

BRISTOL ROYAL INFIRMARY INQUIRY

PHASE TWO

Culture - professional and managerial cultures and their impact on the quality of service

Summary Report

This is a summary report of the key points emerging from the seminar discussion on Professional and Managerial Cultures which took place in London on February 16 2000.

The following points were put to the Panel in discussion; they do not necessarily reflect the views of the Panel.

Summary of the discussion

The purpose of the seminar was to explore the concept of culture within organisations and occupational groups, focusing specifically on managerial and professional cultures within the NHS, and to consider the impact of culture on service quality. The seminar included participants from the legal and health professions, health service management, user organisations as well as from academia. The seminar started with a discussion of the concept and definition of culture; the characteristics of NHS culture, and the specific cultures of key occupational groups, including medicine, nursing and management. The wider context was highlighted: the NHS both reflects, and is influenced by, issues of class, race, gender, age and inequality. The strength of professional cultures and the apparent lack of a patient focus to the culture of the NHS were noted. The idea of 'healthy' and 'unhealthy' cultures was discussed and some characteristics of 'healthy' cultures were identified. The seminar moved on to consider how NHS culture might be changed to improve quality, looking first at obstacles to change and specific strategies and general principles which might lead to beneficial change. Key points made are summarised below. Many are elaborated in position papers submitted in advance of the seminar and available on the Phase Two Section of the Inquiry's website.

1. Defining culture

- (i) An organisation's culture could be understood as a set of ideas and behaviors. While each organisation or group has resources, buildings and a physical environment which influence its activities, it also has a set of ideas, shared understandings, norms, conventions and values. Such ideas and understandings are embodied in symbolic systems such as ceremonies, rituals, language and the linguistic shorthand used. Membership of an organisation or group is defined by the ability to understand and use these cultural symbols. The existence of culture helps to define and maintain the boundaries between groups, and between organisations.
- (ii) A shared culture benefits an organisation or group through the promotion of coordination and efficiency, reducing uncertainty and increasing trust. An organisation's culture can also be a conservative force, making it difficult to respond to change or to dealing with new situations. Being both intangible and deeply grounded, a culture may be very hard to change and attempts to change culture may have unintended or perverse effects.

2. Organisational, professional and managerial cultures within health care

- (i) Within the NHS there are several dominant but inter-related cultures: organisational, occupational and environmental and participants explored the main characteristics of the sub-cultures including the culture within hospitals and the specific cultures of medicine, nursing and management. Participants also reflected on patient cultures and the wider social and political context within which the NHS exists.

2.1 NHS culture

- (i) Participants spoke of the complex nature of the NHS culture mirroring the NHS's many objectives and the range of its activities. A contrast was drawn with the private sector, where the aim of building a business and making a return for shareholders creates much greater unity of purpose. In the health service, the ultimate shared purpose is to maximise the quality of patient care, but within the system, health professionals and managers have differing roles and potentially conflicting interpretations of how to meet that purpose. For example, where does duty lie? Professionals may focus on doing their best for individual patients, while managers tend to think in terms of patients collectively. Further, tensions between managers and clinicians may be heightened

where politically determined objectives focussing on patients, collectively, are thought to have a detrimental impact on a certain individual patient.

2.2 Hospital culture

- (i) Hospitals are characterised by the wide range of cultures they have to accommodate.

There is the overall culture of the organisation, of which every employee is a member.

Within the hospital the loyalty of organised occupations and professions may lie as much outside, to a Royal College for example, as to the hospital itself. Patients bring additional cultures, and must be taken into account both as users and taxpayers. These differing perspectives mean that both terms and concepts (such as teamwork) may have quite different meaning and significance for different groups, and such differences are rarely transparent. It was suggested that a hospital is like a honeycomb, with little interaction between the cells.

- (ii) Several other characteristics of hospitals were identified as influencing their culture.

They were described as 'institutions shrouded in anxiety' where people can be very sick and many deaths take place. Modern acute hospitals often extremely large and thus, like ocean liners, difficult to slow down or to alter course. Opportunities for staff to reflect are rare and need to be carefully planned. With the exception of consultants and permanent nursing staff whose appointments are usually stable and long term, hospitals are characterised by a relatively quick turn over both in management staff and junior clinical staff, particularly at the training stages. In recent years the turnover in nursing has been increasing.

