Culture in the NHS
Pulse report 2018
Pulse support NHS and care provider organisations to transform and optimise culture.

A positive workforce culture is shaped by the behaviours demonstrated every day; by what we do, rather than what we think or say.

Working with executive leadership teams, Pulse evaluate an organisation’s strategy, identifying the barriers that impede progress and the key ‘signature behaviours’ that are necessary to drive required change.

These behaviours are for everyone, across the organisation and at all levels - from ward to board. By promoting individual accountability and measuring the degree to which every person positively demonstrates the signature behaviours, it is possible to bring strategy to life and for staff to see the impact of their own contribution to the collective success of the organisation - effectively connecting people to purpose.
Foreword

Today’s NHS culture stems directly from its foundations 70 years ago. Its core principle - treatment free at the point of need - came directly from the wartime experience of solidarity, but is lived, every day, by over a million dedicated NHS staff. Even in trusts that are in special measures, the CQC regularly speaks warmly of the compassionate care provided by staff.

Less happy features of NHS culture also go back to those beginnings. I have no doubt that the ‘learned helplessness’ this welcome and timely report diagnoses is partly the result of the command and control culture that was familiar from large, successful industries. Information flowed up through management layers; decisions were sent down to the front-line.

But command and control, appropriate during and immediately after the war, is increasingly irrelevant in a world transformed by digital technologies, where people expect to be treated as partners, not grateful patients. Unfortunately, old bureaucratic and medical hierarchies tip over into the bullying culture that too often forms part of the CQC diagnosis, along with silo working, blaming others - within one’s organisation or in ‘partners’ - or simply keeping one’s head down. All are exacerbated by structures that promote competition at the expense of collaboration.

Thankfully, we can see a welcome shift to partnership across places and systems. The near-merger of NHS England and NHS Improvement will, we all hope, change the ‘tone from the top’ and remove conflicting signals to providers and commissioners. At the front line, strong clinical governance - essential for patient safety - needs to sit within a culture that enables every member of staff to work as part of a team, contributing ideas and able to speak freely when they believe something is going wrong. The consultant has unique expertise, but so does the patient - and every other member of the team. Particularly for the growing number of people with multiple, complex, long-term conditions, a culture of respectful team working is the only way to create truly effective care.

Of course, as this report illustrates, not every NHS organisation has the same culture. And cultures can be changed. The recommendations - including the proposal that culture itself needs to be regularly measured - will, I am sure, be welcomed by many NHS leaders and, I hope, adopted by NHS Improvement. We can all think of too many cases where a trust in special measures has been ‘turned around’ in the short term, only to fall back into problems because the underlying issues - culture, behaviour, leadership - have not been effectively addressed. Unless these are tackled through focusing on workplace culture, we will continue to see too many people ‘disconnected from purpose’, with adverse effects on quality, safety, sickness, retention and productivity.

This report’s recommendations apply equally to systems. In Norfolk & Waveney, we are learning from the experience of Norfolk Health and Community Care (NCHC) - recently rated ‘outstanding’ by the CQC - and East Coast Community Healthcare (ECCH), a staff-owned social enterprise. We want to use their experience of creating positive cultures, and other learning, as we build our integrated care system, focusing on culture, values, behaviour and leadership from the outset.

I hope that this report will stimulate a richer conversation about the cultures that already exist within the NHS, the cultures that we would all like to work within - and what we need to do together to create them.

Rt Hon Patricia Hewitt
Chair, Norfolk & Waveney Sustainability and Transformation Partnership (STP)
Former Secretary of State for Health

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### Scope of the research

#### The issue

Workforce culture lies at the very heart of several key challenges facing the NHS and the health and social care system. It sits above everything, influencing all that we do and how we do it. It is persistently cited by sector experts as a root cause of system failure when things go badly wrong. Cases such as Mid Staffordshire, Winterbourne View, Southern Healthcare, Morecambe Bay and Liverpool Community Health have been well-publicised examples of this. With more staff now leaving the health sector than joining, and with many in-post feeling unsupported, undervalued and at worst, bullied, it is no surprise that performance has worsened in a number of key areas, including patient safety. In Pulse’s experience, these are symptoms of poor leadership, disconnected staff and a vacuum of accountability.

