing an ambitious programme which attempts to meet conflicting agendas. Rather than prioritising one agenda (developing commissioning) and paying lip service to another (integration), Smalltown is actively attempting to follow both aspects of policy. The conflict and tensions arising from this may therefore be seen as a sign of progress in these areas. The absence of conflict may represent lack of change or stagnation, therefore, rather than a wholly desirable state of affairs.

7.15 Implications for future research and theoretical generalisation/ development

Whilst PCTs have been subject to performance measurement for a number of years, the case study raises questions about the ways in which culture/performance linkages evolve and change as performance measurement and competitive tendering becomes more established

The study highlighted that being cushioned from national reforms (e.g. PCT reconfiguration) created stability which enabled PCTs to manage change. Further research, which examines whether PCTs which were reconfigured have suffered in terms of subsequent performance, culture and relationships, compared with PCTs, which retained their original boundaries, would help shed light on the impact of stability for future performance and culture change.

Our study suggests that leadership is important in influencing culture and performance. Strong and clear leadership was credited with helping the PCT retain its original boundary. However, subsequently, senior leaders were seen as out of step with provider concerns and espousing a narrative of unity at odds with the contestability agenda. Staff in the provider arms reported leaders as lagging behind them in the desire for change. Future research should pay greater attention to the role and nature of leadership at various levels of the organization rather than focusing on formal leadership designations (e.g. members of the PCT senior management team) in order to understand the dynamic and complex relationship between leaders and followers in a changing environment.

Clashes of culture (between health and social care or between commissioners and providers) create tensions which may not be amenable to resolution. A vision of health economy relationships, culture and performance, as if not a reality then at least as an aim as an inclusive, consensual, community is questionable. The narrative of unity sustained by senior managers and the suppression of questioning about the desirability of integration fails to acknowledge that conflict is a necessary and fundamental aspect of social relations[15]. Future research which examines the creative potential of conflict, perhaps using action research techniques or participant observation to encourage participants to reflect on conflict, rather than ignore or suppress it, would be helpful in broadening our

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[15] Hoggett, P. Overcoming the Desire for Misunderstanding Through Dialogue, Local Government Studies, 2003; 29: 118 – 127.

understanding of the complex relationships and cultures operating within health economies.

7.16 Implications of the case study for conceptual development

In Smalltown, Lundberg's (1985) model of culture change could provide an excellent framework for the external enabling conditions, internal permitting conditions, precipitating pressures, triggering events, cultural visioning and culture change strategy. All of these issues are hopefully apparent from the above commentary.

Dyer's (1985) cycle of cultural evolution emphasises the importance of crisis and leadership. This is mainly supported by our description of Smalltown. The sense of urgency within the organisation relates to clear measures of population health and wellbeing, or illness and lack of wellbeing in this case.

Using Schein's (1985) life cycle model of organisational change, it seems likely that Smalltown has passed through 'birth and early growth' to a stage of organisational midlife. Planned change and organisational development characterise much of our case-study. Incrementalism, in the sense of building on existing structures and past success is a prominent feature of organisational life. Schein's (1985) definition of culture at three levels (artefacts, values and assumptions) may have face validity but assumes a degree of organisational maturity not necessarily arrived at in Smalltown. The need to expound and re-emphasise values on a regular basis suggests that they have not yet attained the status of assumptions.

Gagliardi's (1986) incremental view of organisational culture fits some parts of the Smalltown case study. We encountered people who expressed idealized (emotionally transfigured) values, but this was not universal. Gagliardi's evolutionary model emphasises the gradual development of historical existing cultures and the steady acquisition of new competencies, collective successes and internalisation of assumptions. In Smalltown, this was a conscious but slow process. The coherence with which Smalltown leadership adopted clear explanations of cause and effect in relation to success also appears in this case-study, as hypothesised by Gagliardi.

Brown's (1995) social-psychological composite model of organisational change also has considerable consonance here. The organisation has experienced considerable 'unfreezing' and continues to experience steady change. Conflicts are seen as inevitable in this model, and some evidence of this was found in Smalltown. Also present were efforts to reduce resistance, increase support and enhance ownership of change. Isabella's (1990) description of 'confirmation', where individuals make sense of events using past experience and traditional explanations relates to some of inter-professional differences identified in Smalltown. However, examples were

also found of individuals who has passed this stage and adopted 'culmination stage' approaches to understanding change in the new context. Some management efforts in Smalltown reflect the change in the refreezing phase of this composite model, but stability of purpose and commitment to partnership may provide a better description.

The key messages from the culture change literature can all be confirmed in this case-study. The importance of crisis, leadership, success and relearning make this is a text book example in many ways. The lack of ambiguity about the nature of Smalltown's problems and the energy of the leadership have assisted the process of active organisational and cultural change. Despite this, the precise means of achieving change are likely to be locally contingent.

8 Drawing together the empirical work and discussion of key findings

8.1 Introduction

In this section we integrate across our empirical work and provide an overview and assessment of the contribution of our research by drawing out the common patterning and divergence in our various sources of data and interpreting our findings within the context of the broader theoretical and empirical literature.

8.2 A reminder of the ambitions of this study

The overall aim of the project was to understand the nature and dynamics of organisational change in the NHS, with a particular emphasis on documenting and assessing the implications of changes in cultures, relationships and performance within health care organisations and across health economies. Through theoretical work and empirical study we have sought to:

1. identify and classify the extant cultures in key NHS organisations;

2. explore how these cultures evolve and transform over time, both in response to external policies and as a result of internal or cross-boundary drivers;

3. analyse the (longitudinal) relationships between changes in cultures and performance at both an organisational and a local health economy level;

This is the first large scale longitudinal study of culture and performance in the NHS. The triangulation of data collection methods, data types and data sources maximised our chances of developing a comprehensive and integrated understanding of the processes of organisational change and how these are related to performance in the NHS. Throughout the empirical work we have sought to investigate the shared accomplishment of service delivery through uncovering aspects of intra- and inter- organisational coordination.

In the rest of this section we focus our discussion around addressing each research aim in turn, integrating and synthesising our empirical evidence along the way.

8.3 RESEARCH AIM 1: Identifying and classifying extant cultures in key NHS organisations

Whatever the approach that is taken in assessing culture, it can only ever give a partial glimpse of the shared meanings, norms, values, beliefs and ways of behaving that shape and underpin organisational life. Given the methodological difficulties in exploring organisational culture and the diversity of approaches to understanding and assessing cultures, we decided to adopt a multi-method approach, integrating both quantitative and qualitative methods. In attempting to capture the breadth of cultures in the NHS we conducted national quantitative surveys in NHS hospital Trusts, PCTs and a smaller sub-set of GP practices using a validated culture assessment instrument – the Competing Values Framework. Whilst quantitative instruments can elicit much valuable information that is amenable to rigorous statistical analysis, they are less effective in recording the dynamic processes underlying the actions recorded in the instrument. Therefore in order to provide added depth and richness to our study we adopted a multiple case study approach (in both acute and primary care organisations undergoing significant organisational change) alongside the national surveys to explore the internal processes and mechanisms through which cultures are accomplished and reproduced within particular health care settings and how these link to performance across the health economy.

Cultures in NHS acute hospital Trusts

There are no national data on managerial cultures in the NHS prior to our base line survey in 2001 and therefore our empirical analysis is limited to assessing changes in managerial cultures between 2001 and 2008. Our longitudinal analysis, based on data taken at three time points over this period identified a significant shift in dominant managerial cultures in English hospital Trusts since 2001. Between 2001/02 and 2006/07, 'Clan' remained the dominant type of senior management team culture although its prevalence was in decline with a corresponding rise in 'Hierarchical' cultures from 2001. Over the same period 'Rational' cultures accounted for a roughly consistent proportion of hospitals. The proportion of 'Developmental' cultures also remained relatively constant. However, one year later in 2007/08 dominant 'Rational' culture had overtaken 'Clan' to become the most frequently reported dominant culture type. These changes were matched by corresponding falls in the frequency of 'Clan' as the dominant culture.

The continued prominence of 'Clan' as the dominant culture from 2001/02 to 2007/08 is broadly consistent with the findings of qualitative empirical studies of NHS organisation over a long period and is likely to be related to

the degree of autonomy typically associated with professional work in formal organisations (Mintzberg, 1991). The rise in frequency of 'Hierarchical' as a dominant culture is consonant with contemporary commentary on the increasing manifestation in the NHS of bureaucratic rules (such as clinical guidelines and protocols, National Service Frameworks and other aspects of the current audit and inspection regime) over this period (Harrison and Smith, 2003; Davies and Harrison, 2003).

The appearance of competitive or 'Rational' cultures as the most frequent dominant type in 2007/08 is also consistent with an NHS policy context in which pro-market developments such as the 'payment-by-results' hospital funding system, practice-based commissioning and greater involvement of private sector providers have become increasingly prominent (Mannion and Street, 2009). The inclusion of the word 'competing' in the title of our culture assessment tool (the CVF) reminds us that these shifts in dominant cultures do not imply that the characteristics of other culture types are suddenly absent from the hospitals studied; indeed, the slight decline in strength of prevailing dominant cultures reinforces the point that even dominant cultures have values that 'compete' with other values.

Government policy for the NHS has espoused the desirability of competition since the late 1980s, albeit with something of a respite between 1997 and 2002. Our data suggest that corresponding changes in the cultures of NHS hospitals, as reported by their senior managers, are finally beginning to occur, a conclusion that is consistent with the findings of international comparative research that associates differences in hospital culture with differences in countries' political economy (Gerovitz et al., 1996). There are good theoretical and empirical reasons to expect that changes in senior managers' reports of their hospitals' dominant culture will have a substantive impact. In particular, the Institutional Economics literature suggests that the cultural context within which senior managers work does affect their motivations and behaviour (Bowles, 1998; Throsby, 2001). In the context of NHS hospitals, this implies that senior managers espousing 'Rational' organisational culture will act in ways that affect the way in which subordinates construe their work and the way in which this relates to the hospital's performance. Given that changes in the cultures of NHS hospitals are occurring, we would expect in turn that these organisations are more likely to pursue more competitive strategies.

Given resource and time limitations our national CVF survey targeted senior management and therefore only captured cultures as perceived and experienced by senior hospital managers; and while we believe that our approach is partially justified given the relative influence and agenda setting powers of senior managers (as well as the contingent associations between senior management cultures and performance identified in our earlier work) we in no way want to suggest that our national quantitative data are representative of the rich patterning of professional and sub-cultures cultures lower down the hospital hierarchy or across different occupational groups and clinical specialities. In particular we were aware

that within any organisation the culture found may be far from uniform or coherent (Martin, 1992). Indeed looking for commonality may be less rewarding than an examination of differences (Box 8.1). It was to uncover such differences that our detailed case studies explore specific organisations and their cultural evolution in some depth.

