



# **Understanding the dynamics of organisational culture change: creating safe places for patients and staff**

## **NIHR SDO Funded Project**

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# Structure of Presentation

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- **Project aims**
- **Project team**
- **Methodology**
- **Theoretical framework**
- **Some key findings and implications**



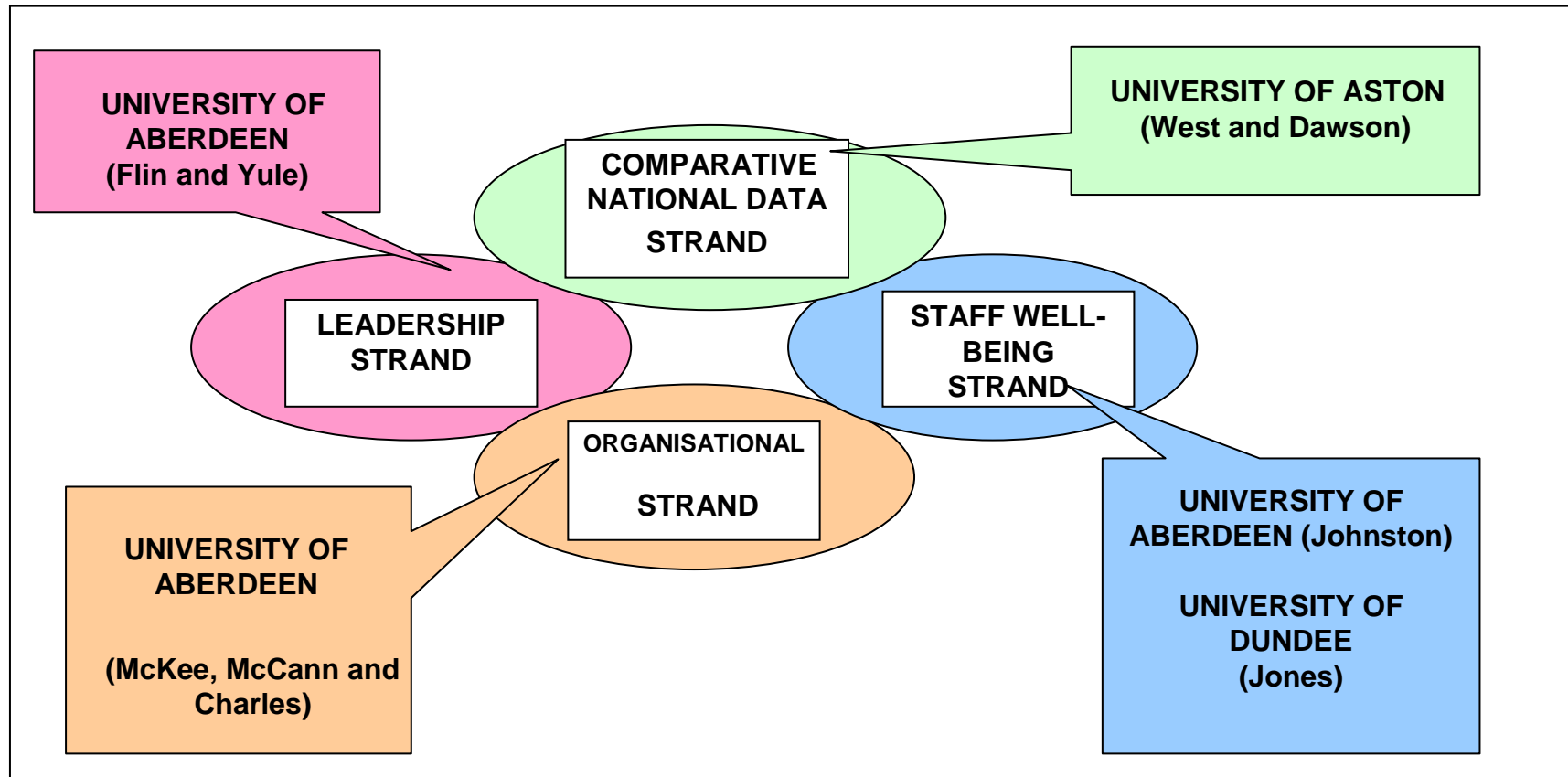
# Project Aims

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- **To extend the evidence base on organisational culture change and organisational performance**
- **Identify high/low performance for patient safety and staff well-being and links to organisational culture**
- **Identify policy and environmental change context issues: focusing on the separation of change receptive and change intransigent contexts and their links to culture, leadership and staff well-being and patient safety performance**



