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Culture change, leadership and the grass-roots workforce

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ABSTRACT

The NHS is arguably entering its most challenging era. It is being asked to do more for less and, in parallel, a cultural shift in response to its described weaknesses has been prescribed. The definition of culture, the form this change should take and the mechanism to achieve it are not well understood. The complexity of modern healthcare requires that we evolve our approach to the workforce and enhance our understanding of the styles of leadership that are required in order to bring about this cultural change. Identification of leaders within the workforce and dissemination of a purposeful and strategic quality improvement agenda, in part defined by the general workforce, are important components in establishing the change that the organisation currently requires. We are implementing this approach locally by identifying and developing grassroots networks linked to a portfolio of safety and quality projects.

KEYWORDS: Complexity, culture, engagement, leadership, medical education, qualitative research methods, workforce

The NHS is arguably entering the most challenging era of its 70-year existence.[1–3] The current climate asks that it does more for less – the imperative being to increase quality and decrease costs at the same time as it conducts an evaluation of its culture. Perhaps because of this, there are now strong and differing views throughout society about the organisation and its leadership. Although members of the public may have an unclear image of the NHS as a singular entity, they frequently have a positive opinion of the health professionals they deal with on a daily basis. This faith, built on the relationship between members of the public and those who care for them, as well as the organisation's size and monopoly status, serve to keep it afloat. The 2012 Health and Social Care Act means that competition is now beginning to enter the equation; the impact of this is yet to be seen.

Many who work within the NHS may recognise a version of reality within the Francis Report[4] – the picture painted ensuring that an indelible line that it is no longer acceptable to cross has been drawn. The recommendations in the report have served as a salient reminder about the need for everyone to take responsibility for change, with a renewed focus on improvement of patient safety and care. However, there is a serious risk that those in charge of quality management will distil the 290 recommendations of the report into assurance-linked tick boxes and, in doing so, will oversimplify the multifaceted equation between culture and safety. The risk of the report being used in this manner should be apparent to all and, as Davies and Mannion point out, there are 'more complex and nuanced relations between cultures, practices, and outcomes than Francis implies'.[5]

The call for culture change is now widely accepted as the correct prescription for the NHS and has been underscored by the recent publication of *Hard truths*.[6] Understanding what might be involved at the grassroots of an organisation in among such change is not clear. Our perception and definitions of culture vary and to further complicate matters we are to achieve this wholesale task at a time when the financial situation requires that every penny within the healthcare budget is accounted for. This is perhaps our most challenging dilemma; reconciling the need to invest in cultural innovation during a period of financial contraction.

John Kotter, an international change and leadership expert, has described culture as 'the way things are done around here' and argues that there is no practical choice; investing in the development of a culture that embraces change is fundamental to the survival of large organisations in the current challenging financial climate.[7,8] Without investment, the processes designed to affect change are liable to fail, so the outlay should be considered mandatory to ensure that change is brought about by a critical mass of like-minded activity sufficient to overcome the inertia of the status quo. Kotter's answer to this problem of culture change (not dissimilar to the recommendations in the Francis Report) is to be found within 'the right kind of people and the right approach to leadership'.[7] This seemingly simple combination conceals a much more complex issue – the inter-relationship between leadership and culture.

Keith Grint[9,10] – developing Rittel and Webber's typology[11] – describes the problems we might face within organisations as falling into three main categories; critical, tame and wicked.

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Importantly, each type of problem requires a different leadership style and approach.

Critical problems are steeped in urgency and their resolution relies on a coordinated response to an impending disaster. The situation requires strict hierarchical adherence to the issued command; deliberation is costly and, as a consequence, consensus is sacrificed in favour of expedience. The leadership approach in this situation is coercive and authoritarian: 'command and control'.[12] A call to a cardiac arrest is a good example of this – an immediate response is required, the most experienced clinician takes charge and their orders are followed.

Tame problems differ in several ways. The timeframes for delivery are less urgent, the nature of the problem is predictable, and the problems tend to have well-defined start and end points. The variables in this category are identifiable and may be resolved through the linear application of a singular, albeit potentially very complicated, process. An example of such a problem might be the design and construction of a new hospital site. The principles required to resolve a tame problem are notably similar to the hierarchical organisational structures typically seen within the NHS; a top-down approach to cascaded instruction is favoured, as those in charge will have confronted this problem or something very similar beforehand and are thus best at managing it according to principles learnt previously and known to be effective.

