



ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH PAPER

A shared purpose framework to deliver person-centred, safe and effective care: organisational transformation using practice development methodology

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Abstract

Background: A shared purpose is an essential part of developing effective workplace cultures and one of the founding principles of practice development in establishing person-centred, safe and effective practices that enable everyone to flourish.

Aims and objectives: The paper describes the aims of a piece of work first commissioned in 2011 (Phase 1) to review specialist practice – initially nursing and midwifery – across a large National Health Service trust in England. It then focuses on how this piece of work informed the development of a trustwide, shared purpose framework relevant to all staff, culminating in the strategies, processes and systems being used at individual, team and organisational levels to embed the framework, with the workplace as the main resource for learning. The challenges and successes along the way are highlighted.

Methods: Practice development, a complex intervention, is used together with a strong partnership joint appointment model between the trust and the England Centre for Practice Development at Canterbury Christ Church University, to enable a transformational journey of cultural change across the organisation, starting with the creation of a shared purpose framework.

Results: Examples from the trust’s workplace programmes are presented to demonstrate how the shared purpose and the skills required for transforming culture are brought to life, enabling a critical mass of people with transformational leadership skills to grow.

Conclusions and implications for practice: The strength of this work is underpinned by the partner relationship, which drives the focus of innovative programmes of research, scholarship and continuing professional development so that the local university offers systematic support to the organisational strategic objectives of delivering person-centred, safe and effective evidence informed care. The support is designed to develop these skills, using learning and development strategies that draw on the power of the workplace for active learning, as well as focusing on the outcomes and impact important to service providers.

Key messages include:

- Regardless of the size of any initiative, it is important to establish a shared purpose at the start
- Collaboration, inclusion and participation principles, and associated practice development methodology, enable a focus on achieving person-centred, safe and effective cultures at organisational and at micro-systems levels
- Once shared purpose is agreed, ways of working that reflect it also need to be agreed
- Systems for learning, development, research, innovation and evaluation need to be established that enable shared purposes and values to be embedded in everyday activity

Keywords: Shared purpose framework, culture change, transformation, clinical leadership, workbased/ workplace learning, practice development

Introduction

This paper illustrates how practice development as a complex intervention has enabled an organisation-wide journey of cultural change, starting with the co-creation of a shared purpose framework. The programme of work is underpinned by the methodology of emancipatory practice development (McCormack et al., 2004; Manley et al., 2008; McCormack et al., 2013) to enable frontline staff and others to use the workplace as the main resource for learning, development and transformation (Dewing, 2008; Manley et al., 2009; Jackson and Thurgate, 2011). Historically, practice development as an approach has focused attention mostly at the micro-systems level – the level at which healthcare is experienced and provided (Manley et al., 2008), rather than at organisational level. However, active and coherent organisational support has long been recognised as being essential at executive and strategic levels if practice development is to achieve its full potential (McCormack et al., 1999).

The paper describes the methodology and methods used to develop the shared purpose framework, highlighting the challenges and positive experiences along the way. It then illuminates how the framework is being brought to life and embedded, giving examples from organisation-wide workplace and workbased programmes designed by the trust to develop the skills required for individual and team effectiveness, focus on shared purposes and explicitly attend to workplace culture as a powerful factor in sustaining them.

Unique to this work has been the creation of a joint appointment position at professorial level to oversee the transformational journey towards a strong collaborative foundation between a large NHS foundation trust in south-east England and the England Centre for Practice Development, hosted at a local university. This appointment supports transformation from within the organisation, working strategically to influence practice from executive board to ward, and alongside individuals, teams, departments and services to influence workplace culture and practices so that they are person-centred, safe and effective, and enhance the wellbeing of staff and service users alike. The role is held by the first author and bridges healthcare practice, research and learning, integrating practice development methodology to develop effective workplace cultures that are person-centred. Employed by the NHS and funded two days a week by the England Centre of Practice Development, it provides a model for its partnerships with healthcare providers.

What is shared purpose, and how does it link to practice development to achieve impact?

Purpose is the ultimate ‘why’ of the practice and/or service we provide; it is positioned above all other strategic statements and expresses our identity and the reason we exist (Finney, 2013).

‘Shared purpose results when a group of individuals aligns their belief systems or values with a common challenge, vision or goal’ (Finney, 2013, p 5).

The importance of having a shared purpose has recently been recognised by the NHS in its shared purpose model (NHS, 2013). Drawing on the work of the Roffey Park Institute, the NHS promotes the positive impact that a strong shared purpose can have on successful change programmes and on organisational performance (Gifford et al., 2012; Finney, 2013).

‘Purpose taps into people’s need for meaningful work; to be part of something bigger than ourselves. It encapsulates people’s cognitive, emotional and spiritual commitment to a cause... purpose becomes shared when we find commonalities between our values, beliefs and aspirations’ (Finney, 2013, p 6).

A shared purpose is therefore a powerful strategy for unifying diverse stakeholder groups in collaborative enterprise, enabling everyone to work creatively together in the same direction, embracing agreed

values such as keeping people at the heart of care and fostering shared decision-making (Manley et al., 2011b). This shared purpose enables barriers, silos, non-collaborative working and conflicting agendas to be challenged and overcome. Developing clarity of purpose leads to agreement on how purposes can be achieved and what this means for ways of working and priorities.

Developing a shared purpose is one of the key activities of practice development work in all its forms (Manley et al., 2013) and one of its founding principles (Manley, 2000a; 2000b; Manley and McCormack, 2004). A range of approaches is used to achieve this, such as values clarification (Warfield and Manley, 1990), varied creative approaches such as visualisation (Coates et al., 2006) and other means such as the use of collage, poetry and dance (McCormack et al, 2006).

Practice development is a complex intervention that integrates the systematic development of practice with empowerment of practitioners and cultural change that sustains specific outcomes. A shared purpose is a key attribute of an effective workplace culture based on shared values (Manley et al., 2011b). Since its conception in the 1980s, practice development has focused on the achievement of person-centred and evidence informed care, although more recent refinements embrace the concepts of human flourishing (Titchen and McCormack, 2010) and establishing workplace cultures that enable everyone to flourish, as identified in the first of nine principles of practice development:

'Principle 1: PD aims to achieve person-centred and evidence based care that is manifested through human flourishing and a workplace culture of effectiveness in all healthcare settings and situations' (Manley et al., 2008, p 4).

In summary, practice development as a methodology achieves a shared purpose and outcomes (Manley et al., 2011a) through:

- Using the principles of collaboration, inclusion and participation (CIP principles), which develop ownership for change and direction as well as self-empowerment
- Agreeing values and beliefs about what is to be achieved, as well as, ways of working (including creativity), which provides a frame of reference that enables self-direction, mutual challenge and support for agreed values and behaviours
- Involving all in decision-making, which accords value to those involved and enables engagement, joint responsibility and multiple perspectives and differences to be recognised and acknowledged
- Embedding shared values and beliefs and related patterns of behaviour into workplace culture through social systems that reduce dependence on single/specific individuals

Recognising the need to change

The NHS foundation trust is a major healthcare organisation, comprising three large acute hospitals with 7,500 staff spread across a mix of rural and urban communities and serving a population of around 759,000. Two triggers influenced the project's inception in early February 2011. The first was the need, set out by national policy (Department of Health, 2010) to improve patient experience and safety, and nurture innovation and productivity. These factors were a key driver in the trust's direction and this was widely recognised. However, a lack of shared purpose existed in relation to what these words meant in everyday practice and to the values and beliefs, activities and behaviours that would be expected to achieve these outcomes. While purposes were articulated as words and goals at organisational level, the fact that there was no explicit framework meant there was little shared understanding about what this would entail for practitioners, clinical leaders and other staff at the frontline. The second trigger was the need to develop an effective workplace culture to embed core values and ways of working identified in a recent re-organisation. The need to address organisational culture so as to deliver better services using an affordable model of service delivery was highlighted following extensive staff interviews. In particular, there was recognition of the need to:

- Work collaboratively with staff as a key resource for improving quality
- Enable staff to contribute to the future success of the organisation

- Help staff take responsibility for their actions
- Develop leadership capability if the organisation's vision was to be achieved

It was recognised at executive level that leadership and cultural change skills were required to implement and sustain a shared purpose within and across mixed staff teams and pathways. Cultural change was needed to address barriers such as silo working, duplication of effort, lack of shared purpose and invisibility of impact. There was also a need to enhance staff creativity and leadership in order to develop workplaces where everyone could flourish, and where service-users and staff could consistently experience person-centredness and contribute to its evaluation. Before this work started, many practitioners were cynical of organisational motives, feeling demoralised, demotivated and 'done to'.

