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Improvement Cultures in Health and Adult Social Care settings

A Rapid Literature Review for the Care Quality Commission

SQW

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Executive Summary

1. The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. CQC's remit is to ensure health and adult social care services provide people with safe, effective, compassionate, high-quality care, and to encourage services to improve.

2. CQC commissioned SQW (an independent research consultancy) and their subcontractor the Kings Fund Library Service in December 2022. They delivered a rapid literature review into improvement cultures in health and adult social care settings.

Methodology

3. SQW delivered scoping interviews and reviewed key documents to inform a search protocol. This set out the parameters of the rapid literature search. The Kings Fund Library Service then delivered a search of literature databases and websites. A call for evidence was also issued to key stakeholders identified by CQC. In total, SQW identified 254 documents as potentially relevant for review.

4. This literature was sifted to identify and review the most relevant documents, via:

- Title sift: a review of document titles, identifying 122 potentially relevant documents
- Abstract sift: a review of the 122 document abstracts. A total of 40 of these documents were identified as suitable for full text review, with a further 34 documents added to a 'reserve' list
- Full text review: to extract relevant evidence from the full text of the selected 40 documents. A coding framework was used, to identify findings aligned with the research questions.

The evidence base

5. Overall, the quality of the evidence in this review is fair, based on the Nesta Standards of Evidence framework[1]. Over half of the documents (22) were classified as Level 2 against the framework. There were no documents classified as Level 3 or above. This limits the extent to which judgements can be made about the impact of a good improvement culture.

6. The evidence used in this review is recent, broadly relevant for the health and adult social care context in England, and spans a range of settings. But, there are some limitations to the literature:

[1] Standards of Evidence: an approach that balances the need for evidence with innovation. (no date). [online] Available at: https://media.nesta.org.uk/documents/standards_of_evidence.pdf.

- Evidence from adult social care settings. Only five of the 40 documents incorporated into the full text review focused on adult social care, of which one was published by CQC itself.
- Breadth of evidence across health. There are six specific healthcare sectors identified in the literature. Most of the documentation on healthcare either did not specify a type of setting or spanned multiple setting types.

7. The findings from this review should therefore be interpreted with caution when considering relevance and strength of evidence within this sector.

Key findings: improvement cultures

Defining culture

8. Despite its common use, the term ‘culture’ does not have a universally accepted definition. However, several literature sources provide their own unique definitions of culture. The most common elements refer to the shared values, goals, beliefs, attitudes, assumptions and behaviours of organisations.

9. There are several ways in which the literature conceptualises culture. This indicates that there may not be a ‘right’ way to conceptualise culture.

10. The literature reflects that organisations do not always have a single unified culture. The literature discusses the role of sub-cultures and sub-cultural diversity. This includes by department, ward, specialty or occupational group. The role of sub-cultures within organisations is important in the context of regulation. It suggests that what works for one sub-culture may not work for another.

11. Across health and adult social care there are variations in culture. Several pieces of evidence describe the complexity of culture. They highlight that there is no single ‘best’ culture leading to successful outcomes. The role of context in culture is also highlighted, including internal and external contextual factors.

The role of culture in improvement

12. Culture is described by literature sources as a key element, or even a prerequisite, of quality as well as improvement. There is some evidence on the relationship between culture and improvement. But, some literature sources highlight significant gaps in understanding how culture and improvement are linked.

13. That said, there are a number of key findings around the role of culture in improvement:

- Improvement cultures are cyclical in nature. The conditions needed for a good improvement culture to develop are closely related to the characteristics of what a good improvement culture should look like

- Culture is multifaceted in nature. There are different characteristics that work together to drive improvement
- The development of an improvement culture relies on commitment, consistency and sustainability. Its development is a long-term process, rather than a short-term fix or intervention.

Characteristics of a good improvement culture

14. The characteristics of good improvement cultures have been categorised into five key themes. These relate to both health and adult social care settings.

- Reassurance and safety:
  - An environment where individuals can raise concerns without fear (i.e. 'psychological safety')
- Quality and effective:
  - Empowering and engaging with staff and having mechanisms in place to support staff engagement
  - Supporting teamwork and collaboration, and strong interpersonal relationships between individuals
  - Impact is measured and assessed
- Caring and person-centred:
  - Commitment to compassion, civility, respect and person-centred care
  - Involving people in improvement efforts
- Learning organisations:
  - Encouraging collective problem solving
  - Encouraging learning, in terms of learning from mistakes, and supporting evidence based learning
- Leadership:
  - Compassionate, diverse and inclusive leadership
  - Open, honest and transparent leadership
  - Facilitating mutual trust between leadership and staff
  - Leadership buy-in and championing of improvement.

Key findings: development of improvement cultures

15. The evidence identifies a range of conditions required for a good improvement culture to develop. It also identifies barriers to its development. The findings reveal that conditions

do not stand alone. They work in conjunction to create (or inhibit) an environment in which a good improvement culture can flourish.

16. These conditions can be categorised into four key themes, as presented below.

Leadership

17. Having a consistent and stable leadership or leadership team is a key enabler to improvement. However, a change in leadership can act as a catalyst to driving improvement. Other enablers include:

- The development and communication of a clear vision and direction from leadership
- Identification of a clear rationale for change
- A cohesive and aligned leadership team.

18. There is no consensus regarding the most effective leadership structure. One study argues for a non-hierarchical approach. Another reports the facilitation of an improvement culture through top-down leadership. Further structural enablers for improvement cultures identified include devolved leadership structures, effective utilisation of middle management, and involving clinicians in leadership.

19. Leadership behaviours also influence improvement cultures. Enablers to improvement cultures include:

- The visibility of leadership within settings
- Leaders who proactively invest time to listen to and engage with staff.
- Leadership which is open to innovation and experimentation by frontline staff.

20. The inverse of the enablers are considered barriers to improvement cultures.

Engagement

21. Staff engagement is a key influencing factor in the development of improvement cultures in the literature. Key mechanisms to enable staff engagement include:

- Involving staff in strategy development
- Inviting staff to regularly participate in senior management meetings
- Encouraging staff to contribute to improvement initiatives
- Collecting data on staff needs, ideas and suggestions
- Allowing adequate time for staff to adjust to the ‘new direction’ of an organisation

- Creating an environment in which staff feed valued, respected and supported by senior management.

22. The use of incentives to enable staff engagement is also highlighted as a key enabler.

23. Involving people who access services and their families is also identified as an enabler to improvement cultures. Listening to the voices of people reveals improvement gaps. Mechanisms for involvement identified include:

    - Developing specialist patient councils, residents' forums or frequent listening events
    - Training people in quality improvement methodologies.

24. The evidence base recognises a link between a focus on internal and external partnerships and relationships, and a positive culture for innovation. Multi-disciplinary teams, interprofessional teams and an effective skills mix enable improvement cultures. Siloed working limits the ability to embed improvement into organisational culture.

Capabilities and capacity

25. The availability and quality of training for staff is a key enabler to improvement cultures. Examples cited include:

    - Specialist training or coaching around cultures of improvement
    - Bringing in external support for training and development
    - Enabling staff to share best practice and learning.

26. Having processes in place to support consistent and meaningful training is key.

27. The literature also highlights the importance of leadership skills and ability. These can drive forward cultures of improvement.

28. Some literature highlights the influence of quality improvement approaches on improvement cultures. This includes LEAN management thinking. These methodologies enable improvement cultures through providing a structure to delivering improvement. However, other literature saw quality improvement methodologies as a barrier to embedding improvement. For example, quality improvement methodology can lead to the perception amongst staff that they are being monitored.

29. Measuring and assessing an improvement culture is identified as challenging. But, there are multiple ways of measuring change which can help settings to understand whether they are making progress. This includes:

    - Benchmarking key indicators
    - Drawing on people's views and feedback

- Using readily available diagnostic or self-assessment tools.

30. The evidence highlights that the time and space to engage with quality improvement and innovation activity is a key enabler. Staffing levels and resourcing influence the delivery of improvement cultures. Workforce shortages limit the scope for improvement cultures. This particularly features in literature focused on adult social care settings.

Systems, structures and processes

31. Access to accurate and timely data is identified as key, as is using and disseminating a wide range of data. Where access to data is limited, or the right data is not used effectively, this can pose as a barrier to an improvement culture.

32. Implementing strong quality assurance structures and processes supports the development of improvement cultures. This includes well-structured appraisals. Infrastructure to support communication within organisations also supports improvement cultures. This enables shared learning, openness and transparency.

33. General resistance to change is a significant barrier to improvement cultures. Aligning the development of improvement cultures with existing processes, infrastructure and policies is highlighted in the literature as offering mitigation to this issue. It is also an enabler in its own right.

34. Regulation can provide a significant rationale for change. It can contribute to a clear direction and vision for settings, enabling improvement cultures. However, regulation of services can also be a barrier. It can contribute to a culture of compliance and over-reliance on central guidance, stifling innovation.

Key findings: outcomes of improvement cultures

35. Overall, there is a positive association between 'good' culture and 'good' outcomes. The literature identifies a range of outcomes associated with good improvement cultures.

- Service performance:
  - Improvements in service productivity (e.g. "working smarter")
  - Improvements to workload management and reduced unnecessary referrals
  - Increasing responsiveness of services. Staff are able to respond more accurately and quickly to situations as they occur
  - Reduced waiting times
  - Improved recruitment and retention, and reduced reliance of external staffing agencies
- Quality of care:
  - Reduced mortality rates

- Lowering of aggressive behaviour, reduced use of restraint and sedation, reduction in incidents relating to physical violence
- Reduction in mistakes, including medication errors
- Improved technical practice (e.g. observation processes, surgical techniques, compliance with safety checklists)
- Increased direct care time
- Improved ability to learn from incidents, recalls and alerts

- Experience of people who access services:
  - Improvements in staff bedside manner, including treating service users with dignity and respect
  - Improved engagement of people in planning their care
  - Improvement in people's access to appointments
  - Implementation of a more relaxed environment, reducing agitation
- Staff skills, knowledge and experience:
  - Improved staff skills and knowledge, via knowledge sharing activities
  - Improved communication with staff
  - Improvements in staff morale and motivation
  - Improved staff experience, as a result of feeling listened to and valued
  - Improved staff satisfaction
  - Improved staff engagement
  - Improved staff wellbeing or psychological health
  - Improved employee retention
- System change:
  - Increased integration between services (e.g. primary and tertiary care)
  - Improved collaboration between services
- Other outcomes:
  - Improved ratings (as assessed by regulators)
  - Increased external recognition of good practice
  - Financial benefits.

36. However, there is some evidence in the literature of cultural change leading to negative outcomes, or to few or no benefits. The literature comments on the difficulties in demonstrating impacts of culture change programmes. It calls for high quality research into associations between organisational culture and outcomes.

Conclusions and considerations for CQC

37. The findings from this rapid literature review provide relevant insights for CQC. The implications for CQC, and the possible areas for consideration, are set out below. The key considerations below are thematically grouped. There is no significance in their ordering.

Regulatory functions

- Viewing improvement holistically is important. Multiple different elements of ‘good’ culture need to be in place for improvement to be achieved and sustained.
- Both espoused and ‘lived’ culture are key. Any disconnect between espoused and experienced culture may indicate disfunction (although it could also indicate early evidence of change). This could perhaps be something to identify and explore.
- The evidence highlights the importance of sub-cultures. Exploring cultures at organisational, department and team levels, and across shift patterns, is likely to prove key.
- CQC may wish to assess and inspect for evidence of an environment where people feel they can speak up and that their voice will be heard. They may also wish to frame messaging to ensure regulation isn’t perceived (and doesn’t serve) to stifle innovation.
- It is important to monitor and assess the extent to which services effectively capture and utilises people's voices.
- Training and support for people to be involved in co-production and service improvement activities is a key enabler. CQC may have a role to play in sharing examples of good practice in this regard. CQC could also inspect and assess for this as part of its regulatory function.
- CQC may wish to consider how staff empowerment and influence are captured as part of the assessment process. CQC could consider sharing examples of good practice.
- Developing an improvement culture takes time. Therefore, ensuring realistic expectations, including identifying expected interim outcomes, may prove useful. A logic model or theory of change could support this.
- Wider factors can support or inhibit improvement. The literature reveals that culture, whilst a critical enabler, is not the only factor that leads to improvement. Understanding the wider drivers and influences will be key to understanding an organisation’s culture and its progress towards improvement. It also may enable CQC to further support settings.
- The role of organisational, departmental and team leaders in encouraging, driving, modelling and enabling improvement is evident in the literature. Identifying the extent to which this is in place, as part of regulatory activity, would perhaps prove useful.

Influencing role

- Setting out clearly what CQC defines as an improvement culture within health and adult social care, may help to provide clarity and direction to the sector.
- Consider how CQC colleagues can communicate the cultural behaviours sought from health and adult social care settings. CQC could explore and promote examples of where top-down and bottom-up culture setting are both implemented successfully.
- CQC may wish to consider its own relationships at a local and national level. The literature reflects that to support improvement, the relationship between national bodies and providers should reflect the relationships present in a good improvement culture between leaders and their staff. Namely, supportive relationships demonstrating trust.
- CQC (and others) may wish to consider the role of education providers and supervisors in influencing the culture of the future workforce.
- CQC's forthcoming role in assessing ICS's may be worth reflecting on. The literature demonstrates the importance of effective, active collaboration at a local level. CQC may wish to explore how best this can be encouraged and good practice shared.
- Others may benefit from the findings of this review. CQC may wish to consider how (and to whom) to share the findings.
- There are gaps identified through this review. Notably, the comparative lack of evidence around improvement cultures in adult social care settings. CQC may wish to consider whether (and if so, how) to address the identified evidence gaps.
- The evidence indicates a need for realism as to how far CQC can influence or encourage improvement cultures in settings it regulates. Reform and improvement are more likely to be achieved through commitment and investment in staff, rather than a focus on compliance. This indicates that CQC may also wish to consider how it exerts its influence.

1. Introduction and background

Background and context

1.1 The Care Quality Commission (CQC) is the independent regulator of health and social care in England. CQC make sure health and social care services provide people with safe, effective, compassionate, high-quality care and encourage care services to improve.

1.2 In May 2021, CQC published a new strategy for the changing world of health and social care[2]. The strategy aims to make regulation more relevant to the way care is now delivered and more flexible to manage risk and uncertainty. It will enable CQC to respond in a quicker and more proportionate way as the health and care environment continues to evolve. The strategy sets out CQC ambitions under four themes:

- People and communities
- Smarter regulation
- Safety through learning
- Accelerating improvement.

1.3 CQC aims to use its unique position in the health and adult social care landscape to raise awareness of areas that need to improve and that need additional support. In order to achieve these strategic aims, it is therefore important to better understand what underpins good improvement cultures, how these develop and how CQC can best support and drive improvement through their regulatory mechanisms.

1.4 To support this, CQC commissioned SQW (an independent research consultancy) and their subcontractor the Kings Fund Library Service in December 2022, to deliver a rapid literature review into improvement cultures in health and adult social care settings.

This report

1.5 This report presents findings from a rapid evidence review into improvement cultures in health and adult social care settings. The review aims to inform CQC's approach to assessing and encouraging improvement, improvement cultures and improvement capabilities of services, while maintaining and strengthening CQC's regulatory role. It also identifies gaps in the current evidence base (i.e. the body of literature focused on improvement cultures).

1.6 The following research questions were determined by CQC and have underpinned the review. The research questions are split into three themes: the scope and content of the

[2] A new strategy for the changing world of health and social care (cqc.org.uk)

available literature; the findings from the available literature; and the implications of these findings for CQC.

Table 1-1: Research questions

Theme	Questions
Scope and content	• What existing research has been undertaken/evidence generated? How does this vary across sectors and settings? • What gaps exist in the literature/evidence base?
Findings	• What is the role of culture in improvement in health and adult social care? • What are the characteristics of a good improvement culture within health and adult social care? Does this vary across different settings/contexts? • What conditions are needed for such a culture to develop? • What barriers/challenges exist to good improvement cultures? How have these been overcome? • What is the evidence that the 'right' culture leads to improvement? What is improved – e.g. quality, safety, staff morale etc.?
Implications	• How can existing research/evidence be used to inform CQC's assessment of improvement cultures? • How can the CQC encourage the development of good improvement cultures in health and adult social care?

1.7 This report presents the key insights from the literature in relation to each of the research questions.

Report structure

1.8 The report is structured as follows:

- Chapter 2: Methodology
- Chapter 3: The evidence base
- Chapter 4: Key findings: Improvement cultures, reflecting on findings around the role of culture in improvement and the characteristics of a good improvement culture
- Chapter 5: Key findings: Development of improvement cultures, presenting findings around the conditions needed for an improvement culture to develop and the barriers/challenges in place
- Chapter 6: Key findings: Outcomes of improvement cultures, reflecting on findings around what is improved as a result of an improvement culture
- Chapter 7: Discussion of review findings
- Chapter 8: Considerations for CQC.

1.9 A bibliography of the documents reviewed, the literature search protocol, call for evidence briefing note, and acknowledgements of the individuals and organisations involved in this research study, are included as annexes.

2. Methodology

2.1 This section describes how the rapid literature review was conducted to align with the specification set by CQC. It details both the process used to search for and identify relevant evidence, and the analytical framework applied during the review of that evidence.

