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'Culture of Care' Barometer

Report to NHS England on the development and validation of an instrument to measure 'Culture of Care' in NHS Trusts

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Foreword

Compassion in Practice, the national strategy for nurses, midwives and care staff, was launched in December 2012. Since that time a significant programme of work, through six action areas, has created a momentum across the country which has recognised the crucial role that organisational culture plays in determining the experience of patients, users of our services, and staff.

The national Compassion in Practice strategy has at its core the values of the 6Cs: care, compassion, competence, communication, courage and commitment. All are interlinked and all are underpinned by the culture in organisations.

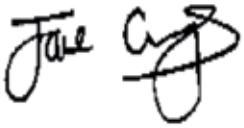
In November 2014, NHS England published *Building and Strengthening Leadership – Leading with Compassion* in response to a call to action to put compassion at the centre of how care is delivered and led. This built on previous work to support the inextricable links between patient experience and staff experience, "positive experiences are unlikely to happen, one without the other." It goes on to highlight the challenge for the system to create environments where compassion can thrive. The authors also assert that culture at organisational level has the potential to *'trump'* other determinants of whether compassion will thrive.

In recent years, a number of reports have been published that have cast the spotlight on the quality of care patients have experienced. More often than not these reports have been negative and have highlighted failings in our systems, many of which can be attributed to the culture of care in organisations. These reports do not make comfortable reading and, in the majority of cases, the failings and the negative impact on patients and staff could have been prevented. The lack of a consistent culture of care and compassion can impede the spread of good practice across organisations and result in devastating experiences for patients, their loved ones and the staff caring for them.

The Culture of Care Barometer report was developed from the early discussions of a group of professionals, carers and managers, who were so perturbed by the failings at Mid Staffordshire Hospital that they were determined to explore what could be done to improve the quality of care for patients. As a result, the first early blueprint of a tool to measure the culture in care organisations was developed. In April 2014, NHS England under my leadership and through the Chief Nurse for London, Caroline Alexander, commissioned the further development of this blueprint along with a detailed report and literature review. This has resulted in the Culture of Care Barometer, a tool unique in its form, and cultivated from the care environment and care staff. This report and the Culture of Care Barometer are long awaited and highly anticipated by care providers and commissioners. It is my expectation that organisations will embrace the report and the tool and use it to engage their staff and patients in talking about the culture of care in their organisations. The aim of these conversations must be to ensure that staff can provide good care to patients, patients have a good experience of their care episode, and staff feel valued and satisfied that they are able to raise their concerns when necessary.

The report was authored by Anne Marie Rafferty, Professor of Nursing Policy at King's College London, and has been endorsed by the organisations who participated in the pilot. I would like to take this opportunity to thank Anne Marie, the nurse leaders who first developed the idea of the Culture of Care Barometer, and all those who have piloted and provided feedback on its development.

I hope you will read and share this report and its Barometer widely with your Board, your colleagues and among all staff working within your organisations. I hope that you will use this tool to encourage and support the meaningful and courageous conversations that will allow us as a nation to promise that the failings at the Mid Staffordshire Hospital NHS Foundation Trust, Morecambe Bay Foundation Trust and other organisations will not happen again.



Jane Cummings
Chief Nursing Officer England

Executive Summary

Background

The healthcare agenda over recent years has been dominated by 'quick fix' solutions. As a result, both the complexity of issues involved and the amount of time it takes for real and enduring change to occur have been underestimated. Consequently, the 'little things' that define the quality of the environment in which patients receive care and in which staff provide that care have been subordinated to more pressing priorities. Learning from high profile crises in care delivery indicates that quality and culture are not uniform within let alone across organisations. This was evident in the description and analysis of events (and the context to those events) at Mid Staffordshire NHS Trust, described by the Robert Francis Inquiry. Pockets of excellence can coexist alongside the worst examples of care failure; lack of consistency in care culture impedes the spread of good practice across organisations.

Evidence suggests that major failures are not usually brought to light by the systems for quality assurance or improvement that are part of most healthcare organisations in developed countries - such as incidence reporting, mortality and morbidity reviews, inspections, accreditations, clinical profiling and risk and claim management. Since these cultural attributes are not picked up in the measures of quality and performance currently in use; metrics fail to capture the meaning and reality of care culture for patients or staff.

This document reports upon a project commissioned by NHS England as part of the Compassion in Practice programme of work. The project aimed to develop and validate a measurement instrument with which to gauge the different attributes of environments in which care is delivered and so help understand the culture of care in healthcare organisations. This Culture of Care Barometer aligns closely with the Compassionate Leadership strand.

Design of the Culture of Care Barometer

The elements underpinning the design of the tool reflect themes identified from previous research as strongly linked with staff commitment, engagement and productivity. These were:

- **the resources to deliver quality care**
- **the support needed to do a good job**
- **a worthwhile job that offers the chance to develop**
- **the opportunity to improve team working.**

The Culture of Care Barometer has been developed with an awareness of existing tools (such as the staff survey) and was informed by an earlier approach used by the Commission for Health Improvement (CHI) in 2003 for auditing the NHS in relation to the protection of Children and Young People. It has been designed to complement existing regulation and inspection frameworks, a key objective of which was to ensure that it provides a useful and meaningful adjunct, with minimal bureaucratic burden. It was designed to be used by staff as a reflective developmental tool, whilst also providing an organisational mechanism for benchmarking purposes.

Method

Phase one: A first version of the tool was piloted with a sample of 2,000 nursing staff (registered nurses and health care support workers) in an acute hospital Trust in London by the NNRU at King's College London. The initial focus of development and piloting was on nursing within acute hospital environments.

The aim was to test the construct and face validity of the tool, and explore the extent to which the Barometer served the purpose for which it was designed: that is to measure the culture of care across and within an organisation, and stimulate reflection about the nature and variability of the culture found. These findings were presented to the participating Trust in a separate report.

Phase two: The idea of a tool to gauge the culture of care generated considerable interest across the health service and with funding from NHS England, the tool went through a second stage testing. The revised Culture of Care Barometer tool from phase one was tested with a wider range of staff groups, beyond acute settings. Two pilot sites, one mental health and one community NHS Trust across England were identified and took part in Phase two.

Findings

The Culture of Care Barometer

The tool has been subjected to a series of statistical tests to examine how well it has performed and test its psychometric properties through the relationship between variables. From the analysis of the data four factors were identified:

- **Factor 1 is linked to Trust level values and culture**
- **Factor 2 is concerned with team level support and management**
- **Factor 3 is linked to support and respect between colleagues**
- **Factor 4 concerns constraints in undertaking the job.**

Pilot site experiences of using the tool

Culture was seen by Trusts within the study as a particular way of doing things - a form of signalling what the values of the organisation are. The Barometer was perceived as useful in providing a reference point for Trusts to gauge where they were on a cultural spectrum or journey. It was significant that organisations responded very much in terms of the cultural challenges they were confronting, large scale restructuring for instance, and geographical dispersal, which made it harder to create a coherent and consistent vision of culture around which all groups could coalesce.

Discussions about the Barometer in debriefing discussions brought these challenges to the fore. One of the hardest elements of the post-Francis challenge was encouraging people to speak out ('how do you do it?").

It was recognised that the Barometer could be useful as a tracking device to gauge where organisations were for example, on a Foundation Trust journey or the product of mergers and therefore encompassing many cultures over time. The Barometer was seen as a useful probe into the different cultures prevailing in geographical pockets and therefore as an index of identity, specifically the organisation with which staff identified. It was interesting that in both Trusts, participating in Phase two, the Barometer stimulated discussions about 'us and them' divisions between staff groups and between staff and management. The Barometer's surfacing of such discussions suggests it is tapping into something quite sensitive and significant within the 'DNA' of the organisation i.e. the degree of social as well as geographical distance staff groups feel from each other. It was also perceived as useful for delving into more detail and promoting dialogue around staff issues, especially at team level.

Overall, the Barometer was seen as simple and easy-to-use as well as quick to complete. It was valued as a useful adjunct to other tools such as the staff survey and Friends and Family Test and sensitive to surfacing sub-cultures where these existed. Its added value seemed to rest on its capacity to delve more deeply into cultural issues around the care environment; provide an enriched source of feedback for Trusts and prompt 'quality conversations' for groups as well as Board/Executive level. It was regarded as a valuable stimulus for reflection through the issues it targeted.

Conclusions

The positive reception of the Culture of Care Barometer by Trusts and the value added to existing tools suggest that the Barometer could be extended and rolled out to other settings.

The Trusts we spoke to were enthusiastic about embracing the Barometer and anxious to begin using it immediately. From our discussions with Trusts there is a strong appetite for using the Barometer. One of the benefits of the Barometer is its sensitivity to groups. The tool was considered particularly useful within teams or groups of staff as a way of breaking down barriers, challenges and problems distinct to a particular area. It provided a useful stimulus for discussion and reflection with the opportunity to create and start a dialogue at different levels within the organisation. It also surfaced social and geographical concerns and divisions.

By embracing a multiplicity of cultures within organisations it demonstrated the importance of the cultural link with staff identity and those with whom staff identify in the organisation. Above all it drew attention to the social processes at work within the organisation and the value placed on positive collegial relations. The response rate however was lower than hoped for and the main group of respondents, both at staff discussion groups and online, were nurses. It is important that the Barometer is championed by the Board and seen as 'owned' by the organisation as a whole and not simply as a 'nursing' tool and therefore that culture is something nurses 'do' and are responsible for. Strategic direction and leadership are clearly essential in ensuring that culture is seen as everybody's business.

Important though it is to emphasise what the Barometer can do it is also important to stress what it cannot do. From the outset there have been high expectations of the Barometer and what it might be capable of doing.

We have developed the Barometer using a robust process and are confident of its potential to stimulate enquiry and encourage teams and organisations to ask questions of themselves and each other and explore how to take the dialogue forward, however it is not a 'magic wand' whose talismanic properties are capable of transforming culture. Much depends on how it is being used as well as the capabilities of those using it and for what purpose.

Culture is not something that can be conjured or called into being as if through magic. Rather, the potential power of the Barometer lies in the hands of the user. We have applied a robust process to the development of the Barometer but we are only at the beginning of the journey. The overall utility of the Barometer necessarily relies upon the experience of how it is implemented.

We have been impressed by the enthusiasm and energy with which the Barometer has been embraced but further feedback is needed from the service with regard to how the Barometer performs in practice.

Key messages

- The Barometer developed from concerns with the culture of care in the practice environment and its power to shape the patient and staff experience.
- We have maintained fidelity with the original vision and prototype, but have adapted the design through feedback from users in different care environments.
- The Culture of Care Barometer was developed using a robust process in a variety of settings from the ground up and co-produced with colleagues working in the care environment.
- The Culture of Care Barometer was recognised as adding value to existing tools to stimulate dialogue and reflection on questions of culture and perceived to be of particular value with teams.
- It was seen as adding depth, richness and texture feedback to that received from the staff survey.
- A particular strength of the Culture of Care Barometer is that it is not just a tool but allows exploration of what people feel about the organisation they work in, prompting dialogue about how to take action from data to development work forward.
- It was viewed as short and easy to complete and well-targeted to domains deemed important by respondents.
- It is not a 'magic bullet' with which to transform culture but necessarily relies upon the capabilities of those using it.

Recommendations

- On the basis of the evidence generated the Culture of Care Barometer was reported as adding value to existing tools such as the staff survey and Friends and Family Test and can best be targeted at teams where it was perceived as being particularly useful in fostering dialogue and surfacing how respondents felt about working in their organisation.
- Culture is everybody's business and support for the use of the Culture of Care Barometer needs to come from the Chief Executive and the Board to ensure culture is not seen solely as a nursing responsibility.
- Implementation of the Culture of Care Barometer needs to be supported by a robust engagement and communications plan at Trust level and endorsed by the Board to promote uptake and response rates across different groups of staff.
- Expectations of the Culture of Care Barometer have been high and the energy and enthusiasm with which it has been embraced is to be welcomed, however it is not a 'magic bullet' to transform culture and its use will depend upon the capability of its users as well as clarity of purpose.
- The pilot studies reported here are only the start of the journey; further roll-out of the Culture of Care Barometer needs to be accompanied by a full evaluation of its use in practice and service impact.
- The next steps will involve developing a smartphone application (app) and piloting its use in a range of groups and settings.