#### The purpose

The aim of this study was to understand trends surrounding culture, leadership and accountability at the best and worst performing trusts in the country, as rated by the Care Quality Commission (CQC), and to assess how these trends affect performance, patient safety and workforce satisfaction.

#### The methodology and sample

We undertook qualitative analysis by reviewing the CQC inspection reports of all ‘inadequate’ and ‘outstanding’ trusts in the country and cross referenced this with quantitative performance metrics provided by these trusts to NHS England. The research was conducted in August 2018 using the most recently available CQC reports.

We have kept our research above individual trust level, instead looking at the trends between the best and worst performing trusts. Where appropriate, we have singled out examples of best and worst practice but in the interest of not naming and shaming trusts, we have anonymised our findings.

### Outstanding trusts

- Kingston Hospital NHS Foundation Trust
- Frimley Health NHS Foundation Trust
- West Suffolk NHS Foundation Trust
- Birmingham Children’s Hospital
- The Christie NHS Foundation Trust
- Salford Royal NHS Foundation Trust
- Northumbria Healthcare NHS Foundation Trust
- The Newcastle upon Tyne Hospitals NHS Foundation Trust

### Inadequate trusts

- Northern Lincolnshire and Goole NHS Foundation Trust
- Worcestershire Acute Hospitals NHS Trust
- Isle of Wight NHS Trust
- Royal Cornwall Hospitals NHS Trust
- Norfolk and Norwich University Hospitals NHS Foundation Trust
Executive summary

This report aims to understand issues surrounding culture, leadership and accountability at the best and worst performing trusts in the country, and to assess how these trends affect performance, patient safety and workforce satisfaction. There is clear correlation between the best performing trusts and the quality of their leadership and workforce culture. Conversely, the worst performing trusts tend to struggle with weaker, less stable leadership and a corrosive workforce culture.

Despite acute issues with culture, ‘inadequate’ trusts routinely fail to address culture at a whole workforce level. Our report findings split into three clear sections: (i) strategy and vision; (ii) leadership at all levels; and (iii) learned helplessness and the normalisation of poor behaviour.

Having a clearly articulated strategy and vision is vital for any organisation to succeed, even more so for providers of care with a duty to patients. We found that ‘inadequate’ trusts often had such strategies in place and a vision to deliver the highest standards of patient care, but these were not deeply embedded among the workforces and as such demonstrable behaviours were not aligned.

This is borne out in NHS survey data which finds that 88% of staff at ‘outstanding’ trusts believe that care of patients and service users was their organisation’s top priority, compared to an average of just 68% across ‘inadequate’ trusts.

The best organisations have strong executive leadership who empower people at all levels to lead and be solutions focused. The same is true of “outstanding” trusts, where staff are encouraged to do what it takes to deliver the best patient care. For “inadequate” trusts, the existence of fractured relationships and “inner circles” within leadership teams dominate. These factors stifle progress and stimulate turnover of staff, particularly in top positions.

Another key issue is the existence of learned helplessness. This occurs when an individual experiences repeated adverse situations, leading to a belief that they cannot change the outcome and therefore avoid taking action to ensure no reoccurrence. This is a common issue in many organisations, but particularly in “inadequate” NHS trusts. CQC inspectors found that the normalisation of poor behaviours led to a culture which enabled poor practice to go unchallenged, which undermined patient safety.

Our report also provides a series of solutions to help trusts and regulators confront issues surrounding culture. Firstly, culture is mainstay in all CQC reporting, yet it is not actively quantified. Culture can and should be measured. Secondly, the way a trust views and responds to complaints is a significant factor in turning around a trust’s performance. Trusts must stop being defensive and use complaints as an opportunity to learn and improve. Thirdly, it is possible to shift from learned helplessness to learned optimism. Staff must be empowered to find solutions and congratulated when they do.

Finally, it is impossible to achieve sustainable change without stable leadership. The Government and arms length bodies (ALBs) must accept that change is a long-term process, encourage leaders to make proper assessments of what is wrong and what needs changing, and give them time to implement the change programmes necessary to improve performance.
The 2017 NHS Staff Survey revealed that staff in ‘outstanding’ trusts, compared to ‘inadequate’ trusts, are more confident in reporting unsafe clinical practice, in the effectiveness of their incident reporting procedures, that care is their organisation’s top priority and in recommending their organisation as a place to receive treatment. These trends translate into recognised performance measures such as A&E and referral to treatment waiting time targets, and in staff witnessing potentially harmful errors.