The scope of a wicked problem precludes any one person truly understanding the complexity of the issues that they confront. Wicked problems are comprised of multiple interwoven problem strands that are poorly understood in isolation. For this reason, a fog of uncertainty enshrouds them, the law of unintended consequences binds them together, and leadership becomes critical in identifying a way forward. As Grint highlights, 'The leader's role with a wicked problem is to ask the right questions rather than provide the right answers because the answers may not be self-evident and will require a collaborative process to make any kind of progress'.[9]

Cultural change is a wicked problem, and the style of leadership that is required to bring about this transformation is not the kind that has previously been a dominant force within the NHS. Rather than managing from the top downward, we instead need a collaborative process that engages with the workforce and takes into account the cultural diversity of the many local organisations, professional groups and teams that make up the NHS. Identifying the multiple aspects of a potential solution to this complex problem will require a traditional hierarchical leadership structure closely aligned with its workforce. This stands to benefit the traditional processes in one of two ways: firstly, the organisation benefits from the experience of its workforce; secondly, the workforce is engaged and has evolved beyond its role as service provider into an agent of change. In a similar vein, Don Berwick's recent guidance to the NHS emphasises the need for a greater focus on workforce engagement and specifically on an enabling process to 'improve the processes in which they work'.[13]

The Francis Report has set the scene and created a relevant context for discussions around the topic of culture. Kotter describes an urgent mandate as an essential requirement in order to overcome the inertia of the status quo.[7] His writing is replete with analogies highlighting the difficulty of establishing the first flicker of movement that marks the beginning of change. Taking Grint's classification into consideration, we can see that a 290-point tick-box exercise will be of limited benefit in achieving this movement, as it misclassifies culture change as a manageable, tame problem. When redefined as a wicked issue, the extent of the culture change dilemma becomes clearer; it cannot be readily process mapped or timetabled, and its measurement must take account of the way that different strands influence one another. Creating the early movements required to change the NHS will therefore require coordinated efforts to engage with its entire workforce. Anything less ambitious seems likely to fail.

Berwick's vision of the pathway to improve our culture of safety involves the development of the NHS as a learning organisation rather than a 'top-down mechanistic imposition of rules, incentives and regulations'.[13] He argues that an effective foundation for the evolution of the NHS will be established through the development of collaborative networks, in which the entire workforce is involved with quality improvement agendas. This pathway is much more likely to be successful, as it takes into account the dual components of culture as both an inherited tradition and a potential space for growth. If we want the workforce of the NHS to feel that they work for an organisation that can be changed, this change should be shaped in a way that focuses itself meaningfully on improving patient safety (as opposed to the achievement of targets) and that strives to identify and act on the views and opinions of its staff. What is described is something on which we all now need to focus our collective efforts; if the workforce is not to be held in the past, it must first understand that it has an important role to play in shaping the future.

How might we spread this message? Advertisers and the commercial world have long been aware of the power of connectivity and influence within communities. The sigmoid-shaped curve of social influence and the diffusion of innovation first described by Everett Rogers in 1962 is a reproducible phenomenon that describes the uptake of a novel idea or product into a community. Through a process of social contagion, a small handful of innovators spread the message to the next group, members of which, in turn, are able to successively convey the message to the remainder, with each new person increasing the overall percentage of the community affected until the resistors are ultimately marginalised.[14] The key observation in Rogers' work is that once a small but critical number of people within a community have adopted the change, the self-sustaining nature of its spread is reproducible. It is this phenomenon that we might aim to exploit. If we are able to identify and engage with members of the group who reflect the cultural model we seek to promote, who have the capacity to lead through collaboration, who engage with change and who are representative of the wider workforce, the message stands a chance of diffusing. These networked groups already exist throughout the NHS, albeit in an under-recognised state.

Work at Brighton and Sussex University Hospitals NHS Trust to identify these networks and to highlight their role is ongoing. Underpinning this is an ethos of opportunity and enablement that has the singular aim of improving patient safety through a structured approach to workforce engagement, the development of processes designed to better understand the issues it faces, an approach focused both on innovation and the enhancement of the function of teams and systems through a

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better appreciation of the human factors that govern them. The creation of a number of parallel workstreams and pathways linked to the core principles of this movement has facilitated the growth and development of like-minded activity that crosses multi-professional boundaries at all levels. The support that this movement has received from the formal leadership of the trust has promoted the message that it is the responsibility of the workforce both to embrace and to create its own change.

Collaborative leadership projects that acknowledge the theories described here are shaping the leading edge of corporate business. We might choose to benefit from their experience in order to maximise the potential of our own workforce – our greatest asset in the provision of high-quality care. However, if the status quo persists, the expectation must be more of the same. It seems timely that a frequently quoted phrase has been revised to better suit this difficult era: 'If you always do what you've always done, then you'll always get what you've always got, so if you want what you've never had you have to do what you've never done...'[15] ■

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