# Organisational Culture – A Review of the Literature

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Summary of Key Learning Points

The importance of organisational culture is well recognised across several disciplines. Reviews of serious adverse incidents in healthcare, in the United States, Europe and the UK, have consistently highlighted the need to improve organisational culture to enhance safety and quality of services.

It is clear that assessing and changing culture is a difficult process. The scale and scope of the task is substantial and requires perseverance, as it often takes years for change to occur. Self assessment is needed to identify areas of weakness, but also to highlight good practice as cultural improvements should build on ‘doing what you do better.’ The need for respect to be embraced as a core value is evident, and human resource policies, including appraisal, should recognise and support this. Certain cultures, such as group culture have been shown to be more desirable than other more traditional hierarchical cultures. Peters and Waterman remind us that, ‘people’s greatest need is to find meaning in their working lives,’ and so the importance of an inclusive attitude, where all staff feel valued and appreciated must be acknowledged.

Before embarking on measurement of, and strategies to change culture, it is vital that the purpose of such complex work is well understood. Most often, mixed methods of analysis are required and ongoing research is aimed at deepening understanding using multi-method approaches. To be effective, timely feedback must also be provided for staff.

To succeed in improving culture in health and social care, long term commitment is essential. The need for change must be accepted and adequate resources including time, skill and financial support have to be provided. There is no one size fits all route to achieving this goal, however, it is well recognised that dispersed leadership, meaningful engagement of staff, effective team working and communication, form the cornerstones on which change should be built.

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ORGANISATIONAL CULTURE – A Review of the Literature

Background

Over the last few decades, the concept of ‘organisational culture’ has attracted much attention in management, business and sociology literature (1, 2, 3). More recently, it has also been increasingly recognised as a lever for inducing improvement in quality and performance in health care systems, both in the United States and Europe (4, 5, 6). In the UK, the Kennedy Report into children’s heart surgery at the Bristol Royal Infirmary (2001) and other Department of Health policy documents have acknowledged a need for culture change (4, 7).

Finding a commonly agreed definition of organisational culture is, however, not a straightforward task. The fact that in 1952, Kroebner and Kluckhohn (8) identified 164 separate definitions of culture, highlights the complexity of this issue. Westrum (9) warns that: ‘to speak of organisational culture is to take on many problems. Approaches to organisational culture have been diverse …. there appears to be no common understanding about what culture is.’ Hatch (10) agrees that organisational culture, ‘is perhaps the most difficult of all organisational concepts to define.’ However Bellot (2011) argues that, ‘this does not necessarily mean that organisational culture is a weak or ill defined concept , rather this divergence is indicative of a continually developing body of research.’(11)

Most simply put, organisational culture is, ‘the way we do things around here’ (3). It has been suggested that, ‘culture is to an organisation what personality is to the individual’ (12). The analogy of an iceberg has also been used by Braithwaite (13). This model is shown overleaf, in diagram 1.
Diagram 1: The Iceberg Model of Culture

Above the waterline lie the observable workplace behaviours, practice and discourse. This is ‘the way we do things around here.’

Below the waterline lie the underlying beliefs, attitudes values, philosophies, and taken for granted aspects of workplace life: ‘why we do the things we do around here.’

However, it is the work of Edgar Schein that is most frequently acknowledged, in medical literature, when defining organisational culture (3). He argues that organisational culture is: ‘The pattern of shared basic assumptions- invented, discovered or developed by a given group..... that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think and feel’ (3). Three levels of organisational culture are described - Level1 - artefacts- the most visible manifestations of culture including dress codes, rituals, rewards and ceremonies; Level 2- beliefs and values- espoused beliefs and values; and Level 3- assumptions- the unspoken largely unconscious beliefs, values and expectations (3). Schein’s later work goes on to suggest that, when analysing
the dynamics of change, there are three subcultures in any organisation that are of particular importance (15,16). These are identified as, (a) the operator culture- the group of people on the front line who deliver the service,(b) the engineer culture – the group of people who design the processes by which the organisation delivers its products and maintains itself, and (c) the executive culture- those responsible for the strategic survival of their organisation (17). In relation to the health and social care setting specifically, Scott et al (2003 ) advise that ‘within the overall ‘NHS culture,’ a number of distinct subcultures can be discerned whose relationship to the overall organisational culture is hard to disentangle.’ (18) Lok et al (2011) agree that in health care, ‘in practice the relationship between an organisation and its subcultures is likely to be complex.’ (19)

The longstanding academic debate on the differences between ‘organisational culture’ and ‘organisational climate’, adds a further layer of complexity to this issue. There has been vast amounts written in the literature about this (11), and again even defining organisational climate is in itself controversial. A commonly used definition is ‘the relatively enduring organisational environment that is (a) experienced by the occupants, (b) influences their behaviour and (c) can be described in terms of the values of a particular set of characteristics or attributes of the environment.’ (94)

