HSRUK virtual workshop:
The challenge of culture change in the NHS

Graham Martin, Director of Research, THIS Institute
Naomi Chambers, Professor of Health Management, Alliance Manchester Business School (workshop coordinator)
Jeremy Taylor, Director for Public Voice, National Institute for Health Research
Suzie Bailey, Director Of Leadership and Organisational Development, The King's Fund

Chaired by Michael West, Professor of Organisational Psychology, Lancaster University & Visiting Senior Fellow, The King's Fund

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Creating a ‘culture of openness’ in healthcare

How are new policies translating into change in NHS organisations?

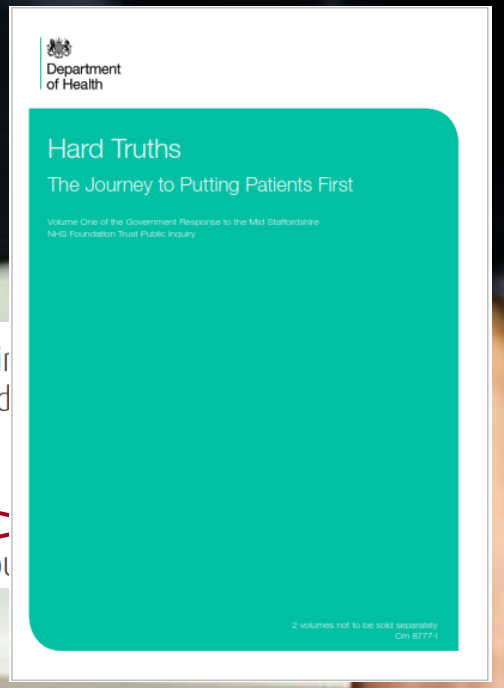
Graham Martin

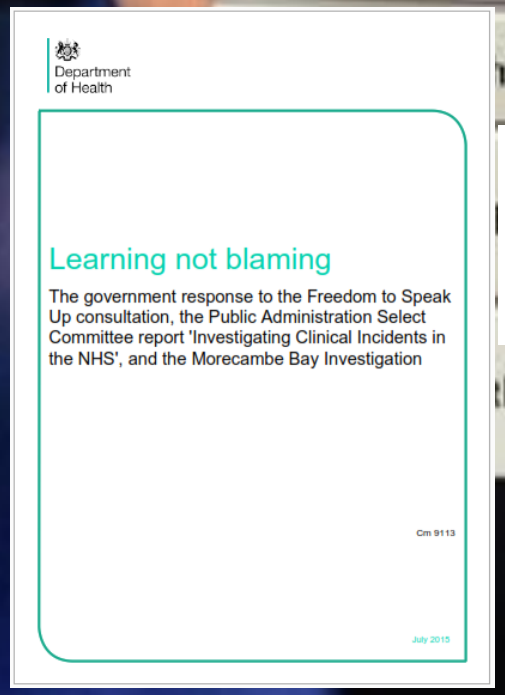
Director of Research, THIS Institute

graham.martin@thisinstitute.cam.ac.uk

@THIS_Institute
@graham_p_martin

Together the responses to the Inquiry's recommendations seek to **build and strengthen a culture of compassionate care**, looking to an NHS future in which world class leaders working with highly skilled and caring staff consistently strive to improve the care they give to patients.





These changes are necessary, but they are insufficient on their own to secure the consistency of experience and reliability of care that patients should be able to take for granted and that staff are striving to provide. **The remaining critical component is culture**, in the context of financial sustainability.

Organisational culture and cultural change

- ‘The way things are done around here’
- Long seen as fundamental to organisational performance
- “Culture eats strategy for breakfast” (Peter Drucker, attrib.) and all that
- Culture change as the key to success?
- *But…*

Culture as something that an organisation **has**, or something that an organisation **is**?