1. Introduction

1.1 Background

Delivering high quality care is a common commitment among healthcare organisations internationally, yet patients continue to suffer avoidable harm and substandard care (Dixon-Woods et al. 2013, de Vires et al. 2008). Despite evidence of improvement in quality and safety this is not uniform and large variations exist within, let alone across, organisations and sectors (Dixon-Woods et al. 2013).

England's National Health Service (NHS) has seen a number of high-profile cases involving failings in the quality of care. The Robert Francis Inquiry (2013) at Mid Staffordshire NHS Foundation Trust demonstrated that pockets of excellence can co-exist alongside the worst examples of care failure, indicating that lack of consistency in care culture can impede the spread of good practice across the organisation.

The British healthcare system is not alone in experiencing such high profile organisational failings. In studies examining examples of major failures - defined as breakdowns in healthcare services or provision that do substantial harm to many patients - from six countries including the United States, United Kingdom, Australia, New Zealand, Canada and Netherlands, Walshe and Shortell (2004) indicated that the causes and characteristics of these failures are remarkably similar despite the different ways of organising and funding healthcare services in these countries. The authors suggested that the problems and consequently the potential solutions were deeply embedded in the nature of clinical practice, the healthcare professions and the culture of healthcare organisations (Walshe and Shortell 2004). In a similar vein, Francis identified the failings at Mid Staffordshire NHS Foundation Trust as systemic with the underlining faults being cultural in character (Dixon-Woods et al. 2013).

Evidence suggests that major failures are not usually brought to light by the systems for quality assurance or improvement that are part of most healthcare organisations in developed countries such as incidence reporting, mortality and morbidity reviews, inspections, accreditations, clinical profiling and risk and claim management (Walshe and Shortell 2004). Moreover, the healthcare agenda over recent years has been dominated by 'quick fix' solutions and as a result both the complexity of issues involved and the amount of time it takes for real and enduring change to occur have been underestimated. Consequently, the 'little things' that define the quality of the environment in which patients receive care and in which staff provide that care have been subordinated to more pressing priorities. Since these cultural attributes are not picked up in the measures of quality and performance currently in use, metrics fail to capture the meaning and reality of care culture for patients and staff (Hesselink et al. 2013, Mannion et al. 2008).

The government's response to the Francis Report: *Hard Truths* (Department of Health 2014) outlined a series of measures designed to 'lever up' and improve the consistency of quality across the NHS. While the cumulative effect of the implementation of these measures may enhance the culture of care this was not the sole intent of say the new inspection regime of the Care Quality Commission (CQC), whose remit stretches beyond the culture of care per se.

To address this gap, the purpose of this study was to develop and validate a measurement instrument with which to gauge the different attributes of environments in which care is delivered and so help understand the culture of care in healthcare organisations.

1.2 Inception of the Culture of Care Barometer

In 2008 the NHS, in conjunction with the major trade unions, the Healthcare Commission and Academy of Medical Royal Colleges, carried out a major piece of research including interviews with staff from 50 NHS Trusts and a range of GP practices (Ipsos MORI, 2008). This research found that staff commitment, engagement and productivity were strongly linked to four 'themes':

- **the resources to deliver quality care**
- **the support needed to do a good job**
- **a worthwhile job that offers the chance to develop**
- **the opportunity to improve team working.**

These themes underpin the idea of the Culture of Care Barometer as it was first conceived by a group of leading nurses and health care managers[1]. The Barometer builds on existing tools, such as the staff survey, but was intended to be much shorter so that it can be used more frequently as a 'dip-stick' test of the culture of care at different times and in different parts of a Trust.

[1]The group comprise: Baroness Audrey Emerton, Dame Elizabeth Fradd, Prof Tricia Hart, Sir Stephen Moss, Flo Panel Coates, Prof Anne Marie Rafferty.

A key objective was to provide a useful and meaningful adjunct to existing tools with minimal bureaucratic burden. Key features of the Barometer as it was first conceived was that it should be able to:

- **act as a mechanism for 'ward to board' communication**
- **provide an early warning system to identify care culture 'red flag' areas in an organisation**
- **be short and quick to complete**
- **complement not duplicate other measures, quality programmes and regulation**
- **prompt reflection and identify the actions required.**

The expectation was that the Culture of Care Barometer might work in two ways:

- **as a measurement tool, to assess the 'culture of care' (and different dimensions of that) and to see how this varies within an organisation, or over time**
- **as a tool to prompt reflection on the underlying issues involved in creating a culture. For example, it was envisaged that the Culture of Care Barometer could be used in one-to-one, or group, discussions with staff to stimulate dialogue about the culture of an organisation and prompt staff to think about what part they can play in creating a positive culture.**

The first version of the tool was piloted with a sample of 2,000 nursing staff (registered nurses and health care support workers) in an acute hospital Trust in London by the NNRU at King's College London (Phase one). The initial focus of development and piloting was on nursing within acute hospital environments. The aim was to test the construct and face validity of the tool, and explore the extent to which the Barometer served the purpose for which was designed: that is to measure the culture of care across and within an organisation and stimulate reflection about the nature and variability of the culture found. These findings were presented to the participating Trust in a separate report.

The idea of a tool to gauge the culture of care generated considerable interest across the health service and with funding from NHS England; the tool went through a second stage testing. The revised Culture of Care Barometer tool from Phase one was tested with a wider range of staff groups, beyond acute settings. Two pilot sites, one mental health and one community NHS Trust across England were identified and took part in Phase two. This report presents the findings of Phase two.

1.3 Research design and project overview

The research project consisted of three interlocking strands.

A literature review, based on systematic principles, that sought to explore the concept of organisational culture as relevant to healthcare settings, provided the theoretical underpinnings of this research. The literature review also focused on uncovering developed tools and approaches used in healthcare settings to measure organisational culture to inform the development of the Culture of Care Barometer tool.

A focus group discussion exercise sought to explore any insights about the prototype Culture of Care Barometer. This also served to complement the theoretical underpinning of the tool, and incorporated a more pragmatic approach to the tool development by understanding the interests and needs of NHS personnel around the assessment and shaping of health care organisational culture.

An empirical assessment of the Culture of Care Barometer in practice, by two further NHS organisations as case studies, to validate the tool's scales and to gain insights into the practical application of the Culture of Care Barometer tool in NHS organisations.

1.4 Structure of the report

Chapter 2, drawing on a brief review of the published literature, sets out the theoretical backdrop to the main concepts surrounding 'culture of care', which have underpinned the development of the tool.

Chapter 2 also provides a brief overview of existing instruments and tools for measuring organisational culture in healthcare with a particular focus on the culture of care. We then provide an overview of the methodological approach and describe the procedures we followed in the various stages of instrument development and validation in Chapter 3.

In Chapter 4, we review the tool and present the results of factor analysis, as well as a discussion on the implementation and usefulness of the tool to the participants and the two pilot studies. Chapter 5 concludes this report with a summary of the tool's limitations and a reflection on the potential contributions it may make to a better understanding of the culture of care.

2. ‘Culture of Care’ in theory

This chapter presents the process of unpacking what is meant by ‘culture of care’. It introduces the conceptual and theoretical underpinnings of the study. The discussion that follows is informed by a review of literature on understanding and managing culture in healthcare organisational settings. The chapter then turns to a brief review of relevant tools and their use in measuring culture within healthcare organisations and in particular the concept of ‘culture of care’. Firstly, we review briefly some of the key policy influences and the drivers of culture change that have been the focus of the NHS over the last few years and that prompted the focus of this work.

2.1 Culture and the NHS

For more than a decade now international policy advocates in healthcare have argued for a major transformation of professional and organisational cultures to enable the instilling of new values, beliefs and assumptions to guide and underpin new ways of working in healthcare organisations (Mannion et al. 2009, Mannion et al. 2008). The increasing international interest in culture transformation is based on the notion that if the desired improvements in quality and safety are to be achieved alongside structural and procedural changes then major cultural transformation is also needed (Mannion et al. 2009). The interest in managing organisational cultures, particularly in healthcare, is not new and many reforms in the NHS have embraced culture change as a key element for improving clinical quality, safety and organisational performance (Mannion et al. 2009).

The inquiry at Mid Staffordshire NHS Foundation Trust brought a fresh focus on culture within the NHS. This influential report, published in 2013, diagnosed serious culture deficiencies within the Trust and recommended a fundamental cultural change in the wider NHS (Francis 2013). The overarching theme of the 290 recommendations from the report puts culture at the heart of the scandal of fundamental care failings and addresses the need for a 'focus on culture of caring' mostly within nursing but also more widely by all staff who work for the NHS.

A large body of research evidence provides insight into the nature of culture and the possibilities for shaping culture change to produce the desired outcomes (Davis et al. 2000, Mannion et al. 2008). The sheer volume of literature associated with organisational culture, culture of compassion and safety culture highlights the centrality of culture to the provision of healthcare and its importance has become increasingly recognised following the reports from the Robert Francis Inquiry and most recently Sir Robert Francis's Freedom to Speak Up Review (Francis, 2015) has highlighted the need for a culture of safety and learning in which staff feel safe to raise concerns and these conversations take place as part of everyday practice without fear of blame or recrimination. Sir Robert also stressed the importance of staff having time to explore issues, analyse the system and share good practice. The spirit of Sir Robert's report aligns closely with the intent of the Barometer.

The current policy agenda highlights cultural change as one means of improving healthcare services and pays particular attention to the culture of care. Yet, in any consideration about how the culture of care can change for the benefit of the service provided, it is necessary to first explain the concepts of organisational culture and, in particular, the culture of care.

The next section draws on the published literature to provide the theoretical background and the main concepts that form the focus of this research. There is a wealth of literature on organisational culture and associations with healthcare performance, quality of care and outcomes. The aim of this review was not to replicate work in the field but rather to utilise key and influential work that would help contextualise our research and identify important domains associated with the culture of care that could inform the development of the Barometer tool.

2.2 Organisational culture

Culture derives from the Latin root *'colere'*, meaning to tend, or to cultivate. Thus, culture was originally a noun describing the process of fostering the growth of something, especially a plant or an animal (Oxford Dictionary 2010). Significantly, the root of the word 'nurse' is the Latin 'nutricius' meaning to nurture or nourish. Thus the two words share a common etymological heritage and meaning. This common heritage links the concepts of 'culture' and 'nurse' suggesting the centrality of nursing to fostering and cultivating care and compassion, a factor which may have fuelled the media representation of nursing as a lightning rod for poor care after the Francis inquiry.

Several definitions of organisational culture can be found in the literature from simply 'the way we do things around here' (Lundy & Cowling 1996) to a more established classification proposed by Schein (1985, p9) defining culture as a learned product of shared experience: "the pattern of shared basic assumptions – invented, discovered or developed by a given group as it learns to cope with its problems of external adaptation and internal integration..." Much of the literature favours the concept of culture as shared beliefs, norms and routines that a society can be interpreted and understood by.

Davies et al. (2000) argued that there are two broad schools of thought about the concept of organisational culture. The first school of thought regards culture as something that an organisation 'is', therefore the concept that culture acts as a metaphor for describing an organisation rather than a separate entity or easily identifiable element of an organisation (Davies et al. 2000). The culture of an organisation exists in, and is reproduced through, the social interaction of participants (Scott et al. 2003). The second school of thought approaches the concept of culture as something that an organisation 'has' and is therefore aspects of an organisation that can be isolated, defined and influenced (Davies et al. 2000). Here, culture is considered as an attribute along with other attributes of an organisation, such as structure and strategy (Scott et al. 2003). According to Davies et al. (2000) the distinction between viewing culture as either an attribute or as a metaphor has very important implications for policy. If culture is something that an organisation has (as an attribute) then it might be possible to create, change and manage culture in the pursuit of wider organisational objectives (Davies et al. 2000). However, if an organisation is a cultural entity then the study of this helps to understand the process of social construction but does not offer insight in terms of shaping change (Davies et al. 2000).