It has been suggested by many researchers that climate is a manifestation of culture (3, 21). ‘The disciplinary origins of climate and culture overlap, with both sharing common sociological threads‘; however they have different intellectual meanings and roots and ‘climate research is grounded in psychology … whereas culture embodies references to anthropology.’ (11) Denison observed that the development of culture ‘wrecked havoc with climate researchers introducing new methods and allowing for variation of assessment,’ he concludes that ‘although it is
clear that culture and climate are very different perspectives on organisational environments, it is far less clear that they actually examine distinct phenomena… or whether they represent closely related phenomena from different perspectives.’(21)

**Methodology**

It is against this nebulous background, that we attempted to review the wealth of literature now available on organisational culture. The key issues we aimed to explore include the relationship between organisational culture and the quality of health and social care, the methods used to measure culture and effective strategies for changing culture. The methodology used incorporated a comprehensive electronic search of the HONNI databases (Cochrane, Medline, Cinahl, Health Management Information Consortium, Health Business, Psychology and Behavioural Sciences, SOCIndex, Abstracts Library, Information Science & Technology), NHS Evidence and Google Scholar search engines. The advice and opinions of regional and UK experts, in health and social care policy and management, were also sought.

**Organisational culture and quality**

It is widely believed that organisational culture is related to performance (9, 18, and 20). In management, and other sectors, much work has been done examining these links (1, 19, 20, 22, 23). Glisson (2007) recognises that, ‘a number of studies in various organisations link culture…. to service quality, service outcomes, worker morale, staff turnover, adoption of innovations, and organisational effectiveness.’ (24) In 1982, Peters and Waterman even went as far as to declare that they had identified the corporate cultural characteristics that lead to ‘excellence’ (1). However critics of early, non healthcare related, studies examining this relationship highlight the, ‘unsubstantiated assumption of a unitary culture that underlies such work, the lack of
an operational definition of cultural strength and the weak methodologies employed in the original empirical work.' (25)

Research in this area in the health care setting, is relatively speaking, still in its infancy. The role of effective human resource management, in reducing patient mortality and morbidity outcomes, has been repeatedly demonstrated by West et al (26, 27, 28 and 29). West and colleagues showed that extensive staff management practice including training, appraisal and team working were strongly associated with lower patient mortality rates (29). Therefore, the importance of effective human resource management within the NHS is now well accepted. Similarly, the potential role of culture in improving the NHS has created much interest. In their February 2012 report, the CHKS Top Hospitals Programme advisory group acknowledged that ‘organisational culture is one of the five elements that we have discovered to be common across award winning acute sector organisations in the UK.’ (30) However, providing strong primary evidence to support this observation has proved challenging. Lok et al 2011 (19) conclude that ‘there is a gap in the literature requiring further empirical investigation,’ and Davies et al (2007) agree that, ‘systematic reviews of the evidence, both outside healthcare (20) and specific to health care organisations (25), offer some tantalizing possibilities but provide little substantial or consistent evidence in support of the culture/performance hypothesis’ (31).

A comprehensive qualitative review by Scott et al (25) identified over 1700 bibliographical records examining culture and performance. However, of the 69 full articles retrieved, only 10 health care studies were included in the final analysis- 8 of these were conducted in America, 1 in Canada, and 1 in the UK. The authors noted
that the types of health care organisations included, participants used, levels of culture assessed and methodologies followed, varied between the studies. They concluded that they showed ‘some, problematic but supportive evidence for the relationship. 4 of the 10 studies reviewed claimed to have uncovered evidence for the hypothesis,…none (of the other 6 studies)… found much evidence against.’ They outline their 3 key findings as, ‘first, health care organisations do differ in their dominant cultural orientation; second, that this cultural orientation is associated with various aspects of performance; and third, that if we want to understand relationships between culture and performance we should explore aspects of performance that are valued in the dominant culture….. relationships between culture and performance…. are far more likely to be multiple, complex and contingent.’ (25)

Despite this, Davies et al (31) do admit that ‘a number of empirical studies in health care have offered illuminating glimpses into the relationships between shared ways of thinking and aspects of performance’ (32,33,34) The work of Gerowitz et al (1996, 35) into top management culture and performance in 345 Canadian, 120 US and 100 UK hospitals is one of the key studies that has been acknowledged as suggesting that dominant culture is related to performance (23, 26, 31). Speroff et al (36) also examined the variation in organisational culture and connection to patient safety in 40 hospitals in the US and found that ‘the type of culture relates to the safety climate within the hospital… group culture hospitals have significantly higher safety climate scores than hierarchical culture hospitals.’