A well-formulated strategy establishes the foundation from which hospital trusts can create, monitor and measure their success.
A strong and authentic vision must be agreed by the leadership and openly and proactively communicated to the workforce at every level. It attracts like-minded staff and motivates them to work in a more aligned way. It takes the emphasis away from societal issues around entitlement that many employers experience, i.e. What’s in it for me? – and towards the idea of working collectively in the best interests of the organisation, celebrating success together. When times are tough, we tend to explore our motivations, i.e. Why are we doing this? A strong vision and sense of purpose answers this question and provides context and meaning to our work.

There was evidence of a strategy and vision in place at most trusts assessed, however, the effectiveness and staff awareness of them varied. Trusts rated as ‘outstanding’ overwhelmingly demonstrated evidence of a clear strategy and vision, aligned to well-defined objectives. Several ‘outstanding’ trusts had a vision to deliver the highest standards of patient care, with a key focus on patient safety. Inspectors found examples of staff behaviours being aligned to this vision. Equally, with poor performing trusts, whilst they claimed to have a vision to deliver the highest standards of patient care, this vision was not deeply embedded throughout the organisation and as such, demonstrable behaviours were not aligned to this. This is borne out in NHS survey data which finds that 88% of staff at ‘outstanding’ trusts believe that care of patients and service users was their organisation’s top priority, compared to an average of just 68% across ‘inadequate’ rated trusts.

There was also variance in the awareness and knowledge of trusts’ visions and strategies from their own staff. In ‘outstanding’ trusts, inspectors repeatedly cited that staff at all levels, from ward to board, had excellent knowledge and understanding of their trust’s strategy. Inspectors found the strategies in place at a number of ‘inadequate’ trusts were either not well established or understood by staff, or were simply not internalised by staff. This is typified by one trust where inspectors found staff were not aware of the strategy and were not able to describe the trust’s values “beyond the P.R.I.D.E acronym”.

Pulse’s experience in working with particularly challenged organisations supports the findings that ‘inadequate’ trusts suffer from a lack of clear vision or strategy; we regularly find a concerning disconnect between the leadership team and all levels of management.

Often, front-line staff feel as though they are the only ones who care about their patients, and perceive their leadership teams to care only about other priorities, such as cutting costs and introducing unnecessary layers of bureaucracy.

In the case of the NHS, there is inherent common ground between all staff in terms of why they come to work – to provide the best possible care to their patients. However, this needs to be translated into clear goals that all staff can understand and play a part in delivering. Moreover, if this is underpinned by a strong culture where staff at all levels are demonstrating behaviours that are aligned to and support the achievement of these goals, then the effect can be transformational.

To achieve this, the leadership must role model the right behaviours and communicate in a clear and concise manner, the link between role modelling the right behaviours and achieving shared goals. The more these right behaviours are demonstrated at all levels of the workforce, the faster an organisation will move towards achieving its shared goals.

"It is imperative that trusts, as with any organisation, unite their staff behind a collective vision or a common goal."
Leadership at all levels

Behind every trust’s vision and strategy is an executive leadership team and the workforce tasked with delivering this at every level. Our research looked at staffing at every level across the trusts to assess management and leadership capability.

Executive leadership

In ‘outstanding’ trusts, at the executive level we found leaders who were respected, driven and often inspirational. There were examples of good practice, including board walk-arounds on wards and a CEO open door policy, where staff could personally raise matters and ideas with the CEO.

The starkest trend we observed was the ability of the ‘outstanding’ rated executive teams to create an environment that was supportive and cohesive, whilst being open to challenge where necessary. Our research repeatedly saw inspectors cite this as central to a trust’s success. Apart from the obvious observation one could make from this – that these leadership teams would be creating better relationships with their staff, more empathy within the organisation and a sense that everyone is working together – there are other reasons why this is important.

In Pulse’s experience, leaders who welcome new ideas and are comfortable with being challenged, do not feel uncomfortable with ambiguity or uncertainty and tend to be much more successful leaders. They allow themselves time to reflect on what they are being told, rather than personalising feedback and defending their positions.