# Project team



# **A multidisciplinary, multi-method research approach**

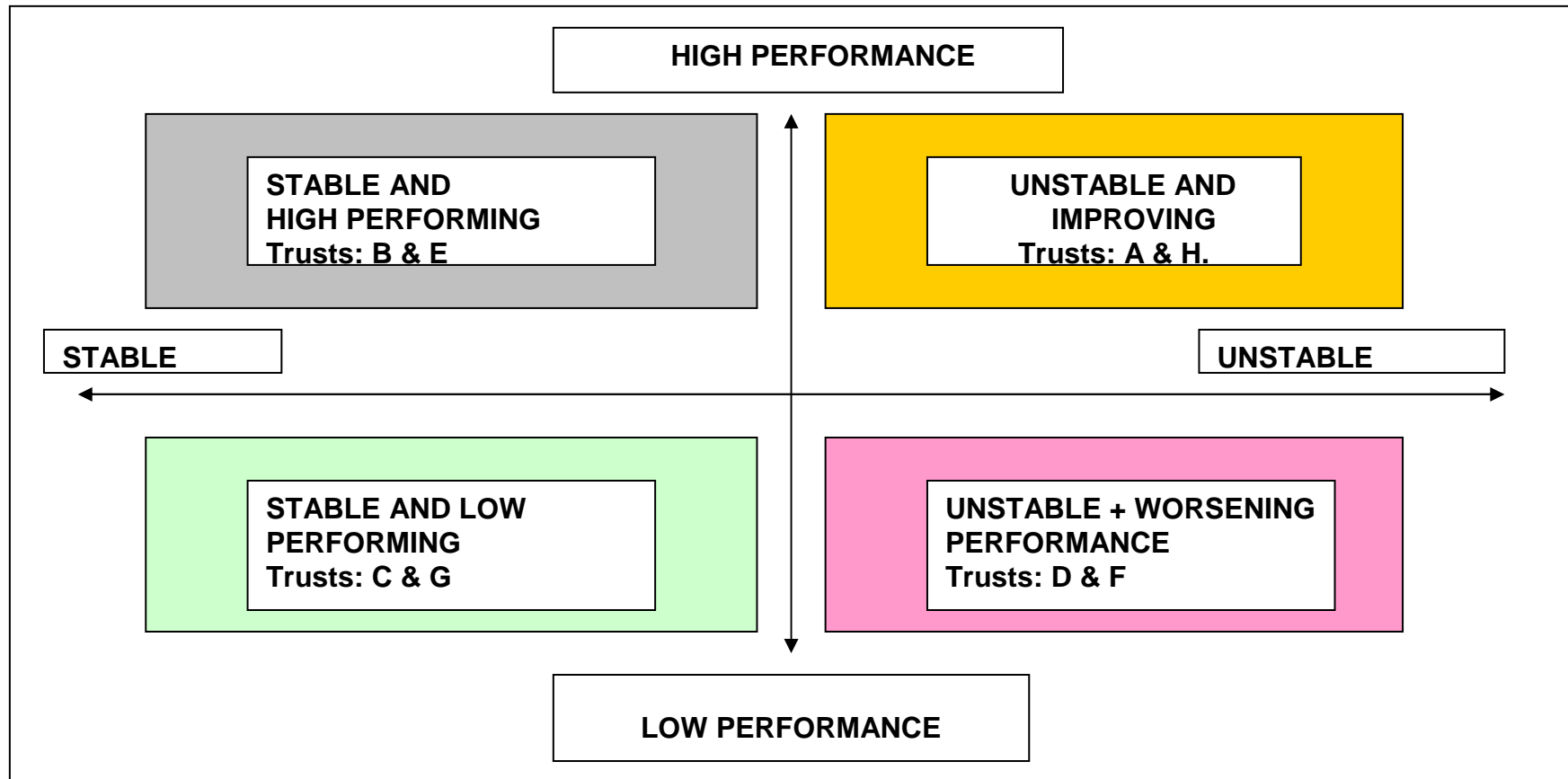
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## **Four research strands:**

- **Organisational strand – organisational level**
- **Senior leadership strand – senior leadership level**
- **Staff well-being – frontline nursing staff**
- **Comparative data strand – NHS National Staff Survey identified eight acute Trusts (A-H) and informed comparative analysis**



# Sampling frame criteria



# Data sources per strand

<b>Strand</b>	<b>Trusts</b>	<b>Data sources</b>
<b>Organisational</b>	<b>4 Depth Case studies A B C D</b>  <b>4 Mini Case studies E F G H</b>	<b>100 semi-structured interviews, Trust documents, observation of five meetings</b>  <b>44 semi-structured interviews, observation of four meetings, Trust documents</b>
<b>Leadership</b>	<b>Trusts A B C D E F G H</b>	<b>7 semi-structured interviews with Trust CEOs</b> <b>23 upward appraisal questionnaires completed by executive directors</b>
<b>Staff well-being</b>	<b>Trusts A B C D</b>	<b>233 self completed questionnaires by nurses</b> <b>248 hand held diaries completed by nurses</b>