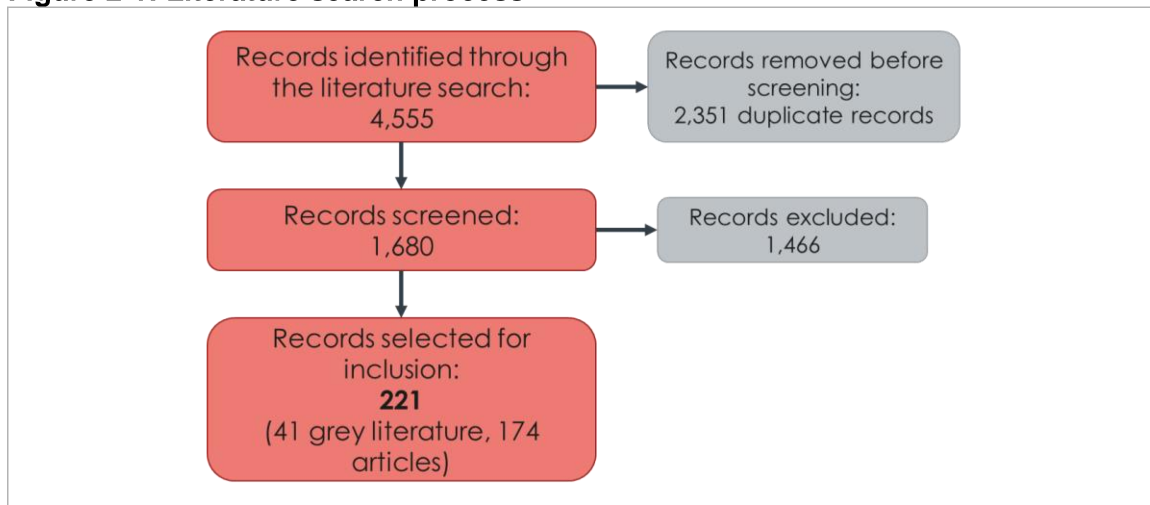
Literature search and call for evidence

2.2 The review commenced with a rapid scoping phase, comprising a rapid review of publicly available documentation and six scoping consultations with individuals from CQC. This phase informed the development of the search protocol for the study (see Annex B) and helped to further refine the study parameters. The parameters determined what geographies should be focused on, how far back in time the search should go, and what types of document should be included. It also detailed a set of search terms to be included, covering:

- Terms synonymous with improvement cultures (e.g. 'culture' 'quality improvement'), as identified during the scoping phase
- Health and adult social care settings in which improvement cultures may exist
- Terms synonymous with change, impact or benefit
- Characteristics associated with improvement cultures.

2.3 The King's Fund Library Service undertook the literature search in accordance with the search protocol agreed by CQC. This involved a search across 11 databases and four websites, to identify literature (including grey literature) which aligned with the specified parameters. In total, 4,555 pieces of evidence were found, of which 2,351 were duplicates, and 1,466 were subsequently excluded as they did not align with search protocol parameters. This resulted in 221 records.

Figure 2-1: Literature search process



Source: Kings Fund Library Service

2.4 This literature search was supplemented by a call for evidence issued to key stakeholders identified by CQC, which yielded an additional 33 documents. Stakeholders identified for the call for evidence were contacted by individuals within CQC using a call for evidence briefing note developed by SQW (see Annex C). Stakeholders included other regulatory bodies in the UK, national agencies (e.g. NHS England) and academic/voluntary and community sector organisations focused on improvement and/or culture change in health and adult social care.

Literature review and analysis

2.5 The literature search and call for evidence returned a total of 254 potentially relevant documents. These were compiled into MaxQDA software to enable a systematic extraction and coding process. A three stage review of the literature was then undertaken by SQW, using an inclusion/exclusion framework. This comprised a title sift, abstract sift, and full text review.

Title and abstract sift

2.6 SQW reviewed the titles of the 254 potentially relevant documents; documents clearly out of scope for this study were excluded. Reasons for excluding documents during the title sift were:

- Date of publication (with documents excluded if they were published before 2015)[3]
- Geographical coverage, with documents excluded if they were based on countries where findings would be less transferrable to the English context (including the USA)

[3] This exclusion criteria was loosened following review of the title sift outputs, see overleaf for details.

- Scope (i.e. the focus did not align with the research questions)
- Recommended for exclusion for other reasons (e.g. duplication).

2.7 The results of this initial title sift were shared with CQC for review. Based on CQC's review of the titles, 12 documents of interest that had been discounted on the basis of being published pre-2015 were subsequently included in the abstract sift.

2.8 Based on the title sift, 122 documents were taken forward to abstract sift stage. SQW reviewed the abstracts of these documents and coded each against the following themes:

- Geography
- Type of health and adult social care setting
- Research question alignment
- NESTA standards of evidence[4]

2.9 CQC determined 40 documents were suitable for full text review, with a further 34 documents added to a 'reserve' list.

Full text review

2.10 A more detailed coding framework was used to extract relevant evidence from the full text of the selected 40 documents. This coding framework was developed to align with the research questions, and sought to identify findings which focused on:

- The role of culture in improvement in health and social care settings
- Characteristics of good improvement cultures
- The conditions needed for a good improvement culture to develop, and barriers to improvement cultures being developed in health and social care settings
- Evidence of improvements made as a result of a good improvement culture.

2.11 The coding framework also included additional codes, for example relating to methodology underpinning each document, and any limitations. This process identified the key findings presented in the following chapter of this report.

2.12 During the full text review, four documents were subsequently excluded (due to duplication, geographical coverage). Therefore, four additional documents were added to the review from the reserve list, following selection and agreement by CQC.

[4] Standards of evidence.pdf (nesta.org.uk)

Key considerations and caveats

2.13 When reading this report it is important to keep the following methodological considerations in mind:

- This study was delivered over a relatively short timescale (December 2022-March 2023). The budget and timescale parameters meant that no more than 40 documents could be fully reviewed. Other relevant evidence identified for the 'reserve' list may have yielded useful insights, but it was not possible for SQW to review additional documents within study parameters.
- The volume and depth of evidence varies across different parts of health and adult social care. This was anticipated at the outset, and findings from 'underrepresented' sectors/sub-sectors have been specifically drawn out in this report where appropriate. This includes adult social care, for which there was relatively little evidence compared with health care. Gaps in the evidence and associated limitations are explored in the next and final sections of the report.
- Specific illustrative examples have been presented where relevant throughout the next section of the report. These have been identified to illustrate examples from the literature, and should not be interpreted as the only specific examples identified through the review.
- The terminology used within this report to describe those accessing health and social care is varied within the literature. Throughout this report, those accessing health and social care are referred to as 'people', rather than terminology including 'patients', 'service users' or 'residents' (unless directly quoted from a literature source).

2.14 The review has drawn on evidence from England and countries with comparable health and adult social care sectors, including Canada, Australia and New Zealand, as well as Europe and other parts of the UK.

3. The evidence base

3.1 As outlined in Chapter 2, this report is based on a full review of 40 documents related to improvement cultures. Based on the Nesta Standards of Evidence framework[5], the overall quality of the evidence base is fair. Over half of the documents (22) were classified as Level 2 against the Standards framework, citing correlational evidence such as interviews, focus groups, questionnaires and surveys. A further two documents presented narrative evidence, so were classified as Level 1. Of the remaining documents, five were reviews of literature and so were not classified, and the remainder were unclear.

3.2 There were no documents classified as Level 3 or above. This limits the extent to which categoric judgements can be made about the impact of a good improvement culture on outcomes such as quality of care, service performance and staff skills and knowledge.

3.3

3.4 Table 3-1 provides an overview of the evidence base in terms of year published, geography and setting. While this demonstrates that the evidence used within this report is recent, broadly relevant for the health and adult social care context in England, and spans a range of settings, it does raise some limitations in the literature. Specifically:

- **Evidence from adult social care settings** – only five of the 40 documents incorporated into the full text review focused on adult social care, of which one was published by CQC itself. A further four documents were identified through the abstract sift, although these were excluded from full text review. The findings from this review should therefore be interpreted with some caution when considering relevance and strength of evidence within this sector.
    - It is important to note that while this rapid review only found a handful of relevant documents focused on adult social care, it does not mean that this literature does not exist, only that it was not uncovered within the parameters of this search.

      Findings from this review have been presented thematically, bringing together common themes from across settings. This means that findings are broadly transferrable, including from health to adult social care settings, and vice-versa.
- **Breadth of evidence across health** – while there are six specific healthcare sectors identified in the literature, most of the documentation on healthcare either did not specify a type of setting or spanned multiple setting types. There was also limited evidence around improvement cultures across partnerships or systems, such as ICSs. In addition, there is insufficient depth of evidence within any of the six specific sectors to draw robust conclusions and comparisons which are setting specific. Therefore, while differences are drawn out where possible in this report, there is limited evidence

[5] Standards of Evidence: an approach that balances the need for evidence with innovation. (no date). [online] Available at: https://media.nesta.org.uk/documents/standards_of_evidence.pdf.

of variation in improvement cultures and their underpinning characteristics across different types of settings.

Table 3-1: Overview of the evidence base

Feature	Details across the 40 documents reviewed in full
Year published	Six documents were published pre-2015. 20 documents were published between 2015 and 2019. 12 documents were published from 2020 onwards. Two documents had no date.
Geography	24 documents presented evidence from England. Seven documents presented evidence from the UK. Nine documents presented evidence from a comparable country, including Canada, Australia, Norway and Portugal.
Setting	31 documents focused on healthcare. Specific settings included general practice, dentistry, urgent care, ambulatory care, mental health and surgery. Five documents focused on adult social care. Specific settings included residential care and domiciliary care. Four documents did not identify a setting. With regards to scale, 14 documents focused on one setting whilst 11 focused on multiple settings.

3.5 In addition, while we have attempted to do so in this report based on the evidence reviewed, defining improvement cultures is challenging, with different interpretations and descriptions used in different sources of evidence. The terminology can be varied, with close links to phrases such as quality improvement or learning cultures. Therefore, the evidence base used in this report has a considerable focus on improvement, given the availability and quality of existing literature around this subject. While this report attempts to unpick findings around improvement cultures specifically, often the two are inextricably linked within the evidence. This report should be read with this in mind. We reflect on the implications of this in Chapter 8.

4. Key findings: Improvement cultures

4.1 This section sets out the evidence around how culture is defined, and how it may vary across different contexts or settings. It then explores the role of culture in improvement within health and adult social care settings. The section then presents the key characteristics of an improvement culture, as discussed in the evidence base.

Defining culture

4.2 Despite its common use, the term 'culture' (referring to organisational culture) does not have a universally accepted definition (Willis et al., 2021).

4.3 Several literature sources provide their own unique definitions of culture, with the most common elements referring to the **shared values, goals, beliefs, attitudes, assumptions and behavioural norms underpinning organisational life** (Apekey et al., 2011; Benjamin and Chung, 2022; El Chamaa et al., 2022; Firbank, 2010; Dixon-Woods et al., 2014; Mannion, 2022).

4.4 Importantly, culture is described as being shaped by "*everyday actions of every individual*" within an organisation (Bailey and Bevan, 2017).

4.5 The evidence base also contains **two frequently cited two definitions of culture**. The first is relatively colloquial: "*the way things are done around here [within the workplace]*" (Dixon-Woods et al., 2014; NHS Institute for Innovation and Improvement, 2005). The second on the other hand is a more elaborate definition provided by Schein: "*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 – that has worked well enough to be considered valid and therefore to be taught to new members as the correct way to perceive, think and feel in relationship to those problems*" (Mannion, 2022).

4.6 There are several key theoretical conceptualisations of culture depicted in the literature:

- **Schein's three levels of organisational culture**: (i) visible manifestations, or the surface-level attributes of the physical and social environment that are immediately perceivable within an organisation; (ii) shared ways of thinking, including the values and beliefs that guide and are used to justify behaviours; and (iii) deeper shared assumptions, which are largely unconscious and unexamined and underpin day-to-day practices (Mannion and Huw, 2018).
- **Corporate culturist vs interpretive approaches**: In the corporate culturist view, culture is an attribute, or "*something that an organisation has*", which can be influenced by purposive management decisions (Mannion, 2022; Firbank, 2010). By contrast, the interpretive approach views culture more holistically, as "*something that the*

organisation is", which arises spontaneously from social interaction and cannot be isolated or easily influenced (Mannion and Huw, 2018).

- **Espoused culture vs culture in practice**: Several authors draw attention to the distinction between espoused culture, as codified in official documentation such as mission statements or corporate brochures, and culture in practice, which is created by employees and experienced by people on a day-to-day basis (Mannion, 2022; Firbank, 2010).
- **Cultural typologies**: Three literature sources mentioned typologies of organisational culture: the competing values framework (Armstrong et al., 2019), Quinn and McGrath's 1985 framework (Firbank, 2010) and Handy's four corporate cultures (Rodgers and Antony, 2021). These were not, however, present in other pieces in the evidence base.

4.7 The range of conceptualisations of culture identified within the literature indicates that there may not be a 'right' way to conceptualise culture. For CQC, this suggests that multiple interpretations should be considered in attempting to regulate, monitor and assess improvement cultures.

4.8 Crucially, organisations do not always have a single unified culture; the literature discusses the **role of sub-cultures** and **sub-cultural diversity**, patterned by department, ward, specialty or occupational group (Mannion, 2022). In his typology of organisation sub-cultures, Mannion differentiates between *enhancing subcultures*, which can develop in specialist work teams or units that adhere more closely to the dominant organisational culture than the rest of the organisation; *orthogonal sub-cultures,* arising in subgroups whose members subscribe to both the dominant organisation culture and enact their own professional values; and *countercultures*, espousing values that overtly or covertly challenge the dominant organisational culture.

4.9 The role of sub-cultures within organisations is important in the context of regulation. It suggests that what works in enabling and supporting an improvement culture may not be universal, and what works for one sub-culture may not work for another. Capturing this complexity is likely to be challenging, but important in considering the extent to which a good improvement culture (or cultures) exists within an individual setting.

4.10 The evidence base also examines several factors external to an organisation, which impact on its internal culture. For example, different healthcare professionals are **socialised into different professional cultures** through training and early professional education (Mannion, 2022). Moreover, **public opinion, media reporting and regulatory frameworks** can exert an influence on organisational culture, as can **national, ethnic or religious cultures** of international staff (Mannion and Huw, 2018).

4.11 Finally, **culture was described to reflect what has worked well in the past** (NHS Institute for Innovation and Improvement, 2005). Successful explanations and solutions to various health or adult social care challenges are likely to be considered the best way to

respond to similar challenges in the future. As such, these approaches start to become part of a team culture.

Variations in culture across health and adult social care settings

4.12 Across the health and adult social care space there are inevitable variations in culture across settings with different processes, personnel and environments. Several sources in the literature base described the **complexity of culture**, with Mannion emphasising the fact that **there is no single 'best' organisational culture associated with successful outcomes** (Mannion, 2022).

4.13 A key aspect of culture is **context**. Silver et al. illustrate different levels of context (2016):

- The *external environment* refers to community and society, including socioeconomic and political forces
- The *macrosystem* is the organisation in which improvement work occurs, touching on key factors such as senior leadership and organisational experience
- The *mesosystem* refers to the major divisions and interactions within the macrosystem, such as the departments, laboratory services and health information technology
- The *microsystem* represents the frontline units where care is provided; important factors include local leadership, the motivation to change and improvement team dynamics.

4.14 These different elements of context interact with quality improvement or other cultural change interventions (Silver et al., 2016). As such, **efforts to make change must take into account the unique attributes of an organisation**. In the context of CQC, efforts to regulate change must also consider the varying contexts and environments present within an organisation or setting.

4.15 The evidence base contains **many illustrative empirical examples of variation in culture across healthcare settings**. A case study from an acute hospital in the south of England describes two adjacently situated departments whose staff have undergone similar training, hold similar values and maintain a high degree of clinical quality, which nonetheless exhibit very different approaches to the formality of relationships with people (NHS Institute for Innovation and Improvement, 2005). A social network analysis of five participating Trusts revealed stark differences in social connectedness of staff, ranging from close mutual collaboration to many one-directional exchanges (Jones, 2022). Lastly, in their analysis of data from hospital board administrators in Portugal, Dias and Escoval (2015) find varying degrees of organisational capacity to develop and build new knowledge.

The role of culture in improvement

4.16 Culture is described by many literature sources as a key element, or even a **prerequisite, of quality** (Apekey et al., 2021; Mannion, 2022; My Home Life, 2016), **as well as improvement** (Armstrong et al. 2019; El Chamaa, 2022; Firbank, 2010; Jabbal, 2017; Jones 2022; Willis et al., 2016).

4.17 In one literature source, culture is portrayed as a "*substrate on which improvement focused change is being sought*", thus **providing a backdrop to all improvement-related interventions** (Mannion and Huw, 2018).

4.18 Firbank explains that an organisational culture establishes a **"*patterned way of doing things*", which permeates most aspects of organisational life** (2010), or "*get[s] everyone on the same page*" (CQC, 2018, quoting a Non-Executive Director). As such, larger organisation-wide programmes aimed at culture change, as compared to discrete projects focused on specific elements of the service, can ensure that continuous improvement happens at scale and is part of standard ways of working (Jabbal, 2017). By relying on diffusion of norms, culture is described to be a **more effective means of change than "*rules, standards and control strategies*"** (Armstrong et al., 2019).

4.19 Empirical evidence offers further insight into the role of culture in improvement.

- First, Communities of Practice, that were implemented across practice areas in the Alberta Health Services in Canada in order to facilitate its transition to a fully integrated healthcare system, were described to achieve improvement by enabling the flow of information and team members' learning from one another. They were described as **unlocking the wealth of knowledge and talents held by employees** (Auer et al., 2020).
- Additionally, describing intervention which sought to improve staff training processes in psychosocial rehabilitation (PSR), in the Canadian Mental Health Association in Sudbury Manitoulin, Mathewson (2014) purports that a **culture of learning leads to creativity and faithfulness to the values of their care approach**.
- Lastly, a case study of East London NHS Foundation Trust (ELFT), which undertook concerted efforts to change its organisational culture by promoting bottom-up quality improvement and implementing Plan-Do-Study-Act (PDSA) cycles, described how the resulting internal capability allowed the Trust to **pursue a quality journey with increasing independence** (Institute for Healthcare Improvement, 2016).