Starting a journey of transformation – Phase 1 project

Between February and May 2011, the trust commissioned the England Centre for Practice Development to undertake a three month project to develop a framework to reflect the contribution of specialist nurses and midwives to person-centred, safe and effective care, and a to culture that could sustain this across the trust (Manley, O'Keefe, Jackson, 2011c). 'Specialist nurses' in this context is an umbrella term to include nurses and midwives working with different groups of patients and service users across the patient pathway, such as clinical nurse specialists, nurse specialists, advanced practitioners, nurse practitioners, clinical leaders, practice development facilitators and consultant nurses/midwives. It also includes other clinical nurses working between bands 6-8, such as clinical educators, research nurses and clinical site managers, as well as ward managers.

The project's frames of reference were:

- To develop, collaboratively with specialist nurses, a career structure and framework for developing, sustaining and evaluating care that is person-centred, safe and effective across the patient pathway and services (integrating team effectiveness)
- To scope the number, range and contribution of roles across the organisation, making recommendations for implementation and education commissioning
- To identify the contribution of specialist, advanced practitioners and consultant nurses, midwives and allied health professionals to the quality improvement, innovation and productivity agenda across the patient pathway
- To identify the specific skillset required by clinical leaders within the framework to develop a workplace culture that delivers and sustains person-centred, safe and effective care and innovation across the patient pathway, including system change
- To make recommendations for the rollout of the framework, the development of an integrated practice development strategy for the trust for Phase 2, and the resources required
- To make recommendations for the local university regarding nursing and midwifery curriculum development

The project steering group comprised membership from local patient groups as well as allied health and medical colleagues, and ethical approval was sought from the university ethics committee.

Project methodology

Practice development as an intervention in its own right was the agreed approach for achieving the purpose – which was, specifically, to develop a framework that focused on providing person-centred, safe and effective care and workplace cultures to sustain these outcomes. Practice development also encompasses systematic evaluation and is underpinned theoretically by critical social science and critical creativity. This theory includes identifying and working with everyday assumptions and the barriers to action through enabling participants to become first enlightened (self-aware) about the barriers both within themselves and in the external environment, then to be motivated to act by this self-awareness (empowered), and then to implement these actions in their everyday practice within a culture of ongoing critique and learning (emancipation).

Participants

The trust's news bulletin was used to recruit 400 self-selecting nurses and midwives, initially in four groups. A fifth group was added early in the project to include site clinical managers.

1. Specialist nurses: clinical nurse specialists, nurse specialists, advanced practitioners, nurse practitioners with other titles (bands 6-7)
2. Clinical leaders: ward managers and ward sisters, team leaders across each of the three hospital sites (bands 6-7)
3. Practice development facilitators (band 7)
4. Consultant nurses (band 8)
5. Site clinical managers

The remit was expanded early in the project to include clinical educators and research nurses who were included in group 1. A number of other groups have been identified who were not able to be included in this first phase of the project, including emergency nurse practitioners. To facilitate consistent communication, a Google wiki was established. This is a private website that can offer access to tools and documents, and provides a safe environment for participants to discuss the project.

Project methods

Participants were invited to attend a series of six active learning sets to engage in a self-assessment against six relevant frameworks, a qualitative 360 degree feedback process including patients and service users (Garbett et al., 2007), and a reflective review (see Tables 1 and 2). The frameworks were:

- Person-centredness, effectiveness and innovation
- Transformational leadership
- Facilitating learning and development in the workplace
- Consultancy practice
- Research and scholarly inquiry
- Practice development

Patients, carers and service users were incorporated into the 360 degree feedback through a specially designed protocol developed with Kunle Thomas, the trust's head of patient experience, that protected the anonymity of the patients and applied no pressure on them to participate. These activities were used to construct collaboratively the shared purpose framework for the organisation.

Table 1: The focus of active learning activity within each group

Group	Number of sessions	Focus and activity
Group 1: specialist nurses	Invited to attend ideally in the region of six dedicated sessions of two to three hours from a menu of 54 sessions offered across the three sites, including evening sessions	<ul style="list-style-type: none"> • Hopes, fears and expectations for the project • Self-assessment against six frameworks • Qualitative 360 degree feedback • Reflective review • Recommendations for specialist review
Group 2: clinical leaders/ward managers (bands 6-7)	Six sessions of one hour were provided within the quality and safety review meeting that all ward managers (band 6/7) attend on WHH and KCH. Four sessions of one hour were provided at the QEQM site	<ul style="list-style-type: none"> • Introduction to three frameworks: <ul style="list-style-type: none"> – Principles of Nursing Practice (RCN, 2010) – Supervisory Role of Clinical Leaders and Ward Managers (RCN, 2010) – Framework for Developing Cultures of Effectiveness (Manley et al., 2007) • Negotiated focus varied around the three sites but included aspects such as: role in Symbiotix, strategies for providing high support and high challenge; introduction to the high support and high challenge matrix; transformational leadership; peer support and review; and strategies for supervising others • Recommendations for specialist review
Group 3: practice development facilitators	Five sessions of two hours	<ul style="list-style-type: none"> • Hopes, fears and expectations for the project • Role of practice development facilitators • Self-assessment against six frameworks • Qualitative 360 degree feedback • Reflective review • Strategies for obtaining peer active learning for the future
Group 4: consultant nurses	Five sessions of two to three hours	<ul style="list-style-type: none"> • Hopes, fears and expectations for the project • Role of consultant nurses in project • Information about the specialist review and opportunities to critique • Recommendations for specialist review • Action learning
Group 5: clinical site managers	Nine sessions of two to three hours	<ul style="list-style-type: none"> • Hopes, fears and expectations for the project • Develop a common vision and role definition for clinical site managers • Self-assessment against six frameworks • Qualitative 360 degree feedback • Reflective review • Recommendations for specialist review

WHH – William Harvey Hospital; KCH – Kent and Canterbury Hospital;
QEQM – Queen Elizabeth The Queen Mother Hospital

Table 2: Main methods, their contribution to the project and their purpose

Method	Description	Purpose
Self-assessment	<p>Self-assessment against six relevant frameworks:</p> <ol style="list-style-type: none"> 1. Nursing practice linked to evidence base and innovation 2. Consultancy approach in terms of getting as much expertise to as many people as possible 3. Transformational leadership as the leadership style most influential on effective workplace cultures 4. Facilitating workbased learning and the skills required to facilitate formal and informal learning in and from practice, as well as its evaluation and impact on the patient 5. Practice development: the skillset required to enable others to develop, provide and sustain person-centred, effective care and cultures of effectiveness in the workplace 6. Facilitating inquiry, evaluation and evidence use, including research skills and expertise across different relevant research approaches 	<ul style="list-style-type: none"> • To provide data to inform the development of the framework • To enable practitioners to become familiar with the key skills and ideas necessary for providing person-centred and effective care and a culture of effectiveness in the workplace • To enable practitioners to start their own journey of inquiring into and reflecting on their own effectiveness and development
Qualitative 360 degree feedback	<p>This involved practitioners identifying their role and asking for open feedback from representatives of each role group in relation to four questions:</p> <ul style="list-style-type: none"> • What is your understanding of my role? • What have you experienced that I do well in my role? • What constructive feedback can you give me to help me become more effective in my role? • What other feedback would you like to give me on my role? <p>Patients, carers and service users were incorporated into the 360 degree feedback through a specially designed protocol developed with Kunle Thomas, head of patient experience, that protected the anonymity of the patients and applied no pressure on them to participate</p>	<ul style="list-style-type: none"> • To develop role clarity for self and others. • To begin to learn how to give and receive open and direct feedback about one's effectiveness • To develop skills in qualitative analysis of data • The first two characteristics (role clarity and giving and receiving feedback) are essential for effective workplace cultures
Reflective review	<p>This method, based on the work of Chris Johns (1995), encouraged participants to reflect on their experience in the active learning sets by using the following reflective questions:</p> <ul style="list-style-type: none"> • What are your aims and hopes at the beginning of active learning? • What internal and external factors will help or hinder you in the process of active learning? • What are the main work themes that emerge for you? • What is your learning from the process? • What are the work themes that you need to address for the future? 	<ul style="list-style-type: none"> • To encourage participants to link their past and present learning to their future ways of working by encouraging them to reflect on their experience in the active learning sets and in using the methods

