ResearchSummary

NHS
National Institute for Health Research

Measuring and assessing organisational culture in the NHS

Increasing interest in shaping the basic values, beliefs and assumptions that underpin patterns of behaviour among key NHS staff calls for better understanding about the nature of organisational culture and has prompted a practical need to understand what instruments and tools exist for assessing cultures in health care contexts. In view of the widespread policy, managerial and clinical interest in this area, we wanted to know what tools are used currently in the NHS to assess organisational cultures and how well these tools meet the practical requirements and needs of those interested in assessing and changing cultures.

This research summary, based on research led by Russell Mannion at University of York, commissioned by NIHR Service Delivery and Organisation Programme (SDO), reports on measuring and assessing organisational cultures in the NHS.

It is for policy makers, managers, health professionals, users and carers.

Key findings

- We identified seventy instruments and approaches for exploring and assessing organisational culture that have emerged over the past five decades.
- About a third of NHS organisations in England are currently using a culture assessment instrument to support their clinical governance activity. Almost all the tools and instruments used in the NHS focus wholly or in part on the assessment of safety cultures.
- There is much more convergences than divergence in the views and perspectives of key stakeholder groups around the particular cultural attributes that underpin high quality care and which therefore should be expressed within the design of culture assessment instruments.
- The use and impact of culture assessment instruments in particular organisations contexts may depend on a range of socio-technical factors, both intrinsic to the instrument and in combination with internal and external influences on the organisation and staff.

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Background

Many individuals and agencies concerned with health care quality and performance have emphasised the need for cultural change to be wrought alongside structural, financial and procedural reforms (Mannion *et al* 2005). This interest in understanding and shaping the basic values, beliefs and assumptions that underpin patterns of behaviour among health professionals calls for better understanding about the nature of organisational culture, how it can be assessed and measured, and how such assessments can be integrated into beneficial programmes of change. In view of the widespread interest in this area, it is important to know what tools are used currently in the NHS to assess organisational cultures and how well these tools meet the practical requirements and domains of interest of those interested in assessing and changing cultures within their organisation and across local health care communities.

Practical findings

In this section we summarise the main findings of the research relating to each of the study objectives.

Research objective 1

Existing tools and instruments available for measuring and assessing organisational cultures in health care.

We identified seventy instruments and approaches for exploring and assessing organisational culture that have emerged over the past five decades, with most instruments emerging since the mid 1980's. Traditionally, the sectors most interested in organisational culture have been business, healthcare and education. This is reflected in the contexts from which the identified instruments have emerged and to which they have been applied: although a large number of instruments have a business background, numerous of these have seen some application in healthcare settings, mainly within an US and/or Australian context. The few instruments that have been applied within British healthcare settings include the Competing Values Framework, Critical Incident Technique, Organisational Culture Survey, Practice Culture Questionnaire, General Practice Learning Organisation Diagnostic Tool, the Ward Organisational Feature Scales, and Perceived Organisational Culture. However, other instruments that to-date have not seen any application within the healthcare arena might still be worth considering: with hospitals sharing numerous characteristics of hospitality organisations, one such example might be the Hospitality Industry Culture Profile.

A variety of methodological approaches and research designs can be identified amongst the instruments. These range from structured questionnaires to comparatively unstructured and emergent ethnographic approaches. Despite such methodological variety, the predominant approach taken by the instruments are questionnaires, usually of a self-report nature. These offer the advantage that they are less time – and resource-consuming in respect to their implementation and analysis. Qualitative and quantitative approaches offer different strengths and weaknesses. It might therefore be advisable to use a combination of the two paradigms. In terms of psychometric assessment, twenty two instruments reported adequate measures of internal consistency, 15 were rated 'unclear', and 11 reported no data to assess. Eight measures also reported on test-retest reliability, with 5 rated 'adequate' and 3 'unclear'. Ten reported 'adequate' data on issues concerning aggregation of culture scores from individuals to higher level units such as organisations. In terms of validity, only one was rated

as providing 'extensive' data on associations with descriptive variables, while nine reported 'moderate' levels and 15 reported 'minimal' levels. There was little evidence of tests of validity in terms of relationships with other measures of culture, with only five reporting 'minimal' data. Over a half reported data on the association between the measure and outcomes. Of those, 19 reported associations with subjective outcomes in cross sectional studies, and six reported associations with subjective outcomes in longitudinal studies. Only one reported associations with objective outcomes in longitudinal studies.

Many of the instruments identified in the search must be considered at a preliminary stage of development. The degree to which any measure is seen as 'fit for purpose' will depend on the particular purposes for which it is to be used, and the data presented in this report can be used to identify those measures which have made greater progress in terms of validation, and those that require further assessment.

