An exploration of culture in one Irish health service organisation*

Research Report

* Former North Eastern Health Board which is now part of the Health Service Executive Dublin North East
An exploration of culture in one Irish health service organisation*

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September 2005

* Former North Eastern Health Board which is now part of the Health Service Executive Dublin North East
Foreword

This research report entitled An exploration of culture in one Irish health service organisation is published at a time of significant reform and development in the Irish health services. The current reform process is targeted at the whole health system and the interconnections and interdependencies between services, teams and people. Successful organisational change on this scale can only take place if there is a balanced approach to addressing the people and cultural aspects of change and the context in which people work on a daily basis. The decision to research culture was based on a realisation that our cultural mindset is the most significant factor that will contribute to our success in leading and guiding whole-system development and innovation.

The findings of this research provide us with a rich body of information about our organisational culture. The research areas targeted, as noted below, are consistent with the identified priorities of the Health Service Executive:

- People orientation
- Information and communications
- Leadership and direction
- Accountability and performance
- Integration and teamworking
- Continuous improvement and development

The publication of this research report is timely. We are now moving from an initial focus on structures to the leadership challenges at national, area and local level to bring about the cultural changes required to embed a unified national health system and to adapt to local service needs. The evidence gathered from this research in one Irish health service organisation will significantly inform our decision making in relation to real and lasting change and will provide us with a benchmark in moving forward within the context of the HSE.

I would like to thank all those who so willingly gave of their time and energy to the research process and contributed to its success. In particular, I would like to acknowledge Dr Noreen Kearns who led this research on behalf of the Organisation Development Unit for her committed and professional approach.

I am confident that the data from this research into organisational culture will make an invaluable contribution towards understanding and influencing the interventions required to address the people and cultural aspects of change.

Caitriona Heslin
Director of Organisation Development
Health Service Executive Dublin North East
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Acknowledgements

The author of this research report, *An exploration of culture in one Irish health service organisation*, would sincerely like to thank all the people who contributed to its development.

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To each staff member who took the time to complete the *NEHB Organisation Cultural Survey* (2004) and without whose participation this research would not have been possible, and to staff who contributed to the pre-testing and piloting of the survey instrument.

To Dr Freda Donoghue, of Trinity College Dublin’s Centre for Nonprofit Management, for her thorough counsel and contribution to overseeing the research aspects of this report.

To the members of the Organisation Development and Integration Working Group for their support and for their input at the pre-test and pilot stages of the survey.

To the members of the NEHB Regional Partnership Committee for their support and guidance on the research study and for participating in the piloting of the survey.

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Chapter 1

Introduction
Chapter 1 – Introduction

The external and internal contextual environment

The future direction of the Irish health system is primarily influenced by the significant changes in the external environment associated with the national health strategy, Quality and Fairness: A Health System for You (2001) and the Health Service Reform Programme (2003).

The empirical research conducted for the purposes of this report is based on one former Irish health board, the North Eastern Health Board (NEHB). In January 2005, the NEHB merged with the Northern Area Health Board (NAHB) in Dublin to become the Health Service Executive (HSE) Dublin North East. These changes were part of the overall restructuring of the Irish health services based on the national reform programme.

In addition to these pivotal external forces of change, the NEHB published a strategic framework entitled A Health Strategy for the People of the North East – A Framework for Change and Development (AHSPNE) in December 2003. This document translated the key national objectives of Quality and Fairness: A Health System for You (2001) and the Health Service Reform Programme (2003) into a regional strategic plan by establishing five high-level goals, objectives and associated actions.

AHSPNE (2003) was developed taking into account the need to ensure its relevance and transferability into the new system. It therefore provided a significant reference point for the development of this research and has been used to assist in the process of analysing the findings as outlined in this research report.

In essence, one could assert that these key external and internal strategic policy documents are core reference points in describing the desired culture in contemporary Irish health service organisations, the ultimate aim of which is to provide an improved health system for patients, service users, the public and health service staff. It follows that a vital task for health service organisations is how to negotiate an appropriate organisation/environment fit which enables the achievement of the desired future state of health care delivery. This research argues that a core component of negotiation in this regard comprises organisation cultural change, the first step of which entails an exploration of the existing organisational culture.
Why research organisational culture?

In the context of the challenges and opportunities inherent in the large-scale reforms associated in particular with the restructured health system and the strategic framework of the NEHB, this research asserts that it is necessary to understand the influence of culture on effective change. It is recognised in the relevant literature, as discussed in Chapter 4, that the importance of the ‘softer’ human and cultural factors associated with large-scale change and restructuring processes are frequently neglected or underestimated. In addition to the so-called structural and technical dimensions of change, softer cultural elements, including values, attitudes, beliefs, behaviours, practices and so on, play a pivotal role in change processes and outcomes.

This research asserts that the unprecedented changes taking place in the environment of contemporary health care organisations contain significant cultural dimensions which require appropriate cultural responses. A ‘business as usual’ approach is not appropriate. On the contrary, health care organisations are increasingly required to function differently in order to become more effective and responsive to the increasing pressures and demands in the health services. It is necessary, therefore, for health care organisations to understand the core characteristics of their own cultures. Based on this process of reflection, organisations are then positioned to determine in what respects and where cultural change is required.

This empirical research study, through an examination of the existing organisational culture and subcultures within the NEHB, provides valuable knowledge which may be used as a foundation to guide and implement change. The data from this exploration of organisational culture will contribute to a greater understanding of the degree of alignment between this organisation’s main cultural characteristics and the type of culture aspired to in key national and regional policy documents. This information will be outlined in greater detail throughout this report.

The development of the NEHB Organisation Cultural Survey (2004) emerged as a result of the recognised need to develop an informed understanding of the existing culture and subcultures within the organisation. Since it was developed at a time of significant change and reform in the Irish health services, cognisance was taken of the changing internal and external environment in order to ensure the relevance of the data being collated and the continued relevance of the research findings for the emerging new health system.

The NEHB Organisation Cultural Survey (2004) was conducted in June 2004 in the period prior to the formal national restructuring of the health services in Ireland. The framing of the questions was therefore in line with the structures that existed at the time in the NEHB.
The questionnaire also provided an opportunity to assess key emerging issues in terms of the national reform programme and the strategic direction provided nationally and regionally. Therefore, for the purposes of this research report, the findings are presented with reference to the former NEHB. However, the potential of the data to transfer nationally across the HSE and to the HSE Dublin North East area is acknowledged and where appropriate these linkages have been made in this report.

Examining organisational culture from the perspective of staff

Since health service staff are integral in terms of translating, shaping and implementing the proposed external and internal changes into meaningful outputs at service-delivery level, their views on the existing nature of organisational culture are highly relevant. The NEHB Organisation Cultural Survey (2004) was used as a diagnostic tool which sought to examine the key characteristics of the existing culture within the organisation from the point of view of staff members. This research, therefore, provided a unique opportunity for approximately one-fifth of the total staff population to share their views, perceptions and insights into important aspects of organisational culture at a point in time.

Working group recommends research of culture

One of the working groups established as part of the development process of AHSPNE (2003) was the Organisation Development and Integration (OD&I) Working Group. As part of its work, a submission paper was prepared in May 2003 entitled The Journey Towards a Developed, Integrated, People Centred Organisation. The paper emphasised the importance of recognising that culture works alongside other key organisational dimensions. It stated that ‘a developed organisation is one where there is congruence between the component parts of the organisation, i.e. culture and people, strategy and policy and structure and processes.’ The OD&I Working Group concluded that it would be valuable to research the culture of the organisation. The group suggested that such research would create a benchmark of ‘where we are now’, thereby increasing understanding of the nature of the existing culture in different parts of the organisation and influencing plans for change and development. One of the key recommendations made by the OD&I group in its submission paper was ‘to carry out research into our culture as part of the implementation phase for the NEHB strategy and thereby increase our understanding to support sustainable organisational change.’
Development and approval of research proposal and survey instrument

Deciding on the best research approach to adopt in measuring culture and the most appropriate timing for conducting such research was considered by the Organisation Development Unit following the above recommendation. Subsequently a research proposal was developed in January 2004. This proposal was approved by the NEHB’s Chief Executive Officer and Corporate Management Team in March 2004, thereby providing the organisational mandate to pursue this research. In February and March 2004, the Organisation Development Unit developed a draft organisation cultural survey questionnaire. During May 2004, the survey was piloted by members of the OD&I Working Group and the NEHB Regional Partnership Committee. Both of these groups nominated staff who also participated in this phase of the pilot process. In June 2004, the final version of the NEHB Organisation Cultural Survey (2004) was sent to a random, representative sample of 1,500 staff (see Chapter 3).

This research work comprised a key element of the Organisation Development Unit’s Service Plan for 2004 and 2005.

The purpose of the research

- To provide an overall assessment and increased understanding of the existing culture and subcultures within the former NEHB.
- To guide future decisions and actions regarding the cultural aspects of the health service reform process and associated organisational changes.

Research objectives

- To provide quantitative baseline data on the following cultural dimensions:
  - People orientation
  - Information and communications
  - Leadership and direction
  - Accountability and performance
  - Integration and teamworking
  - Continuous improvement and development
- To examine perceptions of the national reforms of the Irish health services.
- To provide baseline cultural data and analysis across the whole organisation in line with the promotion of an organisation development (OD) approach to change and development within the organisation.
- To provide a representative sample of staff across the whole organisation with an opportunity to describe the existing culture.
• To assess the capacity of the organisation and its members to adapt culturally and respond to the key influences within the significantly changing environmental context.

**Research outcomes**

This research report provides an analysis of the main findings of the quantitative data in respect of the Organisation Cultural Survey in the former NEHB. In broad terms, it discusses the overarching organisation cultural characteristics of the former NEHB, while more in-depth analysis focusing on subcultures within the organisation is explored based on respondents’ staff groupings, level of direct patient/service user contact and service area.

The outcome of this research provides an insight into aspects of the organisation’s culture at a particular point in time, i.e. June 2004. It is acknowledged, however, that culture is a complex area and that a more in-depth analysis would be required to provide a more comprehensive assessment. However, the findings that have emerged provide a solid platform upon which to build in a meaningful way at a number of different levels. The results from this cultural analysis of one Irish health service organisation have the potential to promote further research in this field. The organisational data and learning in respect of one health service organisation, studied for the purposes of this research, may potentially be used to influence and shape national and area decision making across the health system as a whole, in planning the cultural aspects of the change necessary for an improved and more effective health service.
Chapter 2

Methodology
Chapter 2 – Methodology

Methodological approach
Given the complexity and diversity of the concept of organisational culture, it is not surprising that the empirical assessment of culture is a complex endeavour. From a methodological perspective, the two most common means of researching organisational culture are quantitative and qualitative approaches, both of which have their benefits and drawbacks (Scott et al, 2003c). The methodology used to study organisational culture in turn determines the extent and depth to which culture can be studied.

A quantitative methodological approach was utilised to meet the requirements of the main purposes and scope of this organisation cultural research, as outlined in Chapter 1. Numerical data was collected based on a primarily closed-ended, self-administered postal questionnaire (see Appendix 1). The value of this approach was the provision for the first time of baseline data on a range of core cultural components within the former NEHB. Additionally, the use of a questionnaire as the survey instrument provided a substantial proportion of the organisation’s staff with the opportunity to share their opinions and perspectives. Finally, the research data is a useful benchmark from which to comparatively assess future changes and developments in organisational culture.

A number of methodological limitations of this piece of empirical quantitative research are acknowledged. Survey-based approaches, which are used to research organisational culture, can elicit the views of a large number of people in a systematic way. They can, for example, gather perceptions and views on a range of issues, including how staff feel they are treated, communication and information sharing, leadership and direction, teamworking, continuous improvement and so on. However, some cultural manifestations which exist at a deeper level, such as values, feelings and assumptions, are often much more latent, subtle, unconscious and are generally manifested in behaviours and actions (Schein, 1984; Hofstede et al, 1990). Therefore a quantitative approach, while gathering data from a large sample of staff on perceptions of key cultural issues, cannot provide an in-depth analysis.

The carrying out of further research based on multiple research methods and types would enable a more comprehensive understanding of the various dimensions, levels, intricacies and complexities of organisational culture. The gathering of information from a number of sources in order to confirm research findings is referred to as triangulation. Triangulation sources, which have different strengths and complement each other, reinforce alternative methods (e.g. interviews, surveys) and data types (e.g. qualitative, quantitative and documentary). This approach in turn enhances the overall reliability of research findings (Miles and Huberman, 1994) and provides scope for further work in this area.
In empirical research terms, the *NEHB Organisation Cultural Survey* (2004) could be regarded as the starting point on a continuum of organisation cultural research which has uncovered areas and issues that are worth exploring further. It is envisaged that the next phase of this research work would use qualitative methods, such as one-to-one or group interviews and/or focus groups with selected staff members, in order to probe more deeply various issues and trends arising from the quantitative cultural findings, and to further explore aspects of the organisational culture.

Qualitative approaches could also be used to gather the views of particular staff groupings (in the case of this research study, medical/dental and support service staff) whose response rates to the quantitative survey were particularly low. In this instance, an alternative approach to gathering their views and opinions is required. More in-depth organisation cultural research would however necessitate additional resources and an appropriate time period.

**Research instrument**

As mentioned above, a quantitative approach was used to study the organisational culture in the NEHB. A purposely designed draft questionnaire was developed internally by the Organisation Development Unit during February and March 2004. The questionnaire was developed following a review of a substantial number of relevant publications on the themes of organisational culture and organisational change with a specific focus on the health care sector. These included: Cameron and Freeman, 1991; Lund, 2003; Mackenzie, 1995; Tourish and Hargie, 1996; Lyden and Klengale, 2000; Bratton and Gold, 1999; Dolan and Garcia, 2002; Glaser et al, 1987; Quinn and Rohrbaugh, 1981; Davies et al, 2000; Frost and Gillespie, 1998; Ashkanasy et al, 2000. In addition, a selection of the quantitative-based instruments which have a track record in health care organisations, selected by the authors Scott et al, 2003c, 2003d, were examined.

In terms of the Irish health care sector, the core cultural and change dimensions associated with the following Department of Health and Children publications were considered: *Quality and Fairness: A Health System for You* (2001), the *Action Plan for People Management in the Health Service (APPM)* (2002), and the *Health Service Reform Programme* (2003). The *Partnership Diagnostic Toolkit* (2002), published by the Health Service National Partnership Forum, was also reviewed. Important internal documents which were examined in terms of their cultural content included, *AHSPNE* (2003), the NEHB *Human Resource Management Plan* (2004), the *Joint Development Plan for Partnership in the North Eastern Health Board* (2001), and the OD&I Working Group Submission to *AHSPNE* (2003).
The sections and questions within the *NEHB Organisation Cultural Survey (2004)* were devised on the basis of this extensive literature and documentation review.¹

The value of utilising an internally developed survey was the scope to tailor the survey content and questions to the specifics of the NEHB, taking account of its unique characteristics, its main health and social service delivery roles and responsibilities, and the contents of its strategic framework for change and development outlined in *AHSPNE (2003)*.

The sections contained within the *NEHB Organisation Cultural Survey (2004)* were as follows:

- Section A – Personal details
- Section B – People orientation
- Section C – Information and communications
- Section D – Leadership and direction
- Section E – Accountability and performance
- Section F – Integration and teamworking
- Section G – Continuous improvement and development
- Section H – National reforms of the Irish health service

Given the quantitative nature of this research study, the majority of the questions in the survey were closed-ended, with a number of alternative answers provided from which respondents selected one or more. A small number of open-ended questions were also included, enabling respondents to formulate their own answers (De Vaus, 1996).

The questionnaire was self-administered and posted to the work addresses of the sample population of staff, along with an explanatory letter and stamped addressed envelope for return to the Organisation Development Unit. The respondents were assured that all information obtained from the completed surveys would be treated as confidential and no individuals would be identifiable in the final report.

¹ See Appendix 1 for a copy of the *NEHB Organisation Cultural Survey (2004)*.
Pre-test and pilot phases

Ensuring a rigorous standard regarding the survey instrument was the main priority during the pre-test phase between March and May 2004. This involved a series of meetings and discussions with a range of NEHB staff members. Expert research advice and guidance was provided externally by the Centre for Nonprofit Management at Trinity College Dublin’s School of Business, other experts in the area of culture, and research colleagues both internally and externally.

In May 2004, a draft of the *NEHB Organisation Cultural Survey* (2004) was piloted by members of the OD&I Working Group, the NEHB Regional Partnership Committee and a selection of nominated staff from both of these groups.

On the basis of the external and internal pre-test and pilot processes, a number of amendments were made to the final version of the survey, which was completed in June 2004.

Survey sample

The focus of the study was on organisational culture operating within the former NEHB so the study population consisted solely of employees working in the organisation. In order to facilitate the sampling process, categories of staff were stratified using the human resource information system, Personnel, Payroll and Related Systems (PPARS). The PPARS database comprises a combination of the following five main staff groupings within the NEHB: Allied Health Professional, Management/Administration, Medical/Dental, Nursing, and Support Services.

Following statistical advice and consultation both within and outside the organisation, a computer-generated stratified, purposive sample was selected. This sample was chosen in order to access a wide selection of views and perceptions according to the overall proportion of staff in each of the five work-group strata (i.e. stratification), and based on the level of staff members’ influence on organisational culture (i.e. purposive sampling). Random sampling was then applied within the five work-group strata. On the basis of information obtained from PPARS in March 2004, the overall population of the NEHB organisation totalled 7,997 staff members. From this total population, a sample of 1,500 staff was randomly selected, representing 19 per cent of the overall NEHB workforce.

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2 See Appendix 2 for an outline of the various categories of staff which were grouped under these five main headings.

3 Home Help staff were not included in this study. This research aimed to elicit staff perceptions of organisational culture based on their experiences of working within the NEHB, and more specifically within their particular work team, unit, department and service. Home Help staff work primarily outside the organisation, in service users’ and clients’ homes in a largely independent capacity.
**Response rate**

In June 2004, the *NEHB Organisation Cultural Survey (2004)* was posted to a random sample of 1,500 staff. The initial response rate of 34 per cent increased to 44 per cent following a second mailing of the survey to the entire sample. This response rate was revised, however, since 44 questionnaire surveys were returned as ‘undelivered’ for a variety of reasons, including the respondents had retired, were on sick leave, secondment, a career break or were no longer working in the organisation. This resulted in an adjusted sample size of 1,456 and response rate of 46 per cent (n=666), as shall be outlined in greater detail in Chapter 3.

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4 n= signifies the total number of respondents who answered the questions.
Chapter 3

Personal details
Chapter 3 – Personal details

The questions contained within Section A – Personal Details of the *NEHB Organisation Cultural Survey* (2004) gathered a broad selection of background information regarding the survey participants. For instance, questions regarding staff grouping, service area and geographic area in which respondents worked were also contained within this section of the survey. The length of time which respondents had worked in the organisation, their current job position and type of contract were outlined. The survey data provided information on the extent to which respondents’ roles involved direct patient/front-line contact. Data concerning the gender and age category of respondents was also gathered.

The *NEHB Organisation Cultural Survey* (2004) sample and response rate

As mentioned in Chapter 2, the overall response rate to the survey was 46 per cent. A more detailed examination of the response rate by each of the five staff groups revealed a significant level of variation in the response rate, which ranged from a high of 63 per cent for the Management/Administration staff group to a low of 23 per cent for the Medical/Dental staff group. Table 1 below presents the overall staff group populations within the NEHB, the samples selected for this research study, the adjusted response rates according to each of the five staff groups, and the overall response rate to the survey.

Table 1: Response rate based on staff grouping (Q1)

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff numbers</th>
<th>Sample size</th>
<th>Number of respondents</th>
<th>Response rate %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied Health Professional</td>
<td>792</td>
<td>237</td>
<td>122</td>
<td>51</td>
</tr>
<tr>
<td>Management/Administration</td>
<td>1435</td>
<td>335</td>
<td>212</td>
<td>63</td>
</tr>
<tr>
<td>Medical/Dental</td>
<td>628</td>
<td>180</td>
<td>42</td>
<td>23</td>
</tr>
<tr>
<td>Nursing</td>
<td>2907</td>
<td>450</td>
<td>176</td>
<td>39</td>
</tr>
<tr>
<td>Support Services</td>
<td>2235</td>
<td>298</td>
<td>95</td>
<td>32</td>
</tr>
<tr>
<td>Not answered</td>
<td></td>
<td></td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>7997</td>
<td>1500</td>
<td>666</td>
<td>44</td>
</tr>
<tr>
<td>Adjusted total</td>
<td></td>
<td>1456</td>
<td></td>
<td>46*</td>
</tr>
</tbody>
</table>

* Note: The adjusted total emerged due to the return of a number of questionnaires noted as 'undelivered'. This resulted in an overall response rate of 46%.
As a result of the low response by the Medical/Dental staff group (23 per cent), the survey findings cannot be generalised as reflective of all Medical/Dental staff working in the organisation. In research terms, the low response rate among the Medical/Dental group is of concern since this group of professionals constitute a powerful and influential group which plays a pivotal role in the health services. Hence, the various issues and themes contained within the cultural survey would need to be teased out with Medical/Dental staff in another way, perhaps through focus group interviews, to capture their opinions and experiences. It is also acknowledged that further analysis with some staff groupings, particularly those working in the acute hospital setting and those with high levels of direct patient/service user contact, would assist us in reaching a deeper understanding and level of analysis of organisational cultural and subcultural issues.

**Service areas where respondents worked**

The categorisation of the main service areas where survey respondents worked was based on the NEHB organisational structure as it existed when the Organisation Cultural Survey was being devised in March 2004. Subsequent organisation structural changes have occurred as a result of the national health service reforms. Table 2 provides a detailed breakdown of the service area in which respondents worked. The data revealed that over two-thirds worked in either the acute hospital services or community services (36 per cent and 34 per cent respectively). A combined total of 17 per cent of respondents worked in regional services, including Primary Care, Mental Health Services, Health Promotion and Ambulance Services. Seven per cent of respondents worked in Head Office, while the remaining 6 per cent of respondents who answered this question were distributed across a mixture of the various service areas.
Table 2: Service areas where respondents worked (Q2)

<table>
<thead>
<tr>
<th>Service Area</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Hospital Services</td>
<td>235</td>
<td>36</td>
</tr>
<tr>
<td>Community Services:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services for Children and Families</td>
<td>43</td>
<td>7</td>
</tr>
<tr>
<td>Disability Services</td>
<td>49</td>
<td>7</td>
</tr>
<tr>
<td>Services for Older People</td>
<td>71</td>
<td>11</td>
</tr>
<tr>
<td>Other Community Services**</td>
<td>60</td>
<td>9</td>
</tr>
<tr>
<td>Regional Services:</td>
<td>111</td>
<td>17</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>46</td>
<td>7</td>
</tr>
<tr>
<td>Primary Care Services</td>
<td>38</td>
<td>6</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>Health Promotion Services</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Head Office, Kells</td>
<td>47</td>
<td>7</td>
</tr>
<tr>
<td>Other***</td>
<td>36</td>
<td>6</td>
</tr>
<tr>
<td>Valid total</td>
<td>652</td>
<td>100</td>
</tr>
<tr>
<td>Not answered</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>666</td>
<td></td>
</tr>
</tbody>
</table>

Note: The categorisation of the main service areas where respondents worked was based on the NEHB organisational structures that existed when the survey was being developed in March 2004.

* n = number of respondents
** Includes some respondents who worked across a number of the Community Services listed
*** Includes some respondents who worked across a range of different types of services

Geographic area where respondents worked

The distribution of respondents across the counties for which the NEHB was responsible for service delivery was also examined in this section of the questionnaire. Since the counties of Cavan and Monaghan are combined for service provision purposes in terms of hospital group and community care areas, these two counties were merged for analysis purposes.

As Table 3 indicates, of those who answered this question, almost identical proportions of respondents were based in either County Cavan/Monaghan (32 per cent) or in County Louth (31 per cent). Almost a quarter (24 per cent) of respondents were based in County Meath and more than one in 10 (13 per cent) of respondents had a regional brief, covering various combinations of these four counties.
Table 3: Geographic area where respondents worked (Q3)

<table>
<thead>
<tr>
<th>Area</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cavan/Monaghan</td>
<td>214</td>
<td>32</td>
</tr>
<tr>
<td>Cavan</td>
<td>116</td>
<td>17</td>
</tr>
<tr>
<td>Monaghan</td>
<td>98</td>
<td>15</td>
</tr>
<tr>
<td>Louth</td>
<td>204</td>
<td>31</td>
</tr>
<tr>
<td>Ardee</td>
<td>25</td>
<td>4</td>
</tr>
<tr>
<td>Drogheda</td>
<td>115</td>
<td>17</td>
</tr>
<tr>
<td>Dundalk</td>
<td>64</td>
<td>10</td>
</tr>
<tr>
<td>Meath</td>
<td>160</td>
<td>24</td>
</tr>
<tr>
<td>Regional brief</td>
<td>83</td>
<td>13</td>
</tr>
<tr>
<td>Valid total</td>
<td>661</td>
<td>100</td>
</tr>
<tr>
<td>Not answered</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>666</td>
<td></td>
</tr>
</tbody>
</table>

**Length of service in the NEHB**

Respondents were asked how long they had worked in the NEHB. The survey findings indicate that of those who answered this question, the average length of time worked in the NEHB was approximately 11 years. As is evident from Table 4, a large number of respondents, consisting of over three-fifths (62 per cent) had worked in the organisation for 10 years or less, while the remainder (38 per cent) had worked in the NEHB for between 11 and 39 years.

Table 4: Years working in the NEHB (Q4)

<table>
<thead>
<tr>
<th>Years</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-10 years</td>
<td>395</td>
<td>62</td>
</tr>
<tr>
<td>11-20 years</td>
<td>116</td>
<td>19</td>
</tr>
<tr>
<td>21-30 years</td>
<td>108</td>
<td>17</td>
</tr>
<tr>
<td>31-39 years</td>
<td>14</td>
<td>2</td>
</tr>
<tr>
<td>Valid total</td>
<td>633</td>
<td>100</td>
</tr>
<tr>
<td>Not answered</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>666</td>
<td></td>
</tr>
</tbody>
</table>
Length of time in current job position

Respondents were also asked the length of time in which they had worked in their current job position. Almost three-quarters of respondents (73 per cent) had worked in their current job for five years or less, and the majority of respondents had worked in the organisation for 10 years or less. These findings indicated a relatively high movement of staff to different job roles within the organisation. Such findings are particularly relevant in terms of the required supports for staff who move roles or change jobs within the organisation, as discussed in detail in the analysis of the open-ended Question 43 in Chapter 10.

Table 5: Length of time in current job position (Q5)

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 5 years</td>
<td>468</td>
<td>73</td>
</tr>
<tr>
<td>More than 5 years</td>
<td>171</td>
<td>27</td>
</tr>
<tr>
<td>Valid total</td>
<td>639</td>
<td>100</td>
</tr>
<tr>
<td>Not answered</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>666</td>
<td></td>
</tr>
</tbody>
</table>

Type of job contract

Of those who indicated their employment status, the vast majority (85 per cent) were employed on a permanent basis with the NEHB, compared to just 15 per cent who were working on a temporary basis. Since most respondents (71 per cent) did not indicate whether they worked on a full-time, part-time, contract or job-share basis, this information was not used for analysis purposes.

Table 6: Type of job contract (Q6)

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent</td>
<td>513</td>
<td>85</td>
</tr>
<tr>
<td>Temporary</td>
<td>91</td>
<td>15</td>
</tr>
<tr>
<td>Valid total</td>
<td>604</td>
<td>100</td>
</tr>
<tr>
<td>Not answered</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>666</td>
<td></td>
</tr>
</tbody>
</table>

Level of direct patient/service user contact

The level of respondents’ direct contact with patients/service users is an important consideration given the role of the NEHB organisation as a health and social care provider. Therefore, the survey contained a question asking respondents to indicate approximately what percentage of their working time involved direct contact with patients/service users. When analysing this survey question, the responses were
divided into three distinct categories. Those who spent none to 20 per cent of their working time in direct contact with patients/service users were grouped in the ‘none to little’ level. Those who spent between 21 to 60 per cent of their working time in direct contact with patients/service users were grouped in the ‘moderate to high’ level. Respondents who spent over 60 per cent of their working time in direct contact with patients/service users were grouped in the ‘very high’ level.

The survey results outlined in Table 7 reveal that 57 per cent of respondents reported having a very high level of direct contact with patients/service users. This compares to one-fifth who had moderate to high levels of contact, while almost a quarter had none to little direct contact with patients/service users. Thirteen per cent of respondents did not answer this question.

**Table 7: Level of direct patient/service user contact (Q9)**

<table>
<thead>
<tr>
<th>Category</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>None to little (0-20%)</td>
<td>134</td>
<td>23</td>
</tr>
<tr>
<td>Moderate to high (21-60%)</td>
<td>112</td>
<td>20</td>
</tr>
<tr>
<td>Very high (61-100%)</td>
<td>330</td>
<td>57</td>
</tr>
<tr>
<td>Valid total</td>
<td>576</td>
<td>100</td>
</tr>
<tr>
<td>Not answered</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>666</td>
<td></td>
</tr>
</tbody>
</table>

**Gender of respondents**

The survey respondents showed a breakdown of approximately three-quarters female to one-quarter male.

**Table 8: Respondents’ gender (Q7)**

<table>
<thead>
<tr>
<th>Category</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>148</td>
<td>23</td>
</tr>
<tr>
<td>Female</td>
<td>506</td>
<td>77</td>
</tr>
<tr>
<td>Valid total</td>
<td>654</td>
<td>100</td>
</tr>
<tr>
<td>Not answered</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>666</td>
<td></td>
</tr>
</tbody>
</table>

In addition, significant variation was revealed ($p<.000^5$) in terms of the survey participants’ gender breakdown when examined by staff group. The Nursing and Allied Health Professional staff groups were found to be female dominated, with gender ratios of approximately 3:1 and 2:1 female to male respectively. In contrast, the

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5 $p$ value = the probability value. This is used in interpreting the probability of error involved in accepting the observed results as valid. It is expressed as a decimal fraction. In many areas of research, a $p$ value of 0.05 is treated as an acceptable level of error.
Medical/Dental staff group was heavily male dominated, consisting of approximately 6:1 male to female. Management/Administration and Support Service staff groups had more even distributions of male and female staff, with just over 10 per cent more males than females in the Management/Administration category, and just over five per cent more males than females in Support Services. It is important to take account of such gender distributions in relation to both organisational culture and subcultures.

**The age group of respondents**

As Table 9 shows, of those respondents who indicated their age, most (89 per cent) were spread between the age groups: 26-35 years, 36-45 years, and 46-55 years. In contrast, very few respondents were aged either 25 years or less, or 56 years or over (4 per cent and 7 per cent respectively).

**Table 9: Respondents’ age group (Q8)**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 years or less</td>
<td>28</td>
<td>4</td>
</tr>
<tr>
<td>26-35 years</td>
<td>183</td>
<td>28</td>
</tr>
<tr>
<td>36-45 years</td>
<td>218</td>
<td>33</td>
</tr>
<tr>
<td>46-55 years</td>
<td>188</td>
<td>28</td>
</tr>
<tr>
<td>56 years or more</td>
<td>44</td>
<td>7</td>
</tr>
<tr>
<td>Valid total</td>
<td>661</td>
<td>100</td>
</tr>
<tr>
<td>Not answered</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>666</td>
<td></td>
</tr>
</tbody>
</table>

**Final remarks**

The information contained within this chapter provides a description of the main characteristics of survey participants involved in the *NEHB Organisation Cultural Survey* (2004). As shall be evident in Chapters 5 to 11 of this report, a number of questions contained in this section of the survey were used to examine the survey findings in more depth. The survey questions used for this purpose related to the staff group to which respondents belonged (Q1), their level of direct patient/service user contact (Q9) and the service area in which they worked (Q2). This more detailed examination of the survey results is useful in terms of exploring the more subtle subcultural nuances contained within the overall organisational survey data.

The next chapter presents a review of the relevant literature with regard to the interrelated themes of organisational culture and organisational change with a particular focus on the relevance of these issues in the health sector.
Chapter 4

A review of the literature on organisational change and organisational culture in the health care context
Chapter 4 – A review of the literature on organisational change and organisational culture in the health care context

Introduction

The primary focus of this research is on organisational culture and its role with regard to organisational change in the health care sector. More specifically, it empirically examines organisational culture and its role with regard to organisational change in one Irish health organisation, namely the former NEHB, (now part of the Health Service Executive Dublin North East).

This literature review is divided into two parts. In order to contextualise this research, the first part of this chapter presents an overview of the key trends and developments regarding organisational change and culture in the contemporary health care environment. At the broadest level, it highlights important, commonly occurring changes in health care systems generally.

Within the Irish context, it describes the significant changes in the external environment of the health care sector over the past decade. At the organisational level, the significant external and internal changes occurring in the context of HSE Dublin North East are outlined.

In order for organisations to translate, accommodate and ultimately manage the consequence of the significant changes which are taking place in their environments, a solid understanding of the nature of such changes and developments is required. The unprecedented changes taking place with regard to health care organisations entail significant structural, technical and managerial transformations. However, increasingly the important cultural aspects and human dimensions of such change are being considered. Therefore, a discussion of the notions of organisational culture and organisational subcultures, with particular reference to change and reform in the health care context, is also presented in Part I of this chapter.

The second part of Chapter 4 provides a description of the core cultural dimensions which were selected as a means of examining organisational culture within the NEHB organisation. As outlined in Chapter 1, these dimensions were people orientation, information and communications, leadership and direction, accountability and performance, integration and teamworking, and continuous improvement and development. Perceptions of the national reforms of the Irish health service were also sought.
Part I: Key trends and developments regarding organisational change and organisational culture in the health care sector

Change and reform within the broad health care environment

At a macro level, health care systems all over the world, and particularly the developed world, have experienced an unprecedented level of change and reform over the past three decades or so. The health care literature contains much discussion of the key demands and challenges faced by modern health care providers in a significantly changing environment.

Several pertinent factors underpin the significant demands and challenges faced by modern health care systems, including an ageing population, advancing technological developments and medical knowledge, pressures to contain rising costs, ever-increasing demand, and growing consumer awareness and expectations (Javetz and Stern, 1996; Burke et al, 1999). Other noteworthy pressures in modern health care systems across the developed world include: a greater emphasis on public accountability and performance, value for money and efficiency, and the quality of services provided to patients, service users and the general public.

The move towards greater cognisance of consumer involvement and participation in health care, and more explicit regulation by health care funders (primarily government) of the health services is highlighted by Shaw and Kalo (2002). Essentially, at the societal level, there is a requirement on the part of contemporary health services to meet their public service requirements and to build a sense of trust among their many constituents (Gilson, 2003). As shall be outlined later from both a formal and informal perspective, the pressures, demands and challenges in the environment of the health care sector have resulted in significant structural, technical and cultural implications for modern health care systems.

Change and reform within the Irish health care system

Since the late 1990s, the architecture of the Irish health sector has been characterised by an unprecedented level of transformation. Indeed, this level of reform is by far the most significant and all-encompassing which the system has witnessed in over 30 years. In terms of the major initiating factors and influences of change within the sector, these can be traced to the following major developments.

Over the past decade, two health strategies, *Shaping a Healthier Future*...
(Department of Health and Children, 1994) and the current national health strategy, *Quality and Fairness – A Health System for You* (Department of Health and Children, 2001), have provided the national strategic policy context for the development of the Irish health system.

More recently, the overarching rationale officially given for the current *Health Service Reform Programme*, launched by the Department of Health and Children in June 2003, was to modernise existing organisational structures and management practices within the Irish health service, to facilitate the implementation of the 2001 health strategy and to ultimately improve health services.

The scale of this current reform process is the most significant since the establishment of a system of eight regional health boards empowered with responsibility for the provision of health and social services in their functional areas under the Health Act, 1970. The *Health Service Reform Programme* (2003) identified a number of system priorities which include a national focus on service delivery and executive management of the health system, reduced fragmentation of the current system, clear accountability, better budgeting and service planning arrangements, continuous quality improvement and external appraisal, robust information-gathering and analysis capability, and preservation and building on the strengths of the existing system. The implementation of the reform programme, which will continue over the coming years, will entail unprecedented structural and managerial changes in the Irish health system, as well as having important cultural and human implications. A further discussion of this reform process is outlined in Chapter 11 – National reforms of the Irish health service.

**Change and reform within the NEHB**

Organisational effectiveness is dependent on a clear purpose and direction. It follows that an important aspect of organisational culture is the overall strategic direction of the organisation as a whole, indicating purpose, forward planning and high-level thinking and reflection. The significance of organisational strategy was highlighted by Nadler (1987) who described strategy as the set of key decisions about the match of the organisation’s resources to the opportunities, constraints, and demands in the environment within the context of history. Moreover, he pointed out that the output of the system is, in general, the effectiveness of the organisation’s performance in meeting the goals of the organisation’s strategy.

The publication of *AHSPNE* (2003) represented the central focus of internal organisational change and development within the NEHB. While service-level strategies had been developed by various component parts of the organisation, the development by the NEHB of an overarching organisation-wide strategic plan
represented an important milestone. In particular, the basis for the development of *AHSPNE* (2003) was to provide a framework for the organisation in dealing with the challenges and opportunities associated with the significant national developments in the health system, namely *Quality and Fairness: A Health System for You* (2001), *Primary Care: A New Direction* (2001) and the *Health Service Reform Programme* (2003). This framework for change and development, *AHSPNE* (2003), is therefore strongly aligned to the national reforms. It represents a values-based approach and therefore has the potential and flexibility to be adapted and applied in the new health system in Ireland.

**External focus, environmental monitoring and ‘organisation–environment fit’**

It is evident from the preceding discussion that the institutional environment of the health services has undergone radical transformation and development over recent decades. A critical issue for all organisations operating in dynamic and uncertain environments is the management of change (Nadler, 1987). The future direction and changes required in order to attain the desired future state for the health services generally are largely pre-determined by such government-led, top-down reforms and organisational strategic developments. The core task for the HSE is how to change and develop organisational culture(s) so that it is/they are congruent with and supportive of the achievement of the desired future state associated with such change.

There is a high degree of consensus on three phases of change. These include the current state, the transition state and the future state (Beckhard and Harris, 1977, 1987). Utilising these three phases of change, Nadler (1987) contends that it is useful to think of changes in terms of transitions, with the effective management of change involving the development of an understanding of the current state (A) and an image of the desired future state (B) and moving the organisation from A through a transition period (C) to the desired future state (B). Core strategic and policy documentation, including the current national health strategy, *Quality and Fairness: A Health System for You* (2001), the *Health Service Reform Programme* (2003) and *AHSPNE* (2003), describe this desired future state.

From an open-systems perspective, cognisance of developments in these dynamic environments is vital in order to contextualise and negotiate an organisational response and determine an appropriate ‘organisation–environment fit’. For instance, Nadler (1987) states that consistently effective organisations are those that appropriately position themselves in their environment. Repositioning an organisation involves modifying the way it functions or does business, whereby strategies, formal structures, processes, cultures, operating styles and people all may have to be changed. Research in the private sector reported by Pettigrew and Whipp
(1991, 1992) demonstrates that the starting point for strategic focusing and change derives from an organisation’s skill in environmental assessment. The need is for organisations to become open-learning systems which acquire, interpret and process information about their environment (Pettigrew et al, 1992). In a similar fashion, the contextual dimension of Bate’s framework (1999), with regard to the issue of cultural change, highlights the need to assess the ‘fit’ or alignment between an organisation’s culture and the wider environment. As the external environment changes so must the internal culture to avoid obsolescence and gauge the gap between the current culture in use and the required culture that is the desired future state. Bijlsma-Frankema (2001) identifies the management of the relationship with the external environment in terms of designing an external strategy to enable the new organisation to exploit environmental opportunities and neutralise environmental threats. This is seen as one of three main leadership tasks with regard to organisational restructuring in the case of mergers, acquisitions and associated cultural change processes.