Participants were given a choice of 65 pre-arranged sessions (of which they chose six to attend). Sessions were organised at different sites and times, including evening sessions, over a three month period to enable accessibility and inclusivity. A set of common ground rules were developed collaboratively, based on participants' perspectives of the factors that would enable them to experience a safe environment for learning, support and challenge. These rules were used consistently across all active learning sets, as the combination of participants attending any one set were not the same each time. This way of undertaking active learning is a variation of a more 'ideal' approach where the same group of staff learns together over an agreed number of sessions; such an approach was not possible because of the short timeframe of the commissioned piece of work, the number and range of staff involved and the complex organisation with multiple sites across a wide geographical area. So, facilitators (the joint appointment and colleagues from the local university) worked flexibly to support participants to attend up to six sessions of their choice from any published slots available across the organisation. However, there were benefits from this variation in approach in that specialist practitioners were exposed to each other's expertise, values and practice aspirations for the first time outside the professional specialist silo groups. This was influential in developing cross-organisational networks and mutual appreciation of each other's contribution.

The active learning sets supported participants to begin their own journeys of cultural change (although they did not recognise this at the time) through being exposed to ways of working that reflected the CIP principles. The focus of activity was self-assessment against six frameworks to help participants develop their own insights about where they were across a number of continua relevant to providing person-centred, safe and effective care, and where they wanted to be (see Table 2).

Clinical leaders were simultaneously supported through shorter sessions and these focused on identifying issues that were important to them in their daily work, as well as helping them to work together to support and challenge each other (see Table 1). The CIP principles were therefore used at two levels – first, as the principle ways of facilitating the project and second, to support participants in using these principles with their own teams, patients and stakeholders. In all groups, it was clear that practitioners were not used to working collaboratively outside their own immediate silos, with many feeling isolated and unsupported as well as sceptical about the organisation's motives for developing the framework. Systematic process evaluation was undertaken across all active learning sets, with individual and collective opportunities for learning that addressed perceived need.

Practitioners' own self-assessment data, generated by using the tools and methods outlined in Table 2, provided an independent dataset arising from each method. Each dataset was analysed independently using inductive thematic analysis. The themes, with associated examples, were then integrated under the four purposes derived from the original frames of reference to structure subheadings and identify performance indicators, related knowledge and knowhow linked to the NHS Careers Framework levels of registered practitioner (level 5) to consultant practitioner (level 8). Participants' self-assessment revealed a number of gaps, particularly around person-centred care and its evaluation, team effectiveness, research and inquiry, peer review, reflection, culture change, clinical leadership and how to use the workplace as the main resource for learning. This was accounted for by it being a new focus for the trust. To fill these gaps, the self-assessment tools were used to guide the population of the shared purpose framework, as the tools had been derived from practice related research and inquiry projects and/or the literature. Other components integrated into the framework included the trust's competences for patient safety and organisational effectiveness.

The resulting framework, project report and recommendations were exposed to practitioner critique through extensive consultation. The impact on participants of this first phase is summarised in the quote below and in Box 1:

'...with investment in a safe environment; time spent addressing practitioners' concerns and issues; focusing on developing a common vision around the framework's purpose; and providing flexible support with the methods involved, the project began to demonstrate the early outcomes expected of using practice development processes. These included, for example, participants taking responsibility for their own actions, becoming self-directing, and supporting and challenging each other – all steps towards an empowered workforce' (Manley et al., 2011c, p 20).

Box 1: Excerpt from final report summarising the experiences of participants at end of the phase generating the shared purpose framework (Manley et al., 2011, p 20)

Generally, those who were able to participate in all the methods demonstrated excitement about the project as they could see the potential benefits. It helped give individuals time to think in a deeper way about their roles and how they could work with others to improve care and services for patients, as well as work more efficiently by learning lessons from others. Many of the concepts introduced to participants were new and unfamiliar, and perseverance was required to work with them or see their relevance. Others struggled to complete the work at the same time as completing academic assignments. Many chose to come into active learning on their days off or after their work. One of the greatest benefits was the opportunity to share and celebrate examples of excellence in care as well as getting to know others across the trust and realising that participants were not alone in their reflections about their work. Another key benefit was the revealing of examples of high quality nursing and midwifery care and innovation – this was experienced by all as humbling.

The following haikus were generated during the project by different groups but capture the sentiment of most participants at some point in the project's journey.

*'Nervous and inspired
Overwhelming. Challenging
See the way forward'*

*'Reflective hard work
A thought provoking headache
Challenge, reassurance'*

*'Honest, uplifting.
Supporting, understanding.
Not a waste of time!'*

*'Challenging, inspired
Thought provoking, emotive
Insightful, timely'*

The shared purpose framework

The framework was the main output of the project from Phase 1. It has been structured around the NHS Career Framework and is based on the 'outcomes' approach to competence, favoured by Skills for Health and the NHS Knowledge and Skills Framework (Department of Health, 2004). This approach makes clear the actions expected in the workplace, informed by the knowledge, skills, knowhow as well as the behaviours required. Key contextual drivers are also identified. Both the Knowledge and Skills Framework dimensions and the trust's own organisational effectiveness criteria were mapped to the framework.

The trust's subsequent 'shared purpose framework' identifies four key purposes (see Figure 1):

- **Person-centredness** – how we work with patients, service users and each other
- **Effective care** – how we use and develop evidence to underpin our interventions, approaches and the ways we organise care delivery
- **Safe care** – how we practice safely but also develop safe environments
- **Developing effective workplace cultures and teams** – how we sustain the above outcomes through leadership, enabling continuous learning, improvement, research, development and innovation

These purposes have subsequently become the trust's working definition of quality and are aligned to its three core values – care, safety and making a difference – identified through extensive engagement with service users and staff in the trust's 'We Care' campaign in 2012/13.

The four purposes of the shared purpose framework are easy to remember and make explicit what is expected of staff at every level of the NHS Career ladder. It integrates performance indicators, knowledge and know how, attitudes and behaviour and contextual factors. Each purpose is therefore linked to the trust's quality strategy and also embraces the 6Cs (Care, Compassion, Communication, Courage, Commitment and Competence) arising from the UK's national nursing and midwifery strategy (Department of Health, 2012). The trust subsequently endorsed the relevance and importance of the shared purposes and the 6Cs for all staff groups. The framework was expanded to include staff at bands 2 to 4 of the NHS Career Framework and to embrace the contribution of others through the development and refinement of self-assessment tools through workbased programmes. Through support of the consultant allied health professional (AHP) and integration of AHPs and clinical scientists as participants in the workplace programmes, the relevance of the shared purpose framework is becoming embedded for a wider range of healthcare staff. Work continues in this area as more groups of staff are engaged in the framework and its link with organisational values. To illustrate the focus of each purpose, Table 3 identifies the sub-purposes.