4.20 Although there is some evidence on the relationship between culture and improvement, one literature source explains that there remain **significant gaps in the understanding of how culture and continuous quality improvement implementation are associated with one another** (Firbank, 2010). Relatedly, Mannion (2022) argues that developing a nuanced understanding of culture's impact is key; specifically, Mannion advocates for

developing an awareness of which components of culture might influence which aspects of performance.

4.21 Mannion (2022) also draws attention to the difficulty in disentangling the direction of causality between culture and quality or performance, as well as improvements to these organisational outcomes. Although there is an increasing focus within literature around how culture affects improvement, the author cautions that performance can drive culture, or that the two are "*recursive, mutually constituted and reinforcing*". This can lead to what Mannion and Huw (2018) describe as "*virtuous circles*", by which high performance contributes to high expectations of future performance, or "*spirals into decline*", where perceived failings engender feelings of demoralisation and resignation.

4.22 It is important to note that culture is not the only factor that leads to improvement. The literature sources identified other factors which can influence improvement. These include: internal factors, like **individual skill, attitudes and, crucially, resourcing**; and external forces, such as **wider governance arrangements or incentive structures, government regulations, market competition and pressure from funding agencies** (Mannion and Huw, 2018; Firbank, 2010). Some of these factors are explored in relation to culture in Chapter 5.

Characteristics of a good improvement culture

4.23 There are limited attempts in the evidence base to *holistically* characterise a good improvement culture in health and adult social care settings. This may link to the gaps (as outlined earlier in this chapter) in understanding how culture and improvement are associated with one another. However, two literature sources did provide an indication of the key characteristics of a good improvement culture, focused specifically on health care settings.

- In their guidance on building and nurturing an improvement culture, the NHS Institute for Innovation and Improvement (2005) highlighted seven features of an improvement culture: patient centredness, belief in human potential, encouragement of improvement and innovation, recognition of the value of learning, effective team working, communication, and honesty and trust. The guidance stated that "*an improvement culture can be judged by the extent to which these aspects are shared and lived by the people within the team*".

- In a paper on the success factors of continual improvement in healthcare, Brandrud et al. (2011) state that the characteristics of improvement cultures reflect the eight domains of knowledge: healthcare as a process, variation and measurement, customer/beneficiary knowledge, leading, following and making changes in healthcare, collaboration, social context and accountability, developing locally new useful knowledge, and professional subject matter.

4.24 The characteristics of a good improvement culture identified through this review can also be categorised by key themes. This is summarised in the table below, and further explored within this chapter, drawing on examples and findings from literature relating to both health and adult social care settings.

Table 4-1: Summary of the key themes emerging regarding the characteristics of good improvement cultures

Key theme	Summary of characteristics
Reassurance and safety	• Providing an environment where individuals can raise concerns without fear of retribution (i.e. 'psychological safety')
Quality and effective	• Empowering and engaging with staff, viewing them as integral to change, and having mechanisms in place to support staff engagement • Supporting teamwork and collaboration, and strong interpersonal relationships between individuals • Ensuring impact is measured and assessed
Caring and person-centred	• Ensuring a commitment to the values of compassion, civility, respect and person-centred care • Involving people who access services in improvement efforts
Learning organisations	• Encouraging collective problem solving • Encouraging learning, in terms of learning from mistakes, and supporting evidence based learning
Leadership	• Having compassionate, diverse and inclusive leadership • Having open, honest and transparent leadership • Facilitating mutual trust between leadership and staff • Ensuring leadership buy-in and championing of improvement.

Reassurance and safety

4.25 The concept of **'psychological safety'** features strongly in the literature as a characteristic of a good improvement culture. Cream et al. (2022) define psychological safety as an environment in which "*people feel comfortable raising concerns and disagreeing*". Individuals are able to question poor practice and say what they feel without fear of retribution, and the emphasis is on identifying system errors as opposed to blaming individuals (Jabbal, 2017).

4.26 The literature outlines a range of examples of ways in which psychological safety is fostered. This includes:

- Staff in an adult social care setting being encouraged to question their own practice (Cream et al., 2022)
- Staff in a primary healthcare setting (dentistry) being encouraged to seek feedback from colleagues (Parker, 2020)

- An NHS Foundation Trust partnering with a local university to create a training programme for managerial staff that embodied the principles of a 'no blame' culture (NHS Employers, 2021).

Quality and effective

4.27 **Staff empowerment and engagement** is the mostly commonly cited characteristic of improvement cultures in the literature. Staff are often closest to complex quality problems and thus are uniquely positioned to identify areas for improvement and contribute ideas (Jabbal, 2017). A good improvement culture is one where staff are viewed as integral to change and there are established mechanisms for staff engagement (West et al., 2021; The King's Fund, 2021), staff are given the freedom to identify opportunities for change (Benjamin and Chung, 2022) and staff are empowered and supported to take on leading roles in effecting change (CQC, 2017). When these elements are in place, staff feel listened to, feel that their suggestions are acted upon and have a sense of shared ownership (West et al., 2021; Willis et al., 2016).

4.28 **Teamwork and collaboration** is prevalent in a good improvement culture. In the context of health and social care, effective teamwork is described to be underpinned by a mutual appreciation for different roles and strong interpersonal relationships (My Home Life, 2016). It was also described by one Foundation Trainee Doctor (interviewed as part of a 2017 CQC study into how eight NHS Trusts had achieved a significant improvement on their inspection ratings) as *"an unspoken camaraderie – almost like being in the trenches – a feeling of 'we're all in it together'"*.

4.29 Willis et al. (2016) explain that efforts to create collaborative interpersonal relationships have the most impact in settings that recognise the value of collaboration, and have considered how staff can engage in such work.

4.30 Jabbal (2017) explains that quality improvement in healthcare (though this thinking also applies to adult social care) requires a systematic approach based, in part, on continuous testing and measurement. The **measurement of impact** is identified in the literature as a characteristic of a good improvement culture. Mannion (2022) and Willis et al. (2016) highlight that qualitative, quantitative and mixed methods approaches can be utilised to measure and assess change in organisational culture. Mannion (2022) states that mixed method approaches are particularly effective as they combine the detailed insights and depth offered by qualitative approaches with the examination of larger sample sizes and breadth provided by quantitative approaches.

Caring and person-centred

4.31 A good improvement culture is underpinned by a commitment to the **values of compassion, civility, respect and person-centred care** (The King's Fund, 2021; Dixon-Woods et al., 2014). Closely linked to the latter, Jabbal (2017) states that the **involvement**

of people who access services in improvement efforts is key. The perspective of these groups should be a central source of intelligence for change programmes; this can ensure that change can be co-produced and genuinely delivers outcomes that matter to the people that use services (West et al., 2021; Jabbal, 2017).

4.32 "*In Your Shoes*" listening events at Mid Essex Hospital Services NHS Trust is one example of people's involvement cited in the literature (CQC, 2017). These events – held after the Trust received a "*requires improvement*" rating from the CQC – were the first step the Trust took to examine organisational culture. The events comprised focus groups with people accessing services, and joint meetings with both people and staff, to explore the levels of service and care being provided at the Trust.

Learning organisations

4.33 A characteristic highlighted in the literature is **problem solving**. Improvement huddles – regular (daily or weekly) 10-15 minute meetings among frontline staff to assess performance and anticipate problems – are one way that an organisations can demonstrate this characteristic. The structure supports the swift correction of problems and shifts efforts from trouble shooting to prevention (Silver et al., 2016).

4.34 Closely linked to problem solving, two types of learning are identified as characteristics of a good improvement culture. These are **learning from mistakes** and **evidence-based learning:**

- Parker (2020) states that it is in the response to mistakes where improvement lies. A good improvement culture looks at a challenging situation with hindsight and asks, *"what happened and what can be learned from it?"*. Organisations that have strong processes for reporting and learning from mistakes demonstrate their commitment to this principle.
- With regards to evidence-based learning, a briefing paper published in 2016 by My Home Life (a UK-wide initiative which aims to improve the quality of life for those living and working in nursing and residential homes) states that positive cultures in these adult social care settings are underpinned by evidence of what makes a good facility. In the context of healthcare, Zamboni et al. (2020) identify evidence-based practice as a core *"habit for improvement".*

Leadership

4.35 **Compassionate, diverse and inclusive leadership** is identified in the literature as indicative of a good improvement culture. The King's Fund (2021) describe this as *"leadership of all, by all and for all"* - leadership that understands and nurtures inclusiveness, promotes equity and values diversity. Armstrong et al. (2019) state that successful organisations with strong cultures of innovation and creativity encourage diversity at all levels through to the boardroom.

4.36 One hospital chief executive interviewed as part of a 2017 CQC study said that *"If you can't be who you are at work, you are not going to give 100%"*. To tackle issues of equality and diversity in their Trust, the chief executive took steps to engage representatives from the British Associations of Physicians of Indian Origin to help the Trust understand the issues that staff from ethnic minorities face.

4.37 A good improvement culture is also characterised by **open, honest and transparent leadership** (CQC, 2017; CQC, 2018). In practice this manifests in leadership that clearly explains the basis for decisions and is transparent about plans for improvement and progress (NHS Institute for Innovation and Improvement, 2005; Jabbal, 2017).

4.38 The presence of **mutual trust** is also noted in the literature. NHS Institute for Innovation and Improvement (2005) state that without mutual trust, improvement cannot take place. This is because managers must be able to trust that staff will use time, space and resources afforded to them for improvement wisely, whilst staff must be able to trust that any improvement activities they undertake will be appreciated and valued.

4.39 **Leadership buy-in,** when senior leaders champion and demonstrate a commitment to quality improvement, is also indicative of a good improvement culture (Jabbal, 2017). The authenticity of leadership buy-in can be determined by the extent to which leaders' actions align with their rhetoric, or in colloquial terms *"practice what they preach"* (NHS Institute for Innovation and Improvement, 2005). In the absence of this commitment there is a risk that any performance gains will be isolated to specific services or care pathways (Jones, 2022).

5. Key findings: Development of improvement cultures

5.1 This section details the conditions required for a good improvement culture to develop, as identified in the literature. It also sets out evidence around the barriers to developing improvement cultures, and, where relevant, how these can be mitigated.

5.2 When considering the enablers and barriers to improvement cultures detailed in this chapter, it is important to note that the literature does not often talk about these factors in isolation. Rather, the evidence indicates that in order for a good improvement culture to develop, **a range of 'conditions' or enabling factors are needed**.

5.3 In addition, a key theme running across the conditions detailed in this section is the importance of **consistency and sustainability of these conditions or enabling factors**, to allow improvement cultures the time to develop. West et al. (2021) illustrate this in their evaluation of the NHS Culture and Leaders Programme:

"'The best Trusts do not finish the programme. Once they get to the end of the process, they start again. The best Trusts never stop.' This comment reflected the view amongst interviewees that there is no 'magic pill' for changing and sustaining high quality care cultures."

5.4 The content is presented thematically in this chapter, focusing on: leadership; engagement; capabilities and capacity; and systems, structures and processes. While findings from both health care and adult social care are evident in all of these themes, as set out earlier in this report, there is less evidence focused specifically on enablers for improvement cultures in adult social care. Where findings relate to adult social care settings, this is explicitly identified in the narrative.

5.5 The findings set out in the remainder of this chapter are summarised in the table below.

Table 5-1: Summary of themes influencing the development of improvement cultures

Theme	Summary
Leadership	
Leadership structures	Having a consistent and stable leadership or leadership team is a key enabler to improvement, although it is noted a change in leadership can also act as a catalyst to driving improvement. Other enablers include the development and communication of a clear vision and direction from leadership, identification of a clear rationale for change and a cohesive and aligned leadership team. The literature outlines varied findings in relation to leadership structures. One study argues for a non-hierarchical approach, but another reports facilitation of an improvement culture through top-down leadership. Further structural enablers for improvement cultures in the literature include devolved

Theme	Summary
	leadership structures, effective utilisation of middle management, and involving clinicians in leadership. Barriers to improvement cultures include a lack of engagement by individuals with their leadership responsibilities, a lack of clear vision or direction (often due to competing pressures and complexity of external expectations) and a lack of accountability.
Leadership behaviours	Enablers to improvement cultures include the visibility of leadership within settings, and leaders who proactively invest time to listen to and engage with their staff. Leadership which is open to innovation and experimentation by frontline staff is also considered an enabler, but balancing this creativity with leadership responsibility to fix problems that prevent staff from functioning well is key. The inverse of the enablers are considered barriers to improvement cultures.
Engagement	
Staff engagement	Key mechanisms to enable staff engagement include involving staff in strategy development; inviting staff to regularly participate in senior management meetings; encouraging staff to contribute to improvement initiatives; collecting data on staff needs, ideas and suggestions; allowing adequate time for staff to adjust to the 'new direction' of an organisation; and creating an environment whereby staff feed valued, respected and supported by senior management. The use of incentives to enable staff and engagement is also highlighted across the literature as a key enabler.
Involvement of people who access services	Involvement of people who access services is considered an enabler to improvement cultures, as listening to people's voices reveals improvement gaps. Mechanisms for involvement identified include developing specialist patient councils, residents' forums or frequent listening events, and training people in quality improvement methodologies.
Partnership working	The evidence base recognises a link between a focus on internal and external partnerships and relationships, and a positive culture for innovation. Multi-disciplinary teams, interprofessional teams and an effective skills mix are noted to enable improvement cultures, whereas siloed working limits the ability for improvement to be embedded into organisational culture.
Capabilities and capacity	
Training and skills	The availability and quality of training for staff is identified as a key enabler to improvement cultures, including implementing specialist training or coaching around cultures of improvement, bringing in external support for training and development, and enabling staff to share best practice and learning. Having processes in place to support consistent and meaningful training is key. The literature also highlights the importance of leadership skills and ability in driving forward cultures of improvement.
Quality improvement approaches	Some literature highlights the influence of quality improvement approaches on improvement cultures in health and social care settings, including LEAN management thinking. Quality improvement methodologies are identified as enabling improvement cultures through providing a structure to delivering improvement.

Theme	Summary
	However, other literature saw LEAN and other quality improvement methodologies as a barrier to embedding improvement into organisational cultures. An example is cited of a quality improvement methodology leading to the perception amongst staff that they are being monitored.
Measurement capabilities	Measuring and assessing an improvement culture is challenging. However, the evidence identifies multiple ways of measuring changes in improvement cultures, to support settings to understand whether they are making progress. This includes benchmarking key indicators, using qualitative data captured from people who access services, and using readily available diagnostic or self-assessment tools.
Capacity	The evidence highlights that the time and space to engage with quality improvement and innovation activity, across all job roles within a setting, is a key enabler. Adequate staffing levels and resourcing also influence the delivery of improvement cultures, with workforce shortages limiting the ability for settings to implement an improvement culture. These barriers are particularly evident in literature focused on adult social care settings.
Systems, structures and processes	
Data accessibility, quality and use	Access to accurate and timely data is key to developing an improvement culture. Using and disseminating a wide range of data is also important. Where access to data is limited, or the right data is not used effectively, this can pose as a barrier to improvement cultures.
Quality assurance and communicat-ion	Implementing strong quality assurance structures and processes is a key enabler to developing cultures of improvement, including well-structured appraisals. Infrastructure to support communication within organisations is also considered to support improvement cultures, by supporting both shared learning and a culture of openness and honesty.
Alignment with existing internal policies and processes	General resistance to change amongst leadership and staff poses a significant barrier to the development of improvement cultures. Therefore, aligning the development of improvement cultures with existing processes, infrastructure and policies already in place in a setting, is highlighted in the literature as offering mitigation to this issue, as well as being an enabler in its own right.
Regulatory systems and processes	Regulation can provide a significant rationale for change and contribute to a clear direction and vision for settings, enabling improvement cultures. However, regulation of services can also be a barrier, through contributing to a culture of compliance and over-reliance on central guidance, stifling innovation.

Source: SQW analysis of reviewed literature

Leadership

Leadership structures

5.6 In addition to being a *key characteristic* of an improvement culture, effective leadership is considered across the literature to be an *enabling condition* for the development of such cultures. The Kings Fund (2021) state that **leadership is the strongest influence on**

culture, and that those in formal 'key leadership roles' are particularly important in influencing the culture of the organisation. Similarly, in their mixed-methods study of culture and behaviour in the NHS, Dixon-Woods et al. (2014) states that observations, interviews and surveys undertaken all emphasise the influence of high-quality management in *"ensuring positive, innovative and caring cultures at the sharp end of care".*

5.7 Having **a consistent and stable leadership or leadership team** is described by multiple literature sources as being a key enabler to the development of improvement cultures (Jabbal, 2017; West et al, 2021; CQC, 2018). In a report on learning from the evaluation of the NHS partnership with the Virginia Mason Institute, Jones (2022) finds that leadership stability plays a crucial role in enabling improvement efforts to *"flourish".* Importantly, they note that alongside stability, leadership teams require experience and expertise. Commenting on the evaluation, the report states:

"The Virginia Mason Institute evaluation suggests that stable executive teams, with experience of how to foster a culture of improvement in complex human systems, are better placed to make the right call (in this situation) than new leaders in challenged Trusts with limited track records of staff engagement and peer learning. Any assessment of Trusts' readiness for improvement must consider the strategic maturity of their executive teams, especially in terms of their approach to staff engagement."

5.8 Interestingly, Jabbal (2017) reports that consistent leadership is important at the *outset* of an improvement journey, but once a critical mass of staff become engaged with improvement, then changes in leadership have less of an effect on the culture of improvement established. In contrast, CQC's 2017 report into driving improvement within eight NHS Trusts finds that **a change in leadership could act as a catalyst to driving improvement**. Mannion (2022) builds on this, noting that *"vestiges of the old culture… can thwart efforts at reform if they hold positions of power*", preventing the development of new values and working practices.