This approach tends to lead to better decision making, with a greater emphasis placed on what is right for the organisation rather than the individual or department. There also tends to be a willingness to empower teams to find and implement solutions, which is recognised as a more effective way to identify and implement change. We know that many of the best ideas and answers to most problems lie within the workforce, and not the leadership. An important role of any leader is to create an environment where ideas can be conceived, shared and implemented.

Conversely, within ‘inadequate’ trusts, we found examples of fractured working relationships and perceived ‘inner circles’ contributing to a lack of openness and transparency within executive teams. Pulse know that this kind of leadership dynamic is not just damaging to the performance of an organisation, but has wider ramifications. When leaders are not demonstrating the right behaviours and communicating common goals, decisions get made in the interests of the few – the most powerful or persuasive – and not in the interests of the wider organisation. Another consequence is that important decisions may not be taken, especially when individuals are more focused on their own needs, or where they fear accountability.
In our experience, stable leadership can be as important as good leadership. Leaders cannot devise and implement change programmes in 6-12 months; building stable and effective leadership teams takes time. Unfortunately, the NHS has seen a very high turnover of leaders, with many regularly given unrealistic timeframes to improve what are highly complex organisations. Our research found organisations rated ‘outstanding’ were more likely to benefit from stable leadership. Inspectors highlighted six of the eight ‘outstanding’ trusts had “stable” and “well-established” leadership, with one trust even recognised for their board-level succession planning.

In contrast, ‘inadequate’ trusts tended to have far higher turnover within their executive leadership teams. One trust experienced significant and ongoing periods of instability at board level, with three chief executives appointed over a two-year period. Nevertheless, it was clear that the value of stable leadership was recognised and several ‘inadequate’ trusts were in the process of building the right foundations for improved stability, which requires time to bear fruit.

The Department of Health and Social Care and ALBs should recognise that change is a long-term process. They must encourage leaders to make proper assessments of what is wrong and what needs changing, and then give them time to implement change programmes to improve performance. Quick fixes should be discouraged.

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Leadership at all levels

Leadership is not just a quality found in senior trust leaders and executives, it filters down to and is demonstrated by staff at all levels. Our research found that the best performing trusts consistently had leaders at all levels demonstrating the capacity, capability and experience to deliver excellent care. These organisations actively encouraged leadership at all levels and staff were often supported to try new initiatives, manifesting in a palpable culture of innovation and service improvement. One NHS client currently working with Pulse has introduced a regular ‘showcase’ programme, where different departments are able to tell their colleagues across the trust who they are, what they do and what they have achieved. This, coupled with a CEO-led mandate to staff to be empowered to find solutions for issues, has resulted in some excellent examples of leadership at all levels.

In the same trust, a junior administrative assistant took it upon himself to address what he saw as a wasteful approach to record keeping and redesigned some forms that were being needlessly photocopied several hundred times across his department. This was reported to the CEO, who publicly congratulated him and invited him to implement his idea across other departments. It is through creating a culture of ownership and accountability, where actions such as this are encouraged, that wider-reaching efficiencies are identified, often by front line staff.

Trusts rated ‘inadequate’ exhibited a greater variance in the quality of leadership at every level, affecting patient safety and service improvement. Inspectors reported an array of concerns in the leadership of certain services at trusts and found service leaders tolerated high levels of risk to quality and safety. While there were some examples of improvements to services, these were inconsistent across the trusts. Following a recent inspection of one specific trust, inspectors found a total lack of progress in addressing the areas of required improvement identified in a previous inspection, with the trust able to give no clear reason for the delay in addressing the issues.
Learned helplessness and the normalisation of poor behaviour

The commonly understood definition of learned helplessness is a state of mind where an individual who is forced to experience repeated adverse situations, becomes unable or unwilling to avoid these situations from reoccurring.

Learned helplessness is a well understood phenomenon that is playing out in wards and in hospitals across the country. It has become more prevalent with system pressures and is particularly dangerous in clinical environments because it often prevents health professionals and wider staff from doing what is right for the patient. This is also demonstrated in our research.

