Diagnosing Organisational Culture During Community Healthcare Reform.  
A Mixed Methods Study  
Applying the Competing Values Framework

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This thesis is submitted to the University of Dublin, Trinity College,  
in fulfilment of the requirements for a Doctor of Philosophy

2022
Declaration

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Abstract

Diagnosing Organisational Culture During Community Healthcare Reform.
A Mixed Methods Study Applying the Competing Values Framework

Background: Across the globe healthcare systems are in a constant state of reform. However, the results of these reform activities are described as weak at best and situational dependent. While the research on organisational culture in healthcare is limited, studies suggest that unless organisational culture is included in pre-reform planning and change initiatives, global healthcare reform will not deliver the necessary changes to address their common challenges.

Aims and Objectives; The research aims to measure and identify the prevailing organisational culture in a community healthcare region during a period of planned reform. The preferred future culture will also be identifying, in order to establish the gap between the current and preferred culture necessary to deliver the transformation. The influences and barriers to the reform will also be investigated as will the alignment between the current policy and the current practices.

Methods: The study adopts a two phased Explanatory Sequential Mixed Methods design. The Competing Values Theory underpins the methodology, which is supported by a survey derived from the theory’s framework. The framework domains are also applied in the qualitative thematic analysis prior to the integration of the findings through joint display.

Main Findings: The prevailing organisational culture was identified as overwhelmingly Hierarchal. The participants (n=445) identified a significant change was necessary to deliver the reform, with the preference for a culture (collaborative and participatory) culture. The qualitative findings collaborated these findings and highlighted the barrier to the desired cultural change. The investigation also confirmed that the current policy is not aligned to current practices, indicating a substantial challenge to the planned reform.

Conclusion & Implications; The current Hierarchal culture does not support the innovative, collaborative, and mentoring culture desired by participants, which is also ideal to deliver whole system reform. The current reform policy lacks specific organisational cultural actions which will facilitate cultural change and deliver reform.
Summary

**Background and Aim:** Across the globe, healthcare often fails to meet the standards and expectations of its stakeholders and service users. To remedy the shortfalls, structures, systems, and processes are often in a constant state of change, without the desired outcomes. The commonly identified shortfalls in healthcare are often cultural in nature, including a resistance to change and a culture of defensiveness and a deference to authority. Seeking to addressing the challenges of modern healthcare, policy makers frequently invoke cultural change but fail to enact or monitor the necessary changes in practices. With the exception of a few countries, there is little evidence that organisational culture in healthcare is being diagnosed, measured, or evaluated in a meaningful way. As global reform measures focus on moving care from the costly hospital centric systems to the lowest point of acuity, a receptive, innovation organisational culture is needed. To this end, organisational culture needs to be the main ingredient to deliver reform in order to futureproofing healthcare delivery in the community.

Against this background, the aim of this research is to measure and identify the organisational culture in a community healthcare setting during a period of planned reform, establishing the team’s readiness and the organisation’s cultural alignment to the planned change. In addition to the current culture participants were asked to identify their preferred future organisational culture, establishing the difference between the current and desired culture. The individual elements of organisational culture were also investigated to establish the strength and prevalence of the cultural types, establishing if there is alignment and compatibility between the current reform policies and the current organisational culture in practice.

**Methodology:** A pragmatic explanatory sequential mixed methods design is applied. The Competing Values Framework and its associated survey the Organisational Cultural Assessment Instrument (OCAI™) provide a theoretical foundation and a survey instrument for the research. The methodology provides an added value which would not be discovered if only one methodology was applied. The quantitative phase provides evidence of the observable levels of organisational culture, while the qualitative phase used the themes from the quantitative instrument to provides a deeper insight into the unobservable elements of the complex construct.
**Methods:** A purposive sample (n=445) of employees, with stratification, were recruited from a public community healthcare region in Ireland in June 2019. All 4,190 employees had an opportunity to participate. This statistically powered sample was representative of both the regional and national community healthcare workforce. A purposive nested sample of 12 informants also participated in semi-structured interviews.

**Findings:** Findings from the analysis indicate the organisation is dominated by a Hierarchy controlling culture (M=39.53, SD 16.10), this is followed by a competitive and externally focused Market type culture (M=24.99, SD 8.36). The collaborative Clan type culture ranked in third place (M=23.14, SD 14.75) indicating low levels of collaboration and participation in the organisation. The mean score for innovation and creativity, represented by the Adhocracy type, was the lowest scoring culture reported in practice (M=12.31, SD 8.36). Comparing the current scores with the preferred future cultural scores indicated a significant culture change was desired. According to the participants the culture change should result in more supportive, mentoring leadership with a focus on employee development and wellbeing. The qualitative results confirmed these findings and also acknowledged the substantial barriers to reforming the service. The barriers included current structures, the lack of resources, behaviours, practices and communication. The integrated results consolidated the findings, provided further evidence of the disconnect between policy and practice.

**Discussion and Conclusion:** The explored literature indicates the increasing importance of organisational culture in healthcare, especially during periods of reform. While the context of this research is the Irish community healthcare setting, the findings can be applied to any healthcare setting planning reform. Pre-reform preparatory planning is important, and should include reform objectives, organisational culture baseline measurement and the inclusion of all team members. Contrary to prior research, it is not just managers who have the ability to identify the culture necessary to drive sustainable reform. The unilateral preference for a more participatory and mentoring organisation indicates the current levels of dissatisfaction with the organisation culture. The inconsistency between the current organisational culture of practice and the espoused organisational culture of policy must be confronted. Moreover, the identified preferred future culture must be firmly grounded in
the organisation, this means successfully altering team member’s behaviours and actions and demonstrating the value and benefits of such changes.

In this healthcare setting the findings suggest an organisation that is overmanaged and under led. The development of a learning organisation, which is inclusive and empowering for middle managers and front-line clinicians, must include organisational culture considerations. Unless organisational culture is practically included in healthcare reform, the reforming of structure, systems and processes will be similar to rearranging the deckchairs on the titanic.
Publications & Presentations Related to this Thesis

Publications


Presentations (Oral)


Presentations (Posters)


Conference Presentations


Webinar

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<td>Accident &amp; Emergency Hospital Department</td>
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<td>ANP</td>
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<td>ANOVA</td>
<td>Analysis of Variance</td>
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<td>OCAI</td>
<td>Organisational Cultural Assessment Instruments™</td>
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<td>OECD</td>
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Introduction to the Research

“our values influence our attitudes and behavior towards those to whom we provide service”
(Tony O’Brien, CEO, Health Service 2015, p. 300)

1.1 Motivation and Background to the Study

Over the last three decades there has been a long list of institutional failures which have been attributed to the “prevailing cultures of organisations” (Molloy 2011). The global healthcare sector has not been immune to such failures of culture, with significant events reported in New Zealand, the United States, the Netherlands, the United Kingdom, Belgium, Spain, and Ireland, to name a few (Wakefield et al. 2001, Walsh & Shorthall 2004, Mira et al. 2017, Scally 2018). Data from several studies suggests that despite the differences in structures and systems, the causes and features of major healthcare failures across the globe were remarkably similar in nature (Mannion et al. 2003). Common failures were cited as poor management systems, a failure to respond to patients concerns, fragmented knowledge, long treatment waiting lists and ultimately a “culture of secrecy, professional protectionism, defensiveness and deference to authority” (Walsh & Shorthall 2004 p. 103). These findings would suggest that the problems and the solutions can be found in organisational leadership and the healthcare organisations themselves (Walsh & Shorthall 2004, Mannion et al. 2005, Mira et al. 2017).

Organisational culture is identified as the key component, or the DNA, which binds an organisation together (Schein & Schein 2016). From a multitude of definitions, to its myriad of levels and dimensions, organisational culture has become an essential element of understanding the behaviours of people in organisations (Janičijević 2011). While organisational culture has been a stalwart of business development since the early 1980, translating the theory into practice in the healthcare sector has been slow. Despite the fact that the need to change organisational culture in healthcare is frequently cited in the
literature, in practice the reform focus has centered on other variables, hospital governance, new national agencies, new local primary care group structures (Duckett 2015), interventions for quality and safety (Ruelas 2015), improvement of organisational standards (Cicchetti et al. 2015), reform of roles, functions and working methods (Matsuyama 2015). While these changes have all been identified as key deliverables in the effort to improve global healthcare quality, achieving this vision is dependent on a profound cultural shift, without which sustainable change will not be possible (The National Academies of Sciences 2018). In summary the sector must change and demonstrate “a willingness to take risks, in the service of learning” (The National Academies of Sciences 2018 p. 17).

Unfortunately, the healthcare sector boasts a unique culture, one which is embedded in clinical professionals during training and socialisation. This clinical professionalism was very evident in the tension between the social factors stimulating change in institutional mental health services in Ireland and the power base of the psychiatric profession, which resulted in the slow change process which spanned over 50 years (Brennan 2013). The change in practices was subject to the professional group establishing their own clinical culture outside of the institutional setting, in the new community setting (Brennan 2013). Clinical culture is anchored in personal responsibility and autonomy of action, it also appears to be the back bone of the non-linear complex system of healthcare delivery (Kohn et al. 1999).

This study provides a timely opportunity to seek clarity on the types of organisational culture which prevail in practice, during a period of whole system Community Healthcare reform (Committee on the Future of Healthcare 2017). The transformation vehicle for this reform is the Sláintecare Report (Committee on the Future of Healthcare 2017). It has called for a change to organisational culture in a healthcare system which is viewed as fragmented (Government of Ireland 2019b). The preliminary Sláintecare Report characterises the desired future healthcare culture as one of openness, respect, support and fairness, with no blame or retribution (Committee on the Future of Healthcare 2017).

This research adopts a deep level of investigation through the application of a mixed method research design, exploring the various levels and typologies of culture, both observed and experienced by the research participants during the period of reform. The
findings will establish if the gap, between the current culture and the desired reformed culture is being bridged. The research seeks to add to existing knowledge at a theoretical, methodological, and practical level, by providing unique insights into the important of organisational culture in healthcare during whole system reform and the connection between policy and practice.

1.2 Objectives of the Research

The aim of the research is to measure, identify, understand, and evaluate the prevailing organisational culture in a Community Health Organisation (CHO) exploring what organisational culture change will support the delivery of the planned reform. The context in which this aim is addressed is within the Health Service Executive (HSE), in Ireland. Formed by the Health Care Act of 2004, the HSE replaced previous organisations and structures. It provides public health services in acute hospitals and community-based settings, under the auspice of the Department of Health. The public healthcare system is primarily funded through taxation (73% in 2017) and Ireland is the only European country which does not provide entitlement to Universal Healthcare Insurance (UHI). This has resulted in a two-tiered system which provides the most expensive healthcare system in Europe to a population of 4.9 million (Health Service Executive 2020, Thomas et al. 2021).

The research objectives are to: -

✓ Measure and identify the current prevailing and preferred future organisation culture in the participating community healthcare area.
✓ Establish if there is congruency between the identified organisational cultures and the respective cultural dimensions.
✓ Understand the barriers and facilitators which will impact the move from the current culture to the preferred culture.
✓ Establish if there is alignment between the preferred future organisational culture of the employees and the planned and documented reform policy actions designed to deliver community healthcare reform.
1.3 Theoretical Framework of the Research

Although not an explicit component of the research purpose statement, this study also aims to contribute to the field of knowledge in the area of theoretical frameworks and their application in mixed methods research. The literature reports that theoretical frameworks impact almost all elements of qualitative research (Anfara & Mertz 2015 p.63), however little have been specifically published about theoretical frameworks in quantitative enquiry and how they are understood and operationalised (Jaccard & Jacoby 2010, Anfara & Mertz 2015). The contribution of theoretical frameworks in guiding the design and implementation of mixed methods is also under researched (Evans et al. 2011). Nonetheless there is some evidence in the nursing sector that practitioners use theoretical frameworks to ground and “hang” their research on (Sandelowski 1999). Anfara and Mertz (2015) proposed that, closely aligned to worldviews, theoretical frameworks provide a lens through which researchers can make sense of the phenomenon of interest and provide a boundary and a foundation on which to build and conduct research. The limited reviews on theoretical frameworks, as a pragmatic guide to complex mixed method studies, suggests that they can “provide navigational devices through the low, swampy group of practice” (Evans et al. 2011 p. 289).

Like organisational culture, there have been many definitions of theory and theoretical frameworks. Kerlinger (1986, p. 9) defined theory as “a set of interrelated constructs, definitions and propositions that present a systematic view of phenomena by specifying relationships among variables, with the purpose of explaining and predicting phenomenon”. Argyris and Schon (1974, p. 4) also provided a similar definition and describe theoretical frameworks “as a set of interconnected propositions that have the same variable as the subject of the theory. Considering the complexity of the construct of organisational culture, the potential application of an appropriate framework was identified, during the planning stage, as critical to the execution of the investigation.

Supported by evidenced-based research, and the findings from the systematised literature review, a theoretical framework was identified which concurred with the research’s concise definition of organisational culture. The Competing Values Framework (CVF) (Cameron & Quinn 2011a) provided a unique and fertile opportunity to establish a mixed methods conceptual framework for the measurement of organisational culture both quantitatively
and qualitatively. The framework’s associated survey instrument (OCAI™) supported the collection of quantitative data, enabling the analyses by which to measure the organisational culture typology. The themes of the framework (Figure 5.2) were then used to investigate the qualitative element of this mixed methods study, supporting the template analysis. While theory guides the inquiry, providing support for design decisions, the collection and analysis of the data, it also redresses that which had previously been referred to as a weak in the research of organisational culture, being its methodology (Scott et al. 2003c). The Competing Value Framework and its validated instrument are further explored in Section 2.1.6.

1.4 Structure of the Thesis

The structure of the thesis is divided into nine chapters as follows:

Chapter 1 introduces the background and motivation for the research including the research aims and objectives. The chapter also provides an outline of theoretical frameworks in research and the unique opportunity of theory in this mixed methods study. This chapter concluded by outlining the structure of this thesis.

Chapter 2 reviews the literature on the key concepts, themes, and theories. This includes organisational culture, healthcare (systems and reform), and community healthcare in Ireland, being the context of this study. The chapter also investigates the challenges in the healthcare sector which are driving the surge in reform activities. As is necessary with complex research topics, a number of definitional classifications are also outlined in this chapter in order to reduce ambiguity in the literature review in Chapter 3.

Chapter 3 reports on the systematised narrative literature review undertaken. This review identifies eligible studies which contribute to the specific research field of knowledge. The identified literature provides a more in-depth review of specific studies which can contribute to the current research aims and objectives. A summary of the examined literature is reported on, including the impact of the findings on this thesis.
Chapter 4 clarifies the researcher’s worldview, and the research ontology and epistemology are recorded. The appropriate research methodology is established and rationalised providing a route map for the study and documenting the research design.

Chapter 5 describes the specific process applied during the different phases of the mixed methods research delivery. The process is presented in a “step by step” format which addresses the sampling strategy, the participant recruitment, and the data management and analysis. Both quantitative and qualitative phases are detailed individually including their respective quality considerations. Finally, the details of the data integration phase are presented before the chapter is summarised.

In Chapter 6 the psychometric properties of the survey instrument are outlined before the statistical demographics of the study sample are presented. The findings from the quantitative data analysis are presented (Q1 & Q2) followed by a review of the demographic variables’ findings. In Section 6.4 the individual organisational cultural domains are analysed by demographic. The chapter addresses the first and second research question, identifying the current prevailing and future preferred organisational culture of the community healthcare area and its congruent or divergent relationship with its domains.

Chapter 7 outlines the characteristics of the interview participants before the qualitative data is analysed. The qualitative findings from the semi-structured interviews are reported using template analysis applying the themes from the theoretical framework of the study (Q1 & Q2). In this chapter the third research question is also addressed, identifying the barriers which are expected to impact on organisational reform and cultural change (Q3). A summary of the key findings are also presented before the integrate findings are presented in Chapter 8.

Chapter 8 bring together the findings from both the quantitative and qualitative analysis. The integrated findings are then presented using a Joint Display (Q1 & Q2). The research objectives are reviewed and revisited through the integration lens before the barriers to the implementation of the planned reform are detailed (Q3). The alignment between the preferred future culture and the documented reform policies are then investigated (Q4)
before the key-inferences from the integrated findings are presented. The chapter concludes with a summary of the mixed methods findings.

The final chapter, Chapter 9, focuses on the contributions, recommendations and conclusion of the research. The research conclusions are examined from a policy and practice perspective. The strengths and limitations of the research are then reported, and the direction of further research is proposed. The chapter also outlines a brief reflexive summary before the research conclusion is offered.
2

Literature Review of Research Themes, Concepts and Theories

“All truths are easy to understand once they are discovered; the point is to discover them”
- Galileo Galilei

This chapter presents the reviewed literature which influences the conceptual and theoretical background to the research topics, which in turn informs and frames the study. The complex and expansive themes of organisational culture (Section 2.1), global healthcare systems (Section 2.2), healthcare reform (Section 2.3), and the Irish healthcare system (Section 2.4) are introduced and explored. The various definitions, theoretical frameworks and evidence found in the literature are discussed in order to reduce ambiguity arising from definitional or disciplinary variances. The chapter provides a broad overview of the knowledge which is already published on the individual themes, commencing with the multidisciplinary, multi-layered, multidimensional phenomenon of organisational culture (Janičijević 2011).

2.1 Organisation Culture Explored

Organisational culture is an ambiguous and latent construct. In healthcare a positive organisational culture is consistently associated with positive patient and employee outcomes (Parmelli et al. 2011, Hesselink et al. 2013, Braithwaite et al. 2017b, Curry et al. 2017). To understand the phenomena of organisational culture and its influence on organisational development, this section explores what culture is, what it is not, what domains contribute to culture in an organisation and how those domains can be measured. Section 2.1.1. explores the development of organisational culture, laying the foundation for a better understand of its theoretical standing. The section then proceeds to define culture, comparing it to climate, another construct which is frequently substituted for culture in the literature. Armed with a definition, the theory of organisational culture is interrogated,
which provides information relating to the dimensional and typology approach by which
culture can be measured. The literature on measurement instruments and theoretical
frameworks used in healthcare are then investigated. First, in order to understand the
theory and context of organisational culture, its history and development are explored.

2.1.1 The Development of Organisational Culture

According to the literature the development of business theory in the mid-twentieth
century was minimal (Peters & Waterman 2004). The stagnation was of particular concern
to corporate America, who were being challenged by Japanese companies successfully
competing in the America market (Peters & Waterman 2004). In response to this new
competition many American manufacturing companies tried to adopt the unique Japanese
management practices. However little attention was paid to the vast national cultural
differences between Japan and the United States (Schein 1985, Peters & Waterman 2004).

It was against this background that Andrew M. Pettigrew (1979), published his seminal
paper on culture and leadership, viewing culture through the multidisciplinary lens of
organisational behaviour. Despite the originality Pettigrew’s approach was perhaps more
had already commenced their 62 case study research into ‘excellent companies’,
investigating the impact of organisational culture on some of the world’s most successful
companies (Peters & Waterman 2004). The research into organisational culture was further
fuelled by companies who wanted to move away from the ‘productivity centre” focus and
emphasis more of the ‘human management’ approach (Schneider & Barbera 2014a p. 6).
Researchers began to move organisational culture studies from anthropology to the arena
of quantitative organisational psychology (Schein 1990, Peters & Waterman 2004). This was
viewed as a rebellious change from the preferred traditional method (Denison 1996 p. 619).
Regardless of the scholarly objections, by the early 1980s, organisational culture had
become a hot topic.

Meyerson (1991, p. 256) described culture as “the code word for the subjective side of
organisational life….”. Pettigrew complained that culture was like “an over nourished,
oisy and enigmatic cuckoo” (Pettigrew 1990, p. 416), which had displaced climate as the
main management and executive interest. Writing in “The Oxford Handbook of Organizational
Climate and Culture”, Schneider et al. (2014) speculated that the concept, language and elements of organisational culture were much more interesting, capturing a richness and depth of organisational studies, in a ways that climate research never had (Schneider & Barbera 2014b). From a consolidation point of view, it was the publication of three bestselling books in quick succession in the early 1980s: Ouchi’s (1980) Theory Z; Peters and Waterman’s (1982) In Search of Excellence; and Deal and Kennedy’s (1982) Corporate Culture which really popularised organisational culture. The fact that all three books advocated that leaders should focus on the culture in their organisations, if they wanted to be more successful and improve their performance, added further to the phenomenon (Russell et al. 2008). Organisational culture as a concept became widely available to practitioners for the first time.

Even as culture became an established field of organisational research in the 1990s, the lack of unity and precision in academic research lead to the development of consultancy tools rather than research methodologies (Chatman & O’Reilly 2016). There was frustration and debate within the academic community concerning the appropriate methodology, discipline and composition of organisational culture. Denison (1996) queried the number of quantitative studies on organisational culture as a “most curious development” (Denison 1996 p. 620). He argued that quantitative studies were the very opposite of the foundational epistemological of culture research, which he believed was qualitative (Denison 1996). This assumption could be considered rather arbitrary, in view of the variety of research methodologies that were being applied in the mid-1990. In fact, a few years later Denison developed a quantitative cultural assessment instrument himself, which is currently available through his consultancy company under licence.

It is not surprising that this period in the development of organisational culture also coincided with the great debate about “paradigms and the politics of research” (Teddlie & Tashakkori 1998 p. 1). The fledgling construct of organisational culture, emerging from a multidisciplinary birth of psychology, anthrology and sociology, was thrust into the great, decade long, methodological debate between disciplines, referred to as the Paradigm Wars (Guba & Lincoln 1994). These paradigm wars did nothing to consolidate or unify the research on organisational culture, which by now was ingrained in the discussion on methodology and paradigms.
2.1.2 Organisational Culture Defined

Notwithstanding the debate on methodology, paradigms and composition, organisational culture has been the subject of academic debate for several decades (Schein 2004). Reviewing the literature there appears to be agreement that “it” exists, that “it” is important but the method of defining “it” is very varied (Deal & Kennedy 1982, Hofstede et al. 1990, Beyer & Trice 1993, Martin 2002, Cameron & Quinn 2011a, Dixon-Woods et al. 2014). The generally accepted position is that culture is a unit level phenomenon, which when developed covers all aspects of a group’s functioning (Schein 2004, Hofstede & Hofstede 2005, Chatman & O’Reilly 2016). While some publications offer a multitude of definitions, others make no attempt to define culture at all (Dowswell et al. 2001, Marshall et al. 2003b, Hann et al. 2007, Mash et al. 2008, Brazil et al. 2010, Adams et al. 2017, Coelho Silva et al. 2017). Of the reviewed publications, the most cited definition of organisational cultural came from Edgar H. Schein, defining organisational culture as the...

“patterns of shared basic assumptions that was learned by a group as it solved its problems of external adaption and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to these problems” (Schein, 2004. p. 17)

When a specific theory or framework was applied in a study, the assumed definition was generally the one associated with that theory. In the case of the publications which applied the Competing Values Framework (Section 2.1.6) to measure organisational culture in healthcare the definition of organisational culture was,

“an enduring set of values, beliefs, and assumptions that characterize organisations and their members” (Cameron & Quinn 2011a p. 169).

There are a number of common elements in all definitions of organisation culture, which includes shared values, behaviours and assumptions by members of a common group or organisation. While this excludes external influencers, like patients in this research, it provides veracity, applicability and neutrality in the standards of quality. However with little evidence of consolidate of definitions the metaphors and idioms discovered in the literature are useful for communication purposes (Table 2.1). Ultimately, with its roots in several disciplines, it is suggested that the definition is heavily influenced by the applied
paradigm of the research (Schneider et al. 2017). Ultimately organisational culture is something that an organisation ‘has’ (Schein 1985, Cameron & Quinn 2011a), or organisational culture is something that an organisation ‘is’ (Smircich 1983). For the purpose of this research, considering the literature, organisational culture is accepted as something the organisation has. This is in keeping with the researcher’s worldview which is discussed in Chapter 4.

Table 2.1 Categories and Metaphors of Organisational Culture

<table>
<thead>
<tr>
<th>Terms / Concepts</th>
<th>Meaning of Term or Concept</th>
<th>Author and Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rules of The Game</td>
<td>Unwritten rules for getting along in the organisation or being shown “the ropes”</td>
<td>(Schein 1985)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Van Maanen &amp; Barley 1984)</td>
</tr>
<tr>
<td>Observable behavioural regularities</td>
<td>Language, tradition, customs, and rituals employed in a variety of situations</td>
<td>(Beyer &amp; Trice 1993)</td>
</tr>
<tr>
<td>when people interact</td>
<td></td>
<td>(Van Maanen &amp; Barley 1984)</td>
</tr>
<tr>
<td>Espoused Values</td>
<td>Publicly announced principles and values that the group claim.</td>
<td>(Deal &amp; Kennedy 1982)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Schein 1985)</td>
</tr>
<tr>
<td>Formal Philosophy</td>
<td>Broad polices and ideological principles, example HP Way</td>
<td>(Ouchi 1981)</td>
</tr>
<tr>
<td>Embedded Skills</td>
<td>Special competencies, passed from generation to generation</td>
<td>(Argyris &amp; Schon 1978a)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Peters &amp; Waterman 1982)</td>
</tr>
<tr>
<td>Habits of Thinking</td>
<td>Shared cognitive frame, software of the mind, perceptions, thoughts, taught to new members.</td>
<td>(Hofstede &amp; Hofstede 2005)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Van Maanen &amp; Barley 1984)</td>
</tr>
<tr>
<td>Shared Meaning</td>
<td>Emergent understanding created by group members as they interact.</td>
<td>(Smircich 1983)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Van Maanen &amp; Barley 1984)</td>
</tr>
<tr>
<td>Formal Rituals &amp; Celebrations</td>
<td>Values and “rites of passage” by members reflecting values.</td>
<td>(Deal &amp; Kennedy 1982)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Beyer &amp; Trice 1993)</td>
</tr>
<tr>
<td>Attributes of Organisation</td>
<td>Can be measured separately from other organisational phenomena</td>
<td>(Cameron &amp; Quinn, 2004)</td>
</tr>
<tr>
<td>Pattern of Basis Assumptions</td>
<td>Assumptions invented, discovered, or learned by a given group as it learns to cope with its problems</td>
<td>(Schein 1990)</td>
</tr>
</tbody>
</table>
Considering this position organisational culture is viewed as an independent variable, which influences other variables in the organisation, therefore it can be measured, managed, and manipulated. The definition applied for this study is that of Cameron and Quinn (2011) as supported by the findings of the systematised review outlined in Chapter 3.

2.1.3 Culture is not Climate – Lessons for Healthcare

Proceeding organisational culture by several decades, organisational climate was originally very much focused on the study of individual behaviours and abilities, associated with life space or work settings (Lewin et al. 1939). The research was conducted through employee surveys, previously labelled industrial psychology, now referred to as organisational psychology (Ehrhart et al. 2014). Throughout the 1920s and 1930s climate research developed many terms including social climate, social environment, work environment, workplace climate, atmosphere, and even human relations climate (Lewin et al. 1939, Pellegrin & Currey 2011, Ehrhart et al. 2014). The examined literature offers several explanations as to the differences between culture and climate, one being its inception, another being the level at which the research is conducted, and yet another being the methodology as suggested by Denison (1996).

<table>
<thead>
<tr>
<th>Table 2.2 Contrasting Organisation Culture and Climate Research Perspectives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organisational Culture</strong></td>
</tr>
<tr>
<td>Has its roots in Anthropology &amp; Sociology</td>
</tr>
<tr>
<td>Focus on an emic or individual point of view.</td>
</tr>
<tr>
<td>Evolves very slowly and is not easy to change.</td>
</tr>
<tr>
<td>It is a highly enduring characteristic of the organisation (historical evolution)</td>
</tr>
<tr>
<td>Level of analysis – underlying values and assumptions, relatively invisible, sub-conscience</td>
</tr>
<tr>
<td>Methodology &amp; Epistemology</td>
</tr>
<tr>
<td>Qualitative field observations - contextualisation</td>
</tr>
</tbody>
</table>
Assigning field notes, stories and qualitative data to culture and quantitative surveys and statistical analysis to climate is however viewed as an oversimplified explanation of the difference considering the methodological and disciplinary developments in both fields. Despite some reservations of Denison (1996) classification of culture and climate, his contrasting table is succinct, and particularly relevant from a research point of view (Table 2.2). In practice Denison (1996) applies the Lewin (1951) perspective that it is managers who create the climate that others work in (Lewin 1951, Denison 1996).

Figure 2.1 Model of Culture and Climate in Healthcare

(West et al. 2014 p. 337) Reproduced Courtesy of Professor Michael West 2019

West et al. (2014) provided further clarification on both constructs specifically in the area of healthcare (Figure 2.1). The framework offered by West et al. (2014) is in keeping with Lewin’s (1939) research on workspace and individual cognition, and also mirrors Schneider’s (1975) earlier proposal. Schneider speculated that climate should be ‘for’ something, a climate for safety, a climate for service or a climate for staff wellbeing.
(Schneider 1975). While organisational culture is focused on collective sub-conscious values and their contextualisation, climate is focused on visible outcomes and employee perceptions.

The important of differentiating between climate and culture is a view expressed by a number of scholars in the field (Schein 2004, Cameron 2011, Ehrhart et al. 2014, Schneider & Barbera 2014b). In the complex sector of healthcare, where restructuring and costly interventions often only provide minimal improvements (Bates & Hughes 2015), which are described as “weak at best and situation dependent” (Braithwaite et al. 2015a, p. 300), it is critical to explore the deep-rooted domains of culture and not just the surface-level ones of climate. However, despite the available research on both constructs, scholars continue to use both constructs interchangeably, often overlapping, especially in healthcare literature (Pellegrin & Currey 2011, Zoher 2014, Health Service Executive 2015, Government of Ireland 2019b). Schwartz and David (1981, p. 33) proposed “one way to understand culture is to understand what it is not”, this section concludes that organisational culture is not organisational climate, concurring with Harris and Ogbonna (2002). If culture is the personality of an organisation, climate is the organisation’s mood. Having established what culture is not (Harris & Ogbonna 2002), an investigation into the theory of organisational culture will establish its composition and measurability.

2.1.4 The Theory and Conceptualisation of Organisational Culture

Having summarised the development of organisational culture and reviewed its definitions, the theory of organisational culture is investigated and discovered in this section. Numerous publications in the scholarly literature have proposed a multitude of theories and frameworks for the complex construct of culture (Deal & Kennedy 1982, Peters & Waterman 1982, Geertz 1983, Smircich 1983, Schein 1985, Cameron & Ettington 1988, Denison 1990, Martin 1992, Beyer & Trice 1993). In addition, organisational culture has also been studied through a variety of disciplines including anthropology, sociology, organisational psychology, and management theory.

Smircich (1983) offered a cognitive, structural and psychodynamic perspective, which merged both culture and organisational theory through an anthropological lens. Peters and
Waterman (1982) provided more of an ideology, rather than a theory, citing the ability to differentiate, analysis and manipulate organisational culture for the improvement of quality, as a competitive advantage for an organisation. Geert Hofstede (1980) adopted a sociological stance, conducting worldwide quantitative research (1968-1972) with IBM employees (n=116,000) across 72 countries (Hofstede 1980). The five dimensions of Hofstede’s theory were used to compare cultures across global IBM plants, but the analysis provided a theory of country culture, not individual, company or unit culture (Landy & Conte 2007). Hofstede et al. (1990) had come to this conclusion himself, following additional mixed methods research in 1990 in 10 different companies, across 62 different units in Denmark and The Netherlands. Regardless of this position, Hofstede et al. (1980) is still frequently cited in research on organisational culture, even though he contested himself that to use the term ‘culture’ to describe both national culture and corporate culture was misleading (Hofstede et al. 1990).

Another eminent scholar in the field provided three different perspectives on organisational culture (Martin, 1992). Martin’s (1992) integrated perspective theory is presented as the glue, binding people together. This aligns culture to the commonly accepted shared values in many other cultural publications (Ouchi 1981, Kotter & Haskett 1992, Cameron & Quinn 2011a, West et al. 2014). This integration perspective is in keeping with the philosophy that the organisation ‘has’ culture (Schein 1985, Cameron & Quinn 2011a). Martin’s (1992) second differentiation perspective is represented by differences and is fraught with conflict. Martin (1992), herself, describes the differentiation perspective as being the manifestation of culture which has an inconsistent presentation as in “when top executives announce a policy and then behave in a policy-inconsistent manner” (Martin 1992 p. 94). Her third offering, fragmentation perspective, is presented as ambiguous and assumes that the culture is unknowable. It is reported that “in the integrated perspective … culture derives its power”(Cameron & Quinn 2011a, p. 25).

One of the most prolific writers in the field of organisational culture, Edgar Schein, introduced yet another social and organisational psychology approach, stressing the theoretical importance of depth in cultural levels (Schein 1985). Schein (1985) proposed three levels, the artifacts, espoused beliefs and values, and finally the underlying assumptions being the different “degrees to which the cultural phenomena is visible to observers” (Schein 2004 p. 25 ). Not an advocate for the measurement of organisational
culture, Schein stated that although team members could be observed, culture itself could not. However, he also suggested that if the researcher engaged organisation members in detailed interviews, using the skill and techniques of a clinical psychologist, the collective shared assumptions, at the deepest level of culture could be understood (Schein 1987).

Table 2.3 Disciplinary Foundations of Organisational Culture

(Cameron & Quinn 2011a p. 167)

<table>
<thead>
<tr>
<th></th>
<th>Anthropological Foundation</th>
<th>Sociological Foundation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Functional Approach</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assumptions</td>
<td>Organisations are culture</td>
<td>Organisational have culture</td>
</tr>
<tr>
<td>Focus</td>
<td>Collective assumptions</td>
<td>Collective behaviour</td>
</tr>
<tr>
<td>Observation</td>
<td>Subjective factors</td>
<td>Objective factors</td>
</tr>
<tr>
<td>Variables</td>
<td>Dependent (understand culture by itself)</td>
<td>Independent (culture predicts other outcomes)</td>
</tr>
<tr>
<td><strong>Semiotic Approach</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assumption</td>
<td>Culture is reality</td>
<td>Culture makes sense of reality</td>
</tr>
<tr>
<td>Focus</td>
<td>Individual assumptions</td>
<td>Individual cognitions</td>
</tr>
<tr>
<td>Observation</td>
<td>Participant’s immersion</td>
<td>Participant’s observation</td>
</tr>
<tr>
<td>Variable</td>
<td>Dependent (Understand culture by itself)</td>
<td>Independent (Culture predicts other outcomes)</td>
</tr>
</tbody>
</table>

Considering the breadth and the range of scholarly theory discovered in the literature, it is beyond the scope of this research to provide a comprehensive analysis of all the types, formats, models, concepts, and theories available on organisational cultural. Nonetheless, this section has sought to summarise the most commonly cited scholars and theoretical foundations discovered in the literature. Exploiting this approach (Table 2.3) summarises the two main theoretical approaches applied in the study of organisational culture, one which is rooted in anthropology and sociology providing a functional approach (culture emerges from collective behaviour) and the other a semiotic approach (culture resides in individual interpretations and cognitions). In keeping with both the most frequently used definition of organisational culture and the most commonly applied theoretical approach used in healthcare, this research adopts the functionalist sociological stance (Table 2.3).
organisation ‘has’ culture; and is considered a socially constructed attribute (Cameron & Ettington 1988, Schein 2010, Janićijević 2011).

**Figure 2.2 Level and Manifestations of Organisational Culture**
(Source adapted from Cameron & Quinn, 2011, p. 19, Schein, E. 2004, p. 26)

Having established a definition and a theoretical position on organisational culture Figure 2.2 provides a visual representation of the attributes of organisational culture and the levels at which they are observable. These levels are derived from the theory of Cameron and Quinn (2011). The framework and associated theory presents organisational culture “as an important factor which accounts for organisation performance in that it encompasses the taken for granted values, underlying assumptions, expectations and collective memories” (Cameron & Quinn 2011a p.19). This manifestations of culture ranges from the observable explicit behaviours and artifacts, to the deepest unobservable level of unconscious beliefs, thoughts and perceptions which define the human condition (Cameron & Quinn 2011a). The elements of organisational culture therefore exist on a continuum from the observable to the unobservable. Other scholars have also adopted this principal of ‘levels’ with Schein providing three levels, including observable artifacts (structures and processes), espoused values and unobservable assumptions, and beliefs. This sociological stance looks deeper to
the collective behaviours, not just the espoused ones (Schein 1985, Cameron & Quinn 2011a). Considering the ‘levels’ approach and the observability of organisational cultural elements, one notable shortcoming in the reviewed literature was the failure of studies to explore deeper than the observable explicit behaviours and artifacts (level 1 & 2). This observation was also made by Scott (2003) in his review of organisational culture and performance in healthcare literature review (Scott et al. 2003c).

Schein (1985) advised that in order to capture the deepest and most unique levels of an organisation’s culture, researchers should compare the discrepancies between the exposed values (what is said) and actual values (what is done) (Schein 1985). Braithwaite (2020) more recently described this position as work imagined versus work done (Braithwaite et al. 2020b). It is proposed that this deep level of investigation can be achieved by greater utilisation of qualitative methods (Scott et al. 2003c). It has also been suggested that to explore the many levels and facets of organisational culture researchers would be better served to apply a mix of both objective and subjective methods (Janićijević 2011). Accepting this understanding of organisational culture, the next stage of the concept review establishes what is being measured in the literature and how is it being measured (Cameron & Quinn 2011a).

2.1.5 Measuring Organisational Culture

Most of the scholarly literature reviewed accepts that organisational culture has a powerful impact on the success, effectiveness and in many instances the performance of an organisation (Deal & Kennedy 1982, Denison 1990, Gordon & DiTomaso 1992). However, organisational culture is also identified as complex, with multiple definitions and even more options when the topic of measuring organisational culture is investigated. Edgar Schein (1985, 2010), among others in the field, directed that what managers pay attention to and apply resources to is what becomes the implicate guidelines for organisational behaviours (Schein 1985, 2010, Schein & Schein 2016). It is therefore prudent to measured and managed organisational culture (Cameron & Quinn 2011a). The literature provides two distinct methods by which organisational culture has previously been measured, dimensionally or typologically (Jung 2009). This study explores research conducted in the healthcare sector using both methods, starting with the dimensional approach.
2.1.5.1 The Dimensional Measurement of Organisational Culture

When investigating the measurement of organisational culture and suitable survey instruments, in the National Health Service (NHS) in the United Kingdom, Mannion et al. (2008) identified 340 unique dimensions of organisational culture which were used across 48 different measurement instruments (Scott 2003, Mannion et al. 2008). Ott (1989) had previously identified 74 dimensions in his studies (Ott 1981), while van der Post et al. (1997) had identified over 100 (van der Post et al. 1997). Denison (1996) suggested that the number of dimensions were only limited by the number of adjectives that theorists, researchers and practitioners could induce to describe the social and psychological environment of organisational culture (Denison 1996). Alvesson (2002) argued that by making the dimensions of organisational culture too open and too broad, the construct would become vacuous, suggesting it could simply be used to cover everything and therefore nothing (Alvesson 2002).

Scott (2003) who has published widely in the healthcare field, observed that the dimensional approach, brought a complexity of choice which did little to address the challenge of measuring organisational culture in a healthcare setting which was already besieged by complexity (Scott et al. 2003a). Revisiting the comprehensive investigation in the NHS (National Health Service UK) over a number of studies, Mannion et al. (2008) concluded that the number of dimensions which contributed to organisational culture, really depended on the setting, the context, and the purpose of the research rather than the features of the organisation. In order to address the dimensional paradox (Alvesson 1993, Denison 1996, Mannion et al. 2008, Jung 2009), the typological approach is considered. This approach goes further than the dimensional perspective, by not only considering the dimensions or domains of culture but also the types of culture (Janićijević 2011). The typology approach seemingly presents a viable option for the measurement of organisational culture in healthcare which is now considered and investigated with a view to legitimising its application in the current study.

2.1.5.2 The Typological Measurement of Organisational Culture

Having established that the dimensional approach to the measurement of organisational culture is only limited by the number of studies (Alvesson 1993, Denison 1996), the
typological approach appears more consistent, more replicable and more pragmatic (Scott et al. 2003a, Schein 2004). Typology-based survey instruments are also commonly based on the values which prevail in the workplace (Deal & Kennedy 1982, Beyer & Trice 1993, Cameron & Quinn 2011a). This is in keeping with the acceptable definition of organisational culture, in contrast to the dimensional approach as previously outlined, which could render the measurement of organisational culture unreasonable, due to the sheer volume of possible dimensions.

The typology approach was initially adopted by the educational sector in the form of the Competing Values Framework and other instruments which were derived from the same framework over time (Cameron & Quinn 2011a, Denison et al. 2014, Schneider & Barbera 2014a, West et al. 2014). Utilising this framework to measure organisational cultural, the construct is presented as having a “limited number of types” (Scott et al. 2003, p. 66). Foundational literature, in the area of physiological archetypes, has confirmed that a limited number of classifications (typologies) could be applied to groups in organisations, in the same way that Carl Jung’s (1923) personality types could be applied to individuals (Mitroff 1983). Kim Cameron’s seminal paper (1985), validated Mitroff’s research and also confirmed that Jung’s identified physiological types agreed, with schemas in a wide variety of collective circumstances, including organisations.