In an attempt to unpick the various elements of organisational culture, Schein (2010) describes three levels of organisational culture. At the first level are the artefacts. These are the tangible, overt manifestations of culture, which people can see and feel such as dress codes, traditions, ceremonies and the reward structures unique to an organisation (Doherty et al. 2013). At the second level there are the espoused beliefs and values. These are various adopted beliefs, values, norms, and rules of behaviour that members of an organisation use as a way of portraying the culture to themselves and others (Schein 2010). At the third level, organisational culture is deeply embedded on assumptions that represent the unconscious and taken for granted beliefs

and values that structure the thinking and behaviour of an individual. These assumptions give rise to organisational values that operate at a more conscious level and represent the standards and goals to which individuals attribute intrinsic worth (Davies et al. 2000). These values constitute the basic foundation for making judgments and distinguish 'right' from 'wrong' behaviour (Davies et al. 2000).

The analogy of a 'culture iceberg' is commonly used to demonstrate the visible and invisible levels of organisational culture, with the visible levels (surface manifestations) of the 'culture iceberg' being more readily manipulated (Doherty et al. 2013, O'Donnell and Boyle 2008). Therefore, change strategies have focused primarily on the more visible aspects such as rites and rituals that help shape behaviour (O'Donnell and Boyle 2008). However, Schein (2004:8) emphasises that: "we can see the behaviour that results, but we cannot see the forces underneath that cause certain kinds of behaviour". Therefore, deep-seated beliefs, feelings and values below the surface of the 'culture iceberg' must be taken into account when considering organisational culture and potential change as these are the powerful but invisible and, to a considerable degree, unconscious elements that impact and can cause certain kinds of behaviour yet may prove more resistant to external influences (O'Donnell and Boyle 2008, Davies et al. 2000).

Schein identifies three subcultures in any organisation that are important to consider when analysing the dynamics of change (Doherty et al. 2013). These are identified as the (1) operator culture - the group of people on the frontline who deliver the service, (2) the engineer culture - the group of people who design the processes by which the organisation delivers its products and maintains itself, and (3) the executive culture - those responsible for the strategic survival of their organisation (Doherty et al. 2013).

West et al. (2014) indicate that culture is co-created through the interactions, communications, influences and collaborations among members of an organisation and in healthcare organisations this can create cultures within specialities, directorates, organisations and whole system. Within healthcare organisations culture is a reflector of the values of the organisation which include quality, safety, compassionate practice (West et al. 2014). According to West et al (2014) if an organisation has strong values of compassion and safety then staff working in the organisation learn the importance of caring and safe practice. Therefore, they advocate that if organisations want to improve care, then they must focus on nurturing appropriate cultures (West et al. 2014).

The sheer volume of literature around organisational culture, culture of compassion and safety culture highlights its centrality to the provision of healthcare and its importance has become increasingly recognised following the reports from the Robert Francis Inquiry, most recently in 2013.

Our research focuses on the culture of the organisation, as it impacts and is experienced by staff in NHS care provider organisations, in terms of the 'culture of care'. The next section delineates specifications of the 'culture of care' concept as the main theoretical base of this study.

2.3 Culture of care

Within healthcare, taking an organisational culture perspective means accepting that care and caring practices are influenced by contextual structures such as political, economic, technical and legal dimensions (Rytterström et al. 2013). According to Rytterstörm et al. (2013) these dimensions create dominant values, norms and beliefs that shape how individuals give meaning to their tasks and how care is practiced. When used with culture, the concept of caring refers to the desire to develop caregiving in a particular direction (Rytterström et al. 2013). Therefore the care culture of an organisation concerns meaning making and how meaning is expressed in the care of patients (Rytterström et al. 2013).

The concept of care in the care culture of an organisation includes both caring and uncaring and is related to how 'care givers' express and create meaning in their performance of care (Rytterström et al. 2013). According to Kawamura (2013) the qualities of care in organisational environments can be divided into three categories: individual qualities such as curiosity, integrity and courage; relational qualities that include nurturing, valuing and fostering; and managerial decision making qualities such as respect, balance and mindful attention.

A caring supportive culture harnesses employees' psychological capital, which has been found to be positively related to employee performance, job satisfaction and organisational commitment (Luthans et al. 2008). The caring organisation is built upon a culture of care that energises the work of organisational members in every position and all members are equal participants in the co-creation of shared values and outcomes. In a caring culture, executives and leaders motivate organisational members to cooperate by inspiring them to care about the purpose of the organisation and supports them to build strong and open relationships with team members, listen to feedback, receive coaching from 'subordinates' and encourage creative contributions and courageous ideas (Kawamura 2013). Similarly, West et al. (2014) identify leadership and leaders as important determinants of developing and maintaining caring cultures since leaders have the power to reward and punish practices, they can also exercise control of information and resources of an organisation and they make choices about structures that can shape the work lives of other employees (for better or worse).

In addition, research evidence indicates high workloads, professional and personal demand and poor control to be associated with low job satisfaction and burnout and have poorer outcomes for patients (Aiken et al. 2013, Ball et al. 2013). Mistreatment of patients and staff in organisations can serve as an example of how care can be influenced by contextual constraints in which caring might not be valued (Rytterström et al. 2013, Ranheim et al 2011, Turkel 2006). Therefore, it can be argued that organisational culture can both reduce and prevent mistreatment but can also normalise mistreatment, as was the case in Mid Staffordshire (Rytterström et al. 2013, Francis 2013).

The concept of caring within healthcare literature overlaps with 'patient-centeredness' as it relates to being compassionate and empathetic (Hesselink et al. 2013). However, caring represents a broader meaning and viewing a caring culture as the only patient-centred model fails to compute the dynamic and reciprocal nature of relationships within healthcare environments. Key to such relationships is the actions of staff and the way staff themselves are treated. For example, West et al. (2014) indicates that how staff talk to or about patients and how they talk to each other may shape the nature of the organisation culture. Moreover, the type of behaviours staff adopt may be assimilated from behaviours they observe in other staff members and this may reveal the value an organisation places to its members. This is considered central to this study.

While considerable research has placed the patient experience at the centre of high quality care, it is widely recognised that such care will not be possible unless staff themselves are empowered and enabled to deliver it (Patterson et al. 2011). This was the case in the study conducted by the NHS, in conjunction with the major trade unions, the Healthcare Commission and Academy of Medical Royal Colleges (Ipsos MORI 2008) and included interviews with staff in 50 NHS Trusts and GPs. As reported in Chapter one this project identified that staff commitment, engagement and productivity was strongly linked to four 'themes': (a) the resources to deliver quality care, (b) the support needed to do a good job, (c) a worthwhile job that offers the chance to develop, and (d) the opportunity to improve team working. These elements underpin the design of the Barometer.

Given the power of context to shape behaviour we also need to understand the environment in which care is delivered can exert a potent influence on quality of care. According to Nolan et al. (2006), an enriched environment is one which patients, staff and family carers experience six senses: security, belonging, continuity, purpose, achievement and significance. This approach to understanding the environment of care is broader than notions of "patient" or "person" centred care, in that it recognises the need for staff themselves to work in an enriched environment if they are to create such an environment for patients and their carers. The role of the organisation's Executive or Board is critical in establishing the culture. It defines the principles that characterise all aspects of the organisations' conduct, in accordance with the values of the NHS, the NHS Constitution and the Nolan rules on probity in public life. But an equally key role is played by clinical leaders such as the ward sister/manager or community team leader in establishing an 'enriched' environment for staff in which they feel valued and supported. Clinical leaders themselves also need to feel they are supported and encouraged. But how can we gauge whether an organisation is successfully fostering a culture throughout that enables this kind of enriched environment to thrive and flourish?

Although many studies focus on measuring aspects of care on a micro level, the implications this has for patient outcomes research is limited to the extent that these cultural aspects of care are supported on higher, meso and macro levels. Therefore, to address this gap, this study brings together items and components in the design of a tool that aims to measure the extent to which a culture of care is shared across members, management and the wider organisation.

While current staff surveys provide insight into staff responses to their environment, the Culture of Care Barometer is intended to offer an additional dimension by capturing the norms of group behaviour in the provision of care, the 'culture of care'. An initial analysis of the literature revealed a lack of suitable items for measuring all of the four defining constructs of caring culture as identified in the previous section. Therefore a tool has been developed, with the help of an expert steering group with experience in inspection, regulation, turnaround teams, workforce and government inquiries (PACT team as previously indicated).

2.4 Approaches to measuring culture

In 2014, the NHS Trust Development Authority, the Care Quality Commission (CQC) and Monitor committed to developing an aligned framework for making judgments of how the leadership, management and governance ensure the delivery of high quality care for patients and promote an open and fair culture. The proposed framework was built along the lines of the existing quality governance framework and within the four domains ten question were proposed that can be used by organisations and reviewers when assessing governance. Within the capability and culture domain, the Board members need to demonstrate that they have the skills and capability to lead the organisation; that they can shape an open, transparent and quality-focused culture and that they support continuous learning and development across the organisation. An example of good practice in this domain is that the Board uses a range of tools to gain insight into cultural differences and performance across the Trust.

The review of the literature to inform this study identified a number of influential works reporting different instruments that have been used in healthcare and in the other organisational contexts to measure and assess organisational cultures. A major study commissioned by the National Institute for Health Research (NIHR) and led by Professor Russell Mannion identified 70 instruments and approaches for exploring and assessing organisational culture (Mannion et al. 2009). According to this study the sectors most interested in organisational culture have been business, healthcare and education (Mannion et al. 2009).

The tools identified varied in terms of their methodological and research approaches with the majority adopting a structured questionnaire approach, self-report in nature; while other more unstructured and ethnographic approaches were also used. The research identified a total of 212 NHS organisations, 96 acute Trust and 116 primary care Trusts using such tools, but a relatively small number of potential available tools is used, with the most commonly used tool being the Manchester Patient Safety Framework (MAPSAF). While the study identified that clinical governance managers found these tools overall easy to use, some concerns from wider stakeholders were raised in terms of the terminology used and also some concerns about the 'transplantation' of tools from other industries or other healthcare systems without necessarily 'fit for purpose' within the NHS context (Mannion, 2009). While the study has identified a plethora of culture assessment tools, the authors indicated a strong demand for tools that serve more formative and diagnostic purposes rather than summative ends and recommends further research into how these tools can be used to support reflexive practices (Mannion et al. 2009). The principle therefore of developing a diagnostic tool to assess the 'culture of care' while at the same time enabling reflection on the underlying issues involved in creating a caring culture were considered important for the development of the Barometer.

Through the literature review it was identified that different instruments offer different insights and they can help reveal some aspects of an organisation's culture but can obstruct others. Our study was particularly concerned with examining the 'culture of care' in an organisation. A recent systematic review by Hesselink et al. (2013), aimed at identifying instruments or components of instruments that measure aspects of a caring culture in hospitals, concluded that an ultimate standard tool to this extent does not exist.

Hesselink et al.'s (2013) systematic review reported seven studies meeting their inclusion criteria, which reported on five instruments measuring a caring culture in hospitals. Two of the tools in their systematic review were developed in the UK for use by staff (Shipton et al. 2008, Haigh & Ormanby 2011). Shipton et al.'s (2008) scale for care quality climate comprises 19 items, rated by staff on a five point scale, grouped into three subscales: leadership (six items), care quality climate (seven items) and job satisfaction (six items). Haigh and Ormanby's (2011) instrument evaluates the organisation and delivery of patient-centred acute nursing care using 45 items. Erickson et al.'s (2004) 38 item tool, developed in the USA, is also intended to be used by staff working in acute health care settings. Items are grouped into eight domains: handling disagreement and conflict (eight items), internal work motivation (seven items), control over practice (seven items), leadership and autonomy in clinical practice (five items), staff relationships with physicians (two items),

teamwork (four items), cultural sensitivity (three items) and communication about patients (two items). Edvardsson et al. (2008) developed two person-centred climate questionnaires to measure how hospital environments are experienced as person-centred by patients and also by staff. Both of the original tools have been psychometrically tested and refined. The instrument for patients comprises 17 items grouped as a climate of safety, a climate of everydayness and a climate of hospitality, and self-rated using a six point scale. For the staff version, on a six point scale, staff rate 14 items grouped into three domains: a climate of safety, a climate of 'everydayness' and a climate of community. The original tools were developed in Sweden and the English language version of both has been tested with patient and staff populations in Australia.