Across a number of trusts rated as ‘inadequate’, inspectors found normalisation of poor behaviours and practices, where a culture of failing to challenge poor practice persisted. Hospital trusts face serious consequences and risk harming patients if these behaviours go unchecked.

Our research found staff at ‘inadequate’ trusts have a lower level of confidence in reporting unsafe clinical practice (on average 5.2% lower) and are less likely to find the procedures for reporting errors, near misses and incidents effective or fair (on average 5% lower), than trusts rated ‘outstanding’.

In our experience, staff must feel confident enough to be accountable for the care they provide and be comfortable challenging poor practice. Although the regulatory changes which arose from the Francis Inquiry have made the NHS safer, a blame culture remains all too prevalent. There must, of course, be consequences where neglect or deliberate actions have caused harm, but as we move towards an accountability culture, hospitals must change the way they view feedback as it all too often discourages staff from taking accountability. It is critically important to promote and reward behaviours linked to accountability and candour.

Our research also found a culture of greater tolerance for risks to patient safety and quality of care across a number of trusts rated ‘inadequate’. Service leaders at one trust were criticised for tolerating unacceptably high levels of risk to the quality and safety of services, and senior managers at another trust told inspectors there were embedded cultures of poor performance and behaviour.

The trusts themselves reported it difficult to turn these behaviours around, a typical outlook in cases of learned helplessness. Indeed, these are typical manifestations that prevent trusts from transforming poor cultures, as there is an inherent belief amongst staff that it is a pointless exercise. It is possible to shift from a state of learned helplessness to one of learned optimism by focusing on encouraging and empowering staff to find solutions for every day issues.

Where learned helplessness exists, it is often embedded and will take a deliberate and concerted approach to turn matters around. Challenging a can’t do culture is achieved by shifting focus from what cannot be achieved to what can be achieved. Initially it may take small steps, but the key is to encourage people to look forward and focus on what they can affect, rather than look back and hold onto historical examples of where initiatives have failed. This can prove to be quite a liberating experience. It is also an important step in building confidence and self-worth, helping to shift individuals and departments from a state of helplessness and negativity to one of optimism.

"You will learn that nothing you do or say makes any difference here, or you will be one of the ones who will last only six months or so.

- Nurse describing learned helplessness.
Culture in the NHS

Solutions

Culture can and should be measured

The themes of culture, leadership and accountability permeate through all “outstanding” and “inadequate” inspection reports (indeed all CQC reports), and yet they are not actively quantified by trusts or regulators. Culture can and should be measured. We know that the quality of an organisation’s workforce culture drives and affects everything it does. It follows therefore that culture should sit side-by-side with financial reporting, minimum waiting time standards and quality of care performance indicators, among others. It also helps providers to share more data with regulators and ALBs.

Transitioning from a culture of blame to one of accountability

While the NHS has become safer overall, a blame culture persists. There must be consequences where neglect or deliberate actions have caused harm, but our reliance on negative feedback discourages staff from being accountable. Pulse has seen that the way in which a trust views and responds to complaints is a significant and essential factor in turning around a trust’s performance. Rather than seeing complaints as an administrative burden and something that should be defended, trusts need to view such feedback as a genuine opportunity to improve and learn.

Recognising and addressing learned helplessness

Many NHS staff suffer from learned helplessness – the general belief that one is incapable of accomplishing tasks and has little or no control of the environment – which is leading to the sense of discouragement and futility widely reported by NHS staff. It is possible to shift from learned helplessness to learned optimism by focusing on encouraging and empowering staff to find solutions for every day issues, and when progress is made to ensure it is acknowledged and celebrated.

Changing culture requires time and stable leadership

The NHS has seen a very high turnover of leaders, who are given unrealistic timeframes to improve complex organisations. The Department of Health and Social Care - and ALBs - must accept that change is a long-term process. They should encourage leaders to make proper assessments of what is wrong and what needs changing, and then give them time to implement the change programmes that are necessary to improve performance.

Recently, NHS Improvement allowed the leadership of one particular trust more time to affect change by focusing on its culture, rather than forcing the trust to adopt a more conventional approach to improving performance. This has already resulted in significant improvements in key areas, because root causes are now being addressed instead of defaulting to an array of short-term ‘fixes’, which are often linked to an underlying sub-optimal culture.
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