The typology approach also provides “the best validation to assess healthcare organisational culture” (Scott et al. 2003a p.63) and the Organisational Cultural Assessment Instrument, OCAI™ (derived from The Competing Values Framework) has been identified as the most widely used typology instruments applied to measure organisational culture in healthcare (Table 2.4) (Gerowitz et al. 1996, Jones et al. 1997, Gerowitz 1998b, Dowswell et al. 2001, Shortell et al. 2001, Wakefield et al. 2001, Gifford et al. 2002, Berlowitz 2003, Marshall et al. 2003b, Bosch et al. 2008, Mash et al. 2013, Scammon et al. 2014, Adams et al. 2017, Hann et al. 2017). The inception of this framework is based on two dimensions. One axis reflects whether the organisations attention is focused inwards towards its internal dynamics, or outwards towards the external environment. The second axis reflects the organisations preference for flexibility versus control (Gerowitz et al. 1996, Goodman et al. 2001). The quadrants yield four culture orientations (Figure 2.3). Each of the cultural typologies has a polar opposite, with the same domains across each cultural type, one of which is leadership which reinforces the cultural values of the organisation type through interaction patterns and

While some culture types have been relabeled over time, the intent has remained constant (Denison & Spreitzer 1991, Cameron & Quinn 2011a). The four cultures highlight the inherent challenges faced by organisations, balancing stability versus innovation and people versus process. An example of the relabeling of the four typologies is Cameron and Freeman’s (1991) Open System Culture, which became Denison and Spreitzer (1991) Developmental Culture, which Cameron and Quinn’s (2004, 2011) relabeled as Adhocracy or a Creative Culture.

1) Clan (Collaborative) / Human Relations Model / Group Type
2) Adhocracy (Create) / Open System Model / Development Type
3) Market (Compete) / Rational Goal Model
4) Hierarchy (Control) / Internal Process Model / Empirical Type


A brief review of the organisational culture types provides the context for the theoretical Competing Values Framework which is outlined in the next section of this chapter.
Can (Collaborative / Human Relations Model)

Clan culture emphasizes flexibility, discretion, and internal focus. Cameron and Quinn (2011) describe clan cultures as friendly places to work, “where people share a lot of themselves” (Cameron & Quinn 2011b p. 30). Cohesive group commitment is valued in this cultural type, where loyalty is important, with a focus on human development. The main assumptions underlying clan culture is that “human affiliation produces affective employee attitudes directed towards the organisation” (Hartnell et al. 2011 p. 679). The organisation emphasises the long-term benefits of employee involvement and empowerment. These efforts are expected to increase staff morale, work satisfaction and commitment (Cameron & Ettington 1988). However, without balance in a clan culture the organisation will become negative and permissive. The environment will become lax and disorderly where outcomes and results are under-emphasised (Cameron & Quinn 2011b), a culture which Goodman et al. (2001, p. 61) referred to as “irresponsible country club”.

Adhocracy (Create/Open Systems Model)

The glue that holds this culture together is commitment to experimentation and innovation. The Adhocracy culture is like Clan culture, in that it emphasises flexibility and discretion; however, the internal focus is different. In this respect the culture is more like the Market culture, with its external focus and concern for differentiation. Adhocracy culture believe that “an idealistic and novel vision induces members to be creative and take risks” (Hartnell et al. 2011 p. 679). The focus of long term growth is on acquiring new resources (Cameron & Quinn 2011a), ultimately organisation flexibility, adaptability, growth, autonomy, and attention to detail is what is valued (Quinn & Rohrbaugh 1983). In this culture these efforts are expected to cultivate innovation, and cutting edge outputs (Denison & Spreitzer 1991). This type of organisation thrives in turbulent times, with agile responses. However taken to the extreme this organisation will become negative, represented by “tumultuous anarchy” (Goodman et al. 2001, p. 61), constant chaotic multiple ideas, with not enough emphasis on achieving predictable outcomes and structure (Cameron & Quinn 2011b).
Market (Compete/Rational Goal Model)

Similar to the final culture typology, Hierarchy, the Market culture is very results-orientated, with a focus on getting the job done, through a tough, oppressive and demanding regime (Cameron & Quinn 2011a). Market type organisations value stability and control, however, instead of an inward focus they have an external orientation with a focus on winning. The principal belief in market culture is that clear goals and contingent rewards motivates employees to aggressively perform and meet key performance indicators and other targets (Hartnell et al. 2011). Market organisations are concerned with competitiveness and the organisation is hard driving, the stress is on the planning and goal setting to achieve efficiency (Quinn & Rohrbaugh 1983). The competitiveness in this organisation in extremes can give rise to self-interests and conflict, as the person-centered issues are ignored (Cameron & Quinn 2011b).

Hierarchy (Control/Internal Process Model)

The fourth and final cultural typology is Hierarchical, referred to by Goodman et al. (2001, p. 61) as a “frozen bureaucracy”. This culture is a very formal and structured place to work. These organisations place great emphasis on stability and control with an internal focus. Hierarchical organisations share similarities with the stereotypical large, bureaucratic corporation. Standardisation is valued as is well-defined structures of authority and decision making. “This model would commend an orderly work situation with sufficient coordination and distribution to provide participants with a psychological sense of continuity” (Quinn & Rohrbaugh 1983 p. 371) Rules and policies hold the organisation together, processes which were often evident in the public sector of the 1960s, referred to as a command and control culture (Cameron & Quinn 2011). Leaders in these cultures are considered coordinated and organised with a focus on efficiency (Cameron & Quinn 2011a). In excess this type of organisational culture becomes bound by red tape, languishing in bureaucracy and organisational stagnation (Cameron & Quinn 2011b).

Having established the most common typologies of organisational culture, an investigation into the supporting framework and its inception provides additional clarification.
2.1.6 The Competing Values Framework (CVF)

Complementary to the typology approach for measuring organisational culture, throughout the 1970s and 80s, a number of studies found evidence of a variety of organisational attributes linked to organisational culture including individual decision making and information processing (Driver 1979, 1983), management style and behaviour (Mason & Mitroff 1973, Gerowitz 1998a), cultural strength and congruency (Cameron 1985) and quality of work life (Goodman et al. 2001). Investigating organisational effectiveness and leadership style independently, Rohrbaugh and Quinn (1981) and Carrier and Quinn (1985), demonstrated almost the exact same types previously verified by Jung (1923) (Quinn & Rohrbaugh 1981, Carrier & Quinn 1985). These individual studies continued to add to, or build on, Jungian theory on the nature and archaic roots of personality types. These developments could be translated into the culture of organisations, using a typology approach which had a “strong provenance in social theory and organisation studies” (Scott et al. 2003c p. 64).

Table 2.4 presents a selection of such studies in healthcare which contributed to the popularity and development of the Competing Values Framework and its respective survey instrument, which has frequently been presented as pioneering. While the definition of organisational culture is far from consensual (Dixon-Woods et al. 2014), it is operationally defined in this study as being determined by the values, beliefs and assumptions of the members of the organisation from the observable to the unobservable (Cameron & Quinn 2011a). It is recommended that a validated theory should be used to ground the methodology, the design of the research and the interpretation of the findings (Creswell & Creswell, 2018).

Having comprehensively reviewed the options, this research proposes the Competing Values Framework as a possible comprehensive theory and framework to measure organisational culture, subject to further exploration in the systematised review presented in Chapter 3. First a detailed investigation is provided on the challenges currently being faced in the global healthcare sector and why reform and cultural change is imminent.
Table 2.4 Competing Values Framework Studies Conducted in Healthcare Settings

<table>
<thead>
<tr>
<th>Scale version</th>
<th>Research Details</th>
<th>Typology and Internal Consistency of Study</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ipsative</strong></td>
<td>Zammuto &amp; Kraower (1991)</td>
<td>Clan .82 / Adhocracy.83 Market .78 /Hierarchial .67</td>
</tr>
<tr>
<td><strong>Ipsative</strong></td>
<td>Shortell et al. (1995) USA n=7,337 staff in 61 hospitals</td>
<td>Group .79 / Entrepreneurial .60 Rational .40 /Bureaucratic .75</td>
</tr>
<tr>
<td><strong>Likert</strong></td>
<td>Jones et al. (1997) n= 260/550 n= 278/550 Caregiver in 4 hospital units during reform</td>
<td>Clan .92 /Adhocracy.91 Market .92 /Hierarchial .92</td>
</tr>
<tr>
<td><strong>Ipsative</strong></td>
<td>Meterko et al. (2004) USA VHA Hospital Staff Culture and Inpatient Satisfaction n=12,406 (1997), n=8,454 (2000)</td>
<td>Group .81 /Developmental Rational .36 /Hierarchial</td>
</tr>
<tr>
<td><strong>Ipsative</strong></td>
<td>Wakefield et al. (2001) USA n=297 Nurses in 6 hospitals</td>
<td>Group .79 /Developmental .51 Rational .46 /Hierarchial .46</td>
</tr>
<tr>
<td><strong>Ipsative</strong></td>
<td>Goodman et al. (2001) n= 276 staff from Hospital Obstetrics unit in 7 hospitals.</td>
<td>Group .80 /Developmental .78 Rational .78 /Hierarchial .66</td>
</tr>
<tr>
<td><strong>Ipsative</strong></td>
<td>Strasser et al. (2002) USA n= 685 clinical and admin staff at 50 in VA hospitals</td>
<td>Not Reported</td>
</tr>
<tr>
<td><strong>Ipsative</strong></td>
<td>Lee et al. (2002) Korea n= 117 in 67 hospitals</td>
<td>Not Reported</td>
</tr>
<tr>
<td><strong>Ipsative</strong></td>
<td>Gifford et al. (2002) USA n=276 staff of obstetrics units in 7 hospital</td>
<td>Not Reported</td>
</tr>
<tr>
<td><strong>Ipsative</strong></td>
<td>Mallak et al. (2003) USA n=432 staff members of hospital</td>
<td>Team .76 /Open System .66 Rational .72 /Hierarchial .72</td>
</tr>
<tr>
<td><strong>Ipsative</strong></td>
<td>Berlowitz et al. (2003) USA n=1,065 clinical staff in 35 VA Nursing Homes</td>
<td>Not Reported</td>
</tr>
<tr>
<td><strong>Likert</strong></td>
<td>Helfrich et al (2007) USA n=71,776</td>
<td>Clan .82 /Adhocracy .85 Market .80 /Hierarchial .69</td>
</tr>
<tr>
<td><strong>Ipsative</strong></td>
<td>Davis et al. (2007) UK 899 senior managers in 189 health care organizations</td>
<td>Not Reported</td>
</tr>
<tr>
<td><strong>Ipsative</strong></td>
<td>Gerowitz et al. (1996,1998) UK, Canada, and USA Hospital Management Cultures (n=271)</td>
<td>Internal Effectiveness.80/ External Effectiveness .86 / External Efficiency .82/Internal Efficiency .79</td>
</tr>
</tbody>
</table>

2.2 Global Healthcare Systems

“Every System is Perfectly Designed to Achieve the Results It Gets”
Dr. William Edwards Deming (1900 – 1993)

The challenges for the current global healthcare systems are complex and interdependent. In order to establish the challenges, reasons for change and reform, this section first looks to the configuration of the services themselves. While a holistic ‘systems approach’ has been adopted by many organisational sectors, healthcare has struggled with the application of this approach, which is reliant on capacity building through learning (The National Academies of Sciences 2018). Across the globe, healthcare systems have been described as significant, complex, and non-linear with an annual global budget of $7.35 trillion dollars (Freedman & Schaaf 2013, Braithwaite et al. 2015c p. 7, The National Academies of Sciences 2018). Unfortunately global healthcare systems have also been described as out-moded and ‘ill-functioning’ (The National Academies of Sciences 2018 p. x), at a time of rapid technology and social evolution (Ham et al. 2012).

The World Health Organisation (2000) charged these ill-functioning systems with the responsibility of protecting citizens from “both the health risks and the financial risks of illness” (World Health Organisation 2000 p. 5), introducing performance indicators for the first time. The formative report also identified some of the challenges for the system, including badly led teams, inadequate funding, and poor structures which they suggest “could do more harm than good” (World Health Organisation 2000). In 2018, The Institute of Medicine, also expressed concerns, highlighting integrity, accountability and transparency as particularly challenging (The National Academies of Sciences 2018). A growing body of published works has established the collective concerns which have contributed substantially to adverse events, harm, injury, and failures in the delivery of healthcare worldwide (Walsh & Shortell 2004, Scally 2018). Research in the area has also established the external challenges which are commonly observed across the globe, including the shifting demographic of an global ageing population (Allen 2019).
2.2.1 An Ageing World - The Demographic Challenge

Despite the associated challenges for health and social care, the encouraging position is that healthcare systems have played a part in the historic, celebratory rise of life expectancy, which is a key indicator of population health (World Health Organisation 2000). In developed countries, the average life expectancy is currently 81 years (Allen 2019, OECD/European Observatory on Health Systems and Policies 2019b). This figure is expected to grow from a global average of 73.7 years (2018) to 74.7 by 2023, expanding the planet’s 7.7 billion inhabitants to 8.5 billion. The percentage of older adults, age 65+ varies from country to country, from 13% in Ireland to 29% in Japan, accounting for an average of 11.8% of the world’s population (686 million)(Allen 2019, OECD/European Observatory on Health Systems and Policies 2019b). This aging of the population has created many associated challenges including the growth of chronic age-related diseases. The complex care needs of older adults and the shifting burden of disease has placed a growing demand on health service resources and finances, which have become unsustainable within any reasonable budget (Layte et al. 2009).

2.2.2 Paying for The Future - The Economic Challenge

With the growing demand on services the estimated cost per capita of healthcare delivery is also likely to grow and continues to be “unevenly spread, ranging from $12,262 per capita in the United States to just $45 in Pakistan by 2023” (Smith & Yip 2016, Allen 2019 p. 2). It is now well established that across the globe governments have been seeking to control public spending, by reducing costs and increasing outcomes (Siehl & Martin 1990, Scott et al. 2003a, Parmelli et al. 2011). With raising expenditure the position is such that, economic investments have not yielded the necessary outcomes and clinical professionals are expected to do more with less (Thomas 2014).

The unsustainability of the European hospital centric system has also been highlighted in the literature (Clemens et al. 2014). The average profit margin in the top hospitals in the Netherlands is 1.8%, signalling the need for major transformation (Allen 2019), while 12% of German hospitals are in financial distress, with growing insolvency (Augurzky 2019). In the United Kingdom, NHS Hospital Trusts had a deficit of £5 billion in 2018-2019, compared to £4.3 billion in 2017-2018 (National Health Service, 2019). These losses are not surprising
considering 15% of all hospital costs in the OECD can be attributed to the financial implications associated with adverse events (The National Academies of Sciences 2018).

Notwithstanding the demand for more efficiency, recent investigations have shown that only 60% of provided care is evidenced based and 30% of all healthcare expenditure is wasted (Braithwaite 2018, Braithwaite et al. 2020a). In China, India and Kenya it is estimated that the adherence to evidence-based treatments for conditions such as asthma, chest pain, diarrhoea and tuberculosis are as low as 25%-50% (The National Academies of Sciences 2018). Apart from the associated costs, less than one in two patients are helped by the treatment (The National Academies of Sciences 2018). Even in low to middle income countries, where financial resources are at a premium, the cost of lost productivity, due to poor quality care alone is estimated to be between $1.4 and $1.6 trillion each year (The National Academies of Sciences 2018).

There is increasing concern about affordable access and Universal Healthcare Insurance (UHI) continually influences the allocation of hospital resources where the focus has been firmly on cost containment and not on reforming access and structures to futureproof the services for a growing population (Clemens et al. 2014). Observing the USA healthcare market Kleinke (1998) argued that managed care has become managed cost (Kleinke 1998). Cost containment has historically included the management of workforce allocations, a resource which the WHO cites as the most critical input in the delivery of services (Frenk 2010). However, this critical input has also been impacted by an ageing demographic and cost containment as outlined in the workforce challenge.

2.2.3 The Human Factor - Workforce Challenges

The demographic shift of this century coupled with the economic challenge of the last decade, have led to massive retirement (both mandatory and voluntary) across Europe. This has had a significant impact on the availability of the workforce in all sectors including the health sector. The European Commission estimated that by 2020 there would be a shortfall of 1 million healthcare professionals in Europe, including 230,000 doctors and 590,000 nurses (European Commission 2017). The WHO estimated the global figure at approximately 18 million, including 2.5 million doctors, 9 million nurses and midwives and 6 million allied health professionals (World Health Organisation 2018). This workforce
challenge is replicated across the globe, with applications to medical schools in the USA down by 21% since 1996 (Waldman et al. 2003). Low nurse wages in the Philippines has encouraged emigration, leaving the country with a shortage of healthcare workers (Allen 2019). India also reports a lack of medical professionals to deliver services to the 71% of their population who live in rural areas (TV Jayan 2019). The hiring and retention of the necessary medical professionals however is not a singular dimensional issue.

Surveys such as that conducted on behalf of The Physicians Foundation in the United States (n=8,774), found decreased productivity and burnout are major factors currently contributing to attrition rates among physicians. In the same study, 46% of respondents were planning a career change, while a further 17%, dissatisfied with their profession, were taking early retirement (Merritt Hawks 2018). The existing body of research provides a long list of contributing factors which impact on the recruitment and retention of healthcare workers including “fragmentation, misaligned payments, unclear goals, poor training, unreliable supply chains, burdensome rules, inadequate information flow, lack of useful data and corruption and fear” (The National Academies of Sciences 2018 p. ix). All of these factors are cited as preventing the most willing workforce from delivering a quality service. It would therefore appear that improvements are needed in working conditions, working hours, and in working practices to improve and futureproof the model of healthcare recruitment (Allen 2019).

While incentives have being applied in some countries, which vary from reduced tax rates (Malaysia), Returning Expatriates Programmes (Ireland and Malaysia), it may be time to addresses the global resource challenge at a collective strategic level. From this viewpoint consideration could be given to the role of informal carers, who in some countries provide in excess of 75% of care (The National Academies of Sciences 2018), or to the expanding role of Advanced Nurse Practitioners (ANP) who can substitute for physicians in some area. However, like any solution in a complex, interconnected system, the solutions are not linear. ANPs have contributed to a reduction in staff moral in some areas and policy makers are cautioned about the “erosion of professional boundaries” (Williams & Sibbald 1999 p. 744). Boundaries have also been cited as a concern for Firth-Cozens (2001) who found ANP and nurses were scapegoated in the search for accountability and blame (Firth-Cozens 2001). None of the remedial actions have provided the necessary results which it was hoped would improve the culture of quality and the return on investment.
2.2.4 The Return on Investment – The Ethical Challenges

Despite the economic challenges data from several studies suggest there is little correlation between the quality of healthcare provided and the cost of healthcare (Weinstein & Skinner 2010, Kelly & Cronin 2011). The WHO Report (2000) proposed that delivering the most valuable, priority service, is not the same as withholding some services based on the rationality of cost, versus value of outcomes (World Health Organisation 2000). The morally complex debate surrounding this statement, suggests there are already interventions in the form of service rationing in the current systems (Ham & Robert 2003). It has previously been observed that GP’s and nurses make everyday decisions about the rationing of limited services, whether conscious or unconscious (Kelly & Cronin 2011, Mandal et al. 2020).

It is complex to evaluate rationing in terms of financial resources in healthcare, when it has even been proposed that evidence-based medicine has been used as a euphemism for rationing, which raises some substantial ethical debates. Evidence from this research reports that diagnostic imaging in the USA has doubled in costs between 2000-2006 to $14 billion, with no evidence of an improvement in health outcomes (Kelly & Cronin 2011). Additional data from the United States suggests that one third of all healthcare costs are duplicated and unnecessary, including 30% of prescription antibiotics which were found to be needless. Globally the system is besieged by wasted resources, wasted equipment and wasted supplies, this coupled with the future consequences of errors and harm, failure to use effective care, and overuse of ineffective care wastes precious time and energy (The National Academies of Sciences 2018 p. 3). In addition patient knowledge and technology is advancing at a rate that the healthcare sector simply cannot keep pace with (Ralston & Larson 2005).

2.2.5 Growing Consumer Ownership and Technology

The consequences of the rationing of healthcare can be further complicated by the growing expectations of patients who are influenced by a consumer driven, informed society. Patients are no longer passive consumers of health services. Extensive research found they are adopting a more active role, which is facilitated by digital technology and a shift to “consumer ownership” (Ralston & Larson 2005, The National Academies of Sciences 2018 p. 81). This change from traditional engagement, has enabled patients to manage their own
care and health, driven by the expectation of a more empowering and engaged health service (Allen 2019). Patients concerns are also shifting from the diagnosis and treatment of a single acute illness to the management of interrelated multiple conditions (Ralston & Larson 2005). Research has established that patients are also demanding openness, convenience and access to information, including their own medical records (Allen 2019). However the sheer scale of the healthcare model is presented as a disconnect between the healthcare systems and the patient as consumer (Smith & Yip 2016).

The patient’s journey is further compromised by the fact that interventions in one part of the healthcare system can activate penalties in another area, creating complex patterns (Austin & Claassen 2008). Growing digital literacy is also likely to impact on service delivery, as information technology is critical for the integration of clinical information systems. Technology and e-health also have the potential to support older adults to live in their own communities. The technology care support market is estimated to become a $1.4 trillion business by 2023. This will include a mixture of home hospitals, remote patient monitoring via telehealth and telemedicine, and community intervention teams. In addition to supporting the changing needs of patients, developing technology should also support a change in how care is delivered to increase patient safety and reduce adverse events (Ralston & Larson 2005).

2.2.6 When Healthcare Fails

A sector the size and value of healthcare is vulnerable to adverse events and governance challenges, with $455 billion lost annually through fraud and corruption alone (The National Academies of Sciences 2018). There is a growing body of literature which has investigated the corruption issues including fraud, informal payments and bribes (The National Academies of Sciences 2018), fabrication of medical research and financial records (Vian 2008), staff absenteeism, false claims to insurance companies, falsification of costs associated with construction and equipment acquisition and the forgery of invoicing and procurement purchasing (Transparency International 2006).

Like the corruption and fraud in the sector, when adverse events were investigated, they too were not limited to one country. The cervical cancer scandal in New Zealand, left woman untreated to monitor the progression of their disease for twenty years. Thirty years
later in Ireland positive cervical cancer screening results went unreported (Cartwright 1988, Scally 2018). Likewise the contamination and failure of the blood service in Ireland and Canada, (where almost 30,000 patients were harmed) were cited in the same publication (Walsh & Shortell 2004). In the United Kingdom a public enquiry resulted in shocking revelations of 1,200 avoidable deaths at the Mid Staffordshire National Health Service (NHS) (Francis 2013). The report highlighted a number of shameful disclosures, where appalling care was enabled to flourish, with no one accepting responsibility for the provision of care and generally unacceptable practices (Francis 2013).

In low to middle income countries research findings highlighted 134 million adverse events annually, contributing to 2.5 million deaths. In addition over 830 million people with noncommunicable diseases (NCD) receive no treatment, with 4 million associated deaths because of ineffective care in these cases (The National Academies of Sciences 2018). The WHO (2017) estimated the annual global cost of medication error to be $42 billion or almost 1% of global health expenditure (World Health Organization 2017). Existing literature recognises the systematic, chronic failures which impact on large groups of patients, with growing number of significant hospital events year-on-year across the globe, with the exception of the Netherlands who have had a hospital inspectorate for 150 years (Walsh & Shortell 2004 p. 107).

It has also been established, that another common theme across global healthcare failures is non-disclosure. In all cases the literature found the main reason for non-disclosure was a distinctive healthcare culture of professional protectionism (Walsh & Shortell 2004). The systems was cited as being anchored in a ‘blame culture’ where the initial reaction to errors was “to find and blame someone” (Kohn et al. 1999 p. 49). Events were covered up, at the loss of learning from mistakes (Rafter et al. 2015). Data from several studies showed that the culture which employed best practice, and valued learning rather than blame as a response to errors, provided the best environment for safe care (West et al. 2014, World Health Organization 2017).

2.2.7 Organisational Culture in Healthcare

In addition to the identified failures in healthcare delivery, a growing body of evidence indicates the impact organisational cultural has on the performance, sustainability and the
health and wellbeing of employees in healthcare (Hartnell et al. 2011, West et al. 2014, Curry et al. 2017). Dixon-Wood et al. (2014) reported that good staff support, high quality leadership, and an ethos of learning and honesty, all contributed to positive organisational culture in healthcare, which should receive the same amount of attention during period of change as systems (Dixon-Wood et al. 2013). However, research also suggests that professional cultures across the medical professions are deeply engrained in individuals and their professional grouping. Revisiting the findings from the Francis Report (2013), which detailed the failures in the Mid-Staffordshire Trust of the National Health Service in the United Kingdom, the disengagement of managers and consultants was described as deteriorating tribalism with a hostile bullying culture which was a result of external threats (Ballatt & Campling 2011). The quest for perfection and avoidance of blame, coupled with a poorly resourced threatening culture experienced by front-line staff, facilitated further denial of the faults and actively distorted the truth and power relationships (Ballatt & Campling 2011). The distribution of professional power in healthcare is well established, especially in the historic case of the Irish institutional mental health setting (Brennan 2013).

However, the construct of organisational culture is complex, and is also subject to external influences similar to national and social cultures as experienced by individuals. The research provides evidence that professional cultures in the medical sector are deeply engrained in individuals, their social and professional groupings. These professional groupings could be compared to what Erving Goffman referred to as “total Institution” (Gambino 2013). While the position of organisations as institutions is beyond the scope of this thesis, at the most cursory level, the identification of norms in behaviour and social practices can be aligned to the observable artifacts of organisational culture (Schein 1985, Gambino 2013). These accrued social practices also align with Pierre Bourdieu’s classic habitus theory (Nice 1977). The professional clinical cultures, acquired during training and socialisation, could also be presented as social inequality as claimed by Bourdieu and reproduced in the hierarchal setting of healthcare. Indeed, it may be logical to suggest that large, centralized organisations like healthcare systems can provide a source of power and identity (Foucault, 1977), which unless distributed and addressed could inhibit the success of healthcare reform. The sometimes-contentious views expressed by Foucaultians could also be applied to societal culture as it is transposed into organisational culture by the organisation members. While it should be recognised that the association between power
and knowledge is well investigated and established, unfortunately power can often be exercised without knowledge as is evident in many of the modern political global systems.

Organisational culture also has a direct impact on the quality of care delivered to patients (Davies et al. 2000), with the results from 60 global case studies reporting a 90% positive correlation between culture and patient health outcomes (Braithwaite et al. 2019). However, research has also provided evidence that the culture of healthcare is not always positively disposed towards patient safety and positive outcomes (Section 2.2.6). The evidence found an “endemic culture of secrecy and protectionism in health care facilities in every country” (Walsh & Shortell 2004 p. 107). The previously cited Francis Report (2013) reported “an insidious negative culture, involving a tolerance of poor standards and a disengagement from management and leadership responsibilities” when adverse events were investigated in the UK (Francis 2013 p. 3). The reported ‘club culture’ of some clinicians, ultimately placed their own self-interest and that of their institute, above that of the patient (Francis 2013). Kohn et. al (1999) speculated that the inimitable culture of healthcare was driven by clinical professionals, who expected perfection, in a culture which regarded errors as careless or incompetent (Kohn et al. 1999).

In healthcare, as in other sectors, no ideal organisational culture has been identified or recommended in the literature (Mannion et al. 2003, West et al. 2014). The culture is determined by the characteristics valued by management which ideally should be aligned to the stated specific desired outcomes of the organisation or even unit (Davies et al. 2007). Extensive research conducted over a number of years in the N.H.S., has proven that healthcare organisations which promoted and valued innovation, and focused on staff empowerment and development were more likely to score higher on national healthcare league tables (Mannion et al. 2003). Translating these findings, these high performing cultures could be labelled Clan and Adhocracy.

Evidence from a number of studies in acute settings reported 54% of management teams (n=899) in 189 hospitals were found to have a Clan (collaborative) type culture. This was characterised by fewer patient complaints and higher staff morale, with patients scoring high on dignity and respect (Davies et al. 2007). This type of correlation is also reported in a study conducted in 125 USA hospitals (n=8,454) where Clan culture was also positively associated with patient satisfaction (Meterko et al. 2004). In contrast the opposite was true.
of the 6% of hospitals who identified a Hierarchical (controlling) (Davies et al. 2007). These Hierarchical hospitals reported long patient waiting lists, poor data quality and a negative correlation with patient satisfaction (Meterko et al. 2004, Davies et al. 2007). Gerowitz (1996) found that Clan culture dominated UK hospital (50%) and Canadian hospitals (52%) with USA hospitals reporting more balance across cultures with Rational (32%), Clan (25%) and Open (25%) culture types reported (Gerowitz et al. 1996). Gerowitz (1996) suggests in this case the culture was heavily influenced by the external political economy. Research conducted by West et al. (2014) suggests that all studies which reported a Hierarchal or controlling culture performed poorly (West et al. 2014).

The impact of organisational culture on healthcare outputs cannot be overstated, with hard evidence provided by many publications which demonstrate its link to performance and outcomes (Mannion et al. 2003, Johnson & Nguyen 2016). Unfortunately despite the growing body of evidence which shows the impact organisational culture has on healthcare delivery, many investigators continually find organisational culture in healthcare as negative, dysfunctional (Waldman et al. 2003, Balthazard et al. 2006, Johnson & Nguyen 2016), stress inducing (Merry 1998), uncertain (Williams & Sibbald 1999), error causing (Leape 1994) and defensive (Balthazard et al. 2006). This is in addition to low levels of work commitment and high staff turnover (O'Reilly et al. 1991, Kotter & Haskett 1992).

When the global challenges explored in this section are consolidated, the complexity and interdependency of the reform task becomes apparent. While many of the challenges appear external and outside the control of this inward-looking sector, one could speculate that the current workforce shortages, the fiscal wastage, demanding consumer expectations and the scale of adverse events are all anchored in the culture of the sector. A culture, which in the main, appears centralised and political, risk averse and slow to make decisions and ultimately bureaucratic and multileveled in nature (Kotter 2012). This speculation is based on the evidence which suggests that in order to deliver effective reform in healthcare, detailed consideration must be given to organisational culture. The evidence also cautions that healthcare organisations will not benefit from the integration of care unless clinicians change the way they work (Waldman et al. 2003, Ham & Curry 2011). Waldman et al. (2003) statement on the statues of healthcare provides a comprehensive summary and justification for reform “The healthcare industry has achieved an unenviable consensus: nearly everyone is unhappy with it “ (Waldman et al. 2003 p. 5).
2.3 Healthcare Reform

Considering the identified challenges outlined in Section 2.2, and the lack of inclusion of organisational culture, it is not surprising that healthcare systems are in a constant state of reform. With the ageing demographic (Allen 2019), the financial, economic and workforce challenges (Siehl & Martin 1990, The National Academies of Sciences 2018, Allen 2019), and the considerable toll of clinical and governance failures (Kohn et al. 1999, Davies et al. 2000, Walsh & Shortell 2004, Lee 2016), the health sector has been in the spotlight for several decades (Mannion et al. 2005, Briggs & Isouard 2016). Events like those cited in the Francis Report (2013), have propelled quality and safety up the UK political agenda (Mannion et al. 2005), were it has also placed “cultural transformation at the heart of governments reform” (Mannion et al. 2005 p. xv). Scholars in global healthcare reform suggest that the imputes for the reform is common across most countries being, the containment of costs and the improvement of quality and standards, however the process and content of the reform can vary from country to country (Braithwaite et al. 2015a).

Reviewing the research on global reform activities, they have included reformed legislation in Argentina (Arce & Elorrio 2015), re-arranged structures in Mexico, Australia, Canada and England (Lewis & Kouri 2004, Duckett 2015, Powell & Mannion 2015, Ruelas 2015), and restructured sub-structures in Brazil (Carvalho de Noronha et al. 2015). In developing countries the focus has been on improving the access to healthcare, while increasing and training the workforce (Al-Mandhari 2015, Gyani 2015). Israel, Finland, Sweden, Oman, China and Taiwan have focused on technology (Braithwaite et al. 2019). Policy, governance and access also accounted for a number of initiatives in Japan, India, Iran, Serbia, Rwanda, Venezuela, Argentina and Ireland (Braithwaite et al. 2019), where the previously abandoned governance structure (HSE Board) was reintroduced (Government of Ireland 2019b). While all these reform activities are important, they are not singularly sufficient to improve the quality of care (Davies et al. 2000, Mannion et al. 2003, Mannion et al. 2005). Cultural change needs to be included in reform activities in order to create an environment where excellence can flourish (Mannion et al. 2005). However the barriers and obstacles to reform are described as considerable across many studies (Braithwaite et al. 2006 2003, Briggs & Isouard 2016), especially when studies have tried to incorporate cultural reform (Davies 2002, McDonald 2005, Pascaris et al. 2008, Adams et al. 2017, Nightingale 2018, Al Lawati et al. 2019).
### 2.3.1 Reform Types and Processes

Regardless of the reform activities presented in Section 2.3, the most common type of reform in healthcare is characterised as “slow and steady” or incremental (Braithwaite et al. 2015a p. 306). Historically a number of different reform types have been identified which relate directly to the stage of development of the country’s healthcare system. A brief summary of the most common reform types can be found in the publication of Ham (1997) who reports four main types of reform: Big Bang Reform (UK), Incremental Reform (The Netherlands), Bottom-Up Reform (Sweden), and Reform within Reform (USA). In addition to these self-explanatory processes additional models of reform have also been identified in the literature including the Punctuated Equilibrium Model (Braumgartner & Jones 1993, Braithwaite et al. 2015b, Powell 2016) which is described as periods of stability followed by short bursts of “big bang” attempts (Braithwaite et al. 2015b). In addition the Gradual Change Framework (Rocco & Thurston 2014), with its “small slow and granular reform” (Kickert & van der Meer 2011) has been associated with a number of different terms including “cumulative but transformative change” (Mizrahi & Cohen 2012).

Possibly, because of the lack of success with change initiatives, many types of reform have been criticised. Ham (1994) himself suggested that the Big Bang approach adopted by the UK was lacking in detail and even accused the reformers of making it up as they went along (Ham 1994). The limitations and the likelihood of success and sustainability from a Big Bang approach was also cited, associated with the challenge of implementation (Briggs & Isouard 2016). Incremental reform was actually described as slowing, deforming, and even prohibiting fundamental change. Kirkman-Liff (2017) likened the increasing rigidity, due to the prior reform failures as like “hardening cement” (Kirkman-Liff 1997). His research in the USA reported that it was impossible for the system to move forward (through the cement) over time as the stakeholder relationships had become intractable, frustrated by the constant reforming (Kirkman-Liff 1997). The risk with bottom-up reform is the variances between quality and access to services, considering the different administrative areas, which can leads to inconsistency in services for patients (Ham 1997). Reform within Reform applied in Sweden and the USA appears hard to replicate because of its organic nature and the fact that it is situation dependent.

While incremental reform remains the most common, there is no evidence of a relationship between incremental reform and an improvement in the overall quality of patient care
Assessing the available literature, the exception to this rule appears to be the occasional “bright spot” of condition specific initiatives (Dixon-Woods et al. 2014). These pockets of initiatives have included improved mortality rates for acute myocardial infarction patients in Yale University Hospital, under the ‘Leadership Saves Lives’ initiative (Curry et al. 2017), improved outcomes for stroke patients in Canada and Austria (Hofmarcher et al. 2019, Mitchell et al. 2019), and in St. James’s Hospital, Ireland where a National Haemophilia System was developed (McGroarty 2019). One interpretation of these findings is that the improvement is location and condition specific, having no impact on the overarching healthcare system, and certainly does not appear to impact or change the organisational culture.

Despite the abundance of research on reform types, some investigations contest that the most important element of healthcare reform is the actual process (Ham 1997, Powell 2016). The experience of reform in many countries is consistent with these findings, suggesting that the success of the reform lies with how the reform is implemented and by who (World Health Organisation 1997, Scott et al. 2003a, Briggs & Isouard 2016). Briggs & Isouard (2016) found that because of the continual reform process, healthcare managers were no longer in a position to inform or influence the rotating changes, which were in fact impacting their careers and their roles in the organisation.

In order to address the “how” of the reform question, a number of different corporate tools have been introduced in healthcare to achieve efficiency, undertaking quality improvement methods (QIM). These methods have included Lean Practices (Hung et al. 2019, Parkhi 2019), the Balanced Score Card (Wicks & St Clair 2007), Health Work Environment Indicators (Areskoug Josefsson et al. 2018), EFQM Excellence Models (Jackson & Bircher 2002), and Total Quality Management (Kaluzny et al. 1992, Shortell et al. 2000). Dixon-Woods et al. (2014) reports that in the UK, improvement techniques were often indiscriminately used, in the hope of quick and easy wins. Frontline staff charged with the implementing and managing of QIM initiatives were often not informed or consulted (Dixon-Woods et al. 2014). As a result, initiatives were “abandoned or forgotten after short periods of intense activities” (Dixon-Woods et al. 2014, p. 112). Sustaining a high performance in a dynamic organisation like healthcare was described as paradoxical (Wolf 2011). The ideas of performance (equally as ambiguous as culture) and sustainability are built on traditional attitudes of stability and linear solutions, which simply do not apply to
healthcare (Quinn & Cameron 1988), which is not a simple cause and effect model (Braithwaite et al. 2015a). Evidence suggests that with the continual application of corporate tools, quality techniques, reform activities and the constant reforming, healthcare systems have been unable to move forward and have even regressed (Braithwaite et al., 2015).

Regardless of the type of reform process applied, healthcare reform expert, Jefferey Braithwaite, is among many scholars who contends that unless the hard to change organisational culture, which acts to impede change, is not included and addressed in healthcare reform, healthcare systems will remain “anchored in the status quo” (Braithwaite et al. 2015a). The compelling evidence suggests that healthcare systems, while rich in prescriptions and initiatives, are often lacking in direct cultural diagnosis, which could guide more subtle and productive change. Powell (2016) also noted that reform programmes were often under operationalised. While the number of evidenced based reform case studies continues to grow, there is little evidence of knowledge sharing and a marked lack of evaluation of the reform activities (Braithwaite et al. 2015a). This suggests a dearth of connectivity between academic evidenced-based research and front-line practices and operations.

2.3.2 Reform in Community Healthcare

To date, no large-scale studies have been found which investigate organisational culture in a community healthcare region. The limited community-based research has been primarily conducted in individual primary care centres or at an individual practice level (Dowswell et al. 2001, Hann et al. 2007, Brazil et al. 2010, Pracilio et al. 2014, Adams et al. 2017). In addition, no research has been found that investigated the type and process of whole scale non-acute healthcare reform. The limited number of studies found in non-acute settings found that reform was usually implemented “through a series of subsystems of micro changes” (Chreim et al. 2012 p. 231), or as in the case of the Canadian system, through a series of specially funded initiatives and time limited projects at demonstration sites (Casebeer et al. 2010). This process is not dissimilar to the current planned Irish community healthcare reform. However Parker & Glasby (2008) suggested that in this setting GPs and primary care teams operate in a vacuum, disconnected from the overarching healthcare system (Parker & Glasby 2008). This shows that reform in the community, or non-acute settings is a real challenge of integration and cohesion.
In one of the few studies on reform in community healthcare, Parker and Glasby (2008) alleged that significant resources, including human resources, were wasted through constant reform when management time and precious financial resources were divested in the name of reform and change (Parker & Glasby 2008). Crabtree et al. (2011) suggested that community or primary care reform should not be overprescribed and should be organic, suggesting that in communities and primary care settings, the large-scale macro changes, needs to co-exist with the professional autonomy at a service delivery level. The limited research on reform at a community care level cites interpersonal dynamics, a growing role for nurses, coupled with modification, extended access hours, better access to information and data as important elements of the process of change (Crabtree et al. 2011). Dixon-Woods et al. (2014) outlined the challenges to this reform as conflicting, with unclear objectives, complex duplicate reporting to multitudes of external stakeholders, disjointed goals, and many competing and distracting demands, which created bureaucratic organisations dominated by a proliferation of rules and regulations (Dixon-Woods et al. 2014). In an era where non-acute care provision is imminently identified as the future of healthcare provision, the challenges in the reform of community healthcare are complex.

These global challenges could be compounded even further in the Irish context. General Practitioner, viewed as the lynch pin to reforming community care, provide services via their own private practices, operating within a clinical, confidential, and collegial environment which is the very opposite to the environment of healthcare management which drives the reform (Davies & Nutley 2000). In this study the examination of the concepts and context of the research continues with a review of the Irish healthcare system, its current planned reform, the integration of community healthcare services, starting with the reform history to date.

2.4 Ireland’s State of Health

Healthcare in Ireland is delivered through a mixture of public and private services. The service is governed by the 2004 Health Act and managed by the Health Service Executive (HSE); the organisation established by the Act to deliver the national service. Since its inception in 2005, the HSE has been in a constant state of reform. The national structure has previously been divided into administrative geographical areas, which has changed several times in the recent past. Services are currently administrated through a functional structure.
with nine Community Healthcare Organisations (CHOs), providing all non-acute services supported by six national hospital groups (HG), consisting of 43 hospitals (Health Service Executive 2020). The National Chief Executive Officer reports to the newly re-formed Board of the HSE and to the Government’s Minister of Health, who has responsibility for oversight of national policy. At a regional level CHOs provide services to a community population of circ. 500k. Senior management teams in each region consist of Heads of Services for each of the three main functional care groups, called divisions. These care divisions consist of Primary Care, Mental Health and Social Care (Older Persons and Disabilities), who report to the Regional Chief Executive (Health Service Executive 2019a). This structure, based on care groups rather than geographical areas, provides robust central budgetary controls. At the time of completing this research Ireland remains the only European country which does not provide Universal Healthcare entitlement which was planned as part of the Healthy Ireland Strategy (2013) and every strategic reform plan since. Although it is also a key objective of existing policy, the current planned reform continues in its noticeable absence (OECD/European Observatory on Health Systems and Policies 2019a).

