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HOW CAN PROMOTING A POSITIVE NHS CULTURE PROMOTE AN INCREASED QUALITY OF PATIENT CARE

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INTRODUCTION

The quality of healthcare a service user receives reflects the clinical outcome, the patient outcomes and experiences (Maybin and Thorlby, 2008). Lord Darzi's review of the NHS in England back in 2007 revealed that, whilst capacity had increased, quality and outcomes required further improvement (Darzi, 2008). High quality, safe and effective healthcare is the expectation of every user of NHS services. Yet, the care that many patients receive often fails to meet these requirements (Dixon-Woods et al., 2013). Despite much effort, the delivery of quality care by NHS England still falls short of the expected standards (Hogan et al., 2012). Several high-profile cases have demonstrated significant failings in quality and safety. Yet, despite such scandals, progress has been made towards ensuring the uniform delivery of high quality care (Benning et al., 2011a; Benning et al., 2011b). Factors key to the delivery of quality care have been identified. One such factor is culture. In this article, how a positive organisational culture can increase the quality of healthcare is discussed.

QUALITY IN HEALTHCARE

The concept of quality in healthcare is difficult to define. In his report, Lord Darzi (2008) described quality in terms of patient safety, the patient experience and the clinical effectiveness of the care. Thus, the NHS recognises that good clinical outcomes and safety are necessary to deliver quality care, whilst simultaneously providing a good patient experience. Personal attributes such as patient-provider relations, shared decision-making and the comprehensive meeting of needs all contribute to the quality of care (Jun et al., 1998).

The case of the Mid-Staffordshire NHS Foundation Trust (Francis, 2010) is an example where the NHS failed to deliver quality care. The public inquiry (Francis, 2013) identified a catalogue of failings concerning patient safety and care quality. The systems that were in place to ensure oversight, accountability and influence were inadequate with large-scale failure of control and leadership at all levels (Dixon-Woods et al., 2013). The underlying organisational culture had created an environment ripe for the delivery of sub-standard care. Factors forming the

basis of the organisation's culture such as policies, rules, regulations, resources and incentives, were all found wanting. This led to a tolerance of poor standards and a demonstrable dissociation between managerial responsibilities and front-line staff (Francis, 2010).

Following the inquiry, an extensive survey of NHS England healthcare professionals was performed. Encouragingly, it revealed that the values of care and compassion are at the heart of both organisational and personal commitments at all levels (Dixon-Woods et al., 2013). Consistent with the Francis inquiry, the greatest influence on an organisation's commitment to quality was found at board level. Thus, the tone set at the top filters down throughout the organisation to affect the care that the patient receives. The influence of the board on the performance of all staff reflects the culture of the organisation, representing the priorities and vision of the institution as a whole.

ORGANISATIONAL CULTURE

An environment that supports cooperation between provider and patient is essential to deliver quality care (Mosadeghrad, 2014a). An organisation's culture determines the environment, describing how an institution organises itself, its rules, procedures and beliefs (Handy, 1981). Culture is the overarching theme that describes how and why employees do what they do. Different types of organisational culture are recognised and in healthcare organisations, more than one cultural style is usually found: The different professional disciplines, departments or wards may have different cultures. Such differences can impede cohesive working due to conflicting priorities and communication difficulties.

In the NHS, a Role Culture prevails where individuals all have a specific role. Tasks are spread throughout the organisation leading to specialist roles and removing duplication. These cultures are efficient and productive, but are inflexible and difficult to adapt (Handy, 1981). This overlaps with the bureaucratic culture of the NHS. Bureaucratic cultures are system and procedure-led. They are risk averse and less adaptable with hierarchical structures and non-commercial aims (Handy, 1981). Cultures focused on strong hierarchical structures, centralisation and bureaucratic control act as a barrier to delivering quality care. People at all levels need a sense of autonomy and to feel empowered to make decisions. This requires people to take responsibility and be accountable for their actions, something that is impossible in a blame-orientated culture (Khatri et al., 2009). Blame cultures have historically pervaded healthcare organisations. The process of identifying and blaming an individual when something goes wrong leads to secrecy and the hiding of errors. Cultures that foster secrecy and protectionism, denial of failings and an avoidance of accepting responsibility for addressing them cannot deliver quality care (Walshe and Shortell, 2004). In the case of Mid-Staffordshire, the failure to respond to patients' concerns, poor management systems and the fragmentation of knowledge regarding issues, all contributed to the problem (Francis, 2010). Where failings are not recognised and addressed, quality and safety are compromised (Leape, 1994).