In summary, a critical task for organisations, and in particular organisational leaders and managers, is to develop an external focus and to continually scan the external environment. The purpose of such environmental monitoring is to understand and appropriately translate the core external trends, changes and developments into organisational responses and implications.

**Understanding the principal sources of organisational change**

The above contextualisation and description of change and reform within the health sector is important since both external and internal factors require consideration in relation to understanding the principal sources of change, managing change and influencing culture. In terms of the main rationale for change, Nadler (1987) points out that major transitions usually occur in response to anticipation of organisational input (environment or strategic shifts) or outputs (problems of performance).

The literature addresses a myriad of sources of significant institutional and organisational change. For instance, Kitchen and Daly (2002) cite external factors such as government legislation and prevailing political values, changes in customer expectations and internal factors such as management philosophy, organisational structure, culture, and systems of power and control. Pettigrew et al (1992) discuss the impact of top-down institutional reform based on the Thatcherism era with regard to the radical reform of the National Health Service (NHS) and other public sector institutions in the United Kingdom. In a similar vein, Garside (1998) comments that increasingly managers and clinical professionals in health care are
coming to terms with the need for carefully designed and implemented programmes for change which take into account the external world and its pressures from politicians, professional groups and the public, and the internal world of the organisation with its culture, norms and staff behaviours. Davies et al (2000) discuss important cultural influences outside the organisation (Langfield-Smith, 1995). For instance, they point out that the medical culture within a hospital will be influenced not just by aspects of that organisation, but also most prominently by the prevailing culture of the medical profession, as well as by greater secular trends. Furthermore, the strong professional ethic and sense of professional identity seen in health professions highlight the importance of supra-organisational norms. Public opinion, media reporting and regulatory frameworks also exert influence (Davies, 1999). All these observations have implications for those attempting to manage a cultural shift.

Towards an emphasis on organisational culture and human dynamics in understanding and managing change

It is increasingly recognised within organisational and management literature that organisational culture and organisation cultural change comprise core elements in relation to significant structural reform and change. In essence, as health care organisations undergo radical transformation, it is necessary for the cultures of such organisations to adapt to these changes and negotiate an appropriate ‘organisational–environmental fit’.

As Anderson-Wallace and Blantern (2005) state, most people would agree that the modernisation of our public services involves some significant cultural change. From a humanistic perspective, Blau and Scott (1962) were the first post-war management authors to assert that all organisations consist of both formal and informal dimensions, and that it is not possible to know or understand the workings of an organisation without a sound understanding of its informal character. The informal dimension or character of organisations was subsequently highlighted by the substantial work of Pettigrew (1979) who suggested that organisational cultures consist of cognitive systems explaining how people think, reason and make decisions (Wallace et al, 1999). Galbraith (1987) refers to a trend towards including softer elements of organisations, such as values, symbols and shared beliefs under the label of culture (Schwartz and Davies, 1981).

Therefore, in addition to the ‘hard’ structural and technical issues, cognisance clearly needs to be given to the centrality of the ‘soft’ aspects of organisational culture which comprises values, belief systems, attitudes, behaviours and so on, all of which are central in terms of organisational restructuring and change. This has been recognised by many writers when discussing effective approaches to radical or
strategic change, whereby stress is placed on the role of culture and cultural change (Kanter, 1983, 1989; Tichy, 1983; Nadler, 1987).

In this regard, Ferlie et al (1996) surmise that longer-term change in an organisational system will not be effected or sustained unless the underlying values and belief systems of the members shift. Beer and Nohria (2000) point out that, despite some individual successes, change remains difficult to achieve, and few companies manage the process as they would like. Rather, most companies’ initiatives, such as installing new technology, downsizing, restructuring or trying to change corporate culture, have low success rates.

This perspective is reinforced by Shaw and Kalo (2002) who state that reports from North America, Europe and Australia suggest that problems and solutions in change management centre on the behaviour of people and organisations more than on technical issues. Pascale and Athos (1982) point out that the ‘hard S’ of strategy, structure and systems needs to be supplemented by the ‘soft S’ of style, skills and staff.

An Organisation Development approach is based on understanding, managing and sustaining organisational change (Blackwell Encyclopaedic Dictionary of Organisational Behaviour, 1995). It places a strong emphasis on the human and cultural facets of organisations as critical factors in organisational effectiveness and organisational change endeavours. A briefing paper, Organisation Development Approach to the Modernisation Agenda, published by the Organisation Development Unit, HSE Dublin North East (January, 2005), stated that an OD approach emphasises the importance of planned, lasting and sustained change rather than a ‘quick fix’. The paper noted that OD involves both ‘hard’ and ‘soft’ issues in enabling organisations to achieve optimum performance.

The ‘hard’ issues comprise strategies, policies, structures and systems. The ‘soft’ issues relate to the development of appropriate skills, behaviours and attitudes, and an appropriate culture and style of leadership. The linkages and interactions between strategy and policy, people and culture, and structure and processes are outlined, indicating the holistic or systems perspective upon which OD is founded.

The significant dilemma associated with achieving real organisational change within health care systems has been highlighted in the relevant literature (see Davies, 2001; Casebeer and Hannah, 1998; Garside, 1998). For instance, Garside (1998) points out that in the widespread reorganisations and reviews of acute health services in the United Kingdom and abroad, it has been shown repeatedly that carefully thought-out macro plans for rearranging, merging and closing services are extraordinarily difficult to accomplish.
The micro or process changes involved in quality improvements in clinical services are also equally difficult to achieve. In summary, one of the central facets of organisational change is the neglect or underestimation of the ‘softer’ cultural and human dimensions of change, as shall be discussed later in this chapter. Another common problem is approaching organisational cultural change in isolation or without sufficient cognisance of a whole-system approach which emphasises the need for cultural change in conjunction with other core organisation components such as structure, policy and process.

**The relationship between structural change and cultural change in health care organisations**

As already emphasised, it is important to consider the ‘softer’ cultural and human facets of the changes taking place in recent years in the health services in addition to the radical structural and management reforms. In addressing the question of why so little has changed as a result of large-scale structural reforms in developed nations over the past two decades, Davies (2001) contends that the informal dimension of organisations, sometimes referred to as the ‘software of the mind’ (Hofstede, 1994), which can be thought of as its ‘culture’, has been largely neglected in the course of such reform. From a cultural perspective, he argues that the psychological and social structuring that govern how we think, what we value and what we see as legitimate may impede change and hence such cultural issues require consideration. It follows that the achievement of cultural compatibility with structural change is imperative. It is noteworthy that Scally and Donaldson (1998) in their discussion on the implementation of clinical governance in the health care arena point out that the feature that distinguishes the best health organisations is their cultures. They state that an organisation that creates a working environment which is open and participative, where ideas and good practice are shared, where education and research is valued, and where blame is used exceptionally is likely to be one where clinical governance thrives.

Similarly, Scott et al (2003b) highlight the trends towards increasing international interest in managing organisational culture as a lever for health care improvement. With regard to the United Kingdom’s NHS for instance, Scott et al (2003a) point out that it is increasingly recognised that structural change alone will not secure sufficient gains in health care performance, and therefore policies over the past five years have also begun to emphasise the importance of developing cultural changes alongside structural reform.

The salience of culture is also emphasised by Ingersoll et al (2000) who explain that as health care organisations undergo major redesigns of their care-delivery processes, more and more emphasis is placed on organisational culture and its role...
in facilitating or inhibiting change. Many of the traditional approaches to developing organisations in the health care arena focus on structures and rules while tending to ignore the cultural aspects of organisations, such as the customs, practices and behaviours of people built up over years (Anderson-Wallace and Blantern, 2005).

**Approaches to managing organisational change – top down, bottom up and systems approaches**

The above description of the types of difficulties associated with organisational change call attention to the considerable challenge presented in relation to dealing with reform and change processes in organisations. The literature describes the common approaches to the management of change. Two well-known divergent approaches comprise a top-down approach and bottom-up approach, while a systems/systemic approach has become more common in the modern organisational environment (Beer and Nohria, 2000; Borins, 2002; Bovey and Hede, 2001; Moran and Brightman, 2001; O’Brien, 2002; Szamosi and Duxbury, 2002; Tosey and Robinson, 2002). The systems approach is based on an integrative, whole-systems perspective and is therefore cognisant of the various organisational levels (i.e. organisation, department, individual, top-down and bottom-up directions) and core components (i.e. structural, technological, political and social). According to Mintzberg (1981), effective organisations achieve coherence among their component parts and do not change one element without considering the consequences of all the others.

The systems-type approach, which combines a mix of top-down and bottom-up approaches, is similarly cited by Pettigrew et al (1992) who emphasise that top-down strategies need to coexist not only with a certain minimum level of readiness and capability at local levels, but also with sound links between higher and lower tiers. They state that policy initiatives are increasingly recognising the need to link top-down ‘revolution’ with local ‘evolution’. According to Pettigrew et al, local action in the form of operational implementation through the linking of higher and lower organisational tiers is key to the successful management of change. Organisational change contains the dilemma of how to orchestrate and sustain generalised pressure for change while leaving some freedom to build customised solutions at local levels which are sensitive to different and changing contexts.

There is evidence in the literature of a growing recognition of the value of this holistic-based approach to culture with regard to organisational change (Bate 1984, 1994; Williams et al, 1996; Donaldson and Gray, 1998). The systems approach regards culture as a component part of an organisation, in conjunction with other core dimensions such as strategy, policy, structure and processes. It suggests that it
is not possible to change culture in isolation from these other core organisational components. Such an approach is integral to the field of OD as outlined earlier. Based on this perspective, a major theme pervading this research is the importance of situating organisational cultural change in the contextual environment of the NEHB, taking into account significant external reform and internal strategic developments.

Organisational culture

At this point, it is necessary to ask ‘What does organisational culture mean?’, and to examine that with regard to change within organisations generally and within the health care system in particular. Organisational culture is a complex phenomenon created from a broad range of internal and external influences (Alvesson, 1991). Davies (2001) stresses the importance of organisational culture which he argues encompasses softer, informal aspects which gives the impression of something powerful, or even dangerous, lurking beneath the surface of any organisation. Therefore, understanding such forces will clearly be important if organisations are to function well. Davies quotes one US hospital group CEO who commented, ‘culture eats strategy for breakfast, every day, every time.’ In other words, for an organisation to develop strategically, an understanding of its culture is an important leadership and management task.

The term culture has its roots in sociology and anthropology, as noted by Anderson-Wallace and Blantern (2005). For the purposes of this research, the definition of culture comes from Schein (1984) who defined it as ‘the pattern of basic assumptions that a given group has invented, discovered or developed in learning to cope with its problems of external adaptation and internal integration, and that have worked well enough to be considered valid, and therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to these problems.’

Culture is taken for granted. It is the ‘glue’ which holds an organisation together and is dynamic in the sense that it is perpetually being formed in that there is constantly some kind of learning going on about how to relate to the environment and to manage internal affairs (Schein, 1983, 1985). The concept of organisational identity comprises an element of organisational culture in the sense that it refers broadly to what members perceive, feel and think about their organisation. It is assumed to be a collectively and commonly shared understanding of the organisation’s distinctive values and characteristics (Hatch and Schultz, 1997).

Over the last 20 years, organisational culture has been a topic of significant interest in the organisational studies literature (Helms and Stern, 2001). It has been variously defined as a shared belief system within an organisation, widely shared core values (Peters and Waterman, 1982), collective understandings (Van Maanen and Barley, 1978), and so forth.
1984), and the pattern of basic assumptions within an organisation (Schein, 1985). Bate (1994) identifies three key features of organisational culture. First, culture is predominantly *implicit* in people's minds. It is not something that is ‘out there’ with a separate existence of its own and neither is it directly observable. Secondly, it is *shared*. It refers to the ideas, meanings and values that people hold in common and to which they subscribe collectively. Thirdly, culture is *transmitted* by a process of socialisation. In summary, culture is a function of peoples' collective mindsets.

Organisational culture therefore represents the frame of reference for organisational members setting out shared and collective values, meanings, behaviours and experiences which are associated with a particular organisation or parts of an organisation (Bijsma-Frankema, 2001; Wallace et al, 1999; Pettigrew, 1979; Schein, 1985; Sackmann, 1991; Hatch, 1993; Denison, 1996).

Furthermore, the culture of an organisation is important for four reasons. First, it conveys a sense of identity for the organisation's members. Secondly, it facilitates members' commitment to something larger than self. Thirdly, it enhances social system stability and, fourthly, it provides a sense-making device to guide behaviour (Anderson-Wallace and Blantern, 2005). In addition, organisational culture can help organisations succeed because it can help members recognise, accept, and live out the values of the organisation (Evan, 1993).

**Levels of culture**

The work of both Schein (1984) and Hofstede et al (1990) is useful in understanding the levels of culture that exist within organisations. Schein (1984) identified the following three key cultural levels – artefacts, values and assumptions. Artefacts are the most visible manifestations of culture, for example, the architecture, technology, layout, behaviour patterns, manner of dress, and public documents characterising the organisation. Values govern behaviour and action and so signify why the organisation and its members behave and act the way they do. Assumptions are generally underlying and taken for granted. They are typically unconscious and learned but are highly significant since they actually determine how group members perceive, think and feel.

In a similar manner, Hofstede et al (1990) discussed three main manifestations of culture which exist from shallow to deep levels within an organisation. They identified symbols, heroes and rituals as ‘practices’ in the sense of being visible to an observer, while their cultural meaning lies in the way they are perceived by insiders. These authors regarded values as the core of culture, in the sense of broad, non-specific feelings that are often unconscious and rarely discussable, and that cannot be observed as such but are manifest in behaviour.
Davies (2001) and Davies et al (2000) have applied these classifications of cultural levels to the clinical context within the health care arena. The most superficial shared understandings are visible manifestations, that is cultural artefacts, such as the use of professional titles, dress codes, standard ways of running services and particular methods of performance assessment, such as peer review and professional self-regulation. At a deeper level are espoused values which operate at a more conscious level and represent the goals to which individuals attribute intrinsic worth. They involve various important medical values influencing standard practice, including the Hippocratic principle of placing the needs of individual patients above broader economic and corporate objectives, a belief in evidence, and a commitment to patient-centred care. Deeper still, and much harder to access, are the hidden or underlying assumptions that underpin day-to-day choices and assumptions, for example, about the relative roles of doctors, nurses and other health and social care professionals, assumptions about patient/service user rights, the nature and sources of ill health, and the use of rational scientific methods in generating medical/clinical knowledge.

**Perspectives of organisational culture**

Martin and Meyerson’s typological framework of organisational culture (1988) is dominated by three alternative perspectives which are useful in interpreting organisational cultural types. The integration perspective portrays culture in terms of organisation-wide consensus about appropriate interpretation of the various cultural aspects. Culture is therefore homogenous in that it is seen the same way by most people, no matter which angle they view it from.

According to Schein (1984), the total culture is composed of subcultures and can be homogeneous or heterogeneous according to the degree to which subgroup cultures are similar or different. For instance, if multiple organisational subcultures conflict with each other, one could not speak of a single corporate culture, but rather multiple subcultures. Scott et al (2003a) emphasise organisational culture as a multiple phenomena, ‘a coalition of patterns of meaning forged by human groups and subcultures’. In a similar manner, Davies et al (2000) explain that the culture found in an organisation may be far from uniform or coherent (Langfield-Smith, 1995; Martin, 1992). Attention now turns to organisational subcultures.

Both differentiation and fragmentation perspectives are particularly useful in interpreting organisational subculture divergences and clashes, and for understanding the basis for resistance to organisational change. The differentiation perspective portrays cultural manifestations that are heterogeneous, whereby subcultures may exist in harmony, in conflict, independently or indifferently to each other. The fragmentation perspective views ambiguity as an inevitable and pervasive aspect of organisations. There is no clear organisation-wide or subcultural consensus of culture, rather interpretations are ambiguously related to each other and constantly fluctuating.
Organisational subcultures

Several organisational culture authors (Martin, 1992; Keeton and Mengistu, 1992; Hofstede et al, 1990; Scott et al, 2003a) argue that although an organisation will strive to instil a common set of values and beliefs into all its employees, it is unlikely that perceptions of the culture within the organisation will be universal. Therefore, it is unlikely that organisations would be able to replicate beliefs and norms effectively throughout an entire organisation. According to Nadler (1987), organisations are composed of different individuals, groups and coalitions competing for power (Tushman, 1977; Salancik and Pfeffer, 1977). It may be argued therefore that organisations generally, and in particular large-scale, diverse organisations, tend to possess multiple, differing groupings termed organisational subcultures. The term subculture contains an important recognition that ideas within a social group are not homogeneous but plural and often contested (Van Maanen and Barley, 1985; Laurila, 1997). It follows that any in-depth analysis of organisational culture needs to identify and assess subcultural groups in addition to the overall corporate or organisational culture.

Organisational subcultures tend to be distinct entities which, according to Scott et al (2003c), by their very nature easily ‘bleed into’ one another. Since health care organisations by nature are large-scale, complex, heterogeneous, multi-dimensional, and frequently geographically dispersed, it is not surprising that the theme of cultural diversity is frequently alluded to in the literature. The pervasiveness and indeed value of difference and multiple cultures within the NHS, for example, has been highlighted by Pettigrew et al (1992), Sutherland and Dawson (1998), and Anderson-Wallace and Blantern (2005).

However, the existence of organisational subcultures also creates significant challenges with regard to organisational integration and collaboration among various organisational professionals, groups and teams. Davies (2001) further explains that during times of change especially, one should also expect to see evidence of counter cultures, where groups work overtly or covertly to challenge and undermine the dominant organisational culture. Such a pattern of resistance is typical of responses to structural reforms such as those of the 1980s and early 1990s in the United Kingdom (Degeling et al, 1998; Lapsley, 1997). For the purposes of this study, such resistance patterns and cultural challenges are especially relevant in the context of the unprecedented changes currently occurring at both national level in the Irish health system and area level within the HSE Dublin North East as shall be variously discussed throughout this report.
Factors influencing subcultural formation and development

The subcultural characteristics of organisations represent valuable frames of reference with regard to analysing organisational culture. There are a number of salient contributing factors which influence perceptions of organisational culture and the development of organisational subcultures. Hence these factors have implications regarding the analysis of organisational culture.

Helms and Stern (2001) explain that employees' perceptions of the organisation’s culture will be affected by both organisational factors and individual factors. Regarding the former, organisational units tend to develop unique subcultures over time (Martin, 1992) precipitated by such items as operating routines and procedures, as well as interaction among individuals in their work patterns. Therefore, one could argue that subcultural formation and development is associated with the local context, that is, the place where one works and the colleagues with which one works closely.

Scott et al (2003c) suggest that each health organisation is a unique cultural configuration because the subcultures that traverse the organisational culture interact and relate differently, reflecting individual and group characteristics and the local environment.

In terms of individual factors, Helms and Stern (2001) explain that an employee's hierarchical level within the organisation is also likely to affect their perceptions about the organisation's culture. The training that employees undergo, their interaction with top management and the amount of information they are exposed to regarding the purpose and values of the organisation are all a function of hierarchical level.

Demographic characteristics also influence cultural perceptions since each individual's perceptions are affected by their set of personal experiences and background. Commonly used proxies in this regard include gender, age, ethnicity, type of job contract and function or functional area.

Davies (2001) contends that education and training and the influence of forces outside the organisation reinforce such differences among professional or occupational subgroups and shape organisational members' views of organisational culture. As we shall see later in this report, some of these background variables were included in our data collection exercise.
Occupational/professional subcultures in health care organisations
The predominant type of organisational subculture repeatedly highlighted within the literature in the health care arena is that of occupational/professional subcultures (Scott et al, 2003c; Davies, 2001; Sutherland and Dawson, 1998; Pettigrew et al, 1992). The two key organisational groups commonly referred to with regard to occupational or professional subcultures are (health service) managers and clinicians. Based on stereotypes of these groups, Sutherland and Dawson (1998) explain that, in general, managers are seen to be accountable to a board of directors and identify themselves as belonging to the particular organisation in which they work.

Professionals, on the other hand, are seen to identify themselves as associated with peer groups such as professional or collegial membership. Furthermore, with regard to organisation identification, Scott et al (2003c) point out that the orientation of occupational subcultural groups is professional more than corporate. In other words, professionals such as those working in the medical, nursing and therapeutic fields, have closer cultural associations with their respective professional bodies and colleagues in terms of their values, norms, and behaviours, rather than with the overarching corporate organisational entity in which they work, such as the health authority or board.

We know from the literature (Cyert and March, 1963; Mouzelis, 1991; Reed, 1992) that the existence of significant hierarchical power groups and power differentials in terms of disproportionate access to power and authority structures are crucial considerations within organisations. It follows that the levels of access to power and control, which both manager and clinician groups have, are highly significant from a cultural perspective in terms of influencing the core functioning of health care organisations.

In the context of reforms in health care, both professional/occupational and team subcultures are an important consideration in understanding organisational culture and how that can interact with or influence change. For instance, Davies (2001) points out that the cultures of medical and clinical organisation subgroups and specific teams can be powerful influences on work patterns.

The salience of the effective relations between health service managers and clinicians, in particular in terms of stimulating strategic and cultural change, is commonly referred to in the literature (Pettigrew et al, 1992; Shortell, Morrison and Friedman, 1990; Davies et al, 2000). It follows that one crucial challenge is to achieve a degree of ‘cultural fit’ between these two significant organisational groups. This is in line with Bijlsma-Frankema’s (2001) second major leadership task which is associated with furthering cultural integration at the level of management.
and employees in order to create synergy. Scott et al (2003c) highlight the utilisation of conflicts between the dominant culture and subcultures within organisations as a decisive spur to change.

The organisational culture conceptual framework – the ‘has versus is debate’

The relevant literature identifies two broad schools of thought with regard to organisational culture (Smircich, 1983; Davies et al, 2000), one of which views culture as something an organisation ‘has’ while the other views it as something an organisation ‘is’. From the perspective of culture being something an organisation ‘has’, culture is regarded as an ‘attribute’, along with other attributes such as structure, strategy, process and so on.

Frost and Gillespie (1998) use the term ‘cultural pragmatism’ to describe this traditional behavioural school of thought on culture. There is evidence to suggest that many Organisation for Economic Cooperation and Development (OECD) countries are focusing on cultural renewal as a potential lever for health care improvement (Smith, 2002).

Scott et al (2003b) note that popular management literature tends to view culture as an attribute and therefore cultural change is viewed as a means to commercial or other technical ends and comprises a range of activities directed to ‘overhaul’ or ‘re-engineer’ an organisation’s value system. For instance, within the health care sector there is now growing literature devoted to ideas of changing or transforming culture as a means of improving quality, efficiency, patient focus and/or broader organisational performance (Scott et al, 2003a).

Another stream of literature regards culture more globally as defining the whole character and experience of organisational life, i.e. what an organisation ‘is’, whereby organisations are construed as cultures existing in, and reproduced through, the social interaction of participants. The emphasis is on achieving a cultural anthropological understanding of how organisations are socially accomplished and reproduced.

Frost and Gillespie (1998) refer to this school of thought as ‘cultural purism’, underpinned by an interpretive approach which does not separate the organisation from its culture. Based on this perspective, culture is ingrained in an organisation’s composition, and so in order to attain organisational change, the entire range of key organisational components needs to be taken into consideration. Therefore, the systems approach mentioned in Part I of this chapter characterises this perspective whereby it is argued that it is not possible to disconnect organisational culture from the other core organisational dimensions of structure, strategy, process and so on.
A link between organisational culture and organisational effectiveness and/or performance

A causal relationship is frequently made in the management literature between organisational culture and organisational performance and effectiveness. For instance, Wallace et al (1999), Scott et al (2003a, 2003b), and Davies (2001) explain that the management literature from the 1980s onwards in particular is renowned for contending an instrumental link between organisational or corporate culture and organisational effectiveness and performance (see Peters and Waterman, 1982; Deal and Kennedy, 1982; Ouchi and Wilkins, 1985; Kilmann et al, 1986; Schein, 1984). Similarly, Anderson-Wallace and Blantern (2005) state that the key question for OD arising from these corporate culture theorists (Smircich, 1983; Schein, 1985) is whether corporate culture as an internal variable can be manipulated in predictable ways to influence the performance of the organisation.

This trend has also permeated the health care sector, with evidence of an increasingly implicit link being made between organisational culture and organisational performance and effectiveness. Scott et al (2003a) point out that there is now a growing amount of literature devoted to ideas of changing or transforming culture as a means of improving quality, efficiency, patient focus and/or broader organisational performance. For instance, in the United States, a study by Shortell et al (1995) points out that health care cultures that emphasise group affiliation, teamwork and coordination have been associated with greater implementation of continuous quality improvement practices. Some work in health care confirms a relationship between culture and organisational performance (Gerowitz et al, 1996; Gerowitz, 1998).

However, there is a need for caution in terms of making such assertions on the basis of a lack of sufficient empirical research work and evidence in support of the relationship between organisational culture and performance (Scott et al, 2003c; Davies et al, 2000; Wilderom et al, 2000; Wallace et al, 1999; Gordon and DiTomaso, 1992; Trice and Beyer, 1993; Smircich, 1987). In essence, culture is undoubtedly a vital component of all organisations and plays a critical role alongside other core organisational dimensions in shaping the overall characteristics and workings of organisations. Nonetheless, specifically singling out organisational culture as the means to improve organisational effectiveness and performance is problematic since such an approach discounts the complex nature of organisational culture and its close linkages with the other dimensions such as structure, strategy and processes. As has been stated earlier, this research therefore argues that a holistic or whole-system approach to organisational culture and organisational change is required, taking account of the multiple factors and influences which shape organisations. It examines organisational culture within the NEHB in terms of a dynamic external and internal context, in particular taking into account the cultural dimensions and implications of...
current structural, strategic and managerial developments and changes. With this in mind, attention now turns to the particular cultural characteristics chosen for examination in the survey of culture within the former NEHB.

**Part II: A discussion of the core dimensions of the NEHB Organisation Cultural Survey (2004)**

As outlined in Chapter 1, the questionnaire survey was constructed on the basis of six core cultural components, namely people orientation, information and communications, leadership and direction, accountability and performance, integration and teamworking, and continuous improvement and development. The final section of the questionnaire explored views on the national reform process in the Irish health system. A description of each of these elements and their significance with regard to researching and understanding organisational culture shall now be outlined based on a review of the relevant literature. It should be noted that a more detailed contextualisation of the survey questions, based on important developments in the Irish health care context and the former NEHB in particular, is contained within the findings/analysis chapters.

**(i) People orientation**

The changes taking place within the environment of contemporary health care systems necessitate new ways of engagement and working with both external and internal stakeholders. As shall be discussed below, the complexity of the health care sector and the demands faced by health care organisations requires the involvement and collaboration with a wide range of people and agencies, including health service providers, other public- and private-sector agencies, regulators and funders. This engagement also requires a particular focus on meaningful involvement of patients, service users, families, carers, and community and advocacy groups. The media is another important external resource which organisations will increasingly have to interact with in a more proactive manner (Bennis, 1987).

The concept of ‘partnership working’ with a wide range of stakeholder groups described in health and social care literature is increasingly recognised as an effective mode of governance and service delivery (Miller and Ahmad, 2000). This commitment to partnership implies openness in the sharing of information, resources, decision making, responsibility, and accountability. A core central component of effective partnership and people orientation is the process of ‘building trust’ (Gilson, 2003). This requires the development of an appropriate relationship and appropriate behaviours, particularly between patients/service users and providers, between employers and employees, and between public- and private-sector agencies.
Internal staff orientation

From the perspective of the human relations school of management theory (Meek, 1988) and humanistic management models, staff or human resources comprise a core element of an organisation (Ferlie et al, 1996). Basically, it is contended that the people side of an organisation is central in terms of offering the greatest opportunities for success and excellence (Block, 2003), and sustainable competitive advantage in organisations (Black and Synan, 1997).

A common feature of organisations that show sustained excellence is that of valuing staff (McGregor, 1960; Kanter, 1984), an easily espoused but often overlooked attribute in organisations (Scally and Donaldson, 1998). Treating staff well from a professional development perspective, in the form of good recruitment, retention and staff-development practices, is also of crucial organisational importance and benefit (Scally and Donaldson, 1998). The significant cultural trait of ‘involvement’ is identified in Ouchi’s (1980) model of organisational effectiveness, while Denison (2000b) refers to ‘involvement’ in terms of the organisation’s ability to develop employee skills, engender ownership and create a team-based workforce that is committed to success.

Common themes reiterated throughout the change management literature include the importance of understanding staff’s perceptions of change, the necessity of attaining the support of staff and rewarding staff in order to achieve sustainable change within organisations (Goodman and Dean, 1982; Pettigrew, Hendry and Sparrow, 1990; Pettigrew et al, 1992; Garside, 1998).

Therefore, on the basis of the centrality of the people side of organisations, Section A – People orientation of the NEHB Organisation Cultural Survey (2004) contained a series of questions which examined respondents’ views on how staff perceived that they were treated by the NEHB, their level of job satisfaction based on several influencing factors, the interlinked concepts of staff commitment, pride and morale, and the most positive and negative aspects of working in the organisation.

External consumer orientation

The other dimension of the people orientation section of the cultural survey comprised a focus on health care consumers and other external stakeholders. Greater cognisance of the patient or service user and the need for greater levels of citizen involvement, engagement and partnership in the health services is a welcome trend in health and social care. This reorientation challenges service providers to change their assumptions and to embrace the change in culture that is emerging. For instance, Mead and Bower (2000) point out that, in the past 30 years, an extensive body of literature has emerged advocating a ‘patient-centred’
approach to medical care, a core element of which comprises enhancing the
doctor–patient relationship.

The increased focus on patients and service users is similarly highlighted by Sullivan
(2002) who states that calls to respect patient autonomy and produce patient-
centred outcomes have recently brought the patient's points of view back into the
centre of clinical medicine. The significance of an inclusive and trustworthy
approach to patient care on the part of health service providers is discussed by
Gilson (2003), who highlights the empowering benefits of directly involving citizens
in decision-making processes which in turn are more likely to build trust.

From a service quality perspective, the involvement of consumers through the
provision of feedback on the performance of health services in terms of
patient/service user-related outcomes is a key consideration (Scott et al, 2003a).
Therefore, the significance of involving and consulting with health care
patients/service users, their families, and the public generally with regard to their
experiences of and satisfaction levels with health services is paramount (Steele,
1991; Shaw and Kalo, 2002).

Based on the above trends and developments, which promote greater participation
of external health care constituents, the *NEHB Organisation Cultural Survey* (2004)
asked respondents whether the unit, department or service in which they worked
involved patients, service users, families, carers, community groups and the general
public in the planning and evaluation of services. The survey sought suggestions as
to how greater involvement of patients and service users could be facilitated. It also
asked survey participants to rate the level of progress which the NEHB had made in
recent years in terms of involving patients and service users.

**(ii) Information and communications**

The importance of communications from an organisation cultural perspective has
been widely commented on in the literature. In essence, the organisational value of
good communications, which are two-way, all-inclusive, timely and appropriate,
forms a core element of an effective organisation. Communication has been
regarded as the most significant cultural symbol because it carries all other symbols
to members of the organisation. Having the capacity to take numerous forms,
communication is central to the concepts of leadership, power, politics, planning,
performance, change and effectiveness within an organisation (Frost and Gillespie,
1998). Significantly, communication has been identified as a key determinant of job
satisfaction, and therefore paying attention to communication has the potential to
yield enormous organisational benefits (Argyle, 1987). Communication and
dialogue with others encourage mutual respect, shared understandings and
collective interest, and so builds trust (Gilson, 2003). Kitchen and Daly (2002) explain that the efficacy of internal communications may be assessed from five perspectives – context, shape and form, methods and modalities, messages, and communication activities. The survey instrument used for the purposes of this research therefore contained a specific section pertaining to communication and information-sharing processes across all levels in the NEHB organisation. Respondents were also asked for their opinions on the most effective methods of information sharing and communications, the most important personal sources of information and the level of progress made by the organisation in recent years in terms of communicating with staff.

Another important recurrent issue arising in the relevant literature is the centrality of effective internal information and communications with regard to change processes and periods of large-scale reform and restructuring. In particular, announcing, explaining and preparing people for change (Spike and Lesser, 1995), reducing confusion and resistance to change (Garside, 1998; Lippitt, 1997), and influencing the ability of organisations to achieve their objectives (Irving and Tourish, 1994) are all highlighted.

In terms of the content of such communications with regard to significant change, Garside (1998) recommends communicating facts as opposed to values (the only effective way to communicate a value is to act in accordance with it and give others the incentive to do the same), using front-line supervisors rather than very senior managers to introduce change to front-line employees, and using face-to-face, one-to-one, informal communications. The literature therefore clearly suggests that developing effective communication and information-sharing processes in light of the unprecedented changes currently taking place both within and outside health care organisations should therefore receive priority attention.

With regard to external communications with the public, patients, service users, consumers, communities and so on, the inclusive partnership approach to health care referred to earlier entails information sharing and a two-way communications process. According to Shaw and Kalo (2002), one of the fundamental rights of patients is to have access to adequate information, to be educated and empowered in self-management of their health, diseases and conditions. A core role of external communications and engagement with external constituencies is the receipt of vital information, perspectives and feedback from organisational stakeholders with regard to service provision, performance, needs, demands and so on. Therefore, the NEHB Organisation Cultural Survey (2004) asked respondents for their opinions on communications with a broad range of external constituent groups by the NEHB generally and the unit, department or service where they worked.
Additionally, organisational communications are directly interlinked with the perception of the organisation by its internal members and externally by the public. Organisational image comprises the feelings and beliefs about the organisation that exist in the minds of its members, including how they believe others view their organisation (Martin, 2002). This is in line with Irving and Tourish’s (1994) description of two distinct frames of reference in terms of external communication strategies, namely the ‘inside looking out’ perspective and the ‘outside looking in’ perspective. Hence, the survey contained a question asking respondents to rate the NEHB’s organisational image.

(iii) Leadership and direction

Leadership and organisational direction are intrinsically interlinked with one another and are broadly recognised in the literature as core organisational cultural components. As Schein (1985) explains, leadership and culture are so central to understanding organisations and making them effective that we cannot afford to be complacent about either one. The pertinence of adequate and appropriate leadership with regard to organisational change and restructuring is also widely recognised as a key factor (Schein, 1984, 1985; Bryman 1996; Scott et al, 2003a; Beer et al, 1990). Therefore, the questionnaire asked respondents to identify the main ways in which the corporate management team within the organisation could support staff in dealing with the changes associated with the current reforms taking place in the Irish health system. Data was also gathered on a range of other key leadership tasks, including setting direction, outlining priorities and communication.

Leadership qualities

It is important to understand what components characterise effective leadership and good leaders. Research by Goleman (1998) has revealed that a commonly shared attribute termed ‘emotional intelligence’, which consists of self-awareness, self-regulation, motivation, empathy and social skills, is an integral personal quality among successful leaders in approximately 200 large, global companies. Other core leadership qualities are the capacity to inspire, to channel the efforts and to hold together teams of professionals (Bass, 1996).

Based on Greenleaf’s essay, The Servant as Leader (1979), Dye (2000) contends that the health care field needs leaders who can rebuild trust, restore efficient processes and ensure quality through organisational transitions. He argues that health service leaders need to become servants to the needs of their organisations and constituents, explaining that servant leadership can be demonstrated through the conduct of the following roles: sharing information, delegating authority, supporting continuing education, ensuring successes for staff, developing succession planning, maintaining a helpful spirit and attitude, leading by vision, and providing performance feedback.
The work of Greig and Poxton (2001) on leaders within large, multi-agency, contemporary health care environments such as the NHS usefully suggests the requirement for eight leadership competencies as follows: negotiation, influence, adaptability, diplomacy, networking, user responsiveness, focus on outcomes and multiple accountabilities.

Given the importance of various leadership skills in health care organisations, and particularly during a period of such radical change, an open-ended question was included in the *NEHB Organisation Cultural Survey* (2004) which asked the survey participants to identify what they perceived to be the three most important competencies of organisational leaders.

**A centralist leadership style**

Given the salience of leadership with regard to institutional, organisational and cultural change, it is important to understand the different leadership approaches and, more specifically, leadership approaches in the context of cultural change. The most common styles of leadership described in the ‘new leadership’ approach which emerged in the 1980s generally comprises ‘transactional’ and ‘transformational’ leadership and is primarily based on Burn’s (1978) study of political leadership (Scott et al, 2003c; Bass and Alvolio 1990, 1995).

‘Transactional’ leadership is based around securing organisational effort, compliance and control by using material motivational factors like reward systems. Organisational members’ behaviours, actions and performance are incentive driven. ‘Transformational’ leadership processes, on the other hand, inspire cognitive change by redefining the meaning of information to which organisational members are exposed.

Transformational leaders have a profound effect upon organisational members (Scott et al, 2003b), with employee relations seen as paramount. This type of leadership is analogous with ‘proactive leadership’ (Bate, 1984) which entails concepts of inspirational motivation, intellectual stimulation, idealised influence and so on.

A third leadership style, albeit less commonly cited is that of ‘laissez-faire’ leadership. This is an inactive, passive approach whereby the leader(s) is essentially disengaged and there is no motivation to influence his/her followers (Bate, 1984). A critique of this typology of leadership is that it is centralist, focusing on top-level leaders, and thereby neglects more localised, informal leadership processes.
A collective, informal style of leadership

More localised, informal concepts of leadership are also recognised in the literature, albeit less frequently than the above-mentioned centralist perspective. As Scott et al (2003c) point out, studies of informal organisation have examined the important role played by leaders of subcultures (Homans, 1950) and counter-cultures (Martin and Seihl, 1983).

The significance of Block’s (2003) research findings pertaining to culture and organisational distance in terms of informal, localised leadership are noteworthy. He states (2003), that leadership is at the heart of effective management in today’s marketplace, regardless of one’s place within the organisational hierarchy. According to Block (2003), the leadership of immediate supervisors is more strongly associated with the cultural perceptions of employees than that of supervisors or leaders working at any other level within an organisation. Block concludes that, as such, immediate supervisors are primary cultural agents in the organisation and are most likely to affect change in the cultural attitudes and beliefs of employees. Therefore, organisations must develop the transformational leadership ability of managers and staff at every level.

Alternative concepts of leadership and leaders may also be based on a differentiation perspective (Martin, 1992) as discussed earlier, which focuses on more informal, group-based leadership associated with subcultures. With regard to health sector organisations, for instance, some health care groupings, such as clinicians, heads of department, general managers and line managers, comprising both formal- and informal-type leaders, have a significant influence upon staff. For instance, the research findings of Pettigrew et al (1992) with regard to key people leading change at district health authority levels in the NHS during the 1980s revealed diversity of leadership in terms of occupational base, including clinicians as well as managers, and hierarchical levels. Leadership was exercised in a much more subtle and pluralist fashion and often it was personalities and not posts that were important. The value of a more informal, facilitative type of leadership is also promoted by Dolan and Garcia (2002) who state that it is increasingly necessary to develop a style of ‘facilitating’ leadership that ensures that the right things happen. Such a style, according to these authors, does away with the reactive tendency more typical of administrators who are always ‘on the defensive’ and which was more orientated to the hierarchical control structures of the early and mid-twentieth century. These alternative perspectives on leadership may be usefully applied in the analysis of the newly forming leadership arrangements in the reformed Irish health system.