More recently studies have also focused on patient outcomes as a marker for performance. This includes the work of Shortell et al (32) who analysed the impact of culture on the care of 3045 patients with CABG from 16 hospitals in the US; their
findings did not generally support a link between culture and performance. However a multicentre cohort trial, by van Windjargen et al in the Netherlands (2010), examining the influence of organisational culture on hospital rates for thrombolysis for acute ischaemic stroke, did show evidence of a positive relationship between the two. The authors concluded that ‘organisational culture may be an important target for interventions aimed at increasing rates of thrombolysis.’ (37) A further example of evidence of this is the qualitative study conducted by Curry et al (2011) in 11 US hospitals investigating what distinguishes top performing hospitals in Acute Myocardial Infarction (AMI) mortality rates. They too conclude that, ‘high performing hospitals were characterised by an organisational culture that supported AMI care.’ (38).

Scott et al (25), however, urge caution when interpreting the direction of any causality between performance and culture, suggesting that it, ‘is equally plausible that certain cultures emerge from high performing organisations.. that is performance may drive culture.’ They highlight that ‘crucially it is not enough to know whether culture is linked to performance .. we also need to discover how and why it is linked … for only then can we decide if policies, strategies and interventions are appropriate.’

It has been suggested that the limited evidence base, and inherent methodological challenges faced, investigating the link between culture and performance in health care, might be better viewed, ‘as absence of evidence rather than evidence of absence’. (25) Encouragingly there is ongoing work, which hopes to develop this evidence base. Deepening our understanding of quality improvement in Europe (DUQuE) and The 'Quality and Safety in Europe by Research' (QUASER)
studies are examples of current research projects both aimed at examining the
effectiveness of quality improvement systems in European hospitals. They are also
both designed to explore relationships between the organisational and cultural
characteristics of hospitals and how these impact on the quality of health care.
DUQuE is collecting data using a cross-sectional, observational study of hospitals in
8 European countries (39). QUASER is adopting a longitudinal multi level
comparative approach across hospitals in 10 European countries (40). DUQuE
began in November 2009 and is expected to conclude in April 2013 and the
QUASER study is also ongoing. Another major English study, *Quality and Safety in
the NHS: Evaluating Progress, Problems and Promise*, has also been ongoing over
the last 2 and a half years and has just produced a report for the Department of
Health, England which is at this stage still confidential. This work was conducted by
an interdisciplinary group of researchers from across 4 universities and led by Prof L
Mc Kee and Prof M West. Prof Mc Kee advises that ‘It involved a vast amount of
data collection including documentary analysis of Board minutes, ethnographic case
studies of Trusts, surveys with front line and senior executives, interviews with
broader NHS stakeholders and patients’. The authors hope that this multimethod
study, the rich data set and insights from the front line will offer practical evidence on
culture in health care and offer an alternative approach to the definitional and
methodological issues that have previously hindered research on culture. (95)
Projects such as these should offer further information on the link between
organisational culture and quality.

In reality there already is a broad acceptance, within health care literature, of the
importance of culture. This is further supported by the work of Koneth et al (2011, 41)
who, when comparing professional and patient perspectives to culture management
in the NHS, found ‘both quantitative and qualitative results … have shown a high degree of convergence in the views and perceptions of clinical governance leads and patient representatives, (two of the most important stakeholders in the health sector), on the importance of culture and culture change to quality and safety in the NHS.‘

**Measuring organisational culture**

Given the ambiguity around defining organisational culture, it is hardly surprising that trying to effectively measure culture is also a complex process. Pellegrin et al 2011, endeavour to demystify the issue, explaining that ‘to the organisational scientists, culture is simply a collection of behaviours; all meaningful behaviours are measurable and what is measurable can be changed (42).’

However Taras et al (2009) acknowledge that there are very real practical challenges when measuring culture, and argue that ‘a single model cannot comprise all aspects of such a highly complex, multidimensional and multi-layered phenomenon’(43).’ They highlight that, as ‘scholars from different fields tend to focus on different elements of culture,’ in practice a wide variety of instruments exist, and therefore recommend that, ’it is very important to specifically define which elements of culture are the focus of a model’.

They conducted a comprehensive literature review of the advances in measuring culture over the last 50 years, including all available instruments quantifying culture, identifying 121 in total. This work was not specific to the health care setting, but valuable lessons may still be learned. Taras et al describe a typical instrument as measuring culture ‘by quantifying values, assumptions or practices along four to eight cultural dimensions or factors,’ with individual models varying depending on the
author’s area of expertise. Whilst they highlight that the superiority of the self reporting questionnaire approach remains controversial, they acknowledge that, ‘because alternative methods such as observation or experiment are more resource demanding, the self report questionnaire remains the most popular method of quantifying culture.’ They do however also recognise that, ‘the qualitative approach has been successfully used for centuries’ and may ‘capture the unique variance that is specific to a few or only one culture alone.’ This is supported by Allen et al (2010) who, when reviewing lessons learned from measuring safety culture in an Australian obstetric setting, observed that ‘the use of … surveys alone… would not have identified the influence of factors external to the clinical setting … Inteviews in combination with surveys provided greater insight into the broader factors’ (44.) In summarising this difficult issue, Taras et al conclude that ‘the science of culture ‘is still developing and the ‘ability to measure culture is still incomplete’. (43)