Figure 1: The shared purpose framework linked to organisational values and statements service users would be making if the purposes are being delivered

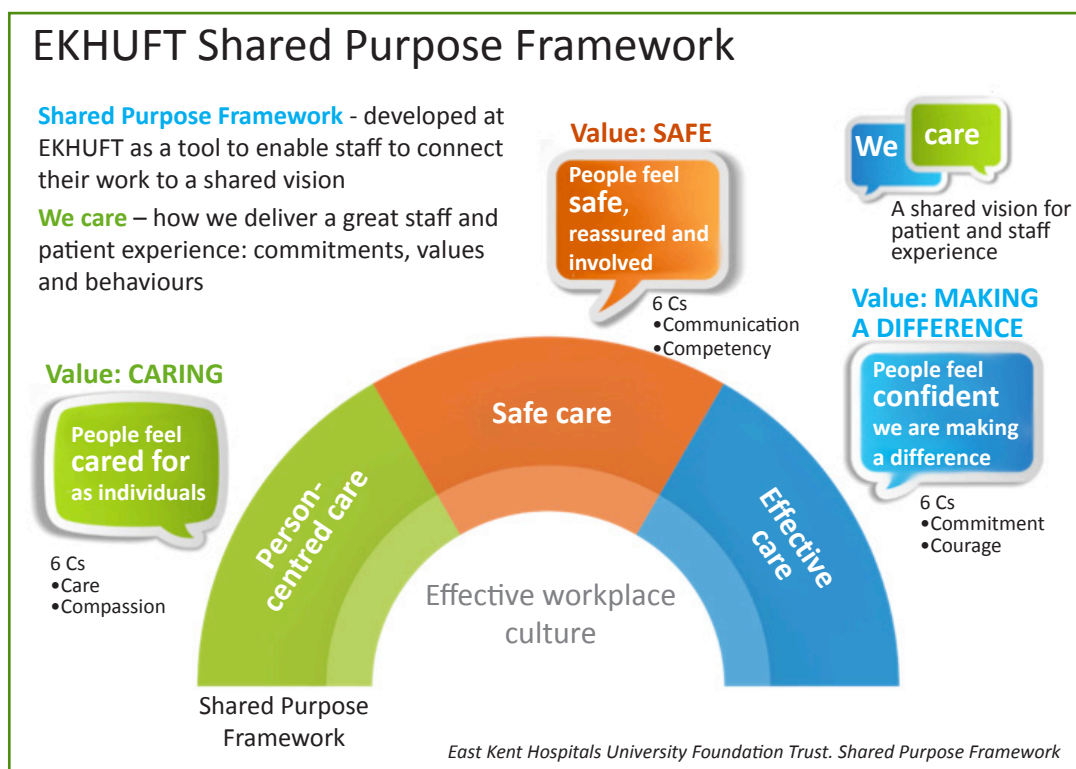


Table 3: Shared Purpose Framework – sub-themes

Person-centredness	<ul style="list-style-type: none"> • Providing person-centred compassionate care • Courageously speaking up for and listening to patients • Inviting and using patient and service user feedback • Working in a person-centred way with others
Safe care	<ul style="list-style-type: none"> • Providing safe care • Embedding the safety culture • Reviewing and improving safety practice
Effective care	<ul style="list-style-type: none"> • Providing effective care to individuals and groups • Maintaining one's own effectiveness and enabling others to be effective • Evaluating and researching effectiveness
Effective workplace culture	<ul style="list-style-type: none"> • Being self-aware and developing effective relationships • Working as an effective team • Leading person-centred, compassionate, safe and effective care • Active learning for transforming care and practice • Developing, improving and innovating

Bringing the shared purpose framework to life: embedding and sustaining shared purpose and values in everyday work

Having identified how the shared purpose framework was developed through the Phase 1 project work, the paper now explores the wider context of culture change identifying the activities that:

- Embed the shared purposes and values through individual and team effectiveness, for example, raising self-awareness and focussing on actions through learning, development and leadership to create a culture of feedback, high support and high challenge
- Introduce systems (structures, processes and patterns of behaviour) that sustain the shared purposes and values in everyday work and practice

Specific examples and the timeline associated with their development are presented, with a focus on enhancing individual and team effectiveness through the following four initiatives:

1. Trust clinical leadership programme
2. Becoming an effective appraiser programme for medical consultants
3. Aspiring consultant practitioner programme
4. Matron-led peer review

Five examples then follow to illustrate how the framework is being embedded to enable organisational effectiveness.

Embedding the shared purpose and values through initiatives focusing on individual and team effectiveness

The paper now describes the four initiatives aimed at embedding the shared purpose framework at the individual and team level within the organisation. The systematic collection of evidence of impact is integral to each initiative and a brief summary of the tools used is provided.

1. Clinical leadership programme

The first challenge was to bring the shared purpose framework to life, with particular attention being given to growing the number of people with the critical mass of skills needed to transform culture; culture cannot be changed by single individuals but needs to be embraced in everyone's relationships and embedded in the social system guiding social norms. The immediate priority was to focus on strategies that achieve culture change at the frontline – specifically transformational leadership, as it is this leadership approach which most impacts on workplace cultures at the micro-systems level (Manley et al., 2011b). A 10 month interdisciplinary clinical leadership programme, running twice a year and accredited with the local university, was launched in June 2012 supported by an organisational mentorship network. The programme uses a cohort approach and participants are self-selecting, operating currently at band 7 or equivalent within the organisation and drawn from all healthcare staff groups. The aim of the programme is to help clinical leaders develop and sustain effective workplace cultures that are person-centred, safe and deliver effective care across their teams, using the shared purpose framework as the bedrock for self-assessment. Participants specifically focus on enabling others to:

- Develop and live a shared purpose
- Give and receive feedback to develop a clear understanding about how they and others perceive themselves
- Provide a culture of celebration, high support, high challenge, self-awareness and learning
- Build in team members the skills required to enable others to become effective, to grow leadership potential and develop self-sufficiency in learning rather than dependence

The programme uses tools including qualitative 360 degree feedback (Garbett et al., 2007) to promote role clarity and confidence; it also uses observations of care (Royal College of Nursing, 2007) and emotional touchpoints (Dewar et al., 2009) to place the patient's experience, and those of relatives, staff and students, at the heart of care – bringing a person-centred approach to life. The 360 degree

feedback tool is not anonymous. This is because effective cultures are characterised by the direct giving and receiving of honest feedback in a way that is respectful and enabling. Using this approach to feedback has been challenging for staff who are used to providing challenging feedback anonymously. Through persevering with growing relationships where direct and honest feedback is becoming the norm, this strategy is beginning to pay off and forms the foundation of an organisational peer review system led by matrons.

Clinicians, such as clinical scientists, have experienced what it is like to use the observations of care tool while waiting in a phlebotomy department and have identified how these departments could become more person-centred.

The programme uses systematic approaches to gathering evaluative data on the experiences of participants throughout each 10 month cycle, including daily evaluations, claims, concerns and issues (Guba and Lincoln, 1989), action plans and participants' critical reflective reviews.

The following quotes illustrate the impact of the leadership programme on participants:

'I was an autocratic manager and building dependency through giving advice had not enabled my team.'

'The most powerful thing for me is that I have changed from being an autocratic manager to being an empowering leader.'

These initiatives are now beginning to have a life of their own with practitioners at all levels, not just clinical leaders, involved and enthused by these developments. The leaders on the programmes are in turn enabling their staff to become leaders – one of the characteristics of transformational leadership.

'The tool to which I frequently return, with my once fractured team, is claims, concerns and issues – a tool I learned to use in the clinical leadership programme. My initial apprehension, thinking it may initiate a tsunami wave of negativity, has been usurped by the overwhelming desire by the team to strive for best practice, finding solutions and making suggestions to improve the experience of our patients' (Clinical leadership programme participant).

Evidence suggests that clinical leaders are taking responsibility for changing the culture of their team and taking additional leadership roles in this respect across their own hospital sites:

'As clinical leaders, we have felt collectively empowered to drive our passion for person-centred care throughout our hospital. At a recent initiative, we invited staff to participate in undertaking observations of care and emotional touchpoints. The experience was powerful, inspiring and humbling. I never want to lose those feelings of being humbled by our patients' experiences, and the feedback from those who participated in our initiative; I would suggest that our staff feel similarly' (Clinical leadership programme participant).

The most noticeable outcome is that mentors of the participants recognise changes in ways of working after a short period of time, augmented by feedback from others in the participants' role sets collected through the use of qualitative 360 degree feedback.

The development of other workbased programmes integrates the shared purposes and values in different ways. For example, in supporting medical colleagues in revalidation and appraisal, it helps them focus on skills that are vital for building effective relationships through giving and receiving feedback, high support and high challenge, and identifying critical questions through reflection.

2. *Becoming an effective appraiser programme for medical consultants*

In the autumn of 2013, the trust held three workshops lasting three hours each at each of the three main sites to support previously trained consultants with the appraisal and revalidation process. Their aim was to help participants to become effective appraisers through:

- Identifying key challenges as appraisers
- Developing skills in giving and receiving feedback
- Providing high support and high challenge
- Enabling appraisees to develop their skills in reflection

The workshops used a claims, concerns and issues tool (Guba and Lincoln, 1989) systematically to gather experiences of the appraisal process for revalidation. This data has been collaboratively themed by participants and used to:

- Inform the focus of each workshop
- Identify areas requiring skills development in giving and receiving feedback
- Create a concept analysis framework summarising the essential enabling factors, attributes and consequences of effective appraisal

The framework provides an aide memoire for individual appraisers, a tool for peer review and support. It also may act as a framework linking the trust's four shared purposes and integrated values into appraisal practice. This programme has been a valuable hook for engaging medical practitioners in embracing shared purpose and culture change on the back of their interest in revalidation. A clinical leadership programme for clinical leads using the workplace as the resource for learning is now being established and this will enable further engagement around developing effective workplace cultures together.