Hesselink et al.'s (2013) review reports their evaluation of the psychometric properties of the five instruments. Of note, on average, only 24% of items in the instruments were considered relevant to the measurement of organisational culture of caring. Thus their contribution to the subject is limited. Developing a tool that can help healthcare organisations diagnose their caring culture therefore, can provide important input in evaluating the quality of care provided within and across organisational settings.

2.5 Summary

Recent healthcare policy agendas with the NHS has reinforced the importance of organisational culture as a key element in understanding and shaping the basic values, beliefs and assumption that underpin patterns of behaviours among employees. Moreover, the sheer volume of theoretical and empirical literature around organisational culture, culture of compassion and safety culture highlights further the centrality of organisational culture to the provision of health care. In view of this widespread interest in healthcare policy and literature and in the context of post Francis inquiry we wanted to explore how healthcare organisations could gauge their culture of care. Our review of current policy and the conceptual underpinnings of the organisational culture identified a rich and diverse empirical work on the notion and nature of organisational cultures as well as culture assessment instruments that could be used to explore, analyse and interpreted these concepts. Our intention here was to make explicit the theoretical elements of the study and to provide a context to the work that influenced the development and refinement of the Culture of Care Barometer tool - the major one being the concept of the culture of care. Building from this and applying well-recognised and comprehensive approaches to instrument development and validation, we employed a multi-stage approach for developing and testing a tool to measure the different attributes of environments in which care is delivered that helps to understand the culture of care in healthcare organisations. These approaches are discussed in the next chapter.

3. Instrument development and validation

In this chapter we set out the approach to the development and validation of the Barometer, before reporting on the response achieved at the two pilot sites participating in phase two of the instrument testing. We then present findings from the complete dataset (for both Trusts) to illustrate the style of the feedback reports produced for each Trust.

3.1 Approach

With funding from NHS London, a first version of the Barometer was piloted with a sample of 2,000 nursing staff (registered nurses and health care support workers) in an acute hospital Trust in London by the NNRU at King's College London (by Professor Anne Marie Rafferty and Jane Ball) (phase one). It was piloted as an online tool and paper-based survey and was in the field from mid-February to mid-April 2013. The pilot comprised:

- **all nursing staff [Registered Nurses (RNs) and Health Care Assistants (HCAs)] in four different clinical care group settings**
- **individuals were anonymous but the departments/units were identifiable**
- **both paper and online versions of the survey**
- **several blanket reminders to encourage responses**
- **a response rate of 24% was achieved (less than the target of 40%).**

Initial findings were fed back to the Trust in May 2013. Key lessons learnt from this pilot and recommendations for further developments were reported to the project steering group in October 2013.

The initial tool presented staff with 37 attitude items clustered under four main themes and asked staff to indicate their agreement with each on a scale of 1-5, from not at all, to fully agree. The first section of the questionnaire covered six statements that explored the issues surrounding resources and quality of care, facilities and equipment, staffing levels and views of workplace in terms of safety and quality. It included the Friends and Family Test as a reference item. The second section comprised 10 items relating to management and support. The third section covered items relating to development, staff involvement in decision making and overall culture at the Trust. The final section covered a range of statements including staff meetings, teamwork and feedback and willingness of the organisation to learn from issues raised, and incidents.

Following data collection, the tool was subjected to a series of statistical tests to examine how well it performed. Factor analysis is a commonly used statistical method for examining the nature of the relationships between variables in a survey. Essentially, the analysis identifies which variables correlate strongly with which other variables and offers a 'sensible' total number of factors. This statistical approach identified variables where responses to items in the Barometer were similar between individuals and allowed them to be brought together as 'themes'. In our analysis of the Barometer, as applied in the first pilot, the factor analysis produced three main factors which could be described as:

- **resources and safety**
- **management and appraisals**
- **values, ethos and responsiveness.**

Table 3.1: Items in the three themes identified from Factor Analysis

Factor 1: Resources and safety	
1a	I have the facilities and equipment I need to do a good job
1b	The Board has an accurate idea of the quality of care provided
1c	Overall, I feel trusted, listened to and valued
1d	There are enough staff for me to do my job well
1e	I would recommend this ward/unit as a good place to work
1f	If a friend or relative needed treatment, I would be happy with the standard of care provided by this unit/department
2i	Trust managers have a good understanding of how things really are
4k	I feel safe, secure and supported to do my job
Factor 2: Management and appraisals	
2b	I have a regular and effective appraisal
2c	Staff here are generally well managed
2e	Bad behaviour is tackled and managed, regardless of who it is
2f	I know who my manager / supervisor is
2g	There is strong and visible leadership from senior staff
2h	My line manager provides support when I need it
Factor 3: Values, ethos and responsiveness	
3g	The values of the organisation are directed towards patient wellbeing and dignity
3h	A positive ethos is visible at every level of the organisation
3i	Success is celebrated and staff are praised for good work
3j	Overall, there is a positive culture that supports the delivery of excellent care
4h	I regularly get feedback on what the organisation learns from patient complaints
4i	I regularly get feedback on what the organisation learns from incidents
4j	My concerns are listened to

Furthermore, reliability tests were also undertaken. Reliability tests allow us to gauge whether proposed 'scales' or themes contain items that perform in a consistent and similar way. Cronbach's alpha is the most common measure of internal consistency (reliability). It is most often used when multiple Likert items in a survey/questionnaire are to be combined to create a scale, as a means of testing whether the scale is reliable. Therefore, this was appropriate for testing the Culture of Care Barometer scales. Table 3.2 summarises the alpha reliability of each section of the questionnaire. It should be noted that an alpha reliability score above 0.7 is considered high, suggesting that all the sections of the Barometer have high reliability when used as a scale.

Table 3.2: Alpha reliability test of the four sections of the Culture of Care Barometer and the three factors identified in the questionnaire

	Cronbach's Alpha	No. of items	Scale mean	Valid/excl. cases
Section 1: Resources needed to deliver quality care	0.877	6	3.15	432/35 excl.
Section 2: Support needed to do a good job	0.894	10	3.50	437/30 excl.
Section 3: Worthwhile job with a chance to develop	0.884	10	3.65	436/31 excl.
Section 4: Opportunity to improve the way team works	0.907	11	3.25	433/34 excl.
Factor 1: Resources and safety	0.905	8	3.08	418/49 excl.
Factor 2: Management and appraisals	0.872	6	3.55	445/22 excl.
Factor 3: Values, ethos and responsiveness	0.887	7	3.16	440/27 excl.

Source: Culture of Care Barometer: Pilot Survey, 2013

Aside from the analysis already undertaken from the first pilot to identify how culture varies across the organisation and between staff (which was fed back to the first pilot Trust), further analysis has focused on reviewing how items within the instrument perform to identify which are key predictors of overall views of culture and whether any items effectively perform the same function and can be removed to shorten the Barometer.

The items and emerging factors have been reviewed against 'domains' related to culture identified in the literature. The revised Barometer was then tested with a wider range of staff groups, beyond acute settings (Phase two). Two pilot sites were identified and agreed to take part in the second phase. The empirical assessment of the tool in these two sites is discussed next.

3.2 Empirical assessment of the Culture of Care Barometer

The aim of the empirical assessment, in phase two, was to test the construct and face validity of the Barometer with a wider range of staff working in community and mental health settings; and explore the extent to which the Barometer served the purpose for which it was designed: that is, to measure the culture of care across and within an organisation and stimulate reflection about the nature of the culture found and how it varied.

The following approach was taken:

a. The face validity of the instrument was tested through discussion groups with a cross section of staff of different levels of seniority and from different settings. Discussion groups were held in early 2014 in which staff completed the tool. The discussion group was then used to get their feedback on each section and their understanding of individual items. The groups were also used to explore staff perceptions of what makes a 'good environment' and key 'signs and symptoms' of a place that has a good, or bad, culture.

b. Pilot testing of the Barometer through a staff survey. The Barometer was finalised for use in the pilot Trusts in early 2014 with a proposed launch date of May 2014. It was offered as both an online and paper-based survey. The pilot involved:

- **all staff in each Trust**
- **individuals completing the survey anonymously although department/ward/specialty/pay band/area were identifiable**
- **survey design using software that allowed both paper and online versions to be produced**
- **several blanket reminders used to boost response rates**
- **a target response rate of at least 40%.**

A key requirement identified at the outset was to work with each Trust in developing a communication and feedback strategy to support use of the Barometer. This was seen as vital, to ensure the highest possible response (which affects the reliability and usefulness of results) and enables the tool to deliver on its objectives. In order to provide a mechanism for enriching the culture of care, the Trust needed to fully engage with the Barometer's use – before, during and after it is in the field – and communicate to staff their commitment to its use and to using the results to make a real difference to patients and staff.

3.3 Response

The online Culture of Care Barometer was sent to the Trusts for circulation in May and June 2014. Most of the online responses were completed in the first three weeks of the survey although it was open for completion for a total of eight weeks. Likewise the postal tool was sent to the two Trusts for circulation in May and June 2014 (1500 copies to each Trust).

In total there were 700 completed questionnaires (online and postal) from Trust 1 representing a 25% response rate and 1005 from Trust 2 (24% response rate). Across both Trusts there was variation in response rates for different areas, functions and services.

The aggregate response rate (25%) for both Trusts was lower than the target of a minimum of 40%. To put this figure in context, nurse surveys undertaken by the NNRU, King's College London as part of the RN4Cast: Nurse Forecasting in Europe study achieved an average of 39%. Meanwhile, the NHS staff attitude survey achieved a national response rate of 50% in 2012.

It is difficult to assess the coverage of the distribution and the achieved response rate without more detailed knowledge of how the reminder strategies were deployed and the degree of marketing and publicity that the survey was given within the Trust. However, it seems the Trusts were doing all they could to promote and circulate the survey.

There were no obvious peaks in response over the survey period that might correspond to specific reminders beyond the initial online reminder after one week.

3.4 Profile of the pilot sites

The two pilot Trusts were very different from one another in scope and geography. One was primarily a mental health Trust in London and the other was a predominantly Community Trust in a mixed urban/rural setting in the South of England. Tables 3.3 and 3.4 summarise the profiles of the two Trusts.

Table 3.3: Staff group by Trust (2014)

	Trust 1	Trust 2	All respondents
Registered nursing and health visiting staff	30	34	32
Healthcare assistant/support worker	13	5	8
Allied health professionals	25	25	25
Estates and facilities	2	4	3
Doctor/Dentist	5	3	4
Administrative and clerical	15	15	15
Central functions and corporate services	4	6	5
Other	4	6	5
More than one ticked	3	2	2
Base = 100%	**651**	**941**	**1592**

By staff group the two pilot Trusts had similar respondent profiles, although one covered more healthcare assistants/support workers whilst the other had a larger proportion of respondents who were registered nurses and health visiting staff.

Key differences between the two pilot Trusts are in terms of the settings covered as Table 3.4 shows.

Table 3.4: Setting by Trust (2014)

	Trust 1	Trust 2	All respondents
Community	36	45	41
Clinics/outpatients	13	14	14
Ward/inpatient units	27	7	15
Office	16	27	23
Other	9	7	7
Base = 100%	**659**	**954**	**1613**

3.5 Profile of respondents

Overall across the two Trusts four-in-five (82%) respondents were female (and just 26% were aged under 40, 32% aged 40-49, 34% 50 to 59 and 8% were aged 60 plus. 95% of respondents were of white ethnic origin and 98% spoke English as their first or main language. There were no differences in the age profile by gender or other demographic variables, or by Trust. However, Trust 1 had more male respondents (26%) than Trust 2 (14%). In terms of variation between groups of respondents in relation to pay band, staff group shows the most significant variation. There was a relatively even distribution of registered nurse and health visiting staff between bands 5, 6 and 7. HCAs/support workers were concentrated on Bands 1-4, as were those working in estates and in administrative and clerical staff groups.