In relation to assessing culture in the health and social care setting, in the UK there has been extensive research commissioned, by the National Institute for Health Research Service Delivery and Organisation, examining organisational culture in the NHS. These projects have been conducted by inter disciplinary consortia of researchers based at various universities across the country, including Mannion et al (2008 45, 2010, 46), and Mc Kee at al (2010, 47). In their work on measuring and assessing culture in the NHS Mannion et al acknowledge that , ‘despite a plethora of culture assessment tools being available in the literature, relatively few of these have seen much use in the NHS’ (45). They identified 70 existing instruments for measuring organisational culture, and whilst they admit that a large proportion of these were developed in the business sector, many have also been used to some extent in healthcare settings, particularly in American and
Australian settings (45). They acknowledge that whilst there are multiple approaches described in the literature to date regarding assessing culture, there is ‘little evaluation of the use and practical application of those tools’.

In the context of the NHS, Mannion et al (2008) identify 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 as the ‘few’ instruments that have been applied. Their survey data revealed that approximately one third of all English NHS organisations are using a culture measurement instrument, to aid clinical governance, with relatively high levels of satisfaction regarding relevance and practical use reported. However they also recognise that these tools almost exclusively focus on safety culture, as opposed to quality and performance, with the Manchester Patient Safety Framework being the most popularly used instrument. In a review of safety culture assessment, as a tool for improving patient safety in healthcare organisations, Nieva and Sorra (48) outline that they may be used, ‘to measure organisational conditions that lead to adverse events and patient harm and for developing and evaluating safety improvement interventions,’ however, ‘there is more to be learned about … the tools that might be used in these transformation efforts.’

Like Taras et al, Mannion and colleagues identified key themes across the instruments, including that the most popular approach was a self report questionnaire, which are less resource intensive and time consuming than alternatives. They, too, acknowledged that both quantitative and qualitative methods exist each with their relative advantages and disadvantages, and they suggest it may be advisable to use a combination of the two (mixed methods). Scott et al (49) agree
that ‘it is unlikely that any single instrument will ever provide a valid, reliable, and trustworthy assessment of an organisation’s culture, and so a multimethod approach will always be desirable’. This was echoed by Mannion et al (45), who highlight that ‘a multiplicity of approaches and tools is expected, simple notions of the”best tool” are misplaced.’ Scott et al (49) urged caution due to the wide variance in reliability and established validity of these tools and Mannion et al (46) recognised that there are also important differences in methodology and research design between different instruments, ranging from structured questionnaires to relatively unstructured emergent ethnographic styles. Also the instruments may vary in their overarching approach with the two main approaches being typological, assessments resulting in attribution of one or more types of culture to the organisation, or dimensional, describing the culture in terms of its position on a number of continuous variables (50).

Whilst it is accepted that insights from cultural assessment may be helpful (46) and provide a starting point to solve problems, Smit (2001) also warns that cultural assessment may be a way to ‘create problematic solutions’ (51). Problematic outcomes may be limited by following the advice of Scott et al (49) that the instrument used in cultural assessment must be determined by the purpose and context of the assessment. This is supported by Mannion et al (45) who argue that the purpose of the assessment, and to what ends the resulting information will be used, must be considered before attempting any cultural exploration.

The importance of understanding the current culture within an organisation before attempting to improve it, is well recognised (45, 49, 52). King and Byers (53) and others suggest that using a culture assessment tool is a good first step (52) with Hamilton et al advising that ‘it may help create the catalyst for transformational
change.’(54). Mannion et al, 2008, also acknowledge that whilst using these assessment tools may provide significant opportunities, ‘in the real world setting… they may also pose… challenges for health care organisations and their staff.’ Some of the difficulties they highlight include problems around understanding and using the instruments, lack of senior management support and they also warn that, ‘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.’

Scott et al conclude that ‘a plurality of conceptualisations, tools, and methods are more likely to offer a robust, subtle and useful insights,’ rather than a singular approach. Mannion et al (55) agree that, ‘the feasibility, acceptability, utility and impact of culture assessment tools in particular organisational contexts depends on a wide range of sociotechnical factors, each of which … must be addressed if cultural assessment instruments are to help deliver the desired improvements in quality and performance.’