Methods

- Workstream 1 (2017-2018)
  - Workpackage 1a: Interviews with senior stakeholders in and around the NHS (51 in total)
  - Workpackage 1b: Survey of board-level NHS managers and clinicians on implementation
  - Workpackage 1c: Retrospective analysis of national NHS survey data to examine identify changes in indicators of openness associated with policy changes
- Workstream 2 (2018-2019)
  - In-depth case studies of six NHS organisations, with a particular focus on (i) the Duty of Candour, (ii) Freedom to Speak Up, and (iii) the revised Serious Incident Framework
  - Three acute trusts, two community and mental health services trusts, one ambulance trust
  - Interviews with staff, patients and family members (88 in total)
- Supported by professional and PPI advisory groups

“We started our patient safety summits about four-and-a-half years ago. So Duty of Candour wasn’t out at that point, so it just became part of what we did as the business for the patient safety summit. […] RCA, Duty of Candour, learning to improve or learning lessons, all part of one process. That is all part of incident-management processes and people have to send the letter that’s gone out of the Duty of Candour, as part of the investigation. So that all gets tied in—each incident’s got a number attached to it, the rapid reviews, the staff reflections if that’s what we’ve asked for, or if we’ve asked for the minutes of the meeting where they’ve discussed this so that we can prove that they’ve actually had the discussion with the wider team, the Duty of Candour, anything like that.” (Acute trust E)

“So the way it works—whether it works well I don't know—the governance team will then draft a vignette, because otherwise it's just, no-one's going to read the whole, the whole report, not everybody, so they'll draft a vignette. That vignette is then fed back to the different teams, and it goes from top, so there's a senior management team, then there's a clinical team, then there's a local—everybody has about a thousand meetings, I find! It filters down, so, eventually the ground-floor staff will have it.” (Community and mental health services trust C)

“They mistakenly thought that they could squash us and we might go away. But we didn’t, and we became quite troublesome really. Which is why we’re very much *personae non gratae* at our trust, without a doubt. […] It definitely feels like that when you’ve got the whole of the NHS against you basically. But to be quite honest the only thing that’s in my favour is I’ve absolutely nothing to lose, except some money. And I’m very willing to go to the extremes this time.”
(Acute trust E)

“My complaint did not fit the form. I imagine for most people, at that point, they give up. Because it was one of those deliberately boxy things where you had binary choices and it was very reductive, it stripped it right down. […] I’m almost certain that they will look into my case on the basis of the really useless form and go, ‘We can’t see anything here’. At which point I will go again. Because I’m not having it. So that’s the next hurdle that most—if people got through the first one, that’s the next one they’ll fall down at. […] Because I’m now at the point where I’m like you have really, really upset me.”
(Acute Trust A)

“I go to every induction, including the student nurses, nursing associates and junior doctors. I go to team meetings: so I targeted each individual directorate, introduced myself to the director, explain what I wanted to do and then found out the matrons, so that I could get invited to team meetings to make sure that I was engaging with staff as far and wide as possible. Just raising awareness about the role—it was my passion that it was about seeing a face rather than just a brand, and knowing that there’s just another mechanism by which people can speak up. I always give the background around the Francis report and use that as the hook to say, ‘This actually refers to us’.”
(Community and mental health services trust B)

“Any sort of profile-raising has to be through social media. CQC, they took my photograph round to all the sites and all the walls, and every time I went on the ward I saw myself—disconcerting! But it is very, very difficult. A lot of it I have to do over the phone. I’ve got a lot [of contact] recently because the CQC, they raised the profile. But I probably don’t get more than about five or six in the quarter.”
(Community and mental health services trust C)

4. Co… …d impr…

"We're doing a whole piece of work around outcome measures and it's a nightmare, it is like going through treacle, it is awful, but we've set it up and I've said, 'This is an organic process. I am not saying that by December next year you will have a suite of outcome measures'. I'm not saying any of that, it is an organic process. It's 'What do we have? What do we need to develop? What do the staff tell us? What do patients tell us? How does it look? How can we do it? What does that picture give us?' And it's building that picture, and I'm being quite assertive about that, saying, 'Don't tell me that you need all these boxes filling because it's not going to happen'. We need to work with people to do it." (Community and mental health services trust B)

Culture change?