Box 8.1 Commonality and difference in organisational cultures

- *Integrated:* Integrated cultures occur when there is broad-based consensus on the values, beliefs and appropriateness of behaviours within the organisation. Although often assumed, such integration may exist only in aggregate, or may be more aspirational than realised.
- *Differentiated*: Differentiated cultures occur when multiple groups within an organisation possess diverse and often incompatible views and norms. The development of subcultures, misunderstandings and conflicts is then to be expected. The NHS has long existed as a collection of loosely coupled differentiated cultures (medical, nursing, professions allied to medicine, administrative and, more recently, managerial groups).
- *Fragmented*: At the most extreme, differentiated cultures may diverge and fragment to such an extent that cross-organisational consensus and norms are absent. Even within specific groups, differences may be more marked than commonality, and agreements that are seen may be only fleeting and tied to specific issues. Thus the organisation may be characterised by shifting allegiances, considerable uncertainty and ambiguity, and unpredictability.

This typology is not intended to suggest that organisations have cultures that are either integrated or differentiated or fragmented. Instead, each of these views may be applied to the same organisation to reveal, rather than hide, an overall lack of coherence.

Source: Adapted and extended from Martin (1992)

Although some cultural attributes may be seen across the organisation, others may also be prominent only in some sections of the organisation. Different cultures may emerge, for example, within different occupational or professional groups, medical specialities, clinical divisions, wards and teams and these groups may seek to differentiate themselves from one another by their cultural artefacts or values (Mannion et al., 2005). Subcultures are likely to be associated with different levels of power and influence within the organisation, whose dynamics may alter over time. And in most organisations there is likely to be a distinction between the *espoused cultures,* by which managers may present a desired or normative view of their culture and *cultures in use* –the actual cultures as experienced by employees (Argyris and Schon, 1978; Brown, 1995). Thus some cultures may share a common orientation and similar espoused values, but there may also be disparate subcultures that clash or maintain an uneasy alliance (Martin and Seihl, 1983).

Our local CVF surveys identified a wide range of cultures across different occupational groups in the case studies. However, the CVF survey is a relatively blunt instrument for exploring the richness of local cultures, particularly in light of the differentiated and fragmented approaches to culture as set out by Martin (1992). Such issues are more amenable to qualitative exploration and analysis and were explored in the three case studies, elaborated below.

Metrotown: fragmentation and differentiation

The Metrotown case study indeed identified a range of different espoused cultures at different levels of the organisation and across different professional groups. In this sense the organisation could most appropriately be described as being a collection of mutually inter-dependent 'clans' as opposed to having a monolithic or homogenous 'clannish' culture. Here culture was experienced as a very local phenomenon with staff aware of the cultures within their own professions, clinical team or wards but not necessarily the hospital as a whole. Indeed, particular committees were described as having their own cultures, with a collective existence independent of committee members who often held different views outside the committee. These finding raises the interesting issue of whether managers and health professionals carry around a fixed set of values and beliefs irrespective of context or whether these are adapted as they negotiate their way around a range of cultural milieus. This case study also highlighted the very different managerial and medical cultures in NHS Trusts and the way in which each group's core assumptions and belief systems can serve to hamper channels of communication and contribute to failings in clinical governance. Within the wider literature there is a small but growing body of literature documenting differences between managerial and medical cultures in health care organisations the implications of these differences for organisational functioning and service delivery (Box 8.2)

Box 8.2 Managerial and medical cultures: points of divergence

	Managerial	Medical
Structure	bureaucratic	Collegial
Group loyalty	low	High
Job security	low/medium	High
Disciplinary base	social sciences	natural sciences
Evidence base	case studies on organizations	clinical studies on patients
Focus	patients as groups	patients as individuals
Skills	managerial/human relations	biomedical/technical
Allegiance	organisational/corporate goals	patient/professional
Discretion	low – rules/procedures	high – clinical freedom
Success Measure	efficiency	Effectiveness
Quality emphasis	consumer-rated quality	technical quality
Performance review	public	Confidential
Professional status	emerging	Established
Social status	medium	High
Public trust	low	High – but vulnerable

Source : Davies et al., 2000

Bigtown: rational with orthogonal subculturing

In the transition to foundation status, senior managers described the trust as good on delivering, innovative and risk taking with a strong focus on performance and most closely associated with the Rational type culture from the CVF framework. This would align with the qualities expected by MONITOR of the high performing Trusts to qualify for transition to Foundation Trust status. However, as in Metrotown, many staff aligned themselves with their own local and professional sub-cultures rather than the organisation as a whole. There was an apparent sharp contrast between divisions. The 'DGH' culture was strongly supportive of the dominant culture and was generally aligned with senior management. The specialist division did not have as uniform a culture as the DGH but were much more cynical of the cultural values espoused by senior management. This links

with conceptual theoretical work which has developed a theoretical framework for classifying subcultures in terms of whether they support, deny or simply co- exist alongside the values of the dominant culture (Box 8.3). (Seihl and Martin, 1990).

Box 8.3: CLASSIFICATION OF SUBCULTURES

Three types of sub-culture can be identified vis a vis their organisational functionality.

- *enhancing cultures*: these represent an organisational enclave in which members hold core values that are more fervent than and amplify the dominant culture. For example special hospital units which constitute centres of excellence.

- *orthogonal* cultures: an organisational enclave which tacitly accepts the dominant culture of the organisation whilst simultaneously espousing its own professional values. For example in the DGH culture in our transition to Foundation Trust case study.

- *counter cultures*: an organisational enclave that espouses values which directly challenge the dominant culture. For example, the culture of the specialist division in the transition to Foundation Trust case study.

Derived and expanded from Seihl and Martin, 1990.

Our findings thus highlight that strategies aimed at achieving culture change in the NHS need to be mindful of the opportunities, threats and challenges posed by different subcultures in health care organisations, and further demonstrate that 'counter cultures' may resist and even thwart simplistic managerial attempts to 'engineer' change from above.

Cultures in PCTs and GP practices

Data on the cultural orientation of PCTs are not available prior to our initial national survey of 2006/07. However, we found similar shifts to that of hospital Trusts in the relatively short time period between this first survey and our second national sampling in 2007/08. There was a large shift away from Clan dominated PCTs, some loss of Developmental-dominant PCTs, and a sizeable increase in Hierarchical- and Rational- dominant PCTs.

Such cultural patterning in the PCTs was not replicated within practices. Our data for GP practices found that upwards of 80% of practices were Clan dominant at each point in time, with less than 10% each for rational and Hierarchical with almost no Developmental-dominant Practices. We found a

low correlation between Practice cultural orientation and their host PCT orientation and (although our data analysis has several limitations here), and we also found little correlation between the dominant orientation of PCTs and local hospital Trusts, suggesting a lack of cultural congruence across local health economies.

Smalltown PCT: more complex subculturing

As with the hospital trust case studies, the Smalltown case study highlighted that although there appeared to be a dominant overall organisational culture, particularly around openness to risk taking and innovation, staff highlighted the role of sub-cultures, particularly the differences between health and social care cultures, with clinical cultures viewed as being more mechanistic and less spontaneous and more developmental than social care cultures. This distinction between health and social care cultures aligns with previous empirical work (Richardson and Asthana, 2006; Peck et al., 2001; Hiscock and Pearson, 1999; Johnson et al., 2003; Mackay et al., 1995). There was also a perceived growing divide between the cultures of the provider arm and the commissioning arm of the PCT.

Both our hospital and PCT case studies therefore highlight problems associated with accommodating (sub) cultural diversity in NHS. In this regard, Child and Faulkner (1998) have developed a useful typology to assess approaches to managing organisations in the face of cultural diversity. Their analysis is structured by two fundamental choices. The first concerns whether one sub-group's culture should dominate. The second relates to the decision to either integrate different subcultures (in order to derive synergy between them) or segregate the various subcultures (with the aim of avoiding conflict or efforts devoted to culture management). These strategic choices give rise to four possible bases for accommodating cultural diversity (Box 8.4). The first three offer some scope for establishing a cultural fit, whilst the fourth may give rise to serious dysfunctional consequences.

Box 8.4: The Meeting of Cultures: Achieving a Cultural Fit

	The Four Possible Bases for Accommodating Cultural Diversity within Health Care Organisations	
No Domination By	1) Synergy The objective is to meld both partner's cultures and to achieve the best possible fit between the two. The best elements are combined with the objective of making the whole greater than the sum of its parts. The combination of management and clinical roles by clinical directors is an example of this.	2) Segregation Here the aim is to strike an acceptable balance between different subcultures by virtue of maintaining separation rather than seeking integration. In many health systems inter-professional alliances may be seen to be of this type. For example, accommodation between the nursing profession and doctors
One sub culture Yes	3) Domination This is based on recognition that integrating subcultures may prove impossible and accepts the right of dominance of one sub-group's culture. Clinicians have traditionally assumed this role and have until recently been largely self-regulating rather than being the subject to external monitoring and assessment.	4) Breakdown This occurs when a sub-group seeks domination, integration or mutually acceptable segregation but fails to secure the acquiescence of the other group. For example, failed attempts in advanced health systems over many years to usurp the dominance of the medical profession.

Yes   No

Integration

Derived & expanded from a classificatory scheme on strategic alliances developed by Child & Faulkner, 1998.

8.4 RESEARCH AIM 2: How health care cultures transform and change over time

Organisational culture is reproduced and changed through social interaction. Thus culture is not thought of as something fixed and static, but is seen instead as something that is dynamic and shifting, something all those in an organisation are constantly creating, affirming and expressing. Cultural shifts, drifts and dislocations do not occur in a vacuum, but happen in the complex social and institutional environment within which the organisation

is embedded. Understanding these processes of change – and their influences – is where we next turn.

Conventionally the culture literature is divided into two broad camps (Smircich, 1983). One stream approaches culture as an *attribute*, something an organisation *has*, alongside other attributes such as structure and strategy. Another stream of literature regards culture more globally as defining the whole character and experience of organisational life-what the organisation *is*. Here organisations are construed as cultures in and reproduced through the social interactions of their participants. This may be termed the culture as metaphor approach. The distinction between viewing culture as either an attribute (a defining quality or variable) or a metaphor holds important policy and managerial implications, with 'culture as attribute' offering more scope for purposive manipulation than 'culture as metaphor'. For the purposes of this study we tread a middle path between each of these dominant approaches by treating an organisation's culture as an emergent property.

> *Organisational culture is the emergent result of the continuing negotiations about values, meanings and properties between the members of the organisation and with its environment.*

(Seel, 2001)

As shown in Section Three a diverse range of models for understanding culture change have been developed, this diversity reflecting a lack of theoretical consensus surrounding both definitions of organisational culture and processes of organisational change. Despite some manifest differences between the culture change models reviewed, they all share some common foci:

- *Crises*: as a trigger for significant organizational change.

- *Leadership*: in detecting the need for change and in shaping that change.

- *Success*: to consolidate the new order and counter natural resistance to change (as one of the functions of organisational culture is to establish and stabilise a way of living, resistance is inherent to any culture change efforts).

- *Re-learning* and re-education: as a means of embedding and helping explain the assimilation of new cultures.

Our empirical work was informed by the culture change literature as we sought to track the dynamics of cultural change in the NHS through documenting and exploring the range and impact of drivers, facilitators,

barriers and unintended and dysfunctional consequences of culture change, including of purposive attempts by organisations to 'manage' or influence the formation of desirable organisational cultures.

