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Research papers

Investigating organisational culture in primary care

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ABSTRACT

This paper discusses the concept of measuring organisational culture in primary care and reports on the construction and early pilot work surrounding the development of the Practice Culture Questionnaire (PCQ). The PCQ was designed specifically to identify variations in resistance culture to quality improvement activities in UK primary care teams. Questions were derived from a model of clinical governance and from interviews of primary care teams about quality improvement activities. A 25-item measure was devised and piloted with a sample of 21 practices. Response rates were satisfactory and the findings discriminated between primary care teams. Further evaluation of the measure is now required. The value of a measure that identifies resistant culture to quality improvement in primary care teams is discussed.

Keywords: clinical governance, organisational culture, primary care, quality improvement

Background

Over the last 20 years, organisational culture has generated significant research interest within a variety of academic disciplines including sociology, management science and psychology. The way these disciplines approach the construct of organisational culture is often radically different, as there is little agreement amongst them on precisely what the concept is.[1] The division in agreement about what organisational culture might be is mirrored in the debate about whether it is possible to measure it and if so how. Qualitative researchers argue against a quantitative research methodology on the grounds that it misses out the rich nature of culture.[2,3]

Quantitative researchers on the other hand argue that in order to investigate culture in different organisations, standard measures must be developed.[4,5] This latter approach reflects a management science perspective, implying that culture is an attribute that organisations have and that it can be identified and changed.[6,7] This idea has been challenged by sociologists and anthropologists who argue that the culture of an organisation does not exist in the sense that it can be identified and changed, but exists only in the sense of it being a conceptual value system. The differences are only in the degree to which the values are socially constructed and shared by people in an organisation.[3]

Organisational culture as a measurable concept in UK health care was promoted by Liam Donaldson in a series of publications that stressed the importance of overcoming a 'resistant to quality improvement culture' in UK healthcare organisations.[8–10] As the new Chief Medical Officer and architect of clinical governance, he urged healthcare managers to recognise that quality improvement was an organisational issue. Organisations in his view needed to embrace the new modern NHS and create a culture of continuous quality improvement.

When discussing organisational culture in primary care he presented a list of qualities that he believed were associated with a culture that was resistant towards a culture of quality improvement.[10]

His list was drawn from a review of the business and healthcare literature and is reproduced in Box 1.

Box 1 Qualities associated with health organisation with a resistant culture to clinical governance (from Donaldson, 2000)[10]

- No clear vision shared by staff
- Poor organisation
- Resistance to change
- Resistance to routine measurement of organisation's performance
- Resistance to the idea of measurement of personal performance
- Little enthusiasm for making contacts in other organisations
- Resistance to providing education and training for all staff
- Resistance to the idea of learning from mistakes
- Poor attitude to the need to keep up to date
- Little interest in having customers as primary focus
- Reluctance to include everybody in quality improvement programmes
- Little recognition of the value of involving consumers

Here then were 12 qualities of resistance contributing to a culture that the Chief Medical Officer in 2000 felt were shared by healthcare organisations – including general practices – that would hold back developments in provision of high-quality care. The qualities that Donaldson identified were not isolated aspects of individual behaviour but very much linked to teamwork and organisational culture and supported by other writers at the time.[11] Donaldson was keen to emphasise in his writings that clinical governance was essentially an organisational concept. He acknowledged that the introduction of clinical governance and the creation of primary care trusts would push organisational culture to the top of the healthcare agenda.

> The importance of primary care organisations working cohesively within a framework with clear goals and objectives directed towards quality improvement will be one of the keys to the success of the initiative.[10]

Donaldson's view of organisational culture, by his own admission, was drawn from the business and marketing literature. An organisation's culture has been defined in the business and marketing literature as the 'complex set of values, beliefs, and assumptions that define the ways in which a firm goes about its business'.[7] This view suggests organisational culture can be understood from accessing the shared beliefs about the workplace that exist between colleagues in the organisation. This includes the beliefs, attitudes, values and norms of behaviour within the organisation and how staff perceive these. Another similar approach is to consider the way in which people share a common understanding of 'how things get done' in their organisation.[1,11]

Is there a measure of organisations in health care working cohesively together within a framework with clear goals and objectives directed towards quality improvement? Would such a measure be useful in helping identify organisations that have got such a framework and those that have not?