2.4.1. Challenges in the Irish Healthcare System

Ireland faces the same healthcare challenges as other countries across the globe (Section 2.2). While people are living longer, not all those living longer are living healthier. In Ireland fifty percent of those aged over 65 have at least one chronic, life limiting condition. With one of the youngest demographics in Europe, the attendance at both primary care (GP visits) and hospital care (Accident & Emergency) is below the EU average; however, this is not reflected in the average cost of service. Ireland spends 20% more than the EU average on the delivery of healthcare per capita, €1,110 in 2017 versus an EU average of €835 (OECD 2019).

Like other countries, particularly in the EU, the economic challenge can be attributed in part to the hospital centric system which consumes 33% of the annual healthcare budget of €4.7 billion (Lawlor 2018). A report commissioned by the Irish Government’s Economies and Evaluation Services in 2018 reported that despite an increase in hospital funding over a three-year period from 2014 - 2017 (€680 million), plus an increase of 17% in the workforce, there was no increase in hospital activities (Lawlor 2018). The management of budgets at the countries 43 acute hospital remains a constant challenge. Even after the introduction of
Activities Based Funding in 2016, annual budgets continued to overruns by 5% in all but one hospital (Lawlor 2018). Following a review of capacity in 2018, the findings confirmed the unsustainability of the hospital-centric model of care delivery (Department of Health (DoH) 2018). The report also cited the all-party ten year strategic healthcare plan, Sláintecare, as the way to deliver integrated community based healthcare (Committee on the Future of Healthcare, Department of Health (DoH) 2018). However, the implementation of integrated community care is not without its challenges, it requires the rethinking of care location and changing traditional clinical roles.

While salaries for specialists, senior doctors and nurses in Ireland are above those paid in Western Europe, it has not alleviated the current workforce challenge. The ratio of doctors per 1,000 population in 2017 was 3.1, compared to an EU average of 3.6. This is despite Ireland having the highest numbers of medical graduates in Europe (Department of Health (DoH) 2018). The situation is complicated further by restrictions in training capacity for new doctors and the limited internship opportunities, which do not match post-graduate outputs. These issues result in Irish, and non-Irish, medical graduates seeking positions outside Ireland, contributing to the growing shortage of doctors in acute and community setting (OECD/European Observatory on Health Systems and Policies 2019a).

The community-based workforce shortage extends beyond doctors, with many services in the community under resourced. The demand for Public Health Nurses (including the planned reform activities) is expected to increase by 67% (O Connor 2019). Community Home Care Packages are also expected to increase by 122% and Home Help hours (millions), which are an integral part of community healthcare, are expected to increase by 118%, from 10.6 million in 2016 to 23.10 million by 2031 (O Connor 2019). The system has been described by the Department of Health itself as “unfair to patients; it often fails to meet their needs fast enough; and it does not deliver value for money” (Department of Health (DoH) 2012 p. i). This 2012 report, now almost ten years old, stated that it would not be possible to implement the necessary changes within the confines of the current system, citing “large scale change that delivers fundamental reform” as necessary (Department of Health (DoH) 2012 p. i).
2.4.2 A History of Healthcare Reform in Ireland

Regardless of the continual reform, the cited ‘large-scale’ reform remains elusive. The Irish government’s default setting for reform has been structural, rather than the whole system organisational reform which has constantly been identified as necessary (Thomas et al. 2021). The locally governed, eight Health Boards introduced in the 1970s became 11 in 1999, before being dissolved in 2005 in favor of a more centralised system. The new centralised system was managed by the newly established agency, the Health Service Executive (HSE). In additional structural changes, separate Hospital Groups (HGs) were formed in 2013, proposed as a transition to Independent Hospital Trusts, a move that was underpinned by a single-tiered health system based on Universal Health Insurance (Department of Health (DoH) 2013). This particular restructuring necessitated the dissolution of the existing 17 Integrated Service Area (ISA), which were replaced by the Hospital Groups and Community Healthcare Organisations (CHO) (Health Service Executive 2014).

Over the years the number of CHO has changed and in 2019 were technically replaced by Regional Integrated Community Organisations (RICOs) which were designed to be gealigned to hospital groups but are not yet operationalised. Since the commencement of this research, three major national structural changes have occurred in community healthcare between May 2018 and December 2019.

Reviewing the current planned reform strategy there is limited inclusion of organisational culture, despite the fact that organisational culture has a profound effect on all aspects of organisational life (Goodman et al. 2001). The weight of evidence suggests that “organisational culture is as much as a prerequisite of failure as it is fundamental to the success of healthcare” (Mannion et al. 2005, p. xvi). In forward planning its critical role has been overlooked. This is despite the proclamations by previous Ministers and healthcare leaders over several decades. The previous Minister of Health, Leo Varadkar, discussing reform stressed the important of address healthcare culture in an interview on reform stating,

“The next set of actions are not enormously expensive, but they are the trickiest because they involve changes in working practices, changes in culture. If I could sign a cheque for €1 million and make these things happen I would but they don’t work like that”

(Varadkar 2015, p. 26)
Despite the lack of organisational culture inclusion the current Irish reform plan is cited as the most substantial healthcare reform since the 1970s (Committee on the Future of Healthcare 2017). Significant investment has been made in the plans (Sláintecare Report 2017), which was produced by a coalition Parliamentary Committee, the first of its kind, on the Future of Healthcare in Ireland. This undertaking, with political consensus, was cited as a unique opportunity to completely reform the Irish healthcare system (Committee on the Future of Healthcare 2017). The principals underpinning the reform are based on the provision of equitable care, through a single-tiered system, where patients would be treated promptly based on need (Committee on the Future of Healthcare 2017). The foundational element of this single-tiered system is the entitlement to Universal Healthcare Insurance. While cited as a journey and a vision by the current Minister for Health, Stephan Donnelly, T.D., four years into the current reform plans UHI remains undelivered (Government of Ireland 2019b).

However, the community healthcare sector, which is the current focus of reform, has delivered some local interventions. These have included the Integrated Care Programme for Older People (ICPOP), which launched test care solutions for older adults, with a ring-fenced budget of €4.2 million. The 13 pioneer sites (2016-2018) have tested care pathways, multidisciplinary working, holistic geriatric assessments, ICT devices and integrated care teams (O Connor 2019). Some impact on local services has been reported including a 34% reduction in length of hospital stay (>85 yrs.), and a 24% reduction in re-admission (>75 yrs.), however these are still limited to the local pilot sites (O Connor 2019). The weakness in upscaling these improvements include the lack of up-to-date information, a lack of agreed care pathways across the different stakeholders, the absence of modern community and acute care infrastructures and finally a lack of governance and oversight. These challenges have been reported by the Sláintecare reform office in their 2021-2023 implementation report (Government of Ireland 2021). The jurisdiction of the Sláintecare reform office over the Health Service Executive also remains ambiguous.

Another challenge for the Irish reform programme is the continued affordability of the implementation plan. According to the most recent OECD report on Ireland’s State of Health (2019), concerns have been expressed about the level of financial funding which has been made available for the implementation of the reform in comparison to that which was envisaged by the original Sláintecare Report (2017) (OECD/European Observatory on
Health Systems and Policies 2019b). The reported annual cost of the ten year reform programme, including the patient entitlement expansions and reoccurring annual costs, is €463 million (Thomas et al. 2021). Implementation progress has also been cited as slower than expected, although the restrictive historic GP contract of service has been renegotiated in part and citizen engagement has escalated (Thomas et al. 2021). The OECD report (2019) states that the original Sláintecare Report (2017) provided a roadmap to deliver reform but “the department of health has been selective so far in implementing its recommendations” (OECD/European Observatory on Health Systems and Policies 2019b). Burke (2021) commented on the implementation advised that after a 15 month delay in the actually adoption of the reform plan, what was eventually approved was a much reduced version of the original plan (Burke 2021). It is also noted that the governmental annual budgets, have not been aligned to the key deliverables and principals outlined in the initial Sláintecare Report 2017 (Thomas et al. 2021). Moreover, despite all the structural changes previously adopted by the Irish healthcare system, the current planned structural re-alignment, designed to enable infrastructural integration and the development of strategic workforce planning and funding, has yet to be achieved (Burke 2021).

The planned structural de-centralisation, from the current nine CHOs to six regional areas, continues to remain a major roadblock to the delivery of current healthcare reform (Government of Ireland 2021). At the time of completing this research the HSE has yet to cooperate with the advancement of the regionalisation plans of Sláintecare reform (Murray 2021). This current progress has raised serious questions about the governments’ commitment to the current reform plans, which some have stated was dead on arrival (Howling 2021). It is therefore only natural to speculate that the Irish reform plans could potentially result in yet another failed healthcare transformation attempt.

2.4.3 The Pathway to Integrated Care

Prior to the introduction of the Government’s Sláintecare reform strategy, the seeds of integrated care were sown in Ireland over 35 years ago. “Planning for the Future” was a mental health policy blueprint advocating for a de-congregational approach to the delivery of residential mental health services and a move to a more community-based service (Department of Health (DoH) 1984). This progressive and innovative report was the start of ‘integrated care thinking’, a concept which had not been conceived at the time (O’Connor 2013).
“Shaping a Healthier Future” was viewed as another major step forward on the road to integrated community care (Department of Health (DoH) 1994). While the actual mechanics of the collaboration were not detailed, the objectives of integrating care systems across the acute, and community healthcare network, were clearly outlined (Department of Health (DoH) 1994, 2012). Shaping a Healthier Future (1994) imagined an integrated service which was heavily reliant on GPs as well as voluntary and community agencies. The strategy also recognised the fact that.

“The system is too compartmentalised to achieve the objective of providing care in an appropriate setting, it is essential that there are effective linkages between the services”

(Department of Health (DoH) 1994)

The strategy for the integration of care initially focused on the more vulnerable service users, mainly older adults, those with a disability, children at risk and those living with a mental health condition (O’Connor 2013). The prioritisation of older adults hearkens back to a policy first muted by the Department of Health in 1988, Years Ahead: A Policy for the Elderly (Department of Health (DoH) 1988), which recognised the important of community and care at home for this cohort. Similarly concepts like population health, health promotion and prevention, care in the right settings supported by technology, research and evaluation were all cited in previous healthcare policies (Department of Health (DoH) 2012, O’Connor 2013). What is challenging to reconcile is that, the same year this comprehensive integrated healthcare plan was introduced to “treat patients at the lowest level of complexity that is safe, timely, efficient and as close to home as possible” (Department of Health (DoH) 2012 p. 16), the existing integrated structures binding the hospitals and community care together were dismantled. This also coincides with key policy goals to move staffing numbers from the costly acute services to community services, a move which was designed to improve integration, efficiency, and expenditure (Williams & Tomas 2017). In fact, the reality was the opposite, during this period the job losses in community services were twice as many of those in acute services (2008-2014).

The implementation of an integrated care approach in Irish is constantly hindered by the weakness in the primary care system (O’Shea & Connolly 2012). The service is cited as poorly integrated, with a lack of access, which without Universal Healthcare Insurance is costly for patients. Primary Care reform has been slow, health strategies published in 2011
outline the establishment of 500 primary care teams. To the end of 2019, 127 primary care centres have been delivered. The corresponding primary care teams, including diagnostics and therapeutic supports remain unconfirmed (Department of Health 2019b). Despite the aspirations and policies, the implementation of integrated care remains stagnant and is now the responsibility of Sláintecare (Department of Health 2019b).

2.4.4 The Current Reform Plans in Ireland - Sláintecare

Four years on from the initial launch of the current reform plan in Ireland the healthcare system continues to operate in silos (Government of Ireland 2019b). While the documentation produced by the Sláintecare office appears comprehensive, the current report cites the lack of legislation to introduce entitlement to care and the inclusion of Universal Health Insurance as problematic (Government of Ireland 2019b).

While the initial Sláintecare Implementation Report (2019) clearly stated that incremental change would not be enough to reform services, the first phase of the Sláintecare Action Plan was the allocation of €20 million funding for incremental pilot projects (Government of Ireland 2019a). The funding awarded to 120 agencies, voluntary organisations, and healthcare areas, covered a very broad range of health conditions, social activities and campaigns which are presented as an opportunity to explore integration. The €20 million fund is being administrated by a government agency who administrates and manages government and EU funding, supporting disadvantaged communities and social inclusion. Prior research on incremental intervention cautions that one size does not fit all, and the level of customisation at a local level required a degree of professional coordination and pooling of resources (Shaw et al. 2011).

There is no doubt that there are many challenges in the implementation of integrated community healthcare reform, including the sharing of clinical information and the management of the transition of patients between services, all examples which build on the intensity and success of the reform (Leutz 1999). Other scholars in the area have commented on the not so subtle differences between integration at an organisational and managerial level and actual coordination, which happens at a clinical and services level (Shaw et al. 2011). This level of detail is not available from the 120 grant aided organisations funded via the Sláintecare programme. They all operate under different governance structures,
funding and service models and all with different service users and values. Despite these challenges the documented focus remains on the enhancement of community care through increased home care support, needs assessment for older adults, development of 18 community specialist teams for older adults and a host of other programme focused on an older cohort (Government of Ireland 2019b).

In conclusion, despite the evidence based research on the impact of culture on the delivery of healthcare and the government’s policy advocating for culture change, the Sláintecare Implementation Action Plan 2021-2023 makes minimal reference to cultural change activities in the four documented general workstreams (Government of Ireland 2019a). The reference to organisational culture is limited to a statement on open disclosure and employees contracts, which is limited in detail (Government of Ireland 2021). Considering the role leadership plays in changing organisational culture (Schein 1985, Cameron & Quinn 2011a), the buy in and participation of senior healthcare executives is noticeable by its absence. The senior team have yet to cooperate with the advancement of the regionalisation plans documented in reform plan (Murray 2021).

A more detailed look at the relevant literature through a systematised review provides a focused investigation into the research specific area and objectives.
Systematised Literature Review

Having explored the themes, concepts and context of the research, a systematised narrative review was undertaken to provide a more specific and critical analysis of the current published literature in the area of measuring organisational culture in community healthcare. This systematised narrative review includes elements of a systematic review, but stops short of the exhaustive quality assessment element of a systematic review (Grant & Booth 2009). However like a systematic review, the aim of the systematised process is to provide a “replicable, scientific and transparent” (Bryman 2008 p. 85) search, which ensures an unbiased, comprehensive account of the literature, supported by an audit trail to increase the rigor of the method.

3.1 Search Strategy of Literature Review

In addition to the evidence investigated and discovered in Chapter 2, this systematised review seeks to highlight the key findings previously discovered in the area of measuring organisational culture in the community healthcare sector. The review will also indicate the preferred instrument by which to measure organisational culture while also identify inconsistencies, contradictions, and gaps in the literature. The identified literature will also provide analysis on the applied methodology, frameworks and theory applied by other studies.

The review process commenced with a search of MEDLINE (PubMed) and CINAHL on 20th February 2018 (The Joanna Briggs Institute 2015). This initial search established the search strings, including the key concepts presented in table 3.1. The key terms identified in table 3.1 formed the basis of the concept overview in Chapter 2 and also formed the basis of the literature search in this chapter. Once the search strings were refined and the key terms were identified, the researcher applied the key concepts and index terms were searched across the following seven databases - MEDLINE (Pubmed), CINAHL, PsycINFO, ASSIA,
EMBASE, World of Science and the Global Health Library. The outcome of this database search strategy is included in the Appendix Section of this study (Appendix xiii). In order to include the widest possible range of publications, the search strategy included primary research, using quantitative, qualitative, and mixed methods studies. The search also incorporated international academic peer reviewed publications in the English language up to and including June 2019.

Table 3.1 Preliminary Identified Concept Search Terms

<table>
<thead>
<tr>
<th>Key Concepts Terms</th>
<th>Medline (PubMED) keywords</th>
<th>CINAHL Keywords</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational Culture</td>
<td>“Organizational* Cultur*” OR “Organisation<em>Cultu</em>” OR “corporat<em>Culture</em>” OR “Organization* Change” OR “Organization* climate” OR Organisation* Change” OR “Organizational* Cultur*” OR “Organisation<em>Cultu</em>” OR “corporat<em>Culture</em>” OR “Organization* Change” OR “Organization* climate” OR Organisation* Change”</td>
<td></td>
</tr>
<tr>
<td>Health Care Reform</td>
<td>Reform* OR change* OR improv* OR transform* OR “Organisational reform*” OR “organizational reform*” OR “culture<em>reform</em>” OR reforming culture*”</td>
<td>Reform* OR change* OR improv* OR transform* OR “Organisational reform*” OR “organizational reform*” OR “culture<em>reform</em>” OR reforming culture*”</td>
</tr>
<tr>
<td>Community Health Section</td>
<td>“community health service” OR “community healthcare service*” OR “community health care service*” OR “community health care” OR “community healthcare” OR “primary health network*” OR “district healthcare” OR “rural health centre*” OR “rural health center*” OR “community health centre*” OR “primary care” OR “primary care trust*”</td>
<td>“community health service” OR “community healthcare service*” OR “community health care service*” OR “community health care” OR “community healthcare” OR “primary health network*” OR “district healthcare” OR “rural health centre*” OR “rural health center*” OR “community health centre*” OR “primary care” OR “primary care trust*”</td>
</tr>
</tbody>
</table>
3.2 Methodology & Results of Literature Review

Following the execution of the search on 17th June 2019, each database search was imported into a corresponding folder in the citation management software, Endnote X9, Clarivate Analysis (US) LLC. The 2,084 publications were then exported to Covident V1388, Veritas Health Innovations Ltd., where studies underwent a process of further review. The screening process in Covident V1388 is a four-step process as outlined in Table 3.2

<table>
<thead>
<tr>
<th>Stages</th>
<th>Covident V1388 Review Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>Importation of publications from Endnote Library</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Title and abstract screening</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Full Text Screening</td>
</tr>
<tr>
<td>Stage 4</td>
<td>Extraction of relevant publications</td>
</tr>
</tbody>
</table>

Following the importation of the 2,084 publications into the Covident V1388 screening system, a review of titles and abstracts was conducted. This eliminated 1,857 irrelevant publications, many of which included publications on safety culture, quality culture, safety climate and patient safety climate. In stage three, 227 full publications were assessed, this screening stage eliminated an additional 215 studies for the reasons outlined in Figure 3.1. The final stage resulted in 12 studies being extracted for inclusion in the systematised review, as presented in the PRISMA flow diagram (Figure 3.1). The characteristics of the 12 extracted studies are presented in Table 3.3 and as summarised in Section 3.3.

The term Community Healthcare, being the unit of analysis for this study, was found to be ambiguous. Primary, community-based, healthcare delivery included several terms and governance structures. All international terms were considered to maximise the scope of the review. Community based healthcare delivery was identified as Districts (South Africa), Primary Care Networks (Australia), Community Health Centres (USA), Primary Care Trusts (UK) and in the Netherlands Neighbourhood Community Teams via the local authority. In several cases the studies coupled organisational cultural with quality, performance, staff satisfaction and several other variables.
Figure 3.1 Literature PRISMA Flow Chart

Adapted from Concept Analysis Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) extraction from Covidence and Endnote X9
Eight of the twelve discovered publications applied a quantitative methodology with one qualitative case study and two multi-method studies. One study appeared to use a mixed methods approach although the characteristic mixed methods design was not specifically named. The studies recruited participants from eight Primary Care Centres and two GP Practices with two additional study recruiting participants from a Maternity Service and a Community Pharmacy. Sample sizes varied considerably across the studies. The average sample size was $n=327$, with individual sample sizes ranging from $n=42$ to $n=1,794$. The largest study was conducted in the USA, across 15 organised health systems, in 11 different states. Of the 12 eligible studies 9 used the Competing Values Framework (CVF) to measure culture, the other studies applied three uniquely different cultural measurement instruments. The characteristics of the 12 eligible studies are summarised in Table 3.3, before a brief synopsis of the study’s methodology, theory and findings are reported in Section 3.3.
<table>
<thead>
<tr>
<th>Author (Year) Country</th>
<th>Sample / Size</th>
<th>Theory / Instrument</th>
<th>Methodology</th>
<th>Purpose / Main Outcome &amp; Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams et al. (2016) Australia</td>
<td>Exploratory Design Maternity Unit n=120 clinicians (100 midwives &amp; 20 Obstetricians)</td>
<td>Competing Values Framework and Organizational Cultural Assessment Instrument</td>
<td>Quantitative Survey</td>
<td>Readiness for change in a maternity unit. The predominant culture was Hierarchy, with a focus on rules and regulations and less focus on innovation, flexibility, and teamwork. These results suggest that this unit was not ready for change. Preparatory work on culture can influence the success of the outcome of change.</td>
</tr>
<tr>
<td>Bosch et al. (2008) Netherlands</td>
<td>Cross-sectional Study Primary Care Unit (39) N=92 Health Care Professionals</td>
<td>Competing Values Framework and Team Climate Inventory</td>
<td>Quantitative Intervention Science</td>
<td>Restructuring integrated care while establishing teamwork and cultural impact on care. Group/Clan culture was negatively associated with the quality of diabetes care with a more balance culture' positively associated with care quality. Variation in clinical patient outcomes could not be attributed to organisational culture. The study recommends a mixed methods approach in future and a more sensitive application of the measurement instruments.</td>
</tr>
<tr>
<td>Brazil et al. (2010) USA</td>
<td>Cross-sectional Study Primary Care Pediatric Practices (36) n= 374 (127 clinicians /247 non clinicians</td>
<td>Competing Values Framework and Primary Care Organizational Questionnaire</td>
<td>Quantitative Surveys</td>
<td>Exploring the relationship between practice culture, job satisfaction and clinical effectiveness. The culture was found to be associated with both satisfaction and perceived effectiveness. This relationship was true for all participants where practices had Group / Clan or Hierarchical culture.</td>
</tr>
<tr>
<td>Dowswell et al. (2001) UK</td>
<td>Cross-sectional study Primary Care Centres (21) n=49 GPs</td>
<td>Competing Values Framework</td>
<td>Multi-method</td>
<td>Clan organizational culture pre-dominates, general practices which do not generally have well-functioning internal arrangements for the management of clinical evidence and related information.</td>
</tr>
<tr>
<td>Hann et al. (2007) UK</td>
<td>Cross-sectional Study General Practices (42) N= 492</td>
<td>Competing Values Framework Team Climate Inventory</td>
<td>Quantitative Surveys</td>
<td>Establish the association between climate and culture, and quality of care. The complexity of measuring two separate constructed against each other and then quality of care is acknowledged as somewhat problematic and complex, with considerable methodological challenges.</td>
</tr>
<tr>
<td>Mash et al. (2013) South Africa</td>
<td>Cross-sectional Survey Primary Care Service (5) N=152</td>
<td>Cultural Value Assessment</td>
<td>Quantitative Survey</td>
<td>Current organisational values: on sharing information, cost reduction, community involvement, confusion, control, manipulation, blame, power, results orientation, hierarchy, long hours, and teamwork.</td>
</tr>
<tr>
<td>Author (Year) Country</td>
<td>Sample / Size</td>
<td>Theory / Instrument</td>
<td>Methodology</td>
<td>Purpose Main Outcome &amp; Findings</td>
</tr>
<tr>
<td>-----------------------</td>
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</tr>
<tr>
<td>Marques et al. (2018) UK</td>
<td>Instrument Development &amp; Validation Community Pharmacies N=209 pharmacists</td>
<td>Organisational Culture in Community Pharmacy Questionnaire (OCCPQ)</td>
<td>Mixed Methods</td>
<td>Instrument development and validated to measure how participants perceive their organisational culture. Findings suggest that different organisational culture may be linked to different healthcare outcomes.</td>
</tr>
<tr>
<td>Marshall et al. (2003) UK</td>
<td>Case Study Primary Care Trusts n=39 Management (Clinical and non-clinical)</td>
<td>Competing Values Framework</td>
<td>Qualitative Case Study</td>
<td>Management skills case study to establish process change and organisational change. Culture findings denotes two cultures being Hierarchal and Clan, which were noted as a possible source of dysfunction and tension during change process.</td>
</tr>
<tr>
<td>Ose et al. (2010) Germany</td>
<td>Validation and translation of Instrument Primary Care Clinics (54) N=297</td>
<td>Survey of Organizational Attributes for Primary Care (SOAPC)</td>
<td>Quantitative Survey</td>
<td>Factor analysis was applied to validate the four organisational attributes of the SOAPC, communication, decision making, stress/chaos, history of change.</td>
</tr>
<tr>
<td>Pracilio et al. (2014) Italy</td>
<td>Cross-sectional study New Primary Care Units GP’s (n=238)</td>
<td>Survey Instrument unnamed available from the author.</td>
<td>Quantitative Survey</td>
<td>Management style, organizational trust, collegiality were more important elements of organisational culture than information sharing and quality. Cultural scores were positively associated with larger PCU and those with higher levels of older GPs. Female GPs had a negative impact on collegiality, organizational trust, and quality.</td>
</tr>
<tr>
<td>Scammon et al. (2014) USA</td>
<td>Cross-sectoral Study Primary Care Clinic (10) n=162,</td>
<td>Competing Values Framework American Medical Group Association provider satisfaction survey</td>
<td>Quantitative Survey</td>
<td>Culture profiles differed across clinics, with family/clan and hierarchical cultures the most common. Significant correlations between provider satisfaction levels and clinic culture archetypes included family/clan culture. Hierarchical culture negatively correlated with the Relationships with Staff and Resource dimensions.</td>
</tr>
<tr>
<td>Shortell et al. (2001) USA</td>
<td>Cross-sectional study Medical Groups (15) GPs n=1,797</td>
<td>Competing Values Framework Patient Centred Culture Measurement (Secondary Data)</td>
<td>Quantitative Survey x 2</td>
<td>Policy makers/managers need to work on multiple levels when establishing financial incentives (pay, capitation, discounts etc). Procurement of services is influenced by knowledge of incentive policies and practices and evidenced based care. Physicians and physician leaders need to place greater emphasis on accountability for change.</td>
</tr>
</tbody>
</table>
3.3 Narrative Summary of Eligible Studies

Adams et al. (2016) Australia - This study used an exploratory design to identify the dominant culture of a maternity care unit in assessing its readiness for change. The CVF was used in this quantitative study (n=120). The findings indicated that the dominant culture in the unit was hierarchy with a controlling environment. The study hypothesised that the unit was not prepared for cultural change and the implementation of significant change would be challenging. The findings concluded that there was value in undertaking preparatory work prior to the introduction of change initiatives, indicating that the CVF was a useful tool. Interestingly, while the participants expressed a strong desire for the future culture to be different, current reported behaviours and practices did not support this espoused culture change. The publication concluded that the interprofessional collaboration needed to drive change was not evident and the tensions between professional boundaries and hierarchical legacy issues were a threat to the safe delivery of care. Unfortunately, the publication did not explore this aspect of the culture in more detail, and it could be suggested that this depth of investigation could only be delivered through the qualitative phase of a mixed methods enquiry.

Bosch et al. (2008) The Netherlands - This cross-sectional intervention study surveyed a mix of health care professionals (n=140) across forty primary care centres, measuring the correlation between organisational culture, team climate and the quality of care provided to patients with a chronic illness (diabetes n=752). The study sought to close the gap between the practices at the centres and best practices discovered in evidence-based research. As indicated in the other qualifying studies in Primary Care Centres the dominant culture was Group or Clan. In excess this culture can be too inward looking, and a more balanced culture could provide better outcomes depending on the context of the intervention project. The study recommended a mixed methods approach in future research. While the CVF was successfully applied as the cultural measurement framework in the study, it could be suggested that the scope of the study and number of variables was ambitious for the sample size.

Brazil et al (2010) USA - This cross-sectional quantitative study explored the relationship between organisational culture, job satisfaction and clinical effectiveness across thirty-six primary care practices (n=374). The results indicated that levels of job satisfaction and
clinical effectiveness were higher in Group/Clan cultures, with those in a Hierarchal culture scoring lower. The study also confirms that cultural change is needed alongside structural changes to deliver improvements in the healthcare sector and should be considered prior to structural changes. This research is consistent with Adams et al. (2016) and others in this review who recommend pre-reform cultural measurements. Although not specifically named the study used the Competing Values Framework (CVF) and calls for more innovative methodologies in studies of this nature, a call that could be interpreted as a recommendation for a mixed methods approach.

**Dowswell at al. (2001) UK** - The study sought to consider the adoption rate of evidence based clinical guidelines in private practices by GPs (n=49) by organisational culture type. This study applied a multi-method data collection method. Case notes were collected from asma and angina patient files to establish the level of evidence-based medicine (EBM) guidelines applied by GPs in the practices. The questionnaire specifical designed for General Practices was not acceptable in the pilot and the CVF was used. The most common organisational culture was Clan (collaborative), followed by mixed types. The lowest scoring cultural types were Adhocracy (creative), Hierarchal (controlling) and Market (competitive). The correlation of the findings appears to be complicated by the methodology and the number of variables considered in the analysis including clinical measurement like blood pressure and smoking rates of patients. The personal application of EBM by individual GPs appeared to be a better indicator than the collective culture of the practice, although this remains somewhat unclean. The study did establish that practices were more autonomous and independent than top-down policy had suggested. The study would also have benefited from a structured mixed methods design, which would have provided a solid foundation for both the delivery and analysis of the findings.

**Hann et al. (2007) UK** - This study sought to establish the association between culture and climate, and the quality of care in forty-two Primary Healthcare settings. The investigation was part of a larger longitudinal study designed to test the effectiveness of new GP contracts which used financial incentives attached to 136 quality indicators. While the findings indicated that culture and climate are important influences in the delivery of quality care and the implementation of internal and external initiatives during change, the results and the association purpose are unclear. The analysis conducted in 1998 on climate
and diabetes care quality was not consistent with the 2003 analysis between culture and diabetes care quality, while one would not expect the constructs of climate and culture to replicate the same results, this reported failure in this study is unclear. Thirty percent of responses were unusable, which would appear to indicate an issue with clarity. The timing between the data set collections of 1998 and 2003, could presents a validity challenge, which the research acknowledged as a replication challenge. In general, the methodology and sample were confusing, which is perhaps why the research recommended a mixed method in future and a wider debate about the constructs of culture and climate which has already been clarified in Section 2.1.3 of this research.

**Mash et al. (2013) South Africa** - This study measured and compared the personal values of staff (n=154) with the current and desired organisational values in five of the regions forty-five Community Health Centres. The study hypothesised that a change in future organisational values would indicate a change was needed in future organisational culture. The findings indicated that none of the top 10 personal values were replicated in the top 10 current organisational values, supporting the need for culture change and leadership development. The conversion from values to culture however is not robustly explored in the study instrument or findings. The personal values and how they are differentiated from organisational values is also ambiguous. The lack of clarification in both the methodology and the findings further indicates the complexity of organisational culture research and the challenges of research drift. The study did however report that the organisational culture was also not aligned with the current policy, which is presented as a difficulty.

**Marques et al (2018) UK** -This study of organisational culture in five pharmacies developed an instrument using a mixed method approach, qualitative interviews (n=42) and quantitative surveys (n=209). The pharmacy specific validated questionnaire had over 60 items and was designed to benchmark organisational culture and design interventions. Interestingly this paper was the only reviewed publication which specifically mentioned the various levels of organisational culture being measured and the development of comparable benchmarks.
Marshall et al (2003) UK - The qualitative case studies with management (n=39) from Primary Care Trusts was conducted to explore the tension between the skills required to process measurable change and cultural change. The study used the CVF to interpret the findings from the semi-structured interviews, which discovered two different culture types between senior and middle management. The Hierarchal (controlling) style of senior managers was directive, challenging clinical norms and values in pursuit of the political agenda. The Clan (collaborative) culture of the middle management on the other hand was working within the system to promote change from the bottom up. The conflicting differences were noted and proposed as the cause of dysfunctionality and tension across management layers during the change processes. The study concluded that leadership is critical to development of high-quality primary care but the differences between leadership cultural style was notes and recognised as valuable in the change process, and not mutually exclusive. The publication would have benefited from more details on the qualitative application of the CVF.

Ose et al. (2010) Germany - Like the study of Marques et al. (2018) this study sought to validate the German versions of the Survey of Organizational Attributes for Primary Care (SOAPC) with two hundred randomly selected Primary Care Practices invited to participated with fifty-four responding (n=297). In addition to the measurement of attributes, the study found the instrument was useful for mapping the implementation of quality management interventions. Unfortunately, the study like many of the other publications was limited to primary care units only and measured attributes rather than culture of the organisation.

Pracillio et al (2014) Italy - This study investigated organisational culture in twenty-one newly established Primary Care Units (PCU) who intended to deliver integrated care (n =238). The study used the Medical Group Practice Cultural Assessment (MGPCA) to measure 39 items, grouped into 9 cultural dimensions. The study identified management style, organisational trust, and collegiality as the strongest elements of the PCU culture. Cross collaboration, being the purpose of the new PCU, was discovered to be the lowest rated aspect of culture. Female GPs had a negative impact on collegiality. Again, this research was conducted in the limited settings of Primary Care Units, but consistent with other research was considered useful during periods of change.
**Scammon et al (2014) USA** - This cross-sectional quantitative study applied both the CVF (n=162) and the American Medical Group Association (n=63) satisfaction survey. The surveys were administrated during a period when the implementation of a Person-Centred Medical Home (PCMH) service was being introduced. The study findings indicated that attention should be paid to effective methods of changing organisational culture. The identification of the culture type which is associated with provider satisfaction should be used to inform service redesign. The adoption of pre-reform planning and baseline measurement is again recommended. Like many of the prior publication this study also coupled organisational culture with another variables including job satisfaction.

**Shortell at al. (2001) USA** - The objective of this study was to assess the extent to which market pressure, compensation incentives and the medical group culture were associated with the use of evidence-based practices in 56 groups, affiliated with 15 organisation health systems (n=1,791). The study used a likert version of the CVF to measure organisational culture. The findings indicated that the practices lacked a collective culture, and most were “cobbled together” under a legal umbrella, which was wrapped around individual GPs. In contrast to organisational culture the application of evidence-based care practices was significantly associated with external market pressure and compensation incentives. This study is one of the most commonly cited in the field of organisational culture in healthcare, and this may simple be as a result of the significant sample size. The definition of organisational culture as a ‘shared’, above all other elements is verified by this study as none of the individual GPs shared a common culture.

### 3.4 Summary & Conclusion of Literature Review

Having reviewed the eligible studies identified in the systematised review, this section provides a summary of the sample, theory and methodology applied. The overarching conclusions and collective findings are also summarised including the implication of these findings on the current research. Considering the level of healthcare reform identified in Chapter 2 and the global transition to integrated community care, this literature review discovered a relatively low number of studies which explored organisational culture in non-acute healthcare settings (Braithwaite et al. 2015c, World Health Organisation 2016, Irish Government Department of Health 2017, Shaw et al. 2017).
Ten of the studies were conducted across Primary Care Centres only, drawing the samples from individual general practitioner, networks, and groups of clinical practitioners. There is no indication that the scope of the sampling extended to mental health (residential and community based), older persons services (including long term residential settings, and community-based services) or disability services (including residential and non-residential) all of which are part of the Community Healthcare configuration in an Irish setting. The current study therefore provides a holistic sampling opportunity, extending the population of interest beyond that which has previously been investigated. The purposive stratified sample of the current research includes all the aforementioned services in addition to Primary Care Centres making this study sample inclusive and unique. While this provides a fertile research population across many variables, it may be difficult to draw a comparison or generalise the findings from this current research outside of the current context. None of the studies included external stakeholders, including patients, in their sampling strategy. In keeping with the definition of organisational culture only members of the participating organisations were included.

Ten (85%) of the eligible studies identified in the systematised review applied a purely quantitative method. This is not surprising considering the criteria was to measure organisational culture. Research would suggest that historically quantitative methods were the most popular in business development research. However, this methodology limits the investigation to observable cultural domains, lacking the depth and rich experiences which could have been accessed through the addition of a qualitative element. In order to address this limitation one scholar specifically recommends the use of mixed methods in future investigations of organisational culture (Bosch et al. 2008). Another study confirmed this recommendation with the inclusion of a qualitative approach, mainly employee interviews. This supports previous research, which suggests that in order to discover the deep levels of organisational culture, in-depth interviews should be conducted (Schein 1987). For this reason, the present study described in this thesis applies a mixed methods methodology, with the research design to be explored.

The reviewed literature also indicates the high percentage of cultural research which was conducted during periods of planned change, including the introduction of a new strategic direction (Marshall et al. 2003b), a change in policy direction (Mash et al. 2013), a change in service delivery (Scammon et al. 2014), structural changes (Pracilio et al. 2014), quality
management introduction (Ose et al. 2010), a review of the use of evidence-based care practices (Dowswell et al. 2001, Shortell et al. 2001), and general reform (Hann et al. 2007). This confirms the findings of Cameron and Quinn (2011) who suggest that people are unaware of their organisational culture until it is challenged or made overt and explicit by a cultural change programme or new leadership. While localised interventions and incremental changes have been identified in various settings, no study has been identified which fully investigated the implementation of a national community healthcare reform programme through the organisational cultural lens. The impact and important of organisational culture during periods of reform and change is identified as a key finding from the reviewed publications, and moreover is accepted as a potential lever or barrier to the optimal reform outcomes.

Another principal conclusion drawn from the eligible studies is the suitability of the Competing Values Framework (CVF) as a reliable theory and measurement instrument by which to measure organisational culture in a healthcare setting. The framework was used by 66% of the studies. This finding also concurs with the summary of cultural measurement instruments identified in Section 2.1.5., where the CVF was consistently associated with the measurement of organisational culture in healthcare (Zammuto & Krakower 1991, Gerowitz et al. 1996, Jones et al. 1997, Gerowitz 1998b, Goodman et al. 2001, Wakefield et al. 2001, Davies 2002, Gifford et al. 2002, Lee et al. 2002, Strasser et al. 2002, Meterko et al. 2004, Helfrich et al. 2007).

While Primary Care settings in the review identified their dominant culture as Clan or Hierarchal, there was no evidence of an innovative or creative culture, normally required to deliver change. No single organisational culture was identified as preferable in the studies. Ultimately the importance of the dominant cultural being aligned to the reform intention and policy direction, during a time of planned intervention, was outlined as the main objective (Marshall et al. 2003b, Bosch et al. 2008, Mash et al. 2013, Pracilio et al. 2014, Scammon et al. 2014, Adams et al. 2017). In different clinics and centres, even under the same governance, different cultural types were found (Dowswell et al. 2001, Hann et al. 2007, Brazil et al. 2010, Scammon et al. 2014). One interpretation of this finding is that while overarching policies and espoused values were common across organisations, individual units developed different implicate cultural types in line with actual practices and local
leadership. This could also be translated as the inability of top-down change programmes to reach the front line of service delivery.

A summary would suggest that despite the evidence provided on the impact of organisational culture on reform, both positive and negative, many countries continually focus on structure and process changes rather than cultural change, with perhaps the exception of UK (Davies et al. 2000, Berlowitz 2003, Mannion et al. 2003). Even when cultural transformation is included, reformers can still expect to meet resistance as well as unintentional consequences (Davies et al. 2000, Harris & Ogbonna 2002). Goes (2011), is only one of many scholars who identified the limited success achieved through restructuring because of culture resistance (Goes 2011). West et al. (2014) also described the costly failures resulting from surface level structural change when practitioners neglected to factor in the cultural impact on interventions (West et al. 2014). Several additional studies demonstrated the deep-rooted sectorial and political interests at play in the healthcare sector and the inflexible professional resource allocation which is very resistant to change (McDonald 2005, Austin & Claassen 2008, Braithwaite et al. 2015a).

It can be concluded that in order to improve the quality of healthcare, wholesale systematic change is needed including organisational culture (Davies et al. 2000). To approach this challenge, first and foremost pre-reform planning including the delivery of a baseline measurement of organisational culture should be conducted. This planning is best conducted and achieved through a mixed or multimethod research approach. Secondly all employees should be included in the planning and identification of specific actions, concerning behaviours and practices which will bridge the gap between the current culture and the desired culture. Thirdly the management must lead (not simple direct), support and embed, not just the espoused values, but the implicate ones.
Methodology

“Methodology is ever the servant of purpose, never the master”
(Green 2007 p. 97)

This chapter details the methodological and philosophical issues which were considered in the planning and delivery of this study. The research purpose statement and objectives are briefly restated as they underpin all subsequent decisions and situate the discussion in this chapter. While not always explicitly communicated in research, the chapter offers an unambiguous statement of the researcher’s worldview, and in particular its influence on the philosophical choices which legitimise the methodology being proposed. The chapter commences with a discussion on worldviews and paradigms and also includes a review of the elements which influence the researcher’s worldview, specifically ontology and epistemology. Section 4.3 outlines the specific research epistemology, considering the previous discoveries. Section 4.4. introduces mixed methods research designs, the characteristics and general research design options. The chosen mixed methods explanatory sequential design is then detailed in Section 4.4.3, which is followed by a section on the justification of its use (Section 4.4.4). Section 4.5 provides a comprehensive exploration of quality in mixed methods research which is proceeded by the research ethics in Section 4.6. Section 4.7 provides a conclusion to the chapter, summarising the decisions made and providing a primer for the Methods chapter (Research Design in mixed methods) which follows in Chapter 5.