We have summarised above the changes seen in management team cultures in NHS hospital Trusts between 2001 and 2008 and in PCTs between 2006/07 and 2007/08 on the basis of our national survey results. Our case studies explored the processes underpinning these changes in local health care settings and our evidence lends support to our key finding that hospital and PCT management cultures are becoming more competitive and externally focused: that is hospitals and PCTs in the English NHS are becoming less 'Clannish' and more 'Rational' in orientation. However, our case studies highlight that NHS organisations (and local health economies) each have their own unique cultural trajectory, with each 'organisational journey' influenced by a wide array of historical and contextual factors in addition to national system reforms, including styles of leadership and managerial systems, the organisations past performance, traditional working patterns, relations within the health economy and local demographics.

In Bigtown Trust, the movement towards a more Rational management culture originates from before the organisation's transition to Foundation status and the latest pro-market reform agenda. The initial catalyst for change was a highly critical review of acute provision in the early 1990s which resulted in the development of robust performance management systems within the organisation and was spurred on by competing for reputation with a local high status teaching hospital. Although the national system reforms have helped to reinforce and speed up the cultural trajectory, the Trust's dominant Rational culture was a key driver behind the decision to bid for Foundation status rather than being an outcome or by-product of the transition process *per se*.

In Metrotown Trust the shift towards a more Rational culture is less obvious with any change in this direction of more recent origin dating only as far back as a recent Healthcare Commission report which was highly critical of clinical governance arrangements in the Trust and recent 'special measures' need to develop more robust financial management systems to 'turnaround' a large, long standing deficit. However, the organisation remained in many respects internally rather than externally focused because of a very loyal local community, patient demand remained high for its services and it was largely unaffected by Patient Choice and thus far has done little to gear and adapt its internal systems to address the new market environment.

In Smalltown PCT, which was pursuing a strategy of integrating health and social services as well as creating a split between commissioning and provider functions, there was a general cultural shift in the organisation, from predominantly a Developmental, innovative 'can do' culture towards

more of a Rational cultural orientation. This was particularly so in the provider arm which was trying to develop more business processes and tender for contracts as required by the national constestability agenda. What is particularly interesting about the Smalltown experience is that the move to a more Rational culture was largely driven not by senior managers but by staff lower down the hierarchy, and in some cases more junior staff were challenging the slow pace of change adopted by senior managers. Nevertheless, within a context where national policy imperatives are trying to encourage the adoption of mechanistic and standard processes associated with Rational and Hierarchical cultures, in some areas Smalltown PCT was trying to retain its traditional emphasis on spontaneity and flexibility, particularly within social services, which had more of a Developmental culture compared with health services which were viewed as adopting the more mechanistic approaches associated with Rational and Hierarchical cultures.

Drivers of culture change

All of the organisations that we studied have been subjected to a wide range of cultural influences from the national and local environments. Working from our detailed local case-study data, the key drivers of change can be grouped under five broad headings each of which is discussed subsequently:

- National system reforms

- Crisis and threats to survival

- External assessments and monitoring

- Reputation and status

- Local media

National system reforms

In section Two we outlined the main system reforms in place during the period of the case studies were undertaken (2005-2008). In particular we noted that since 2002 the government has pressed much further than any of its predecessors in introducing pro market reforms. Key structural changes on the demand side include the extension of patient choice of service provider, intended to empower patients to put pressure on hospital providers to improve the quality of elective services; and the development of practice based commissioning with the aim of providing GPs with incentives to reduce inappropriate hospital referrals. These changes have been matched by reforms on the supply side, including an expanded role for

independent and voluntary sector providers and a new prospective funding system for hospitals termed 'Payment by Results' (PbR).

It is clear from supporting policy documents that the government expects behavioural and cultural changes – especially in relation to innovation, service redesign and customer care – to result from the latest raft of reforms. Notwithstanding the discussion above about the malleability or otherwise of cultures, there is evidence from across all three case studies to suggest that the various national reforms are having a significant impact on influencing the cultures of NHS organisations, although the nature and impact of national policies differed between case studies.

In the Metrotown case study the expansion of patient choice was viewed as a relatively unimportant factor in driving internal changes as it was widely believed that there was little local competition for services and the local population appeared to remain loyal to the organisation irrespective of the very public difficulties experienced by the Trust. The new PFI build was also viewed as a strong 'totemic' driver of cultural change in the hospital given its construction on site and the reduced beds it could accommodate would require higher levels of bed turnover and efficiency.

In Bigtown Trust there was also a focus on meeting external performance targets (but unlike Metrotown this was to maintain their high performance rather than turn around under-performance). However, the act of transitioning to Foundation status in and of itself was not seen as a major driver of culture change, but rather more as an organisational development compatible with the direction that the trust had already decided to take. Indeed, there appeared to be little awareness of implications of foundation trust status below senior management level, with only a small proportion of staff aware of the new financial freedoms afforded to foundation trusts and many were not aware of the new governance structures mandating direct local input into the management of the organisation.

Similarly, the culture of Smalltown PCT had been affected by the national system reform agenda , particularly the Commissioning a Patient Led NHS (CPLNHS) reforms of 2006, under which the PCT has been required to create a clear split between its commissioning and provider function. The focus on implementing the contestability agenda had created a lot of work around tendering and had increased anxiety among staff, especially when in house providers hade failed to win the first major contract put out to tender. The contestability agenda was also believed to be changing relationships and structures as well as attitudes to service provision within staff lower down the hierarchy in the provider arm, increasingly driven by the emphasis on performance measurement and contestability which was in contrast with the policy of integration and unity espoused by senior managers. The fact that Smalltown's boundary was left unchanged following the NHS CPLNHS reforms appears to have helped in avoiding the turbulence experienced at other PCTs as part of this national reform.

Crisis and threat to survival

For Bigtown Trust the dominant 'can-do' performance-driven culture was reported to have originated from the organisation's response to a highly critical regional NHS service review in the mid 1990s. At the time the trust had been threatened with closure due to its poor clinical and financial performance, but despite being under-resourced had subsequently improved its performance to the extent that the threat was lifted. This 'heroic' response to subsequent difficulties, and a desire to prove itself, was credited with the current performance culture with its emphasis on achievement and success.

Metrotown too has experienced very significant problems. The Trust has had a long standing financial deficit, which, together with serious failings in clinical governance, were threatening the survival of senior managers, clinical teams and patient services. Yet the lack of movement by patients to alternative providers enabled Metrotown to exist through crises without facing actual extinction.

Around two thirds of PCT have been merged over recent years as part of the CPLNHS reforms and Smalltown PCT's success in preserving its original boundary and avoiding merger was viewed, at least internally, as a recognition of its success in integrating services across health and social care. However, continued survival was not taken for granted, and there was a perception that Smalltown had to continue making rapid progress to justify its status and independence.

External assessments and monitoring

The publication of external assessments and reports were cited as important catalysts for culture change, particularly when they highlighted deficiencies in financial and/or clinical performance. This finding is supportive of previous research which has shown that adverse external assessments can be a very important driver of organisational change, particularly where they throw light on failings previously identified by middle managers, but ignored by senior staff (Mannion et al., 2005).

As noted above Bigtown's improvement in performance dates back to the mid 1990s when a critical report on acute provision in the region which had helped to initiate a series of performance improvement programmes and a new performance management framework for the organisation.

In Metrotown Trust a severely critical Healthcare Commission Report had concluded that it had focused on finance issues to the detriment of patient

care. And although the hospital had continued to run at a significant deficit, a great deal of board energy had been invested in trying reduce the deficit. Although there had been some resistance across the organisation, particularly among a hard core group of clinicians committed to blocking change and maintaining the status quo, the Health Care Commission report but was cited as providing significant legitimacy and impetus for change, with new practices and behaviour becoming established in surgical specialities.

Reputation and status

Research within economic-sociology has highlighted that a desire to maintain (or develop) a reputation as a high status organisation within a local or national is market is often a significant incentivising factor for organisations to seek to improve their performance along a range of dimensions (Lunt et al., 1996, Granovetter 1985). In particular the medical professions are well known to be highly competitive with their peers in terms of relative reputation and status.

In Bigtown Trust, contrasts were made to the neighbouring teaching trust with a longer history, a well-endowed charity and a more significant academic reputation (Uptown Trust). The desire to 'prove itself' in relation to Uptown's performance and reputation was often cited as a key influence on the formation of the highly developed performance management culture within the organisation. It was also reported that the presence of specialist units in the Trust with an established international reputation served to inspire other units within the organisation to attain similar reputations. And managers were less concerned with potential competition from the private sector as they were of threats from other international organisations in terms of research excellence.

Smalltown Trust's success in maintaining their boundary was viewed as external recognition of their good reputation and status both nationally and within the local health economy. The Trusts success in achieving and maintaining high levels of performance and in pioneering the integration of health and social care services had attracted attention from both NHS and international organisations and this was viewed by staff as a positive motivating factor.

Local media

The local media can provide a significant stimulus to change and are an important part of local influencing factors. It is often through local media that formal performance and appraisal data are rearticulated and given extra impetus.

In all three case studies performance improvement within the sentinel organisation had been reported, to a greater or lesser extent, in the local media. In Metrotown Trust the Healthcare Commission investigation was reported extensively in the local media which had focused attention on the organisation and it was reported to have helped galvanise internal action, particularly by senior managers. Indeed the local media were reported to be hostile to developments at Metrotown and this had contributed to creating a 'victim mentality' at the Trust. There is a widely held belief among staff that the organisation is being 'persecuted' by a range of hostile external interests and should be left space to effect change.

Purposeful attempts at change

All three case study organisations were attempting to purposefully manage their cultures towards desired outcomes, with varying degrees of success. In all there was an increased emphasis on developing more robust performance management arrangements and strengthening lines of accountability for clinical quality.

Bigtown Trust had a long history of trying to embed a performance management culture in the organisation dating back to the trust's response to the regional NHS review in the 1990s. The most recent change management programme focused on process indicators, particularly length of stay, but including externally-defined indicators such as the four-hour A&E wait target and the 18-week referral-to-treatment target. The development of indicators was accompanied by a programme of organisational change, introduced division by division, to support achievement of performance improvement, reportedly as a response to patient choice.

In Metrotown, the turnaround process has been successful in that it has allowed the hospital to move closer to financial balance, but alongside this had created a great deal of tension and uncertainty for those that had to go through the process of redeployment. The most recent Chief Executive was attempting make management more personal and immediate and this was having an impact in terms of how the senior management team worked, particularly their increasing willingness to work with middle managers and clinicians. Another recent attempt to change the culture of the organisation was to highlight as 'heroes' through in-house communications those responsible for managing significant improvements. In addition there was an increased use of staff appraisal systems to help instil the new high performance cultures across the organisation.

In Smalltown there were a variety of initiatives to both create and sustain cultural change, using a wide variety of mechanisms including 'thank you sessions', improving working lives, investors in people, and active

engagement. There was also investment in communications, within the organisation and more broadly. However, the emphasis here was often on unity and integration rather than the separation of provider and commissioner functions. Management training had been undertaken by participants in the provider arm of the PCT and it was perceived as beneficial. Providers had worked with both internal allies and an outside organisation to enhance their business culture (business planning, marketing, tender development, financial development and other issues).