- Impossible to say with any confidence how lasting these changes will be
- Top-down policy implementation will undoubtedly achieve very little
- Varied organisational topography means that any change will be uneven

But…

- Some signs at least of what can make a difference
- Sustained efforts in some organisations (often predating Francis) seemed to be sticking
- Maintaining focus and mainstreaming activity crucial to prospects for sustainability

Four enduring challenges

1. The reliance on good will and discretionary effort
2. The limits to approaches based on an ethos of organisational development
3. Caring for staff, patients and relatives who embrace openness
4. The (continued) marginality of patients, carers and families

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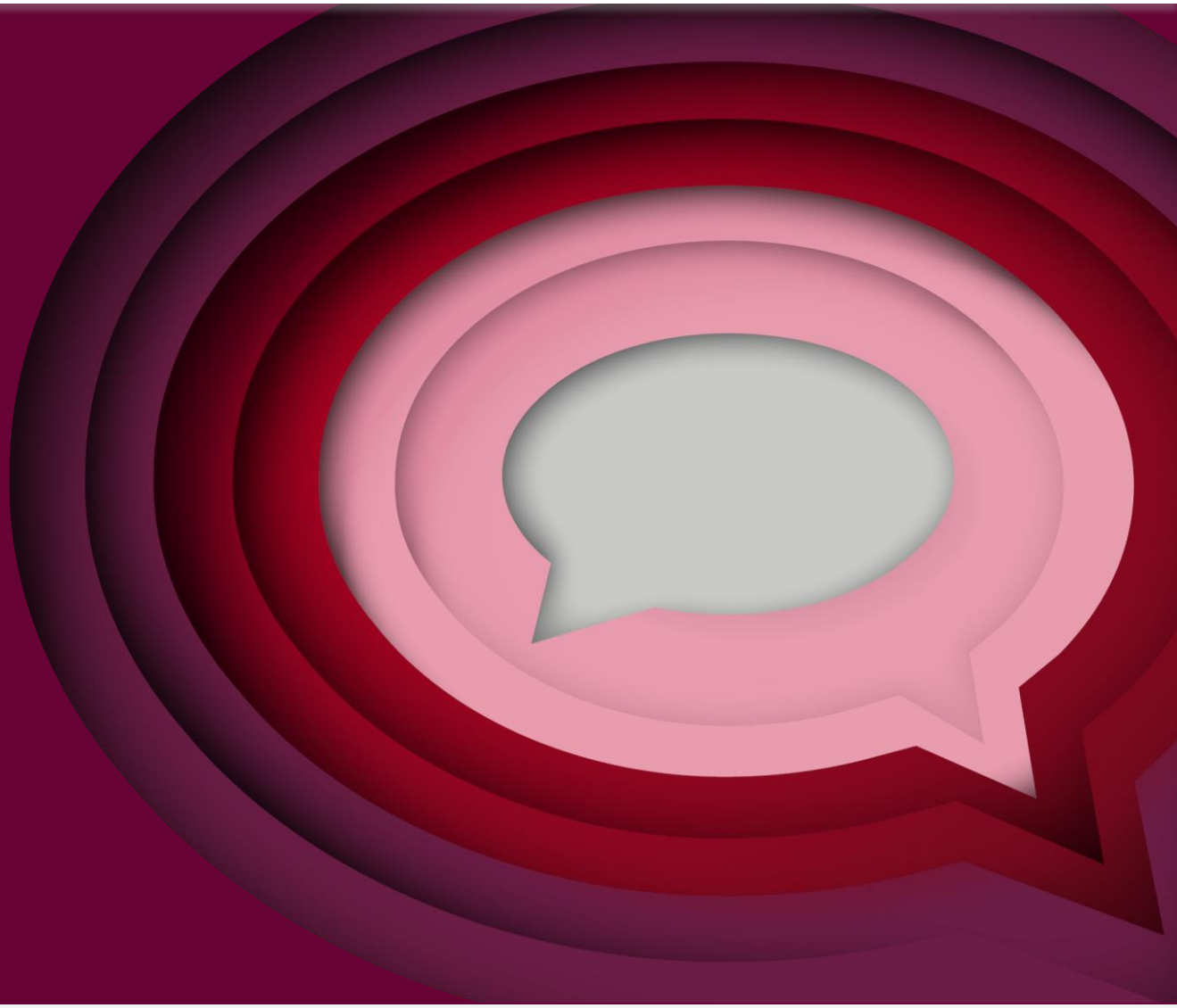