A series of survey questions examined leadership within the NEHB, from both a corporate and local perspective, in terms of levels of satisfaction with the performance of keys roles and responsibilities.
Organisational direction

An important aspect of organisational culture is the overall strategic direction of an organisation as a whole, indicating a vision, purpose, forward planning, high-level thinking and reflection. The fulfilling of these strategic functions impacts directly on organisational effectiveness. As discussed earlier, leadership which provides direction is particularly important during periods of significant change and reform (Schein, 1984; Nadler, 1987; Beer et al, 1990; Bryman, 1996; Scott et al, 2003a), such as that currently being experienced in the Irish health system.

Furthermore, in addition to the setting out of a clear vision and future direction for staff, one of the core facets of organisational leadership is to instil understanding, confidence, support and commitment among staff (Nadler, 1987; Dolan and Garcia, 2002; Bijlsma-Frankema, 2001). This process ensures that the reasons and potential benefits of change and reform become shared and endorsed, and the necessary cultural changes are facilitated in order to realise the changes on the ground, in a tangible and meaningful manner. This is in line with Shortell et al’s (2000) assertion that a leader must be an implementer as well as a visionary.

In terms of overall direction, the development of a strategic framework by the former NEHB, namely AHSPNE (2003), outlined the future orientation for the organisation and its services over the medium term in line with national guidance and the reform process. The literature suggests that a key challenge for organisational leaders is the engagement of all levels of the organisation in developing an understanding of the value of a strategic framework. Leaders are also challenged to motivate staff to buy into the strategy through implementing its core actions.

The survey examined the extent of awareness among respondents of AHSPNE (2003) and sought their opinions on whether or not this organisational strategic framework was likely over time to have a tangible influence on service provision, service planning and service delivery.

(iv) Accountability and performance

Public sector reform

Two other commonly espoused values articulated by contemporary organisations centre on issues relating to accountability and performance. These issues have gained increased prominence in public sector organisations, which have in recent years become subject to greater levels of scrutiny, in particular by the primary funders of public services, namely government. As noted earlier in this chapter, organisational culture and organisational performance are frequently linked in the management literature. The current restructuring and modernisation of public sector organisations are associated with notions of efficiency, decentralisation, organisational flexibility and the transferability of learning and
good practices from the private sector to the public sector (Ferlie et al, 1996; Sheldon, 1998).

In terms of recent Irish public sector reform, the launch of the Strategic Management Initiative by the Department of the Taoiseach in 1994 was a significant development. The three key areas that were identified as initial aims of the Strategic Management Initiative (1994) included the contribution that public bodies can make to national development, the provision of excellent services to the public and the effective use of resources (Boyle and Humphreys, 2001). The objectives of the Strategic Management Initiative (1994) have been revised and updated throughout the decade and continue to be included in the national social partnership agreements which specify actions to be pursued at sectoral level in the civil service, in education, health and local government sectors (Boyle and Humphreys, 2001).

**Performance and accountability issues in the health services**

Demands for greater responsiveness, effectiveness, value for money, and better governance and management within the public sector have direct relevance for public health care systems. Generally speaking, there is a growing lack of confidence in health care systems and increasing levels of discontent with their performance. Public, political and professional dissatisfaction with health services shows a global consensus (Shaw and Kalo, 2002). Commonly cited concerns and problems in contemporary health services relate to clinical effectiveness, unsafe health systems, access, patient safety, consumer responsiveness, user dissatisfaction, inefficiencies, performance variation, poor quality, public accountability, and continuity of care (Schweiger, 2001; Hurst, 2000; Scally and Donaldson, 1998). As highlighted earlier, it is increasingly argued that organisational performance may be enhanced through changing organisational culture (Scott et al, 2003a).

As previously mentioned, within the Irish health care sector the strategic development of the health services over the past decade has been shaped by two national health strategies, *Shaping a Healthier Future* (1994) and *Quality and Fairness: A Health System for You* (2001). In addition, an increased level of governmental scrutiny has taken place, particularly since the mid-1990s, with regard to effectiveness, outputs, performance, efficiency, accountability and the overall structure of the health services. A specific development has been the move towards making health organisations more accountable for public spending in light of the rapid increases in gross expenditure in health which has more than doubled (up by 125 per cent) between 1997 and 2002, rising from €3.6 billion to €8.2 billion (Commission on Financial Management and Control Systems in the Health Service, 2003).

*Quality and Fairness: A Health System for You* (2001) asserted that the service planning accountability framework will be further strengthened to underline the
health boards’ role in providing the best possible value for money and pursuing quality standards. More recently, core themes of the *Health Service Reform Programme* (2003) are the improvement of accountability within the health system through better budgeting arrangements, devolved personal accountability for spending to the most appropriate decision-making level and improved service planning arrangements.

A series of questions were included in the questionnaire used for the purposes of this research in order to examine accountability and performance issues with regard to the NEHB as a whole. For instance, respondents were asked for their opinions on organisational flexibility and learning, utilisation of resources, utilisation of evidence and best practices, implementation of findings of reviews/evaluations, service user and outcome focus, and decision-making processes. Furthermore, a number of survey questions were included relating to the service planning process within the NEHB.

A focus on performance has arisen in response to the above-mentioned concerns and problems in modern health care systems. For instance, Campbell et al (2000) state that health care organisations in many countries across the world have been required to engage in more pointed reviews of their performance, particularly with regard to the quality of care and services which they provide.

In terms of assessing performance in the provision of health and social services by Irish health service organisations, a number of quality assessment mechanisms exist, including performance indicators, service plan targets, national standards, sustaining progress – performance verification process, inspectorates such as those in mental health and social services, the integrated management report and accreditation programmes. The *NEHB Organisation Cultural Survey* (2004) asked respondents to rate the effectiveness of each of these formal measures of NEHB organisational performance, while more informal performance management by respondents’ line managers was also examined in the survey.

**Organisation structural characteristics**

The organisational literature relating to organisational structure is distinctly based on descriptions of two contrasting models. First, there is the older, traditional model of bureaucratic-type organisations, renowned for a high degree of hierarchy and top-down control and, secondly, there are newer, flatter organisational structures, such as network and team-based structures which contain more widespread responsibility and autonomy and are in this sense less controlling (Dolan and Garcia, 2002).

Increasingly, the second model of organisational structure is being developed in organisations situated in highly fluid and complex environments, and facing
increased pressures to improve performance, responsiveness, competitiveness and so on. Hunter (1998) asserts that from a consumer perspective decentralisation is regarded as attractive since central administration is typically not close enough to the users of services to allow appropriate responses to expressed preferences. Pedler (2001) highlights the high level of current interest in the network as an organisational form that has the potential to promote innovation in service delivery. However, it is worth noting the assertion of Pettigrew et al (1992) who point out that, in reality, large bureaucratic organisations will not be able to switch from hierarchies to networks. Rather they will have to build and use both, i.e. hierarchies and local networks.

The *NEHB Organisation Cultural Survey (2004)* presented three models of management, describing the hierarchical type, the decentralised type, and a mix of the two extremes, and asked respondents to choose which they felt most accurately reflected the management structure and processes within the NEHB. The survey also gathered opinions regarding progress by the organisation in the devolution of authority and responsibility.

**(v) Integration and teamworking**

Achieving integration in modern health and social care organisations is one of the most significant challenges facing the system. The literature refers to a number of different types of collaborative activities including inter-agency work, inter-professional work, and partnership, team and group work (Miller and Ahmad, 2000; Holtom, 2001; Cozens-Firth, 1998; Rummery and Coleman, 2002; Friedlander, 1987; Hackman, 1987). The value of working more closely with others, as opposed to individually, to deliver more patient-/service user-focused services is the driving force for integrative and collaborative working methods.

The traditional structures of health care organisations, based on the professional bureaucracy and divisionalised forms (Mintzberg, 1981), are characterised by relatively high degrees of autonomy among professional workers and fragmentation among organisational divisions and units. The concepts of integration and collaborative teamworking are increasingly prioritised in the modern health care arena for a number of reasons, including the ever-increasing complexity of health service organisations, the expansion in the diversity of services which they provide and the very diverse nature of health service employees.

Inter-agency work or partnership working which involves joint working across different organisations and sectors is also being prioritised. As Miller and Ahmad (2000) explain, the concept is not contained within any sectoral boundary but permits organisations to engage with any state, market or nonprofit body. In the health care sector, a move towards an increased level of partnership working between statutory providers, and between the public and private sector, is
increasingly evident, particularly around areas where there is increased pressure to deliver services for which there is growing demand and increasing budgetary restrictions, such as the provision of community-based health and social care services (Gray, 1985; Hudson et al, 1999).

Within organisations, integration involves inter-disciplinary or inter-professional collaboration between professionals with different sets of skills, knowledge and experience. Miller and Ahmad (2000) state that this type of integrative working does not focus on organisational boundaries and procedures, but rather encourages collaboration between staff with different professional roles. It is concerned with acknowledging and maximising the contributions that different groups of professional workers bring to a set of circumstances. Some significant barriers to integration include financial realities, inadequate governance and management structures, talent and skill shortages, and autonomy and control issues (Shortell et al, 2000).

Teamworking comprises an important aspect of internal organisational integration. The benefits of working at a team and/or group level have been increasingly recognised in recent years. The notion of teamwork is analogous with that of a work group which Friedlander (1987) states is broadly considered to be a small set of people with a common overall goal, who are, to varying degrees, socially, structurally and technically interdependent with each other and with the larger organisation. An important contributory factor associated with the advantages of team or group work is the notion of group synergy which Hackman (1987) explains emerges from the interaction among members and affects how well a group is able to deal with the demands and opportunities in its performance situation.

The requirement for the team approach is also discussed by Frost and Gillespie (1998) who state that in order to meet the complex issues they face, organisations need ways to solve problems that lead to top-quality, highly effective outcomes. One approach that seems to be working involves the use of teams.

The benefits of teamworking have also been recognised in the health care sector generally (Cozens-Firth, 1998; the General Medical Council, 1995). Teams have been found to produce better patient care both in terms of improving health delivery and staff motivation (Wood et al, 1994), and in superior patient outcomes (Adorian et al, 1990). Claims are made that multi-disciplinary health care teams allow a more efficient use of staff and service planning (Øvertveit, 1988). Additionally, Ferguson and Lim (2001) contend that there is a growing recognition that successful implementation of clinical governance requires a genuinely integrated team approach to delivering care and consequently the role of clinical teams is central since no single individual has all the requisite skills.
Potential common challenges associated with teamworking and the integration of teams or work groups with the wider organisation include the tensions between professional specialisms and, in particular, issues associated with autonomy and boundaries, and congruence with the values, purposes, objectives and activities of the organisation (Friedlander, 1987; Cozens-Firth, 1998). In terms of effective teamworking, Guzzo and Shea (1992) identified a number of core requirements for teams, including the possession of a clearly defined team task, clear team objectives, unique and meaningful team member tasks, individual team member performance assessment and feedback, and regular feedback on the meeting of team objectives. Similarly, Hackman (1987) discussed the enhancement of team or group working through appropriate team size and skills mix, knowledge supplementation through good educational, training or consultation opportunities, and an emphasis on the sharing of expertise and collective learning rather than weighting contributions on the basis of power or authority differentials.

The integration and teamworking section of the NEHB Organisation Cultural Survey (2004) therefore sought to establish respondents’ ratings of joint working and collaboration within the NEHB organisation and progress made in this regard in recent years. It also gathered views on joint working and collaboration between the NEHB and other relevant health and social care organisations in the statutory and voluntary sector. Furthermore, perceptions of the most crucial facilitating factors regarding collaborative working among different parts of the NEHB were gathered. The NEHB survey also gathered data on the extent and main types of teamworking within the organisation, levels of satisfaction with significant team elements, as well as perceptions of progress made by the organisation in facilitating teamworking.

(vi) Continuous improvement and development

Concepts of continuous improvement, learning and development are regarded as core components of high-performing, innovative organisations and are essential components of organisational change. Critical to the modern organisation is the concept of organisational learning. This involves the detection and correction of errors (Argyris and Schön, 1978). Organisational learning can also be described as the process of improving action through better knowledge and understanding.

The model of the learning organisation is linked closely with the concept of systems thinking which involves being aware of the web of interrelations that exist between the parts and being aware of the parts themselves (Garside, 1998). Furthermore, the close association between learning and change is emphasised by Beckhard and Pritchar (1992) who state that learning and change processes are part of each other. Change is a learning process and learning is a change process.
Continuous improvement and development in health care

The organisational values of continuous improvement and development have been underpinned by several knowledge-based approaches to health care in recent years which support the increased use of research, evidence and good or best practices (Scally and Donaldson, 1998; Haynes, 2002; Niessen et al, 2000; Donaldson and Gray, 1998). Underpinning this move is the widespread recognition of the importance of utilising such knowledge in order to make more effective clinical and managerial decisions, and to develop better health policy and service plans. Interlinked with continuous learning and improvement is the increasing awareness of the need for organisational systems to address the issues of professional development and continuing education. Indeed, the importance of training and development of staff is well recognised in health care (Donaldson and Gray, 1998).

Learning organisations share good or best practices, learn from mistakes and improve practices (Ferguson and Lim, 2001). The issues of recognition, rewards, incentives and sanctions are highly significant in relation to organisational learning and performance issues. Organisational cultures focused on learning and improvement stress the importance of recognising good performance and dealing with poor performance. The most important single instrument for ensuring that learning and change take place is the set of positive and negative rewards that are shown by management behaviour (Beckhard and Pritchard, 1992).

Shaw and Kalo (2002) explain that in the past 20 years, the concept of improvement of health systems has moved away from top-down control and compliance towards bottom-up development, self-regulation and incentives. Commenting on the clinical governance system in the United Kingdom, Ferguson and Lim (2001) are critical of the general tendency within NHS organisations which pay more attention to sanctions aimed at penalising poor performance rather than incentives aimed at rewarding good performance. Scally and Donaldson (1998) contend that the clinical governance agenda provides an opportunity to address current weaknesses in learning lessons from complaints and preventing errors. Overall, the clinical governance agenda aims to raise standards and support staff in meeting these standards, with a particular focus on outcomes from a patient/service user perspective.

The NEHB Organisation Cultural Survey (2004) contained a series of questions which gathered respondents’ levels of satisfaction with the various dimensions of continuous improvement and development discussed above, including the promotion of a quality improvement and learning culture, organisational learning, the utilisation of local knowledge, individual development needs, processes and supports, and training and development.
National reforms of the Irish health service

In Part I of this chapter, the unprecedented changes currently taking place within the health services generally, and within the Irish health system specifically, were outlined. It is important to understand that, in accordance with any large-scale reform process, the structural, managerial and technical changes associated with the reform of the Irish health service entail cultural and human dimensions. It is clear from the literature that problems of change resistance and failure are both common and extensive. Organisational cultures and organisational members are recognised as pivotal with regard to effectively implementing change. Organisational leaders have a particularly important role with regard to organisational change processes.

Therefore, the questions contained within this final section of the *NEHB Organisation Cultural Survey* (2004) sought to examine respondents’ perceptions of the *Health Service Reform Programme* (2003) taking place in the Irish health care system. In particular the focus was on the individual impact and personal concerns arising from these changes, and the needs, supports and appropriate core leadership tasks of corporate management in aiding staff through the reform process.

Two core themes in the relevant literature which particularly apply to this final section of the *NEHB Organisation Cultural Survey* (2004) are the centrality of effective leadership during times of major organisational and cultural transformation and the necessity of paying particular attention to the appropriate management and support for staff during periods of significant change.

Regarding the former, we know from the earlier discussion in Part I of this chapter that change management and implementation is challenging. Common responses to change comprise withdrawal and/or resistance (Cornell, 1996). Almost all resistance stems from the overarching factor of change being perceived as harmful or threatening in one way or another (Trader-Leigh, 2002; Bennis, 1987). During times of change, trust is based on two things, predictability and capability (Garside, 1998). Staff want to know that the process which is about to begin has a predictable, known route and that they will be treated fairly. It follows that the core tasks for leaders are, therefore, to work with staff in exploring the reasons and necessity for change, to motivate staff to become involved in the implementation of change and to support staff appropriately.

Commenting on health system reform and change, Scott et al (2003b) state that leadership plays a central role in any cultural transformation. Therefore, the lack of appropriate leadership is directly linked to organisational inertia and resistance. The task of managing commitment of employees to foster cultural adaptation to the new structure was similarly identified by Bijlsma-Frankema (2001) as one of three important leadership roles associated with cultural change. Similarly, Scott et
al (2003b) highlight the problem of lack of ownership of change and point out that unless a critical mass of employees ‘buy into’ a culture change programme, such initiatives are likely to fail. In recognition of this core leadership task, the NEHB survey asked respondents to identify the main ways in which the corporate management team could support staff in dealing with the reforms.

However, in legitimising, justifying and ‘selling’ the changes to all organisational members, organisational leaders must recognise that different staff are likely to have different perceptions of the changes, depending on their occupational or professional grouping, the service area in which they work, their place in the organisational hierarchy and so on. Groups, for example, may resist change if their group structure, social norms or power base is affected (Garside, 1998).

Therefore, cognisance of the various groupings of staff within an organisation is necessary in order to more effectively bring about change. As a result of the existence of diverse subcultural groupings within health care organisations (Scott et al, 2003b), cultural change programmes must carefully consider the impact of change on specific groups such as doctors, nurses, other health professionals and managers, and design appropriate policies to accommodate this cultural diversity (see Child and Faulkner, 1998; Davies et al, 2000; Scott et al, 2003c).

The issue of cultural diversity within organisations is also discussed by Strebel (1996) who explains that alternative views of change occur because leaders and employees see change differently. To the leaders, change may be an opportunity, a survival strategy or a chance to further their careers. However, to the employees, it may be perceived as disruptive and intrusive.

Interlinked with hierarchical position is the concept of power within organisations. These concepts are particularly influential with regard to organisational change efforts. Any significant change poses the possibility of upsetting or modifying the balance of power among groups. The uncertainty associated with change creates ambiguity, which in turn tends to increase the probability of political activity (Thompson and Tuden, 1959). Galbraith (1987) contends that if management does not involve people whose vested interests are affected by organisational changes, they may choose to resist or engage in what Pettigrew (1973) calls ‘power maintenance’. Bennis (1987) refers to the fear of loss of status, prestige or power which can arouse very strong resistance to change.

The second major role for organisational leaders, particularly relevant to the final section of the NEHB Organisation Cultural Survey (2004), is the effective management and support of individual staff members during periods of significant reform. A frequently voiced question in such times is, ‘What’s going to happen to
me?’ (Nadler, 1987). According to Bennis (1987), people resist changes they do not understand. He notes that many investigators have found a high correlation between the unknown and high resistance. The psychological impact of change is associated with the perceived impact of the change on job security, professional expertise and social status in the organisation (Trader-Leigh, 2002).

According to Garside (1998), most people working in health care organisations do not wish to change their location, style or mode of working. The fear associated with the possible need to learn new skills or work behaviours is another problem (Garside, 1998; Bennis, 1987). Pettigrew et al (1992) explain that the link between the unplanned movement of key personnel and the draining of energy, purpose, commitment and action from major change processes has been established by a whole series of research studies (Goodman and Dean, 1982; Kanter, 1984; Pettigrew, 1985a). Similarly, a key conclusion of a review of patient-focused care referred to by Garside (1998) was that leaders of change significantly underestimated the need for investment in support from human resource personnel in the technical aspects of changing people’s jobs, recruitment, redundancy, training and communication with staff.

The literature commonly associates change with the notion of loss, for instance a loss of identity, of belonging, of meaning (Strickland, 2000) and of mastery (Moran and Brightman, 2001). A loss of identity occurs when the setting in which a job is done changes. These issues are directly relevant to this research since, as explained in Chapter 1, the NEHB as an organisation ceased to exist as part of the national restructuring of the health services and has now merged with the Northern Area Health Board to form the HSE Dublin North East. A loss of belonging occurs when teams are broken up, and relationships that have been developed over time are dissolved. A loss of meaning is particularly devastating and it happens when the occupational values that have sustained individuals over time are changed. It may be the result of the integration of two groups with distinctly different cultures.

A loss of mastery occurs when the job content changes to such a degree that new skills have to be learned in order to perform the job properly. Similarly, Garside (1998) discusses the issue of ‘parochial self interest’, whereby stakeholders expect to lose something as a result of the change being implemented (for instance, loss of power, loss of face, additional workload, loss of income, job insecurity) as one of the reasons why stakeholders might resist change. The loss of privileges as a result of the redistribution of tasks and responsibilities is discussed by Trader-Leigh (2002) as a contributory factor to change resistance. The final section of the NEHB Organisation Cultural Survey (2004) gathered data on the main concerns and sources of supports identified by respondents in terms of the health service reform process.
Analysis of the cultural dimensions of the NEHB organisation

The remainder of this report presents an analysis of the NEHB Organisation Cultural Survey (2004) research findings data with regard to six core dimensions of organisational culture: people orientation, information and communications, leadership and direction, accountability and performance, integration and teamworking, continuous learning and development, and also views of the national reforms of the Irish health service. The analysis pertaining to each of these dimensions is presented in Chapters 5 through 11. This is the first time a quantitative examination of the organisation’s culture has been conducted.

In analysis terms, at the broadest level, a discussion of the core organisational findings, trends and implications are presented, setting out the character of the overarching culture within the NEHB organisation as a whole. This level of analysis, therefore, presents the main cultural characteristics of the organisation as described by a representative sample of staff, and provides useful baseline data on the existing organisational culture at a particular point in time.

As we know from the discussion in Chapter 4 earlier, organisational culture is a complex phenomenon and, in addition to the existence of one dominant organisational culture, there may be several subcultures among various work/occupational/professional groups and/or within various service areas, sections, units and/or departments and so on. This is in line with the differentiation perspective noted in Chapter 4 which is cognisant of cultural diversity within organisations. Therefore, in order to explore the cultural facets of the organisation in a more comprehensive manner, the research findings were examined in more depth as outlined below.

In statistical terms, a procedure referred to as crosstabulation was used as a means of exploring relationships between the responses to the various survey questions on the basis of the following three areas.

First, on the basis of the respondents’ occupation, the data was analysed according to the particular staff group in which respondents were employed, namely Allied Health Professional, Management/Administration, Medical/Dental, Nursing, and Support Services.

Secondly, the research data was analysed in terms of respondents’ levels of direct, front-line contact. Therefore, the approximate estimations given by respondents with regard to the percentage of their working time which involved direct contact with

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6 Crosstabulations are a way of displaying data so that relations between two or more variables can be examined. Two variables are said to be associated or related when the distribution of values on one variable differs from different values of the other. It is useful to summarise the information about association in a crosstabulation by a single figure. In this research report, this was done by calculating Pearson’s chi-square statistic. This statistic is used to test the hypothesis of no association of columns and rows in tabular data of the crosstabulation. A chi-square probability of p=.05 or less is commonly interpreted as a rejection of the null hypothesis that the row variable is unrelated (that is, only randomly related) to the column variable (De Vaus, 1996). Therefore, where p=.05 or less, there is a significant difference in the relationship between the variables in the crosstabulation.
patients or service users were recoded into three levels of contact: none to minimal (0-20 per cent), medium to high (21-60 per cent) and very high (61-100 per cent).

Thirdly, the research findings were scanned on the basis of the service areas in which respondents worked. For analysis purposes, this survey question was recoded into the following four service areas: acute hospital services, community services, regional services and head office. While the analysis of the research data by service areas necessitates more work, since it is not as detailed as that regarding the staff groups and level of direct patient/service user contact, it is nonetheless useful in highlighting broad cultural trends from another perspective.

The data analysis highlighted those instances where significant differences (i.e. strong relationships) among variables were found when examined on the basis of the independent variables noted above, namely, staff group, level of direct patient/service user contact and service area. In the majority of cases, the ‘don’t know’ values were excluded from the crosstabulations since these values were generally low for the majority of questions and would not allow a reliable interpretation of the chi-square value as a result. Where the ‘don’t know’ and ‘unsure’ values were high for particular survey questions, they were included in the crosstabulations.

As shall be evident from the discussion of the survey findings in the forthcoming chapters, in addition to overarching findings regarding the organisational culture of the NEHB, significant differences were discovered on the basis of staff groups, levels of front-line contact and service areas, indicating the existence of important subcultural dimensions within the organisation. The research findings therefore, usefully highlight important cultural nuances in terms of differences of opinion and experience among respondents. This more in-depth level of analysis is beneficial with regard to organisation cultural change since change does not affect all organisational members in the same manner and, therefore, more tailored organisational responses are required as opposed to a ‘one size fits all’ approach. Organisational leaders, managers and those planning change processes in the health arena need to understand these issues as a means of attaining organisation-wide support for change and pre-empting withdrawal or resistance among the diversity of organisational members, groups and sections.
Chapter 5 – People orientation

The perceptions of staff and consumers with regard to how they believe they are treated are important indicators of the kind of culture operating within an organisation. As outlined earlier in the literature review chapter, the value of adopting a human-relations or people-oriented approach to staff is widely recognised in modern management approaches (Ferlie et al, 1996; Meek, 1988). Moreover, the recognition of the human component of organisations and more specifically staff as a vital organisational resource has been emphasised in the relevant literature (Block, 2003; Scally and Donaldson, 1998). It has been argued that a partnership approach with core internal and external stakeholders (Miller and Ahmad, 2000) and processes for involvement (Ouchi, 1980; Denison, 2000b) are beneficial from both an organisational management and service perspective.

In terms of the Irish health and social care context, as a means of achieving the various goals and actions of the current national health strategy, *Quality and Fairness: A Health System for You* (2001), a human resources framework was outlined which aims to develop and explicitly value staff at all levels of the health system. It was pointed out that such an approach in turn benefits service users.

In order to achieve the aims and objectives of *Quality and Fairness: A Health System for You* (2001), improved people management was necessary. Therefore, the strategy set out that an *Action Plan for People Management in the Health Service (APPM)* would be developed by the Department of Health and Children and the Health Service Employers Agency. The plan was published in 2002 and contains details on the development and implementation of seven key human resource themes which were outlined in *Quality and Fairness: A Health System for You* (2001), namely managing people effectively; improving the quality of working life; devising and implementing best practice employment policies and procedures; further developing the partnership approach; investing in training, development and education; promoting improved employee and industrial relations; and development of performance management.

With regard to the north-east area, *AHSPNE* (2003) explicitly recognised the importance of respecting staff and developing successful partnerships with staff based on mutual trust, respect, openness and a shared purpose. The NEHB *Human Resource Management Plan* (2004) centred on the organisation’s responsibilities in terms of the development and support of its staff, and contained 10 key focus areas and actions which are similar to those of the *APPM* (2002).
Recognition of the importance of good practices with regard to staff involvement was also clearly evident in the Joint Development Plan for Partnership in the North Eastern Health Board agreed by the NEHB Regional Partnership Committee in 2001. This plan clearly outlined a commitment to support a culture of staff participation and involvement. Accordingly, while these various core documents espouse valuing staff and supporting staff well, of more tangible relevance is the extent to which these overarching principles are translated into behaviours and actions so that they are practicably meaningful for staff on the ground.

**Part I: Overall organisation cultural findings**

As we have seen from the literature, the complexity of modern health care organisations and the vast array of changes currently taking place in the health care arena necessitate new ways of people orientation in terms of working with both internal and external stakeholders in a more inclusive, open and fair manner. An organisation’s capacity to make this transition towards improved people orientation depends on the culture of the organisation, the relevant plans and procedures which it has in place to facilitate this approach, and the quality and skills of its leadership and management.

In terms of staff orientation, crucial indicators of the culture of an organisation are staff perceptions of how they are treated where they work, and their overall level of job satisfaction, commitment and morale. Consequently, a series of closed-ended questions was contained in Section B of the NEHB Organisation Cultural Survey (2004) in order to assess respondents’ opinions of staff orientation within the organisation in terms of perceptions of staff treatment, job satisfaction, employee commitment, and pride and morale levels.

External consumer orientation was also examined in terms of staff opinions of the involvement of various external stakeholders, comprising patients and service users, families and carers, community groups, and the general public. Furthermore, three open-ended questions were contained within Section B in order to gather the views of respondents regarding the most positive and negative aspects of working in the organisation, and how greater involvement of patients and service users could be facilitated by the NEHB. The survey findings pertaining to these various issues shall now be outlined.
Internal staff orientation

Perceptions of staff treatment in the NEHB

The NEHB survey sought views in relation to staff perceptions on a wide range of issues including, respectful treatment of staff, equal opportunities, fair decisions, an inclusive approach respecting difference among staff, openness and transparency of the organisation, safety to speak one's mind, and induction and orientation (Q10). The figure below details respondents’ opinions in relation to these issues in the NEHB. On the whole, of those who answered this set of questions, viewpoints were very mixed in terms of levels of agreement, disagreement and uncertainty across several areas.

Figure 1: Perceptions of staff treatment in the NEHB (Q10)

The most positive response in this particular question was with regard to respectful treatment by the NEHB of its staff, with 57 per cent of respondents agreeing or strongly agreeing that ‘employees are treated with respect, regardless of their job’. In addition, approximately half the respondents held positive views regarding equal opportunities (51 per cent), fairness regarding decision making (51 per cent), and inclusiveness (48 per cent).

However, views were notably less positive and more uncertain with regard to the issues of openness and transparency and safety to speak one’s mind. For instance, over a third (34 per cent) of respondents either disagreed/strongly disagreed and 34 per cent were also unsure with the statement that ‘the NEHB is an open, transparent organisation’. Additionally, 38 per cent disagreed and 37 per cent were unsure with the statement that ‘it is safe to speak my mind in the NEHB’.
As is evident from Table 10, almost half (46 per cent) the respondents who answered the question pertaining to induction and/or orientation for new staff members rated it as inadequate, while a further 16 per cent were unsure. Such findings are further supported as we shall see later in this chapter. Induction is also referred to in Chapter 10, Open Question 43, whereby one of the most important ways suggested by respondents in assisting staff who move or change roles within the organisation was through the development and provision of more effective induction processes.

Table 10: Adequacy of induction and/or orientation (Q10)

<table>
<thead>
<tr>
<th></th>
<th>n answered</th>
<th>% Agree/ Strongly agree</th>
<th>% Disagree/ Strongly disagree</th>
<th>% Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Induction and/or orientation for new staff members is adequate</td>
<td>651</td>
<td>38</td>
<td>46</td>
<td>16</td>
</tr>
</tbody>
</table>

Generally speaking, the feedback from respondents in relation to the series of statements presented in Figure 1 and Table 10 above suggests that further exploration of how values and principles, such as respect, equality, fairness, inclusiveness, openness and transparency, could be translated into behaviours requires attention. Caution with regard to interpreting these results is also required based on the level of uncertainly noted in the responses. It is also acknowledged that there are limitations to exploring core values through a quantitative methodology such as a questionnaire survey. Therefore, more in-depth qualitative research would be required in this regard.

Job satisfaction

A wide selection of factors identified from a review of the literature on job satisfaction was included in the survey question on this issue (see Q13), as indicated in Figure 2. Generally speaking, respondents were largely content with various aspects pertaining to job satisfaction in the areas where they worked.
As Figure 2 illustrates, of those who answered this set of questions, the majority were satisfied or very satisfied with working relationships with their colleagues (85 per cent), the broad content of their job (70 per cent), the general atmosphere where they work (68 per cent), and the reporting relationship with their line manager (67 per cent). More moderate levels of satisfaction were reported with regard to the level of job challenge and motivation (61 per cent) and guidance and support received from one’s line manager regarding their work (59 per cent).

Nonetheless, while many of the survey participants were satisfied with several of the job aspects discussed above, it is worth noting that a number of aspects of job satisfaction were regarded as unsatisfactory. In particular, of the various aspects listed, respondents were most dissatisfied with their promotional opportunities where they work, with over a third (34 per cent) dissatisfied. The second most commonly rated dissatisfactory issue selected by 29 per cent of respondents was the
way in which conflict is dealt with. An average of over one in five (22 per cent) were dissatisfied with the extent to which their suggestions are listened and responded to, recognition of their work contribution, and working conditions.

This data indicates core areas which require more focused exploration in order to understand particular issues and contributory factors regarding job satisfaction. However, one could suggest that there are early indications of areas which would require more attention in order to improve staff’s job satisfaction levels. As we shall see in Part II of this chapter, more in-depth analysis of what categories of staff were most satisfied and dissatisfied provides further useful information in terms of targeting the various aspects which are related to overall levels of job satisfaction towards particular staff groups and/or types.

Another important aspect of job satisfaction is what motivates staff in their work. In this regard, the survey respondents were asked to comment on the statement that ‘a culture of providing services to the public is an important motivator of staff’. Positive findings were revealed in this regard, with three out of four (75 per cent) of those who answered this question being in agreement with this statement, reinforcing the importance of the public service ethos among respondents as presented in Figure 3.

**Figure 3: A culture of providing service to the public is an important motivator of staff (Q29.1)**

<table>
<thead>
<tr>
<th>Strongly agree/Agree</th>
<th>Unsure</th>
<th>Disagree/Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>75%</td>
<td>17%</td>
<td>8%</td>
</tr>
</tbody>
</table>

**Staff commitment, pride and morale**

Matters such as commitment and pride are integral elements of job satisfaction. Moreover, as we saw earlier in Chapter 4, gaining staff commitment during times of organisational change is an important leadership task (Bijlsma-Frankema, 2001). The survey ascertained respondents’ opinions on the overall level of commitment
and pride at two levels: in the NEHB organisation generally and in the place in which they work locally (Q14).

This distinction is important given the very dispersed and large-scale nature of the NEHB which is composed of multiple services and is geographically dispersed across four counties in the north east, namely Cavan, Monaghan, Louth and Meath. As the figure below demonstrates, the overall data revealed a noticeably more positive rating of staff commitment and pride in respondents’ own work area compared to the corporate entity of the NEHB.

**Figure 4: Organisational and local levels of commitment, pride and morale (Q14)**

More specifically, of those who answered this set of questions, both employee commitment and staff pride were rated as high or very high by 65 per cent and 58 per cent of respondents respectively. In comparison, the levels of commitment and pride in the NEHB were rated more moderately by 40 per cent and 45 per cent of respondents respectively. Based on the notion of organisational distance (Block, 2003), these findings may be interpreted on the basis of the closer identification by staff with the local area in which they work on a regular basis and have most knowledge and experience of, as opposed to the corporate entity. In contrast to commitment and pride levels, staff morale where one works was not rated as positively, with opinions evenly split between moderate and high to very high levels (40 per cent and 39 per cent respectively), while just over one in five (21 per cent) rated staff morale in their work area as low or very low.

As shall be discussed later, the data regarding staff pride and morale contained significant variation in terms of staff group and level of direct front-line contact. The findings that emerged from these particular questions on commitment, pride
and staff morale provide some indications in relation to complex areas that would necessitate more in-depth analysis.

Analysis of the most positive and negative aspects of working in the organisation

The vast majority of survey participants (85 per cent and 83 per cent) responded to the open-ended questions in which they were asked to identify the three most positive (Q11) and negative (Q12) aspects of working in the NEHB. The open-ended questions provided an opportunity for respondents to highlight issues that may not have otherwise emerged. They also reinforced many of the findings from other survey questions, therefore providing additional evidence. The responses were very valuable in terms of providing a sense of reality and an insight into the issues that were significant for staff throughout the organisation.

As the discussion below shall reveal, various aspects which were described by some respondents as positive work factors were simultaneously regarded by others in negative terms. This variance is inevitable given the nature of the open-ended questions. As the description below will outline, the positive factors noted by staff related mainly to value based-type responses, including interpersonal relationships, development opportunities and the overall atmosphere at work. The negative factors were strongly linked to perceptions of management, decision-making and communication processes, resources issues and work pressures.

The most positive aspects of working in the organisation

An open-ended question asked respondents to identify the three most positive aspects of working in the NEHB (Q11). The vast majority of survey participants (85 per cent) identified a diverse array of positive work characteristics. For instance, many respondents identified a range of developmental and job opportunities for staff. Positive interpersonal relations based on friendly and supportive work atmospheres and good working relationships with colleagues, peers, employees, and team members were also commonly cited. The provision of health services and interaction with patients, service users, communities and the public were mentioned as other positive elements of working in the NEHB. The satisfaction derived from doing one’s job and the opportunities for job variety and movement were also mentioned. In addition, several favourable employment conditions were outlined. The values of equality, respect and fairness were outlined as positives in the workplace, while the notion of change was also alluded to. Each of these main positive work aspects identified by respondents shall now be discussed further.
Staff development opportunities
A noteworthy theme with regard to the positive aspects of working in the organisation was the range of opportunities available to staff in terms of ongoing or further education, training, learning, and professional and personal development. It was explained that such developmental opportunities are backed up with support, encouragement, commitment and resources on the part of the NEHB. Furthermore, the prospects for promotion, career progression and advancement were also emphasised, as were the possibilities of widening one’s experience in a large organisation such as the NEHB. From a developmental perspective, it was also pointed out that the variety of work and the possibility of working in or transferring to many different areas, given the large size and diversity of the NEHB organisation, was a positive work aspect. The opportunity of working with a variety of people was also highlighted.

Internal interpersonal relations
Other commonly cited positive elements associated with working in the NEHB were the positive relationships and ambience which respondents described with fellow staff, employees, colleagues and team members. For instance, ‘good working relationships’, ‘rapport’, and ‘liaisons’ between staff, and the ‘friendly working environment’ and ‘atmosphere’ were all commonly mentioned. Furthermore, respondents described many positive traits which they associated with fellow employees, co-workers and team members, including ‘professionalism’, ‘quality’, ‘calibre’, ‘skilled/skill-level’, ‘capability’, ‘competence’, ‘dedication’, ‘commitment’, ‘reliability’, ‘dependability’, ‘enthusiasm’, ‘friendliness’ and ‘comradeship’. Other aspects which respondents commended were ‘teamworking’ and a good or positive ‘team spirit’ where they worked. The issue of ‘support’ and working in a ‘supportive environment’ was cited. In particular, the support received from work colleagues or co-workers was consistently reported, while line or local management and management support generally was also emphasised, albeit to a lesser degree.

Job satisfaction and public service ethos
The personal sense of satisfaction and reward derived from doing one’s job was another frequently mentioned positive. The term ‘job satisfaction’ was commonly cited by respondents. The quality and range of services being provided by the organisation were alluded to. From an altruistic perspective, the sense of job satisfaction among respondents arising in particular from a ‘public service ethos’, in terms of working with the public and delivering services for the people of the region, was clearly identifiable in the responses of some staff members who voiced the belief that the organisation is ‘client’ and/or ‘patient centred’. The provision and delivery of ‘a good, well-run, quality (public) service’ to the ‘clients of the four
counties’ and ‘the public’ generally was referred to as a positive work aspect. In addition, the conscious efforts being made to develop and improve services were also mentioned. One respondent described this in terms of ‘the strong ethos of wanting to develop and improve services for people’.

In professional terms, the sense of personal fulfilment derived from working with a diversity of patients and clients, the ability to help people and the potential of making a difference in people’s lives was highlighted by some survey participants. In this regard, a variety of positives were described in terms of ‘caring for the sick’, ‘nursing’, ‘contact with people and caring for them’, ‘helping, working, dealing with patients, clients, families, carers’, ‘community orientation’, ‘serving the local population’, ‘being part of caring teams for patients and the elderly’, having ‘the opportunity to work in a public service organisation, and delivering services to people with health and social care needs’.