Table 3.5: Staff group by pay band (both Trusts 2014)

	Band 4 and below	Band 5	Band 6	Band 7	Band 8 plus	Base N=
Registered nursing and health visiting staff	5	21	27	36	11	501
Healthcare assistant/ Support worker	96	1	2	1	0	129
Allied health professionals	6	10	30	32	23	387
Estates and facilities	80	4	12	2	2	51
Doctor/Dentist	59	5	8	3	24	37
Administrative and clerical	71	14	7	3	5	238
Central functions and corporate services	9	10	23	20	38	79
Other	42	5	17	25	12	77
More than one ticked	50	6	17	17	11	36
All respondents	**30**	**13**	**21**	**23**	**13**	**1535**

By setting there was less variation between respondents with staff working in office functions distributed across the full range of pay bands. Staff located in community clinics and outpatients were more likely to be employed on Band 7, while ward/inpatient units employed more staff on bands 1-5.

Table 3.6: Setting by pay band (both Trusts 2014)

	Band 4 and below	Band 5	Band 6	Band 7	Band 8 plus	Base N=
Community	19	12	26	31	12	641
Clinics/outpatients	22	9	25	25	19	204
Ward/inpatient units	42	22	12	17	7	229
Office	44	11	14	11	20	365
Other	42	11	18	25	5	101
All respondents	**30**	**13**	**21**	**23**	**12**	**1540**

Two-thirds of staff across the two Trusts worked full-time (68%) with 32% working part-time. Women were more likely to work part-time (36% compared to 13% of men).

3.6 Results

The Culture of Care Barometer presents staff with 30 attitude items and asks them to indicate their agreement with each on a scale of 1-5: from strongly disagree, to strongly agree.

The findings presented in this section represent the summary frequencies across both Trusts looking at differences in response patterns between staff according to: area, setting, service, staff group pay band, mode of working and by gender and age band. The analysis draws out themes in the items and looks at differences in response patterns to these groups of items which are drawn together in a scale.

Overview

Table 3.7 presents the summary findings for each of the 30 items as they are presented in the Culture of Care Barometer indicating where there are statistical differences between the two Trusts surveyed. In each case where a difference was highlighted more staff from Trust 2 responded positively. Overall though, staff from both Trusts responded positively to most of the items. The most positive responses were in relation to:

- **The people I work with are friendly (90% agree)**
- **I feel respected by my co-workers (84% agree)**
- **My manager treats me with respect (82% agree)**

Where there was a more negative response it was in relation to issues concerned with the Trust management and resources. For example:

- **Trust managers know how things really are (48% of staff disagree with this statement)**
- **I am able to influence how things are done in the Trust (45% disagree)**
- **I have sufficient time to do my job well (45% disagree).**

The sections following Table 3.8 bring together items under general themes so that some analysis of variation between different groups of respondents can be conducted.

Table 3.7: Culture of Care Barometer – Aggregate findings (percentages)

	Strongly disagree	Disagree	Neither	Agree	Strongly agree	Mean score	Base N=
1 I have the resources I need to do a good job	9	27	11	46	7	3.2	1689
2 I feel respected by my co-workers	2	5	9	55	29	4.0*	1693
3 I have sufficient time to do my job well	15	30	17	33	5	2.8	1683
4 I am proud to work in this Trust	5	12	29	40	13	3.4*	1691
5 My line manager treats me with respect	4	6	9	44	38	4.1*	1685
6 The Trust values the service we provide	8	18	27	39	8	3.2	1685
7 I would recommend this Trust as a good place to work	8	14	29	40	9	3.3*	1681
8 I feel well supported by my line manager	5	9	13	41	32	3.9*	1687
9 I am able to influence the way things are done in my team	5	12	17	49	17	3.6*	1684
10 I feel part of a well-managed team	6	15	17	43	19	3.6*	1688
11 I know who my line manager is	1	1	2	41	55	4.5	1682
12 Unacceptable behaviour is consistently tackled	6	17	28	40	10	3.3*	1679
13 There is strong leadership at the highest level in the Trust	11	18	37	27	7	3.0*	1678
14 When things get difficult, I can rely on my colleagues	2	7	13	51	27	3.9*	1679
15 Trust managers know how things really are	20	28	29	20	4	2.6	1682

Table 3.7: continued

	Strongly disagree	Disagree	Neither	Agree	Strongly agree	Mean score	Base N=
16 I feel able to ask for help when I need it	2	9	11	58	19	3.8*	1636
17 I know exactly what is expected of me in my job	2	10	11	55	22	3.8	1640
18 I feel supported to develop my potential	8	17	19	43	13	3.4	1636
19 A positive culture is visible where I work	7	16	21	44	12	3.4*	1638
20 The people I work with are friendly	1	2	7	51	39	4.2*	1641
21 My line manager gives me constructive feedback	4	8	17	47	23	3.8*	1638
22 Staff successes are celebrated by the Trust	6	11	33	42	9	3.4*	1635
23 The Trust listens to staff views	11	21	36	28	4	2.9	1640
24 I get the training and development I need	6	15	19	50	10	3.4*	1636
25 I am able to influence how things are done in the Trust	16	30	34	17	3	2.6	1638
26 The Trust has a positive culture	9	16	34	35	6	3.1*	1635
27 I am kept well informed about what is going on in our team	5	11	16	52	15	3.6	1636
28 I have positive role models where I work	4	9	17	50	20	3.7*	1638
29 I feel well informed about what is happening in the Trust	8	14	26	44	8	3.3*	1636
30 My concerns are taken seriously by my line manager	5	9	17	45	24	3.7*	1638

The seven themes that were devised using a combination of bringing together items that were designed to examine similar issues and analysis to test the reliability of the combined items are shown in the Table 3.8 below. All the items are strongly correlated with each other within each theme with an alpha reliability score above 0.7. This suggests that for each group the items are measuring the same 'theme'. Again, * represents where there is a significant difference between the two Trusts and in each case Trust 2 values were more positive than Trust 1.

Table 3.8: Culture of Care Barometer: themes definitions/coverage and mean scores

Theme:	Items (from 3.1)	Definition/ coverage	Mean score	Sig. independent variables	Base N=
Engagement:	15, 21, 27, 29	Communication, being kept informed	3.3*	Service, working hours	1612
Empowerment:	9, 23, 25, 30	Influence and being listened to	3.2	Pay band, service, staff group	1621
Management/ Leadership:	10, 11, 12, 13, 28	Team/line management, role models and leadership	3.6*	Age band, setting	1603
Values:	2, 4, 5, 6, 7, 19, 22, 26	Pride in Trust, recognition, respect and overall culture	3.5*	Service, age band	1582
Role:	17, 18, 24	Training and development and support to develop	3.5	Service	1624
Resources:	1, 3	Resources and time to do a good job	3.0	Staff group, service, pay band	1672
Team:	8, 14, 16, 20	Support from team, colleagues and line manager	4.0*	Service, staff group	1618

Views are most positive in relation to the degree of support respondents feel in their working lives from their team, colleagues and line manager but are more negative in response to the resources and time they have to do a good job.

Views are also relatively negative in relation to the sense of empowerment they feel they have to influence how things are done at the Trust and the degree to which they feel their opinions are listened to and heard by the Trust. The following sections look in a little more detail at each of the themes.

a. Engagement

This group of items looks at views of engagement within the Trust.

Table 3.9: Culture of Care Barometer: Engagement theme (percentages)

	Strongly disagree	Disagree	Neither	Agree	Strongly agree	Mean score	Base N=
15 Trust managers know how things really are	20	28	29	20	4	2.6	1682
21 My line manager gives me constructive feedback	4	8	17	47	23	3.8*	1638
27 I am kept well informed about what is going on in our team	5	11	16	52	15	3.6	1636
29 I feel well informed about what is happening in the Trust	8	14	26	44	8	3.3*	1636

As noted above in Table 3.7, views of the degree to which Trust management know how things really are at the Trust are relatively negative and scored as the most negative response of all the items. Gender is most strongly correlated with engagement across the two Trusts. For example, just 18% of women disagree with the statement 'I feel well informed about what is going on in the Trust' compared to 31% of men.

b. Empowerment

This group of items looks at views of empowerment.

Table 3.9: Culture of Care Barometer: Engagement theme (percentages)

		Strongly disagree	Disagree	Neither	Agree	Strongly agree	Mean score	Base N=
9	I am able to influence the way things are done in my team	5	12	17	49	17	3.6*	1684
23	The Trust listens to staff views	11	21	36	28	4	2.9	1640
25	I am able to influence how things are done in the Trust	16	30	34	17	3	2.6	1638
30	My concerns are taken seriously by my line manager	5	9	17	45	24	3.7*	1638

As noted above, views of the degree to which staff feel able to influence how things are done at the Trust were relatively negative and scored as the second most negative response of all the items (46% disagreeing with the statement). Again, gender is a significant variable with women responding more positively than men on each item.

c. Management and leadership at the Trust

This group of items looks at views of management and leadership at the Trust.

Table 3.11: Culture of Care Barometer: Management and leadership theme (percentages)

	Strongly disagree	Disagree	Neither	Agree	Strongly agree	Mean score	Base N=
10 I feel part of a well-managed team	6	15	17	43	19	3.6*	1688
11 I know who my line manager is	1	1	2	41	55	4.5	1682
12 Unacceptable behaviour is consistently tackled	6	17	28	40	10	3.3*	1679
13 There is strong leadership at the highest level in the Trust	11	18	37	27	7	3.0*	1678
28 I have positive role models where I work	4	9	17	50	20	3.7*	1638

This theme was the second highest scoring of all the themes. Again, gender showed the strongest correlation, in particular with 'I have positive role models where I work'. Nearly three quarters (73%) of women reported agreement with this statement compared to 59% of men.

d. Values at the Trust

This group of items looks at views of values at the Trust.

Table 3.12: Culture of Care Barometer: Values (percentages)

		Strongly disagree	Disagree	Neither	Agree	Strongly agree	Mean score	Base N=
2	I feel respected by my co-workers	2	5	9	55	29	4.0*	1693
4	I am proud to work in this Trust	5	12	29	40	13	3.4*	1691
5	My line manager treats me with respect	4	6	9	44	38	4.1*	1685
6	The Trust values the service we provide	8	18	27	39	8	3.2	1685
7	I would recommend this Trust as a good place to work	8	14	29	40	9	3.3*	1681
19	A positive culture is visible where I work	7	16	21	44	12	3.4*	1638
22	Staff successes are celebrated by the Trust	6	11	33	42	9	3.4*	1635
26	The Trust has a positive culture	9	16	34	35	6	3.1*	1635

Significantly, more respondents replied positively when considering all the items embraced in the theme 'Values' than responded negatively. In particular, there appears to be high levels of respect within the organisations, with three quarters of staff indicating that they feel respected by both their line managers and their fellow co-workers.

There is a significant difference between the two Trusts in response to these items and overall. For example, 89% of respondents from Trust 2 indicated that they felt respected by their co-workers compared to 78% of staff from Trust 1.

e. Roles at the Trust

This group of items look at views of roles at the Trust. Most staff feel they know what is expected of them in their jobs, feel supported to develop to their potential and get the training and support they need.

Table 3.13: Culture of Care Barometer: Roles (percentages)

	Strongly disagree	Disagree	Neither	Agree	Strongly agree	Mean score	Base N=
17 I know exactly what is expected of me in my job	2	10	11	55	22	3.8	1640
18 I feel supported to develop my potential	8	17	19	43	13	3.4	1636
24 I get the training and development I need	6	15	19	50	10	3.4*	1636

Looking at differences between services it is noticeable that women respond more positively than men. For example, just six per cent of women strongly disagree with the statement 'I feel supported to develop my potential' compared to 15% of men.

f. Resources at the Trust

This group of items looks at views of resources at the Trust. Here the responses were the most negative of all the seven themes with 38% of all staff agreeing with the statement saying they do not have enough time to do their job well.

Table 3.14: Culture of Care Barometer: Resources (percentages)

		Strongly disagree	Disagree	Neither	Agree	Strongly agree	Mean score	Base N=
1	I have the resources I need to do a good job	9	27	11	46	7	3.2	1689
3	I have sufficient time to do my job well	15	30	17	33	5	2.8	1683

Pay band is correlated with this statement with staff on higher pay bands more inclined to disagree than those on bands 1-4 and 5.

g. Teams at the Trust

This group of items looks at views of team working at the Trust.