**Changing organisational culture**

In view of the complexity conceptualising organisational culture, the variation and subcultures within organisations, and the difficulties faced when trying to adequately assess culture, it is little wonder that Grant warns, ‘cultural change cannot happen at the flick of a switch… and… change cannot happen without some form of disruption’ (56) Halligan agrees that, ‘there is no more difficult task than that of changing people’s behaviour’ (57). Davies et al (31) advise that ‘the scale and the scope of the task…(cultural change within the nhs)… is substantial.’ They also remind us of a further complicating factor, in that, organisational culture can also be affected by external influences; ‘the … sense of professional identity seen in the health
professions attest to the importance of supra-organisational norms. Public opinion, media reporting and regulatory frameworks also exert influence.' (58) Scott et al (45) recognise that considering the potential impact on specific groups/subcultures (e.g. doctors, nurses, health care managers) is a major challenge when attempting cultural transformation (49).

Davies et al (58) highlight that several valuable cultural traits may already exist in the NHS, particularly a commitment to the founding principles; therefore they conclude that widespread, simultaneous change, 'is unfeasible and probably undesirable'. Instead they suggest that strategies for change should be 'selective, aiming for a balance between continuity and renewal, identifying those aspects to … keep and reinforce and those which need … reworked'. This mirrors the ‘first order’ approach discussed by Scott et al which aims to 'do what you do better'. This is further supported by Schein (1985) who reflects that 'making value judgements regarding cultures may be unproductive, because all cultures at least partially reflect decisions and ways of being that have influenced an organisation’s survival over time.' He agrees that finding leverage points from current culture is often a far more feasible task. An alternative ‘second order, qualitative growth… complete overhaul’ approach may be more appropriate if existing culture is stagnant (59).

Scott et al (2003b) outline the work of Bate, when highlighting the key dimensions to target in a culture change strategy. They describe three distinct dimensions. The structural dimension recognises that the nature of the culture to be changed must be identified, in order for change to be successful. Brooks and Bait reflect that ‘many attempts at changing organisational cultures are strong on prescription but lamentably weak on diagnosis’ (60). The process dimension addresses how cultures can change. One emergent model suggests that cultures develop spontaneously,
and Bate (59) uses the analogy of sailing based on wave momenta to represent this spontaneous change. If the wave is in the same direction then it may be possible to ride the wave using its own energy to deliver the desired change. If however the wave is in a different direction three different outcomes are possible. These include reframing strategies- deflect waves using their own momenta, new wave strategies-waiting until the most powerful waves have passed and then creating new ones and opportunistic strategies- waiting until a new wave is going in the desired direction and ‘hitching a ride’. Finally, the contextual dimension assesses the fit of the culture into the wider environment, this involves an assessment of ‘cultural lag’ (Johnson 1984, 61) to gauge the gap between current culture and that required.

Davies et al (58) acknowledge another obstacle to cultural transformation is that ‘the nature of the cultural destination for the NHS and other healthcare organisations is currently far from clearly specified’. Interestingly as part of their research into culture within the health services Mannion et al (45) engaged with key NHS stakeholders, including clinical governance managers, representative, developmental, and regulatory agencies, patients carers and service users. They found that the main attributes these groups felt were important to assess and develop in the NHS included: senior management commitment, the shift towards patient centred care, the need to encourage clinical engagement, support for innovation, no ‘blame’ rather ‘just’ cultures, standardisation of care, a culture of teamwork, and proper engagement of patients and their representatives. With regards to specifically desirable cultures within the NHS, as mentioned previously Mannion et al (45) recognise that there has been much work in health care settings into ‘safety culture’ and tools to assess a safety culture.

In relation to safety culture, locally, the Department of Health and Social Services
and Public Safety Northern Ireland (DHSSPSNI) issued a safety based framework for sustainable improvement in the HPSS in 2006 (62). This recommended promotion of a safety culture which it states is, ‘everyone’s business’. It lists the main sub components of a safety culture as - 

- **a reporting culture**- in which people report near misses and errors,
- **a just culture**- with an atmosphere of fairness and trust which encourages engagement in safety activities,
- **a flexible culture**- which respects the skills of frontline staff and
- **a learning culture** which draws appropriate conclusions from safety information systems and implements reforms (62). It also recognised the need for ‘**culture change**’ and identified four initiatives which supported this regionally including, the Clinical and Social Care Governance Support Team, the Regional Governance and Risk management Adviser, the Northern Ireland Medicines Governance Team and the Safer Patient Initiative.

Internationally, the experience of the Dana-Faber Cancer Institute (DFCI) in Boston, provides a high profile example of a health care organisation’s attempt to create a ‘**fair and just culture**’. Following two serious adverse incidents in 1995 involving chemotherapy overdoses, the institute ‘**underwent intense organisational self assessment**’ (63). This ‘**difficult**’ process revealed that a, ‘**culture of blame**’ prevailed in the organisation. To address this ‘a **journey of self examination and sober reflection**’ and a plan for change began. This included public meetings, staff satisfaction surveys, and development of a document outlining the principles of a fair and just culture. This document was produced by a multidisciplinary team, including representatives from risk management, pharmacy, nursing, human resources, quality improvement and the legal departments, and was guided by the work of Reason (64) and Marx (65). Marx defines a fair and just culture as one that ‘**learns and improves by openly identifying and examining its own weaknesses** .... Of critical importance is
that caregivers feel they are supported and safe when voicing concerns’.