A description of satisfaction on the part of respondents, derived from contact and interaction with patients, clients, service users, and families, was provided in terms of ‘good patient relationships’ and feeling ‘appreciated’ and ‘respected’ by these constituents. Personal satisfaction was also associated with conducting ‘challenging’ and ‘interesting’ work. Some identified their work as ‘rewarding’ in the sense of being ‘value-added’, (potentially) making a difference/vital contribution’, ‘contributing to the well-being of others’, ‘affecting and helping people’. As one respondent described it, ‘knowledge that the service users benefit even from the limited provision of that service’.

**Favourable employment conditions**

Many of those who completed the survey identified the employment terms and conditions of working in the NEHB as positive. In this regard, a broad selection of specific aspects were cited, one of the most common being ‘job security’ or ‘security of employment, job or work position’, which was consistently reported by respondents. Linked with job security was the notion of ‘permanency’. In terms of work–life balance, a number of particular issues were commented on. The working hours were variously described as ‘good’, ‘reasonable’, ‘sociable’, ‘regular’, and ‘short’. The flexible working arrangements, facilitated mainly through the flexi-time system and also through job-sharing arrangements, were described as another positive work dimension. Such arrangements in turn facilitated a ‘family-friendly’ working environment as indicated by some staff members.

From a financial perspective, salary, pay, wages, income and pension entitlements were all mentioned as a positive. Annual leave or holidays and other leave entitlements, including study leave, parental leave, sick leave, maternity leave and so on, were also specified. Another key benefit highlighted by respondents was
their work location, and in particular the ‘convenience, closeness, or proximity’ of one’s work to home and the issue of ‘minimal travelling’.

**Equality, respect and fairness**

More generally, the notions of equality, respect and fairness were also highlighted by respondents as positive aspects of working in the NEHB. For instance, one respondent stated, ‘it is an organisation trying hard to be well governed, transparent and fair to employees’. The respect shown by staff or employees to internal staff and/or patients, clients and service users was referred to. Some respondents described equal opportunities for and equal treatment of staff.

**Change**

The issue of change was another issue variously referred to by respondents in terms of a positive work aspect. Perceived positive changes taking place within the organisation generally, and within some services and work areas more particularly, were mentioned. Others referred to the benefit of being able to ‘be part of’, ‘contribute to’ and ‘implement’ change, while some respondents identified the ‘scope’ and ‘opportunities’ for change in their work positions.

**The most negative aspects of working in the organisation**

Another open-ended question asked respondents to identify the three most negative aspects of working in the NEHB (Q12). A very high percentage of survey participants (83 per cent) indicated various negative work aspects in response to this particular question. The subsequent analysis of this data revealed a wide variety of key issues, some of the most prominent of which included perceptions of management, communications, decision-making processes, staffing issues and workloads, lack of support and recognition, staff stress, service delivery and service quality, resource constraints, promotion and recruitment, working conditions and facilities, public image and public relations, role responsibility and accountability, change and reforms, planning, teamworking, bureaucracy, and staff training and induction. A more detailed description of these issues shall now be presented.

**Perceptions of management**

A broad selection of problems were identified by respondents with regard to management within the organisation. A common description of the management structure within the NEHB was that it was ‘top heavy’ comprising ‘too many layers’ or ‘tiers’ and ‘excessively hierarchical’. As one staff member stated, there are ‘too many bosses to serve’, while another stated that ‘compared to the private sector, there are too many chiefs’.
The perceived lack of communications or poor communications between management and staff in the organisation was frequently referred to. The sense that senior or higher management and the ‘top layers’ were overly ‘disconnected’, ‘distanced’ or ‘removed’ from staff on the ground and staff in front-line positions was portrayed. As a result, it was felt that ‘management (administrative) are unfamiliar with daily problems’ and ‘what is happening on ground’. Some respondents identified a lack of staff support from management, and in particular senior management. This was regarded as particularly problematic ‘when things go wrong’. Several general problems were identified with regard to management which was variously described as ‘bad’, ‘poor’, ‘weak’, and ‘incompetent’. The lack of proactive management and a ‘crisis management’ approach was referred to. It was felt that ‘leadership’ was lacking and that senior management failed to recognise and appreciate work well done within the organisation. The matrix or dual-management system was regarded as problematic. Senior or higher management was also criticised for ‘talking down’ or ‘looking down’ on staff, while the importance of ‘listening skills in management and senior management support’ was highlighted.

**Communications**

The issue of communication within the organisation arose as another commonly described negative issue. Many simply referred to ‘poor communications’ and ‘the lack of communications’ within the organisation, between staff and between services. Others provided more specific details and descriptions of the problem. For instance, the problematic flow of communications across different levels of staff was highlighted in terms of communications ‘between management and staff’, ‘from senior management to operational staff’, ‘from the top down’, ‘from lower levels of staff to higher layers of management’, ‘from department heads to basic grades’, ‘from management and/or senior management’, ‘between hospital administrators and staff at ground level’, ‘between administrators and grass-roots staff’. Moreover, the lack of communication between departments, disciplines, services or areas such as hospitals and community services was commented on. The lack of communication regarding issues such as ‘policy changes’, ‘decisions’, ‘important information regarding service development and the reforms’ was also cited as a negative.
Decision-making processes

A number of pertinent issues emerged with regard to decision making within the organisation. Poor decision making was consistently reported as a negative aspect of working in the NEHB. Participants referred to the lack of staff involvement and input into decision making. Respondents felt ‘cut-off from the centre of decision making’ as a result of inadequate discussion and involvement at local level. Several respondents were critical of decisions made at management level without adequate cognisance of and consultation with staff. Moreover, some were sceptical of staff involvement, highlighting the problem of staff advice and views being ‘ignored’ in reaching final management decisions.

In terms of action, it was felt that there was great difficulty at getting decisions taken and made, in particular at higher and/or senior levels. As one respondent stated, it is ‘impossible to get anyone in authority to make a decision’. Frustration with the NEHB regarding the slowness of decision making was articulated by respondents. The avoidance of making ‘hard decisions’ was highlighted. The survey participants expressed the need for greater transparency and fairness with regard to decision making and more evidence of action in terms of decisions made.

Staffing issues and workloads

Other commonly cited negative aspects identified by respondents were the inter-related issues of staffing and workloads. Both under-staffing and over-staffing were cited as problematic. Regarding the former, staff shortages, particularly in relation to patient- and client-service delivery were highlighted, leading to poor staff–patient/client ratios. In many instances, it was explained that such staff shortages are compounded by greater demands and have led to ‘increasing’, ‘excessive’ and ‘huge workloads’ for remaining staff members and problems of lowered staff morale. Moreover, long working hours, in particular regarding nursing and medical shifts, were commented on, while others mentioned the lack of flexibility and the unsocial working hours.

In contrast, over-staffing was highlighted as a negative aspect, in particular with regard to management and/or administrative positions which were frequently compared to front-line positions. Reference was made to ‘too many managers, administrative staff and chiefs’ while it was felt that there were ‘not enough staff who are in direct contact with patients, e.g. nurses’. However, some commented on the lack of clerical and/or administrative support, in particular for those working in front-line services. The issue of unequal workloads also arose as a negative, with descriptions of uneven workloads among the same staff grades, and the uneven distribution of workloads across departments. To quote one respondent, ‘good workers carry workloads for poor workers’.
Lack of support, recognition and staff stress

In particular, the lack of support generally for staff was mentioned as a negative aspect of working in the NEHB, while others highlighted the lack of supports for ‘front-line staff’, for ‘staff/professionals on the ground’, and ‘clinicians at the coalface’. A resulting sense of ‘isolation’ was reported in this regard. The need to provide practical ways to support staff was emphasised. Additionally, it was explained that there was insufficient recognition of the contribution of staff, for instance in terms of ‘work well done’, ‘people who do a good job’, ‘effort’, ‘progress and positive work outcomes’, ‘years of service’, ‘dedication’ and so on. In line with this, some respondents also commented on the lack of rewards for ‘achievement’, ‘good attendance’, ‘excellence’, ‘extra effort’ and ‘hard work’. Stressful working conditions were also identified as a negative. It was explained that coping with poor staffing levels and/or staff shortages and increased workloads in turn leads to stress among staff, and particularly those working ‘at the front line’.

The ‘slow recruitment processes’ within the organisation were mentioned as contributing to higher levels of stress resulting from ‘lack of cover when one is off work’. The ‘lack of recognition of stress at work and caseloads’ and the difficulty of staff retention due to the sense of staff feeling overworked and inadequately rewarded were also referred to. To quote one respondent, ‘there are no incentives to stay; management expect way too much of staff’.

Service delivery and service quality

Various problems with the provision of services and treatment of patients, clients and service users were articulated by respondents as a negative aspect of working in the NEHB. As previously mentioned, the lack of sufficient front-line staff, the inadequate staff–patient ratio, and consequential large workloads were highlighted as problematic in terms of the negative consequences on the staff–patient relationship and service provided. The lack of or limited number of services and facilities available to service users and the long waiting lists and times were all identified as negative aspects of working in the NEHB. Some respondents described an insufficient patient- or client-centred focus within the organisation. They suggested that the organisation was ‘inward looking’. Calls were made for more resources to tackle the ‘major increases in patient volume’ and service deficits. Competency in dealing with dissatisfied patients, clients and service users and their complaints was also mentioned.

Resources

The issue of resources was another common theme associated as a negative aspect of working in the organisation. A number of diverse points were made with regard to resources. Some survey participants highlighted the lack of sufficient resources necessary to conduct one’s work, to carry out one’s job properly and to provide
services. As discussed earlier, the lack of staff resources was frequently articulated. Others mentioned resource inadequacies regarding space, IT equipment and bed capacity, etc. The difficulty of meeting increasing demand for services and dealing with the waiting lists, given the current resource levels, were referred to. Respondents variously described the utilisation and distribution of resources within the organisation as ‘wasteful’, ‘inefficient’, ‘poor’ and ‘inappropriate’. More specifically, some respondents were critical of resources and monies being diverted and spent in areas other than patient care, while the negative impact of the perceived misuse of resources on patient care and front-line services was also alluded to.

Promotion and recruitment
The promotional system within the NEHB was criticised on a number of levels by a selection of survey participants. First, the ‘lack of’, ‘limited’ and ‘minimal’ promotional prospects were referred to. Others were critical of what were perceived as ‘unfair’, ‘unequal’ and ‘non-transparent’ promotional systems and procedures. For instance, it was stated that ‘some staff are interviewed, some are just given the job, there is no particular system for promotion’. A number of respondents described a promotional structure of ‘fix me up jobs’ and a ‘jobs for the boys culture’, while it was felt that ‘some advertisements are a cosmetic exercise’.

In addition, views on inequality and unfairness in the promotional system were also highlighted in terms of ‘staff favouritism’ whereby ‘some staff are targeted for promotion, others are left behind’. Some considered promotional opportunities as dependent ‘on who you know, not what you know’, and ‘experience and work performance do not seem to have any bearing on eligibility for promotion’.

Additionally, the lack of a recruitment and retention focus within the NEHB, in particular with regard to the ‘management of contracts’ and ‘long-term temporary posts’ was commented on. The current embargo on recruitment, the staff ceiling, the problem of unfilled posts and the difficulty of and/or delay in replacing staff and processing new applicants were all highlighted as problematic. There was a call for greater clarity in relation to the recruitment and interview process, and the panel (placement) system.

Working conditions and facilities
Other commonly cited negative issues with regard to working in the NEHB were the poor working conditions and facilities. In providing accounts of the poor working environment, respondents referred to issues such as the physical or infrastructural condition of buildings, inadequate room, space, and accommodation, out-of-date equipment, toilet facilities and car-parking facilities. It was explained that there is a requirement for improved facilities in order to enable
staff to deliver a good quality service and standard of care. These poor working conditions were also associated with low or poor staff morale.

**Public image and public relations**
Issues regarding the perceived poor public image of the NEHB and negative publicity, public relations and media coverage, particularly in recent times, were reported by respondents. These issues were in turn regarded as negative for staff working in the organisation in terms of their impact on staff morale.

**Role, responsibility and accountability issues**
Issues surrounding responsibilities and roles were identified by respondents with regard to negative aspects of working in the NEHB. In particular, it was felt by some that there was ‘a lack of’ or ‘no’ role clarity. This problem was variously described in terms of ‘ambiguously defined roles and duties’, ‘the lack of coordination among different roles’, ‘unclear roles for middle management’, ‘a lack of understanding of roles (and departments) in the health board’, and ‘no clear policies/guidelines regarding your role’. Moreover, the tendency in the organisation to avoid taking responsibility was highlighted in terms of a ‘pass the buck attitude’. Others felt that there is an absence of responsibility at management and senior level. The lack of accountability and absence of clear lines of accountability within the organisation were referred to.

**Change and reforms**
A number of specific issues emerged with regard to the theme of change and were discussed by some respondents. A description of a slow pace of change and the difficulty and/or length of time which it takes to implement change within the organisation was commonly commented upon. Perceptions of a ‘reluctance’ and ‘resistance’ to change and organisational ‘inflexibility’ and ‘rigidity’ were linked to ‘the culture of the NEHB’ and some ‘department cultures’. Some respondents referred to the ‘bad’ or ‘poor’ communications processes with regard to changes taking place within the organisation, whereby staff may not be informed or change is sometimes unannounced. The failure of resources to accompany change initiatives was articulated, leading to difficulties of change implementation. A ‘lack of real communication to staff’ in terms of the national reforms was identified, while lowered staff morale, uncertainty about the future, and job security issues were all raised as concerns in the context of the reforms.

**Planning**
Dissatisfaction with planning processes within the organisation was articulated by respondents. Some referred to planning as a negative work aspect per se while others specified problems such as the lack of long-term planning by the
organisation as a result of financial planning and budgetary restrictions, and a crisis approach to management. Some were critical of the service planning process which was described as ‘inadequate’, ‘not working to improve service delivery’ and ‘meaningless and centrally driven’. The need for more transparency in relation to planning and patient-centred planning was suggested. A perceived lack of planning between service areas such as community and acute hospitals was described.

Teams and teamworking
In this regard, a common criticism was ‘the lack of multi-disciplinary teams’ and a ‘multi-disciplinary team approach’, while the loss of skills as a result of this was highlighted. The lack of teamworking between departments and on the basis of county structures was also mentioned. Requirements for ‘more team involvement’, ‘team meetings on a regular basis’, ‘more staff on the team’ and ‘more involvement of middle management on teams’ were all suggested. A perceived lack of understanding of the concept of teamwork among some project managers, directors and team leaders, as well as poor communications from team leaders and/or managers were described. The problem of organisational distance between the corporate management team and local teams was alluded to.

Bureaucracy
Bureaucratic processes, systems and structures were also described by respondents in replying to this question. It was stated that there was ‘excessive’ or ‘far too much’ bureaucracy, red tape and paperwork in the organisation. It was pointed out that the ‘layers of bureaucracy’ made the organisation ‘cumbersome’ and ‘slow to respond’. Some respondents felt that there is evidence of an increasingly bureaucratic attitude within the NEHB, in terms of ‘cover your back’ and ‘it is not my department’ attitude.

Staff training and induction
Perceived problems associated with access to staff training opportunities were articulated. At a general level, it was pointed out that there are insufficient training opportunities for staff of different disciplines and in different work locations. Others were critical of the lack of adequate job training and induction for new staff and relevant training for staff working in a new area.
External consumer orientation

Involvement of external stakeholders in planning and evaluating health services

An important cultural shift associated with contemporary health service organisations generally comprises greater cognisance on the part of health service providers of issues such as citizen engagement and partnership, consumer involvement, feedback, appraisal, responsiveness and a patient-centred approach (Shaw and Kalo, 2002; Mead and Bower, 2000; Miller and Ahmad, 2000; Sullivan, 2002). The effective delivery of health care requires an inclusive, collaborative-based approach involving cooperation between service providers and users (Gilson, 2003), while consumer appraisal of services has become recognised as an essential element of a quality service (Steele, 1991).

This trend has been replicated in Ireland, whereby arising from the objective of placing the patient at the centre in the delivery of care, the national health strategy, Quality and Fairness: A Health System for You (2001), highlighted the need for a more responsive health system which engages with individuals, families and communities. In this regard, it committed to the development of a national standardised approach to the measurement of patient satisfaction as an essential input into policy-planning and local decision-making processes. The national health strategy made further commitments to improve communications between health care professionals and patients and clients, and to develop a more structured approach to community participation.

AHSPNE (2003) takes a similar stance, outlining the development of a people-centred health system underpinned by the development of meaningful ways of working with service users, community and voluntary groups, and the public as one of its strategic objectives.

The survey sought to gauge respondents’ opinions of the NEHB’s relationship with a diversity of external stakeholders comprising patients and service users, families and/or carers, community groups and the general public by asking respondents about the involvement of these constituents in both the planning and evaluation of services in the area in which they worked (Q15). Those who answered ‘not applicable’ were excluded from the analysis of this particular question. In interpreting these findings, it should be noted that the proportion that did not answer this set of questions was relatively high, ranging from 10 per cent to 34 per cent, while an average of approximately 11 per cent answered ‘don’t know’. This indicates a lack of awareness of activities related to the involvement of external stakeholders and the need for further research on this issue. Overall, the survey findings revealed a moderate level of involvement of these stakeholders in planning
and evaluating the NEHB services, while a slightly higher level of involvement in the planning of services compared to the evaluation of services was recorded.

### Table 11: Involvement of external stakeholders in the planning and evaluation of NEHB services (Q15)

<table>
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<td>181</td>
<td>32</td>
<td>118</td>
<td>21</td>
<td>130</td>
<td>23</td>
</tr>
<tr>
<td>No</td>
<td>137</td>
<td>23</td>
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<td>28</td>
<td>178</td>
<td>32</td>
<td>197</td>
<td>34</td>
</tr>
<tr>
<td>Don’t know</td>
<td>60</td>
<td>10</td>
<td>64</td>
<td>11</td>
<td>72</td>
<td>13</td>
<td>68</td>
<td>12</td>
</tr>
<tr>
<td>Not answered</td>
<td>136</td>
<td>23</td>
<td>167</td>
<td>29</td>
<td>194</td>
<td>34</td>
<td>176</td>
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<td>100</td>
<td>562</td>
<td>100</td>
<td>571</td>
<td>100</td>
</tr>
</tbody>
</table>

Note: Valid per cents used. Not applicable values are excluded.

Comparing the different stakeholder groups, as Table 11 demonstrates, the highest level of public involvement was recorded for patients/service users, with over half of respondents (52 per cent) stating that the unit, department or service in which they worked involved these constituents in planning services, while 44 per cent involved patients/service users in the evaluation of services. Almost two-fifths of respondents (38 per cent) stated that the area in which they worked involved families/carers in planning services, while just under a third (32 per cent) involved them in evaluating services. Over one-third of respondents (34 per cent) stated that the area where they work engaged with the general public in planning of services, while almost a quarter (23 per cent) involved the public in evaluating services. The stakeholder least involved in planning and evaluating services was community groups, with less than a third (31 per cent) of respondents stating that the area in which they work involves these groups in planning services, while just over a fifth (21 per cent) involved them in evaluating services.

Additionally, interlinked with involvement and engagement of external stakeholder groups is the concept of communication. As shall be outlined in Chapter 6, while communications by the NEHB organisation as a whole with various stakeholders
was rated in moderate terms, the ratings of communications by the work unit, department or service where respondents worked were noticeably more positive with regard to patients/service users and families/carers in contrast to community groups and the general public.

These findings are also in line with respondents’ perceptions of the progress made in recent years by the NEHB with regard to patient/service user involvement as outlined in Chapter 8. Based on these premises, the survey findings indicate that there is clearly scope to increase awareness of work already taking place with key stakeholder groups in addition to focused attention on increasing opportunities for further enhanced engagement and involvement. However, the organisation appears to be moving in the desired direction as set out in the national health strategy (2001) and AHSPNE (2003).

**Suggestions to improve the involvement of patients and service users**

The survey also included an open-ended question which asked the survey participants to indicate how greater involvement of patients and/or service users could be facilitated (Q16). At the outset, it should be pointed out that a substantial proportion of respondents (43 per cent) did not answer this question, while 5 per cent said it was not applicable. Nonetheless, of those who did give suggestions in relation to how the involvement of external stakeholders could be facilitated (52 per cent), some interesting feedback was gathered, as discussed below. Such data is particularly relevant and useful given that most survey respondents rated the level of progress made in recent years by the NEHB in involving patients and service users as moderate to low, as shall be outlined in Chapter 10 (Q39).

**Involvement methods suggested**

Requirements for improved information, communication and education of patients, service users, families, relatives and the public were highlighted by respondents as a means of empowering stakeholders. The need for the availability of ‘more’ and ‘better’ information and explanation to the general public, patients, and service users about services, and regarding their rights and entitlements, was emphasised.

A number of definitive suggestions were made by respondents as to how the NEHB should ask, listen and gain the opinions, expectations, and experiences of the core external stakeholders, namely patients, clients, service users, carers and families. Numerous suggestions to facilitate improved information, and communication with and participation of these external groups, were made. The most common proposals to facilitate and improve external participation included the utilisation of a mixture of methods, including questionnaires, satisfaction surveys, focus groups, community groups, consumer panels, suggestion boxes, comment cards, direct...
meetings, committees, patient/service user forums, interviews, advisory groups, open days/evenings, local information campaigns, hospital/department information days, local meetings, local drop-in information services, information leaflets, information forums, and television/radio/local media.

In addition, proposals for ‘better education’ on services, procedures/treatments and care through patient leaflets and education groups, for example, were also cited. The use of more regular meetings, assessments, evaluations and reviews conducted for those utilising services on a long-term and/or regular basis was also referred to. On a practical level, some respondents suggested that these techniques should be used ‘on discharge’, ‘on closing a case’, or ‘when a client leaves the service’.

In terms of community (group) consultation and liaison, closer connectivity with local communities was suggested. For instance, it was explained that ‘community consultations could be hosted in local towns and clubs to update the public and to encourage honest participation’. Similarly, others suggested the need for ‘more involvement in community functions’ and ‘local projects’. The benefits of such community engagement were summarised by one respondent who pointed out that ‘health professionals working in the community gain a community knowledge and trust, and service users then feel comfortable and able to let you know about their needs’.

**Benefits of external involvement**

Generally speaking, the advantage of utilising the above-mentioned involvement techniques and their regular usage was articulated in terms of giving people ‘a voice’ in terms of ‘what they really think of what services are available to them’. From a ‘person-centred’ perspective, a wide variety of benefits were highlighted in using such methods. For instance, it was explained that this would lead to more inclusive involvement of patients, clients and service users in their care and/or treatment. It would enable patients, service users, clients and the public to articulate their views and provide feedback regarding the ‘quality of service’ which is received, provided and delivered. It was suggested that such methods would be useful in terms of ‘gauging satisfaction or dissatisfaction with services’, while various ‘improvements’ which patients, clients, consumers and service users would like to see could be articulated so that ‘the health service could better meet their needs’.

**Action on external feedback**

Another important theme centred on the need for real action and implementation on the part of the organisation as a result of the feedback and input of the above-mentioned external groups. The ‘adequate implementation of needs identified by questionnaires, etc.’ and ‘definite commitment to instigate change’ on the basis of consultation was highlighted.
Others were sceptical or critical of the processes, pointing out that ‘the results of service user surveys should be acted upon. Otherwise their input is just offensive lip service’.

It was pointed out that there is ‘lots of planning/meetings, but little in the way of action’ and that there is a need for ‘real listening to and action regarding complaints/comments’. Some respondents indicated that they perceived that ‘we are very quick to undertake patient perception studies but less focused on actions to address what emerges. This must be real in terms of commitment prior to progressing real facilitated patient involvement’.

In terms of transparency, it was proposed that a ‘feedback process’ demonstrating that such external commentary and suggestions led to action or implementation would be beneficial ‘as people like to know if their input goes anywhere’. The need for improved action, based on service review, evaluation data and local knowledge pertaining to services provided by the NEHB, was similarly reinforced in the findings of Q29 in Chapter 8 and Q41 in Chapter 10.

**Resource limitations**

Respondents also referred to ‘problems of organisational constraints in terms of limited resources’ and in particular linked the utilisation of limited resources to difficulties implementing changes. It was explained by respondents that in order to make tangible moves towards implementing the suggestions of external stakeholders and increasing participative work with these groups, service, staffing and resource deficits all required investment. The survey participants provided descriptions of staffing and resource constraints, increased work and patient volumes, and shortages in service provision which, they explained, hampered efforts to act on feedback, and improve patient and service user involvement in their care. It was explained that ‘more resources within patient care’ and ‘better staffing levels’ would enable services to become ‘more person-centred’ and facilitate a ‘more personal interface’, allowing increased time for staff to become involved in this type of engagement and development work with patients and service users.

**Appropriate staff involvement**

A recurring suggestion made by respondents centred on the need for improved ‘staff involvement’ in order to enhance patient and service user participation. These responses highlighted that increased staff involvement will in turn facilitate and enable staff themselves to engage more fully with client groups. In particular, the importance of listening to and involving front-line staff, such as ‘medical staff’, ‘staff at the coalface’, ‘staff dealing directly with clients’, ‘staff directly involved in patient services’, and ‘staff at local level’, in planning and decision making regarding services and patient care was highlighted. Some respondents referred to
the need for supports to ‘educate and empower staff’ to engage in a ‘partnership way’ with patients and/or service users. Others pointed out that in order to assist this external involvement, responsibility for such participation, involvement and/or consultation with these external groups should be designated to particular staff members or professionals.

Views on strengthening patient/service user involvement
To summarise, this open-ended question provided a valuable insight into respondents’ views on how patient/service user involvement could be strengthened. There was a strong emphasis on the need for more focused utilisation of resources in order to facilitate and enable improved engagement with client groups. A range of methods of involvement were outlined and, in some cases, respondents outlined opportunities to explore different ways of delivering services and changing work practices. As the literature outlined, improved involvement of external stakeholders and in particular service users/patients requires not only appropriate resources but also requires a significant change in the nature of the relationship between service provider and service user. The cultural and people aspects of this change process are therefore significant.

Part II: Subcultural analysis of the research data
Chi-square analysis of survey Questions 10, 13, and 14, in Section B – People orientation, was conducted in order to present a more in-depth account of the survey findings. The ‘unsure’ values were included in the chi-square analysis of Q10 as they were relatively high, while the ‘don’t know’ values were excluded from the chi-square analysis of Q13 and Q14, as they were generally very low. This analysis, which examined the various people orientation survey data by respondents’ staff group, revealed several significant divergences. For instance, when the various questions pertaining to staff treatment were analysed, significant staff group differences were found in terms of opinions regarding equal opportunities, and openness and/or transparency issues within the NEHB. Furthermore, when the issue of job satisfaction was analysed on the basis of staff group, several significant differences were found on the basis of job content, working conditions, level of job challenge and motivation, promotional opportunities, and listening and responding to suggestions. Additionally, significant differences of opinion were found between respondents from the five different staff groups regarding organisational and local staff pride.

In contrast, noticeably less variation was found when the chi-square analysis of the survey data pertaining to the theme of people orientation was conducted according to the level of direct patient and/or service user contact which respondents reported. The only differences found on this basis were in relation to levels of satisfaction with recognition of work contribution and staff morale where one works. The discussion below provides a more detailed account of these differences.
A scan of the chi-square analysis based on the service area in which respondents worked indicated an evident trend of more positive perceptions of various people orientation aspects among community service and regional service respondents, in contrast to more negative opinions among those working in acute hospital services.

**Analysis by staff group**

**Allied Health Professional**

On the whole, the Allied Health Professional respondents’ opinions were largely in line with the overall organisational findings. In comparison with the other four staff groups, least significant variation was found among those respondents working in the Allied Health Professions in terms of their responses to the survey questions pertaining to the people orientation theme. The only statistically significant difference found was with regard to their views on the promotion by the NEHB of equal opportunities for all employees, with the highest proportion of those who answered ‘unsure’ coming from the Allied Health Professional group (p<.010).

**Management/Administration**

The data regarding issues of people orientation, which were examined on the basis of Management/Administrative respondents, displayed a broad consistency with the overall organisational findings described in Part I above. There were two noteworthy exceptions to this pattern. Those working in Management/Administrative posts were most satisfied with their working conditions (p<.034). This group of survey participants, along with Support Service respondents, also rated the level of staff pride in the NEHB most positively (p<.007).

**Medical/Dental**

The data revealed several statistically significant differences on the basis of respondents’ membership of the Medical/Dental staff group in terms of their views regarding the theme of people orientation. The medical profession’s role is particularly important in terms of its impact and influence on organisational culture within the health service arena. Hence the specific findings with regard to this staff grouping within the NEHB are pertinent. However, as discussed in Chapter 2, when commenting on the findings of this staff grouping, it is important to reiterate that the overall response rate for Medical/Dental staff was low, with less than a quarter (23 per cent) responding to the survey. As a consequence, caution needs to be taken in interpreting the findings of this group and further research is required in order to gain a more representative account of their views, opinions and experiences.

In terms of the chi-square analysis, in comparison with survey participants from the four other staff groups, those working in this occupational category had
consistently more negative and dissatisfactory views with regard to a number of issues. For instance, with regard to staff treatment in the NEHB, the Medical/Dental respondents displayed a noticeably more negative opinion on the openness/transparency of the NEHB organisation (p<.020) and the promotion by the NEHB of equal opportunities for all employees (p<.010).

In a similar vein, in terms of job satisfaction, respondents from the Medical/Dental professions were significantly more dissatisfied with their job content than any of the other staff groups (p<.001). Medical/Dental respondents, in conjunction with those in the Nursing staff group, reported the highest level of dissatisfaction regarding their working conditions (p<.034). Survey participants from the Medical/Dental posts were most dissatisfied with the level of challenge and motivation associated with their job (p<.042). Medical Dental respondents, along with Support Service respondents were most dissatisfied with their promotional opportunities (p<.002) and also with the extent to which their suggestions are listened and responded to in contrast to the other groups (p<.025).

Additionally, the Medical/Dental group rated both staff pride in the NEHB most negatively (p<.007) and reported significantly lower staff pride in their service area in comparison with the other four staff groups (p<.012).

**Nursing**

On the whole, survey participants from the Nursing staff group tended to have broadly consistent opinions and experiences of the various aspects of people orientation, as discussed in terms of the overall organisational findings for this section outlined in this chapter. Given that nurses constitute the largest staff group in the organisation, this group has a large impact on the overall organisational culture. In this context, therefore, it is not perhaps surprising to find that their overall viewpoints are generally in line with those of the organisation as a whole.

There were three exceptions to this broad trend where Nursing respondents differed significantly from the other staff groups. First, Nursing respondents were the most positive in terms of their views on the promotion by the NEHB of equal opportunities for all employees (p<.010). Secondly, they were most satisfied with the level of challenge and motivation associated with their job (p<.042). In conjunction with the Medical/Dental respondents, they reported the highest level of dissatisfaction (p<.034) with their working conditions.

**Support Services**

With regard to the people orientation theme, the data revealed four areas in which respondents from the Support Services staff group displayed significantly divergent views. The most positive opinions regarding the openness and/or transparency of
the NEHB were found among these respondents, in comparison with the other four staff groups (p<.020). Similarly, those working in Support Services, as well as Management/Administrative respondents, had the most positive opinions of staff pride in the NEHB (p<.007).

On the other hand, Support Service respondents, in conjunction with the above-mentioned Medical/Dental respondents, were most dissatisfied with both their promotional opportunities (p<.002) and the extent to which their suggestions are listened and responded to in contrast to the other groups (p<.025).

Analysis by level of direct patient/service user contact

In conducting analysis of the survey data by the level of direct patient/service user contact which respondents had, this information was recorded in the following manner: none to low = up to 20 per cent, medium to high = 21-60 per cent, and very high = over 60 per cent. Generally speaking, when the answers to the various questions pertaining to people orientation were examined on the basis of level of direct patient and/or service user contact, very little difference was found among respondents. This indicates that regardless of the extent to which one’s work was directly front-line based or not, respondents had predominantly similar opinions of staff treatment, job satisfaction, employee commitment and pride.

In general, no significant differences were revealed regarding the opinions on how staff are treated in the NEHB. However, in one aspect, a significant difference was found in relation to the issue of recognition of one’s work contribution whereby those with least direct patient/service user contact were the most satisfied with such recognition (p<.023). In addition, in terms of local levels of staff morale, those whose job involved least direct front-line contact gave the highest rating of staff morale where they work (p<.034). In summary, the learning from the data suggests a need for greater cognisance and recognition of the work of those staff whose work is mainly front-line in nature. The findings also suggest that the challenges and pressures faced by those whose jobs are front line and service based may in turn be associated with lower levels of staff morale.

Scan by service area

An initial scan of the data pertaining to people orientation, which was examined on the basis of where respondents worked (Q2), indicated particular trends. For example, survey participants from both community and regional services displayed significantly higher levels of positivity in relation to several aspects of staff treatment, job satisfaction, and employee commitment, pride and morale. In contrast, respondents working in acute hospital services consistently reported significantly higher levels of disagreement and dissatisfaction with regard to the
various statements pertaining to staff treatment in the NEHB, and levels of job satisfaction where they worked. They also reported significantly lower levels of employee commitment, pride and morale.

Final remarks

The cultural survey sought to assess the perceptions of respondents in relation to key values espoused in national and regional strategies and inherent in the national reform programme and to determine overall levels of staff satisfaction, commitment, pride and morale. The findings from this section provided valuable insight into key areas requiring more focused attention in order to enable the organisation to maximise the potential of each staff member and to address key employment issues.

This chapter also provided some indications of the stage of development of the organisation in terms of engagement with key external stakeholders. Having examined respondents’ general perceptions of people orientation within the NEHB, we will now examine their opinions of the way in which communication and information sharing occur in the organisation. As we have seen in the literature review, a pivotal means of developing a positive organisational culture and effectively enabling organisational change is the development of good information and communication systems.
Chapter 6

Information and communications
Chapter 6 – Information and communications

Following on from the above discussion on people orientation, a salient consideration in terms of an organisation’s relationship with both its internal and external constituents is the efficacy with which it shares information and communicates with both staff and the public. As is evident from the literature reviewed in Chapter 4, communication, which comprises a core facet of organisational culture, is a key influencer on organisational effectiveness (Grunig, 1992; Frost and Gillespie, 1998; Gilson, 2003). Information is a powerful tool within organisations (Pettigrew, 1973), and the sharing of information leads to greater levels of openness, transparency and trust. Both information and communications are central facets for facilitating organisational change and reducing change resistance (Spike and Lesser, 1995; Lippitt, 1997; Irving and Tourish, 1994).

The salience of good communication processes and information systems is further emphasised in a number of core strategy and policy documents in the Irish health system. The national health strategy, *Quality and Fairness: A Health System for You* (2001), highlighted the importance of appropriate, high-quality, available, accessible and timely information for staff in order to deliver quality health services. According to the *APPM* (2002), communication within an organisation is a key issue in effective people management, and effective communication is a significant factor affecting workplace culture. Poor or ineffective communication contributes to grievances, isolation, inefficiency and resistance to change and improvement.

*AHSPNE* (2003) is similarly cognisant of developing a communication culture to enable better performance. Partnerships and Valuing Communities was one of the five high-level goals of *AHSPNE* (2003) through which the organisation made a commitment to strengthening linkages and continually developing partnerships with key statutory, voluntary and community agencies. Specific actions were outlined in *AHSPNE* (2003) regarding the implementation of a communication and information-sharing policy relevant to communication systems both within and outside the organisation, and sharing information with the public and communities via the media in a proactive manner. The NEHB *Human Resource Management Plan* (2004) outlined various specific actions with regard to communications as a means of improving the quality of working life for staff.
Part I: Overall organisation cultural findings

The survey sought the opinions of respondents on this cultural theme within the NEHB by asking a diverse selection of questions pertaining to issues such as communications regarding key decisions, access to and timeliness of important information, the flow of communications across different levels within the organisation, methods and sources of information sharing and communications, and external communications.

Communications regarding key decisions and information sharing

Overall, based on those who answered the questions pertaining to the communication of key decisions and information sharing, opinions were mixed (Figure 5). No evident pattern was found in terms of communications received regarding key decisions or changes at corporate management team level, with just under a third of respondents (30 per cent) rating it as good/very good, 30 per cent rating it as fair, and just over a third of respondents (35 per cent) rating it as poor or very poor.

While communications received from local management were rated more positively than those from corporate management, nonetheless views were also divided. For instance, 45 per cent of respondents considered both communications received from local management regarding key decisions or changes which relate to one’s job, and key decisions regarding the service planning process, as good or very good. However, 30 per cent of survey participants rated communications in relation to both these issues as fair, and over a fifth (23 per cent and 22 per cent respectively) rated such communications as poor or very poor.

Opinions were slightly more positive in terms of accessibility to information required in order to conduct one’s work, with 56 per cent of respondents rating this as good or very good. However, respondents considered the timeliness of such information more problematic, with just over a fifth (21 per cent) giving it a poor or very poor rating.
Figure 5: Rating communications and information sharing (Q17)

In summary, the data points to the need for greater consideration and increased understanding of how communication from corporate/area and local levels can be developed further. In particular, based on the survey findings above, it is evident that there is a need to address how a more values-based approach to communication can be strengthened in order to improve overall levels of trust and integrity in the system. Furthermore, the findings suggest the requirement for improved information channels which would enable staff to have timely access to the required information they need in order to conduct their work more effectively.

Enhanced communications by management through increasing the wider involvement of staff, and augmenting the information flow within the organisation, would in turn have the advantage of improving organisational effectiveness (Ouchi, 1980; Denison, 2000b). Additionally, good communications and information-sharing processes are particularly important given the unprecedented changes taking place both in the external and internal environment of the HSE. These particular issues will be further discussed in Chapters 7 and 11 of this report.

The flow of communications within the organisation and across different organisational levels

Figure 6 sets out respondents’ views on internal organisational communications between individuals, and among services within the NEHB. In addition, the flow of communications within the organisation, from the top down and bottom up was also examined. Overall, the findings indicated that local communication was perceived positively within teams, with line managers and in the service area where
people worked. In contrast, communication between services, and the flow of communication within the organisation was found to be more problematic.

**Figure 6: Flow of communication throughout the organisation (Q18)**

Of those who answered the set of questions above, most respondents regarded internal organisational communications between their team colleagues (85 per cent), between staff in the service area in which they worked (72 per cent), and between themselves and their line manager (72 per cent) as good or very good. In contrast, opinions of communications between the service in which respondents worked and other NEHB services were noticeably less positive, with just under two-fifths (39 per cent) rating this as good or very good. Notwithstanding innovations in electronic communications such as e-mail and the intranet, the size, complexity and geographic spread of the services of the HSE Dublin North East all pose major challenges in addressing inter-service communication, which is pivotal to integration and cooperative working between services.

Moreover, the flow of communications across different levels of the organisation was regarded as problematic both from a top-down and bottom-up perspective. As illustrated in the figure above, three-quarters (75 per cent) of respondents were of the opinion that communications from the top down, i.e. from corporate management to local management to staff on the ground, were fair, poor or very poor, while a similarly high proportion (69 per cent) rated communications from the bottom up, i.e. from staff on the ground to local management to corporate management, as fair, poor or very poor.
Given the salience of good communications as identified in the relevant literature discussed in Chapter 4, there is clearly a need to continue to prioritise the improvement of organisational communications. Good communications and information-sharing processes are particularly important given the unprecedented changes taking place both in the external and internal environment. Prioritising the improvement in the flow of communication at all levels throughout the system could assist in reducing the ‘them’ (i.e. managers) versus ‘us’ (i.e. employees) attitude which comprises a core element of top-down and bottom-up communicative problems, by encouraging shared understandings and building trust (Gilson, 2003).