4.1 Research Purpose Statement & Objectives

The list of international failures in healthcare have already been outlined in Section 2.2.6 (Cartwright 1988, Walsh & Shortell 2004, Francis 2013, Scally 2018). The evidence suggests that these failures are a consequence of the distinct organisational cultures of healthcare globally. The culture in healthcare is described as secretive and insidiously negative (Scally 2018), full of protectionism, inertia, and embedded behaviors (Braithwaite 2018). However,
the empirical evidence also shows that a positive organisational culture has a positive association with performance (Siehl & Martin 1990, Gordon & DiTomaso 1992, Kotter & Haskett 1992), sustainability (Saame et al. 2011), improved patient outcomes (Bosch et al. 2008, Parmelli et al. 2011, Hesselink et al. 2013, Braithwaite et al. 2017a, Curry et al. 2017, Thornton et al. 2017), staff wellbeing and job satisfaction (Helfrich et al. 2007, Brazil et al. 2010, Pellegrin & Currey 2011). Organisational culture has been acknowledged as a key tool in understanding the behaviour of people in organisations (Janićijević 2011) and a recipe for success across all organisational sectors (Peters & Waterman 2004, Schein 2010, Cameron & Quinn 2011a). Unfortunately the evidence is not always applied in practice, with change and reform in healthcare primarily focused on structures and strategies as previously outlined (Braithwaite et al. 2015a), yielding poor reform successes (Braithwaite et al. 2015a). In addition the rate of adverse events has not improved in the last 25 years (Braithwaite 2018).

With limited research on organisational culture in non-acute settings, this study provides an opportunity to investigate organisational culture during a period of significant active reform in the community healthcare sector. The purpose of this research is therefore to measure and identify the current and preferred organisational culture in a Community Healthcare Organisation (CHO) in the Health Service Executive, Ireland during a period of reform. The intent is to establish what, if any, difference exists between the current organisational culture and the preferred future organisational culture. Where a disparity is discovered, this study will explore the differences and establish what the barriers and facilitators are to the delivery of the prescribed change. The research will also review the current reform policies and establish if they are aligned to support the identified cultural change.

The research aims and objectives are to:

✓ Measure the current prevailing and preferred future organisational culture in the participation healthcare area (QUANT)

✓ Identify if there is agreement between the prevailing organisational cultural type and the respective dimensions of that culture (QUANT)

✓ Understand the barriers and facilitators which could influence organisational culture change in the participating area (Qual)
✓ Establish if there is consistency between the preferred future organisational culture and the planned reform actions of the community healthcare reform plan (Mixed Methods).

4.2 Paradigms and Worldviews Explored

When planning this study, the interconnections of worldviews, paradigms, designs, and research methods were investigated with a view to establishing the most appropriate methodology and design to answer and ‘fit’ the research aims and objectives. Having interrogated the literature it would appear that the terminology surrounding research worldviews and paradigms is often interwoven, inconsistent and contradictory in various publications (Crotty 1998, Bergman 2010).

The term ‘paradigm’ is generally understood to mean the philosophical position of the research, it was first described by Kuhn (1962) as an “accepted model or pattern” which directs the research efforts (Kuhn 1962, p. 23). Instead of paradigm Creswell and Creswell (2018) adopted the term ‘worldview, as a means to communicate “the general philosophical orientation about the world and the nature of research that a researcher brings to a study” (Creswell & Creswell 2018 p. 46). Others have maintained the more traditional term paradigm as ”a basic set of beliefs that guide actions“ (Guba 1990 p. 17), and the philosophical lens and assumptions which influences the decision making in the research. Morgan (2007) choose to use the term “pragmatic approach” avoiding the use of the term paradigm altogether (Morgan 2007, p. 65), while Bergman (2010) suggests “there are as many paradigms as there are authors” (Bergman 2010, p. 173). Considering the identified variations in terminology in this important aspect of research, the current study has adopted the term worldview, being the philosophical assumptions, which underpin the research.

Regardless of the uncertainty surrounding the various terms, most publications agree on the critical importance of the philosophical assumptions of the researcher, stating that the researcher’s philosophical position guides and informs the methodology (Guba & Lincoln 1994). Creswell & Creswell (2018) went a step further, proposing that an author’s
worldview was also heavily influenced by the discipline and the community of interest (Creswell & Creswell 2018). This is in keeping with the position of eminent experts, Teddlie and Tashakkori (1998) who also added the influence of the research question on the worldview. Writing about mixed methods, Creswell & Plano-Clarke (2007) advised that researchers executing mixed methods should explicitly state their philosophical assumption, recommending the use of a paradigm which delivered the study purpose (Creswell & Plano Clark 2007).

To progress the discussion further, clarification is offered on the context of worldviews in order to situate the philosophical underpinning of the current research. Considering the multidisciplinary, multilevel nature of organisational culture, this study is seeking a worldview which can provide the flexibility to explore the many levels of organisational culture. This entails applying the “what works” approach of Creswell & Plano-Clark (2007). Supporting this position, the father of paradigms, Kuhn (1962), appears less concerned with the allocation of a specific paradigm to a specific methodology, suggesting that paradigms could be replicated across any given field, and competing paradigms could exist simultaneously (Kuhn 1962). According to Bergman (2008) qualitative and quantitative classifications were a weak proclamation for paradigms, as analytical techniques do not of themselves necessitate a particular worldview or stance on reality (Bergman 2008). While the debates on paradigms, worldviews and methodologies continues to evolve there is almost universal agreement on the foundational elements of paradigms which are presented in Table 4.1, and which ultimately informed the selected research design of this study.

**Table 4.1 Common Elements of Worldview**

(Adapted from Table 2.2 Creswell & Plano Clark, 2007 p.24, O’ Gorman & McIntosh, 2015, Creswell & Creswell, 2018)

<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.Ontology</td>
<td>The branch of metaphysics which deals with the nature of being and reality</td>
</tr>
<tr>
<td></td>
<td>What is the nature of reality?</td>
</tr>
<tr>
<td>2.Epistemology</td>
<td>The branch of metaphysics which deals with the nature of knowledge.</td>
</tr>
<tr>
<td></td>
<td>What is the relationship between the researcher and that being researched?</td>
</tr>
<tr>
<td></td>
<td>(Distant-objective, closeness/collaborative, practical, what works)</td>
</tr>
<tr>
<td>3.Axiology</td>
<td>The branch of philosophy dealing with values.</td>
</tr>
<tr>
<td></td>
<td>What is the role of values (biased or unbiased perspectives)</td>
</tr>
<tr>
<td>4.Rhetoric</td>
<td>The art of effective and persuasive language use.</td>
</tr>
<tr>
<td>5.Methodology</td>
<td>What is the language of the research, formal, informal, advocacy?</td>
</tr>
<tr>
<td></td>
<td>The study and application of methods of research?</td>
</tr>
</tbody>
</table>
Having explored the literature in the area of worldviews and paradigms in order to establish the worldview of this study, the key elements are investigated fully. These elements include what the researcher considers answerable (ontology), the relationship between the researcher and the researched (epistemology) and the methodology by which the research is delivered (Creswell & Plano Clark 2007). The elements of values (axiology) and language (rhetoric) are also briefly outlined (O Gorman & MacIntosh 2015).

4.2.1 Ontology as Epistemology Primer

The first stage in the formulation of the research design was the articulation of the researcher’s ontology (O Gorman & MacIntosh 2015). At the most basic level ontology is the nature of truth and reality. Ontology determines how one views reality and interoperates the world and is divided into two main configurations: objective and subjective. The objective ontology is usually associated with a quantitative method of enquiry, providing surety and a certainty of position, solid objects can be measured and tested (O Gorman & MacIntosh 2015, Bergman 2016). Traditionally this ontology assumed a positive epistemology (Creswell & Plano Clark 2007) and historically was widely adopted in organisational research (Johnson & Onwuegbuzie 2004a).

Alternatively, the subjective ontology is usually associated with qualitative research and contends that reality is subject to perceptions of experiences and behaviours (O Gorman & MacIntosh 2015), presenting multiple realities (Creswell & Plano Clark 2007). This inductive view is often applied in social sciences, exploring the relationship between theory and research. Research adopting a subjective position accept that social properties are the outcome of the interaction between individuals (Bryman 2008).

Having reflected on the ontological choices, which would add legitimacy to this study, (Creswell & Plano Clark 2007), the researcher argues for an external reality which exists independently of one’s understanding of it. It is therefore possible to establish, explain and measure “universal facts through robust, replicable methods” (O Gorman & MacIntosh 2015, p. 57). Conversely because of the complexity of the research objectives and the various levels of organisational culture the researcher also advocates for the application of a subjective ontological approach, accepting that reality is perceived through observations and experiences. The application of this ontology supports a multitude of co-constructed
realities (Bergman 2016), which are grounded in qualitative methods and discovered through the different perspectives of the research participants (Creswell & Plano Clark 2007). Considering the literature, it is proposed that the truth has multiple perspectives and the objective and subjective stances are not mutually exclusive (O Gorman & MacIntosh 2015). As a result, this study adopts both singular and multiple realities, which are also considered the optimal position to address the research objectives of this research conducted in this thesis (Creswell & Plano Clark 2007).

In summary it could be suggested that to rigidly focus on ontology, as a route map to select the epistemology, and therefore the methodology of this study, may actually introduce or impose a constraint on the very nature of reality itself. Crotty (1998) proposed that scholars find it difficult to separate ontology and epistemology, considering the symbiotic nature of truth and knowledges. Moreover it would appear that ontological and epistemological issues “tend to emerge together” (Guba & Lincoln 1994, Crotty 1998, p. 18). On a practical level, Crotty (1998) advises that to overstate the role of ontology could unnecessarily complicate the methodology framework, when the real anchor of worldview is epistemology, which he describes as the most influential element of worldview (Crotty 1998).

4.2.2 Epistemology as Research Anchor

As a core indicator of worldview assumptions, and one of the most debated elements, epistemology explores the relationship between the researcher and that being researched (Creswell & Plano Clark 2007). Originally epistemology was dominated by two traditional approaches. Positivism subscribed to the objective stance and constructivism subscribed to the subjective approach both fostering their own associated methodologies (see methodology map Figure 4.1). This rather inflexible approach fuelled the decades of “paradigm wars” and adversity between both methodologies (Guba 1990, Guba & Lincoln 1994, Denison 1996). The purists contend that methodologies could not and should not be mixed (Teddlie & Tashakkori 2009). However, this claim was largely disproved as scholars demonstrated that it was possible to integrate methods in their research, rejecting the incompatibility thesis (Teddlie & Tashakkori 2010).
The range of epistemologies (and sub-categories) have since expanded to include critical theory (Crotty 1998, Alvesson et al. 2009), postmodernism and poststructuralism (Crotty 1998, Symon & Cassell 2012), and advocacy or participatory as research worldviews (Creswell & Plano Clark 2007). The most common philosophical assumptions are summarised in Table 4.2 which includes transformative and pragmatism. In order to select the most appropriate epistemology for this current study, the practicalities of the process (methodology) are further investigated (Section 4.3) following a brief overview of research axiology and rhetoric.

4.2.3 Axiology & Rhetoric in Brief

Axiology, as an element of worldview, examines the role of values in the research (Creswell & Plano Clark 2007). The positive stance accepts a “degree of separation between the knower and the known”(Bergman 2016 p. 13). This is a necessity in value-free research, supported by robust quality oversight to eliminate bias. Conversely when adopting a constructive axiology the research is assumed to be value-laden, and as such the researcher cannot be separated from the research subject, as in the case of organisational ethnographic (Bergman 2016 p. 13). O’Gorman & MacIntosh (2015) contended that all research was value-laden and inherently biased, a position which is considered by this current study. In
summation the values of the researcher influence the bias of the research, which can be value-free or value laden and will ultimately determine the qualitative approach in particular. Every opportunity has been sought to eliminate or reduce the risk of bias in this research, which is considered an integral part of the axiology of this study, and one which benefits the enquiry, from an experience and an understanding point of view (Creswell & Plano Clark 2007). The researcher remains external to the data and does not consider themself a co-constructor of the data, maintaining a critical independent stance (Yanow et al. 2012).

Rhetoric, the final element of worldview to be discussed, is not usually overly considered in the literature. However, it is an important aspect of the multidisciplinary study of organisational culture. It is traditional for the use of language to emanate from the particular discipline of the study. In this current study there are a number of disciplines at play, being health science, sociology and anthropology and the field of experience of the researcher being business and finance. The study therefore applies the language which is most relevant to this particular literary space, using the prevailing assumptions relating to the meaning of words and phrases as appropriate to the study disciplines (O Gorman & MacIntosh 2015). The style is therefore a mix of formal and informal.

4.2.4 Methodology as the Servant of Purpose

The methodology of the study (like all other elements) is influenced and informed by the purpose of the research and the epistemology of the researcher, which eventually translates into the research methods (Figure 4.1). Traditionally the choice of methodology, which influences the methods, was limited but this area has developed. The Constructivist-interpretivist researcher for example, may apply an organisational ethnography approach, seeking to subjectively understand and co-interpret organisational culture, while Pragmatism has as its tenet, the resolution of identified practical problems and the application of the best methodology to answer the research purpose (Johnson & Onwuegbuzie 2004b, Yanow et al. 2012), in this case surveying and interviews organisational employees. The ability of pragmatism to “sidestep the contentious issues of truth and reality” (Feilzer 2010, p. 8) provides a practical solution which allows the use of both quantitative and qualitative methodologies in a single study (Teddlie & Tashakkori 2010).
Having considered all the common elements of worldview and the elements of this research which influence their selection, the methodology chosen for this current study is mixed methods, which is both a methodology and a method and is outlined in greater detail in Section 4.4. This methodology is supported by the research epistemology which is detailed in Section 4.3. A clear and unambiguous definition of mixed methods as presented by Johnston et al. (2007) and applied by experts in the field is adopted (Curry & Nunez-Smith 2015, Bazeley 2018a, Creswell & Creswell 2018).

“Mixed Methods research is the type of research in which a researcher combines elements of qualitative and quantitative research approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inferences techniques) for the purpose of breath and depth of understanding and corroboration” (Johnson et al. 2007 p. 123)

**Figure 4.1. Worldview & Methodology Map of Research**
4.3 The Research Epistemology ~ Pragmatism

Mixed methods are the most common methodology adopted by those with a pragmatic worldview, often being described as a third methodology (Teddlie & Tashakkori 2003, Curry & Nunes-Smith 2015 pp. 3, Curry & Nunez-Smith 2015). Technically mixed methods has also been described as both a methodology and a paradigm, with its own paradigmatic perspective and distinct method of enquire (Creswell & Plano Clark 2007). The methodology map (Figure 4.1) provides a clear and structured process to all elements of decision-making thus far which have informed the methodological and epistemology of this current study.

Pragmatism as the epistemology of this study solves the debated issues of real truth and reality by focusing on solving the research problem with a commitment to what works “in the real world” (Creswell & Plano Clark 2007). The pragmatic approach to epistemology allows the research design to be tailor made, focusing on what is useful in order to answer the research questions (Johnson & Onwuegbuzie 2004b) and also what is practical within the confines of the available resources. This assignment acknowledges the philosophical variances between the different worldviews but advocates that the objective and subjective approaches are logically independent and therefore compatible (even when combined). The research is both inductive and deductive as in reality, human reasoning is complex and agile (Patton 1990, Morgan 2007).

In order to justify the suitability of pragmatism, as the epistemology for this study, research suggests that the influential elements of the research’s worldviews should be explicitly stated (Creswell & Plano Clark 2007). Given this direction, the ontology of the study is fluid and is not confined by “rigid classifications” (Creswell & Plano Clark 2007, p. 22), reality is neither determinable nor all knowing. In the context of this research, the human experiences of organisational culture in the workplace reside neither exclusively in the real world, nor in the minds of the participants, being subjective in nature (Green 2007). This acceptance paves the way for a pragmatic worldview, adopting what is useful in answering the research question, a position which is widely acknowledged (Creswell & Plano Clark 2007, p. 24, Johnson et al. 2007, Doyle et al. 2016).
The pragmatic position of this study requires the use of both quantitative and qualitative methods, identifying the methodology as mixed methods, which maximises the yield of the study (Creswell & Plano Clark 2007, Curry & Nunez-Smith 2015). Pragmatism has been cited as an alternative framework to accommodate the duality of mixed methods (Tashakkori & Teddlie 2003, Teddlie & Tashakkori 2003, Creswell & Plano Clark 2007, Feilzer 2010b). It is also the epistemology typically preferred by mixed methods researchers (Creswell & Plano Clark 2007). Having explicitly adopted a pragmatic worldview, the methodology and design of this current study are outlined in Sections 4.4 and 4.4.3, respectively.

4.4 The Research Methodology ~ Mixed Methods

There is a growing consensus that the application of mixed methods is an important methodology, particular when investigating and exploring complex healthcare problems (Curry & Nunez-Smith 2015). Many contemporary phenomena are so complex, that they cannot be measured by quantitative enquiry alone (Curry & Nunez-Smith 2015). Additional justification for the application of mixed methods is outlined in Section 4.4.4. Figure 4.2 presents the key outcomes of mixed methods research which differentiates it from other methodologies.

One of the unique attributes of mixed methods is the yield, which indicates that the whole is greater than the sum of the parts. In the current study the descriptive analysis provides ‘measurable’ domains of the organisational culture under investigation, while the qualitative enquiry provides an insight into the deeper levels of the organisational culture, each data set elevating and enriching each other increasing the overarching value of the study. Like Green and Hall’s (2010) continuum analogy, Curry & Nunez-Smith (2007) suggest that mixed methods sits in the nexus of a methodological continuum, with the scientific traditions of qualitative and qualitative methodology existing on the same continuum (Curry & Nunez-Smith 2015). This combination of both methodologies is cited by Miles & Huberman (1994) as being a “very powerful mix” (Miles & Huberman 1994, p. 42), which includes the generalisable and valuable asset of quantitative enquiry, combined with the deep, complex, real-world findings from the qualitative study.
4.4.1 Characteristic of Mixed Methods

Having provided a clear definition of mixed methods (Section 4.4), the core characteristics of the current study methodology are outlined. These characteristics form an important part of the quality appraisal applied in mixed methods (Creswell & Plano Clark 2007, O’Cathain 2010, Curry & Nunez-Smith 2015, Creswell & Creswell 2018) and include,

1. The incorporation of **rigorous methods** (data collection, data analysis, and interpretation) in both the quantitative and qualitative data are detailed in the respective sections of the study being Section 5.2 and 5.3.

2. The procedures are incorporated into a distinct, **named mixed methods core design** being an Explanatory Sequential Design, which indicates the procedures to be used in the study (Fetters et al. 2013).
The collection of both qualitative (open-ended) and quantitative (closed-ended) data in response to the research aims and objectives are evidenced in the **Procedural Diagram** in Section 5.1 and throughout Chapter 5.

**The integration of data** occurs at several points in the research, including at data collection (connecting) and during phase two planning and delivery (building). The final stage of integration occurs when the findings from both data sets are brought together through integration in Chapter 8 (Creswell & Plano Clark 2007, Fetters et al. 2013).

These procedures are **framed within a philosophy** (or worldview) being pragmatism and a theory, being the Competing Values Framework (CVF).

As outlined in Figure 4.2, the additional characteristic of yield, is denoted as being of particular relevance in the field of health science, where the output of the research is greater than that which could be achieved by a single methodology alone (Curry & Nunez-Smith 2015). In addition to the yield the judgement of quality can also be based on the level of integration, sampling strategy, analysis or interpretation, and even the type and content of publications derived from the study (O’Cathain et al. 2007).

### 4.4.2 Data Collection and Integration Options

In mixed methods data collection, the timing influences the relationship between the elements of the research (the sequencing) which ultimately influences the selection and naming of the core mixed methods research design (Morse & Niehaus 2009). Whether the phases of the research are conducted together, or sequentially, is considered a matter of purpose but may also be influenced by the availability of resources. The decision on the timing of the data collection determines whether the research is convergent, explanatory, or exploratory, seeking to explain or explore the phenomena of interest (Creswell & Plano Clark 2007, Curry & Nunez-Smith 2015).

In addition to timing the weighting is also considered in some studies, where a greater emphasis is placed on either the quantitative or qualitative data collection. Morse (1991) suggests that a pragmatic worldview can result in either an equal or unequal weighting, depending on the context of the research and the research question (Morse 1991). Morgan (1998) proposed that the weighting decision is based on either methodologies ability to
answer the research question (Morgan 1998), a position which would appear to discount the value of mixed methods altogether. In keeping with the research of Creswell and Plano-Clarke (2007) this study focuses on the research purpose, the sampling strategy, and the data collection process, which determines both the timing and the weighting.

Having established the timing of the current study as sequential, with the quantitative data collection followed by the qualitative data, as one informs the other, the study design is sequential. Reviewing the purpose, the study is explanatory in nature, with the qualitative data explaining the quantitative findings. The selected mixed method research design is therefore an explanatory sequential mixed method design with is discussed in more detail in Section 4.4.3

Despite the importance of data integration in mixed methods some research describes the integration elements of the early research as “under theorised and understudied” (Green 2007 p. 125) with the qualitative data merely embellish the quantitative data or vice versa. As previously outlined the integration of the data, as a characteristic of mixed methods, “defines the ultimate relationship between the various components of the study” (Creswell & Plano Clark 2007 p. 9).

It is the explicit robust, systematic, and purposeful integration of data sets which ultimately provides the additionality in the research. While there have been many publications on the very specific nature of integration (Teddlie & Tashakkori 1998, Yin 2006, O’Cathain et al. 2007, Fetters et al. 2013, Bezeley 2015, Guetterman et al. 2015, Bazeley 2018b), the integration of data sets in mixed methods remains the most challenging aspect of the methodology (Creswell & Plano Clark 2007, Curry & Nunes-Smith 2015, Curry & Nunez-Smith 2015). In the chosen research design, there are several integration techniques which align themselves to both the research design and the research objective (Figure 4.3).

Connection occurs when one type of data informs the other (Curry & Nunez-Smith 2015). Connected integration takes place at several points during the current study including, the development of the survey, during the recruitment of the participants, as the qualitative questions are developed and finally during the analysis (Creswell & Plano Clark 2007). The integration of data through connection is used in both explanatory and exploratory
sequential designs and has more recently been referred to as building with one data set building on the other (Fetters et al. 2013, Creswell & Creswell 2018).

Figure 4.3 Types of Mixed Methods Data Integration

![Figure 4.3 Types of Mixed Methods Data Integration](image)

In this study the data sets connect throughout the study as indicated with final integration achieved through merging, which establishes if the findings are complementary, concordance and discordance (Curry & Nunez-Smith 2015, p. 10).

According to Guetterman et al. (2015) the most innovative method by which data sets can be merged is through the use of Joint Display, which is the proposed method of integration used in this current study (Guetterman et al. 2015). Implementing this technique, the findings from both data sets are merged through joint display, following the extraction of the quantitative findings (using the CVF and statistical analysis) and the qualitative findings (using template analysis, assigning the CVF themes). Having explored the integrated results in health sciences Guetterman et al. (2015) demonstrated the inclusion of a visual Joint Display provided a promising insight and clarity into data integration which is the centrepiece of this methodology (O’Cathain et al. 2007, Guetterman et al. 2015).

4.4.3 The Research Design ~ Explanatory Sequential

The selected research design is influenced by the pragmatic methodology of mixed methods, the timing (sequence or order), and weighting (explanatory or exploratory),
applying an explanatory sequential design. This design is one of the core designs of mixed methods (Creswell & Creswell 2018). The chosen design ensures that the qualitative phase adds clarity to the quantitative findings through the exploration of qualitative scholarship (Creswell & Creswell 2018). The design involves a three-phased process. Survey data is collected in the first phase and the second qualitative phase is informed by the findings from the first phase. The collection of data in an explanatory sequential design provides a “rigours quantitative sampling in phase one and purposeful sampling in phase two” (Creswell & Creswell 2018p. 354). The data integration options as outlined in Section 4.4.2 and conducted in the third phase, which provides the meta-inference from the study which addresses the research objectives.

Phase 1 consists of a cross-sectoral descriptive study which was conducted at a fixed point in time and over a short period (Levin 2006). Phase 1 commenced on 11th June 2019 and the survey closed on 30th August 2019. The objective of the self-reporting on-line survey issued in Phase 1, was to establish the current and the preferred future organisational culture. The quantitative instrument used was the Organizational Cultural Assessment Instrument (OCAI™) which is derived from the theoretical framework being the CVF.

Phase 2 adopts a qualitative descriptive method to the collect of the interview data. This method was cited as being of particular significance to healthcare studies (Caelli et al. 2002). The epistemology of the researcher and the timeframe of the qualitative phase precluded the consideration of an organisational ethnographic approach. The study is not concerned with organisational culture as interpreted by the researcher but concerned with the employees’ thoughts and feelings on daily interactions and their own manifestations of culture. The goal of the qualitative phase of the study is therefore was to provide a deeper understanding and explain the quantitative findings, providing rich data which includes the participants’ voice (Sandelowski 2000b). This phase culminates in the generation of data from the semi-structured interviews which are then analysed using template analysis as the organisational culture codes and themes are already accessible via the quantitative survey (Figure 4.4).
The third and final phase of the study is the integration of the findings from phase 1 and phase 2, often described as the most challenging element of mixed methods (Sandelowski 2000a, Bryman 2007, Fetters et al. 2013). In this study the integration has been aided by the theoretical framework of the study and the domains of organisational culture which have been applied to all phases of the study design and data analysis.

4.4.4. Justification for the Design Selection

The simple additionality of both quantitative and qualitative methods are not, in and of themselves, justification for the application of the chosen methodology, although the augmentation does provide additional perspectives which enrich the research findings (Bergman 2016). Creswell and Plano Clark (2007) maintained that one of the preliminary considerations when choosing mixed methods research is the philosophical assumptions of the researcher. Existing research recognised the purpose statement and the research questions, also inform the worldview, and are not simply informed by the worldview (Creswell & Plano Clark 2007).
As previously indicated the chosen methodology is intended to have the qualitative data provide more depth and more insight into the quantitative findings, providing a depth of investigation which individual methodologies could not provide on their own. This pluralism stance takes “advantage of the strengths and controls the weaknesses in each individual method” (Bergman 2016 p. 12). Notwithstanding the importance of mixed methods in health science interventions as detailed by Curry & Nunez-Smith, (2007), Scott et al. (2003) suggests that a mixed methods design also facilitated the exposure of nuances through individual qualitative sampling, in his organisational culture investigation in healthcare (Scott et al. 2003a). This can also manage the biases, which research suggests are inherent in both methodologies, facilitating objective research results (Bergman 2016).

More importantly the adoption of the study methodology is designed to explain the observable organisational artifacts, and the less observable deep-rooted implicit values and assumptions. In organisational culture these values account for what research participants actually do, as opposed to what they say they do (Scott et al. 2003a). While the observed behaviours and practices are presented to the participants in the situational quantitative research statements for selection (Cameron & Ettington 1988), the personal experiences and subconscious assumptions are reported in the qualitative interviews (Scott et al. 2003a). Feilzer (2010) suggested that where phenomena are multi-layered, mixed methods can provide a solution by measuring some aspects of culture with quantitative methods and some with qualitative methods (Feilzer 2010b). The same conclusion is drawn by Curry & Nunez-Smith (2015) who suggest that when the enquiry is multifaceted and multidisciplinary “mixed methods is appropriate (Curry & Nunez-Smith 2015, p. 7). Bazeley (2018) suggests that mixed methods provides a flexibility, enabling a diverse approach to “embrace the multiple perspectives that behavioural, social, and professional complexities demand (Bazeley 2018ap. 4). The chosen method capitalises on the advantages of mixed methods, ensuring the challenging research questions can benefit from diverse data collection (Curry & Nunez-Smith 2015). It could be speculated that the above justifications may be the very reason that mixed methods continues to grow in popularity in the health sciences.

4.5 Evaluation & Quality in Mixed Methods

Quality in mixed methods has been cited as “one of the provocative methodological issues and most debated topics in the mixed methods field in recent years” (Ivankova 2014). In the last decade
quality measures in the methodology have evolved in an organic way, as more and more studies adopt a mixed methods approach, especially in health sciences and education (Güterman et al. 2015). In this study a growing body of literature has been reviewed in the search for excellence in quality during the planning of this research. The development of “Best Practices for Mixed Methods Research in the Health Sciences” (2010) commissioned by the Office of Behavioural and Social Sciences Research (OBSSR), National Institute of Health, United Stated, and led by John W. Creswell, Ann Klassen, Vicki L. Plano Clark, and Katherine Clegg Smith has provided valuable guidance on best practice (Creswell et al. 2010).

One of the main challenges identified by contemporary research in mixed methods is the question of whether the study should use the quality concepts and terminology attributed to quantitative studies or apply the unique standards and terminology created exclusively for qualitative studies (Curry & Nunez-Smith 2015). Sandelowski (2000) suggests that standards in mixed methods are not influenced by paradigms at all, while Curry and Nunez-Smith (2015) on the other hand suggest that the complexity of quality in mixed methods research warrants a third sets of standards (Sandelowski 2000a, Curry & Nunez-Smith 2015). Historically quality and rigor in both quantitative and qualitative research have been explored extensively (Onwuegbuzie & Johnson 2006, Johnson et al. 2007). The challenge for mixed methods does not lie with quality in either of the individual methodology, as both are firmly grounded in the consensus and principals of scientific rigor (Curry & Nunez-Smith 2015). The challenge is concerning with the quality when combining data sets which have different conceptualisations. In this instance the introduction of mixed methods is cited as having complicated the issue of validation (Collins et al. 2007, Onwuegbuzie & Collins 2007, Bazeley 2018b). As a solution, the term legitimation has been proposed by Onwuegbuzie and Johnson (2006) to distinguish validation in mixed methods research, using a bilingual nomenclature, as recommended by Tashakkori and Teddlie (2002, 2006) to differentiate the quality in the different methods.

The lack of certainty concerning the quality aspect of integration in mixed methods may actually have contributed to another challenge, being the actual integration itself. On a methods level, the literature has identified the lack of integration between the quantitative and qualitative elements as a considerable risk (Bryman 2006). O’ Cathain et al. (2008) investigating quality in mixed methods health service research (n=188) reported an absence
of integration, with inadequate mixed methods design description and a lack of transparency in both the qualitative and quantitative methods as additional challenges to quality (O’Cathain et al. 2008). O’Cathain et al. (2008) contended the absence of formal education in mixed methods research was also a “contributory factor to the variances in quality” (O’Cathain et al. 2008, p. 1147).

**Figure 4.5 Common Standards of Appraisal in Mixed Methods**

Source adapted from **Lincoln and Guba (1985)** *Currey & Nunez-Smith (2015)*

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**Veracity in Mixed Methods**

Veracity is the first quality standard identified by Curry and Nunez-Smith (2015) and outlined in Figure 4.5. Veracity concerned the “true value” of the research findings (Lincoln & Guba 1985), and in this study applies to the degree to which the findings truthfully and precisely represent organisational cultural in the community healthcare area (Curry & Nunez-Smith 2015). The veracity refers to the validation in quantitative research and the credibility in qualitative research, which are further expanded upon in Research Design and Methods (Section 5.2.8 and 5.3.6)
Consistency in Mixed Methods

The second quality standard presented by Curry and Nunez-Smith (2015) is consistency. Consistency is represented by the reliability of the quantitative research and dependability of the qualitative research (Curry, 2015). Reliability in the context of this research is the consistent, precise, and comparable outcomes of an OCAI™ instrument with repeated use (Burns and Grove, 2009). Dependability, as a qualitative quality criterion, is similarly concerned with the reliability of data over time, with similar participants and in a similar context (Polit and Beck, 2006). The study acknowledges this challenge in relation to organisational culture and the subjective nature of employees perception and the nature of the researcher ‘as instrument’ in the qualitative phase (Curry & Nunez-Smith 2015 p.176). This risk is counteracted by the application of the CVF in the template analysis, more details of which are provided in Chapter 7. In mixed methods research both reliability and dependability are interdependent and are discussed further in Chapter 5 under the respective qualitative and quantitative sections.

Applicability in Mixed Methods

The third common standard identified in mixed methods is Applicability (Curry & Nunez-Smith 2015). Applicability is essential in order to progress knowledge to other community healthcare settings, and is determined by the generalisability of the quantitative research, and the transferability of the qualitative phase of the research (Curry & Nunez-Smith 2015). The generalisability and the transferability of both the quantitative and qualitative methods are further outlined in Sections 5.2.9.4 and 5.3.6.2.

Neutrality in Mixed Methods

The fourth and final quality standard from the framework of Curry and Nunez-Smith (2015) is Neutrality. Neutrality addresses the researcher a priori assumptions which may prejudice the research, “either the implementation of the study or the integration of the results” (Curry & Nunez-Smith 2015). Neutrality is underpinned by the objectivity of the quantitative research and the confirmability of the qualitative research (Curry & Nunez-Smith 2015). Neutrality is less frequently perceived as a risk in the quantitative phase of the study, where protocols and statistical computations protect against the risk of bias (Curry
& Nunez-Smith 2015). The research acknowledges the risk of reduced neutrality in the qualitative phases of the study but guided by the research framework and the template analysis the study is less vulnerable to bias. However, this matter is address in the justification section and additional details are provided in Chapter 5.

**Figure 4.6 Comparing Standards of Quality Criteria in Mixed Methods Research**

(Courtesy of Professor Leslie Curry, 2021)

<table>
<thead>
<tr>
<th>QUALITATIVE Appraisal Criteria</th>
<th>STANDARD</th>
<th>QUANTITATIVE Appraisal Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credibility - The degree to which the findings plausibly explain the phenomenon of interest or cohere with what is known; attention paid to alternative explanations; correspondence between the researcher’s and respondent’s portrayal of respondent experience</td>
<td><strong>Veracity</strong> - The degree to which the study results are correct for the sample of people in the study or that a measure actually represents what is intended to measure</td>
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<tr>
<td>Dependability - The degree to which the researchers account for and describe the changing contexts and circumstances during the study</td>
<td><strong>Consistency</strong> - Reliability - The degree to which observations, measures or results can be replicated (for the same participant or in different studies)</td>
<td></td>
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<tr>
<td>Transferability - The degree to which findings or research protocols can be transferred to other settings, contexts, or populations</td>
<td><strong>Applicability</strong> - Generalizability (or external validity) - The degree to which the study results hold true for a population beyond the participants in the study or in other settings</td>
<td></td>
</tr>
<tr>
<td>Confirmability - The degree to which the findings of a study are shaped by respondents and not researcher bias, motivation, or interest</td>
<td><strong>Neutrality</strong> - Objectivity - The degree to which researchers can remain distanced from what they study so findings reflect the nature of what was studied rather than researcher bias, motivation, or interest</td>
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</table>

Given what is already know about mixed methods studies, its quality appraisal is more than the separate rigor of each of the quantitative and qualitative phases. The additional elements of quality of this mixed methods study as detailed in the characteristics of the methodology (Section 4.4.1) from critical components of the quality appraisal, including (but not limited to) the named research design quality, the method and quality of integration, the transparency of interpretation, and the justification for the use of mixed methods (Curry & Nunez-Smith 2015). In summary the common quality standard of mixed methods research detailed in this section are further highlighted in Figure 4.6 and are linked to the rigor and appraisal criteria of both qualitative and quantitative phases which are detailed in Section 5.2.8 and Section 5.3.6 respectively.
4.6 Ethical Considerations of Research

Ethical issues can arise from any part of the research process, from research design planning to data collection, from data analysis to results reporting. As a result, ethical approval was sought from and granted by the School of Nursing and Midwifery Research Ethics Committee, Faculty of Health Sciences, Trinity College Dublin in January 2018 (Appendix xi. Further permission for access was obtained from the Health Service Executive (HSE) in 2019, where the Senior Management Team of the Community Healthcare Organization (CHO) agreed to participation in the research. Throughout this study the researcher is guided by The Declaration of Helsinki (World Medical Association 2013).

Respect for the person

The principal of respect and dignity for personhood is applied as outlined in the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Science (1979). Employing this principal, the researcher respects the individual’s right to self-determination and autonomy. The right to respect is closely linked to the right to informed consent. The information in relation to the purpose, risks, benefits, confidentiality and right to withdrawal from the study are included in the Participants Information Leaflet (Appendix iii), as are the contact details of the researcher (Teddlie & Yu 2007). Communication was identified as a key element in relation to accessibility therefore information was provided in a clear and legible format; confidential assistance was offered to anyone who wished to participate in the study but required assistance, the survey was also available in both hard and soft copy.

Informed Consent

Autonomy is inherently linked to the individual’s ability to provide informed consent. Prior to the distribution of the quantitative survey to all employees, posters, and Participants Information Leaflet (PIL) was distributed to all Community and Primary Healthcare Centres across the five counties (Appendix ii-iii). A dedicated website, www.culturechange.ie was setup to provide information about frequently asked questions. It also enabled the potential participants to contact the researcher at any time. Included in the introduction to the survey was information about the voluntary nature of the survey. Participants were advised that their consent to participate was inferred by their completion
of the on-line survey or by the return of the paper copy version. The researcher did not have access to the identity of the participants as the invitation to participate and link to the on-line survey was distributed through the Office of the Chief Officer and the Communications Officer, of the Community Healthcare Organisation (CHO).

In relation to the qualitative interviews, participants were invited to participate in the one-to-one interview from a purposeful sample of the quantitative survey and from those who expressed an interested in participating. The invitation was issued a minimum of fourteen days prior to the interview, following an expression of interest. The interview was schedule by email, at which point a research Consent Form (Appendix ix) and PIL were provided for review. Those who agreed to proceed signed the consent form at the commencement of the interview at which point the form was co-signed by the researcher.

Confidentiality
With respect for privacy of the participants the survey did not collect any identifying information. The survey was self-reporting, and no identifying data was requested or collected at any stage of the research including IP addresses. The software collecting and processing the data produced an automatic record number which did not identify the participant. Those who participated in the qualitative interviews were afforded the same level of confidentiality. Anonymised interviews were recorded on a digital device. The anonymous interviews were allocated a unique identification code and were then uploaded onto a dedicated password encrypted computer, where there were transcribed and analysed by the researcher in person. Interview audio and digital transcripts were sorted on a dedicated encrypted hard drive which is stored in the locked cabinet in the office of the research institute and is accessible by the researcher only. Informed consent documentation only collected the participants names, and no other personal data was collected. All confidential data collected during this research will be stored for five years following completion of the analysis and dissemination in keeping with the Faculty of Health Sciences, Trinity College Dublin (2015).

Justice
The right to fairness and equitable access is not applied in this research as outlined in the research of Tappen (2011) in Advanced Nursing Research (Tappen 2011). As all employees of the Community Healthcare area were invited to participate the principal of justice as
cited in this publication do not apply. The right of justice by participations is also outlined in The Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Science) as fairness of process and entitles the participants to privacy, confidentiality and anonymity which was applied throughout all aspect of the research (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Science 1979).

**Veracity**

Veracity as an ethical principal of the Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Science) differs in terms of veracity as a quality standard in mixed methods. In ethics it is related to the rights of research participants to truthfulness from the researcher. Full disclosure was provided to the participants throughout the study and in relation to all aspects of the research. All participants were provided with a timeframe for delivery of the final report and the dedicated website was and continues to be updated bi-annually with all relevant information (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Science 1979).

**Fidelity**

The building of trust was critical to the conducting of this research and the principal of fidelity was exercised throughout the study. In the one-to-one interviews the building of the relationship was important to enable the participant to relax and feel confident in the trustworthiness of the researcher. All information was clearly communicated in the Participants Information Leaflet (Appendix iii). The contact number of the research was available and published on the study poster (Appendix i), website, information leaflet (Appendix iii) and on all form of communications. If participates had any concerns, questions or indeed comments they wished to make about the study the research was always accessible. Two queries in relation to the survey were received by email which were responded to in confidence with reassurance and additional information.
4.7 Summary of Research Methodology

While epistemology is acknowledged as the more influential element of worldview, Crotty (1998) advised in reality, the planning and design of scientific research rarely starts with epistemology. Given this understanding, this research is directed by the methodology and the methods, which in turn justifies the theoretical perspective, which informs the epistemology (Crotty 1998). This approach correlates to the research of Creswell & Plano-Clark (2007) and others who advocate for a pragmatic epistemology (Creswell & Plano Clark 2007, Green 2007). This study has rejected the purist, traditional distinction between quantitative and qualitative research in favour of a mixed methods approach, seeking a more pluralist methodology.

In this study the design selection has been influenced by a number of critical elements, the most important of which is the appropriateness of the design to address the research question and the epistemology of the researcher. The discussion concerning the advantages and disadvantages of suitable qualitative data collection methods is largely misplaced considering the influence of these elements. In this regard the selection of the research method, both the quantitative and qualitative is not a matter of simply selecting a method from a toolbox (Yanow et al. 2012).