3. *Aspiring consultant practitioner programme*

A 12 month programme was launched in July 2013 for aspiring non-medical consultants – nurses, midwives, allied health professionals and clinical scientists. It is based on an evaluated programme of support previously researched at the Royal College of Nursing Institute, which demonstrated the impact of developing consultant practitioner skills on individual, team and organisational effectiveness (Manley and Titchen, 2012). Participants select an internal and external mentor to assist them with achieving their potential. This unique programme, the only one of its type in the UK, enables participants to assess themselves against the trust's shared purpose framework, and to develop and achieve a personal development plan to demonstrate their readiness to apply for a consultant practitioner post. As future clinical and strategic leaders at the pinnacle of their specialism, participants are supported to obtain academic credit at Masters level through the Masters in Practice Development and Innovation run by the local university, or begin to prepare for a clinical doctorate or PhD. Box 2 illustrates a pilot project involving two aspiring consultant practitioners in an initiative to improve and embed person-centred, safe and effective care across urgent care pathways

Box 2: Piloting consultant nurse posts to improve and embed person-centred, safe and effective care across urgent care pathways

The trust is investing in consultant nurse roles because of their expertise in culture change that transforms practice, and delivers and sustains the organisation's shared purpose of providing person-centred, safe and effective care.

A programme for aspiring consultant practitioners (non-medical) has been established across the trust to develop expertise in culture change as well as continuous improvement, development and innovation through a Quality Improvement and Innovation Hub.

The initiative involves two aspiring consultant practitioners on this programme who have grasped the opportunity to pilot a consultant nurse role in acute care, at the same time as addressing the trust's priorities across urgent care, by working collaboratively with each other and stakeholders to address this agenda at two of the trust's sites, which have large A&E departments.

The objective of the initiative is to add value to the patient journey in urgent and emergency care, initially through a six month pilot.

4. Matron-led peer review

Currently the trust is implementing Matron-led peer review for the following purposes:

- To develop and implement a peer review system for assuring quality of care and services
- To celebrate and share best practice and improving approaches
- To identify and action points for development
- To embrace and embed the four purposes (quality) across the trust
- To give and receive feedback

Each review team comprises six members:

- Matron/senior nurse/head of nursing
- Ward manager
- Consultant/doctor
- Patient representative/governor
- AHP/administrator
- Student (nursing/midwifery/AHP/medical)

It is hoped that this system will further contribute to ensuring person-centred care and culture, developing team effectiveness through an appreciation of the contribution of all, and building a strategy for recognising and celebrating teams that excel in evidencing their achievement of the four purposes.

Embedding the shared purpose and values through initiatives focused on implementing systems for organisational effectiveness

One of the attributes of effective workplace culture is 'Formal systems that enable continuous evaluation of learning, evaluation of performance and shared governance' (Manley et al., 2011b p9). Systems enable purposes and values in social systems to be embedded and endorsed, reflected in the saying 'form follows function'. Person-centred, safe and effective care and cultures need to be supported by 'whole systems approaches', through integration and interaction to embed shared values and purposes in structures, processes and patterns of behaviour (Plsek, 2001). Five examples of organisational initiatives and systems to sustain shared purpose and values across the trust are illustrated below:

- 'We Care' values campaign
- Front Line Friday initiative
- A Quality Improvement and Innovation Hub (QII Hub)
- Portfolio development linked to related learning and development provision
- Research, development and innovation strategy

'We Care' values campaign

The trust conducted a 'We Care' feedback survey in July 2013, listening to more than 1,500 patients and members of staff to distil new trust values and behaviour standards. The objective of the survey was to 'sense check' whether the values, linked to the shared purpose framework, were right for the organisation. The values describe how the trust aims to be with patients, family members and among staff, and sets out the organisation's ambition to 'show that we care', and to:

'...provide an excellent experience for everyone we work with. They will become part of the way we work, how we recruit and appraise, how we care for patients and colleagues, and how we measure and improve their experience.'

Each of these values will be evidenced through a more detailed description of behaviours that staff and patients are looking for (see Box 3). The 'We Care' campaign was launched in September 2013. It is clear from the survey that while many staff welcome of a set of shared values and behaviours, they reserve judgment on how successful this can be until they see action being taken – action to acknowledge good practice, challenge poor behaviours and address the feedback they have given through the anonymous comments made on staff 'graffiti boards' and other listening exercises.

Box 3: 'We Care' values

CARING People will feel cared for as individuals. Because we are welcoming and polite, attentive and helpful; we respect people, their dignity and their time, and we have the courage to speak up when others don't.

SAFE People will feel safe, reassured and involved. Because we are consistently safe and reassuringly professional, we listen and communicate clearly, and work as an effective team.

MAKING A DIFFERENCE People will feel confident we are making a difference. Because we take responsibility for delivering the best outcomes, act as leaders where we can, and we look to improve and develop ourselves and our services.

Embedding the framework through the Front Line Friday initiative

An evaluation of the Front Line Friday initiative has helped to clarify the strengths of the implementation programme to embed the shared purpose framework and to highlight the areas that require further development. The evaluation was undertaken to focus on the role of:

- Senior executive nurses in understanding and experiencing the everyday working lives of frontline staff and being visible at the frontline
- Matrons in establishing an interdisciplinary peer review system based on periodic three hour observations in relation to the culture and environment, patient experience and documentation to provide both immediate feedback and strategic action
- Specialist nurses and midwives in contributing to the patient pathway and evidencing this through annual reports (this is currently being piloted by acute oncology matrons)
- Registered healthcare practitioners (nurses and midwives) and administrative staff working in non-frontline roles in relation to how they can support frontline staff at times of major challenge (specifically, internal incidents, major incidents, black bed state, extreme winter pressures) through a the trust's Adopt-a-Ward Scheme

Using a stakeholder evaluation approach, the benefits of Front Line Friday for the organisation include the visible presence of senior nurses and managers in clinical areas, enabling them to be accessible to staff and patients. This presence has been well received by staff, patients, families and friends. There have also been benefits for participating individual senior staff, enabling them to retain, use, and learn new clinical skills. However, the main findings identified the need for:

- Clarity of primary purpose
- A process to deliver on the purpose
- A way of measuring the impact and effectiveness of Front Line Friday

The findings of the evaluation have been presented and discussed at the heads of nursing meeting and the matrons' forum, leading to four integrated approaches being identified to take forward the Front Line Friday concept integrated with the delivery of the trust's shared purposes and values. A six monthly review of the action plan will enable ongoing evaluation to take place.

Quality Improvement and Innovation (QII) Hub

The Quality Improvement and Innovation Hub, is an initiative originating from the trust's quality strategy, aimed at supporting all staff to bring about improvements and developments in the way they work, practice and organise services, across the trust and the wider health economy, to deliver on the four shared purposes and enable the trust to achieve its strategic and annual objectives. This requires support for staff to be streamlined, integrated and focused across the shared purposes in a way that improves access to information and expertise around ongoing learning, improvement, development, inquiry and innovation. In due course, the QII Hub will provide in one place the support necessary to enable a critical mass of skills and expertise to be grown across the organisation and avoid duplication of resources and effort and the financial consequences (see Box 4).

Box 4: The purpose of the QII Hub

The Hub will enable staff to:

- Share, integrate and access all improvement and development approaches (methodologies and methods), experience and expertise available across the trust. Currently, different approaches with similar processes and slightly different tools are used by different teams, all approaches focus on one or more of the four purposes. All approaches, tools and resources will be brought together in one place so they can be accessed and used appropriately
- Build on learning, experience and expertise from across different areas of the trust so as to enable a coherent and integrated path into the future, refining rather than reinventing the wheel
- Access the skills, support, learning resources, expertise and mentorship required to enable the workplace to become the main source of learning, improvement, development and inquiry
- Evaluate the impact of improvement, development and inquiry projects

Table 4 unpacks further the system the QII Hub provides in identifying the structures, processes and patterns of behaviour required to sustain the trust's purposes and values.