5.9 Barriers to developing effective improvement cultures exist when there is a lack of consistency in leadership, leading to a reduced sense of purpose amongst staff (Jabbal, 2017), and a lack of clarity around expectations (CQC, 2018). Similarly, a **lack of engagement by individuals with their leadership responsibilities** also forms a key barrier to the development of a culture which drives improvement and innovation. In the context of General Practice, Apekey (2011) states that the reluctance of some general practitioners to fully acknowledge their leadership role (as a result of being more concerned with their day to day healthcare delivery), stifles a culture of innovation.

5.10 The **development and communication of a clear vision and direction** from leadership are important factors in the development of improvement cultures identified in the literature. Clearly articulated and communicated direction from leadership (including focused aims and objectives, particularly around care and quality) is considered key to driving improvement cultures (Benjamin and Cheung 2022; Firbank 2010). Dixon-Woods

et al. (2014) report that staff require a clearly articulated vision, including a limited number of explicit goals, to succeed in delivering high-quality and safe care. Jones (2022) agrees with this, noting that if improvement is seen to be something delivered by only a handful of people, it will not enter the *"mainstream consciousness"*. But, if a clear vision around improvement is seen by leaders as being core to an organisation's identity, and as something that will inform how all staff approach their work, then it stands a strong chance of being embedded within organisational culture.

5.11 Conversely, barriers to a continuous improvement culture are experienced when there is no clear vision or direction from leadership in place. Dixon-Woods et al. (2014) reflect on the findings of the 2014 Francis Public Inquiry into Mid Staffordshire, noting that a major problem was the number of different agencies and bodies with a say in the NHS, which contributed to *"fragmentation, multiple competing pressures, ambiguity and diffusion of responsibility"* within the Trust.

5.12 Dixon-Woods et al. (2014) note that a major challenge to creating a unifying vision for improvement, as exemplified in Mid-Staffordshire, is the range, diversity and complexity of external expectations and requirements faced by organisations working within the NHS. The challenge of developing a coherent vision is also experienced in adult social care settings, with Cream et al. (2022) stating:

"One of the biggest and least tangible challenges that shapes how quality improvement is adopted in adult social care is disagreement over what improvement is for."

5.13 Linked to the importance of clear vision and direction in driving improvement cultures, **identification of a clear rationale for change** is also reported to enable culture change towards improvement. Mannion (2022) states that crises can act as a "*trigger*" for significant organisational change. Mannion cited the Covid-19 pandemic as a trigger across systems, resulting in *"rapid swings in organisational norms and established patterns of working".* However, the literature also indicates that crises, or 'burning platform' issues locally, can result in a greater focus on improvement. In its study of the East London NHS Foundation Trust, the Institute for Healthcare Improvement (2016) states that the initial impetus for change was the death of three people over a short period of time in the Trust's care.

5.14 The Institute for Healthcare Improvement (2016) reports that an improvement culture was developed in East London NHS Foundation Trust through a **clear vision coexisting with a very open, non-hierarchical leadership approach**. Letting go of control and supporting staff empowerment for implementing a collective vision were key enablers to improvement. Similarly, Dias and Escoval (2015) highlight a hierarchical leadership structure as a key barrier to innovation and performance, given overreliance on highly standardised (and often bureaucratic) procedures.

5.15 In contrast, Mannion (2022) reports that high-performing Trusts identified in a qualitative study of NHS Trusts are characterised by *"top-down, command-and-control styles of*

leadership" able to express and embody corporate vision. The contrasting findings of both of these studies, undertaken within similar settings, suggest that **clear vision and direction is key regardless of leadership structures**.

5.16 Leadership structures are discussed more broadly within the literature.

- **More devolved structures within settings are championed** by some literature sources. Armstrong (2019) encourages a *"collective leadership approach*", and advocates moving away from overly hierarchical structures to a more flexible and agile organisation to enable improvement cultures. In Willis et al.'s research into sustaining organisational culture change in health systems (2016), it is reported that distributed leadership structures (where responsibility is shared) are central features identified in studies focused on improvement cultures. It is noted that distributed leadership also facilitates the recognition of leadership skills from those who may not actively identify as leaders, and this untapped potential could be more effectively utilised to drive improvement.
- **Effective utilisation of middle management** is also highlighted in the literature. Jones (2022) reports that middle managers *"have been shown to play a critical role in creating the conditions for improvement to flourish in health care organisations*", but are sometimes underutilised and insufficiently trained. This is also identified by Cream et al. (2022), noting that within adult social care settings, middle management has been "*stripped out*" through government austerity measures, depleting the workforce and reducing leadership capacity. This is highlighted as a barrier to improvement cultures.
- **Involving clinicians in leadership** is considered vital to improvement across both health and adult social care literature. Ravel and Kenney (2015, cited in ElChamaa et al. 2022) argue that the most important facilitator to quality improvement is a dedicated clinical leader. CQC (2017), when discussing improvement within a Trust, agree with this, noting that the chief executive of the Trust emphasised the importance of clinicians having *"a vital role in setting the standard of what good looks like".*

Box 1: Extract from Mannion (2022) focused on developing the concept of organisational culture (p.17)

In popular management books, it is often assumed that by using the right strategies, senior management can change, manage, or manipulate organisational culture to beneficial organisational ends. An alternative perspective is that organisational members do not always respond predictably to these efforts. They may even be resistant to top-down efforts to change organisational values, assumptions, and beliefs that underpin ways of working. Since a basic function of organisational culture is to provide a stable and durable platform for a way of living and working, it is small wonder that even modest

changes to a working culture may stall or may perhaps provoke apparently disproportionate reactions of anger and resistance.

5.18 A **cohesive and aligned leadership team** is considered key to enabling improvement cultures. Armstrong (2019) reports that collective and collaborative leadership enables the breakdown of siloes and empowers frontline staff. West et al. (2021) discuss this in the context of a Culture and Leadership Programme, reporting that governance members within health settings should work as an integrated team to offer collective support for the programme. Collective accountability which comes from a cohesive and aligned leadership team is also emphasised as a key enabler to improvement cultures. Furthermore, the Institute of Healthcare Improvement (2016) highlights examples of leadership team members holding each other to account if they are not exhibiting the correct standards of behaviour.

5.19 **A lack of accountability** is reported to be an issue for leaders operating at system level. Discussing this in the context of adult social care settings, Cream et al. (2022) report that a key challenge facing local authority leaders is that (unlike in many cases within the NHS), they do not directly employ the workforce delivering care, and this poses a barrier for system level delivery of improvement cultures.

Leadership behaviours

5.20 The **visibility of leadership** is considered key to enable improvement cultures to develop. In particular, it is highlighted that having a visible leadership team enables a closer working relationship between leaders and frontline teams, and "*translated into a more engaged workforce*" (Jabbal, 2017). However, it is emphasised that visibility needs to be meaningful.

5.21 When reflecting on their findings of a mixed-methods study into leadership practices which enable and inhibit a continuous improvement culture in an NHS Trust, Benjamin and Cheung (2022) state that leaders must be both visible *and curious*, and that without taking the time to listen to and understand issues experienced by frontline staff, visibility could be seen as a "*tick box exercise*".

5.22 Where visibility of leadership is poor, this poses a barrier to the development of improvement cultures. Mannion (2022) discusses this issue in detail, noting that senior management regimes described as remote and disconnected generally have poor improvement cultures. Other phrases used to describe management regimes which do not support improvement include *"clique", "inner circle"* and *"untouchables"*, emphasising the separation between leadership and frontline staff.

Box 2: Extract from CQC's (2017) report into driving improvement within eight NHS Trusts (p.9)

Our case studies point to leadership qualities that really help to drive improvement. Leaders knew they needed to be visible and approachable in order for staff to feel supported. For example, Mid Essex Hospital Services' 'Clinical Tuesday', where all the matrons and lead nurses come and work on the ward, bridging the gap between the management and the ward staff; the meetings where the Chief Executive of University Hospitals of Morecambe Bay (UHMB) takes questions from staff; and the accessible video briefings from the Chief Executive of University Hospitals Bristol.

5.23 Linked to this, **leadership which proactively invests time to listen to and engage with their staff** is linked to enabling staff empowerment and mutual respect (Jabbal, 2017; My Home Life, 2016; The Kings Fund, 2021). In the context of adult social care settings, CQC (2018) identify an "*open door*" approach between leadership and staff, which is considered a key facilitator of a "*listening*" culture and staff engagement, as an enabler to the development of an improvement culture. In the context of health care, Benjamin and Cheung (2022) describe this as the "*linchpin*" of enabling factors for continuous improvement cultures. Citing Halaychik (2016), Benjamin and Cheung go on to discuss the benefits of "*participative leadership*", which is described as a "*human-oriented*" approach which involves staff in decision-making processes within the organisation.

5.24 A review of improvement in nine adult social care services undertaken by CQC (2018) highlights that "*very controlling, top down*" management means that staff, people and relatives do not *"speak out"*. This poor culture forms a key barrier to improving care. Benjamin and Cheung's (2022) study of continuous improvement cultures in an NHS Trust agrees with this. They report that "*not feeling listened to or supported to find the right solution*" is the most frequently occurring barrier to continuous improvement cultures highlighted by staff via interviews and a survey. This led to staff not voicing their opinions and sharing their ideas, despite their closeness to the 'reality' of the work. Dixon-Woods et al. (2014) illustrate this, stating:

"Lack of support, appreciation and respect, and not being consulted and listened to were seen as endemic problems by staff in some organisations."

5.25 A key enabler to improvement cultures outlined in the literature is the **openness of leadership to innovation and experimentation by frontline staff**, which enables staff empowerment and problem solving. Benjamin and Cheung (2022) note the importance of leaders giving their staff space to experiment with their own ideas as a key enabler for the development of a culture of continuous improvement, noting that leadership should not

intervene directly in problem solving, but ask the right questions to support the problem solving process. They reflect that when this is not in place, the resulting frustration from frontline staff poses a barrier to improvement cultures, reducing the level of ideas shared and resulting in staff disengagement. Rodgers et al. (2021) detail this further, stating that even though services in their study of cultures of continuous improvement in Scottish Ambulance Services claimed to have a positive culture for innovation, they found that "*many were more neutral, tending to neither support nor hamper innovation*". It is expected this will limit the ability of teams to be innovative in delivering improvement.

5.26 However Dixon-Woods et al. (2014) reflect on the **need to balance staff creativity and innovation with leadership responsibility to fix problems that prevent staff from functioning well**. In other words, while frontline-led innovation is an important enabler, it will not create an improvement culture alone. Apekey et al. (2011) similarly highlight the importance of achieving a balance whereby creativity and innovation is not stifled, but is not so open as to leave innovation entirely up to frontline staff.

Box 3: Extract from Armstrong et al. (2019) focused on the diagnosis of organisational culture within an NHS emergency department (p.22)

Develop a system for rewarding staff, teams and directorates that recognise creativity and innovation. These reward systems should reward good ideas and assist new ideas being developed and subsequently adopted. Encourage more thoughtfully developed risk-taking and widen organisational diversity to create further opportunities to innovate, by activating the heretics, radicals, disruptors and mavericks within the current workforce, and by balancing the extroverts with introverts within teams. (Too often, there is disconnect within organisations, between the aspiration for radical change and the need to preserve stability and control and the avoidance of risk.)

Engagement and involvement

Staff engagement

5.27 As outlined in chapter 4, staff engagement and staff empowerment are key characteristics of improvement cultures. The literature highlights a range of mechanisms to enable this:

- **Involving staff in strategy development**. In the NHS Culture and Leadership Programme's discovery phase, over 1,500 colleagues were involved in 'designing the culture', helping to develop values and principles for respectful behaviours (Kings Fund, 2021).

- **Inviting staff to regularly participate in senior management meetings** about performance and improvement, which, in the context of adult social care settings, is reported to expose a wider team to quality issues, build staff understanding and increase their ability to lead improvement work (Cream et al., 2022).
- **Encouraging staff to contribute to improvement initiatives** and take ownership of those contributions, described as "*organisational progressiveness*" in adult social care settings by Firbank (2010).
- **Collecting data on staff needs, ideas and suggestions**, for example delivering frequent and meaningful surveys (Armstrong et al., 2019).
- **Allowing adequate time for staff to adjust to the 'new direction' of an organisation.** At the East London NHS Foundation Trust, leaders are reported to have invested a year in engaging with and listening to staff (Institute for Healthcare Improvement, 2016).
- **Creating an environment whereby staff feel valued, respected and supported by senior management** (Jones, 2022) and are given the space and time to foster collegial relationships between each other (ElChamaa et al., 2022). It is important to note while mutual respect is highlighted as a characteristic of improvement cultures, it is also considered a key enabler for further improvement to take place. As Jones (2022) describes of one of the Trusts involved in the evaluation of the NHS partnership with the Virginia Mason Institute:

"One of the first steps on Surrey and Sussex's improvement journey was to make sure that staff were, as Michael Wilson, the Trust's former Chief Executive, put it, 'speaking well of ourselves, well of each other, well of our organisation and well of our community'. Once this becomes the norm, it becomes easier for people to have meaningful conversations about improvement. This exemplifies one of the key themes of the evaluation: that delivering sustained, large-scale improvement first requires a concerted effort to create a positive organisational culture."

Box 4: Summary of Armstrong et al.'s (2019) proposed six steps to help improve staff involvement in achieving successful change within an organisation (p.22)

- Reach consensus regarding the current organisational culture. This research has shown that both the OCAI and Rich Pictures diagnostic tools are helpful in this regard.
- Reach consensus of the desired future organisational culture. Effective staff engagement is crucial at all stages of change, to agree buy-in.

- Determine what changes are required, and what this will mean for affected staff, and remember the ripple effect.
- Identify illustrative stories to help staff understand the journey ahead, and the employer's expectations.
- Develop a strategic action plan. This may include identifying small wins, building coalitions, agreeing accountability arrangements, sharing information, agreeing measurement indicators, explaining why, holding a funeral to celebrate the past and implementing symbolic as well as substantial change.
- Develop an implementation plan. Establishing correct leadership style and set of behaviours will be crucial, the literature review carried out for this research indicates that a kind, compassionate, authentic, humble and collaborative leadership style may be most appropriate within a health-care environment to change organisational culture.

5.28 The **use of incentives to enable staff engagement and empowerment,** and in turn support improvement cultures, is highlighted across the literature, with Dias and Escoval (2015) describing incentives as a powerful change agent.

- My Home Life (2016) states that appreciation from people and their families to staff members in care homes is an important motivator for engagement. Jabbal (2017) also recognises this in the context of health settings, reporting that management recognising achievements and celebrating successes creates a 'virtuous cycle' where recognition of achievements often encourages others to follow suit.
- In their study of barriers and facilitators to the implementation and adoption of continuous quality improvement in surgery, ElChamaa et al. (2022) also outlines that recognition can support engagement with improvement activities. They report that there is some evidence to suggest physicians are more likely to participate in quality improvement efforts "*with documented benefit of academic advancement and professional recognition*".
- Armstrong (2019) advocates for innovation celebration events within organisations and across departments/directorates. In addition to providing a mechanism for recognition, it is also noted that these events enable the sharing of best practice and new learning.
- Willis et al. (2016) highlight a range of financial and non-financial rewards to encourage engagement in improvement activities, including "*salary supports, pay-for-performance programs, specific training opportunities, time-release options, public recognition, or even organized workplace social events*". However, it is noted that

incentives need to be appropriately tailored to the contextual factors and organisational cultures which exist, suggesting rewards and incentives are not one size fits all.

5.29 However, Rodgers et al. (2021) report that the desire for recognition is individualised. This suggests that while recognition and reward may be appropriate for some staff, it may not be so for others; the form of that reward and recognition may also need to vary, or risks achieving inconsistent effect.

Involvement of people who access services

5.30 Involvement of people who access services, in addition to being a characteristic of improvement cultures, is recognised within the literature as an enabler to improvement cultures. In a report on embedding a culture of quality improvement, Jabbal (2017) interviews chief executives of NHS provider organisations, and states that they all highlight the importance of people's engagement in their improvement strategy. It is noted by multiple sources that **listening to people's voices and (more so in the context of social care) their families, reveals improvement gaps**. Brandrud et al. (2011) illustrates this, stating:

"By involving the patient and family, by anchoring the efforts to the leadership and the professional environment, and by utilising the power of the personal ambitions of the people involved, we have an improvement strategy. If everyone has two jobs, making and improving healthcare, we develop an improvement culture."

5.31 The literature also identifies key mechanisms for involvement. These include developing specialist patient councils, care home residents' forums or frequent listening events to establish formalised processes for people's involvement (CQC, 2017; CQC, 2018). Jabbal (2017) specifically highlights that training people accessing services in quality improvement methodologies enables them to more effectively contribute to driving improvement within Trusts.

Partnership working

5.32 Processes in place to support partnership working are also highlighted in the literature as enablers for improvement cultures. In a study on leadership, innovation culture and the uptake of quality improvement methods in General Practice, Apekey et al. (2011) state that most practices reported that a **focus on both internal and external partnerships and relationships supported a positive culture for innovation**. In the context of health care, the literature indicates that strong relations with other local organisations, including suppliers and universities, are demonstrated in the cultural profile of 'high' performing hospitals (Dias and Escoval, 2015; Mannion and Davies, 2018). Dias and Escoval (2015) report that these partnerships enable the development of a systemic approach to knowledge creation, which could contribute to innovation and improvement. In the context of adult social care, CQC (2018) highlight the impact of partnership working on capacity

for improvement in adult social care settings, particularly from local commissioners and health professionals.