Thus, across each of the organisations studied in detail, specific initiatives generated internally sought to manipulate local cultural values, sometimes in direct response to external demands and developments.

Facilitators and barriers to planned culture change

Although organisational cultures are constantly in flux, their purposeful management and manipulation to serve wider organisational ends is a difficult and uncertain business. Moreover, culture change initiatives may not always proceed unhindered and therefore a key determinant as to the success or otherwise of a culture change programme may depend on the extent to which barriers to change are surmounted. Across the Trusts staff identified a range of levers used by the trust to enact culture change as well as a range of organisational impediments which served to block or attenuate planned efforts at culture change.

Guardians versus reformers

Any organisation subject to change is likely to have both members or sub-cultures who support the desired change (enhancing sub -cultures) as well as those who wish to protect the current order (counter cultures) or block change. The relative influence and power of these groups to drive through or block change will determine the pace and impact of purposive attempts at culture change.

In Metrotown both managers and professionals appeared split between the 'guardian' and 'challenger' positions regarding their acceptance and willingness to engage in cultural change initiatives. It was apparent the closer staff were to patient care, the more 'guardians' were found and there was widespread resistance of frontline staff to the 'top down' initiatives that were being implemented across the organisation.

In the Smalltown PCT, resistance to change by some long standing, nominally senior supervisory staff were identified as barriers to change. In some cases, staff simply refused to consider different ways of working.

Senior managers perceived that some staff were defensive and negative (qualities that were perceived to have no place in the 'can do' organisation) and the view was expressed that such people would not be tolerated in the long term.

This one way of understanding the sometimes faltering nature of cultural shifts is to identify challenging behaviours and counter cultures.

Receptivity to change

In Smalltown the developmental culture (creative, adaptive, leader as risk-taker, emphasis on innovation) meant that changes was viewed as a positive organisational attribute. The willingness of senior management to embrace innovative approaches to delivering services (from whatever source or philosophical approach), accompanied by a stubbornness when they believed outcomes would be threatened by the rigid implementation of (usually central government) initiatives appeared to be an important facilitator of change. This willingness to innovate and adopt flexible approaches on the part of senior management also appeared to filter down the organisation. In contrast, in Metrotown the local environment was less conducive to change. Not only was there little external pressure from patients and the local population for change but there were powerful forces within the organisation that were overtly resistant to change and sought to maintain

Size and coherence of the organisation

For Smalltown, being a small PCT appeared to be both a facilitator and a barrier with regard to change. Being small enabled the PCT to be 'faster moving'; but at the same time small size placed significant limits on its capacity to deal with some issues. In contrast, the size and diversity of the two hospital Trusts that we studied made it difficult for them to drive through trust-wide organisational and culture change, particularly as staff tended to align themselves with their local cultures rather than the trust as a whole. Thus considerations of size and diversity are important issues in understanding the dynamics of local cultural change.

Unintended and dysfunctional consequences of culture change

In addition to driving beneficial outcomes, culture change was reported to have induced a range of unintended and dysfunctional consequences for organisations and staff, including increased levels of stress and anxiety, and instability brought about through organisational turbulence.

If culture represents a meaningful thought-system, then even small changes in working culture can provoke seemingly disproportionate reactions of anger, resistance, stress and anxiety. Across the case studies it was reported that the increased emphasis on meeting external targets and the shift towards more performance management cultures was creating high levels of stress and anxiety, particularly among front-line staff. The increased marketisation of the NHS was also reported to be a source of increased anxiety for hospital managers as services were increasingly threatened by competition from rival providers (including the independent and private sector) and financial flows under Payment by Results were more uncertain that the traditional system of block funding used to fund hospitals.

In addition to contributing to increased levels of anxiety and stress the hectic pace of change and general instability associated with continuing 'redisorganisation in the NHS' (Smith et al., 2001) was hampering long term planning and follow through of existing programmes. In Metrotown, the rapid turnover of senior management, in particular the number of successive Chief Executives, had contributed to instability and the follow through of policies and programmes within the organisation. And even in the Smalltown PCT which had benefited from not being merged in the latest round of primary care reforms, extensive organisational change was underway, including service redesign, relocation and deployment of staff. There was a general feeling that the degree of organisational change expected in the NHS was focusing too much attention on structural rather than cultural change.

8.5 RESEARCH AIM 3: Analysis of the relationships between changes in culture and performance at both an organisational and a local health economy level;

In the study we have examined a wide variety of dimensions of performance which reflects the difficulty at the heart of performance assessment and why relationships between organisational culture and performance are hard to determine: there is almost as much dispute over how to define performance in health care as there is about defining culture (Smith, 2000). Although frequently presented as a hard-nosed, bottom-line concept, performance is, in practice, almost as nebulous, elusive and as complex as culture. There exists, for any organisation, a range of possible measures. This is true especially of health care, with measures of clinic process, health outcomes, access, finance, productivity and employee variables all offering some potential (Mannion and Goddard, 2002). In addition, different channels of communication may convey different performance information, for example the apparent 'hard' information contained in league tables may differ from the 'softer' intelligence circulated around informal and professional networks (Goddard et al., 1999).

In methodological terms there is a concern over the degree of separation between the 'variables' of 'culture' and 'performance'. At one extreme, conceiving organisational culture as 'the way things are done around here' sounds suspiciously like a definition of realised performance. Thus there is a danger of clouding cause and effect and so clouding rather than illuminating any culture-performance link. A further difficulty lies in disentangling any direction in causality between performance and culture. Although almost all previous studies have focused on how culture affects performance, it is equally plausible that certain cultures emerge from high (or low) performing organisations. That is, performance drives culture. More likely still is that culture and performance are reciprocal, recursive and mutually reinforcing.

Our base line data for hospital Trusts identified clear associations between culture and performance along a range of performance dimensions (Davies et al., 2007) and in particular evidence to support a contingent relationships between culture and performance: that is organisations tended to excel in areas valued within their dominant culture. However, linking culture-performance using later data proved more problematic due to the number of merged organisations, and lack of continuity of performance data since the base-line study. Nonetheless we did uncover some evidence of a contingent relationship between culture and performance using more recent data. Our case studies provided richer insights into the linkages between culture and performance both within the sentinel organisations and across health economies.

Bigtown Trust has an open, performance driven, rational culture, which is focused on innovation. This culture seems to have originated over a decade ago, in a period during which the Trust's performance has changed from being a poorly-performing to a high-achieving organisation. Senior interviewees in the trust attributed some features of its culture to a response to being labelled as poorly performing in a regional review of services. The dominant culture was most evident in the senior management team, and at senior level in one division. In less senior staff, and in another division which had not undertaken the trust's most recent organisational change programme, the dominant culture had less of a hold. The trust's performance had been improving by national indicators and financially, and some interviewees gave the trust's culture some of the credit for this improvement. A culture conducive to performance improvement may need to permeate only certain critical groups in order to have an impact. A question arises from this as to whether, as it 'owns' its identity as a high achieving organisation, the effect of this driver will start to wear off.

In Metrotown Trust, culture is often described as being very locally constituted. Committees have cultures, especially where they have long-standing members who expect to be able to behave, in that forum, in a particular way. A metaphor for the performance problems the Trust appears to have experienced might be that of a 'downward spiral', in which clinical governance and financial problems have led to managers having to impose

very transactional systems upon the organisation, increase the amount of internal controls, and attempting to overcome problems by being far more interventionist. This has led to middle-level managers expressing resentment of central interference in their jobs, and nurses and doctors often being extremely upset at staff reductions and programmes of redeployment that they believe have been handled badly. This might be thought of the move of a clan-based organisation to one that is more hierarchical, but which reduces trust within the organisation as it becomes more rule-based instead – or moves from what Klein described as from a system based on trust, to one based instead on contracts (Klein 1993). This leads to greater resistance from disaffected staff, and potentially for the centre to want to get more involved at operational levels of the organisation again – a potentially destructive spiral downward in which performance suffers as managers have less space to manage, and where staff feel increasingly de-motivated.

Smalltown Trust was widely described as having a dominant 'can-do' Developmental culture which values spontaneity, creativity, innovation and risk taking was open to testing new ideas and working practices. Relationships between health and social services were reported to be very good with a staff working across professional boundaries with the shift towards integration of services and the co-location of health and social care staff. However, differences were highlighted between health and social care cultures within the organisation, with health services viewed as having a more hierarchical and mechanistic approach to service provision necessitated by the need to respond to clinical risks and enhance patient safety. The contestability agenda was reported to have resulted problems around integrating health and social care services some managers viewing this as 'integrated separation' whereas frontline staff perceived it more as 'separated integration.' The provider arm was believed to be evolving more quickly into a Rational type culture which was based on more of a business model and with a growing emphasis on marketing their services to compete with rival providers. Smalltown PCT serves a population with high levels of deprivation and it was reported that managers were focused on reducing health inequalities across the health economy, although narratives of deprivation were deliberately downplayed so as not to stifle attempts to position Smalltown as serving a thriving local community which was attractive to the business world and would be a good place to live and work.

System reform

Modern health care relies increasingly on good intra and inter-organisational co-ordination and the shared accomplishment of delivery through clinical and professional networks, partnerships and a range of collaborative working arrangements between acute, primary and community services. Implementation of key system reforms, including the creation of Foundation Trusts, Payment by Results, Patient Choice and the agenda in primary care, formed the policy background to our study and our empirical work, in particular the in-depth case studies and afforded a unique opportunity to explore in depth how these national system reforms played out at the local level were impacting on relationships and performance across local health economies.

Impact of Foundations Trust status

When the idea for establishing Foundation Trusts was set out (Department of Health, 2002) there were concerns that such powerful organisations would be able to dominate local health economies, and in particular local PCTs would not have the leverage (or cadre of managers) to counterbalance their power to determine the organisation of local health services.

The Bigtown case study would suggest that such concerns are over-played as staff within the Trusts as well as local PCTs believed that transitioning to Foundation status had made little difference to how the organisation operated within the local health economy and how it was perceived by key local stakeholders. It had not changed the good relationships between the trust and the PCTs, and PCT interviewees reported their confidence in the judgement of the trust in taking independent action. There were some reports from staff in Bigtown Trust regarding PCTs making unreasonable demands for information to support commissioning, but the PCT account of how financial trust status had affected the relationship suggested that it might be influenced by the Department of Health attempting to make PCT monitoring substitute for direct management of Foundation Trusts by the department.

Impact of Payment by Results

The new prospective funding system, termed Payment by Results in England (PbR), under which hospitals are paid on the basis of the type and amount of work they undertake also had influence. PbR replaces block contracting arrangements, according to which hospitals receive a fixed annual sum in order to provide a pre-specified level of activity. Moreover, instead of locally negotiated prices, PbR introduces a set of national prices (tariffs) which fix the amount payable for the provision of hospital care to each type of patient. The stated objectives of PbR are to stimulate hospital activity (thereby reducing waiting lists), reward efficiency, facilitate patient choice and encourage a mixed economy of provision by allowing 'money to follow the patient' By design, the new financial arrangements will create high powered incentives for NHS organisations to behave differently. In very crude terms: NHS hospital Trusts have incentives to increase activity to maximise their income and PCTs have incentives to manage local demand and prevent hospital admissions in order to balance their budgets (Mannion et al. 2008b; Mannion and Street, 2009).