There is no such thing as an 'ideal' instrument or approach for cultural examination: an instrument that works well in one case may be inappropriate in another. Different instruments offer different insights: they reveal some areas and aspects of an organisation's culture but obstruct others. It is up to the individual explorer of organisational culture to decide on the appropriate dimensions, methodology, and available resources for her or his project. The SDO report (Mannion *et al* 2007) provides a way of identifying candidate measures that meet certain criteria concerning administration, content, and psychometric testing, and can assist the researcher to either select the instrument that offers the largest degree of synergy or to develop instruments further so as to meet the specific requirements.

Table 1: Number of trusts using a particular culture assessment tool

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

Research objective 2

Review of the extent to which culture assessments tools and qualitative approaches have been tested and used in the NHS and other health care contexts.

As noted above a range of instruments have been used in British health care contexts and reported in the research literature. In this part of the study we were concerned to find out what instruments are currently being used in the NHS and how these are integrated into quality and safety improvement initiatives and support local programmes of change.

Clinical governance managers increasingly view quality and safety improvement in cultural terms and perceive culture management and transformation as a key part of their clinical governance responsibilities. Most managers are amenable to the idea of shaping local cultures toward desirable outcomes. Nevertheless the majority believed that there are aspects of the prevailing cultures that serve as barriers to quality improvement and a significant number of organisations were reported as still having a considerable way to go before any meaningful cultural change could be realised.

Despite a plethora of culture assessment tools being described in the literature, relatively few of these have seen much use in the NHS. On the basis of our survey about third of NHS organisations in England are currently using a culture assessment instrument to support their clinical governance activity. Almost all the tools and instruments used focus wholly or in part on the assessment of safety cultures rather than broadly on perspectives of quality and performance.

By far the most frequently used culture instrument was the Manchester Patient Safety Framework (MaPSaf) this was followed by the Safety Attitude Questionnaire, and the Safety Climate Survey, A wide variety of other tools were used by a very small numbers of organisations (Table 1).

There appeared to be a high degree of satisfaction with existing tools and instruments, in terms of ease of their use and relevance. Although extant tools such as the MaPSaF and the Safety Attitude Questionnaire cover many of the most important cultural attributes of high quality care as identified by clinical governance managers, including senior management team commitment to quality and safety improvement, teamwork and collaborative working, our survey highlighted other cultural attributes which link to the interests and aspirations of local clinical governance leads, including the development of a blame free or 'just' environment and support for innovation that are not well served by extant instruments.

Organisational culture assessment can be done for different practical purposes, formative, summative, or diagnostic. Formative assessment can be used to provide feedback on the cultural components of performance with a view to effecting local development and learning. Summative assessment can provide a measure of culture as it relates to other organisational variables – an approach that informs judgement on various attributes or dimensions of culture. Diagnostic assessment is directed at evaluating existing cultural traits and their usefulness in terms of promoting desirable organisational modus operandi and outcomes. For both acute and primary care trusts, the overwhelming majority of respondents, 85%, indicated that culture assessment should satisfy a formative purpose whereas 64% believed that it should serve summative ends, with a sizeable proportion, almost one third (29%), actively disagreeing with the latter notion. This suggests that the way tools are introduced and used may have important implications for their acceptability.

Research objectives 3 and 4

The needs and interest of key NHS stakeholders with regards to their need for understanding, assessing and shaping organisational cultures.

We identified a range of specific cultural attributes that different stakeholders (including national regulatory agencies and professional bodies) were interested in shaping and/or assessing in the NHS and which therefore should be expressed within the design of culture assessment instruments. There was a high degree of convergence around the following key themes:

i) senior management commitment and support for quality and safety improvement leading to an organisation-wide awareness and commitment to patient safety and quality;
ii) maintenance of a core public service ethos amid pro-market reform in the NHS;
iii) the shift towards patient centered care, particularly the cultural problems associated with getting health professionals with different values and of traditions of working together effectively;
iv) the need to support and encourage clinical engagement with programmes of change and quality/safety improvement; this was linked to a desire to develop leadership capability and capacity within the medical profession;
v) a capacity for organisational learning was viewed by many stakeholders as an essential ingredient of a high performing organisation, this in turn was linked to organisational attributes such as openness and trust;
vi) risk taking and support for innovation, including the scope to develop new and innovative ways of promoting and ensuring high clinical quality and safety.
vii) 'no blame' or 'just ' cultures which were viewed as an important part of ensuring high quality and safe care as it was thought to encourage staff to report and learn from mistakes and near misses;
viii) standardisation of care that could result in higher quality care, although it was also recognised that in some areas care should be tailored to the needs of individuals;
ix) a culture of teamwork associated with the need to organising care around the needs of patients and the requirement to get multi-disciplinary teams to work together effectively;
x) proper engagement of patients and patient representatives as genuine partners in service design and delivery, including full sharing of information and respectful inclusive dialogue.