Table 4: Quality Improvement and Innovation Hub – a system to embed shared purposes and values

Structures, roles, enablers	<ul style="list-style-type: none"> • Facilitators and mentors to enable integration of improvement, development, innovation and inquiry approaches within and across divisions, supported by corporate expertise • Programmes of workplace learning with accreditation • Central repository providing: <ul style="list-style-type: none"> – Consistency of templates – Access to tools and approaches – Co-ordination, knowledge management/administration • Improvement indicators <ul style="list-style-type: none"> – Individual effectiveness – Team effectiveness – Service effectiveness – Organisational effectiveness • Organisational strategy, support and governance structures
Processes	<ul style="list-style-type: none"> • Helping people to become effective and efficient • Helping people to access expertise and support • Knowing and building on what is happening in and across the organisation • Learning, improving and motivating together • Demonstrating improvement
Patterns of behaviour	<ul style="list-style-type: none"> • Collaboration, inclusion and participation • Continuous improvement, development and innovation • Learning by using the workplace as the main resource for learning • Acknowledging and using expertise in a wide range of improvement, development and inquiry approaches • Using resources effectively and efficiently rather than duplicating or reinventing the wheel

Portfolio development and integrated approaches to learning and development

Portfolio development as a learning and development strategy enables the trust's purposes to be implemented and demonstrated in individuals who are attending workplace programmes (see Figure 2) through the use of self-assessment tools. Staff are supported by mentors linked to the QII Hub identified above. Portfolios are also valuable datasets for demonstrating the individual and collective impact of initiatives and ways of working arising from reflective learning and achievements.

Through close partnerships with the local university, programme accreditation is being achieved. This means that through developing a portfolio against the shared purpose framework and using structured reflection to make sense of the related theory, participants are able to obtain academic accreditation for what they have achieved in their workplaces. The outcomes of new curricula in the university at both undergraduate and postgraduate levels emphasise the same purposes of person-centred care. At the first level of workplace programme (see Figure 2), the expectation on completion is that participants produce a portfolio to enable 'link-worker' competences (Royal College of Nursing, 2012) to be developed across one of the four purposes for their own workplace team. This will enable, over a longer period, further development of a true shared governance approach in every workplace team.

Figure 2: Workplace programmes

Supporting staff with an integrated approach to:		
<ul style="list-style-type: none"> • Quality improvement • Practice development • Service improvement • Workplace inquiry 	<i>Facilitating inquiry, evaluation and Innovation</i>	<i>Inquiry, evaluation and innovation</i> <i>Masters level accreditation/ Clinical doctorate/PhD</i>
	<i>Facilitating service improvement across organisation</i>	<i>Improving patient flow across the patients' journey, and organisational effectiveness</i> <i>To be explored</i>
	<i>Facilitating quality improvement</i>	<i>Improving the patient's experience, enabling and demonstrating harm free and evidence informed care</i> <i>Masters accreditation</i>
	<i>Facilitating team effectiveness</i>	<i>Leadership for effective teams, safe and person-centred cultures. The clinical leadership programme</i> <i>Graduate Masters accreditation</i>
	<i>Facilitating individual effectiveness</i>	<i>Using the workplace as the main source of learning for individual effectiveness</i> <i>Graduate Masters level accreditation</i>

The local university has developed an innovative workbased and workplace Masters programme in practice development and innovation. Through flexible and virtual learning and development strategies, this enables the critical mass of skills required for effective workplace and person-centred cultures to be further grown. Virtual approaches enable participants to connect internationally with others developing these skills across the world. The modules again echo and build on the skills necessary to deliver on the four purposes of the trust's shared framework (see Box 5).

Box 5: Masters programme in practice development and innovation

Generally, those who were able to participate in all the methods demonstrated excitement. Using creative approaches to active learning, the programme aims to develop person-centred leaders and facilitators who can improve and sustain outcomes in person-centredness and effective care in the workplace to grow a critical mass of practitioners with practice development and innovation expertise. The programme will enable participants to develop the confidence, competence, knowledge and skills to become more effective within their organisation and to evaluate their impact as a practice developer or innovator in the workplace.

Core themes of the programme:

- Person-centredness
- Effective care
- Workplace culture
- Facilitation of learning
- Improvement and innovation
- Sustainability
- Workbased and workplace learning
- Growth, thriving and flourishing

Core modules. The programme consists of seven modules:

Year 1:

- Person-centred practice: outcomes and evaluation
- Negotiated workbased learning module
- Influencing effective workplace culture

Year 2:

- Facilitation theory for practice
- Becoming a facilitator in practice
- Participatory research: principles and methods

Year 3:

- Final practice development and innovation project

Linked initiatives across the trust to foster ongoing learning, development and inquiry, as well as enabling career progression and innovation, complement the above opportunities and include:

- A focus on growing internal mentors with the sophisticated skills of Critical Companionship (Titchen, 2003; 2004) – a mutual person-centred learning and development relationship
- Trust masterclasses that aim to bring expertise, innovation and fresh approaches into the trust across integrated agendas that embrace quality, improvement, development, research and inquiry, drawing on international speakers as well as local expertise and inspiring leaders
- Creative spaces to provide opportunities to make sense of masterclass sessions in terms of staff's own practice, and to share and take forward new innovations, practice developments and research in an enabling and safe environment, or just bring ideas and questions for exploration

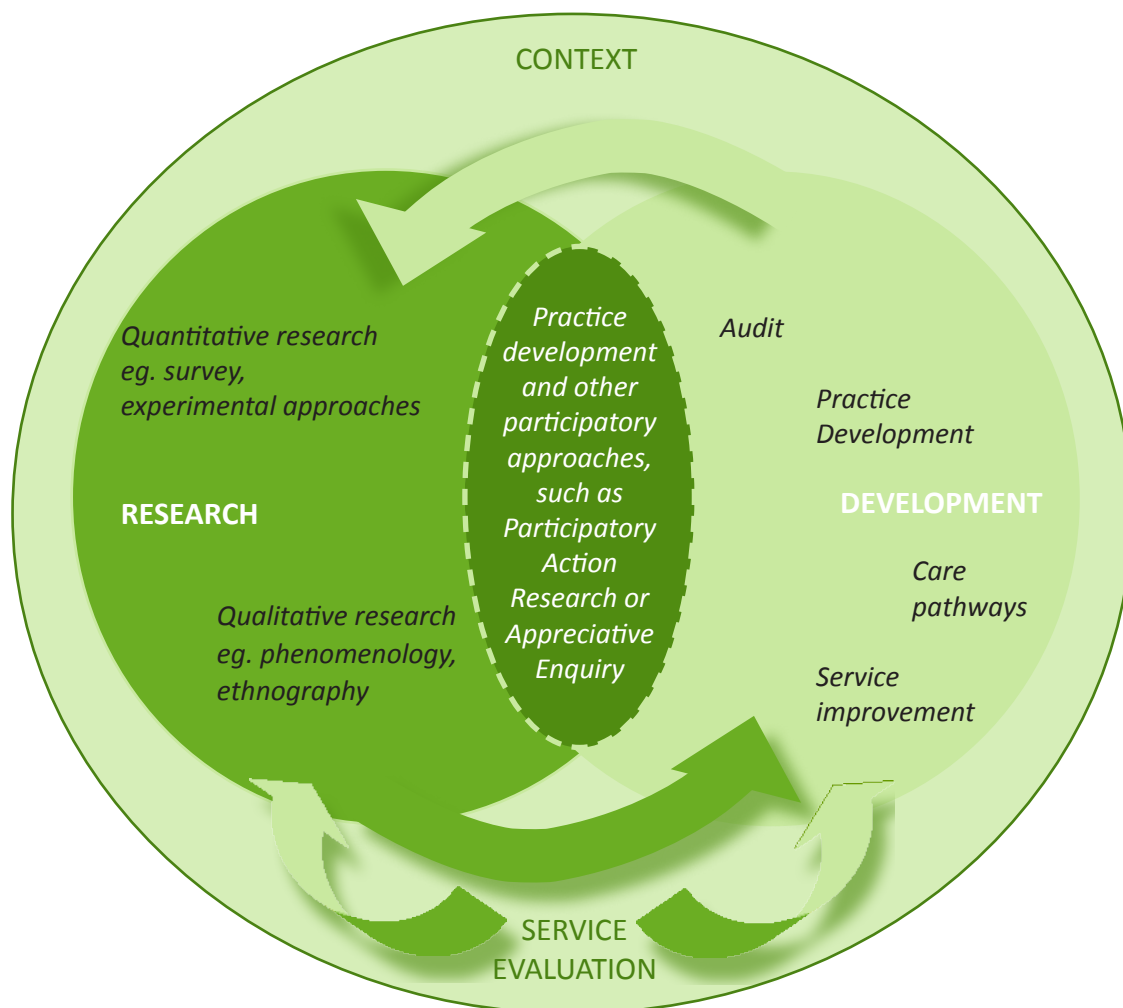
Professional portfolios and linked systems for learning, development and inquiry endorse and embed the trust's purposes by ensuring that they and the associated ways of working are at the forefront of learning and development. In addition to enabling the trust to reinforce its values and grow the

critical skills required, this provides focused opportunities for individuals to help them with academic accreditation, revalidation and/or demonstrating readiness for career progression, as well as celebration of their achievements.