Table 3.15: Culture of Care Barometer: Teams (percentages)

	Strongly disagree	Disagree	Neither	Agree	Strongly agree	Mean score	Base N=
8 I feel well supported by my line manager	5	9	13	41	32	3.9*	1687
14 When things get difficult, I can rely on my colleagues	2	7	13	51	27	3.9*	1679
16 I feel able to ask for help when I need it	2	9	11	58	19	3.8*	1636
20 The people I work with are friendly	1	2	7	51	39	4.2*	1641

Team working would appear to be the most positive aspect of the working culture at both Trusts with high levels of agreement across all the items. The high level of agreement means that differences between different groups of staff are minimal. However, it is worth noting that staff in Trust 2 were more positive in their response to these items than staff in Trust 1 and it is this area where the Trust differences are greatest. For example, 83% of staff in Trust 2 agreed with the statement 'When things get difficult, I can rely on my colleagues' compared to 70% of staff in Trust 1.

Action needed to improve culture of care at the Trusts

After responding to the 30 items addressing the culture of care, respondents were asked to comment if they felt any action was required to improve the culture of care where they work. Table 3.16 summarises the responses into categories. In total, 131 respondents provided comments (13% of all respondents).

The most frequently cited issue (by 26% of respondents) concerned the Trusts valuing their staff more by communicating better, keeping staff informed, listening and respecting the opinions of staff. One in four wanted to see improvements to management, specifically being more understanding, better interaction and not having unrealistic expectations.

Table 3.16: Culture of Care Barometer: Actions needed to improve culture

Theme	Detail	% cases
Recruitment/retention	Recruiting/retaining wrong staff/too many managers	9
Management	Unrealistic expectations/better understanding/more action/ less micro-management/better interaction/supervision	25
Staffing levels/skill mix	Insufficient staff/shortages/sickness problems	20
Teamwork	Less individualism/more co-operation	2
Targets	Target driven culture/wrong targets/missing point of care/ bureaucracy/put patients first/paperwork	11
Reorganisation/restructuring	Stop restructuring/stop wasting money/reinventing wheel	3
Training and development	More opportunities/more funding	11
Culture	Gossip/cliques/favourites/bullying	11
Funding/Financial/pay	Financial cuts/lack of funding	5
Equipment/IT	Access to better IT/protocols etc.	6
Workload	High workload/pressure/stress/low morale as a result	8
Value (communication)	Respect opinions/listen to staff/inform staff	26
Value (reward)	Reward/congratulate/recognise	9
Value (care of staff)	Look after needs (parking/staff rooms etc.)	9
Other comment		5
Base No. of cases		**129**

The Barometer seemed capable of identifying important foci for improvement and items that management could take forward in enhancing relationships with staff. The need for Trusts to value their staff by communicating better; keeping staff up to date with developments, and listening more adeptly were strong themes. The Barometer also prompted reflection from staff on what action they needed to take based on their basis of their response to the Barometer. The need to include an item in the Barometer regarding responsibility of taking action forward by both management and staff can be highlighted and included in a revised version. Clarity of expectations on both sides was paramount and a necessary foundation for building trust.

4. Review of the Barometer

4.1 Identification of 'themes' through Factor Analysis

The Barometer has been subjected to a series of statistical tests to examine how well it has performed. As in the first phase of pilot testing factor analysis was used as a way of examining the nature of the relationships between variables, to identify 'factors' or themes that may be held in common. In our analysis of the data from the pilot of the Barometer, in stage two, four factors were identified.

Having identified the factors and established which items are associated with them, we considered the factor lists and looked for high loading variables (greater than 0.4). The four factors can be broadly summarised as:

- **Factor 1 is linked to Trust level values and culture**
- **Factor 2 is concerned with team level support and management**
- **Factor 3 is linked to support and respect between colleagues**
- **Factor 4 concerns constraints in undertaking the job.**

Composition of scales

The four factors are produced from responses to the items where respondents were asked to indicate the extent to which they agreed, or disagreed, that each of the characteristics listed were present in their current job. The five response categories were: strongly disagree, disagree, neither, agree and strongly agree. The composition of the factors was based on aggregating the scores for each item to create a single score for each factor and dividing this figure by the number of items in the Barometer to provide a meaningful 'average' value.

The items included in each factor are shown in the four tables below, with the constituent items ranked in terms of their loading. Those items with the higher loading values can be considered most indicative of the factor coverage.

Table 4.1: Composition of scales Factor 1

	Factor 1: Trust: values, culture and communication	Loading
23	The Trust listens to staff views	0.84
26	The Trust has a positive culture	0.77
13	There is strong leadership at the highest level in the Trust	0.75
25	I am able to influence how things are done in the Trust	0.74
7	I would recommend this Trust as a good place to work	0.70
29	I feel well informed about what is happening in the Trust	0.70
22	Staff successes are celebrated by the Trust	0.70
6	The Trust values the service we provide	0.69
15	Trust managers know how things really are	0.68
4	I am proud to work in this Trust	0.65
19	A positive culture is visible where I work	0.50
24	I get the training and development I need	0.40

Table 4.2: Composition of scales Factor 2

	Factor 2: Team: support and management	Loading
8	I feel well supported by my line manager	0.87
5	My line manager treats me with respect	0.84
21	My line manager gives me constructive feedback	0.83
30	My concerns are taken seriously by my line manager	0.81
10	I feel part of a well-managed team	0.60
27	I am kept well informed about what is going on in our team	0.52
18	I feel supported to develop my potential	0.50
11	I know who my line manager is	0.45
9	I am able to influence the way things are done in my team	0.44
16	I feel able to ask for help when I need it	0.44
12	Unacceptable behaviour is consistently tackled	0.40

Table 4.3: Composition of scales Factor 3

	Factor 3: Colleagues: respect and support	Loading
20	The people I work with are friendly	0.81
14	When things get difficult, I can rely on my colleagues	0.79
2	I feel respected by my co-workers	0.76
28	I have positive role models where I work	0.56

Table 4.4: Composition of scales Factor 4

	Factor 4: Ability to do the job	Loading
3	I have sufficient time to do my job well	0.79
1	I have the resources I need to do a good job	0.72
17	I know exactly what is expected of me in my job	0.41

Reliability analyses were performed on each factor. This provides a measure of how the items contained within the factor can be seen as 'going together'. An alpha reliability score of 0.7 or higher can be considered a positive endorsement of the scale and factor.

Table 4.5: Reliability analysis

	Factor 1 Trust level values	**Factor 2** Team support	**Factor 3** Relationship with colleagues	**Factor 4** Job constraints
Items	11	11	4	3
Alpha reliability	0.93	0.93	0.84	0.70
Valid N=	1568	1557	1617	1616
Mean score	3.7	3.2	4.0	3.3

Clearly, respondents are most positive about their relationships with colleagues, with an average score of 4.0 (out of 5). Most staff in both Trusts feel well supported and respected by their colleagues and feel they can rely on them when times get hard. Most staff in both Trusts also feel that overall, there is a positive culture. Less positive scores can be found when looking within the team: support, communication and management. Similarly, when looking at constraints within the job in terms of staffing levels, resources and what is expected of individuals in their jobs, there is a more negative overall response.

Table 4.6: ANOVA: significant correlations with independent variables

	ANOVA: significant correlations
Factor 1: Trust level values	Name (Trust) F=12.7 Trust 2 responds more positively B4 (staff group) F=2.6 (estates and admin respond marginally less positively) B7 (gender) F=16.4 women respond more positively
Factor 2: Team level support and management	Name (Trust) F=15.3 Trust 2 responds more positively B7 (gender) F=12.7 women respond more positively
Factor 3: Colleagues: support and respect	Name (Trust) F=52.2 Trust 2 responds more positively B2 (setting) F=13.68 community responds more positively than ward/inpatients B4 (staff group) F=9.9 nursing/AHP respond more positively than estates/admin B6 (working hours) part-time more positive than full-time B7 (gender) F=48.6 women respond more positively BME (white/BME split) F=29.7 white respondents more positive than BME
Factor 4: Constraints in the job	Pay band F=27.7 higher pay bands more negative than lower. B4 (staff group) F=9.3 community more negative than ward/inpatients BME F=13.9 BME more positive than white respondents B4 (staff group) F=9.3 community more negative than ward/inpatients BME F=13.9 BME more positive than white respondents

When this analysis is run for each Trust, for Trust 2 (with more respondents) the scales are more or less identical but for Trust 1 there are only three factors that come out of the analysis with all of factor 4, some variables in factor 2 moving into factors 1 and 3 which contain more variables than when the analysis is run on the data for both Trusts.

4.2 The value and usefulness of the Barometer to participants

The results from the survey were presented to the Trusts through two independent reports detailing the findings from the Barometer in each Trust. Following the presentation of the results key individuals in the two Trusts were invited to a follow up session to discuss these and provide feedback on the usefulness of the tool. These sessions were recorded and analysed thematically. This section summarises the combined findings from the two sessions, focusing on the value and usefulness of the Barometer to participants.

Culture was seen by Trusts within the study as a particular way of doing things, a form of signalling about what the values of the organisation are. The Barometer was perceived as useful in providing a reference point for Trusts to gauge where they were on a cultural spectrum or journey. It was significant that organisations responded very much in terms of the cultural challenges they were confronting, large scale restructuring for instance, and geographical dispersal, which made it harder to create a coherent and consistent vision of culture around which all groups could coalesce. Discussions about the Barometer in debriefing discussions brought these challenges to the fore. One of the hardest elements of the post-Francis challenge was encouraging people to speak out…"how do you do it?" It was recognised that the Barometer could be useful as a tracking device to gauge where organisations were, for example on a Foundation Trust journey or the product of mergers and therefore encompassing many cultures over time. The Barometer was seen as a useful probe into the different cultures prevailing in geographical enclaves and therefore as an index of identity, specifically the organisation with which staff identified. It was interesting that in both Trusts participating in the pilot the Barometer stimulated discussions about 'us and them' divisions between staff groups and between staff and management.

The Barometer's surfacing of such discussions suggests it is tapping into something sensitive and significant within the organisation - the degree of social as well as geographical distance staff groups felt from each other. It was perceived as useful for delving into more detail and promoting dialogue around staff issues.

Implementation of the Culture of Care Barometer tool

The two pilot studies used similar approaches to disseminate and implement the Culture of Care Barometer within their organisations.

The implementation of the tool in the two Trusts with multiple sites at each site presented a range of challenges such as the logistics of implementing the survey in large and geographically dispersed organisations with minimal administration burden and on tight resources and time frames. The tool was also implemented at a time when different surveys were running concurrently and therefore this may have contributed to the low response rate. Both sites utilised different approaches to increase staff awareness about the project and the distribution and follow up of participants. The main focus of these strategies was the broadly-based communication of the project within the Trusts and the alignment of the project with other culture-related initiatives that were running at the same time. Both sites used an impressive range of communication strategies such as blog entries, disseminating information through Trust conferences and executive meetings, as well as through emails and other means to achieve maximum coverage of staff and increase response rates. The sites were also able to align the project with other culture-related initiatives such as 'culture transformation projects' to help and inform their actions and strategies on culture transformation.

Role of the Culture of Care Barometer tool

The role of the Barometer as a diagnostic 'dip-stick' at one or several points in time seemed to be appreciated as well as a broader index of change. The fundamental value of the Barometer was reflected in the belief that 'culture changes by talking about it' and the Barometer helped to surface issues for discussion. People enjoyed the opportunity to meet and talk about culture, so focus groups were lively and in the words of one senior manager. "I had a lot of people phoning me to ask about the results…the fact that people were asking before the results were ready was a message in itself."

The brevity of the tool, the fact that it was easy to complete and was perceived as targeting the right domains was appreciated by staff. It also seemed to triangulate well with the positives people reported in the staff survey: working in teams, their relationship with their line manager and resources to do a good job. These were seen as helpful in drilling into further detail or using it as a prompt for a 'quality conversation' for instance, with smaller, discrete groups, teams or where it was felt things were not quite right or organisations felt the need to gauge the impact of changes they had made.

Managing expectations

Respondents were also aware of the dangers of survey and the potential of the Barometer (amongst other initiatives) to overload staff or repeat items in the staff survey and Friends and Family Test. The consensus overall was though that the Barometer chimed with these other instruments, adding 'colour and depth' to them. As one senior executive commented: "I think it is a much richer type of feedback than we get from the staff survey. We liked the logic and flow and could appreciate the sense of questions."