5.33 Internally, partnership working is felt to support improvement cultures to develop across settings or systems. Where programmes for improvement are operating in silos, it limits the ability for improvement to be embedded into the organisational culture. The literature also highlights the enabling effects of multi-disciplinary teams, interprofessional teams and an effective skills mix on improvement and "*promoting a positive culture*" (My Home Life, 2016), particularly in terms of improving relationships between staff (Willis et al., 2016).

Capability and capacity

Training and skills

5.34 The **availability and quality of training for staff** is considered a key enabler to the development of an improvement culture. Perhaps unsurprisingly, the literature identifies links between "*improved staff training and development to enhancing or embedding a culture of continuous improvement*" (Rodgers and Antony, 2021). In a study on delivering psychosocial rehabilitation training to staff working within a Canadian mental health service, Mathewson (2014) argues that simply providing staff training was not enough to embed a culture of learning. A coherent programme of training delivered by specialists was developed, which was reported to support a learning culture within the service.

5.35 There are also arguments in the literature for implementing **specialist training or coaching around cultures of improvement**. Armstrong (2019) recommends developing opportunities for frontline staff to receive training in the "*concepts, practices and responsibilities in regard to a culture of safety, quality and service improvement*".

5.36 The literature also highlights examples of **improving capability through bringing in external support for training and development**, which is considered a key driver for improvement. This includes liaising with local training organisations (resulting in increased training frequency for adult social care staff) (CQC, 2018), purchasing organisational subscriptions for online learning programmes (Institute for Healthcare Improvement, 2016), or accessing facilitators to support cultural improvement processes (NHS, no date).

"In the aftermath of the first inadequate rating, Anil employed a consultant to provide oversight and start a change in culture. He explains, "For this, the type of consultant is important, as most consultants look at details and lose sight of the bigger goal. For example he made us define the 'values' of the home."
CQC, 2018

5.37 Enabling opportunities for staff to **share best practice and learning** is also noted to support the development of improvement, both internally and externally.

- As Jones (2022) states in the context of the NHS partnership with the Virginia Mason Institute, a strong culture of peer learning and knowledge sharing is a critical enabler of organisation-wide improvement, and that Trusts should "*prioritise efforts that allow staff to come together on a regular basis to share ideas and learning in an open and respectful way*".
- Hurtley (2017) discusses sharing good practice through developing *"innovative, forward-thinking"* care homes as learning centres, where staff from other care homes can *"seek support and observe good practice"*.
- ElChamaa et al. (2022) also recognise the importance of seminars in giving surgeons the opportunity to share with their colleagues practices they believe "*are important to their exemplary outcomes*".
- Auer (2020) highlights the benefits of Communities of Practice in sharing best practice (in this case, within an organisation) through "*building information pathways*" for timely knowledge sharing between staff. That said, it is noted that often, Communities of Practice are considered a "*time-consuming add on*", limiting their ability to enable change.

Box 5: Extract from the Institute for Healthcare Improvement's (2016) report in building a culture of improvement at East London NHS Foundation Trust (p.5)

East London NHS Foundation Trust leaders also organized a series of visits for their executives to observe other organizations that had implemented QI [quality improvement]. Site visits included Scotland, Salford Royal NHS Foundation Trust, Tees Esk & Wear Valleys NHS Foundation Trust, and Qulturum in Sweden. In addition, three executive directors and about a dozen clinicians attended the 2013 International Forum on Quality and Safety in Healthcare, a large annual conference hosted by the British Medical Journal (BMJ) and the Institute for Healthcare Improvement (IHI).

5.38 Some of the literature emphasises that it is not just access to training that is an enabler to improvement cultures, but also the **processes in place to support consistent and meaningful training.** Jabbal (2017) notes that improvement should align with commitment, rather than compliance, to enable staff to achieve continuous improvement over the long term, as well as in the short term. Where the appropriate conditions for training and learning are not in place, challenges are experienced. Benjamin and Cheung's (2022) case study on a continuous improvement culture in an NHS Trust illustrates this; there was reported to be "*frustration*" amongst staff who had an appetite to "*learn and improve individually and collectively*".

5.39 The literature highlights the **importance of leadership skills and ability in driving forward cultures of improvement.** The requisite skills were outlined by the NHS Institute

for Innovation and Improvement (2005), as presented in the box below. The wider literature both affirms and builds on this assessment, highlighting the nuanced and often intangible skills required from leadership in building a culture of improvement. In the context of adult social care, Cream et al. (2022) emphasise the challenges of leading improvement within complex systems, and highlight the importance of leadership, who can both corral support from staff and have the ability to understand whether a change made translates to improvement. In a health care context, Jones (2022) agrees with this, noting that leaders need to be skilled in selecting, aligning and orchestrating improvement, with an understanding of how change happens in complex systems. Jones elaborates that knowing when to lead, when to engage others, and when to support others, is a particularly important leadership skill in the context of improvement.

Box 6: Extract from the NHS Institute for Innovation and Improvement's (2005) report on building and nurturing an improvement culture (p.32)

Leading a culture change initiative requires a high degree of emotional intelligence and the ability to manage yourself and your relationships with others effectively. This ability is made up of:

- Excellent self-awareness
- Empathy
- Political awareness
- Influencing skills
- Conflict management skills
- The ability to maintain your focus when the going gets tough.

Quality improvement approaches

5.40 A range of quality improvement approaches are identified in the literature. Some of the literature **highlights the influence of quality improvement approaches on improvement cultures in health and social care settings**. This includes **LEAN management thinking**, which is reported to increase staff engagement and improve organisational performance through focusing on a continuous improvement culture (Benjamin and Cheung, 2022). LEAN methodology was integral to the Virginia Mason Institute Programme (as outlined in Jones, 2022), and this approach was considered to have enabled improvement cultures to develop within Trusts. However, the use of LEAN methodology is considered by some literature sources to pose a barrier to embedding improvement into organisational cultures. It is noted that there can be a perceived misfit between the LEAN approach and care of people accessing services, which can affect staff

(and leadership) buy-in (Willis, 2016). This perception aligns with broader critiques of LEAN methodology within the literature, as an approach which is not compatible with "*developing a culture of ongoing improvement and structural problem solving*" (Radnor et al. 2012, cited in Willis et al., 2016).

5.41 Other quality improvement approaches identified to enable improvement cultures include:

- **Listening to Action projects** which are proposed by frontline staff (CQC, 2017, Till et al., 2016), embedding quality improvement in the culture of organisations by empowering staff to take responsibility for improvement
- The Kings Fund (2021) highlight the use of the **NHS England and Improvement cultural diagnostic tool** to understand what was driving the culture at a Trust involved in the NHS Culture and Leadership Programme. It was reported that as a result, subsequent actions were targeted towards the core issues identified.

5.42 Firbank (2010) also reflects that participants in home-care services appreciate being able to **rely on quality improvement methodologies and tools as a structure for delivering improvement**, suggesting that methodologies/tools could enable easier integration of improvement into organisational culture. However, it is recognised that fidelity to a chosen quality improvement approach is 'critical' to sustaining and embedding quality improvement within organisational culture (Jabbal, 2017), and therefore, consistency seems key.

5.43 The literature also outlines instances where the use of quality improvement methods can act as a barrier to the development of an improvement culture. Jabbal (2017) notes that several chief executives contributing to the study of quality improvement cultures said that the use of data-focused quality improvement methods could potentially lead to the perception amongst staff that they were being monitored. However, this was mitigated through adequate engagement of staff to address these perceptions.

5.44 Dixon-Woods et al. (2014) reflect the key challenge of quality improvement methods being seen as a 'quick fix' to solve often systemic issues, which results in abandonment after a short-term burst of intense activity.

Measurement capabilities

5.45 The literature notes that **measuring and assessing an improvement culture is challenging**, with limited instruments, tools and approaches available to do so (Mannion, 2022). It is also recognised that even where measurement is being undertaken, it often takes a considerable amount of time for improvement cultures to demonstrate impact.

5.46 Within the evidence, multiple ways of measuring improvement cultures, or changes as a result of improvement are identified:

- Jabbal (2017) reports seeking the use of a series of **informal indicators** to understand whether initiatives are "*on the right track*", for example qualitative comments from staff, and the demand for training in the specific approaches implemented.
- **Benchmarking key indicators** against similar settings, including the NHS Staff Survey or clinical indicators (The Kings Fund, 2021).
- **Using qualitative data captured from people and their families to assess progress**. The Kings Fund (2021) share an example from Northumbria Healthcare NHS Foundation Trust, who capture real time information from more than 50,000 people each year, including from people who are still in hospital (to feed back immediately to teams), and from following up with people and families at home after care.
- **Using readily available diagnostic or self assessment tools,** such as the self-assessment tool focused on cultures for innovation (developed by NHS Institute for Innovation and Improvement, 2005) or using existing dashboards which present cultural performance of organisations (The Kings Fund, 2021).

Capacity

5.47 A key enabler to developing an improvement culture was reported to be the **time and space to engage with quality improvement and innovation activities**. In Jabbal's (2017) study into embedding a culture of quality improvement, it is reported that several participants felt it imperative that resources be found to ensure staff have dedicated time to engage with training and/or quality improvement activity. It is noted that for some participants, adequate time is the key enabler cited in the success of their quality improvement work. However, the literature highlights the substantial barriers in place across systems and sectors to free up time for engagement. As Rodgers et al. state, "*unless improvement activities are actually built into roles and workloads, there will be no capacity for [improvement] within the organisation*".

5.48 The time and space for leadership to engage with improvement was also considered important for the development of an improvement culture. Jones (2022), when discussing one Trust's experience of the NHS partnership with Virginia Mason Institute, noted that conflicting priorities can be a barrier to improvement, as it can reduce leadership engagement and buy-in. It was noted that in this example, it resulted in the siloed development of improvement work, but little progress made in embedding a culture of improvement across the Trust.

5.49 Importantly, the **time to dedicate to improvement needs to be consistent throughout all job roles**. Commenting on organisational cultures within an NHS emergency department, Armstrong et al. (2019) stated that while some doctors in the department had ring-fenced time in their role to engage with improvement activity, this was not the case for

nursing staff and other professions. They advocated for more consistent dedicated time amongst professionals to be able to access training, and support the redesign of services.

Box 7: Extract from Jabbal's (2017) report into embedding a culture of quality improvement (p.14)

Ultimately, however, most senior leaders mentioned a moment when they fully realised the resource requirements of adopting a quality improvement approach, and had to 'hold their nerve'. One chief executive said:

"*When we started doing improvement workshops, the first time it happened one of my directors said the improvement programme starts on Monday and will take 16 people out of their job for a week. It dawned on me then and I sat in my office thinking, how are we going to cope, without replacing them? And of course, now you just do it. And it just happens automatically, we don't replace anybody and we'll often be running a rapid improvement workshop followed by a Lean for Leaders programme where we've got 40 people on it.*"

5.50 Commenting on adult social care, Firbank (2010) highlights the **impact of resourcing implications on organisations' abilities to deliver improvement cultures**. Firbank reflects on the ability of larger and well established public organisations to tap into a larger pool of resources. In addition, it is noted that the financial position of an organisation influences the extent to which management can free-up staff to engage with improvement activities (including team meetings). However, Firbank reflects that compared with hospitals, adult social care resources (both financially and in terms of the competencies needed to deliver improvement) are limited.

5.51 **Adequate staffing levels** are also considered to be a key enabler to the development of an improvement culture. Cream et al. (2022) comment on ensuring that management capacity is appropriate, highlighting an example of an adult social care organisation introducing a new role specifically to support quality assurance and improvement. In their study of culture and behaviour in the NHS, Dixon-Woods et al. (2014) also report that when staffing levels are perceived to be adequate, it contributes to staff feeling that they could "*complete their work successfully, could explore new ways of improving quality and could develop reflective practices*".

5.52 However, the literature reflects that **workforce shortages** pose a significant barrier to settings having the capacity to develop cultures of improvement. An interviewee working within the adult social care sector reported that the sector needed to recover from the impact of Covid-19 before they could begin to focus on improvement; "*he described staff being tired, many being ill, and how 45 per cent of their care homes had closed*" (Cream et al., 2022).

5.53 Enhanced capacity to develop improvement cultures can also be supported by **drawing on external capacity at varying levels**, from setting level to system level. Cream et al. (2022) reflect on adult social care teams delivering a sector-led approach to improvement,

which "*enabled teams to borrow staff with specific expertise or to access mentoring from colleagues in neighbouring areas*". Cream et al. also reflect that some organisations commissioned paid consultants to provide extra capacity to support their improvement journey, who also acted as "*knowledge brokers*" between different parts of the adult social care system. In their evaluation of the NHS Culture and Leadership Programme, West et al. (2021) also highlight the availability and capacity of an experienced and effective organisation development team within Trusts as a key enabler to ensuring appropriate training for staff, increasing their capacity and capabilities.

Infrastructure, systems and processes

5.54 Having **appropriate infrastructure in place** enables improvement cultures to develop. In a study of culture and behaviour in the NHS, observations identified that staff wasted time working with "*poorly designed IT systems, negotiating clinical pathways with obstructions and gaps, and battling with multiple professional groups and subsystems (e.g. pharmacy, microbiology and imaging, and many others) that did not operate in integrated ways*" (Dixon-Woods et al., 2014).

Data accessibility, quality and use

5.55 Effective systems and processes **to access accurate and timely data** are key to improvement cultures. This includes implementing systems and processes for recording and learning from mistakes, complaints and clinical incidents (Armstrong, 2019; CQC, 2017). In the context of a surgical setting, ElChamma et al. (2022) report that having someone with "*boots on the ground*" within a department with responsibilities for ensuring clinical data are collected both continuously and accurately is a key facilitator to improvement.

5.56 In the context of adult social care, Cream et al. (2022) reflect on the challenges of accessing data as a key barrier to improvement. While they noted that government policy has committed to address the data issue within social care, it remains difficult for adult social care settings to measure change following an intervention to support improvement, limiting its ability to be sustained and embedded into culture and practice. It is also noted that while the sector has developed resources to support benchmarking, it is often difficult for settings to understand where they are doing well, and where they are not. This indicates a barrier for delivering a culture of improvement, if it is not clear where improvement is required and where there is good practice for replication.

5.57 Dixon-Woods et al. (2014) **emphasise that the *right* intelligence needs to be gathered, interpreted and fed back to staff on the frontline**. They note that this intelligence encompasses a wider range of data than mandated measures (e.g. performance indicators), and includes softer intelligence. They describe various ways in which this softer intelligence could be collected including "*active listening to patients and staff; informal, unannounced visits to clinical areas; and techniques such as 'mystery shoppers',*

shadowing of staff, and swapping roles for a short period". Laverty (no date) agrees, noting that data around people's experience in particular motivates staff when good practice is highlighted, and also enables problems emerging to be quickly "*nipped in the bud*".

5.58 Where the right intelligence is not used, or not prioritised, it poses a barrier to improvements being implemented. Jones (2022) highlights that at Shrewsbury and Telford Hospital NHS Trust, one of the Trusts participating in the Virginia Mason Institute programme, the decision to prioritise the preferred improvement targets of influential leaders, rather than following the data and focusing on the Trust's biggest *"burning issues"* led to frustration amongst staff. Dixon-Woods et al. (2014) also highlight the dangers of using data as a "*comfort-seeking*" mechanism, using data to support the narrative that all was well, and leaving 'blind spots' for poor improvement cultures.

5.59 Over-reliance on using national indicators can also reduce the drive towards improvement if settings feel they are "*doing alright*", even if the quantitative evidence does not fully reflect the broader context and issues present within a setting. The Institute for Healthcare Improvement (2016) reflects:

"In the NHS system, the quality assurance program monitors metrics such as levels of C. difficile and MRSA, and whether people are waiting more than 28 days for appointments. If you meet those targets, you get green marks on the dashboard; if you're within 5 percent, the marks are yellow; if you're more than five percent off, the marks are red. "As long as all your targets are green, then you're doing all right," says Warren - at least, that was the message conveyed by the system. And ELFT's [East London Foundation Trust's] targets were nearly all green. But, shaken by the patient fatalities, leaders at ELFT began to wonder if there wasn't a better way to think about quality."

Quality assurance and communication

5.60 Implementing **strong quality assurance structures and processes** is a key enabler to developing cultures of improvement. Willis et al. (2016) reflect that settings with robust measurement and reporting policies may be better positioned to learn from and adapt to change.

5.61 Dixon-Woods et al. (2014) report that higher levels of staff engagement, health and wellbeing, are associated with **well structured appraisals** (including identifying agreed objectives), and ensuring staff feel valued, respected and supported during the process. A range of examples around implementing effective appraisal processes for improvement are identified, including:

- Using appraisals with staff to inform service improvement plans (CQC, 2017)
- Re-defining appraisals as a wellbeing check-in with staff (NHS, no date)

- Implementing peer review processes, giving staff the opportunity to participate as a reviewer and receiver of feedback (Cream et al., 2022)
- Involving staff in evaluating and appraising their superiors (Armstrong, 2019).

5.62 **Infrastructure to support communication within organisations** is considered to support improvement cultures, by supporting both shared learning and a culture of openness and honesty. It is noted that wide internal networks across departments and divisions are 'requisite' to continuous learning, and that knowledge should be communicated efficiently, in a timely manner and honestly (Dias and Escoval, 2015). In its report on driving improvement in adult social care, CQC (2018) highlight an example of honest communication, noting that one agency had implemented regular meetings to review learning from incidents, and staff were sent emails and texts that highlighted the main learning points. It also identifies mitigations implemented in a care home which had previously experienced poor communication processes:

"At the time the home was rated inadequate, internal communications were poor, with staff sometimes receiving mixed messages from managers. This has been addressed in a number of ways; for example, there is a short daily managers' meeting at 10am, the notes from which are posted in staff rooms and fed back through regular team meetings."