Of the other material considerations, the timing (order or sequence) of the data collection and the usage of the data is another key influencer, followed by the weighting (or emphasis) of the data type (QUANT or Qual). These elements culminate in the decision on the mixing and integration of the data. Considering these key elements, a mixed method explanatory sequential design is chosen to deliver the research objectives. The process is detailed in the procedural diagram Section 5.1, and the details of the design execution are highlighted in a step-by-step process in Chapter 5.
Chapter 5

Research Methods

“A broad approach to scientific inquiry specifying how questions should be asked and answered”
(Teddlie & Tashakkori 2009 pp.24)

This chapter outlines the research design and the method by which the research is delivered. Section 5.1 introduces the design and presents the procedural diagram, outlining the three sequential phases. This is followed by a step-by-step guide to the execution of both the quantitative (Phase 1) and qualitative (Phase 2) phases of the research. The quantitative sampling strategy, the recruitment of participants, the challenge of maximising the response rate, and the data collection and management are detailed in Section 5.2. This section concludes with details of the quality evaluation (validity and reliability) applied in the quantitative phase of the study. Section 5.3 outlines the qualitative phase and includes the recruitment of participants and the execution of the semi-structured interviews. In Section 5.3.5 the qualitative data management and analysis are documented before the quality aspect of the phases is outlined including the credibility and rigor. The final phase presented in Section 5.4 outlines the planned data integration, which is the hallmark of mixed methods.

5.1 Introduction to the Research Design & Methods

One of the key considerations in relation to research methods is the development of a robust sampling strategy. The individual sampling strategies of the quantitative and qualitative phase are detailed in Sections 5.2.1. and 5.3.1 respectively. In keeping with the systematised research findings, and the definition of organisational culture as defined in Section 2.1.2, only employees of the participating organisation were included in the measurement of organisational culture as “members of the organisation”. While the influence of patients as consumers continues to develop there will potentially impact the significant healthcare market, as will other external stakeholders.
The procedural diagram (Figure 5.1) introduces the details of the three phases of the research, providing a road map for the study delivery and is also a critical elements of the study’s quality evaluation outlining.

1) The details of the research design and its various phases
2) The associated research questions,
3) The procedures which connect the data sets at various points in the process,
4) The merging of the data findings through Joint Display in Phase 3.

**Figure 5.1 Mixed Methods Explanatory Sequential Procedural Diagram of Study**

The procedural diagram (Figure 5.1) details the sequencing of activities, the flow of information, and the points of data connections and final integration. Figure 5.1 demonstrates that the,
Findings from the quantitative data analysis in phase 1 address research questions 1 and 2 (RQ1 and RQ2, Figure 5.1).

The quantitative findings then inform the qualitative sampling and interview strategy.

The qualitative data analysis then refines and explains the statistical results of phase 1, by exploring participants’ views on organisational culture in more depth (RQ3, Figure 5.1).

The final merging of both data sets is achieved through Joint Display, which provides the meta-inferences of the integration. Finally, the fourth and final research questions is addressed (RQ4, Figure 5.1).

5.2 Phase 1: Quantitative Survey

The quantitative data was generated through the on-line validated survey instrument the Organisational Cultural Assessment Instrument (OCAI™). The survey was distributed to the entire population of the CHO by the Communications Officer, who was one of the main research gate keepers (Appendix i). A total number of twenty-one email distribution lists were used to distribute the survey link, as a single definitive employee database was not available. The instrument selected was identified following an extensive review of the literature in Chapter 3 and through the investigation of organisational culture theory and measurement instruments previously used in the healthcare setting (Section 2.1.5).

5.2.1 Quantitative Sampling Strategy

The sampling strategy aimed to maximise the survey response rate using established processes (1989, Crosby et al. 1989, Anema & Brown 1995, Schaefer & Dillman 1998, Dillman & Bowker 2000). The processes were applied to counteract the falling response rates of on line surviws, which were identified as no longer enjoying high response rates (Schaefer & Dillman 1998). Despite this identified challenge, an on-line survey was designated from a cost, resource, and convenience point of view.

A four phased strategic technique was applied, using an adapted version of Dillman’s (1978) classic phone and mail survey design. An initial advance notice email was issued by
the Chief Executive Officer to all employees on 14\textsuperscript{th} June 2019. The email introduced the research and acknowledged the importance of participation (Appendix vi). The second email to all employees, from the Communications Officer, one week after the first email, contained an introduction to the study and the actual on-line live survey link (Appendix vii). A third reminder email, 5\textsuperscript{th} July 2019, was emailed to all employees by Heads of Services, three weeks following the initial advance notice from the CEO. In addition to this multi-contact strategy the study also adopted the \textit{Guiding Principles for Mail and Internet Surveys} which included practical advice on spacing, alignment, visual presentations, and instructions (Dillman \textit{et al.} 2009).

In line with expectations, the sampling strategy continued to evolve as the data collection progressed. Following an initial slower than expected response rate, in consultation with the Senior Manager Team, a promotional roadshow was scheduled four weeks after the on-line survey went live. The roadshow distributed additional updated posters (Appendix viii) to sites and areas where response rates were poor. Additional hard copies of the survey and sealed return boxes were distributed to canteens, office spaces and staff only areas across the region. The physical additional distribution also included care divisions where the response rate was low. This resulted in an additional 72 hard copy questionnaires (Appendix i) being completed.

A dedicated website was also developed which enabled employees to complete the survey on non-work computers, off-site and during non-working hours. The website (www.culturchange.ie) which contained the on-line survey, was also compatible with smart phones, tablets, and included SSL (Secure Sockets Layer) certification, ensuring end-to-end encryption and digital security. This digital strategy enabled the response rates to be monitored in real time. This real-time information facilitated prompt interventions, when necessary, in the form of additional posters and hard copies of surveys. By promoting the survey to low responding work categories and care divisions, an additional 36 completed questionnaires were received. This real time monitoring also enabled study gate keepers to be informed of the progress on a weekly basis, which elicited additional promotional support for the study and facilitated cooperation on recruitment in specific areas.
5.2.2 Recruitment of Study Participant

In order to access employees from the community healthcare area permission was first needed from the Health Service Executive, being the community healthcare employer. An introductory meeting was conducted in October 2017 with the National Transformational Director with a view to establishing a relationship at national level to support both the process and the research delivery. During the protracted research access negotiations between October 2017 to February 2019, the Health Service in Ireland was undergoing a broad range of changes and restructuring, as part of planned reform. This process was not without its problems. The original National Transformational Director changed roles three times, at a national level the organisation had three different Director Generals. The national governance and senior management changes were replicated at a regional level where the participating region had three different Chief Executive Officers during the same period.

From the initial meeting in October 2017, to the issue of the final questionnaire in May 2019, an extensive number of meetings, discussion and presentations took place at both a national and local level. While all the meetings were positive and supportive of the study, the actual decision-making process necessitated several meetings both vertically and horizontally throughout the organisation. It appeared that the approval of the study was complex and evasive. The negotiation at a national and regional level was not unsubstantial and took a total of twenty-two months.

In February 2019, approval for the distribution of the survey was granted at a regional Senior Management Team meeting following an additional presentation. Unfortunately, the region had also been selected to pilot “The Work Positive National Healthcare” surveys in January 2019 which was not concluded until June 2019. The Senior Management team advised that employees had already expressed feelings of “survey fatigue”, having completed the National Staff Satisfaction Survey in Nov 2018. This was identified as a possible challenge to survey response rates.
5.2.3 Projected Survey Response Rate

The application of the sampling strategy (Section 5.2.1.) mitigated against many of the identified response challenges. The importance of an appropriate response rate was acknowledged as critical in determining the degree of statistical and analytical generalisation of the study (Onwuegbuzie & Collins 2007, Teddlie & Yu 2007). To ensure the representativeness of the study and the sample of employees a power sample analysis was conducted. Analysis indicated a sample size of 352 participants was required for a precision confidence interval of ±5% at a confidence level of 95%. The inclusion of the entire employee population in the sample was chosen in order to maximise the opportunity to participant, providing the necessary sample size. Previous response rates for the HSE’s National Staff Satisfaction Survey in 2018, resulted in a collective Community Healthcare Organisation response rate of 10% (including Section 39 voluntary service providers). The average national response rate including Hospital Groups and Ambulance Services was 15%. Across the nine individual Community Healthcare Organisations, the response rates ranged from 10% to 21%, with the participating CHO recording a response rate of 12% (Ipsos MRBI, 2018). At the planning stage of the study, it was estimated that the response rate needed for the study would be between 10-15% of the population, and the actual response rate was 11% (n=445).

5.2.4 Maximising Survey Response Rate

addition, eighteen Directors of Nursing in Community Hospitals and fifteen area Home Help Coordinators also received the same personalised communication as an introduction to the study and as an advanced personal advisory. To coincide with the study launch, a presentation was made at the Annual Conference of the Institute of Community Healthcare Nursing in May 2019. The study was also promoted across the CHO’s social media accounts.

5.2.5. The Survey Instrument - OCAI™

Permission to use the qualitative instrument (OCAI™) was sought and granted by the author in person, Professor Kim Cameron, in November 2018. The survey is derived from the research theory, the CVF, and includes 6 core questions, represented by four situational statements each which represents a different organisational culture (Questions 1-6). The desired organisational culture of the future is also represented by the same six situational statements (Questions 7-12), which this time refers to future desired cultural elements. In context, the participants are asked to consider their own team, department, or clinic, when completing the survey instrument, rather than national leadership or values. Using a ipsative scale the participants then scored the highest number of points from 100 to the situational statement which best represented their team or clinic, allocating the remaining points across the other three cultures as appropriate. The instrument provided employees with the opportunity to reflect on basic assumptions, interactive patterns, and the organisational direction as observed in their daily practices (Cameron & Ettington 1988). The selected preferred future organisational culture identified the cultural type which the participants indicated was best suited to deliver the planned community healthcare reform.
The situational statements in the questionnaire (Appendix i) are based on the six domains of the CVF’s organisational culture typologies (Figure 5.2). These six domains are also used as the basis of the thematic analysis outlined in Section 5.3.5. Questions 13-21 of the survey requested basic demographic and professional category information on the participants. This information was aligned to the classifications in the CHO, as coordinated with the Human Resource Director. This alignment would enable future comparable studies and enable the replication of the study across additional CHOs in the future.

5.2.6 Refining & Finalising the Questionnaire

During the literature investigation on the research themes and concepts in Chapter 2, and the subsequent systematised review in Chapter 3, several variations of the survey instrument were identified which deviated from the original OCAI™ (Marshall et al. 2003a, Yun Seok et al. 2010, Morais & Graca 2013). In one study the language of the questions were changed to suit the research environment, changing “organisation” to “maternity ward”
(Adams et al. 2017), while in other studies a number of additional questions were added, including a 24 item version, which was introduced to capture effectiveness, performance, and quality (Cameron & Quinn 2011a). Cameron and Quinn (2011) have confirmed however that the six item scale is equally as predictive in identifying the culture of an organisation, as many of the extended version, which have sought to incorporate other variables into the framework, often clouding an already complex construct (Cameron & Quinn 2011a). In consultation with the developer of the instrument and expert researchers in the area, the study has been loyal to the original wording, order and scale used in the instrument. Another established criterion was the duration of the survey, it was critical that the survey could be completed in a prompt and convenient way by busy healthcare employee. The average completion timeframe of the survey was 8-10 minutes.

Finally, the demographic questions (Appendix i) of the survey were reviewed by a team of 3 potential participants for usefulness and validity. Additional reviews were conducted in collaboration with both the Regional and National Human Resource Directors to ensure demographic and category variables were in line with the organisation’s own classifications. A review of the reliability and validity of the instrument in Section 5.2.8, supported by the literature, dictated that the final survey instruments received very little refining.

5.2.7 Quantitative Data Management and Analysis

As stated in the Research Design introduction (Section 5.1) once the quantitative data collection phase was closed the management and analysis of the quantitative data commenced. The sample suitable for analysis was n=445. Of the participants, 74% (n=331) had entered their responses directly on-line using SurveyMonkey Inc. An additional 16% (n=72) returned completed hard copies, which were manually entered on the survey software. A further 10% (n=42) completed the survey at the roadshow via the dedicated research website (www.culturechange.ie). The survey data was exported from the proprietary database (Survey Monkey Inc.) into Microsoft Excel and subsequently imported into IBM SPSS v25.0 Inc. (IBM, 2017). Once the SPSS data variables were entered and categorised, additional combined variables were created in line with the survey groupings and cultural typologies. The data variables were configured in IBM SPSS v25.0 Inc. and checked for a final time at which point the data was deemed suitable for analysis.
Using SPSS, univariate descriptive analysis were generated to examine the key characteristics of the survey respondents (Section 6.2). Variance analysis was conducted to compare the mean difference between the cultural types using paired sample t-tests. This provided evidence of the level of the prevailing cultural types and detailed the variances between the scores of the other cultural types. Additional inferential statistics showing the association between variables are presented in the quantitative findings in Section 6.4., where a more comprehensive analysis and comparison of domain variables are discovered.

5.2.8 Validity and Reliability of Quantitative Phase

The clear consensus in the field of quantitative data, in relation to the fundamentals and principals of scientific rigor, becomes more complex in the field of mixed methods where both quantitative and qualitative data are combined (Curry & Nunez-Smith 2015). There are two schools of thought which are detailed in the methodology chapter of this study (Section 4.5). One advocates for a combined quality assessment framework in mixed methods being ‘Legitimation’ (Onwuegbuzie 2007) or ‘inference quality’ (Teddlie & Tashakkori 2003), while the second option proposed by Curry and Nunez-Smith (2015) details Common Standards of Appraisal in Mixed Methods. The rational for this application is outlined in more detail in Section 4.5 where the discussion and proposal for a third set of mixed method standards are outlined.

For the purpose of transparency and completeness in this study, as recommended by experts in the field (O’Cathain et al. 2008, Wisdom et al. 2012), the study adheres to the individual standards of quality in quantitative research in relation to the sampling, data collection and analysis (Teddlie & Tashakkori 2009, Morse 2010, Creswell & Plano Clark 2018). In the first instance a pre-validated instrument, with a proven track record of measuring organisational culture in a healthcare setting was selected. Secondly to further improve the validity of the survey a pilot test (n=40) was undertaken in August 2018. Thirdly experts in the field, including the instrument’s developer and author provided advice and recommendations on the research questionnaire. Fourthly previous conducted research in a healthcare sector using the instrument were investigated and verified before the internal consistency of the instrument was tested in the study population.
5.2.8.1 Face Validity

Casual face validation of the study instrument was conducted in March 2018, when the instrument was provided to a selection of potential participants and untrained individuals for review. These individuals included several Community Healthcare employees plus three Ph.D. candidates from the School of Nursing and Midwifery, and the School Librarian from Trinity College, Dublin. The individuals were asked to review the instrument under the following headings.

1. Ease of understanding questions
2. Length of survey
3. Duration of survey completion
4. Ease of understanding concept of survey
5. Any survey bugs or typos noticed.

While face validation is generally not considered a scientific measurement (Litwin 1995), it did provide advice and assistance on visual aspects of the survey which were amended. The original cultural labels were also shown to have better face validity than alternative labels offered by Gerowitz et al. (1996) and Shortell at al. (2000) who also applied the CVF in healthcare setting (Gerowitz et al. 1996, Shortell et al. 2000).

5.2.8.2 Content Validity

Content validation of the study involved contacting instrument and discipline experts. Confirmation of content validation provided strong support for the instrument building on its methodological rigor. Validity from the expert group provided support and advice on the use of the instrument scale and changes to the survey statements, while confirming the relationship between the variables of interest in the study population.

5.2.8.3 Criterion Validity

In light of the complexity of the phenomenon under investigation and the lack of unity and precision surrounding the definition of organisational culture, finding a consensual “gold standard” (Litwin 1995 pp. 37) survey instrument was challenging (Chatman & O'Reilly 2016). The literature revealed some 70 instruments for measuring organisational culture,
many of which were unvalidated and study unique (Jung 2009). Having considered the options, the study holds that the Competing Values Framework in the form of the Organizational Cultural Assessment Instruments (OCAI™) is a fitting “gold standard” instrument (Scott et al. 2003b, Mannion et al. 2008). The instrument has been used in over 10,000 companies and by 100,000 participants and is the leading instrument to measure organisational culture in healthcare (Cameron & Quinn, 2011). The instrument is also intrinsically linked to the personal worldview of the researcher, the theoretical framework and the applied understanding and definition of organisational culture in the context of this study. Furthermore, the survey was used by 75% of studies discovered in the systematised review.

5.2.8.4 Construct Validity

Construct validation, is one of the “most difficult ways to assess an instrument (Litwin 1995 pp. 43) and has subsequently become the dominant objective of validity (Creswell & Creswell 2018). The instrument has been used at an operational level for over thirty years, across multiple sectors and in multiple settings. It has its foundation in some of the most enduring and well know psychometric theories of all time being that of Carl Jung (1923) and Myers and Briggs (1962). While Litwin (1995) demonstrates the challenges of assessing an instruments construct validity, either convergently or divergently, the longevity, robustness, and consistent nature of the OCAI™ especially as applied in healthcare, presents a meaningful theoretical instrument to measure organisational culture in this community healthcare setting.

5.2.8.5 Reliability in Quantitative Phase

In addition to the variety of validity measures taken, reliability was the foremost appraisal criteria applied in the quantitative inquiry phase. As previously indicated, to minimise the challenge to reliability, a validated reliable instrument was used. The internal consistency of the distributed instrument was tested using Cronbach Alpha (Cronbach 1951b) which reported alpha values of Clan Culture .83, Adhocracy .78, Market .80, and Hierarchy .748. This provided confirmation of the homogeneity of the scale, reflecting how the various elements of the cultural domains correlated together in the population sample (Litwin 1995, p. 82).
The internal consistency measured the degree to which the sets of items in the instrument perform in the same way over time (Creswell & Creswell 2018). In this study the sets of items, being the six domains of organisational culture, are measured and reported as \( r \) values (Litwin 1995, p. 82), indicating the correlation value. This internal consistency measurement, which is discussed further in the quantitative analyses of Chapter 6, confirms that the instrument scales were assessing the same construct, and that the scale items have suitable intercorrelation (between +1 and −1). This correlation also provided evidence of the interrelatedness, between and across the scales, of the OCAI™ survey instrument. As the participants response, may in fact change over time, the test-retest was not considered an appropriate test for the purpose of testing the reliability of the research questionnaire, this was also in line with the findings of the instrument authors (Cameron & Quinn 2011a). As the OCAI™ had not previously been used in the community healthcare setting, or in the population of this study, the internal consistency was revalidated in the study sample, documenting the “consistency of its psychometric properties, including reliability” (Litwin 1995, p. 27). The reliability of the research was also enhanced by piloting the survey instrument and by extensive data cleansing prior to analysis (Curry & Nunez-Smith 2015). Further psychometric analysis is included in the quantitative findings Chapter 6.

5.2.9 Quantitative Pilot Study

To further improve the validity of the survey it was pilot tested in August 2018. The pilot study was used to highlight any technical issues in the use of the on-line questionnaire, and ultimately to test the research procedures. A convenient sample of 40 community healthcare employees were recruited from an alternative community healthcare area. The volunteers completed the survey on-line following the distribution of the survey link via a Head of Service in that area, who acted as a gate keeper for the purpose of the pilot study. Feedback from the pilot study revealed that the survey took an average of 5-7 minutes to complete. This was considered a distinct advantage as previously conducted National Surveys had consisted of 65-100 questions, which demanded considerable allocation of valuable time. 50% of the pilot participants (n=20) only completed the first question and did not proceed to page two of the survey. Following an investigation, the page break and layout of the on-line version was identified as an issue. To resolve this problem the survey page was reformatted, ensuring a continuous format (all questions on one page). There was therefore
no requirement for the respondent to select ‘next page’, which was an unsuspected roadblock to completion.

Several respondents also reported that they were more familiar with the use of a likard scale, finding the forced choice, ipsative scale, required more concentration. While the questionnaire was available in both a likard and ipsative format, the study identified the forced choice (dividing 100 points across 4 statements) as one of the distinct advantages of the original questionnaire format. The forced choice, rating scale of the instrument “highlights and differentiates the cultural uniqueness that actually exists in organisations (Cameron and Quinn, 2011 p. 183). This scale forces the respondents to make a trade-off, similar to choices which are actually made in practice. When the likard scale, which is the common alternative, is used, respondents tend to rate either all option statements high, or all option statements low, providing less differentiation (Cameron and Quinn, 2011).

Finally, a small number of clarifications were added to the introduction paragraph in the survey as highlighted by the pilot respondents. The pilot survey had raised the question as to who ‘the organisation’ was. In the revised questionnaire, participants were advised to consider the organisation as their own team, department, or clinic rather than the entire organisation. For the second qualitative phase of the study, the qualitative data collection protocol was developed with two volunteers from the CHO and included observations for the first two interviews.

5.3 Phase 2: Qualitative Interviews

The study has outlined the steps in the qualitative phase of the study with the same degree of detail and rigor as those applied to the quantitative phase. The qualitative process is outlined in a step-by-step format providing the transparency and insight into the individual research phases as recommended (O’Cathain et al. 2008), including the specific qualitative quality appraisal including the credibility, dependability, transferability, and confirmability of the qualitative phase of the study.
5.3.1 Qualitative Sampling Strategy

The study uses a purposeful sampling strategy, sometimes referred to as a non-probability sample (Curry & Nunez-Smith 2015 p.204). Participants from the second phase of the study provided an explanation for the initial quantitative findings (Creswell & Plano Clark 2018). Employees who had participated in the quantitative phase, self-volunteered to be interviewed. The objective of this type of sampling is to add to, generate new knowledge and explain the findings from the quantitative phase of the study (Miles & Huberman 1994). Those who self-volunteered were also divided into strata to produce a stratified purposeful sample scheme, ensuring the maximum number of staff categories and divisions were represented (Curry & Nunez-Smith 2015). In order to reduce the threat to quality, the sample size was not determined in advance, as the sample was seeking to achieve data saturation (Curry & Nunez-Smith 2015). The strategy ensured the sample size was neither biased nor predetermined (Creswell et al. 2003, Curry & Nunez-Smith 2015). A review of the literature post data collection offered minimum sampling sizes for the most common forms of research designs, including optimal number of participants for data collection by interview as follows; as 6-9 (Krueger 2000), 6-10 (Langford et al. 2002) or 6-12 (Johnson & Christensen 2008).

In additional to the above sampling strategy the study also identified information-rich, key informants, based on the reasoning that they would provide a depth of information and a unique perspective on organisational culture relative to the investigation (Sandelowski 1995). They were also viewed as having the appropriate source of knowledge and experience (Patton 1990). Adopting this rational, all Senior Managers were invited to participate, this provided the widest, and most senior points of view in the CHO. At the conclusion of the data collection 12 semi-structured interviews had been conducted as detailed in Table 5.2. All care divisions were proportionately represented but have not been detailed to protect the identity of the participants.
Table 5.1 Qualitative Purposeful Sample

<table>
<thead>
<tr>
<th>N</th>
<th>Male</th>
<th>Female</th>
<th>Positions</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>3</td>
<td>9</td>
<td>Chief Executive Officer&lt;br&gt;Clinical Nurse Manager (CNM11)&lt;br&gt;Community Hospital Care Attendant Director of Nursing&lt;br&gt;Director of Public Health Nursing&lt;br&gt;Divisional Finance Director&lt;br&gt;Head of Services x 2&lt;br&gt;Home Help&lt;br&gt;Home Help Co-Ordinator&lt;br&gt;Manager Health &amp; Wellbeing&lt;br&gt;Nurse Manager&lt;br&gt;Staff Nurse</td>
</tr>
</tbody>
</table>

5.3.2. Semi-structured Interview Guidelines

The semi-structured interviews in Phase 2 were concluded between September 2019 - November 2019. Interviews enabled the interviewer to meet interviewees where they were, in their own capacity and role in the organisation, seeking clarification in real time on the quantitative findings (Teddlie & Tashakkori 1998).

Prior research suggests that interview guidelines can be as brief as a list of memory prompts. While the interview protocols (Appendix viii) were developed around the themes and domains of organisational culture, as identified in the quantitative survey instrument (Appendix i), a flexible approach was applied. The interviewer followed the participants led, when exploring themes identified by the interviewee as being of most importance to them personally. Participants were supported to explore themes deeply rather than completing all questions. In general guidelines on respecting power imbalance and developing rapport and probing were also considered (Kvale 2007, Bryman 2008). As the aim of the interview was to establish the individual experiences of organisational culture semi-structures, open ended interview questions were used, with a funnel technique which drilled down in the themes of interest.

5.3.3 Recruitment of Interview Participants

As previous outlined the participants for Phase 2 were recruited from the respondents of Phase 1, who consented to participate in the interview stage of the study. Once the
respondents expressed an interest in being included in the qualitative interviews. A Participant Information Leaflet (Appendix iii) and a Consent Form (Appendix ix) were provided to them directly by email. The potential participants were asked to review the content of the documents provided and revert if any further information was required. These documents were sent 14 days in advance of the planned interview. Interview appointments were agreed at a mutually convenient time, and were re-confirmed, by phone or email, 24-48 hours before appointment.

5.3.4 Preparing and Conducting the Interviews

Contingency planning was an important element of the interview planning process, as a delay in Phase 1 of the data collection would directly impact Phase 2. The interviews were conducted in several dedicated meeting rooms supplied by the organisation. Other issues addressed prior to the conducting of the interviews included the checking of the digital recording equipment, the checking of the backup digital recording equipment, the supply of drinking water, comfortable seating, noise, and ventilation/heating in interview room. The interviews were conducted during participants normal working hours. The allocation of a specific dedicated space enabled the researcher to guarantee privacy and provided adequate preparation time prior to the commencement of the interviews. The participants were welcomed and thanked, and at the commencement of the interviews the participants returned the consent forms (Appendix ix), which were then co-signed by the interviewee and the interviewer. A dedicated study number was assigned to the consent form which correlated with the anonymised interview audio.

The study applied a funnel technique to the semi-structured interview questions, a technique which is particularly suitable to mixed methods research (Teddle & Tashakkori 1998). To this effect the interviewer started with very broad questions and eventually narrowed the scope of the questions down to address the thematic domains of the research framework (Appendix ix). The interview duration ranged from 35 minutes to 1.20 minutes with the average time being 49 minutes. No more than two interviews were conducted per day to allow the audio to be transcribe and reviewed on an ongoing basis. This process enabled the researcher to revisit the quantitative findings, a technique which is described as “constantly having conversations between the qualitative and quantitative components of the
research” (Curry and Nunez-Smith, 2015 p. 20). The data was collected using two separate digital recorders which recorded simultaneously. A third recording device was available on standby. Once the interviews were concluded the participants were thanked and the timeframe for the publication of the research findings was explained. The participants were advised that updates would be provided on the dedicated website www.culturechange.ie. No requests for interview transcripts have been received to date.

5.3.5 Qualitative Data Management and Analysis

Having conducted and transcribed the interviews, as well as cleansed and condensed the audio, the data was very familiar on the commencement of the analysis. The digital transcripts were uploaded to MAXQDA 2020 Analysis Pro for management and analysis. Data interrogation was conducted using a style of thematic analysis called template analysis. Template analysis provided both a high degree of structure and a level of flexibility which reflected the needs of the research (King 2012). Template analysis which is growing in healthcare research (Howard et al. 2008), was chosen for the following four reasons;

1) It was based on the worldview of the researcher
2) it provided flexibility in the coding structure
3) it facilitated the priori themes of the research theoretical framework
4) it enabled the use of the initial template of the framework (King 2012).

The various phases of thematic data analysis were applied in support of the template analysis of the study, where the data analysis codes were generated from the survey’s cultural domains, providing an established hierarchal coding system. These thematic codes are detailed in Figure 5.2.1 and include the six domains of the quantitative survey including 1) Dominant Characteristics, 2) Leadership 3) Management of Employees 4) Organisational Glue 5) Strategic Emphasis and 6) Criteria of Success. Additional codes were developed independently from the template analysis as detailed in the qualitative findings section of Chapter 7. This ensured that nonthematic codes were also included in the reporting, which included emerging themes and barriers to change implementation.
5.3.6 Credibility and Rigor of Qualitative Phase

This phase of the study applied the unique elements of quality appraisal in qualitative research, using the established standards of credibility and rigor. The study applied several methods which enhance the trustworthiness of this phase of the study (Lincoln & Guba 1985). The prolonged engagement in the field is one of such methods, which fostered trust, establishing the contextual factors at play in the complex communication setting of healthcare (Lincoln & Guba 1985). This technique was also complemented by ongoing and “persistent observation” (Teddlie & Tashakkori 1998p. 90), at meetings, during presentations and during the quantitative roadshow.

The self-selection of participants also minimised the research bias and provided assurance as did the representativeness of the participants. A detailed email communications file and a reflexive journal also provides the four elements of Lincoln and Guba (1985) qualitative quality appraisal criteria. The credibility of the study was also demonstrated by the connection of both the quantitative and the qualitative data, which is evidenced at several points in the study. The integration provides further confirmation of the cohesion of findings and consistency of treatment of the phenomenon of interest (Curry & Nunez-Smith 2015).

5.3.6.1 Dependability

Dependability in the qualitative phase is linked to the topic of consistency in mixed methods research (Section 4.5). As identified by previous scholars, a degree of flexibility and responsiveness was necessary at all times in order to reply to the changing context of the study (Lincoln & Guba 1985, Patton 1990). This was mainly demonstrated through the collaborative rescheduling of data collection in consultation with the Senior Management Team and throughout the continual updating and discussions with study gatekeepers. The active nature of the community healthcare reform necessitated this responsive position. The initial data collection scheduled for October 2018 was delayed for the aforementioned reasons and was not completed until April 2019. Through the transparency and consistent record keeping applied during the data collection and analysis, the upmost dependability was assured. The repeatability of any natural interview raises concerns, as timing, content and the research phenomenon may change (Curry & Nunez-Smith 2015). The merits of an
independent audit of “trustworthiness” are acknowledged, however, its use is beyond the limits of this research. A systematic audit trail was maintained by the researcher detailing decisions and maintaining memos in the analysis software MAXQDA 2020 Analytics Pro. All correspondence was also maintained in chronological order from September 2017 to September 2021.

5.3.6.2 Transferability

Transferability in the qualitative phase refers to the degree to which the research themes, protocols and processes could be transformed or generalised to another population, settings and context (Curry & Nunez-Smith 2015). The research has provided a comprehensive repository of the enquiry to facilitate its transferability including the procedural diagram (Figure 5.1) and other frameworks, theory and protocols which underpins the enquiry. The graphic representation of the various elements of the study are also designed to aid transferability. The procedures and processes outlined in the section on sampling, participant recruitment, data collection and analysis all contribute to the transferability of the study including the application of the template analysis.

5.3.6.3 Confirmability

As objectivity is to the quantitative phase, confirmability is to the qualitative phase. Confirmability as a standard of appraisal is defined by the degree to which the research findings are shaped by the research participants and not the researcher (Lincoln & Guba 1985). While the experience and the knowledge of the researcher are valued in the qualitative phase of the research, the contributions are not influenced by the researcher (Burns & Grove 2009). To evidence this quality criteria the researcher created a meticulously hierarchal coded system, transparently and consistently utilising the template analysis coding through a systematic process facilitated by MAXQDA 2020 Analysis Pro and MaxDictio. The use of participant quotations in the analysis and the integration of data sets through joint display further adds to the confirmability of the process.
5.4 Phase 3: Integration Phase

One of the fundamental principles of mixed methods research is the integration of both the quantitative and qualitative findings, which is often under reported and underutilised (Creswell & Plano Clark 2007). When adopting an Explanatory Sequential Mixed Methods Design, in this research, there are several points of connection between the quantitative and qualitative methods. From the research design and sampling, to data collection and finally through the integration of findings from both data set the mixed methods process is intended to build on the strengths of both the quantitative and qualitative methodologies (Creswell & Plano Clark 2018), as detailed in Section 5.2 and 5.3 respectively.

The initial points of data connection in this study are during the research design considerations and identifying a qualitative purposeful sample from the quantitative phase. The in-depth interviews in the qualitative phase, are also informed by the findings from the quantitative phase, which also frame the development of the interview protocol and the template analysis. In the final integration phase of the study the qualitative findings are used to interpret, contextualise, and explain the quantitative results (Figure 5.1).

Figure 5.3 Methods and Process of Integration applied in the Study

![Figure 5.3 Methods and Process of Integration applied in the Study](image-url)
The overall study uses a number of integration techniques, including Connection/Building (Phase 1 & 2) and Merging (Phase 3) (Fetters et al. 2013). While the application of merging is more commonly used in a convergent research design, its application in this study provides the degree of flexibility which is paramount for the pragmatic paradigm which underpins the research. The combinations of integration techniques also ensured maximus disclosure of meta-inferences. Figure 5.3 provides an overview of the integration process.

Once the quantitative and qualitative findings are presented sequentially (in Chapters 6 and 7), the findings from both data sets are brought together for the collective analysis in the integration process outlined in Chapter 8. The presentation of the collective findings are brought together through a visual presentation, providing an ease by which to examine the conclusions. By employing a juxtapose side-by-side technique, the integration illustrates both the commonalities and differences across the data sources (Guetterman et al. 2015, Bazeley 2018b). In addition, the qualitative data clarifies how the organisational culture is personally experienced by the participants, providing a contextual nuance to the quantitative results.

This intentional integration combines the strengths of each method in answering the research questions comprehensively (Guetterman 2019). The visual means of integration selected is a Joint Display. Fetters (2020) suggests that a Joint Display Construct Inventory forms an important part of the integration process (Fetters, 2020). However, the use of the priori framework has rendered this recommendation redundant. Likewise, Bazeley (2018) and Yin (2006) also recommended creating links, between both data sets, through common variables, locations, or profiles as a means to aid integration. Again the application of the research framework has facilitated template analysis which has integrated both the quantitative and qualitative findings through the framework common themes. (Yin 2006, Bazeley 2018b).

The strategy applied in this phase of the research will reduce the potential threats to validity by included the use of the same sample for both the quantitative and qualitative phases, the use of the side-by-side visual display, which ensured satisfactory triangulation of the data, and finally the inclusion of direct quotations from the informants, supporting the convergent and/or divergent results (Bazeley 2018a). While not technical referred to as a
third phase in most research, the mixed methods integration is the final and third phase in this study.

5.5 Summary of Research Design & Methods

Collins (2015) suggested that the complexity in design and sample selection is elevated when conducting mixed methods research. The study’s design and methods includes a variety of phases, a variety of sampling schema, frameworks, and guidelines (Sandelowski 1995, Onwuegbuzie & Collins 2007, Teddlie & Yu 2007, Collins 2015). Rather than complexity, the researcher ventures that the mixed method process offers a degree of flexibility when determining the study design, purpose and fit. Ultimately the method applied to deliver the research was the most pragmatic and practical way to answer the research questions. Following the conclusion of the quantitative phase, the one-to-one interviews exposed rich data which highlighted the personal experiences of organisational culture in the Community Healthcare Organisation by employees. The connection of data at several points throughout the process, enabled the investigation to stay connected to the research objectives prior to the integration of both data sets. This provided a comprehensive, structured, yet flexible route map for the study. The inclusive application of the study’s theoretical framework transcended methodology and could not have produced the depth of enquiry through one single methodology.

This chapter has provided an introduction, directions, and explanations for the step-by-step delivery of the research process. While the sections on sampling strategy and data collection may present with elements of repetition at times, this it is in keeping with the research positioning of being in constant conversation with all phases of the study. Prior to the integration of the data findings, Chapter 6 and 7 analyse and report on the individual findings of phase 1 and 2.
6

Quantitative Research Findings

“If you cannot measure it, you cannot manage it” - Anonymous

This chapter presents the research findings from the quantitative phase of the study. The first phase of the study aims to answer the quantitative questions:

✓ Measure and identify the current prevailing and preferred future organisation culture in the participating community healthcare area.
✓ Establish if there is congruency between the identified organisational cultures and the respective cultural dimensions.

The chapter commences with a brief recap on the psychometric properties of the survey instrument and outlines its scoring mechanism. The internal consistency statistics of the instrument are presented as they emerged from the study. Section 6.2 analyses the demographic variables of the sample and their representativeness. Section 6.3 reports the key findings of the study and identifies the current and preferred future organisational cultural of the participating community healthcare organisation. Having answered the first quantitative research questions, the cultural domains are individually explored to establish if there is congruency between the individual domain type and the overarching cultural type identified by the participants. A chapter conclusion is offered in Section 6.6 before the qualitative findings are investigated in Chapter 7.

6.1 Internal Consistency of Survey Instrument

Internal consistency of the Organizational Cultural Assessment Instrument (OCAI™) was measured using Cronbach’s alpha (Cronbach 1951b). This demonstrated the homogeneity of each of the scale items. The individual cultural scale findings, for both the current and future preferred culture, with an α value of between ≥ 0.7 - ≥ 0.8 were deemed satisfactory (see Table 6.1).
Table 6.1 Reliability of Organisational Culture Construct in the Sample
(Cronbach 1951a).

<table>
<thead>
<tr>
<th>Name of Cultural Type</th>
<th>No of Items</th>
<th>Current Culture Cronbach’s α</th>
<th>Future Preferred Culture Cronbach’s α</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clan Culture</td>
<td>6</td>
<td>.834</td>
<td>.705</td>
</tr>
<tr>
<td>Adhocracy Culture</td>
<td>6</td>
<td>.738</td>
<td>.687</td>
</tr>
<tr>
<td>Market Culture</td>
<td>6</td>
<td>.800</td>
<td>.787</td>
</tr>
<tr>
<td>Hierarchy Culture</td>
<td>6</td>
<td>.748</td>
<td>.716</td>
</tr>
</tbody>
</table>

Having established the internal consistency of the instrument, correlation analyses were conducted across the associated cultural scales. When the dependent variables in the cultural scales were tested, they were found to follow a normal distribution curve, although statistically they were not normally distributed. As a result, both Pearson and Spearman tests reported similar findings. For this reason, both parametric and non-parametric correlation tests were conducted to establish the linear association between the scale variables. The analyses confirmed the significant association between the scales at 0.01 level as reported in Table 6.2. using a Pearson (r) correlation tTest. However, the correlation was not high enough to support excessive conceptual overlapping of the four cultural types. The study has included the Pearson test results, as the associated relationships between the variables were identified as constant and proportional. A change in one variable resulted in a proportional change in the other variable. Although both tests produced similar findings, the instrument scales were identified as nominal and ranked. Using this rational, the Pearson’s correlation coefficient test was applied to the r sample. Table 6.2 presents the inter-item correlation findings, which are not uniformly highly correlated, indicating the uniqueness of the instrument cultural types.

Table 6.2 Pearson’s Inter-Item Correlation Matrix of Current Cultural Scores

<table>
<thead>
<tr>
<th></th>
<th>Current Clan</th>
<th>Current Adhocracy</th>
<th>Current Market</th>
<th>Current Hierarchy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Clan</td>
<td>1.00</td>
<td>.368**</td>
<td>.664**</td>
<td>.471**</td>
</tr>
<tr>
<td>Current Adhocracy</td>
<td>.368**</td>
<td>1.00</td>
<td>-.214**</td>
<td>-.651**</td>
</tr>
<tr>
<td>Current Market</td>
<td>-.664**</td>
<td>-.214**</td>
<td>1.00</td>
<td>-.240**</td>
</tr>
<tr>
<td>Current Hierarchy</td>
<td>-.471**</td>
<td>-.651**</td>
<td>-.240**</td>
<td>1.00</td>
</tr>
</tbody>
</table>

Correlation is significant at the 0.01 level (2-tailed). **
A Pearson’s t-test was also conducted across the future scales of the instrument (Table 6.3) to measure the strength of association between the variables of the future cultural scales. As expected, there was significant correlation between the variables in the current scales and the preferred scales at the 0.01 level, however again this correlation was not high enough to suggest overlapping of the cultural types.

### Table 6.3 Pearson’s Inter-Item Correlation Matrix of Future Preferred Cultural Scores

<table>
<thead>
<tr>
<th></th>
<th>Preferred Clan</th>
<th>Preferred Adhocracy</th>
<th>Preferred Market</th>
<th>Preferred Hierarchy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Clan</td>
<td>1.00</td>
<td>-0.177**</td>
<td>-0.641**</td>
<td>-0.464**</td>
</tr>
<tr>
<td>Preferred Adhocracy</td>
<td>-0.177**</td>
<td>1.00</td>
<td>-0.231**</td>
<td>-0.588**</td>
</tr>
<tr>
<td>Preferred Market</td>
<td>-0.641**</td>
<td>-0.231**</td>
<td>1.00</td>
<td>0.185**</td>
</tr>
<tr>
<td>Preferred Hierarchy</td>
<td>-0.464**</td>
<td>-0.588**</td>
<td>0.185**</td>
<td>1.00</td>
</tr>
</tbody>
</table>

Correlation is significant at the 0.01 level (2-tailed). **

### 6.2 Demographics of Sample

Demographics showed that the response rate was also confirmed as representative of the population of the current work force by gender, by divisions, by staff categories and by type of contract (Table 6.4). Table 6.5 summarises the demographic and professional characteristics of the survey respondents (n=445).