In the Bigtown Trust case study there was concern across the health economy that Payment by Results was serving to frustrate integrated primary and secondary care provision and to damage relationships between NHS organisations as they competed for patients and resources from PCTs. Nevertheless good relationships were seen by some as persisting despite, rather than because of, recent structural changes in the NHS.

In Metrotown there was a generally held view that the trusts had been disadvantaged by a decision by the Strategic Health Authority and local PCT to locate deficits (via Payment by Results) at the PCT and this had caused series financial problems at the Trust. In Smalltown the introduction of Payment by Results was forcing new ways of demand management and the provision of services outside acute settings.

Patient choice

Patient Choice was not considered a major driver of organisational or cultural change in any of the three case studies, with Metrotown in particular being (apparently) unaffected by the policy. Despite Metrotown operating on the fringes of an urban conurbation where there was relatively easy access to several alternative providers of care, and so there being considerable potential for a healthcare market to develop, it did not appear that developing a more externally-focused, pro-market approached had taken root within the organisation. Senior managers within the Trust explained that GP practices seemed to refer patients to the hospitals where they had always referred them, which was usually the nearest to the GP practice, and did not appear to be particularly interested in either advising their patients to go to new providers, or to alter their referral patterns. This goes directly against the idea of the extending patient choice proposals, and did not appear to be changing as a result of greater availability of information about hospital performance. Patients were not being referred to a closer hospital (where new entrants appeared) or more highly-rated providers of care in the new mixed economy of care. Instead, they seemed to be simply going to the care provider they had been referred to in the past. Patients appeared reluctant to travel, to have low expectations of the Trust but not to be looking for an alternative, and senior managers appeared to be of the opinion that there was little danger of patients travelling elsewhere (although there was some acknowledgement that this situation might change in the future, GPs were regarded as driving most referral decisions).

Contestability agenda in primary care

In Smalltwn the national contestability agenda in primary care was thought to have the potential to create a 'them and us' relationship which may jeopardise the apparent high morale and good working relationships within the local health economy. Furthermore since commissioners now need to cooperate with in-house providers in order to develop service specifications for tendering services, but provider involvement may bar them from tendering, the potential for tension was reported to be increasing. In the absence of such inside knowledge and in an environment of rigid arms length contractual arrangements, the PCT was thought to be facing a greater financial risk as they would be responsible for payment of service elements which were omitted from original contracts.

8.5 Concluding remarks

In this section we have summarised and integrated across our findings from the national surveys and in-depth case-studies. The national quantitative data derived from a standardised culture rating instrument provided a broad overview of extant cultures in NHS organisations and highlighted a range of culture change and culture -performance linkages. Our in-depth case – studies support our headline quantitative findings and contribute a richer and more nuanced understanding of how culture and performance are interlinked and accomplished within acute and primary care organisations and across health economies.

In the following section we conclude with both an examination of the policy/managerial implications of our findings and a look forward at the emerging research agenda around these issues.

9 Conclusions, Policy, Management and Research Implications

9.1 Introduction

Although the notion of organisational culture is now invoked frequently in the social science and popular management literature, it remains a contested concept, fraught with rival interpretations and eluding standard definition. This contestability however has not precluded culture change and management from becoming a familiar prescription in health system reform. Nowhere is this more apparent than in the UK health system where the centralised system of the NHS has allowed opportunities for the government to experiment with a top down approach to system reform with the expectation that structural and procedural change will foster new values, beliefs and working assumptions across organisations and lead to enhanced quality and performance.

As we have noted elsewhere (Mannion et al., 2005), seeking quality and performance improvement in the NHS through cultural renewal and regeneration assumes the following step-wise logic:

4. The NHS and its parts posses a discernible culture or cultures.

5. The nature of such culture(s) has some bearing on performance.

6. Such cultures are malleable and not impervious to change.

7. It is possible to identity cultural attributes that are facilitative of high performance (or at least pinpoint those that are damaging).

8. Policy maker can design (an optimal mix of) strategies that influence the formation of beneficial cultures.

9. The benefits that accrue from managed culture change will outweigh any dysfunctional consequences.

Our earlier work shed some light on these issues and we concluded that more sustained longitudinal analysis was required to explore more in-depth the dynamics of culture change in the NHS and how culture change links to performance across local health economies (Mannion et al. 2005). Using a mix of quantitative and qualitative approaches in this study we have taken up this challenge and explored culture change across a variety of health care settings

The rest of this section identifies and elaborates some of the key policy and managerial implications arising from our findings before looking at the emerging research agenda around these issues.

9.2 Key findings and their implications for policy and management

Key finding 1: Culture matters

A key finding of the study is that culture matters and is seen to matter in the delivery of high levels of quality and performance in the NHS. Managers at all levels in both secondary and primary care, recognised the significance of culture and were either actively engaged in trying to shape it or felt constrained by its pervasive influence. We found that cultures within NHS organisations defy simple categorisation and are context dependent as they are the product of a unique configuration of historical, internal and external background factors which combine to create particular cultural profiles for each organisation. Moreover, within NHS organisations rather than one singular culture which is uniform or coherent, a variety of micro or sub-cultures will be in existence, possibly separated along professional and occupational lines. Different sub-cultures may be more or less malleable to (susceptible to managed change of their artefacts, values and beliefs) or may even be avowedly resistant to change. Indeed, it is apparent that some organisations function more or less successfully with discordant sub-cultures, with each culture being no more than 'loosely coupled' to other subcultures or subsystems. While on the one hand organisational culture can be fragmented into various subcultures, it should be remembered that organisational culture itself is a subculture within a larger set of supracultures and within our case studies each organisational culture was obviously influenced clearly by the national and NHS culture.

Policy and managerial implications

There is some justification for the current focus on managing cultures alongside structural and procedural reform. However, simplistic attempts to manage or 'engineer' change in culture are unlikely to bear fruit unless they are sensitive to the complexity, fragmented and multi-level nature of organisational cultures. Organisation culture is transmitted and embedded via a wide range of media, including established working procedures and practices (e.g. rewards ceremonies, exemplary individuals, written documentation, physical spaces, professional demarcations, shift patterns). It is unrealistic to expect culture change strategies to be effective on all these fronts simultaneously. Successful strategies require realistic time-frames to implement the types of complex and multi-level changes required. Policy makers and managers need to be alert of the role of sub-cultures in blocking or attenuating change efforts as well as the practical difficulties of trying to deal with cultural diversity by adopting 'culturally' sensitive strategies and tactics for dealing with different professional and occupational sub-groups. As the influence of outside interests may cut across and sometimes work against efforts at internal reform culture change strategies need to heed the constraints posed by external stakeholders in determining the values and behaviour of health professionals. Attempts to change the culture of the NHS may also need to target external bodies such as the Royal Medical Colleges, which exert control over training and influence the internalisation of professional core values.

Key finding 2: Management cultures in the NHS are becoming more Rational and competitive

The government's pro-market reforms appear to be associated with changes in the ideas, values and beliefs of hospital and PCT managers, although at Practice level Clan is still very dominant. In hospitals and PCTs there has been a decline in Clan cultures (bonded on loyalty and tradition, with an emphasis on morale) and a concomitant rise in Rational cultures (with an emphasis on being competitive and winning). Although, sub-groups lower down the organisational hierarchy are not necessarily aligned completely with the espoused managerial philosophy we did find evidence to suggest that middle managers and some professional groups were increasingly aligned with more competitive cultures and in some cases far from being unwilling participants in such changes were in fact at the vanguard of driving more competitive practice.

Policy and managerial implications

The shift towards more Rational cultures may make it easier for the government to push forward its pro-market system reform agenda. However, much current policy rhetoric espouses the virtues of striking an optimal balance between co-operative and competitive behaviour within local health economy relations, and the drift towards more competitive behaviour among providers and commissioners may make partnership working and the shared accomplishment of service delivery more difficult to achieve. The decline of clan cultures in both hospitals and PCTs (with their emphasis on morale and staff welfare) may also cause problems in terms of developing effective Human Resources policies.

Moreover, the apparent growing divergence between dominant PCT cultures (a large drop in Clan and a significant rise in Rational and Developmental) and GP practices (continued dominance of Clan) picked up by our national study, may have unintended and possibly deleterious consequences for the organisation and delivery of primary care. However, as Practice Based Commissioning and payment for performance arrangements take hold at practice level we may see a convergence towards more Rational and Developmental cultures.

Key finding 3: performance is as complex and contested as culture

Defining organisational performance, is perhaps, almost as difficult as defining organisational culture as for any organisation, a range of possible assessment criteria, with measures of clinical process, health outcomes, access, finance, productivity and employee variables all offering some potential. Indeed different channels of communication may convey different performance information, for example we found that the 'hard information' contained in official performance indicators often differs from 'softer' intelligence circulating around informal networks.

Although the three 'sentinel' organisations in the case studies had all improved their performance over recent years, national system reforms (e.g Foundation Trusts, Patient Choice) were not necessarily the key drivers or main factor in their performance improvement and in the cases of Bigtown and Smalltown were supporting a trajectory that the organisation was already on or, in the case of Metrotown, appeared to have little impact at all on the organisation. We also found examples of national system reforms and local initiatives driving performance change in unexpected and unintended ways and garnering both active support as well as open and covert resistance from staff.

Where performance improvement was taking place this was the outcome of the complex interplay of external stimuli and local contingent factors, including the support of organisational sub-cultures, improving manager-doctor relations and stability in senior management teams. Other drivers of performance improvement included external assessments, and a desire among managers and health professionals to maintain or enhance personal or organisational reputation and status.

Policy and managerial implications

In health care, performance remains difficult to measure and dependent on the purpose and perspective of the evaluation. Given that performance assessment is complex and performance is dependent on a range of locally determined factors (some of which are beyond the control of incumbent management teams) external assessments should be alert to these rather than adopt a 'one size fits all' approach. Organisational longevity and survival may be considered both drivers and the outcome of enhanced performance.

Key finding 4: Organisational culture appears to be linked to performance in a contingent manner

Our base data from 2001 uncovered significant quantitative associations between organisational cultures in hospital Trusts and their organisational performance, as well as qualitative evidence of a variety of mechanisms whereby such associations may be mediated. The CVF typology highlighted that different cultures may be more or less able to perform, depending on those aspects of performance that are valued within that culture. Whilst making inferences of causality from cross-sectional associations is problematic, the in-depth fieldwork provided good corroboration by highlighting many plausible mechanisms by which cultural expectations may influence patterns of working and hence performance. We also drew attention to the ways in which culture and performance interact in an iterative manner, perhaps even being mutually constituted, contingent and bi-directional. Our latest quantitative data using the CVF framework, lends further support to our argument that there is a contingent relationship between organisational culture and performance in NHS hospital Trusts, although assertions of causality need to be tempered by due appreciation of the limitations of the data and methodological constraints. Our in-depth case studies have contributed further understanding of the mechanisms through which culture and performance are accomplished and interact in particular organisational settings and across local health economies. The external context, not least the national system reform programme driven from the Department of Health, was seen as sometimes enabling and facilitating and sometimes disabling, distracting and damaging.