Alignment with existing internal policies and processes

5.63 Within the literature it is reported that **general resistance to change amongst leadership and staff poses a significant barrier** to the development of improvement cultures. Mannion (2022) reflects that the more radical the proposed shift, the greater the resistance is likely to be. There are multiple reasons cited for this in the literature, with the Institute for Healthcare Improvement (2016) stating that some staff mistrust the intentions of change. A fear of failure, or being perceived as failing, is also highlighted as a reason for resistance, particularly for leadership. Bartlett et al. (2017) describe this issue as a "*powerful negative mechanism*".

5.64 Therefore, **aligning the development of improvement cultures with existing processes, infrastructure and policies already in place** in a setting, is highlighted in the literature as a mitigation to this issue, as well as an enabler in its own right. Mannion (2022) reasons that organisational change requires a balance between transformation and continuity, noting the challenge is to 'remain faithful' to aspects of a culture which work well, while identifying those which need to be replaced. NHS Institute for Innovation and Improvement (2005) notes that valuable cultural traits likely exist on which new improvement cultures can be built. As Alinsky (1971, cited in Willis, 2016) emphasises:

"A new idea must be at the least couched in the language of past ideas; often, it must be, at first, diluted with vestiges of the past."

5.65 But, as the Kings Fund (2021) outline, trying to 'shoehorn' new programmes of work into existing programmes can impact negatively on culture change. Therefore, a balance needs to be carefully found between the two. That said, Mannion (2022) argues that in some organisations, a realignment of existing structures may act as a catalyst for cultural change, through the impact it has on disturbing established patterns.

Box 8: Extract from The Kings Fund's report on the NHS Culture and Leadership Programme's discovery phase (p.34)

"It can be difficult to engage staff in new pieces of work because there is always so much going on in the organisation, so we linked our culture work to a high profile, visible piece of work that was already embedded. We developed key messages that explained 'what's in it for me' and used these consistently in our communications. This helped our culture work to stand out from the crowd. We delivered messages across the Trust using tried and tested mechanisms but also identified key forums where we could discuss the programme."

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Regulatory systems and processes

5.66 **Regulation of services** is reported in the literature as both a driver for improvement, and a mechanism which can pose a barrier. It is noted that in some settings, the focus on improving ratings provide significant rationale for change, and contribute to a clear direction and vision for the setting (CQC, 2017). However, it is noted that sometimes, the "*naming and shaming*" perceived by regulation may be "*detrimental to attempts by Trusts to develop no-blame cultures in which employees feel comfortable reporting errors"* (Mannion, 2022). It is also noted that regulation can contribute to a culture of compliance and over-reliance on central guidance, which can stifle innovation and progress towards improvement (Ham, 2014, cited in Jabbal, 2017).

5.67 In addition, it is noted that regulation at one point in time is not conducive to the ongoing, cyclical and long-term nature of improvement cultures, as reported in Jabbal (2017):

"One challenge raised by some participants was the 'lack of synergy' between the timeframe and approach of quality improvement programmes, and current national approaches to monitoring and measuring performance in the NHS. This led one roundtable participant to remark that this could be quite disheartening for providers pursuing quality improvement approaches:

'The measurement for improvement piece I think is hugely important. Because this issue of 'We're making real progress in Trust X, but you're not hitting the target, so you're still red rated', is a problem. The more we can get people to think in a language that says, 'How are we seeing improvement over time?' the better.'"

6. Key findings: Outcomes of improvement cultures

6.1 Literature review evidence demonstrates that there is an **overall positive association between 'good' culture and 'good' outcomes** (Armstrong et al., 2019), which a 2017 review found to **hold across multiple studies, settings and countries** in about three quarters of cases (Mannion and Huw, 2018; Mannion, 2022).

6.2 This section explores specific impacts of culture on different types of outcomes, specifically the quality of care; service performance; experiences of people accessing services; staff skills and knowledge; staff experience; system change and communication changes. Examples from both health and adult social care settings are highlighted (although there is comparatively fewer examples of outcomes in adult social care settings, given the relative amount of literature reviewed). It also considers the evidence of unclear or negative impact.

Service performance

6.3 The evidence base contains many examples of culture **impacting service performance**, for example through **boosting service productivity**. An analysis of qualitative interviews with improvement team members implementing Breakthrough Series Collaboratives (six to nine month action-learning programmes that aim to institute a culture of continuous improvement through collaborative learning), finds that the intervention made practical improvements to daily routines such as in the use of forms, checklists and other techniques, which ultimately made it easier to **"*work smarter*"** (Brandrud et al., 2011). Similarly, a literature review of LEAN interventions describes productivity enhancements as one of the most commonly resulting service changes (Jabbal, 2017).

6.4 Relatedly, improvement cultures are found in the literature to be associated with **improvements to workload management.** Both a collective case study of Communities of Practice in Alberta Health Services in Canada and an evaluation of multidisciplinary support teams aimed at cultural change in primary care demonstrate this impact on service performance (Auer et al., 2020; Bartlett et al., 2017). In the case of Communities of Practice, part of this effect was seen to be a result of increased integration between primary and tertiary care, which **serves to reduce unnecessary referrals** (Auer et al., 2020).

6.5 Cultural change is described in several literature sources to **increase responsiveness of services.** In the same multiple case study piece on Communities of Practice in Canada, Auer et al. demonstrate that, by improving information pathways at the point of care, staff are able to **respond more accurately and quickly to situations as they occur, and reduce the time between problem identification and solution generation** (2020). Interview evidence from a domiciliary care agency in Surrey shows that, following

concerted cultural change initiatives, the service became more responsive to the needs of its users (CQC, 2018).

6.6 **Waiting times** are found to be affected by culture-related change. An evaluation of the partnership between NHS and the Virginia Mason Institute, through which Trusts aimed to build cultures of continuous improvement, has shown **improvements in 'process lead time'**, i.e. the period of time between a referral and people's appointment or arrival and departure from a clinic (Jones, 2022). Similarly, case study evidence from Wexham Park Hospital, which underwent cultural change after being taken over by Frimley Park Hospital NHS Foundation Trust, reveals that people are treated more quickly and by the right team (CQC, 2017). Evidence from an evaluation of multidisciplinary support teams aimed at cultural change in primary care shows a similar effect, with people having improved access to appointments as a result of the intervention (Bartlett et al., 2017). Additionally, culture change at the East London NHS Foundation Trust is credited with leading to a reduction in its waiting times from referral to first appointment by 19% (Institute for Healthcare Improvement, 2017).

6.7 Three literature sources identified **improved talent attraction** as a product of concerted culture change. In qualitative interviews, Breakthrough Series Collaboratives team members describe advancements to professional knowledge and organisational reputation as beneficial to recruitment efforts (Brandrud et al., 2011). Furthermore, as detailed in a case study, Mersey Care NHS Foundation Trust was able to increase its workforce by 135% and achieve a **reduced vacancy rate** of 3.5%, which was said to be directly attributable to the implementation of a just and learning culture (NHS Employers, 2021). Finally, the East London NHS Foundation Trust's concerted cultural change was seen to result in a **reduced reliance on external staffing agencies**, due to a reliable supply of local staff (Institute for Healthcare Improvement, 2017).

6.8 Other improvements emerging from cultural change interventions, cited by Auer et al. in their study of Communities of Practice in Canada, are a **standardisation of practice** and fostering of **innovation adoption** (2020).

Quality of care

6.9 Culture change is said to lead to **broad improvement in the quality** of healthcare in several sources (Apekey et al., 2011; Auer et al., 2020; Mannion, 2022) and of social care in one source (My Home Life, 2016).

6.10 Many literature sources touch on the effect of culture on specific elements of care. For example, several characteristics of a good improvement culture are linked to **reduced mortality rates**. Analysis of national staff survey data by Dixon-Woods et al. reveals that higher levels of staff engagement, self-reported support from line managers and perceived opportunities to influence and contribute to improvements at work, are associated with lower levels of mortality (2014); this finding is echoed by similar analysis from a 2015 King's

Fund report (Benjamin and Chung, 2022). Relatedly, mortality rates are cited by Bloom et al. to be favourably correlated with the quality of management practices (Jabbal, 2017). Finally, an early analysis by Knaus finds that, in hospitals with similar levels of funding and staff, and which serve similar populations, the quality of interaction and communication between healthcare professionals led to significant differences in mortality (NHS Institute for Improvement and Innovation, 2017). Two literature sources also provide empirical evidence of culture-related interventions – a harm reduction programme in East London Foundation Trust and LEAN methodologies – on mortality rates (CQC, 2017; Jabbal, 2017).

6.11 Improvement cultures have also been linked to **favourable outcomes in other incident-related metrics**.

- In social care, a literature review on the quality of life in care homes found that characteristics of an improvement culture are associated with quality-of-care outcomes (My Home Life, 2016). Specifically, linkages are drawn between increased participation in decision-making among registered nurses and **lowering of aggressive behaviour**, a 'no-blame' safe environment and **a reduced use of restraint**, and staff training to **lessened use of sedation** and restraint.
- In healthcare, several studies discussed a **reduction in mistakes** (Jabbal, 2017), including medication errors (Institute for Healthcare Improvement, 2017). Furthermore, case study evidence of the East London NHS Foundation Trust has shown a 42% **reduction in incidents relating to physical violence**, with a fall of 85% experienced across six months by the Globe Ward where the initiative originated (Institute for Healthcare Improvement, 2017), as well as a fall in the number of pressure ulcers associated with a **harm reduction** programme in East Lancashire Hospital NHS Trust (CQC, 2017).

6.12 A few literature sources identified evidence of **improved technical practice** among staff as a result of an improvement culture. In an evaluation of the Productive Ward: Releasing Time to Care programme in England, Sarre et al. find evidence of improved **observation processes**, with patient observation audit scores increasing with the number of modules completed by staff (2019). Furthermore, El Chamaa et al. highlight two cases of surgeons who provided anecdotal evidence of **adapting their surgical techniques** based on 'positive deviance seminars' (2022). Finally, in a case study of the Isle of Wight NHS Trust, the chief executive describes how attending human factors training enabled the leadership team to **increase compliance with WHO safety checklists** (NHS, no date).

6.13 Sarre et al.'s evaluation of the Productive Ward: Releasing to Care programme also finds impacts of the intervention on **direct care time**, showing a 1.3% increase in this measure associated with the completion of each module (2019).

6.14 The **ability to learn from incidents, recalls and alerts** is also highlighted as a quality-related outcome of cultural change. In a case study of University Hospitals of Morecambe

Bay NHS Foundation Trust, a ward manager explained how weekly meetings of the executive team, in combination with monthly governance meetings with staff to review incidents, led to improved care of people and safety (CQC, 2017).

Experience of people accessing services

6.15 Several literature sources highlight **positive associations between good improvement cultures and experiences of people accessing services**. For example, in their mixed-methods study of culture and behaviour in the NHS, Dixon-Woods et al. (2014) remark that good staff support and management are directly related to people's experience and satisfaction, whilst in a think piece on improvement in primary care settings (specifically dentistry), Parker (2022) states that a culture of improvement can result in improved customer service.

6.16 One paper identified the association between higher levels of staff engagement and **improvements in staff bedside manner,** which in turn translated into people reporting that they were treated with **dignity and respect** (Benjamin and Chung, 2022). Improved feedback from people accessing services is also cited in the case study of Leiston Old Abbey Residential Home (CQC, 2018). The home's leadership was very visible and involved people in improvement activities through meetings and one-to-one conversations. One person said that this had a positive impact on his experience of care: *"Before, you couldn't see the manager very often. Now you can. It made me feel **more contented**, having someone you recognise who will get things done".*

6.17 Experiential outcomes for people accessing services are also cited in relation to specific improvement initiatives:

- In their examination of the Break Through Series Collaborative in Norway – an action learning programme that brought together clinicians from different hospitals to seek quality improvement on a given topic over a six to nine month period - Brandrud et al. (2011) find that participation in the programme resulted in a number of tangible benefits. One benefit was that people accessing services were **more informed and engaged in planning their care**.
- Bartlett, Basten, and McKinley's (2017) realist evaluation of the effectiveness of a multi-disciplinary support team for GPs finds that practices that engaged with the team reported having a better clinic and managerial skill mix. This in turn led to **improvements in people's access to appointments**.
- A staff led quality improvement initiative at East London NHS Foundation Trust successfully reduced the level of intrusive background noise on an older adult mental health ward. This had a direct impact on people's experience by creating a **more relaxed environment,** which in turn was found to **reduce agitation** (Institute for Healthcare Improvement, 2016).

Staff skills, knowledge and experience

6.18 The evidence base shows links between:

- The Break Through Series Collaborative action-learning programme participation (as described above) and improved professional knowledge (Brandrud et al., 2011)
- The use of multidisciplinary support teams in primary care and a "*better skill mix*" among staff (Bartlett et al., 2017)
- Communication training and staff communication abilities in adult social care settings (My Home Life, 2016).

6.19 Improvements to staff skills and knowledge are also described to occur as a result of **better knowledge sharing activities**, for example, in the Alberta Health Services in Canada as a result of participation in Communities of Practice (Auer et al., 2020).

6.20 One domain of staff experience, **staff morale or motivation**, is covered extensively in the evidence base. In an analysis of national staff survey, interview and observation data in the NHS, Dixon-Woods et al. find that several elements of a 'good' culture – including access to appropriate resources, adequate staffing levels with appropriate skill mixes and effectively-functioning systems – led to staff feeling that they could complete work successfully: this, in turn, reinforced levels of morale in a "*virtuous cycle*" (2014). Similarly, Benjamin and Chung's analysis of survey and interview data from the NHS concludes that leadership styles which engaged staff and drew from their knowledge had a positive impact on morale and motivation (2022).

6.21 Many literature sources provide evidence for specific interventions' impact on staff morale. For instance, an evaluation of multidisciplinary support teams aimed at cultural change in primary care found increased morale to be a principal outcome experienced by staff in the practice (Bartlett et al., 2017). Evidence from case studies of NHS Foundation Trusts corroborates this finding; undergoing cultural change is tied to increased scores on morale in Mersey Care's staff survey, as well as high scores for staff believing that "*they can contribute to quality improvement*" in Northumbria NHS Foundation Trust (NHS Employers, 2021; Laverty, no date). A CQC report drawing on case study evidence of eight Trusts that undertook efforts to become 'well-led', summarises the result: "*Trusts that unleashed the potential of their staff now see… higher staff morale*" (2017). One literature source describes morale improvements, specifically with reference to the **pride in their organisation** that the Norwegian Break Through Series Collaborative programme inspired among its participants (Brandrud et al., 2011).

6.22 Evidence from a CQC report, looking at nine case studies of adult social care services which implemented change after having received inadequate ratings or enforcement action, draws attention to improved staff experience as a result of **feeling listened to** (2018). A physiotherapist from a nursing home explained that efforts aimed at enhanced communication allowed her and colleagues to feel listened to, which "*made [them] feel like*

they are part of a team and the decision-making process". In another residential home, a senior carer commented on the importance of regular team meetings, which boosted morale due to a newfound belief among staff that they were being listened to. In addition to being listened to, a case study in this report emphasises the importance of **staff feeling valued**, citing an example of monthly staff awards and informal gestures in care homes such as leaving boxes of chocolates.

6.23 **Staff satisfaction** is another aspect of staff experience explored in the literature. This measure is found by one review of public hospitals to be favourably correlated with the quality of management practices (Jabbal, 2017), as well as with person-centred care approaches such as emotion-oriented care and small-scale living (My Home Life, 2016). Sarre et al. also report increased satisfaction among participants of the Productive Ward: Time to Care intervention whilst they were progressing through the programme (2019).

6.24 The evidence base also provides insight into the influence of organisational culture on **staff engagement.** Generally, Halaychik describes participative leadership, or an involvement of 'followers' (staff), as beneficial for creating a more engaged workforce, where **employees feel they can take ownership of organisation-wide objectives** (Benjamin and Chung, 2022). This finding is echoed by Auer et al., who describe how Community of Practice participants in the Alberta Health Service are better equipped to act on the information, specific needs and interests that motivate them (as a result of being involved in the Community of Practice), which improves staff engagement (2020). Firbank shows how continuous quality improvement initiatives in four home-care agencies were described by participants as "*creative,… fun…, [and] a break from everyday activities*" (2010).

6.25 Case studies offer further evidence of improved staff engagement in NHS Trusts undertaking cultural change initiatives. In an evaluation of the Culture Leadership Programme by West et al., analysis of national staff survey engagement scores shows that Trusts participating in the programme increased engagement by 0.07, as compared to the 0.03 national average, across 2017/18 to 2019/20 (2021). Furthermore, the East London, Mersey Care and Isle of Wight NHS Foundation Trusts have all recorded higher levels of staff engagement as a result of concerted cultural change (Institute for Healthcare Improvement, 2017; NHS, no date.; NHS Employers, 2021).

6.26 Finally, the literature describes how some organisational cultures aim to improve staff experience by targeting **staff wellbeing or psychological health**. For instance, in Mersey Care NHS Foundation Trust, there has been an increase in staff who feel encouraged to seek support (NHS Employers, 2021); the Isle of Wight Foundation Trust has reported similar outcomes, with NHS Staff Survey data indicating the perception among staff that there is positive action on health and wellbeing (NHS, no date). The CQC report examining case studies of social care services which implemented change after having received inadequate ratings or enforcement action contains anecdotal evidence, showing the positive effects of creating a no-blame culture in The New Deanery Care Home: "*Before,*

if we came to management, we were made to feel like were in the wrong. We don't feel like that now…. [Our manager] never makes us feel like we're making a fuss" (2018).

6.27 Through cultural change, the combination of the factors outlined above can contribute to **improved employee retention, i.e. reduced employee turnover**. This is demonstrated in West et al.'s analysis of the Culture Leadership Programme, which shows participating Trusts' rate of registered nurse turnover from 2015/16 to 2019/20 decreased by 1.41%, as compared to 0.8% nationally (2021). This reduced turnover is also shown in Auer et al.'s multiple case study of Communities of Practice in the Alberta Health Service (2020).