Research and development strategy

Research, inquiry, quality improvement, learning and development are integrated in that they inform each other (Central Nursing Advisory Committee Research and Development Group, 2012) (see Figure 3).

Figure 3: Conceptual framework showing potential relationship between 'R' and 'D'



Research and development subgroup of the Central Nursing Advisory Committee Northern Ireland (CNAC R&D 2102)

Scholarly inquiry techniques in quality improvement, service and practice development contribute to the local and national knowledge base, and to evidence based approaches to transforming healthcare context, culture, systems and strategies in order to:

- Enhance patient experience, pathways and staff wellbeing
- Enable knowledge translation
- Achieve effective spread and dissemination of learning, inquiry and innovation

Workplaces that attend to these concepts are associated with the use and development of evidence in and from practice (Manley et al., 2011b), and the context and facilitation expertise required for knowledge translation and mobilisation (Rycroft-Malone, 2013). The first goal and linked objectives of the trust's R&D strategy (see Box 6) illustrate how, through this strategy, systems will enable an integrated approach with a positive impact on the four shared purposes.

Box 6: Goal 1 – Fostering a vibrant research, development and innovation culture

Our **aim** is to foster a vibrant research, inquiry, development and innovation culture across every area of the trust, manifested in: evidence informed practice and services; evidence developed from practice through scholarly, systematic inquiry and evaluation of developments; innovations in practice, the patient experience, service and quality improvement; and increased numbers of patients, service users and staff involved in research across a spectrum of approaches.

Our **success** will be measured by:

- The launch of the Quality Improvement and Innovation Hub and the number of people accessing this
- A mentor system and growing numbers of mentors available to support staff across different research, development and improvement approaches as part of the Quality Improvement and Innovation Hub
- The number of knowledge transfer grants obtained by the trust
- Raised staff awareness and interest through a well attended interdisciplinary masterclass series led by the trust and sharing national and international expertise around varied research, development and innovation approaches and topics. These may include specific health area research topics and innovations, as well as different research and inquiry approaches, methodologies and methods
- The number of action research studies and level of staff attendance at the trust's research forums, to evidence the number of staff involved in scholarly inquiry around their own practice and service
- Increasing the number of applications to 'After *Dragons' Den*' (whereby staff apply for support to implement innovations) that include an evaluation strategy
- Number of research, development and improvement projects with patient/service user/governor involvement

East Kent Hospitals University NHS Foundation Trust R&D Strategy 2013-2016, version 2.3, p 10

Reflection, critique, next steps and conclusion

This paper has presented an example of organisational transformation and culture change using practice development methodology by developing a shared purpose framework, in tandem with helping staff start their own journey of transformation through self-assessment against frameworks relevant to the delivery of person-centered, safe and effective care. The shared purpose framework has four purposes that are easy to remember. The detail underpinning these purposes is captured through performance indicators, knowledge, knowhow and behaviours expected of staff at every level of the NHS Career Framework, therefore providing role clarity when combined with self-assessment and qualitative 360 degree feedback. Role clarity, transformational leadership – the focus of the clinical leadership programme – and the facilitation skills required to enable others to be effective are the three prerequisites individuals need to bring about effective workplace cultures in combination with organisational enablers (Manley et al., 2011b). The attributes of effective workplace cultures at the micro-systems level include a set of values about person-centredness, effectiveness and working with others. Only when these values are realised in practice, though a shared vision and staff working together creatively to implement and embed them, can an effective workplace culture be said to exist. All attributes have begun to be demonstrated in this practice development project across various groups in the trust. But what of its consequences – what difference does it make? Manley et al. (2011b) identify the consequences of effective workplace cultures (see Box 7).

Box 7: Consequences of an effective workplace culture

C1. Continuous evidence that:

- The needs of patients, users and communities are met in a person-centred way
- Staff are empowered and committed
- Standards, goals and objectives are met (individual, team and organisational effectiveness)
- Knowledge/evidence is developed, used and shared

C2. Human flourishing for all

C3. Positive influence on other workplace cultures

Manley et al., (2011, p 9)

While it is increasingly possible to provide evidence of such consequences among the staff and the teams who have participated in the activities described, within such a large organisation there are still others who do not know what the shared purpose framework is or what it means. Constantly using values and purposes to inform decision-making is therefore an ongoing activity that requires resilience and perseverance, and explicit demonstration of how this way of working impacts on organisational, individual and team effectiveness.

Developing effective and flourishing cultures includes using the CIP principles to work with the whole healthcare team. The next steps involve:

1. Building further on the work undertaken with medical staff around becoming effective appraisers to help them develop their clinical leadership skills relative to the shared purposes
2. Widening participation and engaging groups who have yet to be involved
3. Demonstrating more explicitly the impact of culture on ward dashboards, staff wellbeing indicators, the safety thermometer and incident analysis
4. Developing a recognition system for the individuals and teams that demonstrate best practice across the four purposes

Major culture change, in even small organisations, takes years to embed and so it is too early to identify the extent or precise nature of its impact. Manley et al. (2011a) argue that demonstrating the presence of the five attributes that characterise effective workplace cultures can provide feedback that workplaces are travelling in the right direction and are more likely to go on to deliver on improvements in health outcomes, person-centred experiences and flourishing cultures.

Transforming culture is a challenging process, which requires resilient people with long-term commitment, and very good systems of high support and high challenge. The process cannot be sustained without a strong commitment to a shared purpose. This practice development project has demonstrated the development of a shared purpose, which is increasingly reflected in a social movement that has grown up across the organisation and other areas of the local health economy. An increasing and genuine willingness to work together in an integrated way is now more commonly experienced. While there is still some way to go, the authors are optimistic that we are travelling in the right direction and that, over the coming years, if our shared purpose is the main driver to our decision-making and actions, then benefits in terms of cultures that enable everyone to flourish will result. In summary, the key insights arising from this journey of culture change are:

- The importance of using the CIP principles to develop and implement shared purposes and values
- That explicit attention must be paid to developing effective workplace cultures if person-centred, safe and effective care is to be sustained
- The joint appointment between healthcare providers and local universities is a catalyst that enables practice development and knowledge transfer to be aligned with and deliver on the strategic agenda

- It is vital to grow a critical mass of people with the key skills for enabling others to be effective across the organisation, and local university providers are key to this process
- There is a need for organisational strategies such as learning and development, research, innovation and quality to be focused on the shared purpose of the organisation and its staff
- Practice development methodology is a powerful way to help organisations define and embed shared purposes around the development of flourishing, person-centred and effective cultures

It is the leadership of staff at the frontline that will ensure the benefits of the shared purposes are experienced by all in practice – the people we serve and those who provide care and services. When it comes to understanding the power and importance of a shared purpose, these frontline staff deserve the last word:

‘The 6Cs and the shared purpose framework have proved to be the foundation of our shared vision as a ward. Embedding reflection relevant to the 6Cs within our appraisals reinforces a commitment to that shared purpose. I believe that once the culture is “right”, the tenets of the framework – safe, effective, person-centred care – are a natural progression’ (Clinical leadership programme participant).

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A commentary by David Ashton follows on the next page.