Policy and managerial implications

As far it is practicable, there is a need to develop appropriate cultures within NHS organisations that are aligned to the key policy objectives of the NHS. However, the growing evidence to support a contingent relationships between cultures and performance suggests that trade off will have to be made between policy objectives, with cultures then shaped to fit the key priorities. As culture is so embedded in organisations, and is so slow and difficult to change, a degree of realism is needed about the extent to which cultures can be manipulated to align with fast changing policy. The identification of longer-term more enduring values may be more realistic. Given that the performance of individual organisations is highly connected with the performance of the local health economy, which in turn is likely to be influenced by the quality of inter-organisational relationships, co-operation and partnership working among local agencies, policy makers need to develop incentives for senior managers to adopt a 'whole-economy' perspective that promotes collaborative working. One way of doing this would be to incorporate some assessment of the quality of communications and interactions in the local health economy within current accountability arrangements. There is also a need to train and support key boundary spanners who work through networks and are given resources and freedoms to transcend traditional organisational boundaries.

Key finding 5: dysfunctional consequences of system reform and culture change are likely

The case studies identified a range of unintended and dysfunctional side effects that had been induced by the government system reform agenda. In particular we heard that new systems reforms and new performance management cultures were creating increased anxiety and stress for staff as they strive to meet targets and develop new ways of working within the NHS market. We have also shed new light on the damaging consequences of the scale, frequency and rapidity of organisational change in the NHS. Within the case study organisations, particularly Metrotown (which had a high turnover of Chief Executives) organisational instability and discontinuity in leadership styles and strategies made it difficult to instil new working practices and communicate a clear vision for change. These deleterious effects have the potential to undo or overshadow many of the positive aspects of culture change.

Policy and managerial implications

Unintended and dysfunctional consequences of any attempt at culture change (national or local) are likely and should be anticipated and closely monitored, with policies put in place to try and mitigate them. This should be undertaken in an open and transparent manner and, where problems are found, this needs to be clearly reported.

9.3 Challenges in Project Delivery

Research governance and the national survey

The national surveys of hospital and PCT managers and the sub-set of GP practices involved negotiating with over 400 local Research and Development Committees. This was a very laborious and time consuming task as many R&D committees have different forms to complete and require regular reports on progress, with some requiring three-monthly updates.

Over the period of the research the NHS has undergone a series of major reorganisations, with many PCTs and hospital Trusts subject to merger or dissolution. This, along with changes to how performance data is produced and assembled and methodological has made it very difficult to track changes in culture-performance relationships across health economies, particularly since our baseline study in 2001.

However, we are confident that augmentation of our dataset with additional performance data downstream will enhance our ability to perform lagged analysis.

Securing access to case studies

Although we eventually secured access to our three case studies this was a very difficult, protracted and time-consuming business. Several organisations had originally agreed to participate in the study but later declined due to a variety of reasons. Even when the three sentinel organisations we eventually studied agreed to participate we encountered further problems. For example we had to wait until Bigtown Hospital Trust had met the conditions set by MONITOR before it was granted Foundation Trust status and we were sure that it would make a suitable case study. And given the nature of the clinical governance failing in Metrotown Trust much of the data was highly sensitive and it proved difficult to gain (or tape) interviews with some key staff. Metrotown Trust did not allow permission for the local CVF survey within the duration of the study but this has recently be granted and we hope to conduct this in the near future.

9.4 Project Outputs/Looking Ahead

This report as befits work funded by the SDO research programme focuses on real world exploration and practical ramifications of the dynamics of culture-performance relationships in the NHS. Future research outputs will seek to contribute to <u>both</u> the professional and academic literatures.

Publications

- From cultural cohesion to rules and competition: the trajectory of senior management cultures in English NHS hospital Trusts, 2001-2008, submitted to *Journal of the Royal Society of Medicine*, 102 (8): 332-336, 2009

Publications in press/under review

- Management cultures and performance in the NHS: A longitudinal analysis, Journal of Health Economics

- Changing management cultures in the English National Health Service, in Braithwaite et al. (eds) *Culture, Climate and Teams in Health Care Organisations*; Palgrave Macmillan (forthcoming, 2010)

Papers in preparation

- 'Notes on the scandal: clinical governance failure and media coverage' to *Sociology of Health and Illness*

- 'Dealing with organisational culture on the ground: the case of a struggling hospital', to *Human Relations*.

The research team has until recently been very focussed on completing the fieldwork, initial analysis and first-phase report writing. While two papers have been completed and submitted, and the those noted above are in draft, we anticipate a steady stream of papers mining the case studies – singly, and collectively reading across – as well as additional publications from the (ongoing) quantitative analysis of our substantial national culture/performance data set.

Knowledge mobilisation

As well as presenting the work at the usual academic conferences (BAM, EHMA, EURAM, OB in Health Care, ISQuA etc.) we intend to work with the SDO Network (hosted by the NHS Confederation) to reach out to wider NHS audiences. Here we envisage running a series of one-day interactive seminars for audiences invited through SDO Network. The aim of these will be to share our findings through discussion with managers (clinical and non-clinical) and other stakeholders to ensure maximum engagement. From these grounded discussions we would see publications emerging aimed specifically at NHS professional audiences through such outlets as the Health Service Journal.

9.5 Research Agenda

This report provides evidence for the importance of culture in the organisation, delivery and performance of health services. Yet because of the pace of health system reform and the complexity of both culture and performance in the NHS there is still much to explore about these important facets of organisational life. Therefore we suggest that there remains a challenging policy and managerial focused research agenda around culture, culture change and performance in the NHS. Specific areas which warrant further and sustained investigation might be considered in the following areas:

- Our quantitative data has shown a significant change in the nature of dominant senior management team cultures in NHS hospital Trusts between 2001 and 2008. It would be very interesting to explore whether this trajectory continues in the future and similar surveys could be undertaken at regular (say 3 year) intervals. Collection of such data could be used to establish the impact of future system reforms on the management cultures in the NHS. Although it would be very resource intensive, it would be worthwhile conducting national surveys comprising staff lower down the organisational hierarchy and across different professional groups as this would provide a more comprehensive overview of (sub) cultures across the NHS. In addition the analysis of PCT cultures could also be extended into the future, particularly given that we appear to have picked up a significant cultural shift within a very small time.

- Our base-line survey identified significant contingent relationships between culture and performance, which was supported by our latest data. However, due to difficulties associated with discontinuous performance data our analysis is necessarily limited and should be

- interpreted with caution. As performance data become available it should be possible to undertake lagged analysis of culture-performance

- relationships; that is current performance is the result of previous cultures-a finding which is supported by our case study evidence.

- We appear to be witnessing a gradual shift away from Clan towards more Rational and Hierarchical cultures in the management of hospital Trusts and PCTs which is in line with the government's reform agenda. The rise of pro-market values within an organisation that has traditionally been underpinned by a strong public service ethos raises a number of important issues for the future of health care delivery in England. It is important that the implications of this shift in terms of managerial identity, training, recruitment and retention as well as the beneficial and unintended consequences of such changes for local health economies and patients are fully explored in future research.

- The current study has highlighted the potential for dysfunctional consequences to arise from planned culture change. It is important that any unwanted side-effects of the current reform agenda (at national and local level) are monitored and strategies put in place to mitigate these unwanted outcomes. For example it might be worth monitoring whether the focus on more competitive relationships within local health economies are giving rise to problems around partnership working and joint planning, including the design of inter-organisational pathways of care for patients with complex needs. Clashes of cultures (between for example health and social care staff and commissioners and providers) also give rise to conflict within organisations and local health economies, and future research may seek to explore the creative potential of tension within both intra and inter-organisational relations.

- The current study was informed by the culture change literature and adds new insights into the inter-relationships between cultures and performance across local health economies. Although organisational culture (or community governance) through its multilateral enforcement of group norms addresses certain economic and performance problems that cannot be handled efficiently by markets or bureaucracies, it is apparent that like markets and bureaucracies organisational cultures can also fail. For example organisational cultures work because they are good at enforcing group norms, and whether this is a good thing depends on how functional the group norms are vis-à-vis organisational and national policy objectives. The governance limitations of organisational cultures are currently under-specified in the institutional economics literature and would therefore benefit from further theoretical elaboration and empirical testing.

- Although our case studies provide considerable support for key messages from the culture change literature, with Smalltown in particular a text book example, there is also a clear need, based on the findings of our case studies, for the development of new and more sophisticated culture change models and frameworks which allow for a multiplicity of competing

cultures within an organisation rather than assuming a monolithic culture which is sustained until overthrown by the new order.

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Appendix One

CVF Questionnaire used in NHS hospital Trusts

ID ☐☐☐

Organisational Culture and Performance in the NHS – Evaluating the culture of your Trust

We have been funded by the Department of Health (SDO) Programme to explore the nature and dynamics of culture change with a specific focus on the links between organisational culture and performance.

W*e are seeking your views – as a key actor – on the dominant cultural characteristics of your institution.*

The attached questionnaire is part of a national survey of both acute Trusts and PCTs using a validated culture rating instrument (the CVF questionnaire).

There are only 11 questions and the whole questionnaire should take no more than 10 minutes to complete.

Section A

1. **Please tick the appropriate box to indicate the job title closest to yours**

Chief Executive	☐	Dir. of Facilities & Estate	☐	Director of Operations	☐
Dir. of Finance	☐	Medical Director	☐	Dir. of Human Resources	☐
Trust Chair	☐	Dir. of Development	☐	Non-exec Director	☐
Dir. of Nursing	☐	Other (please specify) _____			

2. **How long have you been in this post?** ـــــ months ـــــ years

3. **What is your gender?** Male ☐   Female ☐

4. **Which of these broad age groups do you fall into?**
   Under 40 ☐   40-49 ☐   50-59 ☐   60 plus ☐

5. **What is your gross annual income £ (NHS and other sources)?**

Under 20,000	
20,000 – 49,999	
50,000 – 79,999	
80,000 – 109,999	
110,000 – 139,999	
140,000 plus	

Do you have any clinical/medical background?   Yes □   No □

<u>Section B</u>

There are **5 questions** below. Each question is about a different aspect of your TRUST; for example, its leadership or its reward system.

Please distribute **100 points** among the four descriptions depending on how similar the description is to your TRUST. For each question please use **all 100 points**. Please answer according to what you think, not what others in your organisation think and don't think too hard – we want your gut reactions.