### Table 6.4 Representative Sample of Participants by Work Division & Staff Category

<table>
<thead>
<tr>
<th>Work Division /Staff Category</th>
<th>Frequency</th>
<th>Response %</th>
<th>Workforce %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work Division</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>108</td>
<td>24.37%</td>
<td>26.21%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>116</td>
<td>26.10%</td>
<td>25.26%</td>
</tr>
<tr>
<td>Social Care - Disabilities</td>
<td>38</td>
<td>8.54%</td>
<td>8.58%</td>
</tr>
<tr>
<td>Social Care - Older Persons</td>
<td>183</td>
<td>41.12%</td>
<td>40.04%</td>
</tr>
<tr>
<td>Professional Category</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health &amp; Social Care</td>
<td>74</td>
<td>16.60%</td>
<td>13.50%</td>
</tr>
<tr>
<td>Management &amp; Admin</td>
<td>88</td>
<td>19.80%</td>
<td>18.43%</td>
</tr>
<tr>
<td>Medical &amp; Dental</td>
<td>11</td>
<td>2.50%</td>
<td>3.00%</td>
</tr>
<tr>
<td>Nursing &amp; Midwifery</td>
<td>154</td>
<td>34.60%</td>
<td>34.07%</td>
</tr>
<tr>
<td>Patient &amp; Client Care</td>
<td>118</td>
<td>26.50%</td>
<td>31.00%</td>
</tr>
</tbody>
</table>
### Table 6.5 Characteristics of Respondents

<table>
<thead>
<tr>
<th>Characteristics of Respondents</th>
<th>Male</th>
<th>15.28%</th>
<th>Female</th>
<th>84.72%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>68</td>
<td></td>
<td>377</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Age Groups</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>20</td>
<td>4.50%</td>
<td>87</td>
<td>19.60%</td>
<td></td>
</tr>
<tr>
<td>30-39</td>
<td>180</td>
<td>40.40%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50-59</td>
<td>144</td>
<td>32.40%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60 plus</td>
<td>14</td>
<td>3.10%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mean Age 46.43</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informal/Primary</td>
<td>3</td>
<td>.58%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower Secondary</td>
<td>38</td>
<td>8.58%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Higher Secondary</td>
<td>69</td>
<td>15.58%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Third Level Non-Degree</td>
<td>84</td>
<td>18.96%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Third Level Degree</td>
<td>107</td>
<td>24.16%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Third Level Post-Graduate</td>
<td>142</td>
<td>32.05%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Work Division</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
</tr>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>88</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical &amp; Dental</td>
<td>11</td>
<td>2.50%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing &amp; Midwifery</td>
<td>154</td>
<td>34.60%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient &amp; Client Care</td>
<td>118</td>
<td>26.50%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Main Staff Categories</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Position Tenure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 12 months</td>
<td>22</td>
<td>4.96%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5 years</td>
<td>67</td>
<td>15.06%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-10 years</td>
<td>67</td>
<td>15.06%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11-15 years</td>
<td>84</td>
<td>18.86%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16-20 years</td>
<td>92</td>
<td>20.67%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 years plus</td>
<td>113</td>
<td>25.39%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contract Type</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full Time</td>
<td>358</td>
<td>80.44%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part Time/Job Share</td>
<td>87</td>
<td>19.56%</td>
<td></td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

### 6.2.1 Gender, Age and Educational Profile

Of the 445 respondents, 84.72% (n=377) identified as female and 15.25% (n=68) identified as male (Table 5.5). According to the workforce records in the CHO area, the percentage of female employees is 84.40%, and male employees are 15.60%. Across several staff categories, the employees were exclusively female including Public Health Nurses and
several Health and Social Care professionals’ categories. The highest percentage of male respondents were engaged in Mental Health services (51%, n=35), with a further 28% in Primary Care and 14% in Social Care (Older Persons Services). At a national level the percentage of females employed in the community healthcare service is 81% with 19% male, this analysis therefore confirms that the gender of the survey respondents is representative of the community healthcare service employees census population and the national healthcare population at large (Executive 2019, Health Service Executive 2019b).

The mean age of respondents was 46.43 years (SD 9.12) (Table 6.5). The mean age across the individual work divisions was found to be 43 in Social Care (Disabilities), 43.19 Mental Health, 45.21 in Primary Care, and 50 in Social Care (Older Persons), being the oldest cohort of employees by division (Table 6.5).

The educational attainments of the respondents are also illustrated in Table 6.5. In total, over 56% (n=249) of respondents held a third level degree or a post graduate qualification. Of those who responded, 24% had attended secondary school (n=107), the very small number having attended primary school only were in the 50-59 age group. None of the respondents over 60 reported holding a third level degree or a postgraduate degree. The highest level of education attained by this age group was a third level non-degree, which would include nurses who qualified pre-degree requirement.

### 6.2.2 Work Division

Table 6.5 also included an analysis of respondents by division or care group. For the purpose of the divisional analysis, Communications and ICT, Finance, Health and Wellbeing and Human Resources have been combined with Primary Care. This is in keeping with the classification in the organisation and is due to restructuring legacy issues which have been previously outlined. The combination of this data also protects the anonymity of those working in small work divisions and specialist areas. Table 5.4 has already confirmed the representative nature of the sample across all four divisions, with only minor variances. The largest responding division, which also employed the largest number of employees was Social Care – Older Person’s Services, while the smallest division was Social Care – Disability. Primary Care and Mental Health made up the balance of the respondents.
6.2.3 Professional Categories

The study replicated the professional staff categories applied by the Human Resource Headquarters of the National Health Service. The survey sample (n=445) was found to be representative of the five assigned professional categories of the CHO (Executive 2019, Health Service Executive 2019b). From Registrars to Home Helps, in total 37 professional sub-categories were discovered in the sample. The Nursing and Midwifery category included for example, Nurse and Midwife Managers (n=38), Nurses Other (n=15), Nurse Specialist (n=23), Public Health Nurses (n=22), Staff Nurses (n=53) and Student Nurses (n=5). The most diverse category was noted as the Health and Social Care category, which included Audiology, Social Care, Social Workers, Psychologists, Pharmacy, Physiotherapy, Speech and Language Therapy, and all the therapy professionals engaged in the community sector. The professional grouping with the least number of sub-categories was Patient and Client Care which incorporated only three sub-categories Health Care Assistants, Home Helps and Carers other. The Management and Administrative category included Managers at grade VIII and above, Administrative Supervisors (grade V to VII) and Clerical staff (grade III to V).

6.2.4 Tenure of Employment

In relation to tenure of service, the findings indicated the longevity of service provided by participants. Over 46% of respondents had more than 16 years’ service (Table 6.5). Of those who have joined the service in the last 12 months, 60% were hired for clerical and administrative roles, while student nurses made up 13.65% (although it is speculated that these positions are non-paid, clinical placement posts). Four percent of new recruits were deployed to Physiotherapy, Speech and Language Therapy and to the role of Multitask Assistant. The staff category of Health and Social Care professionals, mainly Physiotherapy, Speech and Language, Occupation and Play Therapists, had zero recruitments in the last 1-5 years. At a national level 46% of Health Service Executive employees had < 15 years’ service, a percentage which is replicated in the sample. The numbers of full time, Job Sharing or working Part-Time is slightly different from the national figure which is 71% full time and 29% part-time (Executive 2019, Health Service Executive 2019b).
6.3 Findings from Organisational Culture

Having examined the parametric properties of the cultural profiles as a prerequisite for the univariate analysis, this section answers the main research question, and presents the overarching and most influential findings of the study. The application of the appropriate inferential statistic determined the current prevailing organisational culture type and the preferred future organisational cultural. Using univariate analysis tests, Table 6.6 presents the mean score findings from both the current and future organisational culture types. Findings from the analysis indicated that the participants observed their current organisational culture to be dominate by a Hierarchy type (M=39.53, SD 16.10), with the mean score for Market and Clan culture type ranking second and third place respectively (M=24.99, SD 8.36, M=23.14, SD 14.75). The current Adhocracy culture mean score scored lowest (M=12.31, SD 8.36). Using the same process, the preferred future organisational culture was also calculated, establishing the highest mean scoring type as Clan (39.79, SD 11.62), with Market (12.64, SD, 8.03) the least preferred future organisational cultural type. The ranking and means scores of the findings are presented in Table 6.6.

<table>
<thead>
<tr>
<th>Cultural Type Current and Preferred</th>
<th>Ranking</th>
<th>Mean Score</th>
<th>Standard Deviation</th>
<th>95% Confidence Interval of the Difference Lower</th>
<th>Upper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Clan</td>
<td>3</td>
<td>23.14</td>
<td>14.75</td>
<td>21.77</td>
<td>24.51</td>
</tr>
<tr>
<td>Adhocracy</td>
<td>4</td>
<td>12.31</td>
<td>8.36</td>
<td>11.53</td>
<td>13.09</td>
</tr>
<tr>
<td>Market</td>
<td>2</td>
<td>24.99</td>
<td>8.36</td>
<td>24.21</td>
<td>25.77</td>
</tr>
<tr>
<td>Hierarchy</td>
<td>1</td>
<td>39.53</td>
<td>16.10</td>
<td>38.03</td>
<td>41.03</td>
</tr>
<tr>
<td>Preferred Clan</td>
<td>1</td>
<td>39.79</td>
<td>11.62</td>
<td>38.71</td>
<td>40.87</td>
</tr>
<tr>
<td>Adhocracy</td>
<td>2</td>
<td>24.99</td>
<td>10.11</td>
<td>24.05</td>
<td>25.93</td>
</tr>
<tr>
<td>Market</td>
<td>3</td>
<td>12.64</td>
<td>8.03</td>
<td>11.88</td>
<td>13.38</td>
</tr>
<tr>
<td>Hierarchy</td>
<td>4</td>
<td>22.59</td>
<td>10.10</td>
<td>21.65</td>
<td>23.53</td>
</tr>
</tbody>
</table>

Further analysis of variance (ANOVA) was conducted to examine the extent of the differences between the mean scores of the various cultural types both current and preferred. The findings from the post hoc t-test, comparing mean values, suggests a
significant difference between all four culture type groups (p < 0.001). This clearly demonstrates that the respondents observed their current culture type to be overwhelmingly Hierarchy (controlling). Analysis of variance (ANOVA) and post hoc t-tests were also conducted to establish the mean difference between and across future cultural scores. The results were also found to be statistically different, not only confirming the extend of the difference between the four future cultural scores but also the difference between the scores of the current and future cultural types as presented in Table 6.7 and Figure 6.1.

The mean difference between current Clan culture and preferred Clan Culture is an increase of 16.65, which is comparable to the decrease in the Hierarchy culture scores at 17.24. The Adhocracy and Market mean differences mirror the change pattern, with Adhocracy increasing by 12.67 and Market decreasing by 12.35.

<table>
<thead>
<tr>
<th>Pair</th>
<th>Current vs Preferred</th>
<th>Mean Difference</th>
<th>Std. Deviation</th>
<th>t value</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Clan vs Clan</td>
<td>-16.65</td>
<td>16.67</td>
<td>-21.06</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>2</td>
<td>Adhocracy vs Adhocracy</td>
<td>-12.67</td>
<td>12.86</td>
<td>-20.79</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>3</td>
<td>Market vs Market</td>
<td>12.35</td>
<td>17.17</td>
<td>15.17</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>4</td>
<td>Hierarchy vs Hierarchy</td>
<td>17.24</td>
<td>18.08</td>
<td>20.11</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

The presentation of mean values in Table 6.6 clearly shows the current and preferred prevailing organisational cultures as Hierarchy (controlling) and Clan (collaborative), the analysis of variance post hoc t-tests in Table 6.7 shows the significance of the mean differences, and the unambiguous discrepancy between the observed and preferred cultures as reported by the respondents. In summary the findings suggests that the participants would prefer an organisational culture which is significantly different from that which they currently observe in practice. Figure 6.1 provides a visual representation of the current and preferred cultural profile for the Community Healthcare area. The prevailing observed culture is identified as Hierarchy, while the preference is for a Clan...
type culture. The current profile has moved from the control - internal quadrant of the matrix to the external - flexibility quadrant (Figure 6.1). This is a significant change. In practice, this means more decentralised decision making and fewer signoffs for decisions, less red tape, and more horizontal communication. Leaders in the organisation, should facilitate more cross-discipline teamwork with less paperwork and micro-management (Cameron & Quinn 2011a). Human Resources play an important part in this change, responding to employee needs, developing leaders and facilitating transformation.

Figure 6.1 Current & Future Preferred Cultural Profile
The change in profile also represents a reduction in competitiveness and the hard driving demands of the Market Culture and a move towards innovation, individual thoughtful risk taking, future planning and learning, and listening to patients (Adhocracy Culture). The current low score of the Adhocracy culture indicated a lack of continuous improvements and innovation, indicating a stagnant organisation where it matters. This is represented in Figure 6.1 by the reduction in the current Market culture and an increase in the preferred Adhocracy culture. The significant preference for an increase in the clan culture indicates a need for more open communication, team building and employee empowerment. Leaders in this future clan culture will be mentors and facilitators, their style will be orientated towards collaboration and creativity. Having identified the collective cultural preferences across the organisation, the next section broadens the analysis to establish if the overarching cultural scores are significantly influenced by the demographic characteristics of the respondents.

6.4 Association of Demographics with Cultural Type

The analysis in Section 6.3 clearly demonstrates the current organisational cultural and the preference to change that identified culture. In this section the demographic variables reported on in Section 6.2 are further explored to determine their possible influence on the cultural scoring. While the associations across many demographic variables by cultural type are nominal, the influences are presented in tables format, indicating the association between the participants characteristics and the current and the preferred cultural scores.

6.4.1 No Association of Gender with Cultural Type

With only two identified genders in the sample an independent sample t-test was conducted to compare the differences between the mean score of female and male respondents. The report showed no significant difference in mean score by gender. Scores from both genders were similarly aligned to the collective mean scores. Based on these results, the findings confirm that there is no significant influence in the observed or preferred cultural type by gender (Table 6.8.).
Table 6.8 Mean Cultural Differences by Gender (Current & Future Preferred)

<table>
<thead>
<tr>
<th>Cultural Type Current &amp; Preferred</th>
<th>Female</th>
<th>Male</th>
<th>t-test</th>
<th>p</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Clan</td>
<td>23.09</td>
<td>23.43</td>
<td>-1.77</td>
<td>.089</td>
<td>23.14</td>
</tr>
<tr>
<td>Current Adhocracy</td>
<td>12.24</td>
<td>12.73</td>
<td>-1.16</td>
<td>.246</td>
<td>12.31</td>
</tr>
<tr>
<td>Current Market</td>
<td>25.26</td>
<td>23.52</td>
<td>8.52</td>
<td>.394</td>
<td>24.99</td>
</tr>
<tr>
<td>Current Hierarchy</td>
<td>39.39</td>
<td>40.29</td>
<td>-1.04</td>
<td>.303</td>
<td>39.53</td>
</tr>
<tr>
<td>Preferred Clan</td>
<td>39.59</td>
<td>41.13</td>
<td>-1.031</td>
<td>.303</td>
<td>39.79</td>
</tr>
<tr>
<td>Preferred Adhocracy</td>
<td>25.11</td>
<td>24.33</td>
<td>.582</td>
<td>.561</td>
<td>24.99</td>
</tr>
<tr>
<td>Preferred Market</td>
<td>12.50</td>
<td>13.27</td>
<td>-1.70</td>
<td>.478</td>
<td>12.64</td>
</tr>
<tr>
<td>Preferred Hierarchy</td>
<td>22.53</td>
<td>20.85</td>
<td>1.24</td>
<td>.215</td>
<td>22.28</td>
</tr>
</tbody>
</table>

6.4.2 Minor Association of Age with Current Cultural Type

The cultural score by age showed slightly more discrepancies than the mean scores by gender. However, differences were mostly non-significant. The 30-39 age group scored slightly above average in the current Clan culture (26.13 vs. 23.14), with the 60+ age group scoring above average in the future Hierarchy culture (26.78 vs. 22.28) scores, indicating a higher preference for a controlling culture in the future. This same cohort also indicated a lesser preference for a future Adhocracy (innovative and flexible) type culture, when compared to other age groups (18.63 vs 24.99). This could perhaps indicate that longer serving members, nearing retirement, are less enthused by innovation and creative change, or simply have no appetite for change. Similar scores were found across the 40-49 age group and the 50-59 age group, who accounted for 74% of the sample.

Table 6.9 Mean Culture Differences by Age Band (Current and Future Preferred)

<table>
<thead>
<tr>
<th>Cultural Type</th>
<th>20-29 Age</th>
<th>30-39 Age</th>
<th>40-49 Age</th>
<th>50-59 Age</th>
<th>60 plus Age</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Clan</td>
<td>22.29</td>
<td>26.13</td>
<td>21.75</td>
<td>22.92</td>
<td>25.89</td>
<td>23.14</td>
</tr>
<tr>
<td>Current Adhocracy</td>
<td>11.04</td>
<td>13.10</td>
<td>11.56</td>
<td>13.08</td>
<td>11.07</td>
<td>12.31</td>
</tr>
<tr>
<td>Current Hierarchy</td>
<td>37.91</td>
<td>41.35</td>
<td>40.25</td>
<td>37.48</td>
<td>42.32</td>
<td>39.53</td>
</tr>
<tr>
<td>Preferred Clan</td>
<td>43.62</td>
<td>39.24</td>
<td>38.81</td>
<td>40.45</td>
<td>43.75</td>
<td>39.79</td>
</tr>
<tr>
<td>Preferred Market</td>
<td>13.66</td>
<td>12.09</td>
<td>12.92</td>
<td>12.65</td>
<td>10.85</td>
<td>12.64</td>
</tr>
<tr>
<td>Preferred Hierarchy</td>
<td>21.87</td>
<td>21.42</td>
<td>22.77</td>
<td>21.82</td>
<td>26.76</td>
<td>22.28</td>
</tr>
</tbody>
</table>

Note: Matching subscript letters denote statistical significance

\( a \text{ } t(180) = -7.02, \text{ } p = .005 / b \text{ } t(144) = -7.11, \text{ } p = .006 \)
A multi-comparison post-hoc t-test following the ANOVA test (Bonferroni-corrected at \( p<.05 \)) explored the statistical difference in the scoring across the age groups (Table 6.9). Most age groups analysed presented with the same patterns as the collective total scores. The only cultural score which was significantly influenced by age group was the current Market culture. The results are presented in Table 6.9 which demonstrates the difference between the 30-39 and the 40-49 age group, and the 30-39 and the 50-59 age group.

6.4.3 Minor Association of Education Levels with Future Cultural Type

An analysis of the educational attainment of the participants by cultural score indicated some difference between the scores of those who have attended third level and those who have not (Table 6.10). Those who attended secondary school only, considered the current culture as more controlling and competitive, scoring higher than the mean average on both the Hierarchy (Control) and Market (Compete) scales (Lower Secondary, \( M = 43.02 \), \( n=38 \) / Higher Secondary \( M = 42.57 \), \( n=69 \)). This could perhaps indicate the level of autonomy or control experienced by this group with minimal education. This group also scored lower than average on the current Clan scale, observing less collaboration and amiability behaviours (M 18.81 and M 19.21), perhaps experiencing exclusion. Those who completed primary school level (\( n=3 \)) scored almost evenly across all cultural types, apart from Adhocracy (representing an exceedingly small percentage).

### Table 6.10 Mean Culture Differences by Education (Current & Future Preferred)

<table>
<thead>
<tr>
<th>Cultural Type</th>
<th>Primary</th>
<th>Lower Secondary</th>
<th>Higher Secondary</th>
<th>Third Level Degree</th>
<th>Postgraduate</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Clan</td>
<td>28.05</td>
<td>18.81</td>
<td>19.21</td>
<td>25.30</td>
<td>24.69</td>
<td>23.64</td>
</tr>
<tr>
<td>Current Adhocracy</td>
<td>18.61</td>
<td>10.43</td>
<td>10.57</td>
<td>11.75</td>
<td>13.08</td>
<td>13.27</td>
</tr>
<tr>
<td>Current Hierarchy</td>
<td>28.08</td>
<td>43.02</td>
<td>42.57</td>
<td>38.95</td>
<td>37.26</td>
<td>39.44</td>
</tr>
<tr>
<td>Preferred Clan</td>
<td>39.53</td>
<td>26.11</td>
<td>38.90</td>
<td>41.44</td>
<td>40.13</td>
<td>39.02</td>
</tr>
<tr>
<td>Preferred Adhocracy</td>
<td>22.82</td>
<td>22.22</td>
<td>24.49</td>
<td>22.07</td>
<td>25.17</td>
<td>27.81ab</td>
</tr>
<tr>
<td>Preferred Market</td>
<td>10.96</td>
<td>16.11</td>
<td>13.33</td>
<td>12.55</td>
<td>13.41</td>
<td>12.66</td>
</tr>
<tr>
<td>Preferred Hierarchy</td>
<td>26.42</td>
<td>25.55</td>
<td>22.65</td>
<td>23.77</td>
<td>21.04</td>
<td>20.19d</td>
</tr>
</tbody>
</table>

**Note:** Matching subscript letters denote statistical significance

- \( a t(69) = -5.08, \, p = .010 \) / \( b t(84) = -5.72, \, p < .001 \) / \( c t(84) = 5.38, \, p = 0.10 \) / \( d t(142) = 6.29, \, p < .001 \)

An analysis between the groups, using a multi-comparison post-hoc t-test following an ANOVA test (Bonferroni-corrected), indicated that these differences in the current cultural
scores were not significant. An analysis of the same test results across the preferred cultural scores presented some significant differences. The main preferred future cultural scores of significant differences discovered were in both the Hierarchy and Adhocracy culture. Participants who completed higher level secondary school (n=69) and post graduate participants (n=142) presented with significantly different preferred cultural scores, as did those who attended third level (non-degree) and those with a postgraduate qualification. The significant differences between the preferred Hierarchy cultural scores includes almost similar participants, postgraduates, and higher secondary school and third level degree participants and higher secondary school attendees. The differences are presented in table 5.10 and indicate that the current cultural scores are not influenced by educational attainment. In contrast the future cultural scores are significantly influenced by those who had completed higher levels of educational attainment and those in the middle to lower end (high secondary) and only in the controlling (Hierarchy) and creative cultures (Adhocracy).

6.4.4 Minor Association of Work Division with Current Cultural Type

The CHO is divided into four divisions or care groups, Primary Care, Mental Health, Social Care - Older Person Services and Social Care – Disabilities (Table 6.5). As previously signposted the Primary Care division includes all employees who were previously engaged in administrative and non-clinical roles in the regional head office before the area was restructured. An analysis of the mean scores across the four-work division by culture type is presented in Table 6.11. A review of the current cultural scores across the divisions shows no divergence in the prevalent Hierarchy and Adhocracy scores, with noted discrepancies in the current Clan and Market types primarily in the Social Care – Older Persons division. An investigation into the differences between care division using a multi-comparison post-hoc ANOVA test (Bonferroni-corrected) indicated no signification difference between future preferred care group scoring. As indicated however the Social Care - Older Persons Division and the Primary Care group showed significant difference for both Clan and Market cultural scores. A signification difference was also discovered for the current Market culture score between Social Care - Older Persons and Social Care -Disabilities. The significant differences are reported in table 6.11.
<table>
<thead>
<tr>
<th>Cultural Type</th>
<th>Primary Care</th>
<th>Mental Health</th>
<th>Social Care Disabilities</th>
<th>Social Care Older Persons</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Clan</td>
<td>26.03</td>
<td>23.57</td>
<td>26.66</td>
<td>20.32</td>
<td>23.14</td>
</tr>
<tr>
<td>Current Adhocracy</td>
<td>13.08</td>
<td>12.74</td>
<td>14.82</td>
<td>11.06</td>
<td>12.31</td>
</tr>
<tr>
<td>Current Market</td>
<td>22.11</td>
<td>23.96</td>
<td>20.02</td>
<td>28.46</td>
<td>24.99</td>
</tr>
<tr>
<td>Current Hierarchy</td>
<td>38.75</td>
<td>38.75</td>
<td>38.48</td>
<td>40.14</td>
<td>39.53</td>
</tr>
<tr>
<td>Preferred Clan</td>
<td>38.28</td>
<td>40.15</td>
<td>36.79</td>
<td>41.17</td>
<td>39.79</td>
</tr>
<tr>
<td>Preferred Adhocracy</td>
<td>24.54</td>
<td>26.36</td>
<td>28.39</td>
<td>23.77</td>
<td>24.99</td>
</tr>
<tr>
<td>Preferred Market</td>
<td>14.02</td>
<td>11.96</td>
<td>13.55</td>
<td>11.98</td>
<td>12.64</td>
</tr>
<tr>
<td>Preferred Hierarchy</td>
<td>23.15</td>
<td>20.87</td>
<td>21.25</td>
<td>22.78</td>
<td>22.28</td>
</tr>
</tbody>
</table>

Note: Matching subscript letters denote statistical significance
\[a \ t(116) = 6.08, \ p = .025 / b \ t(116) = 6.46, \ p = .020 / c \ t(38) = 8.44, \ p = 0.40\]

The findings indicated that the scoring of some current Clan and Market cultural scoring was significantly influenced by work divisions, there was unilateral agreement across the future preferred cultural type with no significant difference in scoring by division discovered.

### 6.4.5 Minor Association of Work Categories with Cultural Types

A comparison of mean cultural score by staff category (Table 6.12) indicates the similarity of trends across all work categories especially in the scoring of current Hierarchy and Adhocracy scales. Marginal differences were found in both the current Patient and Client Care scores, and to a lesser extent in the Medical and Dental category. This Patient and Client Care category represents the largest professional category in the community healthcare area (n=2,033), whereas Medical and Dental represents the smallest category (n=160). The Patient and Client Care category, made up of Home Helps and Health Care Assistants, scored below average on the Clan (Collaborative) scale (M 19.99 vs. M 23.14) and above average on the Market (Compete) scale (M 28.40 vs. M 24.99). This would indicate that this category observed a culture which was less collaborative and more demanding than other staff categories. Further statistical analysis, using the previously applied multi-comparison ANOVA post hoc t-test (Bonferroni-corrected), indicated a significant different between the Management & Administrative (n=88) group and the Patient & Client Care (n=118) group in both the current Clan and Adhocracy mean cultural scores (Table 6.11). No signification difference was detected between professional categories scoring of the current Adhocracy or Hierarchy scores.
An analysis of variances across the staff categories however is more pronounced, from the highest scoring preferred Clan category of Nursing and Midwifery (M 42.15) to the lowest scoring of Management and Administrative (M 35.47). A high Adhocracy mean score (M 27.31) for Health & Social Care and a lower score for Medical and Dental (M 22.65) demonstrates the distribution across the staff categories, when selecting the preferred future culture. Market and Hierarchy show similar breadth of scoring from 11.03 vs. 15.51, and 25.98 vs. 20.32, respectively.

An analysis of the findings across the professional categories indicate that these variables had the most significant influence on cultural scores both current and preferred. This is particularly true of the Management and Administrative group (n=88), who scored significantly different across current observed Clan and Market culture, when compared to Patient and Client Care group (n=118), and across preferred Clan, Adhocracy and Hierarchy groups when compared to the Nursing & Midwifery group (n=154).

<table>
<thead>
<tr>
<th>Cultural Type</th>
<th>Health &amp; Social Care</th>
<th>Management &amp; Admin</th>
<th>Medical &amp; Dental</th>
<th>Nursing &amp; Midwifery</th>
<th>Patient &amp; Client Care</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Clan</td>
<td>23.52</td>
<td>25.93</td>
<td>27.12</td>
<td>23.49</td>
<td>19.99</td>
<td>23.14</td>
</tr>
<tr>
<td>Current Adhocracy</td>
<td>12.74</td>
<td>12.15</td>
<td>10.90</td>
<td>12.58</td>
<td>11.96</td>
<td>12.31</td>
</tr>
<tr>
<td>Current Hierarchy</td>
<td>39.35</td>
<td>39.76</td>
<td>40.37</td>
<td>39.35</td>
<td>39.64</td>
<td>39.53</td>
</tr>
<tr>
<td>Preferred Clan</td>
<td>38.67</td>
<td>35.47&lt;sup&gt;cd&lt;/sup&gt;</td>
<td>36.74</td>
<td>42.15&lt;sup&gt;c&lt;/sup&gt;</td>
<td>40.93&lt;sup&gt;d&lt;/sup&gt;</td>
<td>39.79</td>
</tr>
<tr>
<td>Preferred Adhocracy</td>
<td>27.31</td>
<td>24.25</td>
<td>22.65</td>
<td>25.95</td>
<td>23.05</td>
<td>24.99</td>
</tr>
<tr>
<td>Preferred Market</td>
<td>13.64</td>
<td>15.51&lt;sup&gt;ef&lt;/sup&gt;</td>
<td>14.62</td>
<td>11.03&lt;sup&gt;e&lt;/sup&gt;</td>
<td>11.79&lt;sup&gt;f&lt;/sup&gt;</td>
<td>12.64</td>
</tr>
<tr>
<td>Preferred Hierarchy</td>
<td>20.36</td>
<td>24.75&lt;sup&gt;g&lt;/sup&gt;</td>
<td>25.98</td>
<td>20.32&lt;sup&gt;g&lt;/sup&gt;</td>
<td>23.87</td>
<td>22.28</td>
</tr>
</tbody>
</table>

Note: Matching subscript letters denote statistical significance

This demonstrates that across 50% of current cultures and 75% of preferred cultures the Management and Administrative group scored significantly different than the Patient and Client Care group and the Nursing and Midwifery group. Considering the reported strength of professional culture in healthcare, this is not surprising.
6.4.6 Minor Association of Tenure of Employment with Cultural Types

The frequency statistics for the characteristics of tenure of employment and contract type are provided in Table 6.4. Table 6.13 and Table 6.14 provides a breakdown of cultural scores by these variables, comparing the mean scores and identifying a similar pattern to other key attributes, apart from newer team members. Those with less than one-year service considered the organisation considerably less competitive (Market Score M 17.76 vs collective total M 24.99). This group also considered the current culture to be more collaborative and mentoring (Clan M 30.71 vs. Total M 23.14). Similar pattern were discovered in those with 1-5 years’ service, although the difference was not as great. Adhocracy (Create) scored the lowest across all tenures of service groups and is firmly established as the least observed culture in the organisation.

An investigation into the preferred future cultural scores revealed that new employees would opt for a less creative (M 19.62), and a more controlling culture (M 28.05) compared to other groups. This may indicate a preference for a future environment which is more directive and helpful as new employees develop their skills and confidence. However, this pattern is also replicated in the 25% of employees with over 20 years’ service (Adhocracy M 23.37 and Hierarchy M 23.24). This could indicate their lack of investment in the future, although the change across all cultural mean scores are in keeping with the general scoring pattern.

A closer analysis of the mean differences between and across groups, using the previously applied conversative statistical test, signposted a significant difference across two cultural score types, current Market (Compete) and future Hierarchy (Control). Across these dependent variables the difference was significant noted in participants who had 11-15 years of service (Table 6.13). It was noted that the difference expressed by the 11-15-year group did not expand with longevity of tenure into the longer serving group. This difference articulated in the 11-15-year tenure group may be a result of unfulfilled career or promotional expectations.
A paired sample t-test analysis was conducted to establish the differences between the groups who worked part-time/job shared (n=87) and full-time (n=358). The test reported no significant difference across the mean scores of the current cultural types and the preferred cultural types. These results lead strong support for the conclusion that the type of contract of the employee did not impact on the cultural type scores.
6.4.8 Summary of Association between Demographics and Cultural Type

The statistical analysis conducted across the demographics characteristics of participants provides evidence that, while not all demographics impacted on the scoring of the current and preferred culture, some did, but not across all cultural types or dependent variables. The 40-59 age groups scored significantly different in their perception of the current Market culture (competitive). Education was shown to have a wider impact on the selection of future organisational culture, with both preferred Adhocracy (creative) and Hierarchy (controlling) scoring significantly different by postgraduate and non-degree respondents. The largest division in the organisation, being Social Care – Older Persons (n=184/41%), differed significantly in their responses to current observed culture in both the Clan (collaborative) and Market (competitive) cultural type.

The most prolific differences were established across the professional groupings in both the current culture scores (Clan and Market) and preferred cultural scores (Clan, Market and Hierarchy). This difference, in general, is represented by the significant difference observed by the Management and Administrative group. The environment of operation for this group is pointedly different, working away from clinical operations, in a more stable 9-5pm, Monday to Friday setting. This group may also be more cognisant of the future strategic plans and have access to a larger policy and report repository and are therefore a focus for qualitative investigation. Tenure of employment was the last group demographic to be analysis with differences observed in the 11-15-year group and the under one-year service group, who scored significantly different in the current Market and future Hierarchy culture.

Although some significant differences have been observed in the different scores across culture type and demographics, the high-level findings, have demonstrated an almost unilateral pattern of scoring across the current organisational culture and the preferred future organisational culture. The demographic variables, while influencing the mean differences between and across group scores, did not materially affect or change the overall result.
6.5 Influence of Cultural Domains on Culture Type

This section provides an insight into the six domains which make up the prevailing organisational culture. The cultural typology which governs the individual domains ultimately determines the overarching cultural type in the organisation.

The analysis explores the six domains (of the current culture) as per survey questions 1-6, and for the six domains (of the future preferred culture) as per survey questions 7-12. This establishes if the collective results are congruent with the individual domain types. The level of congruency reflects the extent to which the six individual domains of culture are mirrored in the results of the aggregated mean scores. Each of the six domains of the survey questionnaire has a corresponding cultural type. When amalgamated these situational statements identify the fundamentals of organisational culture being the basic assumptions, interactive patterns and the organisational direction, as observed and expressed by the participants (Cameron & Quinn 2011a).

1. The Dominant Characteristics (the overarching characteristics) - Q1 & Q7
2. The Leadership (style and approach) - Q2 & Q8
3. Management of Employees, (how employees are treated) - Q3 & Q9
4. The organisational glue (what holds things together) - Q4 & Q10
5. The strategic emphasis (what drives the organisation strategy) - Q5 & Q11
6. The Criteria of success (what is valued and gets rewarded) - Q6 & Q12

An analysis of the overall domain scores across the four cultural types, both current and preferred, indicates a high degree of congruency across all cultural scores. The only exception being the domain of leadership where the negligible difference between current Market and Hierarchy has little impact on the unanimous future preference (Table 6.15). The highest-ranking domains both current and desired are presented in bold type in this table.
Table 6.15 Scoring & Ranking of Cultural Domains by Culture Type

<table>
<thead>
<tr>
<th></th>
<th>Clan Current</th>
<th>Clan Future</th>
<th>Adhocracy Current</th>
<th>Adhocracy Future</th>
<th>Market Current</th>
<th>Market Future</th>
<th>Hierarchy Current</th>
<th>Hierarchy Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational</td>
<td>24.89 (2)</td>
<td>32.79 (1)</td>
<td>11.53 (4)</td>
<td>30.98 (2)</td>
<td>22.10 (3)</td>
<td>16.09 (4)</td>
<td>41.49 (1)</td>
<td>20.11 (3)</td>
</tr>
<tr>
<td>Characteristics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leadership</td>
<td>19.36 (3)</td>
<td>40.83 (1)</td>
<td>11.60 (4)</td>
<td>21.77 (3)</td>
<td>34.65 (1)</td>
<td>10.07 (4)</td>
<td>34.36 (2)</td>
<td>27.33 (2)</td>
</tr>
<tr>
<td>Management of</td>
<td>26.34 (2)</td>
<td>46.53 (1)</td>
<td>11.06 (4)</td>
<td>21.89 (2)</td>
<td>25.76 (3)</td>
<td>11.44 (4)</td>
<td>36.84 (1)</td>
<td>20.13 (3)</td>
</tr>
<tr>
<td>Employees</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organisation Glue</td>
<td>24.26 (2)</td>
<td>40.10 (1)</td>
<td>11.36 (4)</td>
<td>23.61 (2)</td>
<td>22.82 (3)</td>
<td>15.52 (4)</td>
<td>41.56 (1)</td>
<td>20.77 (3)</td>
</tr>
<tr>
<td>Strategic Emphasis</td>
<td>20.56 (3)</td>
<td>36.71 (1)</td>
<td>13.16 (4)</td>
<td>27.36 (2)</td>
<td>26.84 (2)</td>
<td>13.81 (4)</td>
<td>39.44 (1)</td>
<td>22.13 (3)</td>
</tr>
<tr>
<td>Criteria of Success</td>
<td>23.46 (2)</td>
<td>41.84 (1)</td>
<td>15.20 (4)</td>
<td>24.36 (3)</td>
<td>17.84 (3)</td>
<td>8.93 (4)</td>
<td>43.51 (1)</td>
<td>24.76 (2)</td>
</tr>
<tr>
<td>Collective</td>
<td>23.14 (3)</td>
<td>39.79 (1)</td>
<td>12.31 (4)</td>
<td>24.99 (2)</td>
<td>24.99 (2)</td>
<td>12.64 (4)</td>
<td>39.53 (1)</td>
<td>22.59 (3)</td>
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<tr>
<td>Cultural Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Having examined the mean score of the cultural domains, establishing their cultural alignment (Table 6.15), an additional analysis of the six domains by demographic variables will provide an additional level of scrutiny. This analysis exposes any signification differences in the mean scoring of the domain by gender, age, division, staff category, education level, and years of service, identifying groups and sub-groups of employees for attention during the change process. This analysis will also expose areas where leadership is problematic or work divisions where possible change champions are located. As previously applied, a multi-comparison ANOVA post-hoc t-test (Bonferroni-corrected) was conducted for each of the cultural domains (represented by survey questions 1-6) as previously indicated starting with the Dominant Characteristic domain.

6.5.1 The Dominant Characterises by Demographic Variable

An investigation of the current and preferred Dominant Characteristics in the organisation by demographics indicated very little divergence. To recap, the domain referred to as the Dominant Characteristic represents what the overall organisation is like, is it friendly, dynamic, competitive or formidable. The only significant difference in the current characteristics (Question 1 and 7) were observed between the 30-39 age group, t(87) = -7.27, p = .020, and 50-59 age group, t (144)=7.27, p=.20, in the area of how competitive the organisation was perceived. Unexpectedly there was no significant difference reported by length of service, work division gender, or contract type by this domain. Across the staff categories the Nursing and Midwifery group scored significantly different in this domain.
in comparison to all other categories. Examining the education attainment scoring for this domain the only significance reported was between those who attended Higher Secondary School and Degree holders. These findings reinforce the natural linkage between professional categories and educational standards, creating a strong argument for a learning organisational model, and a focus on personal development.

6.5.2 Leadership by Demographic Variable

Across organisational leadership (Questions 2 and 8) one might expect to find the greatest deviation. However, the findings indicate no significant difference between the current or desired leadership domain by gender, type of contract, division and more unexpectedly by educational attainment. The findings do however confirm significant differences in the market typology (represented by a no-nonsense and aggressive style) scoring between the 30-39 age group, \( t(87) = -13.48, p = .002 \), and the 40-49 age group, \( t(180) = 13.48, p = .002 \), and between those with less than 1 year service, \( t(22) = -21.06, p = .023 \), and those with between 11-15 years’ service, \( t(84) = 21.06, p = .023 \). The future preferred leadership was also significantly different between the Nursing & Midwifery group (n=154) and the Management and Administrative group (n=88), \( t = -4.93, p = .034 \). This perhaps underlines the difference between the clinical team managers and non-clinical managers and now leadership is perceived in both groups and by both groups. The leadership style domain can vary from mentoring, innovative, competitive or controlling according to the culture typology.

6.5.3 Management of Employees by Demographic Variable

The third domain presented in the instrument is how employees are treated in the organisation (Questions 3 and 9). This domain is manifest in the organisation by the degree of teamwork and participation at one end of the spectrum and security of employment and stability at the other end. Given the variances of location and function across the community service, it is perhaps not surprising that significant differences were noted across several demographic variables. The extent of the difference was most notable in the future preferred of the domain by age group, mainly between the 20-29 age group and the 40-49 age group. The theme of future teamwork and consensus also presented significant
differences between the Management and Administrative group and the Nursing and Midwifery group (t=7.65, p=.002). Across the divisional variable the significant differences were in the current area of competitiveness and high demands, with all four divisions scoring differently. The pattern of difference between the nursing and midwifery and the management and administrative team members is reoccurring.

6.5.4 Organisational Glue by Demographic Variable

The organisation glue or shared values are the mechanism which hold things together in the organisation and can be represented by trust and loyalty, commitment to innovation, achievements or formal rules and policies. The organisational glue options are presented in the survey instrument by questions 4 and 10. Contrary to expectations, this sometimes-abstract concept, garnered considerable variation in scoring across all demographic groups except gender and contract type. Significant differences were found between the 30-39 and the 40-49 age groups (t=-7.65, p.=024), across all professional categories, and between the lowest and highest educational attainments. Again, the influence of professional categories and education is aligned as previously reported.

6.5.5 Strategic Emphasis by Demographic Variable

The strategic emphasis is one of the domains which indicate the organisation direction. When analysing the influence of demographics on this domain (current and preferred) no significant difference was indicated by age, gender, education, or type of contract. Exploring this domain provided evidence of the significant difference in scoring by staff category, work division and years of service. An interesting aspect of these findings is that in the main, the differences were all observed in the future desired preferences. These differences also indicate that a variety of preference as needed in the future between human development, new resources, targets and control all the different representation of strategic emphasis in the organisation.
6.5.6 Criteria of Success by Demographic Variable

The final domain from the survey questionnaire (Questions 6 and 12) examined what is valued and gets rewarded in the organisation. The findings confirm the consensus across gender, education, years of service and contract type in relation to how employees perceive what success looks like by the organisation. Significant difference was noted in the scoring of the criteria of success by the 20-29 age group and the 30-39 age group (t= 14.25, p=.032), looking to the future definition of success the 20-29 age group differed significantly from the 40-49 age group (t=12.83, p=.048). From a divisional point of view only the Primary Care group and the Social Care - older persons service indicated any significant different (t=-10.28, p=<.001). Like other domains the professional categories of Nursing & Midwifery and Management & Administration significant differences in their views on the preferred future criteria of success, which indicates the strategic direction of the organisation.