The team at DFCI acknowledged that changing the culture of the organisation would be a ‘major undertaking ... a multiyear effort’. Recognising the link between the principles and the importance of respect they also realised that, ‘the principles could not move forward until managers and staff embraced respect as a core value.’ (63) Therefore the principles were agreed with the executive committee and then presented to senior management, then mid level management and so on in a step down roll out process. Human Resources also examined how they could incorporate them into the annual appraisal process within the organisation, and they were then added to the induction for new staff from 2006. The team recognised that ‘introducing the principles of fair and just culture is a gradual process ... that requires continual education and discussion among staff at all levels and a commitment to examining and changing many of the systems, policies and procedures that guide the organisation’s work’. As part of ongoing development of the culture they continue to assess the impact through staff surveys. They are realistic about the magnitude of the ongoing task reflecting that ‘initiating this work takes time, commitment and constant attention, every day new challenges emerge.’ (63)

A further example of a strategy to improve quality and standardisation in healthcare is the development of excellence awards, including Baldrige Criteria for organisational performance excellence and the Magnet Status in the US (DeJong, 2009, 66 Armstrong 2006,67), and the CKHS Top hospital awards here in the UK (30). These awards outline criteria for high standards of care and their attainment serves as a quality accreditation.

Whilst in the medical literature there are multiple case studies (68, 69,70,71),
such as those outlined above, detailing attempts at organisational cultural change, high quality evidence on how to successfully change organisational culture in health and social care is lacking. Mc Kee et al (47) recognise that, ‘limited attention is given to implementation and facilitation of cultural change in health care contexts.’ This is further supported by the findings of a systematic review conducted by Parnelli et al (72, 2011) on the effectiveness of strategies to change organisational culture, to improve health care performance, which examined 4239 records relating to this topic. In the final analysis, however, only 2 studies met the inclusion criteria, which focused on randomised controlled trials, controlled before and after studies and interrupted time series. Both of these studies examined the impact of interventions, one using personal and work related outcomes the other clinical outcomes; both were felt to be at high risk of bias. Parnelli et al conclude that ‘current available evidence does not identify any effective, generalisable strategies to change organisational culture.’ They further recommend that before considering implementing culture changing interventions health care organisations should ‘seriously consider conducting an evaluation (of robust design e.g. interrupted time series) to strengthen the evidence.’ (72)

This relative paucity of high quality empirical evidence reflects the reality that ‘it is not possible to offer a one size fits all route,’ (30) to improving organisational culture and that prescriptive guidance is still limited (45). Research into changing organisational culture has, however, highlighted key themes that can facilitate changes, and these can offer some guidance to those wishing to improve culture. Commissioned by the National Institute of Health Research Service Delivery and Organisation programme Mc Kee et al (47, 2010) conducted a 3 year study involving multi level, multidisciplinary, multi method analysis of 8 acute NHS trusts in England
in order to understand the dynamics of organisational culture change. Their work comprised four strands including an organisational strand, leadership strand, staff well being strand and national comparative data strand and aimed to also capture how internal and external factors can shape and reshape cultures. They conducted in depth case studies of culture and compared these across the 8 trusts, with data gathered from the frontline and real time reporting on quality and safety issues. This technique may offer a way around the methodological controversies outlined above. They highlighted several key themes. In relation to safety and quality of care, whilst all staff agreed it was important, it was interpreted and prioritised differently across staff groups. The importance of priorities, values and leadership was emphasised. Setting out a vision or mission statement is seen to be, ‘integral to developing an organisational culture’ (30) with ‘linkage of values to behaviours that can be encouraged through assessment’ viewed as, ‘vital ... in successful organisations the mission and higher purpose comes from the senior management but members of staff are encouraged to buy into the organisation’s values at an early stage.’ Mc Kee et al also recognised that, ‘leadership mattered: in particular in the CEO’s role in communicating strategic vision, giving direction and focus.’ The vital role of leadership is supported widely in the literature. Jasktye (73) highlights that ‘numerous authors have stressed the leader’s role in shaping culture and suggest that the original cultural values originate from the leaders (Schein, 1985, Denison 1990, Chatman and Cha, 2003). Ferlie et al (74) conclude ‘implementation is more likely given active professional support and leadership.’ Denham (75) goes even further arguing that ‘the single most important ingredient for transformational high-performance improvement is leadership.’ Øvretveit (76) agrees that ‘leaders have a strong influence in creating culture’ he quotes Edmondson (2004) that ‘hospital
cultures …are patchwork quilts rather than uniform, smooth fabrics where learning culture, or what some have called patient safety culture, is concerned. The variation is primarily driven by local leadership behaviour’ (77). The Health Foundation acknowledges that ‘organisational fairness can only be successful when actively supported by leadership.’ (78) Mc Kee et al (47) expand on this highlighting the importance of developing leadership ‘competencies to manage disruptive change and buffer staff.’ Leape et al (79) agree that organisation leaders must ‘motivate and inspire…. and create a learning environment.’