Edgar Schein suggests that culture in an organisation is a crucially important factor to a business, and operates at three levels: on the first level are the artefacts, the visible things which people do; second the espoused values that drive the strategies that impinge on the systems the organisation employs; and on the third level are the basic underlying assumptions which are the deeper unconscious beliefs held by employees about the organisation and how it should behave.[7] Schein believes that a measure of an organisation's culture can be found using well-thought out and appropriately worded questionnaires.

Although there are examples of questionnaires to measure culture in secondary care there are very few if any that apply to the working environment of UK primary care. A systematic review reported by Stevenson in 2003, using the search terms 'measuring organisational culture' and 'questionnaire' searching from 1966 to 2003 identified only eight published studies in health care involving the use of a specific organisational culture questionnaire.[12] The studies are listed in Table 1. A review of the studies reveals that only two of the studies involved UK primary healthcare staff.

The two attempts at measuring culture in UK primary care using a questionnaire are different in scope and size. The first study used a questionnaire developed from the established 'learning organisation' model.[20] This study, however, concentrated only on staff in 15 practices and only on the employed staff (e.g. nurses and receptionists).

The study by Stevenson (2000) used a specially devised questionnaire, The Practice Culture Questionnaire (PCQ) that focused on the views of the whole primary care team.[21] The primary care team in this context is viewed as a 'whole organisation', including all those involved in the delivery of care. The questionnaire has, since that publication, been piloted on over 150 practice teams and over 1500 primary care staff.

This paper will explain how the PCQ was developed and then shown through pilot studies to be a reliable and valid measure of what Donaldson regarded as organisational culture in primary care.

Table 1 Studies using an organisational culture questionnaire in healthcare setting 1996–2003 (adapted from Stevenson, 2003)[12]

Author	Culture measure	Country	Primary/secondary care
Anderson *et al*, 2000[13]	Greshorn measure of safety climate	USA	Secondary
Klingle *et al*, 1995[14]	Hospital Culture Scale	USA	Secondary
Seago, 1997[15]	Organisational Culture Inventory	USA	Secondary
Coeling and Simms, 1993[16]	Nursing Unit Cultural Assessment Tool	USA	Secondary
Salyer, 1996[17]	Perceived Environment Uncertainty in Hospitals Scale	USA	Secondary
Kralewski *et al*, 1996[18]	Group Practice Organisational Culture questionnaire	USA	Primary
Menarguez *et al*, 1999[19]	Spanish Primary Care Organisational Climate Questionnaire	Spain	Primary
Stevenson, 2000[20]	Practice Culture Questionnaire	UK	Primary
Sylvester, 2003[21]	Learning Organisation Questionnaire	UK	Primary

Constructing the questionnaire

The construction of the PCQ (see Appendix) was underpinned by the essence of the working definition of culture outlined above which was: 'the shared set of values, beliefs and assumptions of the staff who work in the organisation ...', and was developed with the following guidelines:

- the questionnaire should be easy to complete, e.g. using a simple easy to understand response format
- the questions should be based on how the respondent feels the *practice team* views various clinical governance activities
- the questions should be relevant to all grades of practice staff and relate to the sorts of clinical governance activities the practice could be expected to be carrying out
- the questions should reflect the way primary care staff think about quality improvement activities drawn from earlier reports of what staff had said during interviews
- the questionnaire should look easy to complete for time-conscious healthcare professionals (i.e. fit onto one side of A4 paper).

Since the questions were be based around how the respondent felt the *practice team* viewed various clinical governance activities, the questions were linked to the 12 critical aspects of a resistant organisational culture outlined by Donaldson. His 12 critical aspects, however, were too generic for the specific context of primary health care, and therefore the questions needed to be contextualised to primary care quality improvement activities so that they would be immediately recognisable to all UK practice staff.

For example, UK primary care staff would be more likely to be able to judge whether their practice carried out clinical audit than answering a general question about whether their practice was in favour of 'monitoring clinical performance'. Table 2 illustrates how each Donaldson attribute was 'contextualised' into a clinical governance quality improvement activity.