**Information-sharing and communication methods and sources**

Important considerations with regard to analysing the efficacy of information sharing and communications are recipients’ and users’ perceptions of the ‘how’, i.e. the methods used in communicating and sharing information, and the ‘who’, i.e. the main sources of information and communications. Regarding the former, as is evident from Figure 7, considerable variation was found in terms of respondents’ opinions of the effectiveness of the various methods of information sharing and communications within the NEHB. Of those who answered this question, the three most important sources identified were face-to-face meetings (75 per cent), formal written communications (60 per cent), and e-mail/intranet (54 per cent). These findings concur with the assertion by Garside (1998) of the critical importance of face-to-face methods of communicating. The results also reinforce the importance of dialogue processes in building a culture of participation and involvement. It should also be noted that the telephone and notice boards were also ranked as relatively important by significant minorities of respondents (47 per cent and 39 per cent respectively).

**Figure 7: Most effective methods of information sharing and communications in respondents’ work setting (Q19)**
Respondents were also asked to identify the three most important sources of information for them in the conduct of their work. Of those who answered this question, large majorities of respondents chose their work colleagues (87 per cent) and line manager (74 per cent) as their most important sources of information. In contrast, noticeably smaller numbers referred to the various other sources listed in Figure 8. However, it is of note that the third most important source identified by almost two out of five respondents (38 per cent) was the grapevine.

**Figure 8: Most important sources of information for respondents in their work area (Q20)**

![Bar chart showing the most important sources of information for respondents in their work area.]

- My work colleagues: 87%
- My line manager: 74%
- The grapevine: 38%
- My occupational/professional grouping: 26%
- Local management: 23%
- Media, e.g., newspaper, radio, TV: 18%
- NEHB corporate management: 10%
- Senior clinical management: 10%
- Other: 4%

**External communications by the NEHB**

As previously mentioned, there has been widespread acknowledgement by contemporary health and social care organisations of the need to take greater cognisance of the opinions and experiences of their core external stakeholder groups. This includes greater levels of two-way communications, and affording consumers greater levels of participation in the health services.

Respondents were asked to rate communications with various external stakeholders by the NEHB generally, and also in terms of the unit, department or service in which they work. As Figure 9 indicates, views were very varied based on those who answered this set of questions. It is also noteworthy that many respondents did not know about organisational communications with external stakeholders. The ‘don’t know’ responses were particularly high, averaging 35 per cent, with regard to communications by the NEHB with the Department of Health and Children, local public representatives, other agencies such as educational providers, local authorities, an Garda Síochána, etc.; and other service providers, i.e. statutory, voluntary and social care agencies. A more detailed examination of the data...
revealed that survey participants from Medical/Dental and Support Services, and those with the highest level of direct patient/service user contact, comprised the largest proportions of those who did not know.

**Figure 9: Rating communication by the NEHB with external stakeholders (Q21)**

<table>
<thead>
<tr>
<th>Stakeholder Category</th>
<th>% Good/Very good</th>
<th>% Fair</th>
<th>% Poor/Very poor</th>
<th>% Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients/service users (n=654)</td>
<td>37</td>
<td>35</td>
<td>19</td>
<td>11</td>
</tr>
<tr>
<td>Families/carers (n=646)</td>
<td>32</td>
<td>34</td>
<td>19</td>
<td>15</td>
</tr>
<tr>
<td>Community groups (n=645)</td>
<td>27</td>
<td>35</td>
<td>15</td>
<td>23</td>
</tr>
<tr>
<td>The general public (n=646)</td>
<td>27</td>
<td>34</td>
<td>25</td>
<td>14</td>
</tr>
<tr>
<td>The media (n=642)</td>
<td>26</td>
<td>31</td>
<td>22</td>
<td>21</td>
</tr>
<tr>
<td>Other service providers, e.g. statutory, voluntary, social care agencies (n=626)</td>
<td>28</td>
<td>31</td>
<td>10</td>
<td>31</td>
</tr>
<tr>
<td>Local public representatives (n=637)</td>
<td>27</td>
<td>26</td>
<td>12</td>
<td>35</td>
</tr>
<tr>
<td>Department of Health and Children (n=637)</td>
<td>37</td>
<td>17</td>
<td>7</td>
<td>39</td>
</tr>
<tr>
<td>Other agencies, e.g. educational, local authorities, Garda, etc. (n=640)</td>
<td>32</td>
<td>26</td>
<td>8</td>
<td>34</td>
</tr>
</tbody>
</table>

As Figure 9 indicates, broadly similar ratings were given with regard to communications by the NEHB with both patients and/or service users, and families and/or carers. An average of one-third (33 per cent) rated communications by the organisation with these groups as good or very good, while an average of just over a third (35 per cent) rated it as fair, and just under a fifth (19 per cent) rated it as poor or very poor. Just over a third (35 per cent) rated organisational communications with community groups as fair, and over a quarter rated it as good or very good (27 per cent).

Opinions were more divided in terms of communications by the organisation with the general public, with more than one in three (34 per cent) rating it as fair, while very similar proportions of approximately one in four, rated it at the extremes of good or very good (27 per cent), and poor or very poor (25 per cent). Almost one in three (31 per cent) rated communications with the media as fair, while just over one in four (26 per cent) rated it as good or very good. Very similar proportions of respondents rated communications with local public representatives as good or very
good (27 per cent), and fair (26 per cent). Similarly, most of those who did have an opinion of organisational communications with other agencies such as education, local authorities and an Garda Síochána, rated it as good/very good (32 per cent), and fair (26 per cent).

Essentially, while communicating with these various external groups listed in Figure 9 depends on the specific job role of particular staff members, it was clear that overall awareness of communication with external groups was poor. The findings also suggested that there is a need to enable and support staff to develop their capacity to engage and communicate with key stakeholder groups.

As mentioned earlier, the survey also sought opinions of communications by the unit, department or service where respondents worked with various external constituents. In analysing this data, it should be noted that with the exception of the communications with patients/service users, a relatively high proportion of respondents averaging one in four (25 per cent) did not answer this set of questions.

**Figure 10: Rating of respondents’ work unit, department or service in communicating with external stakeholders (Q22)**

<table>
<thead>
<tr>
<th>Constituents</th>
<th>% Good/Very good</th>
<th>% Fair</th>
<th>% Poor/Very poor</th>
<th>% Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients/service users (n=597)</td>
<td>80</td>
<td>15</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Families/carers (n=530)</td>
<td>77</td>
<td>16</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Community groups (n=481)</td>
<td>54</td>
<td>27</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>General public (n=511)</td>
<td>56</td>
<td>25</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>Other service providers, e.g. statutory, voluntary, social care agencies (n=510)</td>
<td>57</td>
<td>26</td>
<td>7</td>
<td>10</td>
</tr>
</tbody>
</table>

Note: Valid per cents used. Missing values and not applicable values are excluded.

As Figure 10 indicates, most respondents who answered this set of questions rated communications with both patients/service users and families/carers by the unit, department or service in which they worked as either good or very good (80 per cent and 77 per cent respectively). Opinions were also relatively positive with regard to communications by one’s work area with other service providers (i.e. statutory and/or voluntary agencies), the general public, and community groups, with small majorities rating such communications as good or very good (57 per cent, 56 per cent and 54 per cent respectively).
Overall, this data signifies a noticeably more positive association by respondents with the external communicative activities on the part of the local unit, department, or service where they work than with the NEHB in general. However, there is scope to increase awareness of communication activities that are occurring across the wider system and to enable and support staff to continue to develop appropriate communication skills that will strengthen relationships and partnerships. As discussed earlier in Chapter 5, insightful data was gathered from survey participants when answering the open-ended question in terms of their opinions on enabling greater involvement of patients and service users. This information can be used to develop these processes in the future.

Organisational image

Related to organisational interaction with the external environment is the issue of how the organisation is perceived by those outside the organisation or, in other words, its public image (Martin, 2002). From an ‘inside looking out’ frame of reference (Irving and Tourish, 1994), respondents were asked for their views on the public’s perceptions of the NEHB. Of those who answered this question, three out of four (75 per cent) respondents considered the feelings and beliefs about the NEHB that exist in the minds of the public to be negative or very negative. In contrast, just 7 per cent rated it as positive or very positive, while 18 per cent rated it as neutral, as noted in Figure 11.

Figure 11: Respondents’ perception of the NEHB’s public image (Q23)

In Part II we shall see how the organisation’s public image was regarded by the various staff groups and on the basis of direct front-line contact levels. While the NEHB as an organisation is no longer in existence, the learning from these findings is relevant in terms of addressing the public perception of the newly formed organisation – HSE Dublin North East. The data indicates the requirement for the continued development by the organisation of a more proactive and positive
relationship with its external environment. One means of doing this is through the proactive usage of the media by the organisation, as identified by AHSPNE (2003) in terms of having the potential to positively reach out to communities, develop mutual trust and confidence, share information, and deal with difficult issues.

Part II: Subcultural analysis of the research data

Chi-square analysis of Questions 17, 18, 21, 22 and 23 in Section C – Information and communications – of the survey was conducted. As the ‘don’t know’ values were generally low for Q17, Q18 and Q22, they were excluded for chi-square analysis purposes. The ‘don’t know’ values were included in the chi-square analysis of Q21 as they were relatively high. The ‘neutral’ values were included in the analysis of Q23. Overall, such data analysis provides a more in-depth understanding from a subcultural perspective. An outline of the significant differences of opinions regarding information and communications issues found among the different staff groupings is provided. The results are also presented on the basis of the level of direct patient or service user contact which respondents had, and in relation to respondents’ service area.

Analysis by staff group

Allied Health Professional

When compared to the other four staff groups, the Allied Health Professional group had significantly more positive views with regard to a number of communication aspects, as follows: communications received from local management regarding key decisions relating to the service planning process (p<.008); the timeliness of the information required in order to conduct one’s work (p<.044); communications between staff within one’s service area (p<.007) and communications between their team colleagues (p<.045). In contrast, those Allied Health Professionals who completed this survey had the most negative views of communications between their service and other services in the NEHB (p<.001), and of top-down communications from corporate management to local management and staff on the ground (p<.001).

In terms of perceptions of communications by the NEHB with external constituents, comparatively higher proportions of this group of staff rated communications with the general public (p<.021), other statutory, voluntary and social care service providers (p<.002), and other agencies such as educational organisations, local authorities, an Garda Síochána, etc. (p<.012), more negatively, by comparison with the other four staff groups. They also had significantly higher levels of ‘don’t know’ answers regarding communicating with local public representatives and the Department of Health and Children (p<.000). From a local perspective, Allied Health
Professional respondents rated their unit, department or service more negatively on average in terms of communicating with the general public (p<.000).

**Management/Administration**

The opinions of those participants from the Management/Administrative staff group with regard to questions in the information and communications section of the survey tended to be more positive on average in comparison with those from the other staff groups, while some exceptions to this trend were also found. In particular, Management/Administration respondents, in conjunction with the above-mentioned Allied Health Professional respondents, were most positive in relation to the timeliness of the information required in order to conduct one's work (p<.044). Secondly, Management/Administrative respondents rated communications between their service and other services in the NEHB most positively (p<.001). These findings were perhaps related to the nature of the Management/Administrative role which often involves requesting, sharing and gathering information related to the activities of the organisation.

Furthermore, respondents from this staff group gave consistently higher positive ratings of external communications by the NEHB with a broad mix of external constituents including community groups (p<.004), the general public (p<.021), the media (p<.017), other service providers (p<.002), local public representatives (p<.000), the Department of Health and Children (p<.000), and other agencies such as educational, local authorities, and an Garda Síochána (p<.012).

This staff group also rated their unit, department or service more positively in terms of communicating, with three out of the five external constituents listed, namely community groups (p<.024), the general public (p<.000), and other service providers such as statutory and voluntary organisations (p<.011). However, in line with the opinions of Medical/Dental respondents, the Management/Administrative respondents were significantly more negative in terms of ratings of communications by their work area with families/carers (p<.000).

The highest proportion of those who rated the NEHB’s public image as negative were from the Management/Administration staff group (p<.000).

**Medical/Dental**

This group of respondents held the most negative opinions of several information and communication aspects in comparison with the other staff groups. For instance, they rated the following most poorly: communications received from local management regarding key decisions relating to the service planning process (p<.008), timeliness of the information required in order to conduct one’s work (p<.044), communications between staff within one’s service area (p<.007), and both top-down and bottom-up communications (p<.001 and p<.013).
The Medical/Dental group also rated communications by the NEHB with the media (p<.017), the Department of Health and Children (p<.000), and with other agencies such as educational, local authorities and An Garda Síochána (p<.012) more negatively on average. Furthermore, as mentioned earlier, this group of respondents gave the highest proportion of ‘don’t know’ responses in terms of external communications by the organisation with several constituencies, including families/carers (p<.010), community groups (p<.004), the general public (p<.021), other statutory, voluntary and social care organisations (p<.002), local public representatives (p<.000), and other agencies such as educational, local authorities and an Garda Síochána (p<.012).

The Medical/Dental group rated their local work area more negatively in comparison with the other staff groups on average in communicating with patients/service users (p<.001), families/carers (p<.000), community groups (p<.024), the general public (p<.000), and other statutory/voluntary service providers (p<.011).

Finally, of the five staff groups, most of those who rated the NEHB’s organisational image as ‘neutral’ were from the Medical/Dental group (p<.000).

**Nursing**

Nurse participants’ views regarding information and communications were broadly in line with those found in the overall survey findings. Nonetheless, they had significantly more negative opinions with regard to a number of particular information and communication issues. For example, in conjunction with Medical/Dental and Support Service respondents, respondents from the Nursing staff group were significantly more dissatisfied with the timeliness of information required in order to conduct one’s work (p<.044). Also, alongside Allied Health Professional respondents, Nursing respondents rated communications between their service and other services in the NEHB most negatively (p<.001). As well as the above-mentioned Allied Health Professional and Medical/Dental staff groups, Nursing respondents held the most negative opinions of top-down communications in the NEHB (p<.001).

Overall, Nursing respondents were also the most dissatisfied with external communications by the NEHB. They rated communications by the organisation significantly more negatively on the whole, with the following constituents: families/carers (p<.010), community groups (p<.004), the general public (p<.021), other statutory, voluntary, and social care organisations (p<.002), and local public representatives (p<.000).

In contrast, Nursing respondents held the most positive opinions of communications at local level, by the unit, department, or service in which they worked with the following external groups: patients/service users (p<.001), families/carers (p<.000), the general public (p<.000), and other service providers (p<.011).
Support Services

A number of noteworthy differences were also found among those from Support Services who participated in the survey. Support Service respondents, along with the above-mentioned Medical/Dental staff group, rated communications received from local management regarding key decisions relating to the service planning process significantly more negatively than the other working groups (p<.008). Comparatively higher proportions of respondents from Support Services, in conjunction with Medical/Dental and Nursing respondents, considered the timeliness of information required in order to conduct one’s work as poor (p<.044). Respondents from the Support Service staff group were most negative in their ratings of communications between their team colleagues (p<.045). On the positive side, Support Service respondents held the most positive opinions of both top-down and bottom-up communications (p<.001 and p<.013).

In terms of opinions of external communication activities by the NEHB, Support Service respondents displayed a mixture of both positive and uncertain opinions. For instance, they gave the highest positive ratings of such communications with families/carers (p<.010), community groups (p<.004), and the general public (p<.021). They were also more likely to answer ‘don’t know’ in response to questions regarding communications by the organisation with community groups (p<.004), the general public (p<.021), the media (p<.017), and the Department of Health and Children (p<.000).

In conjunction with those from the Nursing and Management staff groups, Support Service respondents were significantly more positive in their ratings of communications at local level, by the unit, department, or service in which they worked with the general public (p<.000).

In relation to perceptions of the organisation’s public image, respondents from this staff group were significantly more positive in comparison with the other four staff groups (p<.000).

Analysis by level of direct patient/service user contact

The findings with regard to the theme of information and communications were also analysed in terms of the level of direct patient/service user contact reported by respondents. Several statistically significant differences of opinions were found on this basis. The overarching trend was for those with the highest levels of direct front-line contact to have significantly more negative views of information and communications at both organisational and local level, in contrast to those whose work involved lesser levels of direct front-line contact.
This pattern was found in relation to opinions on communications received concerning key decisions and/or changes at NEHB corporate management team level (p<.016), communications received from local management regarding key decisions and/or changes relating to their jobs (p<.007), communications received from local management regarding key decisions, and/or changes resulting from the service planning process (p<.000), gaining access to the necessary information needed to do one’s work (p<.036), and the timeliness of this information (p<.000).

Moreover, those respondents who had very high levels of direct patient/service user contact held significantly more negative views of communication between staff in their service areas (p<.031), and the communications flow from the top down (p<.002), in comparison with those whose jobs involved lesser levels of direct patient/service user contact.

The data also revealed significant differences among the respondents according to their ratings of external communications by the NEHB with a general pattern evident, comprising those with the highest levels of direct front-line contact answering ‘don’t know’ more frequently. These respondents also rated communications with other service providers such as statutory and voluntary organisations (p<.008), local public representatives (p<.000), the Department of Health and Children (p<.000), and other agencies such as educational, local authorities, and an Garda Síochána (p<.020) least positively.

Of note however is a contrasting finding, with those respondents with the highest level of direct front-line contact significantly more positive in terms of their ratings of the unit, department, or service in which they worked in communicating with patient/service user groups (p<.003) and families/carers (p<.014).

In summary, the learning from these findings indicates a clear requirement to develop and improve information channels and communications, specifically for front-line staff whose work involves the highest levels of direct patient/service user contact, in order to facilitate them in conducting their work in a more satisfactory and effective manner.

**Scan by service area**

Overall, the data reveals that the survey participants from regional and community services gave significantly more positive ratings of information and communications within the organisation. In contrast, those working in acute hospital services were, by and large, significantly more critical of such processes. With the exception of a small number of responses, the replies of those working in head office tended to fall in between these extremes, reflecting a tendency to concur with the overall organisational findings in relation to issues of information and communications, as discussed in Part I above.
Final remarks

The overall findings pertaining to information and communications as perceived by the survey participants have significant resonance for the leaders and managers of the HSE at all levels. As we know from earlier discussions in Chapter 4, a core function of successful leadership is effective communication, including the promotion of real and meaningful dialogue across all levels of the system. The crucial external and internal oversight roles and responsibilities of organisational leaders and the provision of organisational direction are directly connected with information-sharing and communicative processes.

It is particularly important during a period of environmental turbulence and organisational change, such as that currently being experienced by organisations in the Irish health system, that organisational leaders and managers engage in open, honest and regular communications and information sharing with staff as a means of keeping them as informed and up to date as possible. As we shall see later in Chapter 11, one of the key messages arising from respondents’ answers to the open-ended question on how corporate management can support staff with the current health reforms (Q50) was through effective and comprehensive information-sharing and communication processes. The next chapter shall explore a broad array of leadership and management issues in more depth.
Chapter 7

Leadership and direction
Chapter 7 – Leadership and direction

As already indicated, another core component of organisational culture and change is that of leadership. As outlined in the literature, organisational leaders are charged with an extensive and diverse series of tasks, some of which are generic while others are particularly relevant to periods of high-level change (Schein, 1985; Scott et al, 2003a; Beer et al, 1990; Pettigrew et al, 1992). In terms of complex environmental and organisational change, vital leadership tasks include environmental assessment (Pettigrew and Whipp, 1991, 1992), and the alignment or modification of core organisational components such as culture, structure and strategy with influences and trends in the wider external environment (Bate, 1999; Bijlsma-Frankema, 2001; Nadler, 1987).

Within the Irish health system, a number of high-level strategic and policy documents have discussed the salience of good leadership and management practices. For example, the significance of effective management in terms of working with staff in a partnership manner and enabling real change is reinforced in the national health strategy, Quality and Fairness: A Health System for You (2001). For instance, this strategy referred to the requirement for cultural change in order to enable a participative approach to the management of staff.

It also highlighted the need to build and enhance management capacity among all managerial levels, including front-line managers, and specified people management and communication skills as core managerial competencies. Furthermore, the APPM (2002) pointed to evidence of a gap with regard to such skills and competencies among managers in the health service. In terms of addressing this issue, it outlined plans for the implementation of management competency frameworks, and the development and provision of skill development for all managers in order to bring about behavioural change.

With regard to the NEHB, the promotion of high-performing leadership was identified as one of the eight strategic objectives of AHSPNE (2003). It highlighted that an organisational culture which promotes leadership, and encourages management styles which optimise organisational performance and supports organisational learning, is the key to organisational change and improved performance.

In Section D of the NEHB Organisation Cultural Survey (2004), the views of respondents were gathered on the themes of leadership and direction by asking a broad selection of questions. Such questions dealt with items such as the strategic framework of the NEHB, the carrying out of various key strategic tasks and people management responsibilities by both the corporate management team and local management, and important leadership competencies required in the system.
Part I: Overall organisation cultural findings

Awareness and potential influence of the NEHB’s A Health Strategy for the People of the North East – A Framework for Change and Development (AHSPNE 2003)

As outlined earlier, the organisation’s framework for change and development, AHSPNE (2003), set out the future direction of the organisation and its services over the medium term. It outlined an organisational vision and mission, and was based on a set of core principles, high-level goals, strategic objectives and high-level actions. This strategic framework was developed in line with national health system priorities as set out in Quality and Fairness: A Health System for You (2001) and the Health Service Reform Programme (2003).

Given the significance of a strategic framework in terms of establishing a future direction and core tasks, it was important to determine the extent to which respondents were aware of this plan. The survey data revealed that awareness of AHSPNE (2003) had filtered into many parts of the organisation, with most of those who replied to this question stating that they were aware of it (75 per cent), as presented in Figure 12. Of the quarter of respondents (25 per cent) who indicated that they were not aware of AHSPNE (2003), it is useful to know in which staff groups and service areas these particular respondents are based, and to what extent, if any, awareness of the strategy is connected to the level of direct front-line contact. Each of these areas shall be investigated in Part II of this chapter.

Figure 12: Awareness of ‘A Health Strategy for the People of the North East (2003)’ (Q24)

Of those survey participants who stated that they were aware of AHSPNE (2003), opinions were sought on the possible influence over time of this strategic framework in terms of its impact on service provision, service planning and service delivery. As Figure 13 demonstrates, most respondents believed that the strategy would have an influence on these core service aspects.
Almost three out of four respondents (74 per cent) believed that *AHSPNE (2003)* would provide a clear sense of direction with regard to how services are to be provided, while 77 per cent believed it would influence the way services are planned through the service planning process. Similar findings were elicited in terms of the likelihood of *AHSPNE (2003)* affecting the way services are delivered, with over two-thirds of respondents (67 per cent) stating that it would have an influence.

As previously noted, *AHSPNE (2003)* provided a significant reference point in terms of implementing the significant structural, policy, service, cultural and human changes associated with both *Quality and Fairness: A Health System for You (2001)* and the *Health Service Reform Programme (2003).* As a strategic framework, it has the potential to transfer into the newly reformed health system and be adapted to meet the requirements of the HSE at national, area and local levels.

**Corporate and local management performance**

Management pervades all aspects of an organisation and is a pivotal factor with regard to organisational culture, since the way in which an organisation is managed and staff perceptions of management have a determining influence on the type of culture within an organisation. In this survey, an important distinction was made between corporate management and local management in the NEHB.
The survey sought respondents’ opinions of these two levels of management within the organisation. The corporate level referred to the senior management team which had overall responsibility for the executive management of the NEHB. Local management comprised general and local managers to whom various responsibilities had been devolved, with such management located throughout the various regional and local locations of the board. While the management structures within the HSE have been revised under the health service reforms, nonetheless the learning from the data is of relevance as it provides an insight into core aspects of management responsibilities.

**Perceptions of corporate management**

Several key strategic tasks and people-focused organisational responsibilities of corporate management identified in the relevant literature were included in the survey questions, as shall now be discussed. The corporate management of the organisation has executive responsibility for ensuring its effective operation and so plays a pivotal role with regard to staff experiences within the organisation. This team carries significant levels of responsibility and influence. Therefore, the manner in which corporate management makes strategic decisions and addresses staff issues has an important symbolic cultural influence across the entire organisation.

The recognised need for the development of core leadership and management skills within the Irish health system generally, and within the NEHB organisation more specifically, has been outlined above. In particular, the significance of people-management skills as well as strategic-management skills through working with staff in a partnership-based, participative manner were highlighted. Another key leadership and management task is that of effectively managing change and reform. Overall, the survey data which assessed the performance of the NEHB corporate management team in relation to core strategic roles and organisational responsibilities revealed generally moderate to low levels of satisfaction among the survey participants who answered this set of questions.
Figure 14: Satisfaction with NEHB corporate management (Q26)

As Figure 14 demonstrates, the most positive rating of the performance of the NEHB corporate management team was with regard to establishing key priorities for health and social services over the medium term, with a quarter of respondents (24 per cent) who answered this question satisfied or very satisfied, and 36 per cent fairly satisfied. The remaining data indicates that respondents were more dissatisfied than satisfied or very satisfied with the performance of the corporate management team in terms of core duties, including providing a sense of purpose and future direction; responding to important trends and changes in the organisation’s external environment; being visible and accessible; communicating with staff; and providing a supportive work environment for staff; while an average of just under a third of respondents (32 per cent) rated such performance as fairly satisfactory. The relatively high average percentage of respondents (14 per cent) who answered ‘don’t know’ to this set of questions is of note and indicates a possible lack of association on the part of respondents across the organisation with NEHB corporate management.

In commenting on these findings, it is important to take account of the significant managerial restructuring arising from the Health Service Reform Programme (2003) which has taken place within Irish health and social care organisations. Arising from such developments, the regional health boards and corporate management structures no longer exist. However, these findings on senior management
performance can inform health system leaders in the newly formed structures of the HSE at national, area and local levels.

More specifically, the data reinforces the previously identified national and organisational need for improved leadership and management competencies as outlined in the following core documents, namely *Quality and Fairness: A Health System for You* (2001), *APPM* (2002), the *Health Service Reform Programme* (2003), *AHSPNE* (2003), and the NEHB *Human Resource Management Plan* (2004).

**Perceptions of local management**

The salience of formal and informal leaders and the recognition of the diversity of leadership found within health care organisations (Martin, 1992; Pettigrew et al, 1992; Block, 2003; Dolan and Garcia, 2002) are also crucial considerations with regard to the character of the overall culture within an organisation and organisational effectiveness. In this light, respondents were also asked to comment on various key tasks which are the responsibility of local management. The findings point towards noticeably more positive perceptions of this level of management in relation to the performance of a number of core duties outlined in Figure 15 regarding joint working between services, innovation, supporting staff in times of crisis or difficulty, and involving staff in a partnership way.

**Figure 15: Satisfaction with local management (Q27)**

Averages were used in the analysis of this set of questions, given the broad similarity of answers given. Of those who answered this set of questions, an average of 44 per cent of respondents were satisfied or very satisfied with local management in terms of the tasks outlined above, while a further 28 per cent were fairly satisfied. Even so, this data reveals the opportunities for improvement since, on average, almost a quarter (23 per cent) of survey participants were dissatisfied or very dissatisfied with
the performance of their local management in relation to these important duties. In particular, a more inclusive, partnership-based approach to staff, through improved levels of involvement in local decisions or changes, is an evident requirement arising from the survey findings.

Overall, one can surmise on the basis of this data that local management is perceived in a noticeably more positive light than managers at corporate level on the basis of conducting various core management roles. Notwithstanding this, the data indicated that both senior and local management in the organisation needed to conduct their core strategic and people-management roles in a more effective manner, as a means of gaining the confidence of staff throughout the organisation and facilitating a better functioning organisation.

**Important leadership competencies**

The description below is based on a synopsis of the many suggestions made by respondents in response to the open-ended question which asked them to list the three most important organisational competencies leaders should possess (Q28). Some very insightful learning may be gained from survey participants’ reflections on this issue, in particular as Irish health service organisations enter a new phase. The discussion concentrates on the main themes arising from an analysis of the suggestions made which included communications, managerial skills, decision making, vision and planning, dealing with change, and particular leadership attributes.

**Communications**

The possession of good communication skills was identified by a substantial proportion of respondents as the most important leadership quality. The ability and willingness of leaders to communicate with staff at all levels, and the importance of ‘openness’, ‘honesty’ and ‘transparency’ in terms of communicating with and listening to staff were also highlighted. Respondents in particular spoke of the importance of listening to the ‘ideas’, ‘comments’, ‘feedback’, ‘other views’, ‘concerns’ and ‘grievances’ of all staff. Listening to ‘front-line’, ‘grass roots’ staff working at the ‘coalface’ or ‘at ground level’ in particular were referred to.

It was explained that the value of good communications would facilitate leaders in terms of gaining a better understanding of staff in terms of ‘where others are coming from’, understanding ‘both clinical issues and business issues’, and facilitating a ‘full understanding from root to branch of their service’. It was made clear that such communications would also enable an ‘understanding of what goes on at ground level’, including the ‘day-to-day problems for staff’ and ‘the pressures front-line staff are subjected to’. Adopting a patient-centred approach by demonstrating the capacity to listen ‘to the needs of service users’, and ‘the views of patients’ was referred to as another important leadership competency.
Management skills
A diverse range of issues was raised by respondents in relation to management skills. In particular, ‘people’, ‘staff’, ‘organisational’ and ‘service’ management were reiterated as important leadership competencies. The requirement for ‘good’, ‘effective’, ‘fair’, ‘positive’, ‘open’, ‘accountable’ and ‘competent’ management on the part of organisational leaders was articulated by respondents. ‘Conflict management’ skills and the ability of leaders to ‘manage difficulties’ and ‘problems’ were highlighted. Some survey participants discussed the importance of leaders being able to ‘motivate’ and ‘encourage’ staff. ‘Managing teams’, ‘team-building skills’, ‘project management’ and ‘individual performance’ were also mentioned.

From an integrative perspective, the need for effective (seamless) cross-service management between hospitals and community and cross-disciplinary working was highlighted. Respondents described inclusive, partnership approaches such as making ‘management decisions in partnership with staff on the ground’ and working from a ‘bottom-up’ perspective rather than using a ‘top-down’ approach. It was suggested that top-level management needs to ‘provide both strategic and clinical leadership’, while it was similarly suggested that management needs ‘to include people with clinical backgrounds’. The advantages of appropriate ‘clinical and management training’ for leaders were mentioned. As shall be discussed below, it was pointed out that organisational leaders require ‘change management’ skills.

Decision making
The importance of decision-making abilities and skills were also reiterated by respondents as important with regard to organisational leader competencies, with ‘decision making’ and the ‘ability to make decisions’ consistently cited. The need for ‘good’, ‘excellent’, ‘open’, ‘transparent’, ‘swift’, ‘effective’, ‘strong’, ‘clear’, and ‘logical’ decisions were all outlined by respondents. Some staff members referred to the need for leaders to have the ability and courage to make difficult and unpopular decisions if necessary.

Respondents noted that decisions made should involve the utilisation of ‘a collaborative, consultative approach’, ‘listening to all sides’, and ‘in partnership’ with ‘staff on the ground’. Furthermore, it was pointed out that a best practice approach to decision making, based on the ‘consideration of all options’, the relevant ‘information facts’, and ‘a proper analysis of situations’, should be used by leaders.

Moreover, communications by leaders with regard to decisions was deemed highly important in terms of ‘explaining the reasons for formulating decisions’ and keeping staff ‘informed’ and ‘up to date’. From a patient-centred perspective, ‘user-led service decisions’ were suggested. It was explained that not only is the decision-making process clearly important, but the need for action on decisions, in terms of
the ability to ‘take responsibility for’, ‘follow through’, ‘implement’ and ‘deliver speedily’ on decisions was also stressed. Other competencies mentioned were the need for leaders to ‘guide’, ‘support’ and ‘encourage’ staff in their role as decision makers, providing constructive criticisms of decisions where necessary.

**Vision and planning**

Proficiency in terms of being visionary and having good planning skills were commonly cited as leader competencies. The terms ‘vision’ and ‘visionary’ were consistently used with regard to the organisation and its services. Moreover, others explained that this vision should be ‘clear’ and ‘shared or communicated’ with staff and the general public. Furthermore, the importance of action and implementation with regard to this vision was emphasised in terms of ‘supportive actioning’ and ‘a commitment to follow through’.

The need for good or excellent planning skills was also stressed. An ability to conduct long-term planning, alternatively referred to as ‘planning in advance’, ‘planning for the future’, ‘forward or far-sighted planning’, ‘planning beyond 2010’ was outlined. Planning in terms of taking into account demographic change and assessing ‘the future pressures on all NEHB resources arising from population growth in the north east’ was commented on. The ability of leaders to conduct planning in a holistic and ‘hands-on’ way in terms of initiating and implementing plans, setting standards, and engaging in outcomes or target-based monitoring of plans as a means of ‘seeing them through’ was discussed. Furthermore, the importance of demonstrating ‘strategic leadership’ at the ‘top level of management’ was also cited, for instance through engaging in ‘strategic planning and thinking’, using a ‘strategic approach to service delivery’, and having ‘good strategic planning skills to bring services forward’.

Leadership competency with regard to ‘financial planning and management’ was also cited. For instance, an ‘ability to manage and plan resources’, to ‘plan in order to maximise returns on expenditure’, and the ‘effective coordination of resources’ were identified as core skills. The importance of providing staff with resources and where necessary ‘fighting for’ the required resources in order ‘to get work done’, ‘get results’, ‘implement necessary change’ and ‘improve services’ were all alluded to.

**Dealing with change**

The issue of change arose frequently in the context of leadership competencies and is particularly relevant given the period of rapid change which the Irish health services are currently experiencing. The ability of leaders to manage change using the appropriate change-management skills, knowledge, and understanding was stressed. Some pointed out the necessity of such skills, ‘particularly in the current climate’, and ‘in light of the health service reform’. The need on the part of leaders for ‘strength to cope with changes and uncertainty within health boards’ was referred to.
The need for ‘openness’, ‘willingness’ and ‘ability’ to change was discussed. The abilities to ‘adapt to change’, and ‘guide staff through change’ were identified as important skills. The need for ‘flexibility’, ‘an open mind’ and ‘support’ with regard to ‘innovation’, including ‘new ideas’ and ‘new ways of working or doing things’ were highlighted. It was explained by some staff members that leaders should be ‘informative’, ‘involving and keeping staff up to date on all relevant organisational changes and decisions’.

In addition, a number of respondents referred to external change awareness, citing the importance on the part of leaders of possessing ‘up-to-date knowledge of change in the health system’, ‘being able to make sense of our foggy, changing environment’, being ‘aware of financial and environmental changes’, the need ‘to respond to ongoing changes in society’, and having the ‘strength’ to cope with such ‘changes and uncertainty’. Moreover, the ‘ability to drive forward new initiatives’, ‘implement or carry out’ (necessary) change, and to provide the required resources and gain the support of staff in this regard were stressed. Another issue highlighted by respondents was the possession among leaders of a ‘positive attitude’ towards change, promoting and displaying a ‘confidence in’, ‘support for’ and acceptance of change, including the current change process.

**Leadership attributes**

Another commonly named competence by respondents was that of ‘leadership’ and more specifically the necessity to ‘show’ leadership and the need for ‘more’ leadership. Respondents cited the need for ‘good’, ‘decisive’, ‘strong’, ‘transformational’ ‘trustworthy’ ‘courageous’ and ‘democratic’ leadership. Leadership was associated by some respondents with strong ‘people skills’, to quote one respondent, ‘true leadership, i.e. leaders that work with people (not for people)’. Other diverse, desirable personal attributes for leaders which were mentioned included openness, approachability, flexibility, honesty, fairness, empathy, courage, understanding and trustworthiness, commitment and loyalty. The possession of good communications skills and having a clear vision and purpose were also referred to, as discussed above.

Respondents referred to the need for an ‘in-depth’, ‘deep’ and ‘real’ knowledge of patient, service user and client services, and service demands and deficiencies. Contextual knowledge of the health system was also mentioned. Furthermore, some respondents highlighted the need for ‘organisational knowledge’, ‘professional/specialist knowledge’ and ‘personal knowledge’ of staff and the ‘real workings’ at ground level. From an external perspective, the importance of gaining the ‘confidence of the public’ and being able to ‘politically influence the Dáil’ and ‘voice the needs of services at national level’ on the part of health service leaders was outlined.
Views on leadership competencies
The views of respondents on the leadership competencies that they perceived were important in the current context of change clearly described a values-/people-centred approach to leadership and management. The leadership style described was people-centred with a strong emphasis on style of communication. The expectations of respondents clearly raised a challenge for leaders in the new system.

Part II: Subcultural analysis of the research data
Chi-square analysis of Questions 24, 25, 26 and 27 of Section D of the survey – Leadership and direction – was conducted. The ‘don’t know’ values were excluded in the chi-square analysis of Q25 and Q27 as they were relatively low. The ‘don’t know’ values were included for Q26 as they were relatively high. Several noteworthy statistically significant differences were revealed on the basis of this more in-depth analysis. As the discussion below shall reveal, a number of relatively clear-cut trends were found when the questions contained in this section of the questionnaire were examined on the basis of respondents’ staff group and level of direct patient/service user contact. A brief scan of the chi-square results on the basis of respondents’ work area similarly found some noteworthy patterns.

Analysis by staff group
Broadly speaking, these findings revealed significantly higher levels of negativity and dissatisfaction among the Medical/Dental staff group in terms of the various questions pertaining to strategic direction and the performance of both corporate and local management. This contrasts with both Management/Administrative and Nursing respondents in particular who tended to indicate greater levels of positivity and satisfaction. The least significant variation was found in the responses given by both Allied Health Professional and Support Service respondents to the various questions pertaining to organisational direction, leadership and management. These findings shall now be outlined in greater detail.

Allied Health Professional
Those survey participants from the Allied Health Professional staff group tended not to differentiate significantly from the broad overall organisational findings discussed in Part I above. Just two exceptions to this trend were found. First, this group were the least satisfied with regard to the visibility and accessibility of the corporate management team (p<.010). Secondly, a comparatively higher proportion of this group, in contrast to the other staff groups, were dissatisfied with the performance of the corporate management team in communicating with staff across the organisation (p<.000).
Management/Administration

This group of respondents, together with those from Nursing, were significantly more satisfied with a number of areas of management performance. For instance, Management/Administrative respondents indicated significantly higher levels of satisfaction with the corporate management team in terms of establishing key service priorities (p<.001), providing a sense of purpose and future direction for staff (p<.000), responding to important external changes (p<.002), and communicating with staff across the NEHB (p<.000). This group were also more satisfied, on average, with the support provided by local management for staff during times of crisis or difficult circumstances (p<.006). Management/Administrative respondents were found to have a significantly higher level of awareness of AHSPNE (2003) (p<.000), in contrast to those from the other four staff groups.