Another critical theme identified by Mc Kee et al is engagement with staff, ‘to release creativity in frontline staff, disperse leadership and enable problem sensing and solving.’ This is also widely supported in the literature. The King’s Fund (2012, 80) advise that ‘the business case for leadership and engagement is compelling: organisations with engaged staff deliver better patient experience, fewer errors, lower infection and mortality rates, stronger financial management, higher staff morale and motivation and less absenteeism and stress.’ They recognise that this also includes ‘engagement outside the NHS,’ i.e. with patients and their carers and across the system, (between health and other government departments most notably social services.) In relation to engagement on a more individual level, work from the business and management sectors suggests that ‘excellent organisations are the way they are because they are organised to obtain extraordinary effort from ordinary human beings’. (81) Peters and Waterman (1) report that ‘people’s greatest need is to find meaning in their working lives and the main managerial task is to create meaning.’ This reinforces the need for a clear mission statement and vision. Esler and Nipp warn that ‘beliefs are as real as data, though they often go undiscovered and ignored. The head and the heart must both be engaged to accomplish cultural
The Institute of Innovation and Improvement have produced a leader’s guide to building and nurturing an improvement culture (52); this recognises that ‘people live what they have helped create.’ CHKS reiterate this, urging that ‘the trick is to help people to see the overall context and the contribution that their service is making to the success of the larger organisation and vice versa.’ (30)

In terms of the actual logistics of cultural change, Mc Kee et al also recommended that NHS organisations should develop their ‘cultural capacity’ to assess and change culture. As well as regular self assessment, this incorporates ‘importing critical and systems level thinking on change management and organisational learning from other organisations.’ (47) The importance of communication is widely acknowledged (47, 52) with Frankel et al even suggesting ‘leadership intelligently engaged in Walk Rounds improve safety by using frontline provider insights to directly influence operational decisions’ (83). Effective team working is the other recurring theme, emerging from the literature, that is essential for supporting culture change. (47, 52, 76, 80)

It is evident that changing organisational culture is a complex process. Braithwaite (84) advises that it involves ‘concerted effort, usually over lengthy periods, to influence and shape behaviours and practice on one hand, and attitudes and values on the other.’ Interestingly, he suggests that, in his memoirs detailing the 10 point action plan for success when negotiating the Good Friday Peace Agreement in Northern Ireland, previous British Prime Minister, Tony Blair may have created a valuable blueprint on which a model for culture change in the NHS could be based. These reflect many of the themes outlined above. It is summarised in table 1 overleaf.
Table 1: Blair’s 10 point plan applied to NHS culture change (adapted from Braithwaite 2010, 84)

<table>
<thead>
<tr>
<th>Blair’s 10 point plan for negotiating peace agreement</th>
<th>Principles applied to NHS culture change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ‘At the heart of any conflict resolution must be a framework based on agreed principles’</td>
<td>Articulate what we want in terms of NHS culture</td>
</tr>
<tr>
<td>2. Then to proceed to resolution, the things need to be gripped and focused on.’</td>
<td>Identify who is going to process the improvements across the years, and how, perhaps over a decade or more</td>
</tr>
<tr>
<td>3. ‘In conflict resolution, small things can be big things.’</td>
<td>Key small scale behaviours and practices, and attitudes and values, need to change, or else they can mushroom into major blockages.</td>
</tr>
<tr>
<td>4. ‘Be creative’</td>
<td>Brainstorm novel solutions; compile a mix of initiatives that can be applied to the problem</td>
</tr>
<tr>
<td>5. ‘The conflict won’t be resolved by the parties if left to themselves.’</td>
<td>Clarify the external assistance needed, and the roles for the government, Department of Health, and internal/external agencies in enabling change</td>
</tr>
<tr>
<td>6. ‘Realise that for both sides resolving the conflict is a journey, a process, not an event.</td>
<td>Determine the baggage that each NHS stakeholder carries; and devise ways to address or reduced this</td>
</tr>
<tr>
<td>7. ‘The path to peace will be deliberately disrupted by those who believe the conflict must continue’</td>
<td>Try to predict how and under what circumstances those opposed, perhaps medical, nursing, media or other groups, will try to derail the process, and circumvent these.</td>
</tr>
<tr>
<td>8. ‘Leaders matter’</td>
<td>State clearly who is leading and who is there to help; leadership can come from many quarters.</td>
</tr>
<tr>
<td>9. ‘The external circumstances must militate in favour of, not against, peace.’</td>
<td>Among external agencies, such as HM Treasury, public and private enterprise, show who can provide positive leverage for change.</td>
</tr>
</tbody>
</table>
Lessons from other Industries?