One item that cropped up in discussions was the 'the people I work with are friendly' item and the importance of this as a proxy for getting things done and feeling empowered to make a difference. The role of the Barometer in adding value to data already held within the organisation and helping to guide interpretive discussion was appreciated. In particular, the commentary was identified as providing a rich source of intelligence in helping to unpack: "trying to understand what it is that matters to staff and what they feel about the place that they work in." It was also regarded as helpful in picking up on contradictions that might exist in organisations, as one senior manager observed "where you've got high scores for, my manager treats me with respect, but then, Oh, I don't think my manager understands what the real world is like." The richer feedback than the staff survey helped tease out the contradictions and take the quality of conversation at team level to the next stage.

Equally important was the need to emphasise what the Barometer could not do. There was the recognition that Boards were often keen to quicken that pace of change and see the Barometer as a catalyst. Caution against this was also raised:

> ***Culture, as you've just said… does not change overnight and the fact that it is a prompt to reflect upon has been I think a really powerful aspect of the tool. But knowing that there is a… buffeting wind to say okay, well let's, speed up a change in our positivity and positive culture, or cultures, in our organisation. Is this tool the golden chalice that we've been looking for? Or is it another lens and perspective and tool to enable us to have the conversation? So that pace of change isn't met by undertaking the Culture of Care Barometer. No I don't think it's supposed to. I don't think the purpose of the Barometer is to create that pace and speed.***

It was recognised therefore that the Barometer was not a force multiplier towards a positive culture but designed to assist in measuring culture. Everything depended upon how it was used, not just its inherent properties. Moreover, the fact that it could be used in conjunction with other tools and interventions, for example, appreciative inquiry was regarded as one of the pluses to take forward. It was also regarded as an asset in enabling conversations between the Executive and staff and breaking down 'us and them' barriers since the Executive recognised it had a responsibility to help staff to realise their potential. Also, by combining with other tools the Barometer was seen as enabling action and helping to "unlock some of the things that are worrisome as well as linking to a positive culture and helping build that culture".

Overall, the Barometer was seen as simple and easy-to-use as well as quick to complete. It was valued as a useful adjunct to other tools such as the staff survey and Friends and Family Test and sensitive to surfacing sub-cultures where these existed. Its added value seemed to rest on its capacity to delve more deeply into cultural issues around the care environment; provide an enriched source of feedback for Trusts; and prompt 'quality conversations' for groups as well as Board/Executive level. It was regarded as a valuable stimulus for reflection through the issues it targeted.

5. Implications for practice and next steps

5.1 The focus of the study

Recent failings within the NHS and high profile cases such as the Mid Staffordshire NHS Foundation Trust inquiry have created a greater emphasis on delivering high-quality, safe and compassionate care at a time of limited resources and significant pressures to make efficiency savings. The role of culture within organisations is identified amongst the most important features in improving patient care, safety and organisational performance.

The concept and research field of organisational culture is vast with many different theories of how this can be defined or measured. Whether organisational culture is defined in its simplest terms as 'the way we do things around here' or as the shared beliefs, routines, attitudes and norms of behaviour, organisations are increasingly recognising is that they cannot make sustainable improvements to the care delivered without paying close attention to their culture.

In view of the widespread healthcare policy and organisational interest in this area the Culture of Care Barometer was developed to help healthcare executives and clinical staff assess the culture of care within their care environment, team structures and across their organisations. Through this study, we sought to develop and validate a measurement instrument with which to gauge the different attributes of environments in which care is delivered and help understand the culture of care in healthcare organisations.

We identified four factors relating to the culture of care environment and these were linked to the Trust level values and culture; to the team level support and management; support and respect between colleagues; and constraints in undertaking the job.

5.2 A Culture of Care Barometer: Lessons learned

Enabling the workforce to put the right things in place for patients is key to improving NHS performance in terms of quality and safety and this has been the underlying principle of the Culture of Care Barometer tool. The challenge all organisations face is that there is not one-size-fits-all as each individual is unique and will react differently to the challenges and values of an organisation. Mannion et al (2009) in their comprehensive study aiming to identify tools that are currently used by NHS organisations to assess their culture reported that there is still demand for tools that can be used by organisations for formative diagnostic purposes and can support reflexive practice. This was something that the Barometer set out from the beginning as important and given the feedback from the participating sites the Barometer seems to have both served its purpose as a measurement tool while at the same time capable of prompting reflection and allowing more in-depth discussions and understanding of the culture of care. Moreover, the iterative approach to the development of the tool initially from the PACT group through discussions and feedback from different groups in the organisations has allowed the development of the tool to evolve organically taking due account of the needs and contexts of the actors involved in its development.

One of the benefits of the Culture of Care Barometer tool is its sensitivity to groups. The tool was considered particularly useful within teams or groups of staff as a way of breaking down barriers, challenges and problems distinct to a particular area. It provided a useful stimulus for discussion and reflection with the opportunity to create and start a dialogue at different levels within the organisation. It also surfaced social and geographical concerns and divisions. By embracing a multiplicity of cultures within organisations it demonstrated the importance of the cultural link with staff identity and those with whom staff identify with in the organisation. Above all it drew attention to the social processes at work within the organisation and the value placed on positive collegial relations.

On the other side of the balance sheet the response rate was lower than hoped for and the main group of respondents, both at staff discussion groups and online, were nurses. This was in spite of the energetic efforts made by management at both sites to publicise the Barometer and generate interest and enthusiasm for completing the tool. Given the findings about 'them and us' divisions the Barometer may have been perceived by staff as yet another management tool and therefore not 'owned' by the wider staff group. A further caveat is that the Barometer may have been perceived as the business of nurses and not all staff groups. A similar trend of a higher proportion of nurses participating in such projects was also reported by King's Fund in their recent survey with NHS managers and clinicians about leadership, culture and compassionate care in the NHS (King's Fund 2014).

This trend was also reflected in our survey, possibly reflecting the high media profile of nurses post Francis prompting engagement with cultural issues. However, as West et al. (2014) indicated cultures are co-created by all in the organisation and this is because members within organisations are constantly communicating, influencing, collaborating and competing up, down and across the organisation (p.5). West et al. (2014) indicates the need to develop collective leadership within organisations as this means that everyone is responsible for the welfare of the organisation as a whole and not just for their own jobs or work area. Therefore in order to avoid low uptake and engagement of other groups and promote completion of the tool it is important that the Barometer is championed by the Board and seen as owned by the organisation as a whole and not simply as a 'nursing' tool whose consequence is that culture is something nurses 'do' and are responsible for. Strategic direction and leadership are clearly essential in ensuring that culture is seen as everybody's business and leaders should work on developing a culture that pushes away from 'us and them' and towards 'us' to achieve a change.

Important though it is to emphasise what the Barometer can do it is also important to stress what it cannot do. Given the complex and the dynamic nature of organisational culture concept and the complexity of healthcare organisations themselves, developing an ultimate standard for measuring the Culture of Care in organisations may be misleading. From the outset there have been high expectations of the Barometer and what it might be capable of doing. We have developed the Barometer using a robust process and are confident of its potential to stimulate enquiry and encourage teams and organisation to ask questions of themselves and each other and explore how to take the dialogue forward. But it is not a magic wand whose talismanic properties are capable of transforming culture. Much depends on how it is being used as well as the capabilities of those using it and for what purpose. Culture is not something that can be conjured called into being as if through magic. Rather, the potential power of the Barometer lies in the hands of the user. Though we have applied a robust process to the development of the Barometer, we are only at the beginning of the journey. The overall utility of the Barometer necessarily relies upon the experience of those involved in its implementation. We have been impressed by the enthusiasm and energy with which the Barometer has been embraced, however further feedback is needed from the NHS with regard to how the Barometer performs in practice.

Cognate tools

The Barometer is not the only instrument of its kind in the field. As referred to in the literature review several other instruments exist that can be used to measure the culture of an organisation (Section 2.4). Furthermore, after the Francis inquiry (2013) different related initiatives were introduced to help organisations achieve culture change. For example, the Culture Change project championed by NHS Employers was designed to take forward a piece of work that focuses on developing a compassionate culture of care in the NHS using culture change methodology and practice (NHS Employers, 2014). As part of the project an Organisational Development (OD) readiness tool that allows organisations to identify the conditions which need to be created to achieve maximum cultural change impact was developed, which can be used in conjunction with the Culture of Care Barometer. As with any other initiatives there is no prescriptive formula for developing and changing organisational cultures however culture change is a shared goal among different NHS Trusts and this has led to the formation of the National Advisory for Culture Alignment group by the Royal College of Nursing. This group recognises that healthcare organisations and key individuals need to work together so that they can learn from each other and share best practices for more effective culture change. The main function of the advisory group is to provide expert skills and support during the journey of organisations to culture change. The purpose of these instruments and initiatives however is somewhat different and the Culture of Care Barometer does seem to fill a niche for identifying and understanding the social processes within the organisation.

5.3 Key messages

- The Barometer developed from concerns with the culture of care in the practice environment and its power to shape the patient and staff experience.
- We have maintained fidelity with the original vision and prototype but have adapted the design through feedback from users in different care environments.
- The Culture of Care Barometer was developed using a robust process in a variety of settings from the ground up and co-produced with colleagues working in the care environment.
- The Culture of Care Barometer was recognised as adding value to existing tools to stimulate dialogue and reflection on questions of culture and perceived to be of particular value with teams.
- It was seen as adding depth, richness and texture feedback to that received from the staff survey.
- A particular strength of the Culture of Care Barometer is that it is not just a tool but allows exploration of what people feel about the organisation they work in prompting dialogue about how to take action forward from data to development work forward.
- It was viewed as short and easy to complete and well-targeted to domains deemed important by respondents.
- It is not a 'magic bullet' with which to transform culture but necessarily relies upon the capabilities of those using it.

5.4 Recommendations

- On the basis of the evidence generated the Culture of Care Barometer was reported as adding value to existing tools such as the staff survey and Friends and Family Test and can best be targeted at teams where it was perceived as being particularly useful in fostering dialogue and surfacing how respondents felt about working in their organisation.
- Culture is everybody's business and support for the use of the Culture of Care Barometer needs to come from the Chief Executive and the Board to ensure culture is not seen solely as a nursing responsibility.
- Implementation of the Culture of Care Barometer needs to be supported by a robust engagement and communications plan at Trust level and endorsed by the Board to promote uptake and response rate across different groups of staff.
- Expectations of the Culture of Care Barometer have been high and the energy and enthusiasm with which it has been embraced is to be welcomed, but it is not a 'magic bullet' to transform culture and its use will depend upon the capability of its users as well as clarity of purpose.
- The pilot studies reported here are only the start of the journey. Further roll out of the Culture of Care Barometer needs to be accompanied by a full evaluation of its use in practice and service impact.
- The next steps will involve developing a smartphone application (app) and piloting its use in a range of groups and settings.

5.5 Next steps

Thus, in the context of the above discussion the positive reception for the Barometer by Trusts and the value added to existing tools suggest that the Barometer could be extended and rolled out to other settings. The Trusts we spoke to were enthusiastic to embrace the Barometer and anxious to begin using it immediately. From our discussions with Trusts there seems a strong appetite for using the Barometer. A key issue is trying to find a 'home' for the Barometer's continued use and roll out, preferably one where data generated by the Barometer could be analysed and benchmarked say in the form of an app. This is what NHS Employers have done with their Cultural Change project but that process has taken several months in development. The possibility of housing the Barometer within NHS Improving Quality's (NHSIQ's) prospectus of tools has been explored but again this would not automatically provide a benchmarking service. Alongside exploring technical options such as developing an app further market testing could be undertaken in a launch event to confirm wider appeal and potential for dissemination.

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Appendix 1

Culture of Care Barometer v2 (revised, as tested in phase 2)

Culture of Care Barometer | National Nursing Research Unit | King's College London

Please indicate the extent you agree with each of the following statements by ticking one box on each row. This tool is intended to encourage self reflection, so take your time to consider each statement. When you have finished thinking about the statements, please consider if you need to take any action or talk to anyone.