# Processual Model of Strategic Change

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- **Theoretical framework derived from Pettigrew and Whipp (1991) and Pettigrew, Ferlie and McKee (1992)**
- **Exploring patient safety as a systems-based change**
- **Focus on the context, process and content of change – three dimensions**
- **Framework of 'receptive and non-receptive contexts'**



# Factors in Receptive Contexts

- **Fit between overall change agenda and local organisation**
- **Long-term environmental pressure**
- **Supportive organisational culture**
- **The quality and coherence of policy**
- **Effective managerial-clinician relationships**
- **The availability of key people leading the change**
- **Co-operative inter-organisational relationships**
- **Clarity and simplicity of goals**



# Creating Safe Places: Some Key Findings

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- **Lack of common meanings/ perceptions of risk and safety/ clarity of goals**
- **No uniformity in roles and responsibilities**
- **Responsibility for patient safety dispersed**
- **Patient safety seldom addressed at systems level**
- **Reporting processes not streamlined**



# What is patient safety?

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*I just don't think we've used the words 'patient safety' in a regular and repetitive way. I think it's a bit like the word 'hygiene', 'hygiene' never featured in any documentation, we talked about Infection Control, and Infection Control Team will have talked about the problems that they had encountered in getting it high on Agenda,*  
**Nursing Director**



# What is an incident?

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*You know, something goes wrong, maybe the appendix is very stuck to the bowel and therefore they can't get it off, you know they can't make a clean incision, it's stuck to everything, so they have to (unclear) and actually they nick the bowel while they're doing it so they have to over sew the bowel and maybe do a de-functioning colostomy, now they wouldn't see that as an incident. **Risk Manager***



# Lack of awareness

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## Long chains of consequences:

*And secondly I think that genuinely some people come to work even in health cultures where they are completely oblivious to the consequence of what they do because they only see themselves in the context of what they do and not in the context of what they do and the impact it has on others, and they don't understand the chain of consequence. **Chief Executive***



# Perceived barriers to patient safety

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- **Staffing – shortages, skill mixes, access to training, displacement of staff**
- **Poor communication – professional diversity**
- **Failure to document procedures**
- **Limited awareness of risk**
- **Limitations in physical infrastructure**
- **Priority for performance**



# Staffing

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***If you know you are running a ward with 27 patients and you are the only trained member of staff on and you are working a 12 hour night shift with no break, then clearly you are not doing your best for the patients or for yourself ....and it is a major, major risk.***

***Risk Manager***



# Staffing

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***If I could knit them half a dozen nurses I would sit and knit some. But I can't, and I would have to say from my point of view that staffing has to probably be the biggest single threat. Risk Manager***



# Skill mix

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***I think the skill mix is wrong and I think with the changes that are happening in the NHS at the moment, reducing the length of stay obviously means the client group changes as well and their dependency changes. Matron***



# Priority for performance

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- **TARGETS CLASH WITH PATIENT SAFETY**

*The four hour waiting target for A&E and the requirement to reduce the bed base to save money resulted in the number of medical patients that out lied into surgical beds and at one point in time we were in the situation where we put in extra beds in the wards to accommodate patients – there were clear patient safety issues associated with those practices. Director of Nursing.*

- **A FOCUS ON HIGH PERFORMANCE MEANT THAT STRUCTURES WERE TIGHTLY COUPLED -THERE WAS NO SLACK IN THE SYSTEM**

*We are a hamster on a wheel because you know clinical areas are very busy and corporately there's a lot to do – so we've stripped out as many of the inefficiencies or cushions that we can – which is good but there's no room – there's no slack in the system. Director Corporate Affairs.*



# Leadership matters

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- **Senior leadership prioritisation of patient safety affects performance**
- **Major environmental pressures distracted many senior leadership teams**
- **High performing Trusts could buffer environmental pressures**
- **CEO can galvanise staff – communicates vision**



# Leadership matters

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- **Tenure and stability of senior leadership linked to patient safety and staff well-being performance**
- **Transactional and transformational styles of leadership important**
- **Dispersed leadership linked to patient safety performance**
- **Informal leadership role models critical**



# Role of External and Internal Contexts

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- **Trusts experienced differential environmental pressure and combinations of pressure: high volume and pace of change**
- **Notion of 'environmental shocks' which were downward, sustained, cumulative, complementary from both internal and external sources**



# Broader context and burden of change

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- **Environmental 'shocks':**
  - 1. PCT reconfiguration**
  - 2. Trust merger**
  - 3. Reduction in commissioned services**
  - 4. MRSA and C-Difficile outbreaks**
  - 5. Leadership instability**
  - 6. Financial deficit**