Communication with staff

6.28 There are several examples in the literature of culture change leading to **improvements in communication**. This is predominantly achieved via mechanisms for staff and people engagement. In one adult social care setting, The New Deanery Care Home, mechanisms for people engagement resulted in improvements in formal communication: a residents' forum and regular family meetings ensured that ideas and issues raised by people were communicated to staff and enabled families to be kept up to date. Informal communication was also reported to have improved; a senior carer said *"Every department is involved in everything… You see the chef in residents' rooms chatting with them, seeing what they like"* (CQC, 2018). In a health care setting, the executive team at East Lancashire Hospitals NHS Trust spent considerable time talking to staff on the frontline. This resulted in staff reporting that the Trust was a much more open place to work (CQC, 2017).

6.29 Bartlett, Basten, McKinley's (2017) realist evaluation of the effectiveness of a multi-disciplinary support team for GPs finds that practices that engaged with the team reported improved communication. In another paper, focused on adult social care, communication training is shown to have positive effects on staff communication skills (My Home Life, 2016).

System change

6.30 A handful of evidence sources highlight a positive association between improvement cultures and system change:

- In their paper examining Communities of Practice in Canada, Auer et al. (2020) state that *"Communities of Practice enable the diverse wealth of knowledge embedded in people, local conditions and special circumstances to flow from practice domain groups to programme and service areas, and into the larger system".* They explain that Communities of Practice are viewed as instruments for system advancement, such as **increasing integration between primary and tertiary care.**
- The success of a violence reduction quality improvement initiative piloted at an acute admissions mental health ward in Tower Hamlets in 2012 resulted in the **establishment of the Tower Hamlets Violence Reduction Collaborative** in 2014.

The Collaborative comprised the six mental health wards in the Borough (two psychiatric intensive care units and four acute admissions wards). It aimed to reduce violence on wards by 40% by the end of 2015 through the use of initiatives such as The Broset Violence Checklist (a risk assessment tool) and safety huddles (Institute for Healthcare Improvement, 2016).

- In their assessment of Productive Ward – a programme that gave staff in acute NHS hospitals the tools, skills and time required to implement improvement - Sarre et al. (2019) found that the programme had had a **wider influence on hospital improvement strategies.**
- The notion of improvement percolating into the wider system to affect change is also mentioned by Brandud et al. (2011) in their examination of the Break Through Series Collaborative in Norway. One of the outcomes of the Collaborative highlighted by participants was the *"spread of improvement efforts and methods to other areas and sites through projects, conferences and papers".*

Other impacts

6.31 One literature source explores the association between **cultural change interventions and regulator ratings.** An evaluation of the Cultural Leadership Programme, for example, finds an 15% increase in participating Trusts being rated good or outstanding by CQC between 2018 to 2020, as compared to a 9% increase among all acute, mental health and community Trusts in England (West et al., 2021). Additionally, compared to 14.7% of Trusts being rated inadequate prior to participation in 2018, none were rated inadequate post-programme in 2020. Looking at specific CQC rating domains, participant Trusts improved on all domains except one (responsive) to a greater degree than national averages. Single Oversight Framework ratings also improved among Trusts following the programme, especially with regards to a fall in 'special measures' (11.8%) from 2018 to 2020 and an associated increase in 'mandated support' (8.8%) and 'targeted support' (2.9%).

6.32 Relatedly, a case study of the East London NHS Foundation Trust outlines an **impact of concerted cultural change on external recognition**; the Trust was recognised by the UK Health Service Journal as 'Trust of the Year' at the 2015 Patient Safety Awards, and the Trust won the Staff Engagement Award in the same year (Institute for Healthcare Improvement, 2017). This occurred in parallel to receiving an 'outstanding' CQC rating, making it one of the first NHS mental health providers to earn the top rating.

6.33 The literature also makes some reference to the **financial benefits of improvement cultures.** Benjamin and Chung (2022) report a positive association between the levels of staff engagement and the financial performance of NHS providers, whilst Jabbal (2017) states that the LEAN methodology has been linked to cost reductions. The implementation of a just and learning culture at Mersey Care NHS Foundation Trust was estimated to have

provided economic benefits of around £2.5 million over a five year period (NHS Employers, 2021b). Furthermore, the aforementioned Tower Hamlets Violence Reduction Collaboration – which in one year successfully reduced rates of physical violence across six mental health wards in in the borough by 40% - delivered cost savings of just over £180,000 (Institute for Healthcare Improvement, 2016).

Evidence of negative or unclear outcomes

6.34 There is some evidence in the literature of cultural change leading to negative outcomes. Mannion (2022) states that *"unintended and dysfunctional consequences of culture change strategies frequently arise*". This is reflected in Bartlett, Basten and McKinley's (2017) realist evaluation of the effectiveness of a multi-disciplinary support team for GPs. The study found that some practice managers feared that engaging with the support team would lead to a perception in the wider medical community that the practice was failing; this was interpreted by the authors as an expression of shame. Furthermore, one practice involved in the evaluation stated that a report produced by the support team had the unintended effect of creating divisions amongst staff; this was a contributing factor in two members of staff deciding to leave the practice.

6.35 However, the evidence base does not explore why negative outcomes are experienced when implementing improvement cultures; further research could be undertaken to explore this further.

6.36 Additionally, the evidence base contains several examples where **cultural interventions led to few or no benefits**. A review undertaken in 2003 by Scott et al. concludes that the evidence for an association between culture and performance is weak in healthcare contexts (cited in Mannion, 2022). Some authors draw attention to studies in which quality improvement initiatives lead to modest or no improvement (Silver et al., 2016). For example, a lack of evidence of Quality Improvement Collaborative impacts on mortality after abdominal surgery and on other health outcomes for people in the UK (Zamboni et al., 2019), as well as a randomised control trial showing no significant effect on prescription errors, adverse events and mortality rates as a result of the Safer Patients Initiatives, were cited (Mannion, 2022).

6.37 In an evaluation of the Productive Ward: Releasing Time to Care programme in England, Sarre et al. (2019) show **the difficulties in demonstrating impacts of culture change programmes.** While qualitative data, interviews and observations data suggest that the programme was perceived positively, hospitals had few 'hard data' to prove these impacts. Only one in six case study sites had sufficiently robust data collection systems to enable analysis, which showed no association between programme processes and people and staff satisfaction, despite improvements to patient observation audit scores and direct care time.

6.38 Finally, several literature sources call for **improvements to the quality of research investigating associations between organisational culture and outcomes**. Mannion outlines that a number of claims linking culture and performance are based on methodologically poor research and that "*the evidence base generally is problematic"* (2022). This is due to: difficulties establishing the direction of causality between cultures and outcomes, a concern over the degree of separation between independent and dependent variables (such as espoused values of employee loyalty and commitment vs actual loyalty and commitment), and challenges in establishing the impact of concerted efforts to engineer change in organisational culture.

7. Discussion of the review findings

7.1 This section discusses the review findings outlined in this report.

Reflections on the coverage and strength of evidence base

7.2 The evidence base spans a range of health and adult social care settings, with a particular focus on healthcare settings. The evidence is largely timely, relevant for the English context, and in many cases provides detailed examples. There is much in the evidence which is relevant for CQC's role, and insights will also be relevant for others in the health and adult social care sectors.

7.3 Despite the breadth of evidence, it is difficult to identify robustly evidenced variations in findings between different healthcare settings, given that the majority of evidence encompasses multiple settings, and not all studies are focused on the same elements. There is also comparatively less evidence focused on adult social care settings than healthcare settings. While this was expected, it does mean the strength and volume of evidence regarding adult social care improvement cultures is weaker.

7.4 There are also gaps in the understanding of how culture and quality improvement processes are associated with one another. While the evidence base suggests that this understanding is increasing (certainly since Firbank's statement on the gap in 2010), it does indicate that the evidence base in this space is still relatively emergent. Within the literature, it is difficult in many cases to unpick which learning is specifically focused on improvement, compared with learning focused specifically on improvement cultures.

7.5 It is also important to note that the literature also recognises (and collectively illustrates) the challenge of defining culture. Generating a single agreed definition of culture is challenging, given it is so implicit within an environment and group of people. Whether it is a feature of an organisation or department/team, or a part of it, remains disputed. Culture is highly contextualised and subjective, which has implications for its transferability; what works in one place might not work in the same way in another.

7.6 While the evidence base was generally broad, there was limited evidence around improvement cultures across partnerships or systems, such as Integrated Care Systems (ICSs). Improvement cultures at this level have the potential to model and influence improvement cultures closer to the frontline, and therefore are likely to be strategically important.

Characteristics of improvement cultures, and key enablers

7.7 Despite its highly contextualised nature, the literature is broadly consistent in what it deems to be characteristics of a good improvement culture, and the broad underpinning conditions required. In summary, the key characteristics include:

- **Reassurance and safety**: an environment where 'psychological safety' is fostered (i.e. an environment where people can comfortably raise concerns and question poor practice).
- **Quality and effective**: staff are engaged and empowered, and considered integral to change. Teamwork and collaboration is prevalent. Measurement of impact is embedded and continuous.
- **Caring and person-centred**: commitment to the values of compassion, civility, respect and person-centred care.
- **Learning organisations**: there is focus on problem solving, learning from mistakes and evidence based learning.
- **Leadership**: leadership is compassionate, diverse and inclusive, and open and honest. There is mutual trust, and leadership is bought-in and committed to quality improvement.

7.8 The evidence indicates that to achieve good improvement cultures, there are a number of enabling conditions required. Again, the findings reveal that these do not stand alone, but work in conjunction to create an environment in which a good improvement culture can flourish. The key enablers identified are:

- **Leadership**, which plays a critical role in providing the conditions for an improvement culture to develop: both in terms of how leadership is structured, and the behaviours that leaders exhibit. In particular, the relationship between leaders and frontline staff is integral to an improvement culture, from being open and engaging with staff, to being visible, to demonstrating the behaviours sought in others, to empowering staff to participate in decision making. However, it is important to recognise some of the contradictions present in the literature. These include:
  - Conflicting evidence regarding the effectiveness of consistent and stable leadership, or providing a 'shock' and a refresh by changing leadership within an organisation
  - Having a clear 'top down' hierarchical approach, or having a flatter structure of leadership with devolved decision making

  Despite these contradictions, the presence of a clear vision and direction, modelling by leaders, understanding of improvement processes underway, and clear communication were all emphasised across the literature.
- **Staff empowerment, engagement and morale**. Celebrating success is an important contributor to this. While some of the literature advocates for financial incentives, more often than not, the literature highlights the importance of recognition over reward as a key facilitator to empowerment and engagement.

- **People and family member involvement** (as appropriate for the setting) is both a key feature and an enabler of improvement cultures. It is noted by multiple sources that listening to the voice of people accessing services and (more so in the context of social care) their families, reveals improvement gaps, and can support a user-centred ethos within a team, department or organisation.
- **Working collaboratively with external organisations** in the local area, or those with similar aims and foci. Organisations who work with external partners can share learnings and promote an open culture of curiosity and innovation.
- **Working collaboratively internally**. Providing opportunities for staff to work in multi-disciplinary teams and share best practice resulted in the transfer of skills and learning (improving capabilities).
- **Providing sufficient capacity and resource** to support an improvement culture. This included through providing adequate training to ensure an appropriate skills mix, scope to participate in improvement programmes or initiatives, and mechanisms to enable staff to engage with decision making processes. Prioritising improvement activities is seen as key to enabling new ways of working to become embedded.
- **The accessibility, quality and use of data**. Organisations who use, and encourage their staff to use, the full range of data sources at their disposal (even if there are some issues with data availability and quality) have the opportunity to use data to inform their processes and practices. It is important that this covers all aspects, from staff morale and retention, through to cost data, experiences of people accessing services and clinical/care outcomes.

7.9 Generally, the key barriers identified within the literature are directly inverse to the enablers. Therefore, if these conditions are not in place, it is likely that this will contribute to a "*downward spiral*" (Mannion and Huw, 2018) of an improvement culture.

7.10 However, it is worth noting that while some barriers are within the gift of organisations themselves to address, some of these conditions are largely out of their control (for example, local or national staff shortages or policy changes). This is important in the context of CQC's work; while there may be an impetus or willingness to drive forward a culture of improvement within settings, external factors may act as barriers to prevent or hinder this. Given the nature of improvement cultures (i.e. that conditions and characteristics work in parallel), even if many conditions of improvement cultures are in place, significant barriers may mean that the desired outcomes or benefits that come from a good improvement culture cannot be realised.

7.11 That said, the evidence indicates that a good improvement culture has the opportunity to somewhat mitigate against external barriers. For example, having adequate training in place, involving staff in decision making and fostering good relationships between leaders and frontline staff can contribute towards staff empowerment and morale. This supports staff retention and talent attraction, which can somewhat mitigate against workforce

shortages. Mitigation against external barriers to improvement cultures is an issue CQC may wish to explore further, for example through undertaking additional research to understand if and how CQC can support or influence settings in overcoming these barriers.

The role of culture in improvement

7.12 The literature is consistent in the assertion that culture plays a role in improvement within health and social care. Culture permeates the fabric of organisational structures, processes and personnel, and can considerably influence how, if and to what extent an organisation or setting can change and improve. As noted above, culture and improvement are difficult to disentangle, and each is directly and indirectly associated with the other.

7.13 There are key findings around the role of culture in improvement emerging from this review. The first is that improvement cultures are cyclical in nature. Often, the conditions needed for a good improvement culture to develop are closely related to the characteristics of what a good improvement culture should look like, and conversely, the barriers are often characteristics of a poor culture. This reinforces Mannion and Huw's (2018) concept of "*virtuous circles*" of improvement cultures, as outlined in chapter 4.

7.14 Second, and linked to this, culture itself is multifaceted in nature, with different characteristics that are mutually reinforcing and work together to drive improvement. Where there are positive characteristics in place, they become mutually reinforcing and drive the development of other good characteristics. To achieve a good improvement culture, multiple factors need to work together. Identification of one positive 'characteristic' does not necessarily mean that an improvement culture is pervasive within an organisation. It is also important to recognise that culture needs to be embodied in practice, and cannot only present in written outputs or what is said. It needs to be 'lived' at all levels of the organisation, driven by leadership, for the tone of an improvement culture to be set.

7.15 Third, the development of an improvement culture relies on commitment, consistency and sustainability. Its development is a long-term process, rather than a short-term fix or intervention. Therefore not only should the impacts of an improvement culture be encouraged and celebrated, but also the indicators of positive change or interim outcomes.

Informing CQC's assessment

7.16 As outlined above, the literature is consistent in the characteristics of a good improvement culture identified. This suggests that identification and assessment of a good improvement culture could be incorporated into existing regulatory functions and processes relatively easily. Indeed, many (if not all) of the characteristics of an improvement culture are what CQC already seeks to identify within existing inspection processes. The evidence indicates that it is how these characteristics work together and align to create a 'culture' which leads to improvement.

7.17 While there is relatively little focus on the role of regulation in the literature, the available evidence indicates that regulation (and people's perceptions regarding it) can act as a barrier, through contributing to an over-reliance on compliance over creativity, stifling innovation or desire to be open about and learn from mistakes. For regulators, sensitivity to these issues is key, as is providing clarity where required. Given the focus on collaboration and partnership working in generating a good improvement culture, there are opportunities for regulators to model this from the very top; setting out a clear vision, openly engaging with staff and leaders, and reviewing a wide range of metrics etc. There may be scope for CQC to consider how to use its impact mechanisms to help create a positive regulatory environment that encourages improvement, and to recognise the journey to improvement that providers might be on, to provide motivation and recognition of effort and focus.

Evidence of the 'right' culture leading to improvement

7.18 There are lots of impacts cited in the literature, particularly focused on quality of care, people and staff experience, and service performance. This is extremely encouraging, and impacts have been evidenced using both national and bespoke local metrics. Some literature sources suggest that wholesale transformational change can be achieved through having the right conditions in place to achieve a culture of improvement.

7.19 However, there is limited evidence of direct causation between an improvement culture and positive effects on staff experience, retention/recruitment, people's experiences and outcomes, and efficiency savings.

7.20 Health and adult social care provision does not operate in isolation from external factors; broader contextual issues can affect outcomes achievement. Culture is just one ingredient needed for high quality, safe care, albeit a vitally important one.

8. Conclusions and considerations for CQC

8.1 The literature provides relevant insights for CQC's regulatory functions. Below are some key implications for CQC and possible areas for consideration. These are designed to help CQC consider how the evidence base can support it to assess improvement, improvement cultures and improvement capabilities in the services it regulates. They are also intended to inform CQC's support for health and adult social care services to have the conditions and capabilities needed for the growth of good improvement cultures.

8.2 This section addresses the final research question:

- How can CQC encourage the development of good improvement cultures in health and adult social care?

8.3 The key considerations below are thematically grouped; there is no significance in their ordering. These have also been considered (where relevant) in relation to eight impact mechanisms devised by the University of Manchester and The Kings Fund[6], who identified ways in which regulators could lever improvement in the organisations they regulate (see Table 8-1).

Table 8-1: Eight regulatory impact mechanisms

Impact mechanism	Description
Anticipatory	The regulator sets quality expectations, and providers understand those expectations and seek compliance in advance of any regulatory interaction.
Directive	Providers take actions that they have been directed or guided to take by the regulator. This includes enforcement actions and, at the extreme, may involve formal legal repercussions such as prosecution or cancellation of registration.
Organisational	Regulatory interaction leads to internal organisational developments, reflection and analysis by providers that are not related to specific CQC directions. This leads to changes in areas such as internal team dynamics, leadership, culture, motivation and whistleblowing.
Relational	Results from the nature of relationships between regulatory staff (i.e., inspectors) and regulated providers. Informal, soft, influencing actions have an impact on providers.
Informational	The regulator collates intelligence and puts information about provider performance into the public domain or shares it with other actors who then use it for decision-making (e.g. commissioning, people's choice).
Stakeholder	Regulatory actions encourage, mandate or influence other stakeholders to take action or to interact with the regulated provider.