2.3 Medical culture

- (i) Medical culture has traditionally been based on power. When students start out at medical school they learn how to behave as the medical profession believes doctors should. Examples given of cultural expectations within medicine included pressures: not to show emotion - even if this might help the patient; to be tough and not complain - even when overtired or feeling unwell; to be self managing and self sustaining, drawing on one's conscience rather than on one's peer's for help and not to criticise other doctors. Such expectations are neither made explicit nor openly discussed, but those who defy them may encounter difficulties in their careers.

- (ii) It was noted that medical culture is not a unitary culture, but one which varies between specialties. Medical culture also varies between hospitals and changes over time as new

educational philosophies are introduced, doctors' roles within organisations change (for example to accommodate greater management responsibilities) and treatments evolve through technological and scientific advances (for example through the impact of the new genetics). The Panel heard that there, while the commitment to the 'Hippocratic promise' remains strong, there is an increasing commitment in medical education to training students in areas such as communication and teamworking and basic managerial skills, although training doctors together with other professions in multidisciplinary groups remains unusual.

2.4 Nursing culture

- (i) Nursing has traditionally been based on service with great respect shown to senior nursing staff and to doctors. The almost military organisation of nursing was exemplified in the past by the marking of incremental progress through the ranks by such symbols as gaining a new belt. Nursing has also had a very disciplinarian culture, with often devastating punishments for apparent minor infractions.
- (ii) More recently with flatter management structures the emphasis, on hierarchy has diminished. The student nurse role has changed dramatically with the move away from hospital based training to university education. The shift of nurse training out of hospitals, along with the reduction in junior doctors' hours on the wards, has diminished the opportunities for informal contact between the two groups and for the transfer of knowledge from nurses to doctors about the culture of care as well as cure.
- (iii) A key feature of the nursing profession is that 90% of nurses are women, many of whom have family commitments. Having to go home at the end of a shift excludes them (and women doctors with similar responsibilities) from participation in the informal arenas of information exchange and decision making, such as meeting in the bar after work, which the more macho medical culture tends to take for granted.
- (iv) Participants suggested that nurses tend to be more willing than doctors to alter their behaviour in response to research evidence, sometimes making changes prematurely before all the data are available. One explanation offered for this difference between the professions was that nurses have more of a learning curve and assume they could do better, whereas doctors presume they are already doing what is best. It was also observed that while doctors are trained to work as individuals and give advice, nursing training puts more emphasis on working in a team and considering how to implement what has been learned. Medical culture is rooted in "cure"; nursing in "care".

2.5 Managerial culture

- (i) The rites of passage for managers are very different. Management is not a “profession” and managers do not have to reach an explicit standard to be qualified to practice. Nor do they have 150 years of powerful tradition or a scientific knowledge base equivalent to that of medicine. Managers learn from the world around them, rather than from professional peers. They identify and respond to incentives, which may be politically led, driven by considerations of collective patient interest, rather than directly linked to considerations of individual patient care.

2.6 User culture

- (i) Patients, users and carers are not a monolithic group but represent as many cultures as exist within society. The Panel heard that, historically, users collectively have not exerted a strong influence on health care culture, and that the agenda for care is set by professionals rather than by patients, users and carers. But there is strong pressure for change, reflecting changes in wider society. User cultures are also changing fast to reflect changes in society. At present, technology is driving a change in both the knowledge base and expectations of patients. For example, 30% of people going to outpatients for diagnosis also surf the Internet for information about their condition.

3. Characteristics of a 'healthy' culture within the health service

There was discussion of the concept of 'healthy' and 'unhealthy' cultures in organisations. The following were identified as characteristic of a 'healthy' culture within a healthcare organisation:

- (i) Alignment of values and objectives (*the organisation needs to nurture at every level a positive, healthcare and cure culture*);
- (ii) involvement of the Executive and Non Executive Directors of the Board (*Board members are actively engaged, with the skills, training and knowledge to make their involvement effective. The independence and selection criteria for Non-Executive members of Boards was queried, with concerns expressed about deficiencies in skills, support and training provided to Non –Executives to enable them to fulfil their role and responsibilities*);
- (iii) attitude and behaviour of the chief executive (*the chief executive shows humility, is personally involved, empowering, respects clinicians and their work and is willing to stand up for the quality of clinical care against other pressures*);