Each quality attribute was framed as a statement with an associated response in Likert-scaled format.[22] The construction process ensured that the general

Table 2 How issues relating to a positive primary care quality improvement culture were placed into a clinical governance context

Donaldson's organisational culture constructs	Specific 'practice culture' question in clinical governance context
1 Importance of shared vision	1 Practice having a shared vision of clinical governance
2 Good organisation	2 Practice members have clear understanding of roles within the practice
3 Receptive to change	3 Practice response to idea of change
4 Accepting value of routine measurement	4 Practice views of value of clinical audit
5 Accepting monitoring of personal performance	5 Practice attitude to monitoring clinical practice
6 Proactive in making contacts outside the firm	6 Practice makes efforts to make contact with primary care trust
7 Accepting the value of education and training for all staff	7 Practice attitude to training for all levels of staff
8 Accepting idea of learning from mistakes	8 Practice attitude to importance of single event auditing
9 Accepting the need to keep up to date	9 Practice attitude to practising evidence-based medicine
10 Having customers as the primary focus	10 Practice attitude to patients who complain
11 Importance of including everybody in quality improvement programmes	11 Practice attitude to involvement of all staff in quality improvement
12 Involving consumers	12 Practice attitude to the value of listening to patients' views

quality concepts were covered using statements that focused on activities that were, or should have been, familiar to most practice staff.

Getting the wording right

Earlier interview studies with staff in general practice teams had already illustrated the kinds of statements that practice representatives had made quite freely about their practices.[23] For example:

'We [the practice] have considerable experience in audit.'

'We regard audit as very much part of our activities.'

'We're supposed to be an innovative practice.'

Similar types of statement were forthcoming from primary care staff interviewed in an NHS Trent clinical governance baseline study:[24]

'We don't feel we get much value from patient questionnaires.'

'Our reception staff aren't that interested in going on courses.'

'This practice takes patient complaints very seriously.'

These statements provided the springboard for constructing PCQ statements in a similar fashion that staff working in practices would recognise and feel comfortable agreeing or disagreeing with.

Question construction

To increase the reliability of the scale, each of Donaldson's 12 attributes was used as the basis for two separate statements. The 24 paired statements were then constructed. These became short unambiguous statements about the practice, such that agreement or disagreement by the respondent would provide support for, or against, the view that the practice was positively, or negatively, disposed to the activities of clinical governance (Table 3). As the questions were being constructed, the notion of a blame-free culture emerged in NHS thinking about

Table 3 The paired PCQ questions by number and question focus

Question number	Question focus
1/13	Shared values (everyone understands and agrees principles of clinical governance)
2/15	Active tracking of quality improvement (meeting regularly to track progress of clinical governance activities)
3/16	Positively disposed to change for the sake of quality improvement
4/14	Positively disposed to clinical audit/aware of importance of effective audit
5/23	Accepting the need by professional staff of need to measure clinical performance
6/22	Accepting the lead provided by the primary care group
7/17	Accepting the value of structured staff development for all grades of staff
8/18	Accepting responsibility of staff to minimise risk to patients
9/19	Acceptance of clinical effectiveness through evidence-based medicine
10/20	Accepting the value of users' views of the service
11/21	Active participation of all staff in quality improvement
12/24	Patient focus (value of patient surveys of service)
25	Practice attitude towards staff who make mistakes

health care. Therefore, a 25th statement that asked about how the practice responded to staff mistakes completed the questionnaire items.

These questions that were created now linked directly to Donaldson's 12 critical issues and also mapped onto the essential components of primary care clinical governance suggested by Roland and Baker, namely:

- being responsible and accountable for quality of clinical care
- involving all staff in quality improvement activity
- developing appropriate risk management procedures
- developing appropriate procedures to identify and remedy poor performance.[25]

This suggests a questionnaire measuring resistance to clinical governance built from Donaldson's 12 critical issues would satisfy the initial requirements for content and face validity. Further support for validity of the questionnaire items came from: discussions with GPs and practice nurses who helped fashion the questions to ensure they were appropriately worded for the intended audience; the acceptability of the questionnaire to pilot staff; and the relatively few questionnaires returned uncompleted from pilot studies.

Social desirability

Questionnaires about health practices are sometimes prone to social desirability where the respondent gives answers that he or she believes would be regarded positively. The PCQ items were specifically designed to minimise social desirability effects by focusing on statements about the practice the staff actually worked in and how, in Handy's phrase, the respondent's practice 'went about its business'.[4]

Distributing questionnaires to target group

A methodology for distributing the questionnaires was devised. Once agreement to take part had been given, copies of the PCQ were provided to a practice for completion by the primary care team. The questionnaires were sent to, and distributed to each member by, the practice manager and when returned to him/her (in a sealed envelope if required), forwarded to the author for scoring. The 'practice team' is therefore what the practice defined it to be. There is an argument that different practice organisations will

view the membership of their primary care team differently. The pilot studies described below, however, tended to support the view that the distribution of grades of staff included by practices was largely similar.