thisinstitute.cam.ac.uk

@THIS_Institute
@graham_p_martin

Learning from testimonies given by patients

Naomi Chambers,
Professor of Health Management,
Alliance Manchester Business School
&
Jeremy Taylor,
Director for Public Voice,
National Institute for Health Research

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The University of Manchester
Alliance Manchester Business School

Summary

Background to the (forthcoming) book

The place of storytelling in health service research

The experience of asking and listening

What is important to patients

Background to the book

Working title : Organising care around patients Manchester University Press 2021

Authors: Naomi Chambers & Jeremy Taylor

Purpose: to generate insights into how to provide care that is more patient-centred

Collection of 20 narratives from birth up to the end of life about what it's like when services get it right & wrong in order to provide an immersive experience and paint a rich and varied picture

Influenced by reporting tradition eg *Chernobyl Prayer* (Svetlana Alexievich) and *We Crossed A Bridge And It Trembled : Voices From Syria* (Wendy Pearlman)

Storytelling in health service research

'There is no way to understand the human world without stories. Stories are everywhere. Stories are us'(Storr, 2019)

Concept of 'serious storytelling' to achieve serious goals (Lugmayr, 2016)

'Just listen to your patient, he is telling you the diagnosis' (Osler, famous Victorian physician quoted in Bliss, 1999)

Narrative method recently acquired legitimacy as 'decent' form of health service research (Greenhalgh & Wengraf, 2008)

Potential to facilitate culture change and greater humanism in healthcare (Rose, 2015)

The experience of asking and listening

Storytellers spoke freely – there were no set of questions and no time limits

Deeply personal accounts were possible over the phone

Some tales were fragmented, others were polished narratives

As listener and then reader/editor it was impossible not to be moved and affected by some of the stories

What is important to patients

Kindness

Attentiveness

Empowerment

Organisational competence

Professional competence

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Bliss M (1999) William Osler: A life in medicine Oxford: Oxford University Press

Chambers N & Taylor J (2021 forthcoming) Organising Care Around Patients Manchester: Manchester University Press

Greenhalgh T and Wengraf T (2008) Collecting stories: is it research? Is it good research? Preliminary guidance based on a Delphi study *Medical Education* 42: 242–247 doi:10.1111/j.1365-2923.2007.02956.x

Lugmayr A, Sutinen E, Suhonen J, Hlavacs H Sedano CI, Montero CS (2017) Serious storytelling – a first definition and review Multimed Tools Appl 76:15707–15733 DOI 10.1007/s11042-016-3865-5

Rose R et al (2016) The storied mind: A meta-narrative review exploring the capacity of stories to foster humanism in health care Journal of Hospital Administration **5** 1 52-61

Storr, W (2019) *The Science of Storytelling* London: Harper Collins

Going to the dark side

Suzie Bailey,
Director Of Leadership and Organisational Development, The Kings Fund

Sector Regulation in England

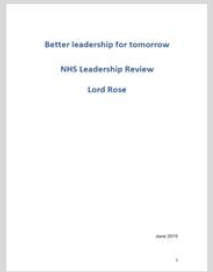
Monitor
Making the health sector work for patients

- Monitor was 'responsible for authorising, monitoring and regulating NHS foundation trusts'
- Ensure they are well-managed and financially strong so that they can deliver excellent healthcare for patients
- Further responsibilities under the Health and Social Care Act 2012

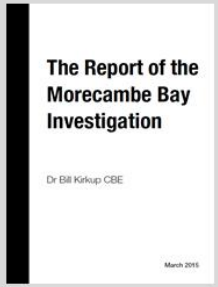
Culture change - a walk in the park?