- (iv) commitment of managers (*managers have - and demonstrate - real commitment to patient care and the welfare of their professional colleagues*);
- (iv) reciprocal respect (*managers recognise the concern of clinicians for their individual patients and clinicians recognise the responsibility of managers towards patients as a group*);
- (v) communication (*there is open, two-way communication up, down and across the organisation*);
- (vi) responsibility and leadership (*power and responsibility is shared, with leaders identified at every level*);
- (vii) clinicians as managers (*the clinician as manager role is supported at many different levels and clinical leaders are grown, rather than appointed by default*);
- (viii) union relationships (*there are good relations with trades unions*);
- (ix) occupational relationships (*the importance of constructive relationships between non-managerial groups is recognised, as well as between these groups and management*);
- (x) training and support for manageable tasks (*people have the resources and opportunities to do what they have been trained to do, are not faced with demands they cannot meet and there is high investment in training*);
- (xi) appropriate responses (*the organisation celebrates success and genuinely invests in people. Mistakes are acknowledged quickly and the organisation is “big” enough to say sorry*);
- (xii) contingency plans (*contingency plans exist for what to do when things go wrong*);
- (xiii) information for patients (*information is provided as a right to patients and carers, in the form and at the time they need it*) and
- (xiv) feedback from patients (*present and past patients and carers have the opportunity not only to have complaints addressed, but also to make positive suggestions and express their views in ways that will be heard and acted upon*).

4. Obstacles to changing culture to improve quality in the NHS

Listed below are the potential obstacles to changing culture for the better in the NHS which were identified.

(i) Complexity

Culture is not easily amenable to change – it is not a question of re-writing an instruction manual.

(ii) Learning capacity

Using the management studies concept of 'learning organisations', the NHS is an extreme 'non-learner'. Reasons for this include its large size, segmented character, high media profile, tight political control and tight performance management.

(ii) Initiative overload

The NHS as a whole is suffering from initiative overload and its staff are exhausted.

(iii) Under-investment in people

It has been suggested (Investors in People) that organisations should invest 3% of available resources in developing their staff. Presently the average consultant receives an average of between £400 and £600 per year to support their continuing development and funds to support non-medical staff come to less than £100 per head, per year. This is considerably less than 3%.

(iv) Systems and skills

The NHS is not yet geared towards implementing a quality strategy. Clinical governance is conceptually strong, but there are real difficulties with implementation and its risks becoming another top down, box-ticking exercise. Systems and skills to implement quality initiatives are not consistently in place within NHS organisations and across professions (for example, the Panel heard that recent research shows that nurses have a strong concept of audit and what their role should be, but actually putting this into practice is very difficult).

(v) Outcomes data

There is very little, good quality, outcome data for clinical procedures. Firstly, outcomes other than death are not easily measurable, nor is there necessarily consensus on their value. Patients, GPs, nurses, managers and consultants may have quite different views on what constitutes a successful outcome. Secondly, collecting outcome data on a range of procedures from a large number of hospitals is both difficult and expensive; process measures such as re-referral rates and length of stay are easier to record. NHS culture does not value information on clinical outcomes, so such data collection is not adequately supported or resourced. Participants differed in their views as to how well existing data is used. Some agreed that those data which do exist are not translated into usable information, others suggested that the picture is not entirely bleak and there are many pockets of good practice.

(vi) Attitudes and relationships

There is a tendency towards adversarial relations between management and clinical professions, with the latter skeptical about the value of what managers do.

(vii) **Complaints and Fear of litigation**

Commitment to openness and trust may be difficult in the context of an aggressive media and a legal system where the legal profession will see every acknowledgement that a clinician could have done better as an admission of liability, opening up the possibility of legal action. Participants noted that some clinicians are aggrieved at the current readiness of managers to acknowledge and accept a complainant's view.