Medical/Dental

In line with the overall broad pattern found among the responses of this staff group, those from Medical/Dental occupations were significantly more dissatisfied, least satisfied, and answered ‘don’t know’ more frequently in relation to several leadership and management issues in comparison with the other survey participants. For instance, they were least satisfied and also answered ‘don’t know’ significantly more frequently in relation to the performance of corporate management in establishing key service priorities (p<.001) and responding to important external changes (p<.002). Medical/Dental respondents answered ‘don’t know’ significantly more often than those from the other staff groups and were significantly more dissatisfied in relation to the provision of a sense of purpose and future direction for staff by the corporate management team (p<.000) and in relation to the provision by the corporate management team of a supportive environment for staff in dealing with work challenges (p<.000). Medical/Dental respondents also answered ‘don’t know’ significantly more often in relation to the visibility and accessibility of the corporate management team across the organisation (p<.010) and the corporate management team communicating with staff (p<.000).

This group of respondents were similarly more negative in their views of local management. The data shows that those in Medical/Dental occupations were significantly more dissatisfied with their local management in terms of encouraging the services in which they work to work across boundaries with other NEHB services (p<.000) and providing supports for staff during times of crisis or difficult circumstances (p<.006). They were also significantly less satisfied with their local management in encouraging staff to be innovative in terms of new or different ways of working (p<.000).
Among the five staff groups, those working in the Medical/Dental staff group reported significantly lower levels of awareness of AHSPNE (2003) (p<.000) in comparison with those from the other staff groups. Moreover, these respondents were significantly less likely than respondents from the other four staff groups to believe that AHSPNE (2003) will influence the way services are delivered (p<.050).

**Nursing**

As previously stated, those from the Nursing staff group had significantly higher levels of satisfaction in relation to a number of corporate management team tasks, including the provision of a sense of purpose and future direction for staff (p<.000), responding to important external changes (p<.002), and visibility and accessibility across the organisation (p<.010).

These respondents were also found to be the most satisfied of the five staff groups with their local management in terms of encouraging the services in which they work to work across boundaries with other NEHB services (p<.000), encouraging staff to be innovative in terms of new or different ways of working (p<.000), and supporting staff during times of crisis or difficult circumstances (p<.006).

**Support Services**

Generally speaking, the responses of this staff group did not tend to vary significantly from the overall organisational findings. However, there are a number of exceptions to this trend. For instance, Support Service respondents were significantly more uncertain, answering ‘don’t know’, in relation to the performance of the corporate management team in establishing key strategic organisational priorities (p<.001) and in relation to the visibility and accessibility of this team (p<.010). The highest proportion of respondents satisfied with the corporate management team in terms of providing a supportive environment for staff in dealing with work challenges were from the Support Services staff group (p<.000).

In conjunction with Medical/Dental respondents, those working in Support Services reported the lowest levels of awareness (p<.000) of AHSPNE (2003).

**Analysis by level of direct patient/service user contact**

Generally speaking, where statistically significant differences were found among respondents, based on respondents’ levels of direct front-line contact, the pattern which emerged revealed significantly lower reported levels of satisfaction with a number of particular aspects relating to both corporate and local management among those whose jobs involved the most direct patient/service user contact. This shall be described in detail on the following pages.
With regard to perceptions of the performance of corporate management, significant differences were found among respondents when examined on the basis of level of direct front-line contact, in terms of the ratings of satisfaction with regard to the establishment of key medium-term priorities (p<.022), responding to important external changes (p<.025) and communicating with staff across the organisation (p<.008). The data revealed that respondents who reported the highest levels of direct front-line contact were significantly more dissatisfied with corporate management and more likely to answer ‘don’t know’ in relation to each of these three core managerial tasks, while those whose jobs involved the lowest levels of direct patient/service user contact were the most satisfied.

A similar pattern was evident regarding respondents’ views of local management. Those who reported the highest levels of direct patient/service user contact in their jobs were the least satisfied with their local management from the point of view of supporting staff in times of crisis or difficult circumstances (p<.050) and involving staff in relevant decisions/changes concerning their unit/department/service (p<.014), while those with least direct front-line contact were most satisfied with these issues.

The overall survey findings indicated that 75 per cent of respondents were aware and 25 per cent of respondents were unaware of AHSPNE (2003). Further analysis indicated that respondents working most frequently on a direct basis with patients/service users had the lowest level of awareness of the strategy. No significant differences were found however on the basis of level of direct patient/service user contact in response to the set of questions regarding the likely influence of AHSPNE (2003) on service provision, service planning and service delivery. These findings highlight the scope to determine more effective ways of communicating with and involving staff working in front-line services.

**Scan by service area**

A significantly higher proportion of respondents from head office in comparison to those from the other work areas were aware of AHSPNE (2003), while those working in acute hospital services were least aware of the organisation’s strategic framework. This data indicated a distinct pattern of significantly higher levels of satisfaction with the carrying out by management of core roles and tasks among respondents from community services in particular, and also those from regional services who tended to be the next most satisfied staff group on average. Survey participants working in acute hospital services consistently reported significantly higher levels of dissatisfaction with the various leadership and direction issues examined in that section of the questionnaire. By and large, the opinions of those from head office who participated in this survey tended to vary least from the overall organisational findings with regard to the theme of leadership and direction as discussed in Part I above.
Final remarks

Effective leadership and management, both at corporate and local organisational levels within the health sector, are linked to the performance of significant responsibilities as discussed above. Two particular managerial concepts which are gaining increasing recognition in the public sector generally, and the health system particularly, are accountability and performance, both of which shall be examined in more depth in the next chapter. In particular, as previously outlined in Chapter 4, the widespread dissatisfaction with many aspects of health and social service provision in contemporary society has instigated various governmental-led, strategic and policy responses. These responses aim to improve the overall management of the health system, thereby leading to improved performance and accountability, in particular through the provision of better quality services, improved patient and client outcomes, enhanced service planning, management restructuring, and a more inclusive way of involving and working with staff at all levels. A detailed account of these issues shall now be presented in Chapter 8 – Accountability and performance.
Chapter 8 – Accountability and performance

As already pointed out in Chapter 4, the shift in the governance and management approach in the public sector generally is based on a heightened emphasis on enhancing public service delivery and performance. With reference to the health sector in particular, there is a considerable level of discontent among its varied constituents from political, professional and public arenas (Shaw and Kalo, 2002). This growing dissatisfaction with various facets of the performance of contemporary health care systems has in turn led to debates regarding how to measure performance.

Resulting from this, a more intense and formalised set of procedures for assessing and monitoring performance at different levels within health care organisations has developed (Shaw and Kalo, 2002). Moreover, consumer feedback and appraisal in assessing health service outcomes and performance have been alluded to (Scott et al, 2003a; Steel, 1991). A common tendency within the health care arena is the promotion and utilisation of evidence-based approaches (Scally and Donaldson, 1998; Haynes, 2002; Niessen et al, 2000; Donaldson and Gray, 1998) in treatment and service provision. It is increasingly recognised that high-performing organisations are those which share good or best practices, learn from mistakes, and improve their practices (Ferguson and Lim, 2001).

Reforms within the Irish public sector, initiated during the mid-1990s, were underlined by issues of improved performance and accountability, as outlined in the Strategic Management Initiative (1994), as discussed in Chapter 4. With regard to the Irish health and social care context, one of the four goals of Quality and Fairness: A Health System for You (2001), is ‘high performance’. This centres on the development of standardised quality systems and national standards of best practice for patient care, and an evidence-based approach to planning and decision making which it asserts will ensure clearer accountability. The increasing level of public expenditure in the health services, in tandem with generally heightened dissatisfaction within health services, has prompted a drive for better financial accountability through more rigorous examination of health service spending, and the efficacy of health service planning and service provision. An increased emphasis on outputs and quality standards of care is also stressed.

More recently, the national Health Service Reform Programme (2003) places strong emphasis on the need to enhance the overall performance of the Irish health system, while the development of clear accountability throughout the system is a major priority, particularly with regard to health service expenditure and resource utilisation. This programme describes a vision for a unified national health system,
with an emphasis on both improved central governance together with increased levels of responsibility and accountability at local levels within the health system.

The translation of these national priorities was contained within AHSPNE (2003). It highlighted the need for improved accountability with regard to planning, decision making and resource utilisation under its high-level ‘public accountability and high performance’ goal.

**Part I: Overall organisation cultural findings**

In terms of assessing accountability and performance aspects within the NEHB, opinions were sought with regard to a broad mix of issues contained in Section E – Accountability and performance – of the survey. For instance, views on various key performance and accountability matters such as organisational and service flexibility and responsiveness; resource utilisation; evidence, best practice and research use; the implementation of service review and evaluation data; service user focus; decision-making processes; and error admittance and learning culture, were examined. Respondents were asked for their opinions on the type of management structure which exists within the organisation and the related aspect of decentralisation. The questionnaire contained a series of questions regarding service planning. The issue of performance was explored at organisational, individual and team level.

**Opinions on key indicators of performance and accountability**

Generally speaking, of those who answered the set of questions pertaining to the performance and accountability of the NEHB in relation to the various areas outlined in Figure 16, the findings were very mixed and a high level of uncertainty was evident. It is acknowledged that the results are based on respondents’ perceptions of the concepts involved and therefore further exploration is necessary to provide more in-depth examination of the themes involved.
In terms of the highest levels of agreement, just under half of the survey participants (48 per cent) agreed or strongly agreed that ‘evidence, best practice, and/or research are used to guide planning, decision making and service delivery’. Forty-five per cent of respondents agreed or strongly agreed with the statement that ‘the NEHB is generally flexible, changing to meet new conditions, demands and problems as they arise’, while 42 per cent agreed or strongly agreed that ‘the NEHB encourages its services to be flexible and responsive to local needs and demands’.

Nonetheless, as is evident from Figure 16 above, substantial minorities were either unsure or disagreed with each of these various statements. Moreover, divergences of opinion were even more pronounced with responses almost evenly split between agreement, disagreement and uncertainty with regard to statements that ‘available resources are used to provide the best possible service and outcomes for patients/service users’, and ‘the NEHB promotes a culture of admitting errors and learning from mistakes’.
The highest level of uncertainty, accounting for an average of approximately two out of five respondents (39 per cent), was recorded with regard to the statements that ‘the findings and recommendations of reviews and evaluations of services are generally implemented’, and ‘services are user-led placing an emphasis on outcomes from the patient and/or service user perspective’. The highest level of disagreement among respondents (43 per cent) was with regard to the statement that ‘decision-making processes are generally open and transparent’. This finding is similar to that outlined in Question 10, Chapter 5 – People orientation, whereby the majority of respondents either disagreed or were unsure with the statement that ‘in general, the NEHB is an open and transparent organisation’.

Overall, this data indicated rather low levels of agreement and high levels of uncertainty with the statements provided. While it would not be appropriate to over-interpret these findings, it is possible to suggest, however, that there is scope to assess these areas in more detail. The Health Service Reform Programme (2003) has clearly indicated the need for improved levels of accountability and performance. It is therefore important that issues such as resource utilisation, openness and transparency of decision making, implementation of key findings from evaluations and the use of evidence to support decision making are all areas requiring ongoing focused attention.

**Type of management structure in the NEHB**

The type of management structure which characterises an organisation is an important consideration with regard to organisational culture. Broadly speaking, large-scale, public-sector-based bodies such as health services organisations would traditionally be renowned for their centralist-based, hierarchical structure. However, it has become increasingly recognised that administrative-based, centralist and hierarchical-control structures are no longer suited to the complexities and requirements of modern organisations. The advantages of decentralised-based styles of managing contemporary organisations, which comprise more widespread responsibility and autonomy, are recognised in the relevant literature (Dolan and Garcia, 2001, 2002; Hunter, 1998; Osborne and Gaebler, 1993). While some facets of the traditional management model are likely to remain in complex multi-level systems such as health care (Pettigrew et al, 1992), nonetheless there is a perceptible move toward the development of structures which ‘get closer’ to patients, clients and consumers. In this context, flatter, more localised network and team-based structures incorporating a widening of responsibility and autonomy are increasingly being developed and promoted.

This trend has also been evident in the organisational structures of the Irish health system over recent years, with the introduction of a general management structure.
at local level in addition to care group management structures. Furthermore, the promotion of more clinical and medical involvement in management has arisen in particular via the ‘clinicians in management’ initiative, and the development of clinical business units within acute hospital services. Such initiatives are broadly reflective of a team-based approach to care delivery. The current reforms taking place within the Irish health system include the development of a more localised approach to deliver regional and non-hospital services via the establishment of county-based local health offices throughout the country.

For the purposes of this survey, respondents were given three options to choose from in terms of describing the type of management structure within the NEHB. One type reflected a centralised, hierarchical model. Another was based on a decentralised, devolved model, while the third described a movement towards balancing power at the central and local levels. As Figure 17 indicates, considerable variation was found among those who answered this question in terms of opinions regarding the NEHB’s management structure.

Figure 17: Statements that most accurately reflect the way the NEHB is managed (Q34)

![Bar chart showing responses](chart)

The findings indicated that the largest proportion of respondents, consisting of more than two out of five (41 per cent), associated the management style of the NEHB with a centralised, hierarchical model whereby management structures and processes reinforce dependence on central corporate authority. A third (33 per cent) of respondents chose the option in which management structures and processes facilitated an increasing balance between central and local responsibility and decision making. The smallest proportion of survey participants, just over one in four (26 per cent), selected the most decentralised and devolved model whereby management structures and processes encouraged independence, responsibility and decision-making authority at local level.
While the NEHB as an organisation is no longer in existence, nevertheless this data is of relevance in terms of the new structural changes within the context of the health service reforms process. For instance, on the one hand, a move towards increased centralisation in the governance and management of the Irish health and social care organisations is taking place via the establishment of the HSE. On the other hand, as mentioned earlier, the provision for the establishment of Local Health Offices and Hospital Networks, and the explicit promotion of devolved responsibility, decision making and accountability to local staff as appropriate, is reflective of a move towards a more decentralised management model. It is envisaged that the newly reformed Irish health system will balance both centralised and localised governance and management as a means of providing a more unified and integrated health system and which affords those delivering services at the front line adequate levels of autonomy. From a humanistic management point of view, the adoption by organisational leaders and managers of a less centralist and more participative management approach would in turn result in a more positive organisational culture.

**Decentralisation**

Interlinked with the types of management structures and processes within the organisation is the notion of decentralisation. As we have seen in the literature review, the theme of decentralisation is currently pervading current health service management models (Hunter, 1998). Decentralisation involves the movement of authority and decision making away from the centralised corporate management level to more local levels and to front-line staff. The reasoning for such a move is to stimulate local-level innovation, flexibility and responsiveness, thereby making services more patient/service user centred.

Moreover, from a staff perspective, decentralisation is associated with positive outcomes (Osborne and Gaebler, 1993). Greater levels of staff involvement improve organisational effectiveness (Ouchi, 1980) and contribute to the development of skills, ownership and a teamwork approach (Denison, 2000b). *Quality and Fairness: A Health System for You* (2001) referred to the empowerment of staff at all levels through the devolution of decision-making responsibility to the lowest feasible level, while the requirement to devolve personal financial accountability to front-line and clinical staff comprises a core theme of the *Health Service Reform Programme* (2003).

A number of questions were included in the cultural survey in order to establish whether respondents believe that decentralisation was perceptible in the area where they work. For instance, opinions were sought in relation to the degree to which decision-making authority and responsibility are devolved to both front-line staff and local managers.
As Figure 18 demonstrates, of those who answered this set of questions, over three-fifths of respondents (62 per cent) indicated that both front-line staff and local managers are given an adequate level of decision-making authority and responsibility. Opinions were comparatively less positive regarding the degree to which budgetary responsibility has been adequately devolved to local managers, with just over two-fifths (42 per cent) of respondents stating that it had been adequately devolved, compared to more than half who either disagreed (36 per cent) or did not know (22 per cent).

It appears from these findings that respondents were generally pleased with moves towards decentralising decision-making authority and responsibility to more local and front-line staff in the areas in which they worked. However, the findings also indicate a more urgent requirement to improve the devolution of budgetary responsibility to local managers. In order to facilitate more rapid local service change, local control and autonomy in relation to financial resources is a key facet.

As previously mentioned, the themes of decentralisation, and local and personal accountability underpin the current reforms of the Irish health service. Hence, developments with regard to these issues are likely to be nationally driven.

Service planning

Health boards have important responsibilities under the Health Amendment Act, 1996 (Accountability Legislation) regarding the level and type of service to be provided under their service plans (Department of Health and Children, 2001). The APPM (2002) identified increasing staff involvement in service planning as one of its actions in developing a partnership approach with staff in health service
organisations. The *Health Service Reform Programme* (2003) emphasises the significance of service plans as the key mechanism through which health and social services are provided to the public, and the need to develop an improved, standardised service planning process across the country.

The questionnaire examined performance at local level, based on the area in which survey participants worked, in relation to the service planning process. In terms of participation levels in the service planning process within the NEHB, a slight majority (55 per cent) of those who answered this question stated that they were not involved in the 2004 service planning process, compared to 45 per cent who said they were involved.

**Figure 19: Involvement in the 2004 Service Planning process (Q30)**

Given the promotion by the organisation of widespread and ongoing involvement in this activity, it is important to know who was not involved in the 2004 service planning process based on the data obtained in this survey. A more detailed examination of the data revealed that involvement was significantly influenced by membership of particular staff groups and the extent to which one’s job involved direct patient or service user contact, and the service area in which one worked, as shall be discussed in Part II of this chapter.

The annual service planning process should facilitate the implementation of annual service targets in line with overall organisational and service direction. Therefore a series of questions pertaining to the perceived value of this planning process was included in the survey. On the whole, Figure 20 shows that views among those who answered this set of questions were largely positive with regard to the needs-based planning of services, the clarity of local service goals and objectives, the congruence of local service goals and objectives with those of the NEHB, the appropriate basis for the prioritisation of services, and service improvement possibilities arising from the service planning process. In summary, this data reveals an encouraging platform from which to further develop the service planning process within the HSE Dublin North East.
Figure 20: Service planning in relation to respondents’ work area (Q31.1)

As Figure 20 reveals, among those who answered this set of questions, the vast majority of survey participants (86 per cent) agreed that in the area in which they work, services were planned around the needs of patients and service users. Similarly, more than four out of five respondents (81 per cent) stated that there were clear goals and objectives guiding their service plan and work. The vast majority of survey participants (81 per cent) also agreed that the goals and objectives of their service were in line with the overall direction of the NEHB. Almost three out of four respondents (74 per cent) stated that services where they worked were prioritised on the basis of appropriate information and evidence. Over seven out of 10 respondents (71 per cent) agreed that service planning supported service improvements in the services in which they worked.

As shall be discussed in Chapter 10, respondents had diverse opinions of the extent to which progress had been made in recent years by the NEHB in terms of involving staff in service planning. While positive feedback was received from most respondents in terms of the usefulness and appropriateness of service planning, nonetheless there is a need to concentrate efforts on improving the involvement of the categories of respondents who indicated that they were not involved in the 2004 service planning process, and those who held more negative views of this process. The identification of such staff groupings shall be outlined in Part II of this chapter.
Organisational-level performance measurement

A core managerial task is that of monitoring and assessing organisational performance (Kovner et al, 1997). The clinical governance initiative is playing a major role in shaping the formal assessment of performance in health and social care organisations in the United Kingdom (Scally and Donaldson, 1998). In Ireland, a number of approaches exist for the purposes of governing and measuring the performance of health care organisations. The most significant internal organisational performance evaluation techniques include service plan targets set annually by the former health boards in conjunction with the Department of Health and Children, and nationally set performance indicators against which the performance of the former health board units, departments and services were measured. Several developments are ongoing with regard to health care accreditation systems. Statutory registration is currently in existence for five professional groups working in the health system, namely, doctors, nurses, pharmacists, opticians and dentists. The registration of a number of other health and social care professionals is also planned.

This survey asked respondents to rate the effectiveness of a list of key measures in terms of assessing the organisational performance of the NEHB, as listed in Figure 21. The overall trend points to a relatively high level of uncertainty with regard to the various measures. The noticeably high percentages of survey participants who answered ‘don’t know’ in relation to the various measures of organisational performance, ranging from 24 per cent to 52 per cent, prompted an examination of the staff groups of these particular respondents. Those from the Allied Health Professions consistently reported the highest levels of ‘don’t know’ in relation to the following measures, namely, Performance Indicators, Inspectorates, the Integrated Management Report, and Accreditation. Meanwhile, Medical/Dental respondents reported the highest levels of ‘don’t know’ in relation to National Standards and Sustaining Progress, whereas Support Service respondents were most unsure about Service Plan Targets.
In terms of those who rated these various measures, viewpoints did not vary greatly with regard to respondents’ assessments of the performance measures listed. Therefore, average percentages are used for summary purposes. On average, less than a third of respondents (31 per cent) rated Service Plan Targets, National Standards, Performance Indicators and Sustaining Progress, as good or very good measures of organisational performance, while 29 per cent answered ‘don’t know’.

In addition, aggregate opinions were comparatively more uncertain and less positive with regard to the perceived effectiveness of the Integrated Management Report, Inspectorates and Accreditation as measures of organisational performance in the NEHB. For example, an average of just one out of four respondents (25 per cent) rated them as good or very good, while almost half (49 per cent) did not know.

In essence, this data indicates that of those who were aware of these various organisational performance measures, only approximately one in four rated them positively, and they were not widely known by substantial proportions of respondents who were, by and large, working in front-line service-delivery posts.
Individual and team-level performance

As outlined earlier in the literature review in Chapter 4, the facilitation of good performance and appropriate management of poor performance are recognised as critical organisational learning and performance issues (Beckhard and Pritchard, 1992; Scott et al, 2003b; Ferguson and Lim, 2001). Furthermore, a key task of leadership is to identify key factors that motivate individuals to improve and optimise their performance. As the management of personal performance is intrinsically linked with organisational cultural change (Pettigrew, Hendry and Sparrow, 1990), this task is particularly salient in light of the current reforms taking place within Irish health care organisations.

Performance management systems for individuals and teams are currently being introduced in the public sector generally (Department of Health and Children, 2001). Based on a recommendation of *Quality and Fairness: A Health System for You* (2001), one of the actions associated with the *APPM* (2002) was the development of performance management in health care organisations so that the performance of all staff is linked to organisational goals, and organisational and individual objectives are managed through a cycle of planning and review. *AHSPNE* (2003) made a commitment to developing performance measurement at individual, service and organisational levels.

The *NEHB Organisation Cultural Survey* (2004) sought to gather opinions on individual personal performance issues at local level, as dealt with by line managers in the areas where respondents worked. As Figure 22 demonstrates, of those who answered the questions pertaining to personal performance, mixed feedback was given.

**Figure 22: Local management of personal performance (Q33)**

For instance, relatively small majorities of survey participants stated that goals for their personal performance were agreed with their line manager (58 per cent), and
rated feedback received from their line manager on their performance as satisfactory (56 per cent). Another vital managerial task comprises the assessment of and taking appropriate measures concerning the personal performance of staff. The survey results were comparatively more positive in terms of the recognition of and dealing with individual performance issues by local management. For instance, over two-thirds of respondents (67 per cent) agreed that good performance was generally recognised by their local management where they work, while more than three out of five respondents (64 per cent) felt that poor performance was dealt with appropriately by their local management.

The learning from these findings highlights the need for increased focus on supporting and enabling improved individual and team performance. The survey findings indicated that respondents would favour a more structured approach regarding the setting of personal performance goals and the provision of feedback from line managers on personal performance.

Part II: Subcultural analysis of the research data

Chi-square analysis of Questions 29, 30, 31 and 33 in Section E was performed in order to examine whether significant differences occurred in relation to respondents’ opinions of the various performance and accountability issues, based on their staff group and their level of direct patient/service user contact in particular. A scan of the data was also conducted in order to find out whether such differences were based on the service area in which respondents worked. Given the relatively high proportion of ‘unsure’ values in Q29, these values were included in the chi-square analysis. The ‘don’t know’ values were excluded for chi-square analysis purposes regarding Q31 as they were generally low. As discussed in Part I above, many of those who participated in the survey answered ‘don’t know’ to Q32 which listed a range of formal performance measures. Hence, this question was not analysed in terms of the chi-square procedure. In overall terms, the data from this level of analysis uncovered several statistically significant differences of opinion among survey participants based on their staff groups, level of patient/service user contact and service area where they worked.

Analysis by staff group

When the responses to questions in Section E – Accountability and performance – of the survey were assessed by respondents’ staff groups, significant differences were found in relation to organisational flexibility and change; the usage of evidence, best practice, and/or research; service planning; and the organisational management structure and processes. No significant variation was found among the staff groups with regard to their perceptions of decentralisation and the management of individual performance. These results shall now be discussed in more depth.
Allied Health Professional
Just two noteworthy differences were found in relation to the Allied Health Professional staff group in comparison with the other staff groups. A significantly higher proportion of respondents from this staff group, together with those from the Management/Administrative group, were involved in the 2004 service planning process (p<.000). Furthermore, most of those who described the management structure of the NEHB in terms of an increasing balance between central and local levels were from the Allied Health Professional staff group (p<.031) in contrast to the proportions from the other staff groups who chose this option.

Management/Administration
In a similar manner to the Allied Health Professional respondents mentioned above, the findings pertaining to the Management/Administration staff group only varied marginally from the general organisational findings discussed in Part I above. With regard to the significant differences found, the highest level of agreement with the statement that ‘the NEHB is generally flexible, changing to meet new conditions, demands and problems as they arise’ was found among those from Management/Administration (p<.014), in contrast to the other staff groups. With regard to opinions of the utilisation by the organisation of evidence, best practice and/or research, of those who were unsure, most were from Support Service and Management/Administrative posts (p<.002). As mentioned above, higher than average involvement in the 2004 service planning process was reported by respondents from both the Management/Administrative and Allied Health Professional groups (p<.000).

Medical/Dental
In line with the general trend, Medical/Dental survey participants differed most from those from the other staff groups in terms of their opinions on a number of aspects pertaining to performance and accountability. For example, the highest level of disagreement and uncertainty was found among Medical/Dental respondents regarding the statement that ‘the NEHB is generally flexible, changing to meet new conditions, demands and problems as they arise’ (p<.014). Also the highest level of disagreement regarding the utilisation by the NEHB of vital information sources such as evidence/best practice and/or research was found among this staff group (p<.002). Medical/Dental respondents alongside those from Support Services reported the highest levels of non-involvement in the service planning process (p<.000).

Proportionately more of those who reported not having clear goals and objectives guiding their service plan and work (p<.001), who did not believe that their services goals and objectives were in line with the overall direction of the NEHB (p<.032),
and who did not consider the service planning process as supportive of service improvement (p<.019) were from the Medical/Dental and Support Service groups. In addition, a statistically significant difference of opinion was found among the staff groups regarding the type of management structure within the NEHB, with significantly higher proportions of Medical/Dental respondents describing the NEHB management structure and processes as based on central corporate authority (p<.031).

Nursing
The nurses who participated in this survey had broadly consistent opinions of the various performance and accountability aspects as found in terms of the overall organisational findings set out in Part I of this chapter. Only one significant difference (p<.002) was found with regard to their opinions of the utilisation by the organisation of evidence, best practice and/or research, with those from the nursing profession agreeing most strongly on the use by the organisation of such vital sources of information in guiding planning, decision making and service delivery.

Support Services
Those working in Support Services who participated in this survey were another group that differed most from the overall organisational findings in relation to a range of issues. Where statistically significant differences were found among this staff group, a trend was for these to mirror those of the Medical/Dental staff group in relation to their views on a number of issues. Respondents from Support Services were most unsure regarding the utilisation by the organisation of evidence, best practice, and/or research (p<.002); having the highest levels of non-involvement in the service planning process (p<.000); not having clear goals and objectives guiding their service plan and work (p<.001); not believing that their services goals and objectives were in line with the overall direction of the NEHB (p<.032); and not considering the service planning process as supportive of service improvement (p<.019). Among the five staff groups surveyed, highest proportions of Support Service respondents opted for the decentralised, local-based management model in describing the way in which the NEHB is managed (p<.031).

Analysis by level of direct patient/service user contact
A lesser number of significant differences were found among respondents when examined in terms of their level of direct patient/service user contact. Where variation occurred, those areas in which respondents differed most were in relation to service flexibility and responsiveness, and service planning. No significant variation in responses was revealed on the basis of level of direct front-line contact in terms of respondents’ opinions of the management of individual performance and the way in which the NEHB is managed.
A significant difference (p<.025) was found on the basis of front-line work, with an evident trend between increasingly negative views of the encouragement by the NEHB of service flexibility and responsiveness as the levels of direct patient/service user contact increased. Regarding service planning, those with the greatest levels of direct patient/service user contact reported significantly lesser involvement in the 2004 service planning process in comparison with those with the lowest levels of front-line contact (p<.000). Furthermore, those whose work involved the lowest levels of direct front-line contact reported the highest levels of agreement that there were clear goals and objectives guiding their service plan and work (p<.050) compared with those with higher levels of direct patient/service user contact. Involving and attaining the backing of staff whose roles are primarily clinical, front-line and service-delivery based is necessary if the service planning process is to have real, tangible meaning at the point where services are provided and delivered to health care patients and service users.

**Scan by service area**

Several significant differences were found when questions pertaining to accountability and performance in Section E – Accountability and performance – of the questionnaire were examined in terms of the service areas in which respondents worked. The broad trend consisted of significantly more positive ratings and agreement levels among community services respondents in particular, and also among those working in regional services, while a small number of exceptions to this trend were found. By contrast, the trend alluded to in the previous chapters continues in relation to the significantly higher levels of dissatisfaction and disagreement among those working in acute hospital services. The views of those respondents working in head office were generally found to be more in line with the overall findings discussed at the organisational level.

**Final remarks**

From the discussion above, it is evident that moves towards improved organisational performance and clearer lines of local accountability are interconnected with the development of more collaborative and integrated ways of working. One of the principle purposes of the Irish health service reforms is to reduce fragmentation and to improve the overall integration of services. The national restructuring of the Irish health services has also emphasised the need for greater levels of local and front-line authority and accountability and integrative approaches to service delivery and methods of working. In the next chapter, we shall examine the issues of integration and teamworking in greater detail. The collaborative approach to working with various stakeholders both within and outside the organisation is explored, while more specifically, opinions and experiences of teamworking are outlined.
Chapter 9

Integration and teamworking
Chapter 9 – Integration and teamworking

Recognition of both the relevance of and increasing need for collaborative, partnership-based working arrangements between organisations, among various professionals and disciplines, and staff groupings within organisations has been discussed in Chapter 4. In recent years, an important development has been the widespread recognition of the advantages of collaborative and team-based approaches to working within the health care sector (Cozens-Firth, 1998; General Medical Council, 1995; Hackman, 1987; Ferguson and Lim, 2001). The need for integrative modes of working between health and social care organisations, and their multi- and inter-disciplinary staff has intensified as increasingly complex health care organisations aim to balance simultaneous demands to deliver more diverse and specialised services. Directly linked with this trend is the increasing recognition of the benefits of teamworking in terms of the overall functioning and performance of the organisation, and more specifically from patient, service user, and staff perspectives.

In a similar vein, the above-mentioned developments are also perceptible in various key strategic policy documents which have shaped change within the Irish health sector in recent years. A clear endorsement of a move towards a more integrated way of working is found in Quality and Fairness: A Health System for You (2001), which recognised the value of an inter-disciplinary team-based approach in providing high-quality services to patients and clients. The requirement for both cultural and organisational structural change was discussed in this regard.

In addition, the APPM (2002) refers to an increased level of multi-disciplinary working as a result of the implementation of this plan. A core focus of the Health Service Reform Programme (2003) is to reduce the high level of fragmentation which was identified as existing within the Irish health system. In this regard, the new structural arrangements provide for the revised functions for the Department of Health and Children and various other existing bodies, as well as the establishment of a new unified management structure and service delivery system under the auspices of the HSE.

AHSPNE (2003) reinforced the requirement for the development of a more integrated service through collaborative and partnership-based work practices. One of its strategic objectives identified the need to ensure a connected service from the first point of contact through the implementation of actions such as establishing integrated service delivery, endorsing teamworking, and developing clinical-care pathways and care-group processes. Additionally, another of its
strategic objectives, namely partnership and valuing communities, explicitly recognises the importance of working in alliance with other service-provider agencies in the statutory, voluntary and community sectors, and involving service users, families, carers, communities and staff. Working together in partnership was identified by the NEHB *Human Resource Management Plan* (2004) as the most appropriate means of implementing both national and service objectives, and the new change agenda. It made reference to actions to underpin the promotion of a culture of integration, co-operation and teamworking as the core way of working.

**Part I: Overall organisation cultural findings**

**Ratings of internal and external integrated working**

This research sought to examine respondents’ views on the merit of collaborative or joint working among the various component parts of the NEHB, and between the NEHB and other organisations, agencies and bodies in the statutory and voluntary sector. Generally speaking, the data in Figure 23 shows that the majority of survey participants who answered the relevant questions on this issue regarded their work areas as performing positively in terms of joint working both within and outside the organisation. For instance, over two-thirds of respondents (67 per cent) rated joint working or collaboration between the unit, department and service in which they worked and other relevant units, departments and services within the NEHB as good or very good. Three out of five respondents (60 per cent) rated joint working or collaboration between their work area with relevant external agencies and organisations as good or very good.

However, the fact that an average of approximately one-third (31 per cent) of respondents rated both internal and external joint working or collaboration by their work area as either fair, or poor/very poor, reinforces the considerable journey which the component parts of the organisation face in effectively working in a partnership manner. Such findings were reinforced as we shall see later in Chapter 10, Question 39, whereby most respondents rated the level of progress made in recent years by the NEHB with regard to joint working between services as moderate to low.
Figure 23: Rating of joint working by respondents’ service area internally and externally (Q35)

Note: Valid per cents used. Missing values and not applicable values are excluded.

From an operational perspective, we know from the literature (Friedlander, 1987; Shortell et al, 2000) that working in a collaborative manner both from an organisational and individual perspective is potentially challenging and requires appropriate leadership, oversight and support. In this light, the survey sought to establish what respondents considered to be the five most important factors which would facilitate joint working within the organisation (see Figure 24). The learning from this information is helpful in considering what respondents perceived to be the most important factors that would facilitate effective joint working.

Figure 24: Rating of the most crucial factors facilitating joint working within the NEHB (Q36)
The top five most crucial factors identified were:

1. Staff support in dealing with the challenging issues that emerge in terms of joint working.
2. Clarity regarding roles, responsibilities and reporting relationships.
3. Common patient- or client-information systems.
4. A focus by the organisation on quality and continuous improvement.
5. Learning and development initiatives such as team development and multi-disciplinary training.

Additionally, as is evident from Figure 24, both senior management support and financial and/or budgetary flexibility were also rated as relatively important factors in assisting joint working.

**Teamworking**

Given the significance of teamworking as a collaborative mode of working as highlighted earlier, a number of specific questions on this subject were included in the survey. The data indicated that within the NEHB approximately nine out of 10 respondents noted that they worked as part of a team.

**Table 12: Types of teams in which respondents predominantly worked (Q37)**

<table>
<thead>
<tr>
<th>Type of Team</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multi-disciplinary team (patient/service-user based)</td>
<td>196</td>
<td>30</td>
</tr>
<tr>
<td>Department team</td>
<td>184</td>
<td>28</td>
</tr>
<tr>
<td>Unit team</td>
<td>90</td>
<td>14</td>
</tr>
<tr>
<td>Management team (local/corporate)</td>
<td>76</td>
<td>12</td>
</tr>
<tr>
<td>Single discipline team (patient/service-user based)</td>
<td>65</td>
<td>10</td>
</tr>
<tr>
<td>Other (includes a mixture of the above-mentioned team types)</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>Not applicable</td>
<td>24</td>
<td>4</td>
</tr>
<tr>
<td>Valid total</td>
<td>650</td>
<td>100</td>
</tr>
<tr>
<td>Not answered</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>666</td>
<td></td>
</tr>
</tbody>
</table>

As Table 12 demonstrates, among those who answered this question, the two most common types of teams in which respondents worked were multi-disciplinary teams and department teams, with almost three-fifths of respondents (58 per cent) working in one or other of these.

Working as part of a team can be both a stimulating and challenging experience since it involves working closely with staff from either different or similar work backgrounds and/or disciplines with a variety of skill and experience levels. In order to assess respondents' experiences of this collaborative way of working, views were sought on their levels of satisfaction with a wide selection of important team elements as outlined in Figure 25.
As Figure 25 demonstrates, positive opinions were given by substantial proportions of respondents in commenting on various team elements. Of these, respondents were most satisfied with their team’s interpersonal working relationships, the purpose and goals of their team, and their team’s skills mix. More moderate levels of satisfaction were found regarding the clarity of reporting relationships, work roles and responsibilities, and the management of the team by the team leader. Respondents were least satisfied with methods of resolving team problems or conflict, evaluating and measuring the achievement of team targets, and evaluating the team approach in maximising benefits to patients and/or service users, where applicable, while the numbers who answered ‘don’t know’ to the latter were noticeably higher than for the other questions.

This data indicates high levels of overall satisfaction with the core elements of teamworking in the NEHB. As we shall see in Chapter 10, positive feedback was also found in terms of respondents’ perceptions of progress made by the NEHB in facilitating teamworking over recent years. Nevertheless, the data indicates scope for improvement, in particular with regard to the evaluation of teams and the
resolution of team problems and conflicts. Given the identified benefits of integrative working within organisations generally, and via teams or staff groups more specifically as outlined in Chapter 4, the overall responses in relation to teamworking within the NEHB in this survey provide an encouraging platform upon which to foster further development and improvement.

**Part II: Subcultural analysis of the research data**

Questions 35 and 38 in Section F – Integration and teamworking – of the survey were analysed using chi-square in order to examine whether any significant differences occurred among respondents in their views on joint working and various teamworking elements on the basis of their staff groups, level of direct patient or service user contact, and service area. As the ‘don’t know’ values given in relation to these two survey questions were generally low, they were excluded for chi-square analysis purposes.

**Analysis by staff group**

Some statistically significant variation was found among Management/Administrative, Support Service, and Medical/Dental survey participants in terms of their ratings of joint or collaborative work with both internal and external relevant bodies, and their levels of satisfaction with the team in which they worked. In contrast, those from both the Allied Health Professional and Nursing staff groups had broadly similar opinions which did not differ significantly from those found at the overall organisational level, as outlined in Part I above.

**Management/Administration**

Those working in this staff group gave the most positive ratings of joint or collaborative working both internally among their work area and other relevant units, departments or services within the NEHB (p<.008), and also among their work area and other relevant agencies and bodies outside the NEHB (p<.050), in comparison with respondents from the other staff groups.

**Medical/Dental**

Survey participants from the Medical/Dental staff group, alongside Support Service respondents, rated joint working between their service area and other relevant internal units, departments and services, and relevant external bodies more negatively on average (p<.008 and p<.050) than those working in the Allied Health Professions, Management/Administrative and Nursing staff groups. Medical/Dental respondents were also least satisfied with their work teams in relation to the evaluation and measurement of meeting team targets (p<.040).
Support Services
As mentioned above, this group of respondents rated their work unit, department or service most poorly in terms of both internal and external joint working ($p<.008$ and $p<.050$). On the other hand, Support Service respondents were most satisfied with their work teams with regard to the evaluation and measurement of meeting team targets ($p<.040$).

Analysis by level of direct patient/service user contact
The ratings of the performance of respondents’ work area in terms of working in a collaborative manner both internally and externally revealed no significant differences when examined on the basis of level of direct front-line contact. However, the findings showed that those respondents who had the highest level of direct front-line contact were most satisfied with their teams regarding the clarity of its purpose and common team goals ($p<.024$), in contrast to those whose jobs involved lesser front-line contact.