6.6 Summary of Quantitative Findings

The data analysis provides consistent evidence of the prevailing organisational culture which currently operates in the community healthcare organisation. Regardless of demographic characteristic, the survey respondents indicated that the main culture typology they observed in current practices was Hierarchy. The consistent prevalence of a single culture type is surprising given the multiple sites and the number of healthcare professions involved in the study. The presence and strength of one single overarching culture exposes its overwhelming penetration and impact across all domains and demographics of the sample.

Looking to the future, the desired future organisational culture was identified as Clan, a cultural type which was universal selected by respondents across all demographic categories. Clan culture is considered a collaborative and participative culture, where teamwork is valued, and mutual trust holds the organisation together. These findings suggest an awareness of a need for cultural change. Like the current culture, the findings consistently indicate that the results and scoring, while statistically different by demographic variables in part, has indicated an overarching preferred culture of the future, which is collaborative and inclusive.
Chapter 7: Qualitative Research Findings

“Qualitative inquiry cultivates the most useful of all human capacities: The capacity to learn” (Patton 1990, p. 2 Halcolm’s Laws of Enquiry)

This chapter first reviews the characteristics of the participants and then proceeds to present the template analysis, as previous outlined in the methods (Section 5.3.5). This form of thematic analysis is supported by MAXQDA Analytics Pro 2020, across the six domains of the organisational culture framework, which form the basis of the template analysis in Section 7.3. The analysis is completed with the presentation of additional emerging themes, which were outside the scope of the a priori framework themes but were part of the discoverable manifestations of organisational culture. The barriers and challenges to the planned reform are then documented in Section 7.4. The qualitative data analysis is presented with direct participant quotations across the six domains of organisational culture as per the theoretical framework, which represent individual experiences and observed behaviours, interactive patterns and highlights the organisation direction. These findings are integrated with the quantitative data in Chapter 8 which provide the meta inferences of the mixed methods integrated findings.

7.1 Characteristics of Interview Participants

A total number of 12 employees from the Community Healthcare Organisation participated in the face-to-face interviews. Of those who participated 8 were female and 4 were male. All four work divisions were represented: Primary Care (n=4), Mental Health (n=2) and Social Care – Older Persons and Disabilities (n=6). The Nursing and Midwifery category accounted for 6 participants including a Director of Public Health Nursing, a Director of Nursing (long-term residential care), Staff Nurse x 2 (Disabilities/Mental Health), Nurse Manager and an Assistant Director of Nursing. The participants also included one Hospital Care Attendant representing Patient and Client Care and Management and Administrative (n=6) including the Chief Executive Officer, and three other Directors / Heads of Service
and a Home Help Area Coordinator. Participants were not asked to identify their age or educational attainments as this was deemed as sensitive and private information. All participants worked full-time, with 5 participants working shift patterns. Figure 7.1 represents the contribution by each participant. The contributions are analysis providing an overview of the extent of each participant input and engagement for the sake of transparency and quality.

![Figure 7.1 Coded Contribution by Division and Staff Category](image)

The interviews were conducted in a relaxed and open atmosphere. All participants seemed open and forthright with their responses. Stories and examples were often used by the participant to support and demonstrate an assumption or behaviour observed in the organisation, or to put a cultural domain into context. Senior Management presented with a more theoretical overview of organisational culture, which may be the reason why previously reviewed research included management and senior executives only. A degree of rapport was developed with all participants. A surprising level of trust and forthrightness was displayed by interviewees. Domains of the preferred future organisational culture were explored in a non-structured way, enabling the participants to identify barriers and influencers to organisational cultural change. These emerging barriers described the anticipated journey of change, for the participants, to the identified preferred culture. Participants were hopeful about the future of their service delivery and were highly engaged and interested in the construct of organisational culture. The average interview lasted one hour, with two falling above this average by twenty minutes, and two below.
The thematic experiences are detailed in the sections below, as they were disclosed by the interviewees.

### 7.2 Template Analysis of Qualitative Data

The consistent application of the theoretical framework applied in this study has guided and framed all elements of the study. The cultural typologies and domains have continued to provide an a priori framework of codes based on the theory of the Competing Values Framework as devised by Cameron and Ettington (1988) and further developed by Cameron and Quinn (2002, 2011). The thematic subcodes, at Level 2 (Table 7.1), are derived from the OCAI™ situational statements, while the codes at Level 1 are the cultural typologies developed by the framework. As previously outlined the Competing Values Framework has at its core, the psychological archetypes by which people obtain, interpret, and draw conclusions about information (Cameron & Ettington 1988). By presenting situational statements which reflect key values and assumptions in the Community Healthcare Organisation, participants were given the opportunity to identify the cultural type in the organisation. The six cultural domains (Level 3) outlined in Section 5.2.5 form the foundation for the interview protocols, which are then explored at a sub-level. During the coding process additional inductive codes also emerged which impacted on, or were reflective of, the type of cultures which operated in the Community Healthcare area. These emerging subjects are summarised in Section 7.4, to ensure completeness of findings. They are closely aligned to the barriers to change as perceived by the participants.

### 7.3 Findings from Qualitative Template Analysis

This section offers an overview of the analysis and provides findings from each of the a priori themes, providing a high degree of structure in the analysis of the interview data. A degree of flexibility was adopted to ensure that any emerging themes, as previously outlined, were also reflected in the findings. The application of the initial coding template was modified as necessary during the data analysis to ensure that no relevant data remained uncoded (Brooks et al. 2015). This process of constant conversation between the data and the thematic analysis coding is outlined in more detail in Chapter 5.
<table>
<thead>
<tr>
<th>Basis Assumptions</th>
<th>Core Domains of CVF Themes Level 3</th>
<th>CVF Cultures Codes Level 1</th>
<th>OCAI Survey Sub-Codes Level 2</th>
</tr>
</thead>
<tbody>
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<td>Dominant Characteristics (1)</td>
<td>Clan (1a)</td>
<td>Very Personal Place</td>
<td></td>
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<tr>
<td></td>
<td>Adhocracy (1b)</td>
<td>Risk Taking &amp; Innovative</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Market (1c)</td>
<td>Achievements &amp; Goals Focused</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hierarchy (1d)</td>
<td>Controlled &amp; Structured</td>
<td></td>
</tr>
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<td>Organisation Glue (4)</td>
<td>Clan(4a)</td>
<td>Loyalty &amp; Trust</td>
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<tr>
<td></td>
<td>Adhocracy (4b)</td>
<td>New Challenges</td>
<td></td>
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<td></td>
<td>Market (4c)</td>
<td>Competitive Staff</td>
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<td></td>
<td>Hierarchy (4d)</td>
<td>Formal Rules &amp; Policies</td>
<td></td>
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<td>Management of Employees (3)</td>
<td>Clan (3a)</td>
<td>Teamwork &amp; Participation</td>
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<td>Adhocracy (3b)</td>
<td>Flexibility</td>
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<td>High Demands &amp; Competitiveness</td>
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<td>Mentoring &amp; Nurturing</td>
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<td>Adhocracy (2b)</td>
<td>Creative &amp; Innovative</td>
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<td>Market (2c)</td>
<td>Aggressive Results Focused</td>
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<td></td>
<td>Hierarchy (2d)</td>
<td>Organised and coordinated</td>
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<td>Strategic Emphasis (5)</td>
<td>Clan (5a)</td>
<td>Personal Development &amp; Openness</td>
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<tr>
<td></td>
<td>Adhocracy (5b)</td>
<td>New Resources &amp; Resourcefulness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Market (5c)</td>
<td>Formal Procedures &amp; Control</td>
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<td>Efficiency &amp; Control</td>
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</tr>
<tr>
<td>Criteria of Success (6)</td>
<td>Clan (6a)</td>
<td>Concern &amp; Respect for Employees</td>
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<td></td>
<td>Adhocracy (6b)</td>
<td>Competitive &amp; Forward Thinking</td>
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<td></td>
<td>Market (6c)</td>
<td>Winning &amp; Budget Adherence</td>
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<td></td>
<td>Hierarchy (6d)</td>
<td>Dependable &amp; Cost Effective</td>
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The unique template analysis (Table 7.1) coding used in the continual revisiting of the data, highlighted each theme in the template, from the organisational cultural type (Level 1) to the manifestation of culture (Level 2) and across the domains of organisational culture (Level 3). Participants in the study were identified as having varying degrees of comprehension in relation to the complex construct of organisation culture and a degree of flexibility was applied in the interview engagement to facilitate maximum engagement, removing perceived roadblocks.

“Studies are too academic for front line staff to be concerned, they are getting it in the neck every day from people in their kitchens, their main concern is who will cover my patient when I’m on holidays next week” (CHO Employee, 15th July 2019, Survey Roadshow)

7.3.1 Theme 1: Dominant Characteristics

At a basic practice level, the characteristics of organisational culture are observed through the assumptions manifested in part of the Level 2 sub-codes. These manifestations then culminate in the corresponding cultural typology of Level 1 codes. Many of the participants described the Dominant Characteristics of the organisation as challenging and pressurised, citing the focus on budgets, measurements, and paperwork as being the main features. This was expressed to varying degrees depending on the level of seniority and areas of responsibility. Participating senior managers were more aware of, and anxious to justify, the historical causes which made the CHO a controlling and overly structured and formal place to work.

“Typically, it's very much financially focused, and about performance, and very much around individual accountability, across the board, management and teams of individuals are focused on their area of accountability” [Interview Transcripts \ #001 Primary Care]

"Well, I think it's just the bureaucratic, hierarchical way that we're set up. And, you know, so within an environment like that, in time people will feel controlled. That's how we disempower, so people are less and less inclined to talk, and from that, I suppose you do get a certain amount of ambivalence and inertia because inertia breathes poor culture, yeah."[Interview Transcripts\ #005 Mental Health]
This explanation for the controlling environment was offered by a participating manager by means of explaining the currently observed organisational cultural characteristics. This was articulated in a more personal way by one participant who described their place of work as “absolutely awful” (Interview Transcript #12 Social Care Older Persons). Initially the experiences expressed by less senior participants did not corroborate the observations expressed by senior and middle management:

“It’s a good place to work. Yes, it’s not too bad, like anywhere, it has good days and bad days but in general its fine. Of course, it depends on the people you have working around you as always” [Interview Transcripts\ #010 Social Care Older Person Services]

“We kind of became very close knit. I mean, there is very good communications right down from the Matron right down to the Ward Sisters, we are all included, we sit in on the report and handover in the morning and anything that happened the day before is discussed” [Interview Transcripts \ #008 Social Care Older Person Services].

On further investigation, and as the participants became more relaxed, the difference between those at the front-line and senior management became less obvious. Participant #8, who had over 40 years of service, confirmed that in fact she had many reservations about the work environment, and was looking forward to retirement. While the Director of Nursing was referred to as Matron, and the CNM2 as Ward Sister (both redundant job titles), there was an acknowledgement of the changes that had been witnessed over several years, which had resulted in a very controlling work environment. It was governed by rules and regulations both internally and externally (HIQA¹, Mental Health Act, 2001). The need for control and formal procedures were accepted, as part of the change, however trying to provide a caring service in this environment was particularly challenging for the participant. Participant #10, who worked as a clinical manager in the Social Care Division (Older Persons Services) eventually gave a very impassioned view and an example of assumptions on the day-to-day operations,

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¹ Health Information and Quality Authority
“……. older nursing staff are reluctant to change, they are just set in their ways. They don’t really want to be working, but they won’t retire either. The main problem is the non-nursing staff, which are horrendous, they run the show, they run the rosters, they run the kitchen, the whole atmosphere is dictated by them. It’s an awful cliché. They don’t report to anyone, or so they think. Nursing staff won’t take them on, they are a lot of family members. You get a good one now and then, but they don’t stay. I’m at this a long time and I have seen it evolve. It’s impossible to get anything done. They go sick then and put terrible pressure on everything. Your almost glad when they come back but you’re not really.” [Interview Transcripts \#010 Social Care – Older Person Services]

The results of the questions on the ‘Dominant Characteristics’ of the organisation suggested that, while small pockets of good teamwork were present, the organisation was currently defined by elements of control. Formal reporting structures, inflexible discipline budgets and what were viewed as unnecessary and unexplained processes prevailed. Budget cuts and the reigning in of overspending, were all foremost in the minds of participants. Efficiency and control were the characteristics of the day. The current structures which had divided disciplines into separate functions, had also fuelled current challenges.

“I suppose in the public sector and state bodies, we tend to focus on the control side of things. We are not that much into competition either, in that everyone wants to do what’s right for the patient. but I think the way we’re structured, now, leads to competition between hospitals and the community sector, and across disciplines” [Interview Transcripts\#005 Mental Health].

The current characteristics of the organisation imbued a sense of control through the current measurement systems, constantly monitoring processes and measuring outcomes through regular reporting. This was furthered enforced by the inflexibilities of strict budget allocations and the lack of options or discretion in the allocation of resources. Responsibility and accountability were also considered main features across the organisation. This was understandable considering the blame ethos which permeated all areas of service delivery:

“We are a learning organisation and I believe staff come to work to do a good job, and until we move from “who’s responsible”, and “who’s head is on the block” for want of a better word and actually get a whole new vision at a lower level, supporting employees when things go wrong as they always will, I think we are going to struggle” [Interview Transcripts\#001 Primary Care Health].
7.3.2 Theme 2: Organisational Leadership

One of the most influential domains of organisational culture is Leadership which tends to saturate most aspects of an organisation. Leadership, like other domains, manifests itself under the four different cultural typologies as four different styles. It is observed as one of the interactive patterns detailed by Level 2 codes. It can exemplify mentoring and team development with a focus on interpersonal relationships (Clan or Collaborative) or focus on developing the control system and directing employees to ensure the monitoring system is kept under control (Hierarchy or Controlling). Most participants identified the role of leadership in influencing all aspects of the organisation, particularly when discussing change and reform. The experience of ‘Leadership’ across the organisation was observed to be dependent on the level of autonomy available to the participant. Interestingly senior management did not consider that they had more autonomy than other team members.

Participants were not asked to describe their personal line manager but were asked to describe the collective organisational leadership in their unit, clinic or centre. The reoccurring comments indicated a preference for loyalty and trust, decision making and support, which were all identified as gaps in current leadership style. Participants articulated their dissatisfaction with current leadership by providing examples and anecdotal stories of leadership shortcomings and the lack of competencies rather than naming the current leadership typology:

"Well, I think the senior management here have years of experience in how not to make a decision about anything. I’d say it’s fair to say, it must go to this meeting, and that meeting, and everyone must discuss it, then everyone must agree, so no one will get thrown under a bus for personally making the decision. Its minuted in the meeting and no one is responsible. Even better still don’t make any decisions ever." [Interview Transcripts\#011 Social Care Older Persons]

"Well, it's more of the same, I mean, the person in charge should be setting the tone for the rest of the staff, and they don't." [Interview Transcripts\#009 Mental Health]
"They need to be able to reduce the number of corporate directives and all the rules and procedures. They need to be able to move the decision-making down to where it actually matters most, with the people who are delivering the service," [Interview Transcripts\#011 Social Care Older Persons]

A sense of frustration was expressed by middle management who presented as having the responsibility, but no authority, to make the necessary decisions and provide the necessary leadership support. For many of the participants, even those in leadership roles, the day was spent firefighting to a large degree:

"No one will take responsibility or ownership... its someone else’s job, it’s not only managers that bully you know, managers get bullied also. Bullied into not being able to move forward and make the right decisions for everyone. The decisions never get made, and eventually 12 months later you’re in the same situation and you have lost another good person and you are just that little bit more exhausted." [Interview Transcripts\#012 Social Care Older Persons]

"I have a very good relationship with the hospitals, and they tend to be very practical but then we get into budgets. My budget or their budget, €700 euro per hospital bed per night versus an hour for someone to give them their tablets and hand them a cup of tea at home. Everyone knows it’s just wrong, but who is going to make the decision or make the long-term change." [Interview Transcripts\#011 Social Care Older Persons]

This level of frustration experienced by the “muddle in the middle” (middle management) was by no means isolated. In the above interview the participant talked about damaged relationship, which would not be easily rebuilt. One Staff Nurse, described an observed situation with their manager:

"She is findings it extremely difficult to get them (team members) to adhere to policies, then you have the Mental Health Commission coming around to inspect and, you know, she expects the staff on the ward to maintain a certain standard and they have not, as a result then the Mental Health Commission ticked them off in different areas." [Interview Transcripts\#009 Mental Health]

One senior manager described their prior experience outside the healthcare sector, and noted the trust and loyalty previously experienced which led to a greater commitment:
“it’s not the money you know. I’ve worked with different line managers and bosses, if you can trust the people you work with and trust that they will have your back, then generally it’s not money. I’ve had some fabulous line managers and bosses and you would work late until 9-10 o’clock at night, you don’t work late in the public sector,” [Interview Transcripts\#002 Primary Care]

The exploration of leadership evoked responses across several areas in the organisation, including the preferred leadership type of the future and several additional emerging themes which are discussed in Section 7.4. The contributions from the participants suggested that leadership in the organisation was frustrated, with minor exceptions. Senior management acknowledged the exceptional skills and competencies in the organisation, however there was a control from a higher level which was strangling all innovation, creativity, and ultimately good will across the teams.

“The direction for the last number of years, has been more silo than integration, mainly because of the different budgets, because he who holds the purse strings, calls the tunes. Unfortunately, especially when there is a budget deficit, you’re trying to safeguard your own budget all the time, rather than trying to work collaboratively, together for the best outcome for the person who needs us. Its strangling collaboration and its divisive”.

[Interview Transcripts\#003 Primary Care]

Given the geographical and functional diversity across the organisation, it was anticipated that the leadership in the various clinics and departments, community hospitals and care centres would vary. While leadership did vary to a degree by function, unfortunately, the supportive, mentoring leader could only deliver so much with internal and external, as well as national regulatory bodies dictating the pace and focus. There were very subtle, yet distinct difference between the clinical leadership and the non-clinical leadership. One tended to view patients as individual, while the other viewed patients in groups. This cultural divergence has an impact on collaborative working. A “them and us” positioning was detected across some professions. One participating Nursing & Midwifery Manager identified the challenges as a senior leader, but also sympathised with their professional clinical colleagues, as a nurse first, and a manager second. This paradox was particularly true in relation to nursing trade union’s collective negotiations. This conflict of identity was noted in several participants.
“We have the legal framework, study days and policies, and they have policies and different circulars, but there are so many different scenarios, and so many different grievances, and so many of them with nurses. A lot of times it’s personal issues, its stuff going on in their own lives, like you deal with so many things like fertility treatments, depression, mental health issues, ........or whatever you know, and you are sitting there thinking Christ what did I sign up for”

“The only good thing, from our (nurses) point of view is that the INMO\(^2\) have sorted out we won’t be changing our reporting structure for these new RICOs. So, our reporting relationship will stay the same, we won’t be reporting to the Network Manager. So, the Network Managers are going to deal with all other disciplines, but not us, but we’d be working with the team” [Interview Transcripts\(#004 Primary Care]

These clinical - management subcultures can be used as a catalyst for innovation and change, if supported and included in the cultural diagnosis. Further exploration with participants elaborated on these findings:

"Medical professionals all come with their own culture. They are all taught differently, and they all work in quite rigid structures. Now, when you put them all together, then they have different regulatory requirements and professional bodies........ because the consultant is the leader of the team and he has a contract as such, he has clinical autonomy, so he is the leader. But, as we also know, you might be a clinical leader because the contract says you are, but that does not make you a good manager and a good leader?” [Interview Transcripts\(#005 Mental Health]

“Nurses, account for 50% of the workforce, they have a very rigid hierarchy. I personally would have a problem with this, in so far, as that it’s shaped like a pyramid, well it’s more like a diamond now, because we have more managers than nurses. So, to me, I would expect, if you have a Director of Nursing, then there should be interfaces between them and Assistant Directors, CNMs\(^2\) or CNM\(^3\) to staff nurses. Managers should be able to see what the interface is a every level, but they can’t. I would be 100% sure that the message from the top very rarely gets to the bottom, or if it does, it’s very diluted” [Interview Transcripts\(#005 Mental Health]

The findings from the qualitative data suggests that the dominant leadership type is focused on control, getting the job done and delivering on budget. It should not be understated however the amount of frustration and pressure this leadership style appeared to generate.

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\(^2\) Irish Nursing & Midwifery Organisation
\(^3\) Clinical Nurse Managers Grade 11
\(^4\) Clinical Nurse Managers Grade 111
The lack of resources and timely decision-making works to constrain and curtail planned initiatives and even day-to-day service delivery. While senior managers, provided explanations and context for the leadership challenges, the middle management, at the coal face felt disempowered and unsupported. There was also an acceptance that, in many instances, middle managements required additional leadership skills training and were currently not well equipped to deal with the management of complex employee legacy issues. It was also reported that middle management struggled with the constant effort to remain fair and approachable with such reporting pressures. Emotional intelligence was also mentioned, on a few occasions, as being a pre-requisite for the development of leaders in the organisation and was also suggested as the missing factor in the sometimes-entitled promotional process.

7.3.3 Theme 3: Management of Employees

Closely linked to the leadership domain in the organisation is the way in which employees are treated. Like leadership this dimension of organisation culture is represented by the interactive patterns observed between team members, whether it be teamwork, individual risk taking, competitive drive or stability. It seems clear from the data that the management of employees, while generally dictated by policies and procedures, was also influenced by general interactive behaviors and patterns within the various departments and units in the community healthcare area and manifest under the template analysis by the codes at Level 2.

Teamwork and participation were acknowledged as important but aspirational, team members often struggled to implement good practices in this area:

“I'd like to say that there is a lot of teamwork, and everyone is working together you know after consultation and things like that, but everyone is so concerned about their own job and they, you know, how they are getting on with the manager of the day, so realistically it's usually down to one or two people who curry favor. But it's the same people all the time, some people are never included, so like I said, it's really about everyone watching their own back, watching their own job, and making sure that they stay in the group they are in, and that they don't fall out of favor” [Interview Transcripts\#011 Social Care Older Persons]
The Disability Division was referenced several times as the most team-based discipline. This was presented as a practical necessity, rather than an operational ethos. This team worked with many voluntary and external organisations who jointly and collaboratively provided services to patients. Some participants reported in general that flexibility, teamwork, and participant were dictated by the level of resources available.

“While the option for family friendly work practices is important when there is no backfilling or replacements, of course it impacts on everything. When the WTE is designated at a level and that level is not achieved, you can’t deliver on plans” [Interview Transcripts #005 Mental Health].

“So, people are aware that staffing is an issue. If somebody goes out sick, one day sick, there's no replacement for them. That leaves other people having to work harder. You just can't get the work done to the level that you want” [Interview Transcripts #006 Social Care Older Persons]

The high demands created by the lack of resources impacted heavily on both the aspirations of the management and the working day of those on the front line. Not only did the constant shortfall in resources impact on teamwork and collaboration, but it was also viewed as an additional element of stress as middle management struggled to provide a safe environment at times:

“We're very discipline focused, and within those disciplines, there is a kind of a hierarchy as well as a preciousness. Well, this is my job, I don't do that... in some multidisciplinary situations’ collaboration is working. The difficulty is, again, when resources get tight, and when there's several vacancies or maternity leaves or sick leaves, then people get pulled back into their own discipline or their area”. [Interview Transcripts #03 Primary Care]

“if you feel that you can't make the place 100% safe, that gives you a terrible feeling, Yeah, probably for the day and the night until you come in the next day and it might be better the next day. That's being honest”. [Interview Transcripts #007 Social Care Older Persons].

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5 Whole Time Equivalent, indicating the full-time number of employees.
This challenge was confirmed repeatedly by several participants. They reported the lack of resources as a considerable influence on how employees were managed and treated. This was particularly true of employees who did not have a digital footprint, in essence lone workers (Home Helps / or PHN’s) where communication was “restricted by the sheer scale of the numbers” as professed by one senior manager:

“For us, the difficulty there is in terms of what level of support can be given because they don’t even have a base as such (lone workers). So, when we look at it, particularly from a staff perspective, how do we engage? How do we support and how do we consult?”

[Interview Transcripts\#03 Primary Care Services]

The impact of shortfalls, from a human resource, a systems and technology point of view also overflowed into what participants observed to be valued and important in the organisation:

“I think health services in general, at the coalface are working in a very car crash mode”

[Interview Transcripts\#05 Mental Health Services]

### 7.3.4 Theme 4: Organisation Glue - Shared Values

The organisation glue is the bonding mechanism which holds the organisation together. Often referred to as the shared values. It can be explicitly presented in the organisation’s mission statement, but it is more realistically evident in the assumptions in the organisation as to what works and what is acceptable, adopted by the employees and what the organisation aspires to be. It is the learned behaviours, which are transferred to newcomers and established by the collective as the most appropriate way to think, feel, and act in the organisation.

At a generally level the participants understood admirable values as fairness, loyalty, respect, and trust, but the articulation of these values in their workplace tended to drift back to control, reports and changes in behaviour and practices which did not appease individuals personally:
“Everyone is juggling, juggling for position, senior staff are juggling, they go on night duty for the last ten years, they are juggling to get as big a pension as they can before they leave. The other staff get burned out after a while and they are only turning up. Some of them barely come in for the day and their input into the workings of the place is very little. Other people are carrying them and that whole atmosphere and that behavior is accepted by all” [Interview Transcripts\#009 Mental Health].

“The staff on duty are very focused on their own needs and not on the wider organisation. It feels like everybody has a different agenda. It might be that people are only really looking at their own area, and what they need, you know, they’re not seeing the bigger picture.” [Interview Transcripts\#007 Social Care Older Persons]

While fairness was referred to in terms of ideal practices, it appeared to matter more when the “fair” behaviour benefited the participant. This was particularly true of those in middle management positions as described by a Nurse Manager, discussing the Christmas roster:

“some nurse I think, stupidly at the time, highlighted to management if you were down for Christmas day, you actually got paid for a long day, even though you only worked six hours, management already knew but no one brought it up, you just split the day, if you did the mornings, you were off in the afternoon, we worked on minimum staff levels. When this (payment) got highlighted, then the management said “now that I know, you can only get paid for the six hours” [Interview Transcripts\#006 Social Care Older Persons]

The ethos of a person-centred organisation, which was assumed to be of foremost value in the organisation, was replaced by audits, indicators and KPIs. While the value of control and accountability were recognised by a small number of senior managers, there was an acknowledgement that the “pendulum had probably swung too far” in the control direction, to the detriment of creativity and collaborative innovation. One of only two participants who mentioned patient care and person-centeredness was a retiring Hospital Care Attendant:

“I just think, you know, person-centered care really is a big thing for me, I think people should be more aware of it ……you have to have dignity and respect here for people and even for colleagues” [Interview Transcripts\#008 Social Care Older Persons]

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6 Key Performance Indicators – usually attached to targets and budgets
“I think what we need to go back to is that we're here to serve. It's about integrated care which will not happen without integrated budgets. The initial reform vision was that the budget would follow the patient. That's what’s needed to drive Sláintecare as well, it’s not a budget for hospitals, or a budget for the community, all separate budget but an integrated budget”. [Interview Transcripts\#003 Primary Care]

In summary dimensions of shared values were not particularly well articulated by the participants as previously indicated, except for one senior manager who had a very comprehensive overview of policy and strategic direction:

“There's a large move needed, and probably not one hundred percent, but there is a significant move required, but I think some of it is around having a shared vision. So, now, we’re developing our Community Healthcare Strategic plan, it does have a very clear vision. It is around everybody counts”. [Interview Transcripts\#003 Primary Care]

“Our building blocks in terms of finance and HR and in particular quality and patient safety and the framework around that and the appropriate staffing levels, it's not right. it's not communication clearly, it’s not flowing from the top right through to the bottom, the way it should be, and so until we have those things rights, I think, we won’t be able to attract people into the system”. [Interview Transcripts\#001 Primary Care]

There was a general feeling that what was valued by some managers was “personal financial reward, position, and being in charge, which holds a big attraction for some members of staff” [Interview Transcripts\#009 Mental Health]. Change and reform were reiterated by several participants who were more animated and positive when discussing the future values and strategic direction of the organisation.

7.3.5 Theme 5: Strategic Emphasis

This theme defines the driving focus or direction for the organisation’s strategy. This coupled with the next domain, Criteria for Success, indicates the strategic direction of the organisation and defines what is important. While one or two senior managers had a comprehensive understand of the strategic emphasis, there was no evidence that this was replicated with other participants, even other managers struggled to see the big picture and the long-term direction:
“Typically, it's very much around financial control, and around performance, and very much around individual accountability, across the board, and the SMT (Senior Management Team) are so focused on their own area of accountability, the ability to think beyond that is challenging”. [Interview Transcripts\#001 Primary Care]

While the national strategic healthcare plans and annual service plan were published and available, there was general dissatisfaction about the strategic direction of the organisation and the ability to deliver the strategic plans. The planned and documented integrated care strategy which would move service away from the acute setting and into the community setting was viewed with a degree of cynicism. The observed organisation direction appeared vastly different from that which was documented.

“One year it's valuing people, the next it's something else, a lot of it is surface stuff, and strategies that have been written years ago. 15 years ago, the then General Secretary was calling for reform, and 8 years ago and 4 years ago. They just keep changing the structures in the areas. We were a Community Healthcare Area, then it was a Community Healthcare Organisation, now we are going to be a Community Networks, first 11, then 9, now 6 areas. Sláintecare, fabulous plan, but not enough money behind it according to the OECD, and they have only recently started to fund pilot project, pilot projects that are going years, like the Senior Helpline and community sports. Most of this is not new, just new covers and new names and no money to actually give Home Care for proven model that have been tried and tested”. [Interview Transcripts\#011 Social Care Older Person Service].

“For managers like me, we are forever being pulled into operational issues, most of my days are spent dealing with operational problems, you very rarely get the chance of thinking strategically or making strategic plans, or, you know, doing extra, you could spend your whole day just dealing with what’s coming in on the email and what the issues are day to day, without ever getting an opportunity to see how can we improve this, you know, and trying to make improvements, trying to get feedback from the staff, meet with staff have meetings, you know, have educational updates”. [Interview Transcripts\#004 Social Care Older Person Service]

“We have no time for strategic thinking or planning. We have to be very responsive, so there is not much room for creativity or taking a step back or looking outside the box or anything, because your whole day is taken up with what is needed to provide the service”. [Interview Transcripts\#012 Primary Care]
“So, one of the strategic pillars are around health service reform, which is around Sláintecare, which is moving in the right direction in terms of integrated care. The other is in terms of long-term chronic illness, which is the greatest challenge. But if we're going to meet that challenge, it's the third pillar that needs to be strengthened, which is about staff health & wellbeing. So, it's focusing on staff. But it's got to come with the time and the resources to be able to do it. So otherwise, it's only lip service.[Interview Transcripts\#003 Primary Care].

One of the main concerns noted was a sense of reform fatigue. One participant noted that Community Healthcare had been in a state of reform since 1970. In the area of mental health, a long serving participant, pointed out, first it was Planning the Future, then Vision for Change, including Sláintecare which did not directly consult with the mental health sector in the community healthcare areas. This was then followed by a third strategic policy Sharing the Change, none of which were fully implemented. The general tenure of the strategic direction of the organisation could be best summarised with a contribution from one of the participants who encapsulated the overall feeling:

“Well, the strategy and the reality are very often two very different things. Strategically I welcome the philosophy and the ideology behind all of that because I'm just too long around. I haven't arrived at cynical yet, but I'm get getting there”. [Interview Transcripts\#005 Mental Health].

7.3.6 Theme 6: Criteria of Success

The final dimension which contributes to the culture in an organisation is based on what gets rewarded or celebrated in the organisation. It may be teamwork and employee commitment or dependable service delivery or low-cost services. The criteria of success tended to follow the same pattern as the strategic direction in the organisation. It is manifested by how achievements are defined and celebrated, with rituals, rewards, and promotions.

The degree of frustration and pressure described in the other domains of culture where also evident in the participants description of the criteria of success. The degree of dissatisfaction
was targeted at the national structure, with decision making being the most criticised element of the process. This was particularly true in relation to the approval of additional resources for successfully delivered initiatives or discipline specific projects which performed well.

“Once upon a time, here, if you just came in and worked every single shift, you’d eventually be acknowledged. Now the culture I think is, you’re only as good as your last day. What’s important on the day, is what suits, I think over the last couple of years, we’ve had huge changes here in management” [Interview Transcripts\#006 Social Care Older Person Service].

“I think people should be rewarded on their merit and for teamwork and service innovation. Sometimes it’s incredible how some people get promoted and move along quickly in the organisation. I think it would be good if teams were celebrated and it would make things less competitive and more productive with people working together. I see some managers and they actively divide people to ensure loyalty” [Interview Transcripts\#011 Social Care Older Person Service].

Ultimately the question of what gets rewarded and what indicates success, was best answered directly with quotations from participants which were frank but articulated the feelings of many participants. When asked “what gets rewarded?” The replies where as follows.

“Not the staff delivering the service anyway, probably the senior management team who provide the data and figures required to head office. That’s what’s important, measuring KPI’s, counting Home Help hours, newborn visits, counting WTE (whole time equivalents) and budget’s only”. [Interview Transcripts\#011 Social Care Older Person Service].

“I just think, you know, people don't pass around compliments. I think compliments are very scarce……., you don't change people you know, there are some people, if you give it 100%, they’ll expect 110%……. I know myself, I’m only a carer. But I am part of the multidisciplinary team, looking after a client right from the doctor right down to the person who works in the laundry” [Interview Transcripts\#008 Social Care Older Persons]

“I don’t know. Success is getting through the day and going home that night with everyone safe”. [Interview Transcripts\#009 Mental Health]

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7.4 Additional Analysis: Emerging Subjects and Barriers to Change

The objective of the additional thematic analysis was to ensure that all aspects of participant’s contributions were captured. This included the influencers and barriers to cultural change plus additional emerging subjects not captured by the template analysis. A summary of the additional emerging topics revealed that many could be considered cross cutting themes in the dimensional areas of organisational culture. As previously indicated, stories and anecdotes were used by participants to describe particular observed behaviours or to explain assumptions. These emerging topics could in truth be designated to several codes but are in essence at the core of organisational culture, being a representation of how things are created, embedded, and manipulated within the organisation.

Figure 7.1 Emerging Subjects from Thematic Analysis

Behaviours and practices which became acceptable over time, were sometimes linked to communication:

“Oftentimes, if you email HR or employee relations looking for advice, they will ring you. They won't put it in writing, they don't answer an email. So, they ring you, and talk to you over the phone. They might say off the record, they will not accept responsibility for advice they give me” [Interview Transcripts\#004 Primary Care].

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“They only answer emails that come from senior managers. What kind of an attitude is that? The message on their email actual says “your email will be answered in order of your seniority” it’s shocking really when you think about it, that it can happen, that’s their priority. So, you can imagine the communication between our offices. But like I said no one wants to rock the boat, small things used to upset me, not anymore”. [Interview Transcripts\#002 Primary Care].

Figure 7.2 Frequency of Reference to Emerging Subjects

While the challenge to communication with lone workers was identified as a difficulty (because of the lack of suitable communication systems and technology) this challenge often made people feel excluded and disempowered. With a minimum of 1,600 employees earmarked as ‘lone workers’ this was an ongoing communications problem. In addition, approximately 5% of employees were identified as not having a digital footprint.

“You never get any difference of opinions, or you never really get any new ideas. What I’d really like to see is a lot more kind of freedom, more talking spaces for consultation with other team members to get involved. It’s easy to keep your head down and adopt the “jobs worth” culture when only a few are included. Even if you have something to say, only the chosen few are listened to and earmarked for glory”. [Interview Transcripts\#011 Social Care Older Persons].
The frustration with the lack of decision making, and the process by which decisions were made was identified frequently by interviewees as a service delivery roadblock. It was also intrinsically linked to the lack of personal accountability, resulting in stress, upset, and an overriding sense of unfairness. One senior participant referred to the process of decision-making approval as providing “air cover” (to avoid blame). This lack of decision making created unnecessary delays in moving forward. The process also ensured that blame could not be personal apportioned. The process of middle management making ‘business cases’ for essential services and resources, required costing and justification. This created several challenges both personally and operationally with team members speculating that their presented “business case” did not even warrant a review. It was considered a waste of time and energy.

“Bloody hell, its brutal, just brutal, the risks are out there, it’s awful in the community because you’re out there in patients houses. Patients are out there in rural areas isolated, and we’re flagging it up, they are sending it in. I saw the email last Friday from the Home Help department, they are sending it up the line, identifying these patients, they should have two people going in or should have one person three calls a day, it’s all gone up the line” [Interview Transcripts\#004 Primary Care].

“Then of course people want the job, but don’t want to work or take the responsibility, so they make no decisions, and nothing happens. The real smart ones can be lost in the system and offices for years, no one really knows what they are doing”. [Interview Transcripts\#011 Social Care Older Persons].

The decision-making and the decision-making autonomy were reported as having been eroded over the last decade with the re-centralization of the decision making to the National Head Offices. This had largely been an effort to manage and curtail runaway budgets and overspending. This also had the effect of distancing the decision makers from the effects of the decision making at the front line:

“We never had a waiting list in this area now there is 145 people on the waiting list, we’ve had our patients and our PHN’s really upset over it, because they are seeing people who need the service and are not getting it…… they’ve done the risk assessments to say we don’t have enough staff, and a lot of it is funding the hours. So, I’ve told the nurses this, what can I do”[Interview Transcripts\#012 Social Care Older Persons].

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7 Public Health Nurse
All these additional emerging themes (Table 7.4) also compound the identified barriers to change and reform which were also identified during the interview process. These identified themes address the third research question, identified the barriers and influencers to change and reform.

7.4.1 Barriers and Influencers to Reform

The identified barriers to change do not stand in isolation from the emerging themes and the template analysis themes. The biggest risk to operations and the future direction of reform, within the community healthcare organisation, was identified as the staffing levels and the ability to retain staff. A senior manager in the organisation professed that the service and organisation was almost at a tipping point “….. when you can actually do no more with the level of staff you actually have…..” [Interview Transcripts\#001 Primary Care]. The current structure with a Head of Service for each division, with a separate budget, had done little to boost personal accountability and had become inflexible and unyielding. Far from moving to an ethos of integrated care, the current structure is reported as divisive and unhelpful. There was a strongly communicated message; that if the new community integration plan, Sláintecare, focused on structure, it would fail.

“At the moment there's a lot of discussion about restructuring, about long-term care in terms of the new RICOs (Regional Integrated Care Organisation). Most people are kind of embracing it as a way forward. But equally reflecting that, that was the way it used to be in the past”. [Interview Transcripts\#003 Primary Care].

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Another obstacle to reform was the lack of leadership skills particularly at a middle management level. In contrast this cohort identified several leadership deficits in senior management. Frontline service managers presented as the most frustrated and stressed, expressing feelings of disempowerment. This frustration appeared to be derived from their dual roles, as clinician and manager. In a situation of stress or frustration the default setting was automatically that of clinician, empathizing and defending clinical team members, adopting a “them and us” stance. This was a common observation, and a paradox which is challenging to bridge. Non-clinical leaders on the other hand felt somewhat safeguarded and while not in agreement, were able to explain the centralised control position of the organisation.

Participants explained that the lack of supporting technology was not limited to the community healthcare sector. Some advances had been made on the technology front in the last number of years, however in the community sector the hospital prioritisation and the lack of confidence in the ability to deliver large scale technology change was cited as having hampered developments. In relation to personal electronic digital records, multidisciplinary data sharing, and even single assessment tools implementation were still considered a long way off for the community sector. Access to local internet broadband was also cited as a basic challenge.
The principle themes identified in the qualitative template analysis were compatible with a hierarchical culture. While the role of leadership was identified as critical to the development of an appropriate culture in the organisation, current leadership was viewed as preoccupied with budgets and measurements, and did not have the proven skills to deliver the planned reform. A lack of personal responsibility and accountability was also suggested as a weakness in the current leadership team, but was attributed to the structures, central control and the lack of innovative leaders. Middle management presented as the most frustrated by the lack of staffing resources and time pressures. At times, this placed them uncomfortably at the coalface of front line service delivery. There was little time and space for innovation and implementation of new or ever tried and tested initiatives in their schedule.

In general the treatment of employees was dictated by rules and regulations with strong unions and professional organisation representation at all levels in the organisation. These external organisations represented the collective interests of the many different professional groups. The predictability and stability of public sector employment was enjoyed at the expenses of job satisfaction, which is a very hierarchical trait. While employees expressed a strong need for change, which should be inclusive and collaborative (Clan culture), like managers, they too appeared to shy away from personal responsibility and accountability. While the ‘espoused values’ of the healthcare system where succinctly captured in both the national and regional strategic documents, it did not appear to filter down to team members, every to those in senior positions. Self preservation appeared high on personal agendas, with little concern for the collective. It was noted that failures in performance or service delivery had no consequence for the individual team members.

The espoused strategic direction of the organisation and its services were also well documented, but did not appear to be operationalised in the practices and behaviours of team members. The overarching operational direction of the organisation was not communicated down to individual roles, and therefore was perceived as disconnected from daily functions. Only two very senior managers referenced current policy, with the majority of participants unaware of its content. There was a sense that little ever changed at the coal face of service delivery. Sometimes names of groups and service access criteria changed,
but in the main, the daily routine of those working as front line community health care workers remained the same year after year, if it was not disimproving. With the exception of two senior participants, the organisation was frequently referred to as a ‘Health Board’, an organisation which was replaced 15 years prior by the current Health Service Executive organisation. The type of preferred organisation was articulated well by all participants, in all divisions and staff categories. There was a unilateral acceptance that things must change within the organisation,

“I'd like to think that the culture is open, and people want the best for the people around them, a trusting one. I'd like to think that it's one where, you know, the people want the best for each other, including our residents. It's certainly not transformational. I'd like to think that it would be more innovative and creative in the way things are done but it's not, and if things ever change it will happen very slow” [Interview Transcripts\ #007 Social Care Older Persons Services]

“So, the culture would be all about respect and dignity for staff members, for patients or for residents for everyone. And that really, that's the environment that you want to work in”.