Other high risk industries such as the aviation, oil, gas and rail sectors have long been aware of the importance of safety, and in particular the need for a ‘safety culture’ (85). Helmreich reiterates that culture is, ‘of vital importance for safety and effective performance... culture has been implicated in accidents in aviation and medicine.’ (86) A review of how the aviation and oil and gas industries have attained their impressive safety record, conducted by Hudson, found that both industries appeared to have achieved this successfully, although in different ways (85). In broad terms commercial aviation adopted a positive attitude towards the safety approach whereas oil and gas employed ‘hard systematic management despite residual poor attitudes.’ (85) Hudson concludes that advanced safety culture can be simplified into four dimensions. These centre on being informed and knowing what is really going on and include the organisation being, ‘informed at all levels, exhibiting trust by all, adaptable to change and worrying- with success not engendering complacency.’ He advises that, ‘informedness feeds trust and provides the raw material for adaptability.’ (85), Heimreich also describes another six step approach used by the aviation industry that could be translated to the health care setting, to establish an error management programme. This includes history and examination of the cause of the error, with diagnosis, followed by detection of latent predisposing factors in organisational cultures, providing formal training in teamwork, feedback and reinforcement on both interpersonal and technical performance and organisational commitment to error management via ongoing training and data
Crew Resource Management (CRM) has also been demonstrated to effectively improve safety in a variety of high risk industries, including offshore oil production, aviation and nuclear power (87, 88, 89). CRM is based on the principle that human error can never be eradicated but is avoidable. It’s aimed at increasing recognition of human limitations and adapting team behaviour and communication to reduce error and adverse incidents (90). Its use has been advocated to improve non technical skills in high pressure medical settings such as emergency departments, surgical and intensive care units. (90, 91).

Preliminary findings from recent a review, by the Australian rail industry into ways to build a model of best practice for safety culture, echo several of the important themes outlined earlier (92). This work was based on the experience of 3 rail organisations dedicated to the mining industry as well as urban rail and national freight operations, and involved both qualitative and quantitative analysis. The authors conclude that ‘the 10 Platinum Rules’, identified from the experience of the Australian mining industry in the Digging Deeper Study, offer the guiding principles to establishing a culture of safety (93). These are (1) remember you are working with people, (2) listen to and talk with your people, (3) fix things promptly, (4) make sure your paperwork is worth having, (5) improve competence in occupational health and safety, (6) encourage people to give you bad news, (7) fix your workplace first, (8) measure and monitor risks that people are exposed to, (9) keep checking that what you are doing is working effectively and (10) apply adequate resources in time and money.

**Conclusion**
Organisational culture remains an evolving area of research and interest for many disciplines. Difficulties defining the concept, inevitably lead to challenges studying it, its effect on quality and safety, and how to effectively assess and change it. The academic preoccupation with how to define and assess culture has hindered progress in this area. However ongoing research projects offer hope of alternative approaches, strengthened insights and further robust evidence in the future (39,40, 95).

Whilst it is clear that culture change is a complicated and lengthy process, for which there is limited prescriptive guidance (30), common recurring themes, that facilitate change, including leadership, engagement, communication and team work, have been identified from work within the health care sector and other industries (47, 76-80). These principles are the cornerstones on which improvement should and must be based, and their importance must not be underestimated.

Importantly, there also appears to be consensus that in order to improve organisational culture we must first assess our current culture and identify what we desire it to be, (45,49,52), only then can we develop the potential enablers and plan to counteract the barriers to achieving this.

When establishing priorities for health and social care in Northern Ireland, in the short term attempting to measure baseline culture and identify positive attributes that should be developed, appears to be the most appropriate starting point. In the medium and longer terms, interventions tailored to improve, and ongoing assessment of, culture should be our key focus.

Evidently due to the complexity and scale of these tasks, the importance of culture must be recognised, prioritised and accepted at all levels within our organisations if
hearts and minds are to be truly won over. To facilitate this we must ensure that our cornerstones of leadership, engagement, communication and team working are well laid. Braithwaite cautions us that culture change is usually long term by nature (84) and Davies et al (31) also warn of the scale of the task of culture change in the NHS, therefore if we are serious about achieving these goals appropriate resources, in terms of knowledge, time and finance, must be committed.

**Limitations**

The broad scope of this review, combined with the growing interest in organisational culture across many sectors, resulted in a vast amount of available literature to analyse. The scale of this, and evaluating the information, in a limited time frame proved challenging. A further layer of complexity was added, by the variable quality of evidence available, and mixed methodological approaches that can be used when assessing culture.
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