Scan by service area
A consistent pattern was found when the responses to survey Questions 35 and 38 were examined in terms of the service areas in which respondents worked. Those working in regional and community services gave significantly more positive views of joint working with external agencies, organisations and bodies than those working in acute hospital services and head office. Furthermore, the survey participants working in regional and community services were significantly more satisfied with several aspects of the teams in which they worked, in contrast to those working in both head office and acute hospitals.

Final remarks
It is clear from the discussion above and in the earlier literature review in Chapter 4 that collective rather than individualised ways of working, both at an organisational and team level, are regarded as increasingly necessary and more effective for patients/service users, staff and the public generally. Additionally, not only are organisations and staff required to engage more with one another in carrying out their core work roles, responsibilities and duties, there is also an evident tendency within organisations to promote a quality-based, learning culture based on continuous improvement and development. The notion of systems thinking, which is based on cognisance of the interconnections between the various parts of an organisation, is linked with the concept of a learning organisation. The next chapter shall present a discussion of this pertinent trend, namely the increased emphasis on the value of continuous improvement, development and learning.
Chapter 10
Continuous improvement and development
Chapter 10 – Continuous improvement and development

The relevant literature on continuous improvement and development asserts the critical importance to modern organisations situated in highly complex and rapidly changing environments of the related concepts of organisational learning (Argyris and Schon, 1978) and systems thinking (Garside, 1998). Contemporary organisations are required to become open learning systems which assimilate information from their external environment (Pettigrew et al, 1992). Beckhard and Pritchard (1992) emphasised the close interconnection between learning and change, asserting that one is part of the other. Good/best practices associated with notions of evidence-based working and decision making are particularly promoted in the contemporary health care sector as outlined earlier in Chapters 4 and 8. In addition, the overall effectiveness and performance of an organisation is directly linked to the quality of its members, and therefore closely connected with the issues of continuous organisational improvement and development are professional and staff development, and continuing education and training (Donaldson and Gray, 1998).

Within the Irish health and social care arena, Quality and Fairness: A Health System for You (2001) specified the requirement for a culture that emphasises the value of continuous learning and improvement in skills and experiences of everyone working in the health system, in particular as a means of attracting and retaining a high-quality health service workforce. One of the major actions identified in this strategy was investment in training and education. In turn, the APPM (2002) stated that the delivery of quality patient-centred services required a renewed focus on education, training and development in the health sector. It contained a series of detailed actions setting out how health service staff would be supported in additional learning, training and education endeavours. The salience of a culture based on quality and improvement is reinforced in the Health Service Reform Programme (2003) which identified continuous quality improvement and external appraisal as one of the major system priorities.

One of the stated high-level actions of AHSPNE (2003) prioritised the provision of opportunities to promote life-long learning and support the advancement of personal development planning for all staff. It discussed the promotion and value of a culture of life-long learning focused on improving organisational performance and innovation. It also highlighted various ways in which such a culture could be developed, for instance, through building on real experiences of staff and service users, focusing on competency requirements, linking individual, team and
organisational performance, and the management and support of performance at local level by line managers. With regard to organisational learning, AHSPNE (2003) pointed out the importance of an integrated quality assurance framework as a means of promoting good governance through the monitoring of service quality, standards, risks and outcomes. The NEHB Human Resource Management Plan (2004) highlighted the significance of the appropriate knowledge, skills, competencies and attitudes of health service staff in order to deliver quality patient-centred services. It discussed the various means by which increased investment in training, development and education can contribute to improved service provision and patient care.

As shall now be described, the survey contained a broad array of questions covering various key themes and issues associated with continuous improvement, development and learning within the NEHB at organisational, team and individual levels.

**Part I: Overall organisation cultural findings**

**Organisational progress**

First, respondents were asked to rate the level of progress made by the NEHB in recent years in relation to some core issues, including the involvement of internal and external constituents, learning and development opportunities, sharing good practices, facilitating devolution, teamworking and joint working, and staff communications. In general, as is evident from Figure 26, organisational progress over recent years on this broad selection of issues was rated as moderate to high by most respondents who answered this particular set of questions.
More specifically, the survey participants were most positive in their ratings of the level of progress made with regard to learning and development opportunities, with over half (52 per cent) rating such progress as high or very high, while almost a third (31 per cent) rated it as moderate. As Figure 26 shows, in comparative terms, opinions were not as positive in relation to progress regarding the other items listed. Nonetheless, one in three respondents (33 per cent) rated progress regarding staff involvement in service planning as high or very high, while over a third (35 per cent) rated it as moderate.

Averages can be used to summarise the remaining findings pertaining to this set of questions, given the similarity of progress ratings given by respondents. For instance, an average of 28 per cent of survey participants rated progress made in relation to sharing good practice(s), facilitating teamworking and communicating with staff, as high or very high, while almost one in two respondents (46 per cent) rated it as moderate. Opinions were comparatively less favourable with regard to perceptions of progress regarding the devolution of authority and responsibility to local level and front line, joint working between services in the NEHB, and patient and/or service user involvement, with an average of just 17 per cent of respondents...
rating this as high or very high and 47 per cent rating it as moderate. It is noteworthy that an overall average of just over one in five (21 per cent) rated the level of progress made by the NEHB in relation to each of these various items over recent years as minimal to none, signifying the remaining work necessary in order to facilitate a more effectively functioning organisation for patients and service users on the one hand, and organisational members on the other.

**What the NEHB is doing well and should develop further**

Following on from perceptions of organisational progress with regard to the above broad range of items, the survey included an open-ended question (Q40) asking respondents to identify aspects which are working well within the organisation that they would like to see further developed throughout the organisation. At the outset, it is important to note that this particular open-ended question yielded the highest non-response rate of the open-ended questions in the survey, with just one out of two respondents (50 per cent) replying to this question. A number of good practices which respondents would like to see encouraged and promoted within the organisation are outlined below. They represent areas where there is scope to work with staff to promote ongoing development, continuous learning, review and evaluation.

**Staff development opportunities**

First, the most commonly cited positive interrelated aspects were training, education, learning and development opportunities, and courses for staff. The value of such ongoing learning from a professional perspective was highlighted in terms of staff keeping up to date with best practices. Initiatives involving cross-site, discipline, team and programme interaction, networking and sharing were referred to as beneficial, and the need for the further development of such collaborations was mentioned.

**Internal and external constituent involvement**

Another commonly cited theme was that of involvement of both internal and external constituents. For instance, respondents stated that they would like to see increased staff participation and involvement across a broad variety of areas, including service planning, the design and delivery of services, policy development, decision making, and new projects and initiatives. Similarly, further progress on improvements in the involvement of patients, clients, service users and families was also cited in this regard.

**Teamworking**

The issue of teamworking emerged as another positive development within the NEHB which respondents would like to see more of. Further encouragement,
support, facilitation, and development of teamworking across a broader range of services and disciplines were referred to. A number of respondents in particular mentioned the benefits of the multi-disciplinary team approach. From an operational perspective, the management of teams, the staffing of teams, and dealing with particular teamwork issues were also highlighted.

**Communications**

Calls were made for greater and/or improved communications with all staff, from the top down, between services, and across sites, disciplines and departments. Specific areas mentioned in terms of communications included the national reforms. Some acknowledged the benefits of information and communications technology such as e-mail and intranet in promoting better communications within the organisation.

**Specific positive developments and initiatives**

Finally, a range of specific positive developments and initiatives which were cited by respondents in answering this question are summarised under the following broad headings:

**Service delivery developments**
- Palliative services.
- Mental health service development.
- Virginia primary care model.
- Hospital and community service expansion.
- Health promotion developments.
- Breast care services.
- Doc-on-call services.
- Community housing for people with disabilities and older persons.
- Family welfare conferences.

**Approaches to service delivery**
- Local service delivery approaches.
- Devolvement of budgets and local management.
- Preventative and early intervention approaches.
- Service integration initiatives.
- Waiting list initiatives.

**Quality, risk and evaluation**
- Quality initiatives.
- Risk management.
- Need-/evidence-based budgeting.

**Strategic developments**
- Development of *AHSPNE* (2003)
Staff support and development
- Personal development planning.
- Focus on performance management.
- Family-friendly work policies.
- Management competency frameworks.
- Competency-/skill-based recruitment processes.
- Occupational health service.

Team approaches
- Partnership working.
- Joint problem solving.

Learning and development within the organisation

Organisational level
The degree to which an organisation attempts to learn and reflect upon the quality of its services, work practices and opportunities provided for staff development comprises an important aspect of an organisation's culture. In order to assess this, the NEHB Organisation Cultural Survey (2004) sought to gather the opinions of respondents on their levels of satisfaction with several aspects of organisational and personal learning and development, as set out in Figures 27 and 28 below. Broadly speaking, based on those who answered this set of questions, the data indicates contrasting levels of satisfaction among respondents in relation to the different characteristics of organisational learning, as shall now be described in more detail.

Figure 27: Organisational learning and development (Q41)
As Figure 27 indicates, the highest levels of satisfaction were recorded in relation to the commitment by the NEHB to promote a culture of quality and continuous improvement, with 37 per cent of respondents satisfied or very satisfied, while more than two out of five respondents (43 per cent) were fairly satisfied. The demonstration by an organisation that it recognises and promotes positive characteristics, and acknowledges and learns from negative experiences is critical in terms of creating a learning organisation which proactively attempts to continually improve. This in turn increases morale and builds confidence among the organisation’s internal and external stakeholders. More than two out of five respondents (43 per cent) were fairly satisfied with the extent to which the NEHB organisation learns from positive experiences, and promotes good practices and ways of working. Just over a quarter (27 per cent) stated that they were satisfied or very satisfied, while over a fifth (21 per cent) were dissatisfied or very dissatisfied. Less satisfactory opinions were given in terms of learning by the NEHB in terms of negative experiences, with just over one in five respondents (21 per cent) satisfied or very satisfied with this, compared to 28 per cent who were dissatisfied or very dissatisfied, while 41 per cent were fairly satisfied.

Another important attribute of a learning organisation is the bottom-up assimilation of the vast array of experiences and practical knowledge of staff at all levels within the organisation in terms of developing and improving services. The survey found that respondents were most dissatisfied with the extent to which local knowledge and feedback are acted upon in order to improve services, with 37 per cent dissatisfied or very dissatisfied, compared to one in five (20 per cent) who were satisfied or very satisfied, and just over one in three (34 per cent) who were fairly satisfied.

**Personal learning and development**

With regard to personal learning and staff development, again rather mixed feedback was received from the survey participants who answered these relevant questions, with no clear pattern evident.
As is evident from Figure 28, respondents were comparatively most satisfied with the opportunities to discuss learning and development needs with their line managers, with 44 per cent satisfied or very satisfied with such opportunities, while over a quarter (27 per cent) were fairly satisfied. A slightly lower percentage of respondents were satisfied or very satisfied with the extent to which the service in which they worked was gaining the maximum benefit from their expertise and skills, with 39 per cent satisfied or very satisfied with this, while just over one-third (34 per cent) were fairly satisfied.

Respondents were least satisfied with opportunities to participate in personal or professional development planning processes, with 36 per cent satisfied or very satisfied, and 27 per cent fairly satisfied. The sizeable minorities of respondents, averaging more than a quarter (26 per cent), that were dissatisfied with each of these personal development aspects is of note. The learning from this data points to a need for greater concentration on advancing individual performance through supported development opportunities and recognising the value of staff’s professional and personal experiential contributions.

**Main sources of personal learning and development support**

In practical terms it is important for the organisation to be aware of the most significant sources from which its members mainly seek personal learning and development support. The questionnaire listed a wide variety of potential sources of such support and asked respondents to identify the three most important sources which they used with regard to their personal learning and development. While Figure 29 shows considerable variation in the responses given to this question, some trends are evident as the discussion that follows shall outline.
Based on those who answered this question, work colleagues and/or peers, and line managers were considered the most important sources for personal learning and development, each of which were chosen by 57 per cent of respondents. This finding emphasises the personalised nature of learning and development which is reliant upon and innately linked to good working relationships between colleagues, and among line managers and their staff. At the formal level, both external and internal training and/or development courses were identified as the next most important sources by an average of over two-fifths of respondents (42 per cent). The informal method of on-the-job training was rated as the third most important by 37 per cent of respondents.

Supporting staff who move jobs within the organisation

Over three out of four respondents (77 per cent) replied to the open-ended question (Q43) which asked for suggestions regarding the main ways staff can be supported in new jobs or roles within the NEHB. This question was considered important from a cultural perspective in terms of enabling staff to adapt to new job positions and to move smoothly between different subcultures within an organisation. It was also recognised that early support for staff in new positions can assist with retention and overall staff performance and satisfaction.

7 In relation to Question 42, respondents who identified Human Resources in the options available were merged under Other as noted in Figure 29.
From a service perspective, continuity can also be enabled through early and appropriate support systems. Arising from the analysis of this question, a number of specific suggestions were made. These primarily centred on the provision of adequate induction and orientation; training; support, mentoring and supervision; role and responsibility clarification; communications and information; feedback, appraisal and review; and meetings, each of which shall now be explored in more detail.

Training

The most commonly cited way to support those who change roles or jobs within the NEHB was the provision of training for such staff. Terms such as ‘adequate’, ‘good’, ‘necessary’, ‘proper’, ‘appropriate’, ‘formal’, ‘relevant’ and ‘tailored’ were used to describe the type of training required, while the need for ‘more’ training was also suggested. Furthermore, a diverse variety of training approaches was mentioned, including formal training courses and programmes, internally based on-the-job and in-service training, external training, ongoing training, and one-to-one training.

Other issues, including the importance of access to training prior to taking on new roles and jobs, allocating an adequate time period for training those who move jobs or change roles, and the benefits of locally based training were also alluded to. One aspect of training for those who move jobs or change roles which was identified as potentially useful by a number of respondents was ‘shadowing’, whereby on-the-job training was received from one’s predecessor.

Induction and orientation

Many of those who answered this question named induction as a core means of supporting those who change roles and move jobs within the NEHB. There were calls for ‘improved’, ‘comprehensive’, ‘good quality’ and ‘well-structured’ induction processes which would provide staff with the required knowledge of the key priorities, tasks and procedures associated with their new roles or jobs in their new work setting. The current provision of one-day, generic induction courses was regarded as insufficient, and the provision of a suitable period of time permitted for induction of staff was proposed. In a similar vein, some respondents referred to the need for the allocation of an adequate time period, consisting possibly of a number of weeks, for a proper and well-planned orientation process for staff as a means of sufficiently preparing them for their new roles or jobs.

Support, mentoring and supervision

The importance of supporting staff who change roles or jobs was commonly cited in response to this question. In general terms, respondents discussed the creation of a ‘supportive environment’ for such staff and the development of ‘support networks’.
In particular, support from one’s new line manager and peers or colleagues was mentioned most frequently, while support from management, senior or department managers, and team leaders and members was also referred to.

Different phases of support were identified including ‘initial’ support when staff move roles or change jobs, and ‘continuous’ support available to these staff as necessary. One particular means proposed to support staff in adapting to new or changed roles or jobs was through a ‘mentorship’ or ‘mentoring’ process. It was pointed out that mentoring would be particularly beneficial in the initiation period of a new role or job. Some survey participants suggested formal mentoring programmes while others referred to mentoring by one’s peers and senior staff. Another frequently cited means of support provision was through ‘regular’, ‘well-planned’, and ‘structured’ supervision from one’s line manager and/or management. Other types of supervision referred to included peer supervision, group supervision, clinical supervision and professional supervision.

**Role and responsibility clarification and job description**

Respondents clearly articulated the need for clarity regarding the new role and responsibilities of staff members who change positions within the organisation. The provision of clear and adequate definitions of roles, outlining the core responsibilities, expectations, goals and guidelines of the new role or post were discussed. It was explained that staff changing roles or jobs should be fully informed and prepared well in advance of taking up new positions within the organisation. The necessity to allow adequate time for staff to fit into their new roles was also reiterated. Some felt that role and responsibility clarification should be given in written statement format, while others mentioned role and responsibility discussion on a face-to-face basis. It was regarded as very important that staff have a good understanding of the purpose of their new roles and/or jobs. In this regard, a number of respondents highlighted the need for the provision of job descriptions which were ‘meaningful’, ‘customised’, ‘clear’, ‘detailed’ and ‘comprehensive’ in assisting staff in new jobs.

**Communications and information**

Some respondents noted that those who change roles or jobs need access to ‘good’ and ‘open’ communications, in particular with their new managers and also across the various organisational levels. The early communication of changes concerning roles, responsibilities or new developments, and the possession of good communications skills were also referred to. Timely access to all the necessary information required to conduct one’s new role or job and the easy transferability of such relevant information were mentioned.
Feedback, appraisal and review
Interconnected with communications and information are feedback, appraisal and review procedures, which are primarily the responsibility of one’s line manager and/or team leader. Some respondents suggested that the provision of feedback for staff on their progress and performance in their new roles or jobs would be useful. Calls were made for ‘early’, ‘ongoing’, ‘frequent’, ‘regular’ and ‘truthful’ feedback for such staff.

Appraisal of staff in new roles and jobs was mentioned by others as a means of assisting them. The carrying out of progress reviews on an approximate three-monthly basis was suggested for staff members who change roles or jobs.

Meetings
The importance of meetings for staff in new roles or jobs was highlighted from a number of different perspectives. For instance, ‘initial/orientation’ meetings were suggested in order to outline new or revised roles and responsibilities. Furthermore, ‘regular’, ‘formal’, and/or ‘face-to-face’ meetings with line managers in particular were discussed as important in aiding staff who move roles or jobs, while staff, peer and team meetings were also mentioned.

Views on supports for staff when changing jobs
The importance of supporting staff when they move jobs within the organisation has significant cultural dimensions. As staff move between jobs and locations, their exposure to the different subcultures that exist is a factor which can assist or impede their early integration into new teams. Staff have identified above a number of ways in which the key aspects of organisational and personal effectiveness can be continually improved from their own learning and experience. These insights provide valuable information to strengthen existing processes at all levels of the organisation.

Training and development
From an organisational perspective, the survey sought to ascertain opinions of the effectiveness and practical relevance of training and development processes within the NEHB in terms of meeting service needs, encouraging teamworking, providing sufficient time for staff development, and the transferability of learning from training and development courses to staff’s work settings. Generally speaking, as is evident from Figure 30, based on those who answered this set of questions, positive feedback was given by the majority of respondents with regard to each of these issues.
The relevance of the NEHB training and development programmes from a patient or service user perspective was reinforced by the vast majority of respondents (83 per cent) who stated that such programmes are targeted to meet service needs. Given the strong emphasis by the organisation on teamworking as a collaborative way of working, it was reassuring to find that more than three out of four respondents (76 per cent) agreed that the organisation’s training and development programmes encourage this approach to working.

From a personal learning perspective, the extent to which appropriate opportunities are made available to staff to develop their knowledge influences job satisfaction levels. The findings in this regard were generally positive, with almost three-quarters of respondents (73 per cent) agreeing that within the NEHB generally, staff are allowed time away from their daily jobs to develop their skills and knowledge. The practical benefits of the training and development courses were reinforced by more than two out of three respondents (67 per cent) who agreed that within the NEHB, opportunities are created to apply the learning from these courses to one’s work setting.

**Part II: Subcultural analysis of the research data**

Chi-square analysis of Questions 39, 41 and 44 in Section G – Continuous improvement and development – was conducted. The ‘don’t know’ values were excluded in this analysis since they were relatively low. Overall, the number of significant differences was particularly high when analysed according to respondents’ staff groups, indicating important differences of opinion among those from the various occupational backgrounds. On the other hand, there were noticeably fewer
significant differences found on the basis of respondents’ reported levels of direct patient/service user contact. A pattern revealing several significant differences among respondents from the four different service areas, namely acute hospital services, community services, regional services and head office is outlined.

Analysis by staff group

As mentioned above, clear divergences of opinion were found among respondents from the five staff groups with regard to their views concerning various continuous improvement and development issues. For instance, the ratings of progress made by the NEHB regarding several issues such as the levels of satisfaction with personal learning and development, and some aspects of training and development, all revealed noteworthy variation on the basis of respondents’ staff group. In line with the evident trend in the previous chapters, the data revealed significantly more negative and dissatisfactory views among Medical/Dental respondents in comparison with the other occupational categories in relation to most of these items. An analysis of the general patterns which emerged in relation to each staff group shall now be presented.

Allied Health Professional

Generally speaking, the views of respondents from this staff group with regard to issues concerning continuous improvement and development did not tend to vary significantly from the overall organisational findings as discussed in Part I. However, where this group did differ from the general findings, they were found to be mainly more positive and satisfied. Some particular findings are of note in this regard. First, the Allied Health Professional group, alongside both Management/Administrative and Nursing respondents, rated progress by the NEHB with regard to learning and development opportunities higher on average (p<.000), compared to those from Medical/Dental and Support Services groups.

Allied Health Professional respondents also rated progress made by the NEHB in recent years in terms of communicating with staff significantly higher than those from the other staff groups (p<.003). Furthermore, the Allied Health Professional respondents were the most satisfied, in comparison with the other staff groups, with opportunities both to discuss learning and development needs with their line managers (p<.009) and to participate in a personal or professional planning process (p<.036). These survey participants were also found to be most in agreement that training and development programmes are targeted to meet service needs (p<.001) and staff are allowed time away from their jobs to develop their skills and knowledge (p<.045). On the other hand, alongside Medical/Dental colleagues, the Allied Health Professional group were more dissatisfied on average with the extent to which local knowledge and feedback is acted upon to bring about service improvements (p<.001).
Management/Administration

In a similar manner to the above-mentioned trend among the Allied Health Professional respondents, the chi-square analysis by staff group indicated that where Management/Administrative respondents differed significantly from the overall organisational findings, they tended to be significantly more positive and satisfied. For instance, progress levels made by the organisation in terms of staff involvement in service planning ($p<.000$), learning and development opportunities ($p<.000$), and devolving authority and responsibility to local levels and front-line staff ($p<.050$) were rated highest by those working in Management/Administrative posts, in contrast to the other staff groups. These respondents, in conjunction with those from Support Services, also rated progress made regarding joint working between NEHB services more positively on average ($p<.042$).

Management/Administrative and Allied Health Professional respondents, as mentioned above, were found to be significantly more in agreement that training and development programmes are targeted to meet service needs ($p<.001$) and that staff are allowed time away from their daily jobs to develop their skills and knowledge ($p<.045$). In contrast to the other staff groups, those in the Management/Administrative staff group were significantly more likely to agree that teamworking is encouraged by the organisation’s training and development programmes ($p<.050$).

Medical/Dental

As mentioned earlier, respondents from this staff group tended to be the most dissatisfied on average with several of the continuous learning and development elements pertaining to the NEHB. For instance, the Medical/Dental staff group gave significantly lower ratings regarding the level of progress made by the NEHB in recent years in terms of staff involvement in service planning ($p<.000$), the sharing of good practice(s) among staff and services ($p<.050$), the devolution of authority and responsibility to local levels and front-line staff ($p<.050$), the facilitation of teamworking ($p<.007$), communicating with staff ($p<.003$), and joint working between the organisation’s services ($p<.042$).

In conjunction with Support Service respondents, they also gave broadly similar low ratings of progress on learning and development opportunities ($p<.000$). Moreover, Medical/Dental respondents were the most dissatisfied of the five staff group categories with the extent to which local knowledge and feedback is acted upon to bring about service improvements ($p<.001$), with opportunities to discuss their learning and development needs with their line managers ($p<.009$), and with opportunities to participate in a personal/professional development planning process ($p<.036$).
Medical/Dental respondents, alongside those from Support Services, had equally negative opinions on whether training and development programmes are targeted to meet service needs (p<.001) and whether staff are allowed time away from their daily jobs to develop skills and knowledge (p<.045). Those from the Medical/Dental staff group were also found to be in least agreement that teamworking is encouraged by the organisation’s training and development programmes (p<.050).

**Nursing**

By and large, this occupational group was found to differ least in terms of its broad opinions of various learning, development and improvement aspects regarding the NEHB. Nonetheless, a small number of significant differences were found. This group, alongside Management/Administrative and Allied Health Professional respondents, rated progress by the NEHB with regard to learning and development opportunities higher on average (p<.000). Nursing respondents gave the most positive ratings of progress made by the organisation in sharing good practice(s) among staff and services (p<.050) and facilitating teamworking (p<.007). Alongside Management/Administrative respondents, respondents from the Nursing staff group agreed more than respondents from the other staff groups that the NEHB’s training and development programmes encourage teamworking (p<.050).

**Support Services**

A number of significant differences were found among this staff group in comparison with the other staff groups in terms of their responses to various questions pertaining to the subject of continuous learning and development. For instance, this staff group rated organisational progress on staff learning and development the lowest of all the staff groups (p<.000). Alongside Medical/Dental respondents, it is also noteworthy that those from Support Services rated progress made over recent years by the NEHB with regard to staff involvement in service planning (p<.000), sharing of good practice(s) among staff and services (p<.050), facilitating teamworking (p<.007) and communicating with staff (p<.003) significantly lower on average than the ratings given by the other staff groups. However, Support Service respondents gave the highest proportionate rating of progress made regarding joint working between the NEHB services (p<.042), and this group was significantly more satisfied on average regarding the extent to which local knowledge and feedback is acted upon to bring about service improvements (p<.001).

This staff group had broadly similar views to those of the Medical/Dental respondents in terms of their higher-than-average level of dissatisfaction with opportunities to participate in a personal or professional development process (p<.036), their equally negative opinions of the organisation’s training and
development programmes meeting service needs (p<.001), and their disagreement that staff are allowed time away from their daily jobs to develop their skills and knowledge (p<.045).

**Analysis by level of direct patient/service user contact**

Considerably less significant variation was found regarding the responses to the set of questions pertaining to continuous improvement and development when analysed according to respondents’ level of direct front-line contact, in contrast to that found when examined by the five staff groups as outlined above. Nevertheless, in line with the general pattern which has been reflected in the previous chapters of this report, the significant differences which were revealed demonstrated the generally less positive and more dissatisfactory opinions among those whose jobs involve the greatest levels of direct patient/service user contact.

For example, respondents whose jobs involved the lowest levels of direct patient/service user contact rated significantly higher levels of progress made by the NEHB in recent years in terms of staff involvement in service planning (p<.000), learning and development opportunities (p<.046), and communicating with staff (p<.001), in contrast to those with the highest levels of direct front-line contact. The largest proportion of those satisfied with the organisation’s commitment to promoting a culture of quality and continuous improvement was found among those with the lowest level of direct patient/service user contact (p<.038).

**Scan by service area**

A very similar trend to that outlined in the previous chapter’s findings continues to pervade the chi-square analysis findings regarding questions in Section G – Continuous improvement and development – in terms of the significant differences among respondents based on their work areas. Once again, respondents from community services and regional services were generally significantly more positive and satisfied on average with several aspects of organisational progress, and organisational and personal learning and development, while those working in acute hospital services were predominantly the least positive and most dissatisfied. The responses of the survey participants from head office tended to vary least from the overall organisational findings.
Final remarks

It is evident from the discussion in this chapter that continuous improvement and development is a core objective for modern health and social service organisations. Factors underpinning this trend include increased expectations among patients and service users, the public, health professionals, and those in the political arena. There is also an increased emphasis on clinical effectiveness, quality and safety and a strong drive towards improved access, equality of service provision and improved responsiveness. Reducing inefficiencies and costs is also high on the agenda of health service reforms (Shaw and Kalo, 2002; Schweiger, 2001).

The major rationale underpinning the unprecedented level of change currently taking place within the Irish health system is to improve the overall quality of care and standard of services which are available and provided to patients, clients and the public generally. The reforms set out to establish a single, integrated system of service planning and delivery based on a national rather than regional focus (Department of Health and Children, 2001, 2003). The next chapter shall examine the survey participants' views of the significant reforms currently taking place within the Irish health services, as well as their main concerns and the main supports required in order to facilitate the implementation of such large-scale change.
Chapter 11

National reforms of the Irish health service
Chapter 11 – National reforms of the Irish health service

As discussed in some detail in Chapter 4 and alluded to at various points throughout this report, the Irish health system is currently undergoing a period of radical transformation. It is over 30 years since such extensive reform took place within the Irish health sector. A highly significant impetus for the current reforms was the national health strategy, *Quality and Fairness: A Health System for You* (2001), which contended that a combination of structural, managerial and cultural change was required in order to successfully achieve the four national goals, namely better health, fair access, responsive and appropriate care delivery, and high performance. It pointed out that organisational structures must be geared to providing a responsive, adaptable health system which meets the needs of the population effectively and at an affordable cost.

In order to achieve its goals, *Quality and Fairness: A Health System for You* (2001) discussed the revised roles and core responsibilities of both existing and new health service bodies, including the Department of Health and Children, the Health Service Executive (HSE), the Health Information and Quality Authority, the health boards, the Health Boards Executive (HeBE) and the Office for Health Management. It also announced that an audit of organisational structures and functions in the health system would take place.

Subsequently, in early 2003 two Government-commissioned reports were published, namely an *Audit of Structures and Functions in the Health System* by Prospectus and the *Commission on Financial Management and Control Systems in the Health Service* by the Brennan Commission. Each of these reports comprised an in-depth examination and critique of the major structures and management of the Irish health services and made substantial recommendations for change and improvements in this regard. The core components of the *Health Service Reform Programme* published by the Department of Health and Children in June 2003 were primarily influenced by the national health strategy (2001), while the various conclusions and recommendations of the two above-mentioned commissioned reports have also shaped the reform programme.

The core structural and managerial elements of the health reforms contained within the Health Act, 2004 included the establishment of the HSE. The original plan for the establishment of the HSE outlined three directorates, namely a National Hospitals Office, a Primary, Community and Continuing Care (PCCC) Directorate, and a National Shared Services Centre. A major structural element of the health

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8 This plan did not comprise the finalised HSE structure since, at the time of writing this report, further consideration of structures was under consideration at national level. See http://www.hse.ie/en/AboutUs/OurStructure/
The stated governmental aims of the reform programme are to provide better patient care, better value for money and better management. The reforms imply the necessity for significant cultural adjustments within the current Irish health system alongside structural and managerial change in order to achieve the stated aims and priorities associated with this reform process. Unless cultural change occurs alongside structural and managerial change, in reality, organisational change will be rhetorical and will have little meaning and impact on health services generally, patients, service users and the general public, and health service staff.

It is recognised in the relevant literature that the successful achievement of large-scale systemic and organisational change is a challenging endeavour. Resistance to change is particularly challenging (Bennis, 1987; Cornell, 1996; Trader-Leigh, 2002). Moreover, the difficulties and challenges associated with achieving real and successful organisational change, both generally (Beer and Nohria, 2000; Beer et al, 1990; Pettigrew et al, 1992) and within health care systems more specifically (Davies, 2001; Casebeer and Hannah, 1998; Garside, 1998; Scott et al, 2003b), are widely recognised.

Cognisance of organisational members experiencing such radical change and the need for effective management and leadership in supporting all those affected by change is of central importance, as outlined in Chapter 4. It follows that the degree to which the main purposes of large-scale change and organisational reform taking place in the Irish health system are accepted by health service staff in turn has consequences for the attainment of their support. Cooperation, acceptance and ultimately implementation of the changes associated with the national reforms are dependent on the confidence and positive attitude on the part of health service staff, and a supportive environment for those who are required to implement the changes.

Consequently, it is important that those responsible for leading, managing and implementing change are aware of staff members' views and possible concerns in relation to change. It is also important that they have the ability to understand and
pre-empt withdrawal and/or resistance to change. This requires particular consideration of the most appropriate ways to gain organisation-wide support for change across different staff groups and work areas. Therefore, it was considered a unique and timely opportunity to gather the opinions of the NEHB survey participants in relation to their views of the significant structural and managerial changes associated with the reform process, and assess their main personal concerns and desired sources of supports during this time of unprecedented change. In interpreting the findings contained within this chapter, it is important to note that respondents were asked for their opinions on various aspects of the health reforms in June 2004, during the early stages of the change process.

**Part I: Overall organisation cultural findings**

**Underlying rationale for health services reform**

Staff were asked to rate what they considered to be the three main purposes of the national health service reforms. As Figure 31 demonstrates, among those who answered this question, ‘improving the quality of health services through reducing waiting lists, improving access, better clinical quality, increasing standardisation and so on’, was considered by the largest proportion of respondents as the main reason for the reforms, with more than two out of three selecting this option (65 per cent). Almost identical proportions of staff listed improving the management of the health services by increasing accountability and performance (57 per cent) and improving efficiency and/or value for money (56 per cent) as the next most important reasons for the reforms. In consequence, there appears to be congruence between the main officially stated aims of the national reforms outlined above and those identified by the NEHB survey respondents.

**Figure 31: Main purposes of the national health reforms (Q45)**
Outcome of the health service reforms for the general public

From an outcome perspective, a pivotal question is whether the reforms will lead to a better health service for the general public. Contrasting views were expressed among those who answered this question. Since the reforms were in the initial stages when this survey was conducted, it is not surprising to find that a substantial proportion of respondents (43 per cent) stated that they did not know if the national reforms would lead to a better health service for the general public. Of those who did have an opinion, views were more optimistic than pessimistic, with 37 per cent believing that the reforms would lead to an improved health service, compared to one in five (20 per cent) who believed they would not.

**Figure 32: Will the national reforms lead to a better health service for the general public? (Q46)**

As the significant health service reforms continue to be implemented, an important monitoring task will be to gauge the opinions of health service staff on the perceived outcomes of these changes for patients, service users and the public generally. It is likely that positive opinions among health service staff are likely to be correlated with cooperation and support by such staff in implementing the necessary changes and vice versa.

Structural change

The national Health Service Reform Programme (2003) has resulted in extensive change in the structure of the Irish health service. This change process has made provision for the executive management of the health system outside the Department of Health and Children via the establishment of the HSE. The rationale outlined for the restructuring was the development of a uniform management structure with a consistent set of national priorities, and the significant clarification of reporting relationships within the system, including increased clarity regarding levels of responsibility and accountability.
Respondents were asked a series of questions in relation to opinions of the details of these various structural reforms. Since the survey findings pertaining to this set of questions revealed very similar results, average percentages were used for analysis purposes. In essence, respondents who answered this set of questions were broadly in favour of the various structural reforms listed in Figure 33, with an average of over three-fifths (61 per cent) in agreement, compared to a very small minority of 7 per cent who were in disagreement with the various health service structural reforms. A noteworthy proportion of respondents, comprising almost one-third (32 per cent), were unsure, indicating that at the time when the survey was conducted, there was considerable uncertainty about the reforms.

**Figure 33: Views regarding structural reforms within the Irish health system (Q47)**

<table>
<thead>
<tr>
<th>Reform</th>
<th>% Agree/Strongly agree</th>
<th>% Disagree/Strongly disagree</th>
<th>% Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishing two service pillars: Acute Hospital Services and Primary, Community and Continuing Care (n=629)</td>
<td>59</td>
<td>29</td>
<td>12</td>
</tr>
<tr>
<td>Establishing a National Hospitals’ Office (n=628)</td>
<td>64</td>
<td>30</td>
<td>6</td>
</tr>
<tr>
<td>Developing shared services, e.g. IT, HR, Finance (n=622)</td>
<td>66</td>
<td>30</td>
<td>4</td>
</tr>
<tr>
<td>Establishing the Health Service Executive (n=628)</td>
<td>60</td>
<td>33</td>
<td>7</td>
</tr>
<tr>
<td>Restructuring of the 10 Health Boards and the Eastern Regional Health Authority (n=632)</td>
<td>58</td>
<td>36</td>
<td>6</td>
</tr>
</tbody>
</table>

**Personal concerns arising from the reforms**

Given the unprecedented scale and scope of the health service reforms, it is not surprising that increased levels of uncertainty and anxiety ensue at individual level among staff as a result of such large-scale change, as discussed in Chapter 4. A major change management dilemma identified by Pettigrew et al (1992) is the creation of both zones of disturbance and zones of comfort in order to stimulate change while simultaneously maintaining the necessary support for change. The large-scale reforms taking place within the Irish health system have direct personal implications for those working in the health services. It follows that this survey sought to examine the human aspects of such change in terms of respondents’ principal concerns. The survey participants were asked to identify three main personal concerns associated with the health reforms, the results of which are outlined in Figure 34.
Among those who answered this question, the three most frequently cited concerns were a change in work conditions (38 per cent), increased workloads (35 per cent) and the possibility of job relocation (31 per cent). Only a small minority of survey participants (15 per cent) reported having no personal concerns about the reforms.

It is evident therefore that the health reforms constitute a significant period of change and upheaval for most respondents. In assisting staff through the transition period, organisational leaders and managers must be aware that the changes will not affect all staff similarly (Garside, 1998). Rather, differences are likely to be dependent on such aspects as one's role, work background, profession, hierarchical level, age, number of years of service and so on.

Furthermore, reference has been made earlier in Chapter 4 to the importance of implementing organisational change on a systems-based approach which utilises both top-down and bottom-up, locally based inputs, approaches and strategies, thereby acknowledging the divergent implications of change for different organisational levels, sections and staff (see Pettigrew et al, 1992; Davies et al, 2000; Beer et al, 1990).

Principal sources of support regarding the reforms

In addition to having knowledge of the types of anxieties which staff have in relation to the health service reforms, it is also important to know what are the likely sources from which staff will seek support in dealing with the various changes. This survey asked respondents to identify the principal sources from which
they would seek most support during the period of change associated with the health reforms.

**Figure 35: Main sources of support for staff in relation to changes associated with the national health reforms (Q49)**

As Figure 35 clearly shows, by far the most significant sources cited by over half of those who answered this question were one’s colleagues (57 per cent) and line manager (52 per cent). The concept of organisational distance (Block, 2003) is relevant in interpreting this data, highlighting the close identification with and perceived importance of one’s team and local line management rather than senior management as key sources of support for most respondents.

**Management team support for staff through significant reform and change**

The survey concluded with an open-ended question (Q50) asking respondents to indicate in what ways the NEHB corporate management team could support staff in dealing with the changes associated with the health reforms. Almost three out of four respondents (72 per cent) answered this open-ended question from which a number of clear and concise messages were gathered, as shall be outlined below. The feedback from this question is particularly relevant to the new leaders and managers of the HSE at national, area and local levels.
Information and communications

The overwhelming concentration of suggestions referred to the interlinked issues of information and communications regarding the health reforms. More specifically, as shall now be described, much of the discussion which took place with regard to these issues can be addressed under the headings of *what*, *when*, and *how*.

In relation to the *what* heading, a particular emphasis was placed on the translation by management of the implications of the changes for all staff, especially at a personal level with regard to their jobs. The need to clearly communicate the practical effects of the reforms in terms of service provision and location, and the likely impact on patients and service users was also referred to. In terms of content, it was explained that information and communication needs to be ‘accurate’, ‘specific’, ‘honest’, ‘open’, ‘ongoing’, ‘up to date’, ‘timely’, ‘readily accessible’ and ‘understandable to all’. There was a sense arising from the various replies to this open question that managers need to empathise with staff on the ground by recognising their real concerns and worries associated with the health reforms and advocate for their staff. With regard to the content of information and communications (i.e. *what*), respondents referred to a need for the corporate management team to communicate and share information regarding the details of the reforms and changes.

In terms of *when* to share information and communicate with staff with regard to the reform process, respondents indicated a desire for ‘continual’, ‘ongoing’, and ‘regular’ communications and information. It was noted that a predicting-the-future scenario is not possible as changes and decisions arising from the reform process are continually occurring but, nonetheless, respondents indicated that all information and decisions need to be readily shared with all health service staff as soon as they emerge.