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COMMENTARY

A shared purpose framework to deliver person-centred, safe and effective care: organisational transformation using practice development methodology

David Ashton

This paper offers a useful contribution to the field of practice development by articulating an organisational intervention strategy. Notions of and approaches to organisational change, particularly when they are discussed in relation to contested constructs around culture, are often difficult to distinguish. The correlation between a particular change intervention and an outcome is sometimes difficult to track and even more difficult to sustain over time.

My connection to this field is partly as a nurse but more accurately as someone working in the field of leadership and organisational development in the NHS in England. Much of my work has involved me in the psychology of identity at work, role transition for people working in the caring professions and inclusion/exclusion and diversity in a work setting.

One of my observations of the paper is the very positive and substantial effort made to include a broad range of contributors to the research. However, there are just a couple of comments I would make on how this could have been enhanced. First, I wonder if the view/voice of the patient, carers or service users might have been used or at least acknowledged in some way. This may have indeed been done but if so I do think it could be drawn out in a more robust way. Second, there is an absence of reference to diversity as an indicator of organisational culture and the part it plays in relation to practice and ultimately patient care. I'm thinking it would have been helpful to reference in particular the work of Michael West and Jeremy Dawson (2012).

Within the project methodology there is a helpful breakdown of participants by job title. Mention is also made to the fact that participants for the study were self-selecting; I wonder if self-selection combined with some targeted participant selection might have yielded different, or possibly more robust, data. As stated, what isn't clear from the paper is the level of diversity within the participant group. If we consider the work done by Michael West and Jeremy Dawson on the correlation between organisational climate, the degree to which black and minority ethnic staff feel included or excluded and the outcomes on patient care, the split of participants in terms of ethnicity would help inform the reflections section of the paper.

I very much like the notion of shared purpose and the links made to practice development. Finney (2013) is well referenced here and I wonder if this could have been strengthened by acknowledging the slightly different perspective offered by the notion of differences of 'primary task' – normative, existential and phenomenal – proposed by Obholzer and Roberts (1994). So while I do concur with alignment of values and beliefs, I do think the darker side of group think, complicity and in/out groups needs to be explored, however briefly, to give some balance. This could have been used to bring into focus the notion of diversity and the space needed to allow for different world views.

This is a helpful paper that adds to the body of knowledge relating to organisational and practice development. It would be helpful to further this research if the authors could consider:

- Revisiting the change approach over time in a longitudinal study
- The perception of service users and/or carers perspective of the change process
- An external view of the impact on quality – for example, by the Care Quality Commission
- The impact that purposefully approaching a range of staff from different cultural and ethnic backgrounds would make

References

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A response to this commentary by the authors follows on the next page.



RESPONSE TO COMMENTARY

A shared purpose framework to deliver person-centred, safe and effective care: organisational transformation using practice development methodology

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Dave Ashton, through raising a number of issues, provides us with an opportunity both to expand on some of the elements of this cultural change project and to challenge and revisit the assumptions we may have made about the direction we have taken.

This project has been facilitated and presented through the lens of transformational practice development, with its focus on developing person-centred cultures of effectiveness, using collaborative, inclusive and participative principles. Other perspectives will provide different insights and nuances that make sense of the factors and concepts considered influential from different frames of reference. Indeed, theory about anything is only a scientist's best explanation of the phenomena focused on, and as no knowledge is value free, we have tried to provide a balanced account of the processes we have used to develop a shared purpose framework, as well as to start a journey of cultural change with many of the staff working at the interface of care.

The first point to explore is the focus we have chosen to take on deliberately attending to workplace culture. This is timely, as the Francis Report (Francis, 2013) emphasises 'organisational culture' as does our commentator. While organisational culture has an impact on frontline care, the main focus within our paper is 'workplace culture' rather than organisational culture. This is not to say that organisational culture is ignored in practice development work – it isn't; it may/may not influence the workplace but organisational cultures cannot guarantee effective workplace cultures at the frontline. The reason, we argue, for paying attention to workplace culture is because it is at this level that staff, patients and service users interface – this is where the relationships are built that enable person-centred care to be lived and experienced. This is the level at which social norms have the greatest impact on the experience of both staff and service users. By developing a shared purpose and values inductively, based on both the experience and expertise of staff and patients and through engagement with them, a journey has commenced that was essentially about engagement and co-creation of values and shared purposes rather than cascading a top down approach. This echoes the sentiments captured in employee engagement by West and Dawson (2012), although embracing partnership with service users is also a key component in practice development work. However, for this type of work to be successful requires organisational commitment from the executive board to enable such a 'bottom up' approach to be supported. This support is recognised by the executive board as needing to foster clinical leadership in frontline teams and using the workplace as the main resource for learning through workplace programmes.

We recognise that shared values and beliefs in some situations can lead to 'groupthink' and agree with our commentator in this respect. We too consider groupthink to be unhealthy, as staff need to feel that their own workplace cultures support flexible and proactive thinking, and empower them to challenge, be creative, to think differently, and to embrace different ideas and innovation. Groupthink is not compatible with the culture we wish to create because it is the antithesis to a positive attitude

to change, open honest and direct communication, willingness to challenge, giving and receiving feedback, critical reflection, providing mutual high support and high challenge and valuing different ideas – the skills we are trying to focus on, not just to achieve effective workplace cultures throughout our organisation, but to resist the consequences of groupthink. Through using tools such as claims, concerns and issues (Guba and Lincoln, 1989), we actively encourage staff to be honest, open and direct, actively to listen to each other and to act on what is heard. The work of Kotter and Heskett (1992) and Dennison (1990) – admittedly regarding ‘organisational culture’ – has influenced how we try to minimise groupthink through focusing on the concept of adaptability. These researchers informed our understanding through recognising that strong cultures with shared values can become dinosaurs unless adaptability is a key value to enable workplaces to respond to a changing context and the needs of patients.

Dave Ashton identifies the need for the voices of patients and service users to be stronger in the process. Hopefully this will be something that will become increasingly evident as our values around person-centredness become more embedded from helping staff understand what being person-centred means and about being authentic in their partnerships with patients and service users who are included in all of our activities. Our emphasis has been on helping staff to work in partnership with people who are patients and stakeholders. These partnership models are growing stronger in the areas of care experiences, improvement and development approaches, learning, research and inquiry endeavours. The example below, provided by a user involved in our matron led peer review system, endorses the commentator’s recognition of the power of the service user’s voice:

‘As a lay person, I found the project incredibly interesting and informative. All the team were incredibly welcoming and helpful. I believe that regular visits will prove to be extremely positive for all concerned.

‘Thank you for involving me in this exciting project. I hope to be allowed to join you again. Thank you’ (Service user).

Concepts of person-centredness for us encompass recognising the person in all their diversity, and this is embedded in the shared purpose competences expected of staff and related self-assessment tools. The communities we serve are complex and varied, and this diversity is lived and experienced every day through the different communities and contexts in which service users and patients live – extending from both deprived and affluent coastal communities and large city conurbations through to many rural communities and specific populations; for instance, our Gurkha and travelling communities form significant sections of our population. Maybe we have not made these values explicit enough but they are fundamental to our understanding of person-centredness in respect of the patients and service users we serve and of our staff who provide the service. These values have much in common with cultures of engagement described by West and Dawson (2012, p 20):

‘...cultures of engagement, positivity, caring, compassion and respect for all – staff, patients and the public – provide the ideal environment within which to care for the health of the nation. When we care for staff, they can fulfil their calling of providing outstanding professional care for patients.’

In this paper we have sought not to undertake research, but to work with staff in a way that is systematic and rigorous, using processes of culture change informed by a practice development methodology that aims to develop flourishing cultures for all by helping staff to use the workplace (and the people in it) as the main resource for learning, and helping them to become aware of their values and purposes and to embed these into both workplace and organisational systems – as ‘form follows function’. We are using approaches that enable a critical mass of staff to begin to develop the skills required for cultural change. We have taken a bottom up approach with patients and staff to generate our shared purposes and values, drawing on the vast expertise of our staff and our service users. We have tried

to be transparent in sharing the processes we have used and although we may not have provided enough detail to satisfy all readers – this would have made the paper much longer – we would hope that our experiences offer food for thought to readers and stimulate further discussion to increase our collective understanding about how to achieve effective workplace cultures at the interface with service users, and what organisations need to do to support this.

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