While such an agenda is undoubtedly challenging, the convergence of diverse stakeholders on their central values is encouraging. Moreover, a willingness to explore empirically the extent of the enculturation of these values offers exciting opportunities for enhanced cultural shifts. Tools therefore are an essential component of such work.

We heard reports that the evidence base linking culture and specific aspects of performance in the NHS is under developed and that this was an area that required further research and development. All stakeholders believed that more research was required to generate evidence of what works in culture change programmes and how such programmes could be measured and assessed.

Although the survey of clinical governance managers found that most managers viewed existing tools as salient and easy to use, the survey of wider stakeholders revealed that existing instruments are

sometimes too sophisticated for lay use. There was also concern that such instruments (and the terminology they embody) should be embedded within the wider values and traditions of working in the NHS.

There were concerns that some existing tools were transplanted from other sectors and industries or other health care systems and that these would not necessarily be 'fit for purpose' within an NHS context. There was also a view that more training was required to support the use of such instruments, particularly among those staff with little familiarity of social science theory or managing change programmes.

Research objective 5

Views and interests of users and patients regarding the value domains they would wish to see expressed in organisational (culture) change programmes and assessments.

There were criticisms among patient representatives in the national survey that the culture of their organisation was such that managers sometimes failed to consider patient perspectives when planning, undertaking and assessing organisational change. There was a strong belief among patient representatives interviewed that culture change within their organisation was driven largely by the demands of external agencies and government targets rather than the needs of patients or the local community.

Patient representative's views on the most important cultural attributes for high quality care were remarkably similar to those of clinical governance managers. The most important culture components include: 'patient centeredness' 'senior management commitment', 'a quality focus', 'clear governance/accountability', and 'safety awareness'. As with clinical governance managers fewer respondents considered 'prioritization of choice', public service ethos, 'focus on cost effectiveness', and 'standardisation of care' as important.

Not surprisingly, patient representatives believed that 'patient centeredness' was a key attribute of high quality organisations. This was for a number of reasons, including a belief that patient centered care would lead to better outcomes (both process and clinical); a perceived need to challenge professional and managerial cultures that were not always closely aligned with the interests of patients and carers; and as view that placing the patient perspectives at the centre of decision making would make the health service more accountable to the people they serve.

Research objective 6

Assessment of the use and impact of culture assessment instruments in NHS contexts.

Selection of appropriate tools or assessment methods that meet the needs of key stakeholders will not in itself ensure that such tools can be used successfully in complex health care settings in the NHS. Application of the tools in real world settings for diagnostic, formative or summative purposes may pose significant opportunities and challenges for health care organisations and their staff.

Benefits of culture tool use in the case studies include: initiating wider discussions about quality and safety within organisations; prompt more reflexive practice around important patient quality/safety issues; and an aid to interdisciplinary discussion and the development of joint strategies for tackling quality/safety issues across different professional sub-groups and clinical teams within health care organisations.

Limitations and drawbacks of tool use include: difficulties around understanding and using instruments; lack of senior management support; credibility and sensitivity to local needs and contingencies. Even when culture assessment is undertaken, only when feedback is provided to relevant staff in a timely and appropriate fashion will the findings be acted upon and lead to improved performance and patient care

Conclusions

Prior to embarking on cultural exploration, it is useful to consider two questions: what is the purpose of assessment and to what ends will the ensuing information be applied? Potential answers to these questions can range from mere curiosity to the solving of organisational problems and need to be considered when reflecting on the applicability of different approaches.

Culture assessment instruments are relatively new tools in the quality and patient safety arena and are used increasingly to inform and assess quality and safety improvement activity in health care organisations. As in other health systems there is widespread interest in the NHS in managing organisational cultures in order to improve quality and safety. Despite a plethora of culture assessment tools being described in the literature, relatively few of these have seen much use in the NHS. Our review of the literature has shown that there are a large number of tools available for assessing organisational cultures in health care and a greater awareness of these and a better matching and linking of extant tools with current needs may lead to an increased (and possibly more appropriate) use of culture tools in the NHS. The SDO report (Mannion *et al*, 2007) and the associated compendium of instruments is a step along the road to achieving that end.