Many of those who completed this question provided suggestions about *how* to communicate and inform staff as to the current health reforms. In line with the earlier finding endorsing face-to-face methods, meetings were commonly suggested by respondents. Several benefits of holding general staff meetings with regard to the reforms were highlighted, including the opportunity to disseminate information, to explain and discuss the changes and issues arising, to share staff’s concerns and anxieties, to listen to mixed points of view and to answer staff’s questions and provide clarification.

Some respondents called for ‘regular’, ‘local’ meetings so that staff at all levels, and particularly those working in front-line service-delivery positions, and those who were most likely to be directly affected by the reforms were adequately informed.
A number of respondents highlighted the two-way nature of communication, emphasising the importance for senior management to listen to staff. It was pointed out that ‘real’, ‘active’ listening by managers was needed in order to take account of the ‘views’, ‘opinions’, ‘ideas’, ‘concerns’, ‘feedback’, ‘expertise’, and ‘needs’ of all staff, while those working ‘on the ground’ and at ‘the front line’ were specifically mentioned. In addition, it was noted by several respondents that listening alone was insufficient unless it was accompanied by appropriate responses and actions.

**Planning for change**

Interconnected with communications regarding such change, was the need identified by some respondents for the corporate management team to engage in the development of proper and realistic plans in consultation with staff. It was explained that such plans should establish how the changes associated with the reforms will be translated and implemented within the organisation and need to be backed up with contingency plans where problems arise.

**Support**

The issue of support arose as another theme. While some mentioned support per se, others referred to the need for the development of a staff support ‘network’, ‘system’ or ‘forum’ through which staff affected by the reforms could access the necessary assistance as required. For instance, those with new or additional roles, staff on the ground and local managers were identified in this context. It was pointed out that more training and development for some staff would be required, in particular arising from the new demands, additional skills, and job relocations associated with the changes. The alleviation of staffing shortages at the front line was also highlighted as a means of the corporate management team supporting staff.

**Visibility and accessibility**

Issues regarding the need for improved visibility and accessibility of corporate management were discussed. It was suggested for instance that the management team should hold meetings and information sessions as discussed above with regard to the reforms and changes. Others explained that the management team needs to become more engaged and connected with what is happening on the ground through visits to various sites and holding discussions with all grades and levels of staff.
Part II: Subcultural analysis of the research data

The survey Questions 46 and 47 in Section H – National reforms of the Irish health service – were analysed using the chi-square test. In both cases, the ‘unsure’ values are included for analysis purposes since they were relatively high. No statistically significant differences were found among respondents when examined on the basis of staff groups, or in terms of their level of direct patient or service user contact, with regard to respondents’ opinions of whether the health service reforms are likely to lead to a better service for the general public. The only statistically significant differences found on the basis of respondents’ staff group (p<.003) and level of direct front-line contact (p<.001) were with regard to the levels of agreement with the establishment of the two separate service pillars for acute hospital services on the one hand, and primary, community and continuing care on the other. A similarly significant difference was found on the basis of where respondents worked.

Analysis by staff group

Allied Health Professional
The views of those from the Allied Health Professions were most in line with the overall organisational findings pertaining to the separate service pillar question, outlined in Part I above.

Management/Administration
Those working in Management/Administrative posts disagreed most with the structural reform entailing the creation of two separate service pillars, in comparison to those from the other staff groups.

Medical/Dental
After the Management/Administrative staff group, the Medical/Dental staff group was found to be the next group which disagreed most with the creation of two separate service pillars.

Nursing
Respondents in the Nursing staff group had the highest level of agreement with the establishment of the two separate service pillars.

Support Services
Support Service survey participants were also more positive on average in this regard.
Analysis by level of direct patient/service user contact
Those whose work involved very high levels of direct patient/service user contact were found to be in most agreement with the establishment of the two-pillar structure for acute hospital services and primary, community and continuing care, compared to those with little or no direct front-line contact who had the highest levels of disagreement with this development.

Scan by service area
Those survey participants working in community services, followed by acute hospital services, were significantly more in agreement with the development of two separate service pillars, while respondents working in head office disagreed to a significantly greater extent, and those working in regional services were most unsure about this structural reform.

Final remarks
The unprecedented changes currently taking place in the Irish health system highlight the necessity for significant cultural adjustments alongside structural and managerial changes in order to achieve the stated aims and priorities associated with the reforms, and thereby lead to improved health services for patients, service users, the general public and health service staff. The information provided in this chapter enhances our understanding of the general perceptions of the NEHB survey participants with regard to the current health reforms and, more specifically, highlights areas of personal concern and the factors considered necessary to support staff in dealing with change. The perceptions and concerns of health service staff, and the supports needed, will continually change as the reforms enter new phases. The information provided will, however, assist in planning appropriate engagement with staff throughout the ongoing implementation of the reform process.
Chapter 12

Conclusion
Chapter 12 – Conclusion

This research report has provided a benchmark of the main cultural components of the former NEHB organisation at a point in time, namely June 2004, as described by 46 per cent of the survey participants. This research process therefore provided staff with a direct opportunity to share their views and experiences of the main cultural characteristics within the NEHB. Such participation and engagement is important since the centrality of health service staff to the accomplishment of organisational and cultural change in the health system is paramount.

One of the core purposes of this research was to highlight the importance of organisation cultural understanding in relation to the facilitation of organisation cultural change. The report provides valuable cultural information for the newly formed HSE Dublin North East. It is particularly relevant considering the complexity of the rapidly changing environmental context of health services at national and area levels.

More specifically, this research has focused on the significant cultural changes required in order to adapt to the provisions of the Health Service Reform Programme (2003) and the emerging new structural and cultural environment of the reforms. Given the dearth of organisational cultural analysis across Irish health service organisations and the unprecedented changes currently taking place within the health sector, it is envisaged that the findings from the cultural analysis of one former Irish health service organisation may stimulate comparative research in the other HSE regions.

Research frames of reference

This research has utilised a number of interrelated frames of reference, including an open systems environmental perspective, a systems approach and an OD approach to organisational change. The research is underpinned by an open systems perspective which has contextualised the concept of organisational culture and organisation cultural change in relation to the wider environment of contemporary health care organisations. It has suggested that such environmental monitoring and learning comprises a vital task for organisational leaders in terms of competently managing and implementing change. The major influencers and shapers of this external and internal environmental change directly affecting the former NEHB, now the HSE Dublin North East, have been detailed, particularly in terms of the Irish Government’s Health Service Reform Programme (2003), and AHSPNE (2003).

A critical issue is how to effectively manage such change in order to successfully achieve the desired future vision of improved health care provision across Irish health
services generally and within the context of the newly formed HSE regions. We know from the relevant literature that organisations must understand their cultures to appropriately respond to the significant demands, changes, trends and developments in both their internal and external environments. From a systems perspective, the pivotal role of organisational culture and the need for cultural adaptation alongside other core organisational dimensions, such as strategy, structure, policy and so on, in affecting organisational change has been well documented.

This research report has also been influenced by an OD perspective which explicitly recognises the importance of the softer cultural and human aspects with regard to organisational change. It also takes a holistic view of organisational change which is cognisant of the interconnections between the various core dimensions of organisations, such as structure, strategy, policy, process, human resources and culture, and so on. It also recognises the requirement for integrated organisation-wide, sustainable change rather than fragmentary programmatic change.

**Dual analysis of organisational culture**

The changes and developments which have been outlined in both the external and internal environment of the NEHB are based on achieving the vision of a better health service. This research report therefore provides organisation cultural data which may be used as a baseline for the HSE Dublin North East in its accomplishment of the core objectives and actions in line with the HSE corporate priorities. The quantitative nature of this research study has provided useful indications of key cultural dimensions upon which to base more in-depth analysis.

In recognition of the complexity and diversity of organisational culture, this report describes the culture of the NEHB in a twofold manner. First, the overarching organisational culture is outlined as described by the survey participants as a whole, and secondly, the organisational culture is described on the basis of subcultural groupings within the organisation. This dual perspective of organisation cultural analysis is beneficial and the learning from these research findings may be utilised in effectively managing and implementing the cultural aspects of organisational change.

**Overall organisation cultural findings**

At the broad level, the research findings revealed elements perceived by respondents to be working well, and aspects in need of change and improvement, with regard to several key organisational cultural dimensions, including staff and consumer orientation; communication and information-sharing processes; strategic direction, leadership and management; accountability and performance; integration and teamworking; and continuous improvement and development. One of the key messages from this research study was the important role of the local
team/unit/service in terms of providing the main reference point and sense of identity for staff, and influencing their perceptions and opinions. For instance, at local level, generally positive interpersonal working relations with respondents’ work colleagues, peers, team members and line managers were described.

The data revealed broad satisfaction with local management regarding several core tasks and behaviours, while also highlighting areas requiring change and improvement at this managerial level. A noteworthy dissonance from the ‘corporate’ or ‘organisational’ level was found. Respondents reported relatively low levels of satisfaction regarding a diverse set of core leadership and corporate or senior management roles and responsibilities, and suggested the requirement for several key competencies and skills for leaders.

The research findings point towards the need for improved organisational performance in relation to several key areas such as:

- Staff orientation and support.
- Decision-making processes.
- Resource utilisation, evidence, best practice and research usage.
- Openness and transparency.
- Conflict management.
- Organisational learning, personal learning.
- Induction.
- Promotional processes and opportunities.
- Staffing and workload issues.
- Organisational flexibility.
- Environmental monitoring and assessment.
- Implementation and action taking.
- Performance measurement at the organisational, team and individual level.
- Communications and information-sharing processes at corporate and local management levels.

This data reinforces the importance of improving such processes, particularly given the current state of change taking place within the organisation as a result of the health service reforms.

Partnership working by the NEHB with core external stakeholders such as patients and service users, families and community groups in the planning and evaluation of services appears to be developing well in different parts of the organisation. While the detail of this engagement or its stage of development could not be determined from this research, it is possible to suggest that there is significant scope for the advancement of such engagement. Joint working at local level between the areas where respondents worked and other internal services and external agencies,
organisations and bodies was regarded as working relatively well. However, scope for improvement was also evident nonetheless in terms of collaborative working both at local and organisational levels.

The research findings highlighted the need for greater connectivity between the front-line, service-intensive parts of the organisation and the Management/Administrative sections of the organisation. Teamworking featured strongly within the NEHB and various core aspects of this way of working were perceived positively. The need for increased teamworking in some areas and more specifically the need for more multi-disciplinary teamworking were highlighted. Generally speaking, staff training and development programmes and opportunities were positively rated. The research data also provided details regarding the core personal concerns and supports required for staff in dealing with the major organisational changes arising from the national health service reforms.

**Organisational subcultural findings**
In addition to the overarching organisational culture of the NEHB, the research report has outlined various subcultural components within the organisation, based on a more detailed analysis of the research findings according to respondents’ staff groups, level of direct patient/service user contact, and the service area in which they worked. This data is therefore pertinent in uncovering divergences from the overarching organisational culture among particular groupings of staff.

Hence, the subcultural analysis is valuable in terms of understanding areas where possible challenges and resistance to organisational change could be expected. For instance, broad subcultural trends revealed the existence of shared mindsets which indicated significantly higher levels of dissatisfaction with many organisational cultural aspects among Medical/Dental respondents and to a lesser extent Support Service respondents, as well as those with highest levels of direct front-line service contact and those working in acute hospital services.

In contrast, respondents from the Allied Health Professional and Management/Administration work groups, those whose work involved the lowest levels of direct front-line contact, and those working in community and regional service areas, collectively were found to be generally more positive and satisfied on the whole with various organisation cultural dimensions. The research analysis found that, in general, the views of survey participants from the Nursing group, those whose work involved medium levels of direct patient/service user contact, and those working in head office tended to reflect those of the overarching organisational
culture. In addition to these broad subcultural patterns, many distinct subcultural findings were uncovered when each of the survey questions were examined by respondents’ staff grouping, level of direct front-line contact, and service area. Hence, this subcultural frame of reference provides an intricate portrayal of the organisation’s culture which requires consideration in terms of addressing organisational change.

Areas for further research
As outlined in Chapter 2, this quantitative-based research on organisational culture could be regarded as one phase of a more intricate examination of the culture in one Irish health service organisation. Another potential phase of this research involving the use of qualitative methodologies such as interviews and/or focus groups would uncover deeper subtleties of culture, such as values and assumptions, which shape the character of an organisation.

Some of the findings arising from the survey also raise questions which require further research in order to uncover a more precise portrayal of overarching cultural characteristics, for instance:

- The findings pose questions as to how to address effectively the significant dissonance found among respondents working primarily in the front line, in medical and clinical positions, and in hospital services.
- The data points towards the need for more in-depth examination of the participation and involvement of external stakeholders in planning and evaluating the services provided by the organisation.
- Further research on communications both at the organisational and local level with these core external groups would also be beneficial.
- The relatively high levels of uncertainty regarding various staff treatment and staff support issues necessitate more detailed exploration.
- The findings point to the requirement for more detailed examination of the performance of the organisation generally, and organisational leadership and senior management specifically.
- The research data also raises questions as to the levels of understanding and development of organisational, team and individual performance measures.
- Addressing the issue of the perceived organisational distance between higher-level management/leadership and staff in the organisation comprises another area requiring further attention.
Application of the research findings to the broader HSE context

These research findings contain significant implications for work and cultural practices within the HSE Dublin North East. Although it is recognised that the original data was gathered in respect of one health board area – the former NEHB, it is acknowledged that there is an opportunity to consider how the findings and implications of the results could be applied in a broader context to the newly merged area and indeed to the HSE at a national level.

Final comments

This research report constitutes a significant and rich body of knowledge regarding the cultural dimensions of one Irish health service organisation. It provides significant and valuable information that will assist the leadership of the HSE at national, area and local levels. A developed understanding of the findings will guide decision makers regarding the future development of a health service that places service users at the centre, improves the working experience for staff and delivers value for money.
References
References


An exploration of culture in one Irish health service organisation


An exploration of culture in one Irish health service organisation


Appendices
All information in this questionnaire is confidential and anonymous. Only the researcher will have access to the information and no individual responses will be identifiable in the final report.

Section A: Personal Details

Q1 Please indicate in which of the following staff groups/grades you are currently employed:

### Allied Health Professional (Please Tick \checkmark one under both Grade and Group)

<table>
<thead>
<tr>
<th>Grade (Tick \checkmark one):</th>
<th>Basic Grade</th>
<th>Senior</th>
<th>Principal/Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group (Tick \checkmark one):</td>
<td>Childcare Worker/Leader</td>
<td>Psychologist</td>
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</tr>
<tr>
<td></td>
<td>Environmental Health Officer</td>
<td>Radiographer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical Scientist</td>
<td>Social Worker</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>Speech and Language Therapist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physiotherapist</td>
<td>Other (please specify)</td>
<td></td>
</tr>
</tbody>
</table>

### Management/Administration (Tick \checkmark one)

| Grade 3, 4, 5 | CEO/Assistant CEO/ |
| Grade 6, 7, 8 | General Manager/Director |
| Community Welfare Officer | Other (please specify) |

### Medical/Dental (Tick \checkmark one)

| Consultant | Dental Surgeon |
| Registrar | Dental Surgery Assistant |
| House Officer | Other (please specify) |

### Nursing (Please Tick \checkmark one under both Grade and Group)

| Grade (Tick \checkmark one): | Staff Nurse | Director/Assistant Director of Nursing |
| Staff Nurse Manager 1,2,3 | Clinical Nurse Specialist | |
| Student Nurse | Clinical Nurse Specialist | Other (please specify) |

| Group in which you currently work: (Tick \checkmark one) | General Nursing | Psychiatric Nursing |
| Public Health Nursing | Mental Handicap Nursing |
| Midwifery | Other (please specify) |

### Support Services (Tick \checkmark one)

| Attendant/Aide | Emergency Medical Technician/Ambulance |
| Care Assistant | Maintenance/Caretaking |
| Catering/Cleaning | Porter |
| Chef | Other (please specify) |

Q2 Please state the service area where you work: (Tick \checkmark one)

| Acute Hospital Services | Services for Children and Families |
| Primary Care | Disability Services |
| Mental Health Services | Services for Older People |
| Health Promotion | Other Community Services |
| Ambulance Services | Other (please specify) |
| Head Office, Kells | |
Q3 In which area is your work based: (Tick one)

- Cavan
- Meath
- Louth – Ardee
- Monaghan
- Louth – Drogheda
- Regional brief
- Louth – Dundalk

Q4 How many years have you worked in the North Eastern Health Board (NEHB)? _______________

Q5 How many months/years have you worked in your current position? ________________________

Q6 Is your job: (Tick two)

- Permanent
- Temporary
- Full-time
- Part-time
- Contract basis
- Job-share

Q7 Are you: Male Female

Q8 Please indicate your age bracket:

- 25 years or less
- 36-45 years
- 56 years or over
- 26-35 years
- 46-55 years

Q9 Approximately what percentage of your working time involves direct contact with patients/service users? _______________

Section B People Orientation

Q10 Please indicate your views on how staff are treated in the North Eastern Health Board:

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Unsure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employees are treated with respect,</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>regardless of their job</td>
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<tr>
<td>Equal opportunities for all employees</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>are promoted</td>
<td></td>
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<tr>
<td>Decisions concerning employees are</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>usually fair</td>
<td></td>
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<tr>
<td>The NEHB takes an inclusive approach</td>
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<tr>
<td>that respects difference</td>
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<td></td>
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<tr>
<td>In general the NEHB is an open/</td>
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<tr>
<td>transparent organisation</td>
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</tr>
<tr>
<td>It is safe to speak my mind in the NEHB</td>
<td></td>
<td></td>
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<tr>
<td>Induction/orientation for new staff</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>members is adequate</td>
<td></td>
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</tbody>
</table>

Q11 Please identify the three most positive aspects of working in the NEHB:

1. ___________________________________________________________________________________________

2. ___________________________________________________________________________________________

3. ___________________________________________________________________________________________

Q12 Please identify the three most negative aspects of working in the NEHB which require improvement:

1. ___________________________________________________________________________________________

2. ___________________________________________________________________________________________

3. ___________________________________________________________________________________________
Q13 Please indicate your level of job satisfaction with the following items where you work:

<table>
<thead>
<tr>
<th>Item</th>
<th>Very satisfied</th>
<th>Satisfied</th>
<th>Fairly satisfied</th>
<th>Dissatisfied</th>
<th>Very dissatisfied</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>The broad content of your job</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Your working conditions</td>
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<tr>
<td>The general atmosphere where you work</td>
<td></td>
<td></td>
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<tr>
<td>The level of challenge/motivation associated with your job</td>
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<tr>
<td>Your promotional opportunities</td>
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<tr>
<td>The reporting relationship with your line manager</td>
<td></td>
<td></td>
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<tr>
<td>Guidance and support from your line manager regarding your work</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>The extent to which your suggestions are listened to and responded to</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>The way in which conflict is dealt with</td>
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<tr>
<td>Your working relationship with colleagues</td>
<td></td>
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<tr>
<td>Recognition of your work contribution</td>
<td></td>
<td></td>
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</tbody>
</table>

Q14 How would you rate the overall level of:

<table>
<thead>
<tr>
<th>Item</th>
<th>Very high</th>
<th>High</th>
<th>Moderate</th>
<th>Low</th>
<th>Very low</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee commitment in the NEHB (i.e. identification with and involvement in the organisation)</td>
<td></td>
<td></td>
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<tr>
<td>Employee commitment where you work</td>
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</tr>
<tr>
<td>Level of staff pride to work in the NEHB</td>
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</tr>
<tr>
<td>Level of staff pride to work in your service area</td>
<td></td>
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<td></td>
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<tr>
<td>Staff morale where you work</td>
<td></td>
<td></td>
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</tbody>
</table>

Q15 Does the unit/department/service in which you work involve:

<table>
<thead>
<tr>
<th>Service</th>
<th>In planning services</th>
<th>In evaluating services</th>
<th>Don’t know</th>
<th>N/A*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients/service users</td>
<td>Yes [ ] No [ ]</td>
<td>Yes [ ] No [ ]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Families/carers</td>
<td>Yes [ ] No [ ]</td>
<td>Yes [ ] No [ ]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community groups</td>
<td>Yes [ ] No [ ]</td>
<td>Yes [ ] No [ ]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The general public</td>
<td>Yes [ ] No [ ]</td>
<td>Yes [ ] No [ ]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q16 Please indicate how greater involvement of patients/service users could be facilitated:

* N/A = not applicable
### Section C: Information and Communications

#### Q17 How would you rate the following:

<table>
<thead>
<tr>
<th></th>
<th>Very poor</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very good</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications received concerning key decisions/changes at NEHB corporate management team level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communications received from your local management regarding key decisions/changes which relate to your job</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Communications from your local management on key decisions/changes resulting from the service planning process</td>
<td></td>
<td></td>
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<tr>
<td>Gaining access to the information you need to conduct your work</td>
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<tr>
<td>The timeliness of this information</td>
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</tbody>
</table>

#### Q18 How would you rate communications between:

<table>
<thead>
<tr>
<th></th>
<th>Very poor</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very good</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff within your service area</td>
<td></td>
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<tr>
<td>Your team colleagues</td>
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<td></td>
</tr>
<tr>
<td>You and your line manager</td>
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<tr>
<td>Your service and other services in the NEHB</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>From the ‘top-down’, i.e. corporate management to local management to staff ‘on the ground’</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>From the ‘bottom-up’, i.e. staff ‘on the ground’ to local management to corporate management</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

#### Q19 Please select the three methods of information sharing and communications which you find most effective in your work setting: (Tick □ three)

- Notice boards
- Telephone
- E-mail/intranet
- Formal written communications, e.g. memos, reports, etc.
- Staff magazine
- Face-to-face meetings
- Teleconferences
- Other □ (please specify)

#### Q20 The three most important sources of information for me in my work are: (Tick □ three)

- My line manager
- My work colleagues
- NEHB corporate management
- The grapevine
- My occupational/professional grouping
- Senior clinical management
- Local management
- Media (e.g. newspaper, radio, TV)
- Other □ (please specify)
Q21 Please rate the NEHB generally in terms of communicating with:

<table>
<thead>
<tr>
<th>Group</th>
<th>Very Good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Very Poor</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients/service users</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Families/carers</td>
<td></td>
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<tr>
<td>Community groups</td>
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<tr>
<td>The general public</td>
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<tr>
<td>The media</td>
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<tr>
<td>Other service providers (i.e. statutory and/or voluntary health/social care agencies)</td>
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<tr>
<td>Local public representatives</td>
<td></td>
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<tr>
<td>The Department of Health and Children</td>
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<tr>
<td>Other agencies such as educational providers, local authorities, Gardai, etc.</td>
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</tr>
</tbody>
</table>

Q22 Please rate your unit/department/service in terms of communicating with:

| Group                                      | Very Good | Good | Fair | Poor | Very Poor | Don't Know | N/A |
|-------------------------------------------|-----------|------|------|------|-----------|------------|
| Patients/service users                    |           |      |      |      |           |            |
| Families/carers                           |           |      |      |      |           |            |
| Community groups                          |           |      |      |      |           |            |
| The general public                        |           |      |      |      |           |            |
| Other service providers (i.e. statutory and/or voluntary health/social care agencies) |           |      |      |      |           |            |

Q23 In broad terms, the feelings and beliefs about the NEHB that exist in the minds of the public (i.e. the NEHB’s public image) are:

<table>
<thead>
<tr>
<th>Sentiment</th>
<th>Very negative</th>
<th>Negative</th>
<th>Neutral</th>
<th>Positive</th>
<th>Very positive</th>
</tr>
</thead>
</table>

Section D Leadership and Direction

Q24 Are you aware of the NEHB’s strategic framework ‘A Health Strategy for the People of the North East (2003)’?

Yes ☐  No ☐  If no, please go to Q26

Q25 Do you think that ‘A Health Strategy for the People of the North East’ is likely over time to:

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Yes, to a large extent</th>
<th>Yes, to some degree</th>
<th>No, not in general</th>
<th>No, not at all</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide a clear sense of direction regarding how services are to be provided</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Influence the way services are planned through the service planning process</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Influence the way services are delivered</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Q26 Please indicate your level of satisfaction with the NEHB corporate management team in terms of:

<table>
<thead>
<tr>
<th>Area</th>
<th>Very satisfied</th>
<th>Satisfied</th>
<th>Fairly satisfied</th>
<th>Dissatisfied</th>
<th>Very dissatisfied</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishing key priorities for health and social services over the medium-term (i.e. the next three years)</td>
<td></td>
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<tr>
<td>Providing a sense of purpose and future direction for staff</td>
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<tr>
<td>Responding to external changes such as population trends, health and disease patterns, etc.</td>
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<tr>
<td>Visibility and accessibility across the whole organisation</td>
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<tr>
<td>Communicating with staff across the NEHB</td>
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<tr>
<td>Providing a supportive environment for staff in dealing with work challenges</td>
<td></td>
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</tr>
</tbody>
</table>

Q27 Please indicate your views concerning your local management in terms of:

<table>
<thead>
<tr>
<th>Area</th>
<th>Very satisfied</th>
<th>Satisfied</th>
<th>Fairly satisfied</th>
<th>Dissatisfied</th>
<th>Very dissatisfied</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encouraging your service to work across boundaries with other services in the NEHB</td>
<td></td>
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<tr>
<td>Encouraging staff to be innovative in terms of new/different ways of working</td>
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<tr>
<td>Supporting staff in times of crisis/difficult circumstances</td>
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<tr>
<td>Involving staff in relevant decisions/changes concerning their unit/department/service</td>
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</tbody>
</table>

Q28 Please identify the three most important competencies leaders within this organisation should possess at the moment:

1. 
2. 
3. 
### Section E: Accountability and Performance

**Q29 Please indicate your views regarding the following statements in relation to the NEHB as a whole:**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Unsure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>A culture of providing services to the public is an important motivator of staff</td>
<td></td>
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<tr>
<td>The NEHB is generally flexible, changing to meet new conditions, demands and problems as they arise</td>
<td></td>
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<tr>
<td>Available resources are used to provide the best possible service and outcomes for patients/service users</td>
<td></td>
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<tr>
<td>Evidence/best practice/research are used to guide planning, decision making and service delivery</td>
<td></td>
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<tr>
<td>The findings and recommendations of reviews and evaluations of services are generally implemented</td>
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<tr>
<td>Services are user-led, placing an emphasis on outcomes from the patient/service user perspective</td>
<td></td>
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<tr>
<td>Decision-making processes are generally open/transparency</td>
<td></td>
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<tr>
<td>The NEHB encourages its services to be flexible and responsive to local needs and demands</td>
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<tr>
<td>The NEHB promotes a culture of admitting errors and learning from mistakes</td>
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</tr>
</tbody>
</table>

**Q30 Were you involved in the 2004 Service Planning process?**

Yes [ ] No [ ]

**Q31 In relation to the area in which you work:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes, to a large extent</th>
<th>Yes, to some degree</th>
<th>No, not in general</th>
<th>No, not at all</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the service planned around the needs of patients/service users?</td>
<td></td>
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<tr>
<td>Are there clear goals and objectives guiding your service plan and your work?</td>
<td></td>
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<tr>
<td>Are the goals and objectives of your service in line with the overall direction of the NEHB?</td>
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<tr>
<td>Are services prioritised based on appropriate information/evidence?</td>
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<tr>
<td>Does the service planning process support the improvement of your service?</td>
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<tr>
<td>Are front line staff given an adequate level of decision-making authority and responsibility?</td>
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<tr>
<td>Has budgetary responsibility been adequately devolved to local managers?</td>
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<tr>
<td>Have local managers an adequate level of decision-making authority and responsibility?</td>
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</tbody>
</table>
Q32 Please rate the effectiveness of the following measures of NEHB organisational performance:

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Very poor</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Plan Targets</td>
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<tr>
<td>National Standards</td>
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<tr>
<td>Sustaining Progress – Performance Verification Process</td>
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<tr>
<td>Inspectorates, e.g. Social Services, Mental Health</td>
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<tr>
<td>Integrated Management Report</td>
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<tr>
<td>Accreditation</td>
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<tr>
<td>Other (please specify)</td>
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</tbody>
</table>

Q33 Regarding individual performance in the area in which you work:

<table>
<thead>
<tr>
<th>Are goals for your personal performance agreed with your line manager?</th>
<th>Yes, to a large extent</th>
<th>Yes, to some degree</th>
<th>No, not in general</th>
<th>No, not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your line manager provide you with a satisfactory level of feedback on your performance?</td>
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<tr>
<td>Is good performance generally recognised by your line manager?</td>
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<tr>
<td>Is poor performance dealt with appropriately by your line manager?</td>
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</tbody>
</table>

Q34 Which of the following statements most accurately reflects the way in which the NEHB is managed: (Tick one)

- Management structures and processes reinforce dependence on central corporate authority
- Management structures and processes encourage independence, responsibility and decision making at local level
- Management structures and processes facilitate an increasing balance between central and local responsibility and decision making

Section F: Integration and Teamworking

Q35 Please rate your unit/department/service in terms of joint working/collaboration with:

<table>
<thead>
<tr>
<th>Relevant units/departments/services within the NEHB</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Very poor</th>
<th>Don’t know</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relevant agencies, organisations, bodies outside the NEHB, e.g. voluntary and statutory agencies</td>
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</tbody>
</table>
**Q36** Which of the following do you consider to be the five most crucial factors facilitating joint working between units/departments/services within the NEHB: (Tick ✓ five)

- Financial/budgetary flexibility
- Common patient/client information systems (e.g. shared records, databases)
- Learning and development initiatives, i.e. team development, multidisciplinary training
- Focus on quality and continuous improvement
- Senior management support
- Appropriate organisational structures
- Clarity regarding roles, responsibilities and reporting relationships
- Dealing with power and autonomy issues among team members
- Service planning process
- Supporting staff in dealing with challenging issues that emerge in terms of joint working

**Q37** Please indicate the type of team in which you predominantly work (Tick ✓ one):

- Single discipline team (patient/service-user based)
- Management team (local/corporate)
- Multidisciplinary team (patient/service-user based)
- Not applicable
- Unit team
- Department team
- Other (please specify)

**Q38** Please rate your level of satisfaction with the following elements of the team in which you predominantly work (as indicated in Q37 above):

<table>
<thead>
<tr>
<th>Element</th>
<th>Very satisfied</th>
<th>Satisfied</th>
<th>Fairly satisfied</th>
<th>Dissatisfied</th>
<th>Very dissatisfied</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarity of purpose and common goals of the team</td>
<td></td>
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<tr>
<td>Interpersonal working relationships</td>
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<tr>
<td>Methods for resolving team problems/conflict</td>
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<tr>
<td>Clear reporting relationships</td>
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<tr>
<td>Clear work roles and responsibilities</td>
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<tr>
<td>The way the team leader manages the team</td>
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<tr>
<td>The skills mix of team members</td>
<td></td>
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<tr>
<td>Evaluation and measurement of meeting team targets</td>
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<tr>
<td>If applicable, evaluation of the team approach in terms of maximising benefits to patients/service users</td>
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</tbody>
</table>
Section G: Continuous Improvement and Development

Q39 Please rate the level of progress the NEHB has made in recent years with regard to:

<table>
<thead>
<tr>
<th>Area</th>
<th>None</th>
<th>Minimal</th>
<th>Moderate</th>
<th>High</th>
<th>Very high</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/service user involvement</td>
<td></td>
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<tr>
<td>Staff involvement in service planning</td>
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<tr>
<td>Learning and development opportunities</td>
<td></td>
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<tr>
<td>Sharing of good practice(s) among staff and services</td>
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</tr>
<tr>
<td>Devolving authority and responsibility to local level/front line staff</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilitating teamworking</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Communicating with staff</td>
<td></td>
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<tr>
<td>Joint working between NEHB services</td>
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</tbody>
</table>

Q40 What is the NEHB doing well that you would like to see more of across the organisation?
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Q41 Please indicate your views regarding the following:

<table>
<thead>
<tr>
<th>Area</th>
<th>Very satisfied</th>
<th>Satisfied</th>
<th>Fairly satisfied</th>
<th>Dissatisfied</th>
<th>Very dissatisfied</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>The NEHB’s commitment to promote a culture of quality and continuous improvement</td>
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<tr>
<td>The extent to which the NEHB learns from positive experiences and promotes good practices/ways of working</td>
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<tr>
<td>The extent to which the NEHB learns from negative experiences and applies this learning to new situations</td>
<td></td>
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</tr>
<tr>
<td>The extent to which local knowledge and feedback is acted upon to bring about improvements in services</td>
<td></td>
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</tr>
<tr>
<td>The extent to which the service in which you work gains the maximum benefit from your expertise and skills</td>
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</tr>
<tr>
<td>Opportunities to discuss your learning and development needs with your line manager</td>
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<tr>
<td>Opportunities to participate in a personal/professional development planning process</td>
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</tbody>
</table>

Q42 Please indicate the three most important sources from which you access support in relation to your personal learning and development: (Tick 3 three)

<table>
<thead>
<tr>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line manager</td>
</tr>
<tr>
<td>NEHB colleagues/peers</td>
</tr>
<tr>
<td>Human Resources</td>
</tr>
<tr>
<td>On-the-job training</td>
</tr>
<tr>
<td>Internal job rotations/placements</td>
</tr>
<tr>
<td>Informal networks/contacts</td>
</tr>
<tr>
<td>Internal training/development courses</td>
</tr>
<tr>
<td>External training/development courses</td>
</tr>
<tr>
<td>Other external supports</td>
</tr>
<tr>
<td>Other (Please specify)</td>
</tr>
</tbody>
</table>
Q43 What are the three most important ways staff who move jobs/change roles within the NEHB can be assisted in their new jobs/roles?

1
2
3

Q44 Within the NEHB generally, do you think that:

<table>
<thead>
<tr>
<th>Section H: National Reforms of the Irish Health Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>The NEHB and its staff are facing a significant level of change as a result of the national reforms of the Irish health service. Your views with regard to the implications of these changes are sought in this section.</td>
</tr>
</tbody>
</table>

Q45 What do you believe are the three main purposes of the national health reforms: (Tick ☑ three)

- To improve the management of the health services by increasing accountability and performance
- To re-organise acute hospital services
- To improve the quality of health care services through reducing waiting lists, improving access, better clinical quality, increasing standardisation, etc.
- To make the health services less bureaucratic and more responsive to needs
- For political reasons
- To improve efficiency/value for money in the health services
- To improve the working environment for health service staff

Q46 Overall, do you believe the national reforms will lead to a better health service for the general public?

Yes ☑ No ☐ Don’t know ☐

Section H: National Reforms of the Irish Health Service

The NEHB and its staff are facing a significant level of change as a result of the national reforms of the Irish health service. Your views with regard to the implications of these changes are sought in this section.

Q45 What do you believe are the three main purposes of the national health reforms: (Tick ☑ three)

- To improve the management of the health services by increasing accountability and performance
- To re-organise acute hospital services
- To improve the quality of health care services through reducing waiting lists, improving access, better clinical quality, increasing standardisation, etc.
- To make the health services less bureaucratic and more responsive to needs
- For political reasons
- To improve efficiency/value for money in the health services
- To improve the working environment for health service staff

Q46 Overall, do you believe the national reforms will lead to a better health service for the general public?

Yes ☑ No ☐ Don’t know ☐
Q47 Please indicate your views regarding structural reforms within the Irish health system in terms of:

<table>
<thead>
<tr>
<th>Structural Reforms</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Unsure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restructuring the 10 Health Boards and Eastern Regional Health Authority</td>
<td></td>
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</tr>
<tr>
<td>Establishing the Health Service Executive (HSE) responsible for the day-to-day management of the health service</td>
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<tr>
<td>Developing Shared Services (e.g. IT, Human Resources, Finance)</td>
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</tr>
<tr>
<td>Establishing a National Hospitals' Office responsible for acute hospitals</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Establishing two separate service pillars:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Acute Hospital Services, and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Primary, Community and Continuing Care</td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

Q48 What are your three main personal concerns regarding the health reforms: (Tick ☑ three)

- Job insecurity
- Change in job content
- Change in work conditions
- Change in salary/benefits
- Increased workload
- Financial implications
- Family repercussions
- Change in job content
- Job relocation
- Unit/department/service will no longer exist
- Loss of talent through staff departure
- None
- Financial implications
- Job relocation
- None
- Job relocation
- None
- Other ☐ please specify ____________________

Q49 From whom do you think you will access most support regarding the changes associated with the national health reforms? (Tick ☑ as appropriate)

- Your line manager
- Senior corporate management
- Your colleagues
- Your team
- Local management
- Other ☐ (please specify) ____________________
- Senior clinical management
- Senior clinical management
- Other ☐ (please specify) ____________________

Q50 In what ways can the NEHB corporate management team support staff in dealing with the changes associated with the health reforms?

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Thank you for taking the time to complete this questionnaire.

Please send your completed questionnaire in the enclosed prepaid and addressed envelope to:
Dr Noreen Kearns
Senior Research Officer
Organisation Development Unit
NEHB
Navan Rd
Kells
Co Meath

This Organisation Cultural Survey was developed by the Organisation Development Unit, NEHB, June 2004.
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Appendix 2 outlines the various categories of staff that were grouped under the main headings of Allied Health Professional, Management/Administration, Medical/Dental, Nursing and Support Services. These categories correspond to those used in the *NEHB Organisation Cultural Survey* (2004). They were agreed with reference to the Personnel, Payroll and Related Systems (PPARS) in March 2004.

<table>
<thead>
<tr>
<th>Allied Health Professional</th>
<th>Management/Administration</th>
<th>Medical/Dental</th>
<th>Nursing</th>
<th>Support Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childcare Worker/Leader</td>
<td>Grade 3, 4, 5</td>
<td>Consultant</td>
<td>General</td>
<td>Attendant/Aide</td>
</tr>
<tr>
<td>Psychologist</td>
<td>Grade 6, 7, 8</td>
<td>Registrar</td>
<td>Public Health Nursing</td>
<td>Care Assistant</td>
</tr>
<tr>
<td>Environmental Health Officer</td>
<td>Community Welfare Officer</td>
<td>House Officer</td>
<td>Midwifery</td>
<td>Catering/ Cleaning</td>
</tr>
<tr>
<td>Radiographer</td>
<td>CEO/Assistant CEO Functional Officer General Manager Manager, Director</td>
<td>Intern</td>
<td>Psychiatric Nursing</td>
<td>Chef</td>
</tr>
<tr>
<td>Medical Scientist</td>
<td>Other</td>
<td>Dental Surgeon</td>
<td>Mental Handicap Nursing</td>
<td>Emergency Medical Technician/Ambulance</td>
</tr>
<tr>
<td>Social Worker</td>
<td>Dental Surgery Assistant</td>
<td>Other</td>
<td>Maintenance/Caretaking</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>Other</td>
<td>Porter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech and Language Therapist</td>
<td>Other</td>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiotherapist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Appendix 2 – Categories of staff within the five main staff groups
The Organisation Cultural Survey results are presented in graphic format in a document entitled *Key messages and survey results* which may be obtained by contacting the Organisation Development Unit at the address noted on the back cover or by downloading it from the intranet site at:
http://intranet/Functions/OrganisationDevelopment/ResearchandDevelopment/

Additional copies of this more detailed research report entitled *An exploration of culture in one Irish health service organisation* may also be obtained from the Organisation Development Unit or by downloading it from the intranet site listed above.
This research was undertaken by:
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E-mail: tara.orourke@maile.hse.ie

For further information please contact the above address