[6] Smithson et al (2018) Impact of the Care Quality Commission on provider performance: Room for improvement? The King's Fund, London.
https://www.research.manchester.ac.uk/portal/files/77461382/cqc_provider_performance_report_septembe r2018.pdf

Impact mechanism	Description
Lateral	Regulatory interactions stimulate interorganisational interactions, such as providers working with their peers to share learning and undertake improvement work.
Systemic	Aggregated findings/ information from regulation are used to identify systemic or interorganisational issues, and to influence stakeholders and wider systems other than the regulated providers themselves.

Source: Smithson et al. (2018) Impact of the Care Quality Commission on provider performance: Room for improvement? The King's Fund, London.

Regulatory functions

1. **Viewing improvement holistically is important**. The evidence indicates that multiple different elements of 'good' culture need to be in place for improvement to be achieved and sustained. The mutually reinforcing nature of the characteristics of improvement cultures are important to keep in mind in assessing improvement in settings; each characteristic should be considered and reviewed, as well as capturing experiences and performance of the service 'as a whole'. (*Organisational)*

2. **Both espoused and 'lived' culture (what is actually experienced and implemented in practice) are key.** The evidence indicates that it is not just what is said or written by management, but the day to day actions and interactions at all levels which are key. Any disconnect between espoused and lived culture may indicate disfunction, and could perhaps be something to identify and explore. This could be undertaken at inspection points, in addition to looking at a range of evidence sources between inspections, to gauge discrepancies. However, this does rest on the assumption that provider staff feel able to honestly feedback to CQC on their own experiences of the culture; a poor improvement culture (e.g. one characterised by blame and fear) may not encourage staff to report negative experiences or feel able to speak openly. It could also rely on recognition of the issue (e.g. by leadership) and openness about this. Capturing external views (e.g. from agency staff) may offer additional insights into improvement cultures within settings.

   Furthermore, there may be times when a disconnect between espoused and lived culture does not indicate disfunction. For example, a disconnect could be seen as a result of leadership aiming to enact change which hasn't yet manifested itself amongst the frontline workforce. It is therefore important to consider broader contextual factors which may influence disconnect between espoused and lived culture. *(Anticipatory, directive)*

3. **The evidence highlights the importance of sub-cultures**; exploring cultures (actual and espoused) at organisational, department and team levels, and across shift patterns, is likely to prove key. As Silver et al. (2016) observed, culture exists at the *macrosystem* level (e.g. the organisation in which improvement work occurs, touching

on factors such as leadership and organisational experience), the *mesosystem* level (the key divisions and interactions within the macrosystem, such as departments and laboratory services) and the *microsystem* (frontline units where care is provided; important factors include local leadership, motivation to change and team dynamics). *(Anticipatory, directive)*

4. CQC may wish to **assess and inspect for evidence of an environment where people feel they can speak up and that their voice will be heard. CQC may also wish to frame messaging to ensure regulation isn't perceived (and doesn't serve) to stifle innovation.** The literature says little regarding the role of regulation in improvement cultures. However, the evidence available indicates that regulation can stifle innovation and any associated improvement, by contributing to a culture of compliance and over-reliance on central guidance. *(Anticipatory, directive, organisational)*

5. **Monitoring and assessing the extent to which services effectively capture and utilise people's voice (as appropriate to the service offer/user group) to inform continuous service improvement, is important.** This is already undertaken as part of maternity service inspections, for example, to explore the extent to which Maternity Voices Partnerships are involved in informing and co-producing improvement. The Provider Information Return survey may also provide relevant insights regarding this. *(Anticipatory, directive)*

6. **Training and support for people accessing services and family members to be involved in co-production and service improvement activities is a key enabler.** This is linked to the implication above; CQC may have a role to play in sharing examples of good practice in this regard, as well as inspecting for this as part of its regulatory function. *(Anticipatory, directive, informational)*

7. CQC may wish to **consider how staff empowerment and influence are captured as part of the assessment process, and consider sharing examples of good practice with others.** Sharing practical tips as to how this is achieved, and what effect this has (for example, on staff morale, retention, innovation, service outcomes etc.) may encourage others to adopt similar approaches in their settings, or at least consider how they may be able to do so. *(Lateral, informational)*

8. Developing an improvement culture takes time. Therefore, **ensuring realistic expectations, including identifying expected interim outcomes, may prove useful.** Developing and sharing a headline logic model or theory of change to outline some of the key inputs and activities/outputs expected in an improvement culture, and the associated interim outcomes expected in the medium term, may help to provide both a roadmap for settings and a realistic indication of their trajectory towards embedding an improvement culture. This could inform CQC's assessment and improvement activities. CQC may wish to consider how they could support their colleagues to inspect for these interim outcomes, particularly if the outcome is not

necessarily 'positive' (e.g. an increase in staff complaints could potentially indicate a reduction of fear, but how the data is used by the organisation would prove key here).

The evidence indicates that the achievement of interim outcomes should be celebrated by settings; CQC may have a role to play in encouraging this and sharing examples of good practice for others to learn from. Positive recognition of progress by CQC may also prove motivating and validating for settings, encouraging then to continue their journey of improvement, even if they have not yet achieved their desired outcomes. However, a core part of CQC's role is to hold services accountable in ensuring safe care for people, and this should be prioritised. *(Informational, anticipatory, directive)*

9. **Wider factors can support or inhibit improvement.** The literature reveals that culture, whilst a critical enabler, is not the only factor that leads to improvement. The literature identifies other factors which can influence improvement. These include: internal factors, like individual skills, attitudes and resourcing; and external forces, such as wider governance arrangements or incentive structures, regulations, market competition and pressure from funding agencies. Understanding these drivers and influences will be key to understanding an organisation's culture and its progress towards improvement in the round. It also may enable CQC to further support settings (e.g. through signposting to resources, or using its levers/relationships to tackle factors which may be outside of a setting's immediate control). This is particularly important given that the findings indicate that settings experiencing particularly challenging external pressures or circumstances may struggle to create a culture of improvement. *(Anticipatory, directive, organisational, systemic)*

10. **The role of organisational, departmental and team leaders in encouraging; driving, modelling and enabling improvement is evident** in the literature. Identifying the extent to which this is in place, as part of regulatory activity, would perhaps prove useful. CQC may also wish to explore how far those in leading roles in organisations (such as partners in general practice) see themselves as leaders, and the extent to which they embody the characteristics and behaviours of improvement cultures. CQC may wish to explore who the 'cultural leaders' are within an organisation, how their roles are defined, and whether or not those setting the culture of an organisation are in leadership positions. *(Anticipatory, directive)*

Influencing role

11. **Setting out clearly, perhaps drawing on the existing definitions, what CQC defines as an improvement culture** within health and adult social care may help to provide clarity and direction to the sector. There are several definitions in the literature, but 'culture' remains challenging to define. A clear definition or framework of what CQC means by (and is inspecting for) in terms of improvement culture characteristics, could prove particularly important in mitigate this. Mapping these characteristics to current assessment frameworks could also support this process. *(Anticipatory, informational)*

12. External factors can influence and affect setting performance. CQC itself is not immune to this influencing function. **Considering how CQC colleagues can communicate the cultural behaviours sought from health and adult social care settings**, such as active listening, encouraging (and providing space) for reflection, and avoiding 'blame' in engagement with settings, may prove useful. *(Relational, systemic)*

13. CQC could **explore and promote examples of where top-down and bottom-up culture setting are both implemented successfully**. For example, where leaders manage to set the agenda for change and communicate this clearly to staff (and themselves model it) whilst also enabling and encouraging staff empowerment and involvement in decision making. *(Informational)*

14. CQC may also wish to **consider its own relationships at a local and national level.** Jabbal (2017) reflect that to support improvement, the relationship between national bodies and NHS providers should reflect the relationships present in a good improvement culture between leaders and their staff – supportive relationships which demonstrate trust. *(Relational, systemic)*

15. **CQC (and others) may wish to consider the role of education providers and supervisors in influencing the culture of the future workforce.** There may be a role for CQC in influencing NHS England (now it has subsumed Health Education England) and/or the Office for Students in encouraging medical and clinical training facilities to embed a mindset and approach which equips practitioners with the skills and approaches needed to encourage an improvement culture in the workplace. This may extend to the culture in placement settings, the extent to which clinical and educational supervisors demonstrate characteristics associated with improvement cultures, and/or the taught curriculum. *(Stakeholder, systemic, relational)*

16. CQC's forthcoming role in assessing ICS's may add emphasis to this; the literature demonstrates the **importance of effective, active collaboration** at a local level, and CQC may wish to explore how best this can be encouraged and good practice shared. *(Lateral, systemic, relational)*

17. CQC may also wish to consider how (and to whom) to **share the findings from this review**. Sharing learning emerged as a characteristic of an improvement culture. We suggest that this review provides insights relevant for other national (and local) agencies involved in health and adult social care, which could inform policy and practice. *(Informational, stakeholder)*

18. There are gaps **identified through this review**; notably, the comparative lack of evidence around improvement cultures in adult social care settings. CQC may wish to consider whether (and if so, how) to address these. As reflected earlier in this report, just because this review has not uncovered as much literature focused on adult social care as on health care, that is not to say that further relevant literature about adult social care does not exist. However, it does suggest that this literature is likely to be

grey literature, and may be either not in the public domain, or not explicitly identified as having an improvement culture focus. Therefore, identifying any additional existing literature (e.g. through a broader call for evidence), or further research in this space may prove useful. *(Informational)*

19. Finally, the evidence indicates **a need for realism as to how far CQC can influence or encourage improvement cultures in settings it regulates.** As Ham (2014, cited in Jabbal, 2017) argues, change is unlikely to come from "*large scale reforms or 'top-down' imposition of targets, or even from external forces such as regulation and inspection*". Reform and improvement are more likely to be achieved through commitment and investment in staff, rather than a focus on compliance, indicating that CQC may also wish to consider *how* it exerts its influence. The evidence base also highlights factors external to an organisation which impact on its internal culture; for example, public opinion and media reporting can exert an influence on organisational culture, as can broader pressures on service delivery which can influence the level of improvement attainable. Organisational buy in is key for realising an improvement culture; the evidence indicates that changes must also be sustainable, which CQC has a role in assessing. *(Relational, informational, anticipatory)*

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Annex B: Search protocol

B.1 The framework below presents the search protocol used in this rapid literature review.

Study title	**Improvement cultures in health and adult social care**
Literature review aims	• To explore the breadth and volume of existing research into improvement cultures, consider what the evidence indicates good improvement cultures look like, and explore what is required for these to develop within health and adult social care settings • To inform CQC's approach to assessing and encouraging improvement, improvement cultures and improvement capabilities of services, while strengthening CQC's regulatory role • To identify any gaps in the current evidence base.
Literature review questions	**Primary literature search questions** • What is the role of culture in improvement in health and adult social care? • What are the characteristics of a good improvement culture within health and adult social care? Does this vary across different settings/contexts? • What conditions are needed for such a culture to develop? • What barriers exist to good improvement cultures? How have these been overcome? • What is the evidence that the 'right' culture leads to improvement? What is improved – e.g. quality, safety, staff morale etc.? **Secondary research questions** • What existing research has been undertaken/evidence generated? How does this vary across sectors and settings? • What gaps exist in the current literature? • How can existing research/evidence be used to inform CQC's assessment of improvement cultures? • How can the CQC encourage the development of good improvement cultures in health and adult social care?
Period	2010 – present
Geography	• UK (including national, home nations, regional, local) • Other countries (European Countries, Canada, Australia, New Zealand, USA)
Language of publication	English
Types of document	• Evaluation or research reports • Journal articles • Guidance documents • Case studies • Academic posters • Policy documents
Databases searched	• British Nursing Index (BNI)

- CINAHL (Cumulative Index to Nursing and Allied Health Literature)
- EMBASE
- Emcare
- HMIC
  - The Department of Health Library and Information Services database
  - The King's Fund Information and Knowledge Services database
- MedLine
- Social Care Online
- Social policy and practice
- PsychInfo

Search terms

Improv*
Culture*
Improvement culture*
Continuous learning
Continuous improvement
Quality improvement

Care
Health care
Primary care
General practice
Community care
Acute care
Secondary care
Domiciliary care
Ambulatory care
Urgent care
Emergency care
Maternity care
Mental health*
Surg*
Adult social care
Reablement
Care home*
Residential care
Nursing home*
Discharge
Rehabilit*
Assistive tech*
NHS
CCG
ICS
System*
Trust*
Care provider*
Provider*
Regulat*
Hospital*
Clinic*
Treat*
Diagnos*

Best practice
Good practice
Effective*
Enabl*
Barrier*
Driver*
Impact*
Outcome*
Case stud*
Evidence
Example*
Learn*
Methodolog*
Implication*
Reflection*
Review
Evaluat*
Study*
Guidance
Implement*
Characteristics
Action*
Behaviour
Framework
Condition*
Insight*
Context*
Assess*
Model*
Challenge*
Data
Demonstrat*
Review
Change*
Approach*
Improv*
Environment*

Leadership

		Governance *Culture* *Management practice** *Staff/employee empower** *Staff/employee morale* *Staff/employee engage** *Communicat** *Patient involvement* *Service user involvement* *Patient engage** *Autonomy* *Trust* *Learning from failure* *Learning from mistakes* *Infrastructure* *Knowledge shar** *Co-design* *Co-produc** *Patient centred care* *Staff feedback* *Monitoring* *No blame* *Transparen** *Honest** *Integrity* *Vulnerab** *Safety* *Health and safety* *Quality* *Flexib** *Inclusiv** *Modell** *Incremental change* *Bottom-up change*

Annex C: Call for evidence briefing note

In 2021, the Care Quality Commission (CQC) published a new strategy for the changing world of health and social care. The strategy aims to make regulation more relevant to the way care is now delivered, more flexible to managing risk and uncertainty, and enable CQC to respond more quickly and proportionately as the health and care environment evolves.

In December 2022, SQW (an independent research consultancy) was commissioned by CQC to deliver a rapid literature review into improvement cultures in health and adult social care settings.

The review was commissioned to support the delivery of CQC's new strategy. It aims to inform CQC's approach to assessing and encouraging improvement, improvement cultures and improvement capabilities of services, while strengthening CQC's regulatory role.

This call for evidence is asking for your support with this process. This is your chance to **identify and provide access to any reports, documents or other evidence** that can be considered as part of the review.
The table below sets out the purpose and aims of this call for evidence, and the overall piece of research that it is supporting. The table details the core research questions that the study will seek to answer, and the types of evidence we are seeking to collect.

Study title	**Improvement cultures in health and adult social care**
Literature review aims	• To explore the breadth and volume of existing research into improvement cultures, consider what the evidence indicates good improvement cultures look like, and explore what is required for these to develop within health and adult social care settings • To inform CQC's approach to assessing and encouraging improvement, improvement cultures and improvement capabilities of services, while strengthening CQC's regulatory role • To identify any gaps in the current evidence base.
Literature review questions	**Primary literature search questions** • What is the role of culture in improvement in health and adult social care? • What are the characteristics of a good improvement culture within health and adult social care? Does this vary across different settings/contexts? • What conditions are needed for such a culture to develop? • What barriers exist to good improvement cultures? How have these been overcome?

	• What is the evidence that the 'right' culture leads to improvement? What is improved – e.g. quality, safety, staff morale etc.? **Secondary research questions** • What existing research has been undertaken/evidence generated? How does this vary across sectors and settings? • What gaps exist in the current literature? • How can existing research/evidence be used to inform CQC's assessment of improvement cultures? • How can the CQC encourage the development of good improvement cultures in health and adult social care?
Evidence we are seeking	
Period	2010 – present
Geography	• UK (including national, home nations, regional, local) • Other countries (European Countries, Canada, Australia, New Zealand, USA)
Examples of types of evidence	• Evaluations, research reports, guidance documents, journal articles on cultures of improvement or characteristics of improvement cultures • Literature reviews exploring multiple studies • Case studies focused on improvement cultures in systems/areas, or aspects of culture which support improvement

Responses to this call can be sent to Jane Meagher at SQW (jmeagher@sqw.co.uk), or you can share your responses directly with CQC, who will share them with the research team at SQW.
Please respond by **Friday 24th February**.
Thank you – your help with this is much appreciated.

Annex D: Acknowledgements

D.1 This report has been compiled by an SQW team comprised of Lauren Roberts, Jane Meagher, Isabel Hampton and Izabela Zawartka. The SQW were supported by the King's Fund Library Service, whose inputs were led by Lynsey Hawker.

D.2 Our thanks go to members of CQC's Research and Evaluation team and Strategy team for their support with design and implementation of the review, in particular Kathryn Breeze, Becky Hodson, Joe Adnams and Jillian Marsden.

D.3 Our thanks go to the stakeholders who have taken part in the review, via scoping consultations and/or the stakeholder workshop. We also thank those who have provided access or signposting to documentation and evidence for consideration as part of the review.

D.4 Without the input of all these individuals and organisations, this report would not have been possible.

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About us

SQW Group

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SQW

SQW is a leading provider of research, analysis and advice on sustainable economic and social development for public, private and voluntary sector organisations across the UK and internationally. Core services include appraisal, economic impact assessment, and evaluation; demand assessment, feasibility and business planning; economic, social and environmental research and analysis; organisation and partnership development; policy development, strategy, and action planning. In 2019, BBP Regeneration became part of SQW, bringing to the business a RICS-accredited land and property team.
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