	Strongly disagree	*Disagree*	*Neither*	*Agree*	*Strongly agree*
1) I have the resources I need to do a good job	☐1	☐2	☐3	☐4	☐5
2) I feel respected by my co-workers	☐1	☐2	☐3	☐4	☐5
3) I have sufficient time to do my job well	☐1	☐2	☐3	☐4	☐5
4) I am proud to work in this Trust	☐1	☐2	☐3	☐4	☐5
5) My line manager treats me with respect	☐1	☐2	☐3	☐4	☐5
6) The Trust values the service we provide	☐1	☐2	☐3	☐4	☐5
7) I would recommend this Trust as a good place to work	☐1	☐2	☐3	☐4	☐5
8) I feel well supported by my line manager	☐1	☐2	☐3	☐4	☐5
9) I am able to influence the way things are done in my team	☐1	☐2	☐3	☐4	☐5
10) I feel part of a well managed team	☐1	☐2	☐3	☐4	☐5
11) I know who my line manager is	☐1	☐2	☐3	☐4	☐5
12) Unacceptable behaviour is consistently tackled	☐1	☐2	☐3	☐4	☐5
13) There is strong leadership at the highest level in the Trust	☐1	☐2	☐3	☐4	☐5
14) When things get difficult, I can rely on my colleagues	☐1	☐2	☐3	☐4	☐5
15) Trust managers know how things really are	☐1	☐2	☐3	☐4	☐5
16) I feel able to ask for help when I need it	☐1	☐2	☐3	☐4	☐5
17) I know exactly what is expected of me in my job	☐1	☐2	☐3	☐4	☐5
18) I feel supported to develop my potential	☐1	☐2	☐3	☐4	☐5
19) A positive culture is visible where I work	☐1	☐2	☐3	☐4	☐5
20) The people I work with are friendly	☐1	☐2	☐3	☐4	☐5
21) My line manager gives me constructive feedback	☐1	☐2	☐3	☐4	☐5
22) Staff successes are celebrated by the Trust	☐1	☐2	☐3	☐4	☐5
23) The Trust listens to staff views	☐1	☐2	☐3	☐4	☐5
24) I get the training and development I need	☐1	☐2	☐3	☐4	☐5
25) I am able to influence how things are done in the Trust	☐1	☐2	☐3	☐4	☐5
26) The Trust has a positive culture	☐1	☐2	☐3	☐4	☐5
27) I am kept well informed about what is going on in our team	☐1	☐2	☐3	☐4	☐5
28) I have positive role models where I work	☐1	☐2	☐3	☐4	☐5
29) I feel well informed about what is happening in the Trust	☐1	☐2	☐3	☐4	☐5
30) My concerns are taken seriously by my line manager	☐1	☐2	☐3	☐4	☐5

What, if any, action needs taking to improve the culture of the care environment where you work?

Culture of Care Barometer v2 (revised, as tested in phase 2) continued

Background: about you and where you work...

B1 Which site do you work in? Please tick all that apply.

Site 1 ☐ *Site 2* ☐ *Site 3* ☐

B2 Which setting do you spend most time in?

Community ☐1 *Ward/Inpatient units* ☐3 *Office* ☐5

Clinics/outpatients services ☐2 *Residential* ☐4 *Other (please specify)* ☐6

Other setting:

B3 Which type of services are you involved with?

Service 1 ☐1 *Service 3* ☐3 *Service 5* ☐5

Service 2 ☐2 *Service 4* ☐4 *Other (please specify)* ☐6

Other service:

B4 Which of the following best describes your staff group?

Registered nursing and health visiting staff ☐1 *Doctor/Dentist* ☐5

Healthcare assistant/Support worker ☐2 *Administrative and clerical* ☐6

Allied health professionals ☐3 *Central functions and corporate services* ☐7

Estates and facilities ☐4 *Other (please specify)* ☐8

Other staff group:

B5 What is your pay band?

Band 1 ☐1 *Band 4* ☐4 *Band 7* ☐7

Band 2 ☐2 *Band 5* ☐5 *Band 8* ☐8

Band 3 ☐3 *Band 6* ☐6 *Band 9* ☐9

B6 What are your working hours? *Full-time* ☐1 *Part-time* ☐2

B7 Are you? *Female* ☐1 *Male* ☐2

B8 What is your age group?

16-20 ☐1 *40-49* ☐4 *65 plus* ☐7

21-29 ☐2 *50-59* ☐5

30-39 ☐3 *60-64* ☐6

B9 Which of the following best describes your ethnic background?

White ☐1 *Asian/Asian British* ☐3 *Any other non-white background* ☐5

Black/Black British ☐2 *Any mixed background* ☐4

B10 Would you consider English to be your first or main language?

Yes ☐1 *No* ☐2

Appendix 2

Culture of Care Barometer v1 (as tested in phase 1)

Is there a consistent culture of care across the Trust..?

How can we gauge whether an organisation is fostering a culture that enables a supportive care environment to thrive and flourish? Evidence from high profile examples of care crisis suggests pockets of excellence can coexist alongside the worst examples of care failure.

Variation in care culture attributes is not picked up in the measures of quality and performance currently in use; metrics fail to capture the meaning and reality of care culture for patients or staff.

Leading nurses from across the country have joined together (1) to develop a tool that can help address these issues, by enabling the culture of care provision to be gauged through the development of a 'cultural barometer'. Previous research has found that staff commitment, engagement and productivity are strongly linked to four 'themes' of what matters most to staff in the NHS:–

- having the resources to deliver quality care
- being supported to do a good job
- feeling that the job is worthwhile doing and that there are chances to develop
- working in a well functioning team

These elements have been used to underpin the design of the care barometer tool.

Why another survey..?

The Barometer builds on existing tools, such as the staff survey, and has been designed to complement existing regulation and inspection frameworks. It aims to provide a genuinely useful and meaningful adjunct to existing data, and to keep the bureaucratic burden on staff to an absolute minimum.

The Barometer aims to:

- be short and quick to complete
- complement not duplicate other measures or quality programmes
- be a mechanism for 'ward to board' communication
- act as an early warning system to identify care culture 'red flag' areas
- prompt reflection to help identify actions required

Who's it for..?

Ultimately we want to develop the barometer so it can be used by all staff in wide number of settings. But we're starting by trying it on nursing and midwifery staff in two acute Trusts. We felt it's important to get the views of the whole nursing team, so it's going to both registered and non-registered nursing staff.

Will my responses be confidential..?

Yes. And anonymous too. The responses of individuals will be completely anonymous and treated in strict confidence by the research team and National Nursing Research Unit, who are administering the survey. No-one from the Trust will see the raw data. But to help us identify areas where there are particular problems - with resourcing or support say - you will be asked about which department/unit you work on. The trust will be presented with the results from across the trust as a whole, and by different departments.

(1) ***The small independent reference group comprise: Flo Panel Coates, Baroness Audrey Emerton, Dame Elizabeth Fradd, Tricia Hart, Sir Stephen Moss, Prof Anne Marie Rafferty.***

Culture of Care Barometer v1 (as tested in phase 1) continued

Presented below are a series of statements about your workplace. Please indicate to what extent you agree with each item by ticking one box on each row (where 1 'Not at all' to '5' 'Fully agree'). This tool is intended to encourage self reflection, so take your time to consider all the statements in each of the four sections before moving on.

When you have finished thinking about each group of statements, please consider if you need to take any action or talk to anyone.

Section 1 - The resources I need to deliver quality care...

Q1 Please indicate to what extent you agree with each of the following statements:

	Not at all					*Fully agree*
I have the knowledge, skills and equipment to do a good job	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
I feel fairly treated with pay, benefits and staff facilities	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Sickness and absence is fairly monitored	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
I am aware the Board is monitoring the quality of care provision	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
I feel trusted, listened to and valued	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
There are enough staff to for me to do my job well	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
I would recommend this as good place to work	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
If a friend or relative needed treatment, I would be happy with the standard of care provided by this unit/department	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

Q2 How much influence do you have to improve things in section 1 above? (please tick one box only)

None ☐ 1 *A little* ☐ 2 *Some* ☐ 3 *A fair amount* ☐ 4 *A lot* ☐ 5

Q3 What(if any) action needs taking to improve resources?

Section 2 - The support I need to do a good job...

Q4 Please indicate to what extent you agree with each of the following statements:

	Not at all					*Fully agree*
I feel part of an effective team	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
I have a regular appraisal	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Staff here are generally well managed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
I know how we're doing on quality where I work	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Bad behaviour is tackled and managed, regardless of who it is	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
I know who my manager / supervisor is	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
There is strong leadership from managers and senior staff	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
My manager / supervisor provide support when I need it	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Senior managers have a good understanding of how things really are	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

Q5 How much influence do you have to improve things in section 2 above? (please tick one box only)

None ☐ 1 *A little* ☐ 2 *Some* ☐ 3 *A fair amount* ☐ 4 *A lot* ☐ 5

Culture of Care Barometer v1 (as tested in phase 1) continued

Section 3 - A worthwhile job with a chance to develop...

Q6 Please indicate to what extent you agree with each of the following statements:

	Not at all					*Fully agree*
I have a worthwhile job that makes a difference to patients	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
I have the opportunity to develop my potential	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
I understand my role and where it fits in	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Families and patients are actively involved in their care	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
I would be happy for my family or friends to receive care here/from this organisation	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
I help to promote high quality patient care	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
The values of the organisation are directed towards patient wellbeing and dignity	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
The values are visible at every level of the organisation	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
The values are used as part of the recruitment, induction and appraisal process	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Success is celebrated and staff commended for what is done well	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

Q7 How much influence do you have to improve things in section 3 above? (please tick one box only)

None ☐ 1 *A little* ☐ 2 *Some* ☐ 3 *A fair amount* ☐ 4 *A lot* ☐ 5

Section 4 - The opportunity to improve the way we work in my team...

Q8 Please indicate to what extent you agree with each of the following statements:

	Not at all					*Fully agree*
I am able to improve the way we work in my team	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
We meet regularly as a team	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Staff feel empowered to make changes at work	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Staff have positive role models where I work	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Care is evolving to meet the needs of users in order to better fulfil our core purpose	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
There is a willingness to change and try new initiatives	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
I regularly get feedback on what the organisation learns from patient complaints	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
I regularly get feedback on what the organisation learns from incidents	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
I feel my concerns are listened to	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
I feel safe, secure and supported to do my job	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

Q9 How much influence do you have to improve things in section 4 above? (please tick one box only)

None ☐ 1 *A little* ☐ 2 *Some* ☐ 3 *A fair amount* ☐ 4 *A lot* ☐ 5

Culture of Care Barometer v1 (as tested in phase 1) continued

Section 5 - Background...

Q10 What is your staff group (e.g. registered nurse, HCA)? (please tick one box only)

- *Group 1* ☐ 1
- *Group 2* ☐ 2
- *Group 3* ☐ 3
- *Group 4* ☐ 4
- *Group 5* ☐ 5

Q11 What setting do you work in (e.g. in-patient, outpatient)? (please tick one box only)

- *Setting 1* ☐ 1
- *Setting 2* ☐ 2
- *Setting 3* ☐ 3
- *Setting 4* ☐ 4
- *Setting 5* ☐ 5

Q12 What is the name of the ward/unit you work in? (please tick one box only)

- *Ward/Unit 1* ☐ 1
- *Ward/Unit 2* ☐ 2
- *Ward/Unit 3* ☐ 3
- *Ward/Unit 4* ☐ 4
- *Ward/Unit 5* ☐ 5

Q13 Which directorate to you work in? (please tick one box only)

- *Directorate 1* ☐ 1
- *Directorate 2* ☐ 2
- *Directorate 3* ☐ 3
- *Directorate 4* ☐ 4
- *Directorate 5* ☐ 5

Q14 What gender are you?

- *Female* ☐ 1
- *Male* ☐ 2

Q15 What is your age?

Years: ☐

Q16 What is your pay band?

- *5* ☐ 1
- *6* ☐ 2
- *7* ☐ 3
- *8* ☐ 4
- *9* ☐ 5

Q17 What are your working hours?

- *Full-time* ☐ 1
- *Part-time* ☐ 2

Thank you for taking the time to share your experiences and views.

Notes

Notes

Notes

Further copies of this report can be obtained from:

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