# Trusts' Adaptation to Environmental Pressures

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## Linked to:

- **Cultural attributes – staff engagement**
- **Organisational capabilities – learning processes**
- **Stability - Longevity of tenure - senior leadership and staff**



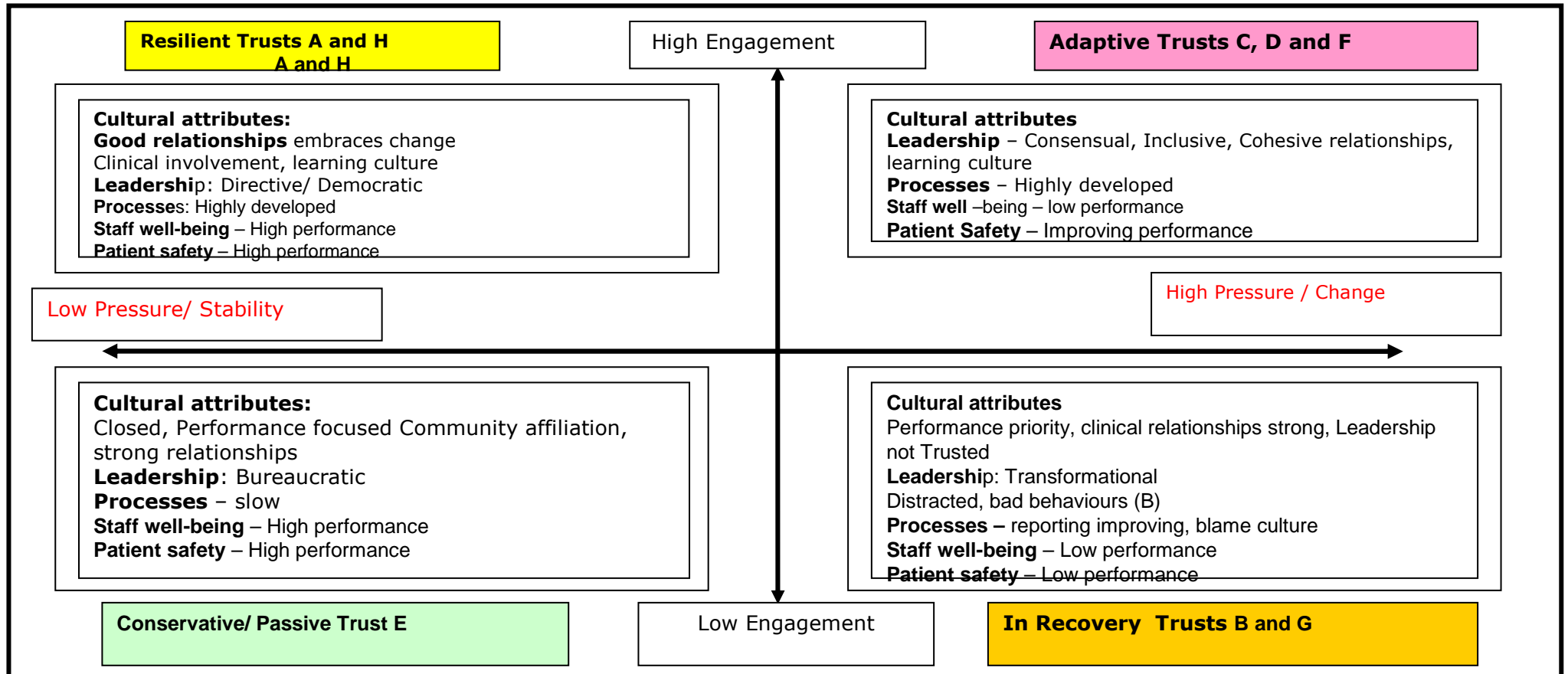
# Typology of Trusts

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- **Resilient**
- **Adaptive**
- **In Recovery**
- **Conservative / Passive**



# The distribution of Trusts by magnitude of environmental pressure and staff engagement



# Policy Implications

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- **Ensuring senior leadership continuity**
- **Assessment frameworks for environmental, cultural and organisational capability assessment**
- **Explicit strategy framework for patient safety**
- **Streamlining of reporting and feedback processes**
- **Emphasis on dispersed leadership**
- **Staff engagement promoted – informal methods**
- **Role models – buffering change**



# Thank You

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- **More information:**  
**Project webpage**

**[http://www.abdn.ac.uk/hsru/research/del\\_of\\_care/org\\_managment\\_policy/UDOCC\\_safeplaces/](http://www.abdn.ac.uk/hsru/research/del_of_care/org_managment_policy/UDOCC_safeplaces/)**

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