For example, in Question 1 if TRUST A seems very similar to yours, B seems somewhat similar and C and D do not seem similar at all, you might give 70 points to A, 30 to B and none to C and D. Question 1 and other examples might look as follows:

Question 1   Question 2   Question 3   Question 4

Question 1	Question 2	Question 3	Question 4
A 70	A 25	A 80	A 0
B 30	B 25	*B 10*	B 0
C 0	C 25	C 0	C 100

Please answer according to what you think that your TRUST is like <u>now</u>. There are no **right** or **wrong** answers! None of the descriptions are any better than the others – they are just different. Don't think too hard – we want your gut reactions.

	points	**QUESTION 1: TRUST characteristics**
		(please distribute all 100 points)
A		TRUST A is a very personal place. *It's like an extended family.*
B		TRUST B is a very dynamic and entrepreneurial place. *People are willing to take risks.*
C		TRUST C is a very formalised and structured place. *Bureaucratic procedures influence how things are done.*
D		TRUST D is very task orientated. *The main concern is getting the job done and people aren't very personally involved.*
total		

	points	**QUESTION 2: TRUST leadership**
		(please distribute all 100 points)
A		The leaders in TRUST A are warm and caring. *They seek to develop their staff members' full potential.*
B		The leaders in TRUST B are risk takers. *They encourage risk taking and innovation from their staff.*
C		The leaders in TRUST C are rule enforcers. *They expect staff to follow rules, policies and procedures.*
D		The leaders in TRUST D are co-ordinators and facilitators. *They encourage staff to meet the organisation's objectives.*
total		

QUESTION 3: TRUST cohesion

(please distribute all 100 points)

	points	
A		The glue that holds TRUST A together is loyalty and tradition. *Staff commitment to the organisation is high.*
B		The glue that holds TRUST B together is a commitment to innovation and development. *PCT B likes to lead the way.*
C		The glue that holds TRUST C together is formal rules and policies. *Maintaining a smooth running operation is important.*
D		The glue that holds TRUST D together is an emphasis on accomplishing tasks and goals. *People want to get jobs done.*
total		

QUESTION 4: PCT emphasis

(please distribute all 100 points)

	points	
A		TRUST A puts a strong emphasis on *cohesion and staff morale.*
B		TRUST B puts a strong emphasis on *growth and readiness to meet new challenges.*
C		TRUST C puts a strong emphasis on *permanence and stability.*
D		TRUST D puts a strong emphasis on *competitiveness and achievement.*
total		

QUESTION 5: TRUST 'rewards'

(By 'rewards' we mean praise, acknowledgement of success etc, as well as resources and financial incentives)

(please distribute all 100 points)

	points	
A		TRUST A distributes its rewards fairly among staff members. *Everyone is treated equally.*
B		TRUST B distributes its rewards based on individual initiative. *Those who are most productive are most rewarded.*
C		TRUST C distributes its rewards based on rank. *The higher you are the more you get.*
D		TRUST D distributes its rewards based on the achievement of objectives. *Those who achieve their objectives are rewarded.*
total		

THAT'S ALL! Thank you for taking the time to complete this questionnaire.

We very much appreciate your help with this research. Please do not hesitate to contact us with any queries or questions. If you would like to see the results of our analysis please give your contact details below _____

_____

_____

*You should be reassured that all information that we receive will be **anonymised**, with no comments or responses attributed to any individual or organisation. This National Survey has received Multi-centre Research Ethics Committee approval, as well as the relevant local Research Governance permissions.*

PLEASE return in the envelope provided, or send to the address below:

Dr. Russell Mannion

Centre for Health and Public Services Management

Sally Baldwin Building Block A

University of York

YO10 5DD

Appendix Two

CVF Questionnaire used in Primary Care Trusts

PCT VERSION

ID

Organisational Culture and Performance in the NHS – Evaluating the culture of your PCT

We have been funded by the Department of Health (SDO) Programme to explore the nature and dynamics of culture change with a specific focus on the links between organisational culture and performance.

W*e are seeking your views – as a key actor – on the dominant cultural characteristics of your institution.*

The attached **questionnaire** is part of a national survey of both acute Trusts and PCTs using a validated culture rating instrument (the CVF questionnaire).

There are only 11 questions and the whole questionnaire should take no more than 10 minutes to complete.

Section A

6. Please tick the appropriate box to indicate the job title closest to yours

Chief Executive □   Dir. of Nursing □   Clinical Director □

Dir. of Finance □   Medical Director □   Dir. of Public Health □

PCT Chair □   Vice Chairman □   Non-exec Director □

Other (please specify) _____

---

7. How long have you been in this post? ____ years

8. What is your gender?   Male □   Female □

9. Which of these broad age groups do you fall into?

Under 40 □   40-49 □   50-59 □   60 plus □

10. What is your gross annual income £ (NHS and other sources)?

Under 20,000	
20,000 – 49,999	
50,000 – 79,999	
80,000 – 109,999	
110,000 – 139,999	
140,000 plus	

11. Do you have any clinical/medical background?   Yes □   No □

Section B

There are **5 questions** below. Each question is about a different aspect of your PCT; for example, its leadership or its reward system.

Please distribute **100 points** among the four descriptions depending on how similar the description is to your PCT. For each question please use **all 100 points**. Please answer according to what you think, not what others in your organisation think and don't think too hard – we want your gut reactions.

For example, in Question 1 if PCT A seems very similar to yours, B seems somewhat similar and C and D do not seem similar at all, you might give 70 points to A, 30 to B and none to C and D. Question 1 and other examples might look as follows:

Question 1	Question 2	Question 3	Question 4
A 70	A 25	A 80	A 0
B 30	B 25	*B 10*	B 0
C 0	C 25	C 0	C 100

Please answer according to what you think that your PCT is like <u>now</u>. There are no **right** or **wrong** answers! None of the descriptions are any better than the others – they are just different. Don't think too hard – we want your gut reactions.

	QUESTION 1: PCT characteristics	
	(please distribute all 100 points)	
	points	
A		PCT A is a very personal place. *It's like an extended family.*
B		PCT B is a very dynamic and entrepreneurial place. *People are willing to take risks.*
C		PCT C is a very formalised and structured place. *Bureaucratic procedures influence how things are done*.
D		PCT D is very task orientated. *The main concern is getting the job done and people aren't very personally involved.*
total		

	QUESTION 2: PCT leadership	
	(please distribute all 100 points)	
	points	
A		The leaders in PCT A are warm and caring. *They seek to develop their staff members' full potential.*
B		The leaders in PCT B are risk takers. *They encourage risk taking and innovation from their staff.*
C		The leaders in PCT C are rule enforcers. *They expect staff to follow rules, policies and procedures.*
D		The leaders in PCT D are co-ordinators and facilitators. *They encourage staff to meet the organisation's objectives.*
total		

QUESTION 3: PCT cohesion

(please distribute all 100 points)

	points	
A		The glue that holds PCT A together is loyalty and tradition. *Staff commitment to the organisation is high.*
B		The glue that holds PCT B together is a commitment to innovation and development. *PCT B likes to lead the way.*
C		The glue that holds PCT C together is formal rules and policies. *Maintaining a smooth running operation is important.*
D		The glue that holds PCT D together is an emphasis on accomplishing tasks and goals. *People want to get jobs done.*
total		

QUESTION 4: PCT emphasis

(please distribute all 100 points)

	points	
A		PCT A puts a strong emphasis on *cohesion and staff morale.*
B		PCT B puts a strong emphasis on *growth and readiness to meet new challenges.*
C		PCT C puts a strong emphasis on *permanence and stability.*
D		PCT D puts a strong emphasis on *competitiveness and achievement.*
total		

QUESTION 5: PCT 'rewards'

(By 'rewards' we mean praise, acknowledgement of success etc, as well as resources and financial incentives)

(please distribute all 100 points)

	points	
A		PCT A distributes its rewards fairly among staff members. *Everyone is treated equally.*
B		PCT B distributes its rewards based on individual initiative. *Those who are most productive are most rewarded.*
C		PCT C distributes its rewards based on rank. *The higher you are the more you get.*
D		PCT D distributes its rewards based on the achievement of objectives. *Those who achieve their objectives are rewarded.*
total		

THAT'S ALL! Thank you for taking the time to complete this questionnaire.

We very much appreciate your help with this research. Please do not hesitate to contact us with any queries or questions. If you would like to see the results of our analysis please give your contact details below. _____

_____

_____

*You should be reassured that all information that we receive will be **anonymised**, with no comments or responses attributed to any individual or organisation. This National Survey has received Multi-centre Research Ethics Committee approval, as well as the relevant local Research Governance permissions.*

Appendix Three

CVF Questionnaire used in GP Practices

GP PRACTICE VERSION

ID

Organisational Culture and Performance in the NHS – Evaluating the culture of your PRACTICE

We have been funded by the Department of Health (SDO) Programme to explore the nature and dynamics of culture change with a specific focus on the links between organisational culture and performance.

W*e are seeking your views – as a key actor – on the dominant cultural characteristics of your institution.*

The attached **questionnaire** is part of a national survey of NHS institutions using a validated culture rating instrument (the CVF questionnaire).

There are only 11 questions and the whole questionnaire should take no more than 10 minutes to complete.

Section A

12. Please tick the appropriate box to indicate the job title closest to yours

Nurse □   Admin Support □   Doctor □

Allied Health □   Practice Manager □   Professional □

Other (please specify) _____

13. How long have you been in this post? _____ years

---

14. What is your gender?   Male □   Female □

15. Which of these broad age groups do you fall into?

   Under 40 □   40-49 □   50-59 □   60 plus □

16. What is your gross annual income £ (NHS and other sources)?

Under 20,000	
20,000 – 49,999	
50,000 – 79,999	
80,000 – 109,999	
110,000 – 139,999	
140,000 plus	

17. Do you have any clinical/medical background?   Yes   □   No □

Section B

There are **5 questions** below. Each question is about a different aspect of your PRACTICE; for example, its leadership or its reward system.

Please distribute **100 points** among the four descriptions depending on how similar the description is to your PRACTICE. For each question please use **all 100 points**. Please answer according to what you think, not what others in your organisation think and don't think too hard – we want your gut reactions.

For example, *in Question 1 if PRACTICE A seems very similar to yours, B seems somewhat similar and C and D do not seem similar at all, you might give 70 points to A, 30 to B and none to C and D. Question 1 and other examples might look as follows:*

Question 1	Question 2	Question 3	Question 4
A 70	A 25	A 80	A 0
B 30	B 25	*B 10*	B 0
C 0	C 25	C 0	C 100

Please answer according to what you think that your PRACTICE is like <u>now</u>. There are no **right** or **wrong** answers! None of the descriptions are any better than the others – they are just different. Don't think too hard – we want your gut reactions.

