Culture of Care Barometer: project plan

1. Background to the Culture of Care Barometer: its origins

The healthcare agenda over recent years has been dominated by “quick fix” solutions. As a result both the complexity of issues involved and the amount of time it takes for real and enduring change to occur have been underestimated. Consequently, the “little things” that define the quality of the environment in which patients receive care and in which staff provide that care have been subordinated to more pressing priorities. These cultural attributes are not picked up in the measures of quality and performance currently in use; metrics fail to capture the meaning and reality of care culture for patients or staff.

An enriched environment is one in which patients, staff and family carers experience six senses; security, belonging, continuity, purpose, achievement and significance (Nolan et al 2006). This approach to understanding the environment of care is broader than the notions of “patient” or “person” centred care, in that it recognises the need for staff themselves to work in an enriched environment if they are to create such an environment for patients and their carers.

The role of the Board is critical in establishing the culture. It defines the principles that characterise all aspects of the organisations’ conduct, in accordance with the values of the NHS, the NHS Constitution and the Nolan rules on probity in public life. But an equally key role is played by the ward sister or community team leader in establishing an “enriched” environment for staff in which they feel valued and supported. Clinical leaders themselves also need to feel they are supported and encouraged.

But how can we gauge whether an organisation is successfully fostering a culture throughout that enables this kind of enriched environment to thrive and flourish? Learning from high profile crises in care delivery indicates that quality and culture are not uniform within let alone across organisations. Pockets of excellence can coexist alongside the worst examples of care failure; lack of consistency in care culture impedes the spread of good practice across organisations.

Leading nurses from across the country joined together¹ to develop a tool that can help address these issues, by enabling the culture of care provision to be gauged through the development of a ‘culture of care barometer’.

¹ The small independent reference group comprise: Flo Panel Coates, Baroness Audrey Emerton, Dame Elizabeth Fradd, Prof Tricia Hart, Sir Stephen Moss, Prof Anne Marie Rafferty
2. Design of the Barometer

In 2008 the NHS in conjunction with the major Trades Unions, the Healthcare Commission and Academy of Medical Royal Colleges carried out a major piece of research including interviews with staff from 50 NHS Trusts and a range of GP practices. This research found that staff commitment, engagement and productivity was strongly linked to four ‘themes’:-

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

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

The Barometer presents a series of statements and asks staff to indicate their agreement with each, in order to help them characterise the nature of the culture of care in their organisation.

Key features of the Barometer are that it:

- should be short and quick to complete
- can act as an early warning system to ‘red flag’ areas in an organisation
- complements not duplicates other measures, quality programmes and regulation
- can be a mechanism for ‘ward to board’ communication
- enables reflection and prompts discussion about action required
3. First phase

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

- All nursing staff (RNs and HCAs) in four different clinical care group settings
- Individuals were anonymous but the departments/units were identifiable
- Both paper and on-line versions of the survey used
- Several blanket reminders used to encourage response
- A response rate of 24% was achieved (less than the target of 40%).

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

4. Second phase (further piloting)

The idea of a tool to gauge the culture of care has caused considerable interest across the health service. With funding from NHS England, the development and testing of the Barometer is to be continued into a second phase of work.

Aside from the analysis already undertaken from the first pilot to identify how culture varies across the organisation and between staff (that was fed back to the first pilot Trust), further analysis has focused on reviewing how items within the instrument perform, to identify which are key predictors of overall views of culture, and whether any items effectively perform the same function, and can be removed to shorten the Barometer. The items and emerging factors have been reviewed against ‘domains’ related to culture identified in the literature.

The revised Barometer is to be tested with a wider range of staff groups, beyond acute settings. Two pilot sites have been identified and have agreed to take part in the second phase.
The approach and sequence of activities at each Trust is:

- Establish internal Barometer lead (estimated commitment is 0.1 WTE over 4 months)
- Engage with the board/key contacts to discuss culture and make explicit what measuring culture can and equally important cannot do; Trust commitment and interest is vital
- Promote the Barometer through internal publicity and communication about the survey – before, during and after
- Determine the sample for Barometer pilot
- Identify distribution methods (eg with pay slips, via website, via emails etc.)
- Agree return methods (eg. free-post returns for paper copies to be sent directly to survey administration team)
- Online Barometer launched (two weeks earlier), followed by paper version follow up (as hard copy and as PDF)
- Data collection (based on an estimate of testing with approximately 1000 staff in total) and reminders
- Data preparation and analysis
- Feedback to board (overview and comparison by staff group and area)
- Board review and plan feedback to staff of key findings and actions arising
- Research team meet with key Trust staff to review usefulness of Barometer (eg. 3-6 months after its use).

Piloting the survey includes:

- Supplying an online and paper version
- Delivery of 1,000 copies of the paper version of survey materials to Trust (questionnaire, reply-paid envelope, participant information sheet)
- Link to the online version (plus PDF of paper version) sent to Trust for circulation
- Response rate estimated at 35%
- Includes all printing, collation, delivery and return postage costs
- Distribution of paper and online surveys by the Trust
- Production of a summary feedback report
5. Proposed timetable

A planned timetable is outlined below. The exact start date and launch date will depend on agreeing the plan and getting R&D approval from each site.

The launch date of the survey at pilot sites will need to be considered carefully to avoid overlapping with other surveys or major events that might compromise the response - mid-May is proposed. The project advisory group will be crucial in planning how the Barometer might be made more generally available (and its use supported) once piloting has been completed.

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finalise study parameters</td>
<td></td>
<td>XX</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IRAS/R&amp;D approval</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Pilotting**

- All pre survey discussion with ‘users/staff volunteers complete
- Revise Barometer – and circulate to project team
- Produce online instrument and print paper copies
- Online survey launched - May 12th (sample – min. 1,000 staff)
- Paper reminder (two weeks later)
- Survey in field (planned 6 weeks) (multiple reminders, aim for min. 35% response)
- Data processing/input paper returns
- Analysis/reporting
- Summary feedback to Trust
- Follow up – Trust reviews of impact/usefulness
- Report on the pilot

**Supporting Barometer ‘roll-out’**

- Reviewing infrastructure needed to support use of Barometer beyond the pilot (with input from advisory group)
- Finding a ‘home’ for Barometer
- Final outputs/mechanisms agreed for wider use