Scoring the responses

With 25 statements on a four-point scale, a scoring strategy was developed that scored each item from 0 to 4. A zero score on an item indicated the respondent's view that their practice had a very poor attitude towards that aspect of clinical governance. For example, if they clearly disagreed that the practice was well organised or that they very much agreed that the practice regarded clinical audit as more trouble than it was worth. A score of 1 indicated the respondent's view that the practice was not generally positively disposed to the item. A score of 2 indicated that the respondent was unsure of the practice position on the issue and a score of 3 or 4 indicated the respondent felt the practice was generally positively or definitely positively disposed to the issue.

The fact that there were 25 items each with a possible maximum score of 4 and a minimum score of 0 provides the PCQ total maximum score for an individual's view of their practice to be 100 points and an individual's lowest total PCQ score for their view of their practice to be zero.

Feasibility and acceptability pilot study

The first pilot study involved circulating 21 practices and was designed to:

- check the acceptability of the PCQ by staff asked to complete it
- assess whether the practices could be differentiated by the average (median) score of the practice on the PCQ scale.

This first pilot study did support the feasibility of the PCQ as a useful measure of practice culture. The mechanism of distributing and collecting the questionnaire through practice managers was successful, with an overall questionnaire return rate of 88%. In summary, 17 out of 21 pilot practices agreed to take the questionnaire; 5 out of 17 practices had 100% return rates against questionnaires issued. Only 3 out of 17 practices had return rates less than 50% against questionnaires issued (Table 4).

Table 4 Number of questionnaires returned in the Nottingham pilot study arranged by professional grade and percentage return

Practice code	Number of GPs (PCQs returned)	Number of nurses (PCQs returned)	Number of administration staff (PCQs returned)	Total number (PCQs returned)	% (PCQs returned)
17	6 (5)	3 (2)	13 (4)	22 (11)	50
10	5 (3)	2 (0)	13 (4)	20 (7)	33
03	2 (1)	1 (1)	5 (5)	8 (7)	88
11	1 (1)	2 (2)	6 (6)	9 (9)	100
14	2 (2)	1 (1)	4 (4)	7 (7)	100
16	3 (2)	3 (3)	6 (6)	12 (11)	92
21	4 (2)	2 (0)	8 (1)	14 (3)	22
20	3 (3)	4 (4)	8 (8)	15 (15)	100
08	2 (1)	2 (2)	6 (2)	10 (5)	50
06	4 (2)	6 (6)	7 (5)	17 (13)	78
09	3 (3)	2 (2)	7 (7)	12 (12)	100
07	1 (1)	1 (1)	5 (5)	7 (7)	100
05	3 (2)	2 (2)	4 (4)	9 (8)	88
13	4 (3)	3 (3)	9 (0)	16 (6)	38
12	3 (2)	3 (3)	9 (9)	15 (14)	94
01	2 (1)	2 (2)	6 (5)	10 (8)	80
19	2 (2)	2 (1)	6 (5)	10 (8)	80
Total	50 (36)	41 (35)	122 (80)	213 (151)	Median 88%

More importantly, the analysis of the pilot data by practice team indicated that the PCQ was also able to differentiate between practices with different attitudes towards clinical governance. The 17 practices that returned pilot questionnaires provided a practice average PCQ score that ranged from 49 to 88. The range of scores within a practice was also noted as a useful indicator of how concentrated feelings were within a practice (Table 5).

Table 6 outlines how four types of practice might be identified through their team median score and their spread score.

What value is this measurement of practice culture?

Practices with high median score and low spread indicate a team that is comfortable with the principles of clinical governance and quality improvement activities. The low spread of scores within the team emphasises the cohesive nature of the team, and suggests they share information and working practices.