A CULTURE TO DELIVER QUALITY CARE

Improvements in care quality require a shift from shame and blame cultures to ones where systems are designed with safety and quality in mind (Reason, 1997). Ironically, external requirements that sought to ensure high-quality, safe care often resulted in organisations displaying defensive and reactive policies (Power, 2003). Many NHS organisations responded to these external pressures by imposing a bureaucratic management style to ensure

compliance. This resulted in broad, prescriptive policies that led to frustration and negativity (Dixon-Woods et al., 2013). This task-focused approach actually reduced quality and safety. Lord Darzi (2008) recognised the need for greater local control and fewer top-down, centrally determined targets to improve quality. The empowerment of local services was pursued with local quality indicators allowing clinicians to benchmark their own performance (Dixon, 2008). Greater emphasis is placed on the clinician's own innate desire to improve the quality of their services with recognition of professionalism and personalisation. Whilst clinical leadership became the new focus, Darzi was aware that managerial tasks were important to improve service quality (Maybin and Thorlby, 2008). Making healthcare professionals more accountable for the services they deliver, and giving them more responsibility for managing and improving the healthcare system, imparted fundamental changes to the culture of the NHS.

The cultures of healthcare organisations are affected by many variables that produce competing and conflicting demands. The needs of patients, carers, families, regulators, providers and partners must all be considered, but are often inconsistent and difficult to define. Historically, the hierarchical culture of the NHS often produced silos: individual units that operate in isolation, ignorant of how their actions affect others. The focus on productivity, efficiency and controlling costs, created a culture detrimental to the delivery of quality care (Gaba et al., 1994). Quality requires the cooperation of patient and provider within a supportive environment (Ovretveit, 2012). Creation of a positive culture where organisations have supportive visionary leadership, forward planning and a collaborative, team-based approach will be best able to deliver quality care.

A culture that prioritises the delivery of quality care will be shaped by this belief and the sharing of this goal will guide the discretionary behaviours exhibited by staff (Glickman et al., 2007). Such a culture must accept that errors will occur and so proactively seek to identify and address potential causes (Westrum, 1992). The harmonious working of all levels of an organisation's staff is enhanced through shared, unifying goals and an alignment of beliefs. Goals allow the recognition of priorities for continual improvement: motivating staff and ensuring the necessary resources are found. Furthermore, the setting of clear goals throughout the different levels is associated with high levels of patient satisfaction (Dixon-Woods et al., 2013). However, disparities observed between the goals set at board level and the practices of front-line staff highlight the difficulties in creating a culture based around a unifying vision (Dixon-Woods et al., 2013). Defining how such goals should be achieved, having the necessary leadership to achieve them, and the necessary quality management systems in place, is crucial (Mosadeghrad, 2014b).

The effect of management on an organisation's culture and the quality of care delivered cannot be underestimated. Standardised mortality ratios are inversely related with positive and supportive organisations (West and Dawson, 2012). Good management and leadership are essential to create a caring, positive and innovative culture (Khatri et al., 2009). Leaders set the direction and tone of the organisation. They encourage and empower staff to address the challenges that they encounter and to provide innovative solutions. Supporting staff through education and training, empowering them to make decisions and facilitating the delivery of patient-centred care all enhance quality (Mosadeghrad, 2014a). There are clear relationships between the quality of care and staff satisfaction and contentment (Haas et al., 2000; DiMatteo et al., 1993). Employees need to be trained and supported, recognised and rewarded, to ensure their good performance (Mosadeghrad, 2013). Individuals and teams who show compassion, cooperation, and civility demonstrate the delivery of quality care. They know what they are doing and why, they are

committed to learning, making improvements and innovating. Patients are treated with kindness and their dignity respected. To facilitate these behaviours, the managerial approach, whilst demanding personal accountability from staff, must identify and resolve systemic constraints that prevent staff from delivering quality care. Where boards take steps to identify and fix system issues, they support cultural change, which ultimately benefits patients (Dixon-Woods et al., 2013).

CONCLUSION

Quality in healthcare is described as the delivery of safe, effective care that meets patient's expectations. Following pressures to increase in productivity throughout the NHS, quality was felt to have suffered. High profile failings of the NHS to deliver quality care led to increased emphasis on this issue with measures and incentives introduced to reward the delivery of quality care. The culture of the NHS and its organisations was recognised as influential in the quality of the care provided. Instilling a positive, quality-driven culture with policies, procedures and behaviours linked to quality improves patient and clinical outcomes.

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