5. Strategies for changing cultures to improve quality

(i) A number of possible strategies for changing cultures to improve quality in the NHS were discussed, these included 'franchising', creation of 'secure environments' and protected educational domains and mechanisms for involving patients more effectively. As well as these specific strategies some general principles were identified. These included the need to:

- * recognise that changing culture is difficult and at best continuous process rather than a discrete task;
- * move away from a culture of blame and indifference, to one of quality that puts patients at the centre;
- * consider the practical implications and training requirements of desired changes and ensure they are addressed, taking into account resource implications;
- * align professionally driven initiatives (such as revalidation) with managerial frameworks for quality;
- * acknowledge that medicine has enormous power and take care to ensure that confidence in it is not undermined;
- * acknowledge that doctors are people with ordinary needs and concerns and to put systems in place to check their well-being and job satisfaction;
- * involve the public from the outset as active participants rather than passive recipients or as complainants provoking professional defensiveness;
- * learn from previous failures - such as the failed implementation of the audit programme, which only succeeded where doctors wanted it to happen - and set about convincing clinicians of the value of change. This means acknowledging and engaging with existing cultures and ensuring that health professionals see the value to themselves and to their patient of initiatives such as clinical governance;

- * make use of the latest information technology to turn data into information and
- * create a more receptive open culture towards improving quality; this means acknowledging that cultures within an organisation are driven from the “front line” and are not easily receptive to top down dictat.

5.1 Franchising

- (i) Seminar discussants heard about the procedures developed since 1993 by the Legal Aid Board for ‘franchising’ law practices involved in providing legally aided services. Aspects of practice covered in the assessment process include: indicators of good management practice (such as the use of nondiscriminatory recruitment procedures); arrangements for internal peer review (with supervision for every category of law in which franchising is sought); content of cases (completed files are assessed against selected transaction criteria which show whether a case has been properly run); and outcome measures (assessed not on individual cases, but on populations of cases). Nearly 5000 solicitors' firms are now under contract, along with about 300 advice agencies and the franchising process is increasingly acknowledged to have been a productive and constructive process.

- (ii) In thinking about the lessons for the NHS it was acknowledged that, in terms of size and complexity, solicitors' practices are more equivalent to general practice than to hospitals. However, it was felt that the principle of franchising would be feasible in the NHS and could perhaps be undertaken by health authorities, though they are not presently equipped to carry out such a role. A framework of franchising could only play a remote part in the process of quality improvement, because nothing driven from outside the individual organisation or group will really make an effective difference. Quality depends on the commitment of those actually delivering the care. Within hospitals, the success of franchising would depend on identifying leaders at every clinical interface because quality of care needs to be critically appraised by and within the immediate clinical team rather than across specialties.

6. Secure environments

- (i) What is needed is a culture in which admitting errors is seen as the right thing to do and which provides mechanisms to encourage this and support for those who do so. It was suggested that openness should become the guiding principle and concealment the

exception. In the past, doctors were told by defence organisations never to admit any liability. The GMC now says that doctors should own up to errors where serious injury occurs. The rules for lawyers are tougher, in that a solicitor who thinks they have made a mistake is professionally bound to say they can no longer act for the client concerned. There was discussion of the need for protected environments for staff to discuss and acknowledge problems to ensure that errors are not driven underground. One option mentioned was that of privileging papers which discuss critical incidents or near misses, to make them immune in any future medical negligence claim. However, concern was expressed that such an approach could conflict with the principle of freedom of information. Another approach discussed was the 'clinical supervision' model currently used throughout nursing, which provides a structured mechanism to enable people to reflect on their practice in a one-to-one setting. A no fault compensation system would be ideal in a perfect world, but the resource implications could be profound.

7. Involving patients

- (i) Various strategies for supporting and actively involving patients were mentioned. These strategies involved distinguishing between individual patients; patients collectively and, citizens in general. Ideas put forward included: fostering a culture where patients and carers, including parents, are acknowledged as experts in their own right and treated with respect; acknowledging diversity among patients and understanding how their expectations and concerns may vary by, for example, age, class, gender, ethnicity and locality; recognising that treating people equally does not necessarily mean treating them all the same; seeking out, welcoming, analysing and learning from complaints; and treating complaints in a non adversarial way; involving users at the start before things go wrong - asking them what they want from the service and involving them in defining guidelines for good practice; using patient advocates; acknowledging the under-funding of Community Health Councils and their outdated statutory powers and developing a properly funded network of consumer organisations (as exists in the Netherlands).
- (ii) It was suggested that despite concerns about potential litigation, in fact, the UK public remain essentially non-complaining and non-litigious. What many people want when things go wrong is admission, explanation and apology rather than compensation. What is needed is to work with patients through direct dialogue.

Inquiry Secretariat, March 2000