Nevertheless, increasing awareness of instruments may not be sufficient to meet current needs as there are clearly important gaps between the cultural attributes assessed by extant tools and the needs and interests of key stakeholders which will require investment in new tool development or at least the creative adaptation and reworking of existing tools. Yet, this will not be sufficient to ensure that culture instruments are employed to beneficial effect in the NHS. The feasibility, acceptability, utility and impact of culture assessment tools in particular organisational contexts depends on a wide range of socio-technical factors, each of which needs to be identified and addressed if culture assessment instruments are to help deliver the desired improvements in quality and performance. The challenge is for managers, health professionals, patients, researchers and a wide variety of interested stakeholders to work together to strengthen the evidence base that informs policy and practice in this area.

Future research

There remains a challenging policy focused research agenda around the measurement and assessment of organisational cultures in health care. Specific issues where there is a gap in current knowledge and/or which warrant further sustained investigation might be considered in the following areas:

- The use of culture measurement and assessment instruments in health care contexts is premised on the notion that there is a linkage between specific cultural attributes and health care performance. Yet evidence is sparse in many areas of health care to support the design and development of well founded tools and instruments. Thus the evidence to date linking culture to performance is suggestive but far from definitive. We therefore suggest that future research should focus on gathering primary data and evidence on the complex and recursive inter-linkages between culture and performance in different health care settings. The complex and dynamic nature of the phenomena under study suggest that research in this area will need to exhibit a number of features. It will need to be naturalistic, taking place in real-world settings and making careful note of the mediating role of contexts. It should be multi-method and multi-disciplinary, drawing on quantitative and qualitative traditions, including detailed ethnographic and discourse analytic approaches. Finally, as the phenomena of interest are essentially dynamic (performance and change), longitudinal study will offer important insights over cross-sectional designs.

- Our survey of NHS stakeholders with a legitimate interest in understanding, shaping or assessing health care cultures has identified a degree of convergence around a number of cultural attributes which health care professionals and key agencies would like to see expressed within the design of culture assessment instruments. As the needs, interest and practical requirements of stakeholders change it is important that the appropriateness or otherwise of extant instruments are subject to regular review and assessment and further developed or refined to reflect important emerging concerns and shifting priorities in the wider health care environment.

- There appears to be a strong demand for tools that serve formative and diagnostic purposes rather than summative ends and further research is required into how tools can be developed to support reflexive practice and organisational development purposes. Given the context specific nature of much health care delivery there is also a need to provide research to support the development of bespoke tools in different health care contexts.

- Selection of appropriate tools or assessment methods that meet the needs of key stakeholders will not in itself ensure that such tools can be used successfully in NHS settings. The feasibility, acceptability, utility and impact of culture assessment instruments in particular organisational contexts may depend on a wide range of socio-technical factors, both intrinsic to the instrument and in combination with internal and external influences on the organisation and staff. Our study has highlighted a number of important socio-technical issues associated with the use of culture tools in health care contexts. Nevertheless, we believe that further research is required into understanding the low take up of culture instruments in NHS organisations and the many practical issues (including unintended and dysfunctional consequences) that arise when tools are used to support and quality and performance in complex health care settings.

About the study

The study was undertaken by an inter-disciplinary consortium of researchers based at the Universities of York, St Andrews, Edinburgh and Manchester and consisted of three distinct but interlocking strands:

1. A literature review based on systematic principles that sought to uncover developed tools and approaches (quantitative, qualitative and multi-method), and both document and assess these against an explicit framework that prioritises 'fitness for purpose'.

2. A stakeholder mapping exercise that sought to understand the interests and needs of NHS stakeholders around the assessment and shaping of health care organisational culture. Core stakeholders identified include: regulatory agencies (e.g. CHAI, Monitor); organisations with representative or developmental roles, health service delivery organisations; and patients, users and carers.

3. An empirical assessment of culture tool application, using case-study methods to gain insights into the practical application of culture assessment tools in NHS organisations. We used one hospital trust and one primary care Trust as case studies to explore the use and impact of culture tools in these organisations.

Members of the research team

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Further information

The full report, this research summary and details of current SDO research in the field can be downloaded at: www.sdo.nihr.ac.uk

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Feedback

The SDO Programme welcomes your feedback on this research summary. To tell us your views, please complete our online survey, available at: www.sdo.nihr.ac.uk/researchsummaries.html

About the SDO Programme

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- commissioning research and producing research evidence that improves practice in relation to the organisation and delivery of health care; and
- building capacity to carry out research amongst those who manage, organise and deliver services and improve their understanding of research literature and how to use research evidence.

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Addendum

This document was published by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) research programme, managed by the London School of Hygiene and Tropical Medicine.

The management of the Service Delivery and Organisation (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. Prior to April 2009, NETSCC had no involvement in the commissioning or production of this document and therefore we may not be able to comment on the background or technical detail of this document. Should you have any queries please contact sdo@southampton.ac.uk