	QUESTION 1: PRACTICE characteristics	
	(please distribute all 100 points)	
	points	
A		PRACTICE A is a very personal place. *It's like an extended family.*
B		PRACTICE B is a very dynamic and entrepreneurial place. *People are willing to take risks.*
C		PRACTICE C is a very formalised and structured place. *Bureaucratic procedures influence how things are done*.
D		PRACTICE D is very task orientated. *The main concern is getting the job done and people aren't very personally involved.*
total		

		QUESTION 2: PRACTICE leadership
		(please distribute all 100 points)
	points	
A		The leaders in PRACTICE A are warm and caring. *They seek to develop their staff members' full potential.*
B		The leaders in PRACTICE B are risk takers. *They encourage risk taking and innovation from their staff.*
C		The leaders in PRACTICE C are rule enforcers. *They expect staff to follow rules, policies and procedures.*
D		The leaders in PRACTICE D are co-ordinators and facilitators. *They encourage staff to meet the organisation's objectives.*
total		

		QUESTION 3: PRACTICE cohesion
		(please distribute all 100 points)
	points	
A		The glue that holds PRACTICE A together is loyalty and tradition. *Staff commitment to the organisation is high.*
B		The glue that holds PRACTICE B together is a commitment to innovation and development. *PRACTICE B likes to lead the way.*
C		The glue that holds PRACTICE C together is formal rules and policies. **Maintaining a smooth running operation is important.**
D		The glue that holds PRACTICE D together is an emphasis on accomplishing tasks and goals. *People want to get jobs done.*
total		

QUESTION 4: PRACTICE emphasis

(please distribute all 100 points)

	points	
A		PRACTICE A puts a strong emphasis on *cohesion and staff morale.*
B		PRACTICE B puts a strong emphasis on *growth and readiness to meet new challenges.*
C		PRACTICE C puts a strong emphasis on *permanence and stability.*
D		PRACTICE D puts a strong emphasis on *competitiveness and achievement.*
total		

QUESTION 5: PRACTICE 'rewards'

(By 'rewards' we mean praise, acknowledgement of success etc, as well as resources and financial incentives)

(please distribute all 100 points)

	points	
A		PRACTICE A distributes its rewards fairly among staff members. *Everyone is treated equally.*
B		PRACTICE B distributes its rewards based on individual initiative. **Those who are most productive are most rewarded.**
C		PRACTICE C distributes its rewards based on rank. *The higher you are the more you get.*
D		PRACTICE D distributes its rewards based on the achievement of objectives. *Those who achieve their objectives are rewarded.*
total		

THAT'S ALL! Thank you for taking the time to complete this questionnaire.

We very much appreciate your help with this research. Please do not hesitate to contact us with any queries or questions. If you would like to see the results of our analysis please give your contact details below _____

_____

_____

You should be reassured that all information that we receive will be **anonymised**, *with no comments or responses attributed to any individual or organisation. This National Survey has received Multi-centre Research Ethics Committee approval, as well as the relevant local Research Governance permissions.*

Appendix Four

INTRODUCTORY MATERIALS FOR INTERVIEWEES IN BIGTOWN

Introductory email

CHANGING CULTURES, RELATIONSHIPS AND PERFORMANCE IN LOCAL HEALTH CARE ECONOMIES

Dear [potential interviewee]

Staff at [Bigtown Hospital Trust] have suggested I contacted you in connection with a research project. The project is being conducted by a group of researchers from the University of York, University of Manchester, University of St Andrews and King's College, London who are interested in assessing organisational culture and its impact on healthcare performance. The aim of the research is: to understand the nature and dynamics of culture change in the NHS, with a particular emphasis on how organisational culture links to health care performance across the whole health economy. The project has been funded by the NHS Service Delivery and Organisation Research & Development Programme (SDO) and has received ethics committee approval.

We are asking a range of key NHS staff to be interviewed, and would like to include someone from [your service] perhaps yourself, and one or two operational staff. The interview would be face to face and would last no longer than 60 minutes, and would be arranged for a time convenient to you. We would seek permission before taping the interview. The study is confidential, and names or any information that could identify interviewees will not be included in any reports or documents arising from the study.

We would very much appreciate your involvement in this study and believe that you can provide a valuable perspective on this topic.

An information sheet is attached, but if you have any questions, please contact me.

I wonder if we could talk soon? I will be at my desk on [dates].

Best wishes, and many thanks

Rhiannon Walters

for the research team

[phone numbers and email address]

THE UNIVERSITY *of York*

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Participant information sheet

Version1 / TrustX (15/01/2006 / 12/06/2007)

Changing Cultures, Relationships and Performance

in Local Health Care Economies: interview with NHS staff

Principal investigator: Dr Russell Mannion

TrustX Researcher: Rhiannon Walters

This research is being conducted to study **"Changing Cultures, Relationships and Performance in Local Health Care Economies"**. You are being invited to participate in this study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information. Please ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for taking the time to read this information sheet.

What is the aim of the research?

The aim of the research is to understand the nature and dynamics of culture change in the NHS, with a particular emphasis on how organisational culture links to health care performance across the whole

health economy. The research is employing a range of quantitative and qualitative methods to collect the data. A national quantitative survey and three in-depth case studies have been planned.

Who is carrying out the research?

The study is being conducted by a group of researchers from the University of York, University of Manchester, University of St Andrews and King's College London who are interested in assessing organisational culture and its impact on the organisational performance. The study team are highly experienced in both quantitative and qualitative data collection, analysis and synthesis. The project has been funded by NHS Service Delivery and Organisation Research & Development Programme (SDO).

Who should take part?

The study is a 36 months project and will take place in 2 main phases including a quantitative national survey and three case studies.

A range of participants will be invited to take part in the study, including:

- Staff at different levels and professionals groups in the NHS.

- People from key external organizations (e.g. Strategic Health Authorities, regulatory agencies)

Is participation voluntary?

Yes, Participation is entirely voluntary. You are free to withdraw from the research at any time without giving a reason and without any detriment to yourself or your organisation.

What does taking part involve?

If you decide to take part in the research, you will be interviewed. The semi-structured interview will take a maximum of an hour and, with your permission, will be audiotaped.

What is the likely benefit to me?

Although there is no direct benefit to you for participating in this study, it is expected that the findings will be of value to your organisation and the wider NHS in obtaining richer insight into the dynamic of culture-performance linkages in and across wide range of NHS organisations. This work will lead to new understandings about the organisational dynamics in health care that can be used to assist both in setting policy and in managing and changing services so that they better meet the needs of patients, users and carers.

What is the possible risk or inconvenience to me?

There are no risks attached to this study. Your interview scripts will be kept strictly confidential; available only to the members of research team. The only tangible cost to the participant will be the inconvenience derived from the time required to attend for interview or focus group.

What will happen to the information you provide?

Interview tapes will be transcribed. All tapes and transcriptions will be locked in a safe place. All the information collected during the course of the study will be viewed by the members of research team, and remain strictly confidential.

This information will be used to write up a project report, publishing articles in professional and academic journals and conference presentations. However, the names of the people who have taken part in the research or any other information that could identify them will not appear in the report or in other articles written after the project is completed.

All who take part in the research will be sent a summary of the final report.

When the study is completed, all the information will be kept in locked filing cabinets in a storeroom of the Department of Management Studies, University of York for 5 years and will then be destroyed.

What is the next step?

We will contact you again shortly to know whether you are willing to participate in the study. A consent form can be signed on the day of interview. The consent form will not be used to identify you. It will be filed separately from all the other information. You can keep this sheet for reference.

Further information:

If you have any concern or further questions about this study, please contact:

- Rhiannon Walters, who is conducting research for the project in Bigtown Hospital Trust on [contact details]

or:

- the principal investigator, Dr Russell Mannion, Director of Centre for Health and Public Services Management, Department of Management studies, University of York on 01904 433431 or email rm15@york.ac.uk

Appendix Five

Interview Topic Guide - Bigtown

Bigtown Hospital Trust Case study

Name:

Job title:

Years in post:

Place and time of interview:

Contact details

Consent taken:

Introduction
1. What are your main responsibilities?
2. What's it like to work here?

Co-existing sub-cultures
3. Which groups do you think of yourself as part of?
4. professions
5. directorates/specialisms
6. levels of seniority
7. management/clinical
8. Does being in those groups affect what it's like to work here?
9. Do any of the groups conflict with other groups?
10. Is that to do with the way the groups work?
11. Or something else
12. Does the way any of the groups work support other groups?

Values
13. What values are important here?
14. Are the stated values of the organisation the values that are actually treated as most important?
15. Would other groups in the trust answer that question differently?
    15a. professions
    15b. directorates/specialisms
    15c. levels of seniority
    15d. management/clinical

Other organisations
16. Which other organisations do you have to work with?
17. What are they like to work with?
18. What do they say about what the trust is like to work with?
19. Is it very different for people who work there to how it is here?
20. Does that make a difference to what it's like for you to work with those organisations?

21. What *does* make a difference [what else makes a difference] to what it's like for you to work with those organisations?
22. Would other groups in the trust answer these questions differently?
    - 22a. professions
    - 22b. directorates/specialisms
    - 22c. levels of seniority
    - 22d. management/clinical

Performance

23. How is your performance and that of your colleagues measured?
24. Do those measures show how well the trust is really doing?
25. Do you think the way the trust works makes a difference to how well it delivers?
26. We talked before about how the way it is to work here is different for different groups – does that make a difference to how well the trust delivers? Any particular groups you would mention?
    - 26a. professions
    - 26b. directorates/specialisms
    - 26c. levels of seniority
    - 26d. management/clinical
27. What *does* make a difference [or what else makes a difference] to the trust's performance?
28. Would other groups in the trust answer these questions differently?

Foundation status

29. How did the way the trust works affect how the preparation for foundation status was tackled?
30. Did the preparation for foundation status affect the what it's like to work here?
31. Was there a change in what it was like to work here when foundation status was achieved?
32. Does it seem as if the trust is more accountable to the public? Does that affect what it's like to work here?
33. Does it seem as if the trust is freer from government control? How does that affect what it's like to work here?
34. Were any of the changes because of foundation status different for different groups?

Changing the culture

35. How easy would it be to change what it's like to work here?
36. Has it been tried?
37. What happened?
38. Was it different for different groups in the trust? which ones?
39. What helped? [What would help?]
40. What got in the way? [What would get in the way?]

Return

I'm hoping to come back in the spring if that's possible, and talk to you again – is there anything you expect or hope will have changed by then?

Appendix Six

Interview Topic Guide – Smalltown

SDO/OC2 project: Smalltown One year later

Date of first interview/interviewer_____

Issues covered in first interview (write in for each person)

Perceptions of organisation

Current issues

Concerns

Other important issues

Are you aware of any changes since then in:

1. National policy context?

2. Local policy context?

3. The organisational structure (development, merger)?

4. Local health economy (relationships between key stakeholder organisations)?

5. Formal Performance assessments?

6. Informal Performance assessments?

7. Your values, beliefs, methods of working?

8. Any professional groups' values, beliefs, methods of working?

9 Any stakeholders' values, beliefs, methods of working?

10. Have you attempted to purposefully manage any culture change?

11. What response have to had to any changes you have proposed?

12. What factors have facilitated change?

13. What factors have obstructed change?

14. Impact of PbC?

15. Where will Smalltown be in a year's time?

Disclaimer:

This report presents independent research commissioned by the National Institute for Health Research (NIHR). The views and opinions expressed by authors in this publication are those of the authors and do not necessarily reflect those of the NHS, the NIHR, the NIHR SDO programme or the Department of Health. The views and opinions expressed by the interviewees in this publication are those of the interviewees and do not necessarily reflect those of the authors, those of the NHS, the NIHR, the NIHR SDO programme or the Department of Health"

Addendum:

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme, and managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO), based at the London School of Hygiene & Tropical Medicine.

The management of the SDO programme has now transferred to the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton. Although NETSCC, SDO has 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.