5YFV

Francis (2015)



Rose (2015)



Kirkup (2015)

DH (2015)

Keogh (2013)

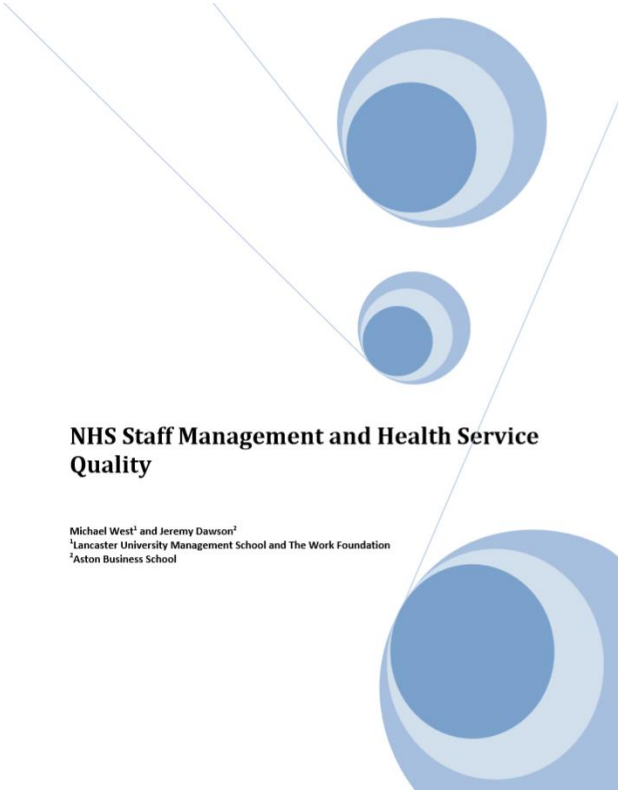
Francis (2013)

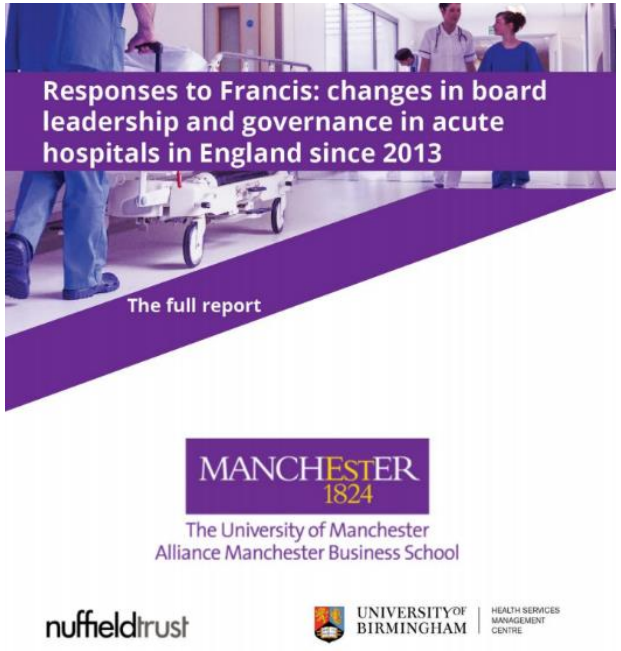
Berwick (2013)

Valuing the evidence

'In God we trust. All others must bring data'

Deming





Policy and Practice

- **Understand** and use the research
- **Develop** the case for change and investment
- **Persuade** the board
- **Create** a team
- **Commission** a credible partner
- **Find partners to co-produce** the work
- **Learn** and iterate the resources and support offer
- **Keep talking** about how change is possible

Central Manchester NHS University Hospitals NHS Foundation Trust

Monitor
Making the health sector work for patients

NHS East London NHS Foundation Trust

NHS Northumbria Healthcare NHS Foundation Trust

The King's Fund

Developing relationships for system change