Table 5 Median practice pilot PCQ scores and range scores for 17 practices in a Nottingham primary care group

Practice code	Practice PCQ median	Practice range (lowest to highest score)	Completed questionnaires
20	88.0	30	15
10	78.5	16	7
05	77.5	15	8
16	72.0	23	11
06	72.0	28	13
13	69.5	7	6
19	69.0	9	8
17	69.0	22	11
14	68.0	11	7
01	67.5	18	10
07	66.0	13	7
03	62.0	8	7
11	61.0	43	9
09	60.0	29	12
21	55.0	20	3
12	55.0	37	14
08	49.0	13	5

Table 6 Proposed typology for practice teams discriminated by PCQ median score and range

Practice team score type	Team type
High median – low spread	Progressive team with shared progressive vision of clinical governance
Moderately high median – high spread	Most of team in favour of clinical governance with a few team members definitely not in favour
Moderately low median – high spread	A few in favour of clinical governance with most of team against
Low median – low spread	Resistant team with shared antagonistic views of the value of clinical governance

Practices with low average PCQ score and low spread suggests a team who feel their practice is predominantly resistant to activities such as those suggested in the questionnaire. The low-spread score indicates that there is general agreement by all the team about the practice and its negative view of clinical governance and associated quality improvement activities. Questionnaire feedback could be used to establish which activities respondents feel that the practice is most resistant to and, if attitude change were sought, appropriate educational support strategies that could be considered.

A practice with an average culture score but high spread suggests that team members may hold markedly different opinions and beliefs about the value of clinical governance in their practice and the quality improvement activities associated with it. The way in which staff in these practices might be encouraged to change may differ, depending on who is most resistant to which particular aspects of quality improvement and to what degree.

Conclusion

This paper discusses a proposed relationship between organisational culture and resistance towards quality improvement activities in primary healthcare teams. The difficulties of measuring organisational culture in primary care are considered, and a description of the construction and initial testing of the Practice Culture Questionnaire has been given. The PCQ was designed specifically to identify variations in resistance culture to quality improvement activities in UK primary care teams. The early pilot work suggests that this approach and the PCQ itself could be useful to practices who are interested in measuring how well they are doing in encouraging their staff, as Donaldson suggests, 'to work cohesively within a framework with clear goals and objectives directed towards quality improvement'.[10]

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CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

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Appendix: Example of the practice culture questionnaire (not to be copied without permission)

Practice code:

PCQ (B) Attitudes to clinical governance

POSITION IN PRACTICE .....

Circle the number that you feel in your opinion best represents the practice attitude to each statement:

		Disagree			Agree	Unsure
1	The principles of clinical governance are well understood in this practice	1	2	3	4	u
2	The practice often meets to discuss progress of clinical governance activities	1	2	3	4	u
3	Changing the way we do things tends to be resisted in this practice	1	2	3	4	u
4	The practice regards clinical audit as more trouble than it is worth	1	2	3	4	u
5	The practice accepts the need for all clinicians to have appraisals	1	2	3	4	u
6	The practice has made *very little* effort to make contact with the PCT	1	2	3	4	u
7	The practice feels continuing education generally improves staff performance	1	2	3	4	u
8	Occasionally mistakes happen; there's not much you can do about it	1	2	3	4	u
9	Evidence-based medical care should definitely be applied to general practice	1	2	3	4	u
10	Patients who complain often have unrealistic expectations of what we can do	1	2	3	4	u
11	Every practice member should participate in quality improvement activities	1	2	3	4	u
12	The practice feels that patient surveys *rarely* tell you anything of value	1	2	3	4	u
13	Clinical governance is a truly shared vision in this practice	1	2	3	4	u
14	Clinical practice has *not* changed here as a result of any clinical audit	1	2	3	4	u
15	Everyone knows exactly who is doing what in this practice	1	2	3	4	u
16	The practice is slow to adapt to new procedures	1	2	3	4	u
17	The practice feels that education and training courses are valuable for all staff	1	2	3	4	u
18	Meeting to discuss one single adverse incident is *rarely* a good use of time	1	2	3	4	u
19	Virtually all the care we provide should come from evidence-based guidelines	1	2	3	4	u
20	Dealing with complaints from patients is *not* a high priority in this practice	1	2	3	4	u
21	The practice believes team meetings should include admin staff	1	2	3	4	u
22	The practice responds to our primary care group *only if* required to do so	1	2	3	4	u
23	The practice accepts that doctors' clinical competence needs regular monitoring	1	2	3	4	u
24	The practice does *not* believe in the value of surveying patient opinions	1	2	3	4	u
25	The practice culture supports rather than blames staff who make mistakes	1	2	3	4	u

Please use the reverse of this form to provide additional comments about these questions or your responses, then return form to your practice manager in the envelope provided. The forms for this PCT will be analysed centrally and results fed back in confidence.