[Interview Transcripts\ #008 Social Care Older Persons Services].

The consensus was that in the future the organisation should be a collaborative and learning one, where individuals felt supported and respected, and change programmers and projects were properly funded, resourced and consistent. As well as explaining and identified the current and preferred organisational culture, the participants also identified the barriers and influences to change and reform in the organisation.

The continual change, which focused on restructuring, has created a sense of reform fatigue, and in fact had created silos, which had frustrated collaboration and the delivery of the planned integrated community care. Participants presented with a degree of cynicism and defeat, coupled with a lack of trust and a sense of disempowerment. This was confirmed by the responses of the senior team members, who themselves had adopted an attitude of disengagement, in 50% of cases. It was also acknowledged that processes and polices had done little to deliver sustainable change and had in fact further demotivate team members who felt unsupported, with not enough basic resources to deliver services.
Some of the current national change initiatives (Values in Action, Swartz Rounds) were introduced selectively in one division or one area, where it was promoted and managed by a champion. These initiatives were not mandatory and were perceived as adopted in “easier” areas. This only served to create further inconsistency across the same healthcare area. Reform and change were not commonly described as a fundamental shift in the values and culture of the organisation, although as stated above participants articulated their ideal future organisational culture with ease. Without a fundamental change in values, ways of thinking, management style, and approaches to problem solving, it is likely that the organisational culture, which affects every element of the organisation, could become more recalcitrant.

The political focus, to the fore, has been around financial and structural reform, pilot programmes, cost containment and legislative change. The constant national political change has impacted on healthcare priorities. These perpetual changes in the complex interdependent structures of community healthcare, has done little to improve the service or reform the organisations. The participants communicated clearly that the organisation must change, but the participants are the organisation, and all change is personal (and not necessarily external). The experience of healthcare organisations that have made the transition from fragmented to integrated community healthcare systems have demonstrates that the work is long and demanding (Ham & Walsh 2013).
Integrated Findings and Discussion

“The end product is more than the sum of the individual quantitative and qualitative parts” (Bryman, 2007 p. 283)

Following the linking of the research process at various points in the study, the final point of data connection is through the integration of the quantitative and qualitative findings. The main objective of the integration is to gain a comprehensive insight into the complex construct of organisational culture, as experienced by the study participants both quantitatively and qualitatively. By integrating the findings from both data sets, a complete picture of the various levels of the organisation’s culture are deliverable. The presentation of the integrated findings in this chapter also highlights the way in which “different data, corroborate, illustrate, or elaborate each other” (Bazeley 2018a p.126). The collective findings of this study provides key insights which would not be available through a single method of inquiry (Guetterman & Mitchell 2016). The integration ultimately adds value to the process, being one of the primary purposes of the chosen methodology (Bazeley 2018b).

Having discovered and analysed the quantitative and qualitative findings independently and sequentially in Chapters 6 and 7, the findings are brought together using a Joint Display. The research objectives 1 and 2 are reported on, through the integrated lens in Section 8.1 and 8.2. Section 8.3 addresses the third research objective, exploring the influences and barriers to the reform and culture change. Section 8.4 explores the fourth and final research objective, being an examination of the alignment between the current policy and the current practices, before the meta-inference of the integration is reported on in Section 8.5.
8.1 Objective 1: Organisational Culture Integrated Findings

Table 8.1 displays the integrated findings, which address the first research objective.

<table>
<thead>
<tr>
<th>Summary Quantitative Findings</th>
<th>Summary Qualitative Findings</th>
<th>Integrated Inference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Hierarchy versus Preferred Hierarchy</td>
<td>t (445) = 20.11, p=&lt;0.001</td>
<td>The controlling culture is driving down innovation (Adhocracy) and creating competition between teams and disciplines (Market). There is an understanding of the need for order and rules, but the over emphasis on measurements and budgets have penetrated every area of operation. Participants want an elimination of this micro-management in the future. &quot;What I’d really like to see is a lot more, kind of freedom, more talking spaces for consultation with other team members to get involved. It’s easy to keep your head down and adopt the “jobs worth” culture when only a few are included&quot; Participant #011</td>
</tr>
<tr>
<td>Current</td>
<td>M 39.53</td>
<td>Integrated Findings are Congruent</td>
</tr>
<tr>
<td>Preferred</td>
<td>M 22.59</td>
<td></td>
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</tbody>
</table>

| Current Market versus Preferred Market | t (445) = 15.17, p=<0.001 | Participants expressed feelings of defeatism with the constant focus on numbers, at all costs. The competition between teams was divisive and was detrimental to relationships. Participants wanted a significant reduction in this type of culture, which also blocked collaboration and creativity. “I think the way we’re structured at the moment, leads to competition between hospitals and the community” Participant #002 |
| Current | M 24.99 | Integrated Findings are Congruent |
| Preferred | M 12.64 | |

| Current Clan versus Preferred Clan | t (445) = -21.06, p=<0.001 | Participants spoke of a current culture which was non-inclusive and pressurised. The future culture should be one which fosters trust and builds moral across teams, ensuring that a Clan (collaboration) culture is the future focus. “It’s all about respect and dignity for staff members, for patients or for residents for everyone. And that really, that’s the environment that you want to work in” Participant #008 |
| Current | M 23.14 | Integrated Findings are Congruent |
| Preferred | M 39.79 | |

| Current Adhocracy versus Preferred Adhocracy | t (445) = -20.79, p=<0.001 | Individuals appeared to have sacrificed personal job satisfaction for job security. Safe risk taking needed to be supported in the future. This culture type needed expansion and leadership support, “I’d like to think that it would be more innovative and creative in the way things are done but It’s not”, Participant #007 |
| Current | M 12.31 | Integrated Findings are Congruent |
| Preferred | M 24.99 | |
The strong congruence of cultural type is noteworthy. The integration of the findings reconfirms the pre-eminence of the dominant Hierarchical (controlling) culture. Cultural congruency refers to the extent to which the same culture is reflected in various parts of the organisation. The strength of the identified Hierarchical culture, will almost certainly rendered all structural, systems and other changes ineffective unless the power of the culture is address and understood in relation to the reform direction. The strength of the future prefered culture is also evident, with participants indicating that the current culture should be replaced by a Clan (collaborate) culture to facilitate reform.

The presentation of the side-by-side, Joint Display findings in Table 8.1, including the narrative summary and quotations, confirms the agreement between the quantitative and qualitative findings both for the current and the future desired culture.

8.2 Objective 2: Congruence of Cultural Domains

By comparing the profiles of each of the six domains (as derived from the six situational statements in the survey instrument) with the findings from research objective 1, the level of congruence between the prevailing culture and its components is identified. By integrating these findings with the qualitative findings, the extent and context of the congruence is explained.

The integrated findings reported in Table 8.2 signposts a high degree of Hierarchal congruence across all current domains except for leadership, where a marginal difference is observed between Market and Hierarchal leadership type. If the domain congruence is examined across the current and the preferred future cultural elements, a picture is presented of cultural domains which are highly congruent across the overarching cultural typology. Research suggests that this level of congruence, across the elements which make up the organisational culture, will ensure very effective organisational behaviour, if the cultural type is aligned to the policy direction. The differences between the current and future domains will likely create discomfort, ambiguity, complications and disconnect across the organisation, which “often stimulates an awareness of the need for change” (Cameron & Quinn 2011a p. 85). The integrated domain findings confirms this as the case in the research findings.
### Table 8.2 Joint Display of Integrated Culture Domain Findings

<table>
<thead>
<tr>
<th>Domain: Dominant Characteristics</th>
<th>Representative Qualitative Domain Findings (n=12)</th>
<th>Congruent/ incongruent integrated Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Score</strong> &lt;br&gt; Hierarchy (Control) M 41.49/SD 24.76 &lt;br&gt; Preferred Score: Clan (Collaborative) M 32.79 /SD 18.50</td>
<td>“I can absolutely see how our staff would feel that there is a lot of control, and we work in a very controlled environment”. Participant #001</td>
<td>The Integrated Findings are Congruent</td>
</tr>
<tr>
<td><strong>Domain 2: Leadership</strong></td>
<td>“There’s a huge amount of good work happening. If we only have the right leadership” Participant #003</td>
<td>Market and Hierarchy equally congruent considering the quadrant position</td>
</tr>
<tr>
<td>Current Score &lt;br&gt; Market (Competing) M 34.65/SD27.77 &lt;br&gt; Hierarchy (Control) M 34.38 /SD 22.62 &lt;br&gt; Preferred Scores &lt;br&gt; Clan (Collaborative) M 40.83 / SD 18.08</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Domain 3: Management of Employees</strong></td>
<td>“Directors of Nursing etc. being told you manage it, is not supportive. People don’t ask for help if they don’t need it” Participant #012</td>
<td>The Integrated Findings are Congruent</td>
</tr>
<tr>
<td>Current Scores &lt;br&gt; Hierarchy (Control) M 36.84/SD 24.45 &lt;br&gt; Preferred Scores &lt;br&gt; Clan (Collaborative) M 46.53 / SD 18.73</td>
<td></td>
<td></td>
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<tr>
<td><strong>Domain: Organisational Glue (n=445)</strong></td>
<td>“We disempower so people are less inclined to talk. And from that, I suppose you do get a certain amount of ambivalence and inertia because inertia breaths poor culture” Participant #005</td>
<td>The Integrated Findings are Congruent</td>
</tr>
<tr>
<td>Current Scores &lt;br&gt; Hierarchy (Control) M 41.56/SD 24.37 &lt;br&gt; Preferred Scores &lt;br&gt; Clan (Collaborative) M 46.53 / SD 18.73</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Domain: Strategic Emphasis (n=445)</strong></td>
<td>“Focus has been around regulations, around safety, to the detriment of long-term actions like, collaboration creativity and new opportunities” Participant #010</td>
<td>The Integrated Findings are Congruent</td>
</tr>
<tr>
<td>Current Scores &lt;br&gt; Hierarchy (Control) M 39.44/SD 23.08 &lt;br&gt; Preferred Scores &lt;br&gt; Clan (Collaborative) M 36.71 / SD 17.29</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Domain: Criteria of Success (n=445)</strong></td>
<td>“I do think personal responsibility is a big issue and a barrier for developing a better cultural awareness” Participant #002</td>
<td>The Integrated Findings are Congruent</td>
</tr>
<tr>
<td>Current Scores &lt;br&gt; Hierarchy (Control) M 43.51/SD 25.82 &lt;br&gt; Preferred Scores &lt;br&gt; Clan (Collaborative) M 41.84/ SD 19.29</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
8.3 Objective 3: Identified Barriers to Reform

The barriers identified in Figure 8.1 are based on the employment of a ‘Word Cloud’ as a coding analysis (MAXQDA 2020 Analysis Pro). Word Clouds are images which give prominence, by frequency, to the themes identified by the participants outside the template analysis and are specifically related to the barriers to change. The qualitative findings (Section 7.3) have already identified and outlined examples of the reported barriers to organisational cultural change. The current hierarchy culture is, in and of itself, seen as a barrier to the planned reform. The current culture is seen as neither flexible nor collaborative and certainly not aligned to the planned reform. The restrictiveness of the current centralised structure is also viewed as divisive and non-collaboration and is one of the many obstructions explored in the following sections.

Figure 8.1 Word Cloud : Barriers to Culture Change
8.3.1 Current Centralised Structure as a Barrier to Reform

As a Level 1 artifact, the current centralised structure and its associated divisional budgets presents one of the most prominent barriers to the planned change. The current structure pitches teams against each other, with limited opportunities for collaboration or multidisciplinary sharing. The structure promotes “silo working” and is described as the worst restructuring decision every made by one of the senior participants. The structure and attached governance has also limited cooperation with the acute hospital sector, especially in relation to discharge planning and the allocation of limited resources. It appears that although the acute Clinical Professionals and Community Team Members involved are cooperative and patient focused, when it comes to the allocation of resources (Home Care Package, Respite Care, Post-Surgery support etc.) “who’s budget” is the deciding factor for action and decision making. This has eventually eroded the established relationship between the acute and the community settings, with patients falling between two disconnected stools.

8.3.2 Lack of Resources as a Barrier to Reform

The lack of current resources also features heavily on the list of barriers presented in the Word Cloud (Figure 8.1). Staffing levels and problems with retention were identified as the biggest risk, not just to the planned reform, but to the basic delivery of current services. The recruitment process was reported as cumbersome (following procedures laid down for public service recruitment). There was an identified need for local recruitment drives. This would convert available Employment Agency Staff, already engaged in the service delivery on a full-time basis, into direct employees. The lack of resources particularly in the nursing field was notably stressful. Across a particular nursing team, 90% of the nurses worked a four-day week due to paternal leave entitlements, 15% were currently on maternity leave and 10% were on long-term sick leave (over a year). None of these positions were replaced due to the long term “pause” in recruitment, even if suitable candidates were available.
8.3.3 Current Behaviours & Practices as Barriers to Reform

The current explicate behaviours, practices and norms were also reported as pervasive across all elements of the organisation. Cameron and Quinn (2011) describe these as the “extent to which innovation or certain activities are tolerated or encouraged” (Cameron & Quinn 2011a p. 20). Martin (1992) referred to these tolerated activities as those which were ‘policy inconsistent’. Espoused implicate and explicit behaviours also included personal accountability and fairness. While the implicate assumptions in the organisation were less observable, they were presented in stories of tacit entitlements, the bias allocation of resources, and behaviours of non-cooperation and non-contribution. The literature suggests that unless managers and employees are willing to undertake individual changes in behaviours and interactive patterns, the organisation will remain recalcitrant (Cameron & Quinn 2011a). Coupled with the current structure, this barrier represents a significant challenge to reform and one that is truly cultural in nature.

8.3.4 Cross Cutting Barriers to Reform

All participants articulated the changes necessary to provide reform and integrated care in the community, unfortunately they did not have the resources, the authority, or the desire to lead the reform. The common practice of referring all decision making up the line, exonerated referring managers from all blame associated with the decision making and the possible repercussions. Potential change agents had neither the individual enthusiasm nor the desire for the level of personal responsibility required. Personal accountability was a reoccurring theme across many areas.

The ease and confidence with which participants discussed the barriers to reform and the desired cultural changes, lead the researcher to believe that there was a personal need to discuss the “undiscussable issues “in the organisation (Argyris & Schon 1978b p.171). Business Theorist, Scholar, and co-founder of Organisational Development, Chris Argyris, describes the ‘undiscussable issues’ as the tacit organisation norms. These norms are covertly safeguarded in order to enable games of deception to be played in organisations where “everyone knew that the realities were being hidden, but no one discussed them, so they became undiscussable “(Argyris & Schon 1978b p. 3). In the case of the CHO, the
“undiscussable issues” were presented in privacy, through stories and instances which included, the organisations complex system of tacit entitlements, the military style pecking order, the patterns of communication and passive aggressive control, the allocation of resources to key performance indicators, the protection of self-interests and the acceptance of the non-transparent career ladder. The openness and contribution of participants was commendable. There was no evidence that senior or other team members, had ever had these uneasy discussions with colleagues or at senior management team meetings. However, of all the open and honest experiences which were divulged during the course of the investigation, the witnessed sense of entitlement and perceived injustices, which can prevail in healthcare systems, was not discussed (Kaufman 2011). This could perhaps be interpreted as a lack of personal awareness and ownership of the current culture which prevailed in the organisation. Communication was an ever-present cross cutting barrier.

8.4 Objective 4: Alignment of Current Policy and Practice

The fourth objective of the study was to identify if there was alignment between the current observed practices in the CHO and the current polices as outlined by the Health Service Executive, The Department of Health, and the Sláintecare Office (Figure 8.3). The strategic direction of the organisation was clearly outlined in national policies and area service plans. From a practice point of view the participants reported the strategic direction through their scoring of the last two domains of organisational culture, being the Strategic Emphasis and the Criteria of Success. As highlighted in Table 8.2 both these two elements of the organisational culture were found to be Hierarchial. Considering the findings from the analysis of national policies as detailed in Figure 8.2 it becomes apparent that the strategic direction in policy is very different from the strategic direction in practice. Exploring these differences in policy and practice provides additional insight into the challenges which will need to be overcome to support reform in additional to the cultural barriers.
8.4.1 Clinical Leadership in Policy and Practice

One of the key deliverables noted in national policies, was the development of clinical leadership. This clinical leadership is intended to support design, implementation, and evaluation of services (Committee on the Future of Healthcare 2017, Health Service Executive 2020, Government of Ireland 2021). While the lack of leadership skills was identified by participants as a barrier to the implementation of reform, it was not necessarily identified as clinical leadership. The focus on clinical leadership in the reform documentation is clearly linked to the planned expansion of Community and Primary Care, which is at the heart of the community healthcare reform strategy. As of 2018, of the 120 Primary Care Centres which were delivered nationally, 13 were in the participating CHO (Department of Health 2019a).

Presented as the foundation of the reform, the plan is complicated further by the current two-tiered healthcare system, with no universal healthcare entitlement, and a dependency on local self-employed General Practitioners (GPs) and privately employed Practice Nurses. The governance of this clinical leadership development arrangement remains
problematic, as currently not all Primary Care Centres are GP lead. More important is the jurisdictional issue, as GPs are self-employed providing a contract for service. Leadership in the CHO was identified on two parallel tracks, being the decision makers and the decision enforces. Middle management lacked training in basic management skills, which were regarded as optional and only accessed by a few motivated team members. Those who self-identified as being in most need, also expressed a lack of time. Longevity of service was often rewarded, rather than competencies, in the promotion of middle management. Problematic senior managers were reported as being promoted up.

### 8.4.2 Restructure in the form of RICO in Policy and Practice

The new Regional Integrated Care Organisation (RICO) structures were identified as a linchpin in reviewed policy documentations. The restructuring was announced in 2019 and was acknowledged by a few senior managers in the study. Although the structural change was operationally planned for 2020, it had not yet been implemented. This is the third such area restructuring in the past five years, one of which initially segregated the acute hospitals from their gealigned corresponding CHOs. The new RICO structure is designed to ensure budgets are allocated at a RICO level, which is intended to facilitate further service integration. The restructuring impact is currently unproven but viewed with some positivity (returning to a structure which was previously worked very well).

“At the moment there’s a lot of discussion about restructuring, and in terms of the new RICOs (Regional Integrated Care Organisations). Most people are kind of embracing it as a way forward, but equally reflecting that well actually that’s the way it used to be. Maybe it took a bit longer than we needed, to realise that integration is the way that it needs to go”. [Interview Transcripts\#002]

### 8.4.3 Chronic Disease Management Programme / Demonstration Sites

While the Chronic Disease Management Programmes were acknowledged by one participant during interviews, this was done in the context of replicating demonstration
sites and upscaling pilot initiatives which was communicated with scepticism. For some participants the initiatives were not viewed as part of the big picture reform, more an accident of local development which was disjointed from national policy and development in other areas.

“First you need to know what the change was. What made it successful? And what were the learnings from it. You won't be able to just take something that happened in one area and say, well, that was fantastic, that's what works and move it to others area……. Because very often the unique element is the person, it's the relationships, or the culture, that is there. Very often people say when we did it the same, it didn't work, [Interview Transcripts\#003]

8.4.4 Culture Change and Evaluation in Policy and Practice

This research has indicated the importance and impact of culture on organisations, particularly at a time of reform. Surprisingly organisation culture does not feature in policy documents in a meaningful way. The Health Service Executive, National Service Plan (2020) indicates that Sláintecare will inform the culture of the healthcare service, ensuring a sustainable culture in which people are happy to work or be cared for (Health Service Executive 2020). As an independent external organisation, Sláintecare’s ability to delivery such a dictate is questionable. The Sláintecare Action Plan (2019) documents cultural change and new ways of working as one of its workstreams. On further investigation this cultural change is documented as “accessing existing health professional contracts, in the context of enabling a shift to significantly enhance community based-care” (Government of Ireland 2019a p. 47 ). This does not appear to coherently address cultural change as understood in this study or any of the reviewed literature. The assessment of contracts of service are primarily governance and strategic HR issue.

Further references are made to culture in policy documents, including a ‘culture of monitoring and evaluation’ and a ‘healthy culture’ with the creation of a people and culture change platform (Health Service Executive 2018). The lack of a baseline measurement restricts the value of this notional evaluation. In the National Service Plan (2020) the reference to culture was in the context of climate, which referred a culture of
safety. As previously indicated, this is often the case in healthcare, where both climate and culture are interchanged (Section 2.1.3). The assignment of development resources, change champions, building change capacity, are all listed as important elements of the planned reform. In the current policy the important of evidence-based interventions are also noted, this may more realistically be translated to evidence-informed interventions (Barry et al. 2018), however neither appears to apply directly to organisational culture or current practices.

While the documentation and publication of strategic reports, updates and action plans in national community healthcare continues, the evidence of consistent implementation at a regional level is limited. The limited resources and lack of leadership skills identified by this study, are also supported by the literature which indicates that healthcare professionals had little time or capacity to focus on change and the implementation of new programmes and initiatives. This challenge is acknowledged in global healthcare reform literature (Braithwaite et al. 2015b). A change framework was published by the HSE in 2018, following a two-year period of development and consultation. The framework, which resulted in a 353 page Change Guide (Health Service Executive 2018) is available to Community Healthcare team members and is designed to complement the reform and the move to integrated care, through the adoption of the Sláintecare Implementation Report (Government of Ireland 2019b). This is the third such change guide produced since 2006. While the guide and framework are freely available online it does not appear to have been activated or utilised by the study participants and was neither referenced nor operationalised in the participating area. The guide is presented as a self-help guide to change and does not appear to be embedded in local management practices or discussion (Health Service Executive 2018). In this regard, the alignment of policies and practices are still unproven, as they have not yet been promoted or implemented at a regional level.

8.5 Meta-Inferences Derived from Integrated Findings

The results from the integrated research findings confirm and consolidate the organisational cultural type in the community healthcare organisation as being predominantly hierarchy. This hierarchal trend is also presented across the domains of the culture, indicating the strength and prevalence of the culture. The level of awareness of
the necessary change transcends divisional groups, staff categories, geographical locations, and demographic variables. When the literature is reviewed these findings are unique. Prior research would suggest that a variety of different organisational cultures, and subcultures, are usually present across organisations, especially large organisations, which may have different managers, different locations and different functions (Martin 1992, Cameron & Quinn 2011a), the integration has found this not to be the case in this study.

The literature also suggests that occupational cultures are particularly pervasive in healthcare systems, where groups of clinicians establish their own codes of conduct and group culture during training and socialisation (Mannion et al. 2005). If the current culture, with its congruency across the organisation is hierarchal, this would also suggest that clinical codes of behavior are also hierarchal. Therefore, the degree of cultural strength coupled with the extent of congruency indicates that the hierarchal, controlling culture, is deeply inter-woven into the cultural fabric of the organisation. This penetration of culture indicates the homogeneity of focus and effort, which can be a really powerful influencer on values, purpose and motivation (Cameron & Quinn 2011a). It is likely that this culture will be exceedingly difficult to change.

O’Reilly et al. (1991) reported that the “fit” between actual organisational culture and individual employee values were also responsible for greater job satisfaction, higher commitment and lower staff turnover (O’Reilly et al. 1991). The preferred organisation culture of the future indicates a high level of strength and penetration in the Clan typology, indicating a complete and significate change in the current culture. It could be suggested that the future desired organisational culture is so different from the current organisational cultural attributes, that the current culture is a source of job dissatisfaction. Unfortunately, in this research the strength and congruency of the current organisational culture would then be counterproductive as it provides evidence of an embedded culture, which is out of kilter with desired employee values and the preferred direction of the organisation.
The front-line experiences as reported in this research provides a visionary example of what Braithwaite et al. (2017) referred to as “work as imagined, versus work as done” (Braithwaite et al. 2017c). This is also representative of Argyris & Schon’s (1978) “espoused theory versus theory in pratice”. The contributions of the research participants provides further evidence that for non-managers in the organisation “control may be elusive, but influence is not” (Johnson & Lane 2017 p. 83 ). To truly embrace empowerment and engagement, all team members should be included in research sampling, to provide the broadest and most detailed version of organisational cultural findings. Previous research in this area has limited investigations to management only (Hofstede 1980, Gerowitz et al. 1996, Gerowitz 1998b), on the basis that they shared the values of other employee (Martin 1992). Research suggested that managers are best positioned to identify and influence the organisational culture (Cameron & Freeman 1991). Such studies could be accused of sampling errors, at least, concluding that the inference drawn from one section of the population reflects the opinions of the entire population. This research proves, regardless of the position of authority, team members were capable of understanding, contributing, and influencing cultural in the organisation.

8.6 Chapter Summary

This chapter has presented the integration findings, while providing a discussion on the results of this mixed methods study in pursuance of the research objectives. The current culture, predominantly Hierarchal, is not one that the participants consider suitable for the current reform or a sustainable future. During a similar period of reform in the United Kingdom’s health service in 1998, Scally and Donaldson (1998) contested that the “feature that distinguished the best health organisations is their culture” (Scally & Donaldson 1998 p. 63).

However, unlike the business sector which have focused on organisational development and culture since the early 1980, current healthcare policy in the areas of culture appears lacking. While policy documents continually advocated for cultural changes, no attempt is made to define or name the operating organisational culture. This is an identified gap between the research of organisational culture and the understanding and application of organisational culture development in healthcare. The use of mixed methods in this study
enables the articulation of organisational culture in real terms as it is observed and explained and as it impacts on a healthcare sector under reform. The theoretical framework is particular valuable when major changes can lead to ambiguity and resistance unless leaders are aware of and understand their organisational culture.

The desire to move from one organisational culture to another, as identified in the study, does not mean the abandonment of cultural traits like control and formal rules. It simply means that in the view of the research participants, the Community Healthcare Organisation could learn to place less emphasis on the formal rules and regulations and foster a culture which is more balanced, more collaborative and which ultimately provides an environment where outcomes, innovation, flexibility and employee engagement and job satisfaction thrive. Leaders as change champions who adopt a level of trust and respect in employee’s ability and move away from a “blame culture”, facilitate an intentional learning culture to grow, built on accepting personal responsibility. The identified hierarchal culture, which is seeking to implement change via top-down edicts, is not aligned to the delivery of care at the blunt edge.

At a global level the findings of this study suggest that reform in community healthcare, and indeed other healthcare settings, would benefit from paying explicit attention to naming and diagnosing organisational culture in their organisations. Reformers can be secure in the knowledge that a positive and appropriate organisational culture is consistently associated with positive patient outcomes including quality of life, reduced hospital stays, increased patient satisfaction, and a decrease in falls, acquired hospital infection and a decrease in mortality rates (Parmelli et al. 2011, Hesselink et al. 2013, Braithwaite et al. 2017a, Curry et al. 2017).
Contribution of the Study, Recommendations & Conclusions

“Research is creating new knowledge”
Attributed to Neil Armstrong

This concluding chapter presents the original contributions of this research and draws together the key recommendations and conclusions which reflect the significance of the study. The recommendations for healthcare reform policy and practice are presented in sections 9.1.1 and 9.1.2, respectively. Section 9.1.3 highlights the unique contribution the study makes to the research of organisational culture through the development and application of innovative theory and methodology. The strengths and limitations of the research are then outlined under the various elements before the direction of future research is proposed. A summary reflection is also provided on the research journey before the concluding remarks are offered in Section 9.5.

9.1 Contribution & Recommendations of Study

Having achieved the main aims and objectives of the study, the weight of evidence indicates that there is scope for significant improvement in community healthcare reform planning and the conceptualisation and understanding of organisational culture in healthcare. Considering the global trend to de-emphasis the costly hospital centric care model in favor of a community-based service, the lack of evidence-based research in organisational culture in community healthcare is concerning. The disconnect between the limited research on organisational culture in healthcare and healthcare reform policies and practices is also disconcerting. A growing body of published research on healthcare improvements across 152 countries advises that the nine aggregated improvement themes includes technology (18%), accreditation and standards (15%), integrated care (14%),
patients-based care and empowerment (14%), human resource development and training (12.5%) and finance, universal healthcare, preventative care and an ageing population (5%-8%) (Braithwaite et al. 2018). While organisational culture is continually acknowledged in these global case studies as being important from a quality, safety, engagement, empowerment, innovation, inflexible, leadership and workplace satisfaction, point of view, its impact as a source of overarching improvement is less well researched.

In addition to the contribution to healthcare policy and practice this research has provided new knowledge in the research of organisational culture from a theoretical and methodological perspective. The contributions and recommendations are highlighted under the various headings.

9.1.1 Contribution to Healthcare Reform Policy

Currently there are significant resources being applied to change and reform in healthcare systems across the globe (Parker & Glasby 2008, Shanafelt & Noseworthy 2017, Braithwaite et al. 2019). While the number of projects and interventions are varied, at a policy level, community healthcare is recognised as both a substantial challenge and a critical opportunity in many countries (Purbhoo & Wojtak 2018, Sheaff 2018). Integrated home and community-based healthcare is intended to address many of the challenges of contemporary healthcare as outlined in Chapter 2.

While the context of this research is the Irish healthcare system the global research suggests that the same reform challenges outlined in Chapter 2 are present across the globe. While the rate may vary from country-to-country global citizen longevity is both a positive outcome and a challenge for the delivery of healthcare. This same increasing longevity also increases economic burdens and human resource challenges. As more and more services are being moved out of costly acute settings developing countries are bypassing the hospital-based systems and moving directly to community-based care. The main identified barriers to the reform challenges of Sláintecare (Committee on the Future of Healthcare 2017, Department of Health (DoH) 2019, Government of Ireland 2019b, Government of Ireland 2021), could easily be applied to Japan and Rwanda who are seeking to introduce universal health insurance, Fiji which wants to strengthen their
primary care, or Hong Kong which is focusing on providing care for older adults following hospital discharge (Braithwaite et al. 2019). As more and more services are being moved out of costly acute settings, this research provides evidence of the disconnect between the current reform policy and current reform organisational culture, which should send a warning signal to international policy makers and policy influencers.

This research reveals a gap between the cursory mention of organisational culture in current reform policy and the significant change in organisational culture identified at a practice level. While policies are focused on innovation, patient and staff engagement and finding more effective, creative, and sustainable ways to deliver accessible healthcare, healthcare teams are observed as inflexible, controlling, and not well positioned to embracing reform. With research reporting that 40% of evidence based medicine is not being applied in the provision of globally healthcare (Braithwaite et al. 2020a), one might expect that the application of evidenced based research on organisational culture in healthcare could be even slower to be adopted. This study provides a highly economic research method, which is very acceptable to participants (5-7 minutes), provides clarity and replicability, and is a highly transferable research tool to measure organisational culture in any global healthcare setting.

This study also demonstrates the lack of pre-reform planning, including the delivery of baseline measurements, which could facilitate reform preparation, implementation and more importantly evaluation in healthcare, an aspect of global healthcare reform which is identified as lacking (Braithwaite et al. 2015a). The importance of pre-reform cultural diagnoses should be no less important, in a global context, than other elements of healthcare reform. This is especially true when reform continues to deliver such poor results as stated throughout many aspects of this study.
9.1.2 Contribution to Community Healthcare Practices

The limited considerations given to the impact of organisational culture in practice, coupled with its lack of prioritisation and conceptual understanding in healthcare, also adds to the limited success of healthcare reform. This study yields valuable results including the most unobservable levels of organisation culture, which could only have been exposed during in depth interviews. The current culture was dominated by a hierarchal typology with controlling and competitive leaders and a focus on rules and regulations. Across all disciplines and departments, the evidence established that employees wanted a significant cultural change. The implication of these findings for community healthcare clearly demonstrates a gap between the current cultural practices and the desired culture. There finding indicate a fundamental desire for change in how employees, including managers, what to work and interact, and how they believe services should be delivered in the future.

This overwhelming evidence suggests that frontline practitioners and all employees are decerning and capable of articulating organisational culture and understanding its impact in the organisation given the right framework and facilitation. In summary, research in this area has shown that unless the core values, behaviors and assumptions manifest through organisational culture are examined and put under the microscope in healthcare,
the danger is that nothing will change. Organisational culture change is a personal journey which takes time, support and above all, awareness of individual behaviors which impacts on the collective outcomes. This positioning and education on organisational culture is deliverable given the practical application of this research framework.

To move the organisational culture from one of hierarchal control to one that is more innovative and supportive, an innovative supportive culture will have to exist in the organisation. Applying this principal across the elements of organisational culture in practice means that leadership, management of employees, shared values, structural direction, and the criteria for success will break the current dependency on the control and command workplace.

**Recommendation and Contributions:**

- Establish the Human Resource Department as the center of practice development, ensuring inclusion of clinical and non-clinical functions, which are anchored in learning and participation.
- Include all levels of employees when establishing what the organisation should do more of and what the organisation should do less of.
- Ensure that practices reflect the overarching organisational policy and are embedded in all aspects of interactive patterns and organisational direction, less observable assumptions should be monitored and measured as part of service delivery.
- Ensure organisational culture developments are included in all aspects of induction training and annual reviews.

One of the main consequences of this research is its contribution to the economic measurement of organisational culture using a mixed methods research design, particularly in a healthcare setting. While delivering the research objectives, the study has integrated existing theory in the form of the Competing Values Framework and developed a qualitative process which explores the complex deeper levels of organisational culture. The novel theoretical framework informed the enquiry and was utilised to underpin all phases and processes of the research delivery. In doing so the study developed a pragmatic and comprehensive solution to the challenge of measuring organisational culture in healthcare. The developed research design provides a mixed methods approach for the future discovery of organisational culture and the replication of this study.
Conceptually the methodology of this study has moved the established Competing Values Framework from its foundations as a quantitative instrument to a conceptual framework which can provide a legitimate structure for the investigation and analysis of organisational culture. The application of the framework themes are used to underpin the thematic analysis of the qualitative phase, providing consistency in analysis across the quantitative and qualitative phases of the study. This is identified as a challenge in the merging of data sets across mixed method in many disciplines. The unique application presents a navigational device which provides a solution to the investigation of complex human behaviors in organisations. The CVF has not previously been applied to develop a conceptual framework which transcends methodology and provides both a validated and reliable questionnaire and a template for thematic qualitative analysis. This research has provided a novel design approach for investigating organisational culture beyond the healthcare sector, extending the limited literature on the investigation of organisational culture at its deepest levels.

The duality of the methodology applied in this study has provided additional insights into the organisational culture under investigation, reaching the deepest levels. This is an aspect of organisational culture enquiry which had previously been identified as under-reported (Scott et al. 2003a, Schein 2004, Scott 2005). Mannion et al. (2008) comprehensive investigation into measuring organisational culture in healthcare reported the predominant methodological utilised was quantitative, with scholars using self-reporting questionnaires (Mannion et al. 2008). The research suggests that the convenience of questionnaires were achieved at the "cost of deeper insights and unanticipated findings" (Mannion et al. 2008, p. 55). In support of these findings and the gap in theoretical and methodological approaches, Scott et al. (2003,2005) reported that the reviewed literature provided evidence of Levels 1 (behaviors and patterns) and Level 2 (attitudes, values, and beliefs) investigation only. Despite the overwhelming evidence of the shortfalls in the use of a single methodology for the measure of organisational culture (Scott 2005, Bosch et al. 2008, Mannion et al. 2008), a mixed methods study has not been found.

This research therefore provides unique evidence of the successful application of a comprehensive replicable methodology which can capture the multiple levels of organisational culture through the application of the CVF as both a quantitative instrument and as a template analysis framework for the qualitative phase, ensuring
effective and transparent integration of both data sets. This evidence makes a case for the adoption of mixed methods as the preferred methodology when measuring organisational culture in healthcare and beyond.

The sampling strategy applied by the research also provided original evidence of the capacity of all employees in the organisation to contribute to reform planning. The findings indicated only nominal differences across the sample, except for management and office-based employees who scored significantly different than those involved in direct care provision. This would indicate that to provide a full and transparent investigation into organisational culture in healthcare all employee categories should be included. Other studies on organisational culture in healthcare have focused on either one professional group (Dowswell et al. 2001, Hann et al. 2007, Pracilio et al. 2014) or have limited the investigation to management and senior decision makers only (Gerowitz et al. 1996, Gerowitz 1998b, Marshall et al. 2003b, Mannion et al. 2010). The sampling strategy of this research is suggested as unique, providing evidence that the inclusion of all employees in organisational culture measurement is central to providing a holistic, inclusive result, which is representative of the entire organisation. These findings therefore contribute to the knowledge on universal sampling strategies for organisational culture. In view of the research contribution to theory and methodology the following recommendations are being proposed.

Recommendations:

➢ Additional research will support the application of the extended conceptualisation of the Competing Values Framework as a mixed method model to measure the multilevel construct of organisational culture at all three accepted levels.

➢ The novel theoretical framework could then be used as a baseline measure prior to reform, providing evidence of organisational preparedness for cultural change.

➢ The framework can also aid pre-reform planning to establish the necessary cultural directional change.

➢ The application of the framework post-reform could provide evidence of change and assist with evaluation, which is identified as one of the key areas of focus across global healthcare improvement.
9.2 Strengths and Limitation of the Study

As is the case with all scientific research, the findings from the study should be understood in the context of their limitations. While the power sample is representative of the demographics of the community healthcare sector in Ireland, the findings may not be generalisable across other healthcare areas in other countries, or other sectors, and should be deemed as such. Other principal limitation and key strengths of the study are highlighted under the various elements of the research.

9.2.1 Strengths and Limitations of Theory and Methodology

The study of organisational culture is deeply contextual to time and place. It is a complex, subjective, often unconscious, multifactorial construct. Identifying and utilising a theoretical framework which transcended disciplines and methodologies is one of the defining strengths of the research. The Competing Values Framework (CVF) is equally as adaptable as a quantitative instrument in the form of the OCAI™, and as a framework for the template analysis of the qualitative data. This study provides a rare opportunity to adopt the more frequent used empirical survey on organisation culture, to include a deeply insightful qualitative enquiry. This provides a pioneering research design in the context of organisational culture in community and other healthcare reform settings globally. The application of mixed methods has provided an insight into the deepest levels of organisational culture, a level which has largely remained unexamined (Mannion et al. 2005). The design and framework of this study therefore offers a robust replicable mixed methods data collection framework by which to identify and measure organisational culture. The complexity and scale of a mixed method study of this nature is both time consuming and requires a researcher who is equally competent in both quantitative and qualitative enquiry, in addition to the standards and current practices in mixed methods which is a continually evolving methodology.
9.2.2 Strengths and Limitations of Sampling, Recruitment & Response Rate

To address any validity threats in the study, the sample for both phases of the research were drawn from the same population. In this regard the sample was drawn from members of the organisation as defined by the definition of organisational culture which excluded other potential influencers including patients, general practitioners and other external stakeholders who it could be argued are important actors but ultimately do not influence the internal operations of the organisational culture in healthcare at a business management level. The sampling period was also restricted by the timing limit of the study. Having spent significant time securing access to the participating region, the time allocated to the collection of the qualitative data was very limited. Due to the ever-evolving structure in the participating organisation it was imperative that the qualitative data collection was concluded within a timeframe of 2 months. This limitation reduced the number of qualitative participants, although there is no evidence that additional interviews would have provided additional insights. While the concept of data saturation was foremost during the data collection period and subsequent analysis, considering the breadth of the CVF themes it appeared unlikely that any new themes would have emerged with additional participants.

The challenge securing permission for access and recruitment is outlined in the Research Methods Section 5.2.2 and was not unsubstantial. One of the main strengths of the study was the ability to recruit and accrue a significant power sample across the entire population of the Community Healthcare Organisation. The recruitment included representative samples across the four main work divisions and across the staff professional categories, which were distributed across multiple sites, and across five geographical counties. The fact that the participating area had, in the previous 6 months, conducted two national surveys, and several lesser individual studies, indicates the interest in organisational culture which was evidenced by the researcher in general. Despite these challenges the study achieved a response rate of 11% (n=445) being in keeping with various other studies conducted in the area which had substantial recruitment resources. Without the congeniality of the relationships established by the
researcher with the Senior Management team the recruitment and actual response rate may not have been as successful.

9.2.3. **Strengths and Limitations of Data Collection Methods and Instrument**

While an extended period of data collection would have yielded a larger response rate, the nature of organisational culture and the rapid changing climate of the community healthcare necessitated a cross sectional study for the collection of both data sets, in quick succession. While the research on measuring organisational culture in healthcare settings is not insignificant (Mannion *et al.* 2008, Jung 2009), the lack of consistent application and variances in interpretation has made comparison of organisational culture across healthcare settings impossible, particularly where governance structures and services vary from country to country. In a rapidly changing sector besieged with healthcare failures (Scally 2018), a moratorium on recruitment and reduced financial resources, it would benefit the understanding and measurement of organisational culture to repeat the survey in two-three years’ time to measure change and progress. The on-line version of the OCAI instrument delivered through Survey Monkey Inc. would have benefited from an automatic reducing score calculator. Future use of the ipsative scale would necessitate this development, which on this occasion was not allocated a budget.

Considering the agile response imposed by the global pandemic in 2020, a revisit to the measurement of organisational culture in community healthcare has become even more pressing. Many of the espoused reform measures which have been included in healthcare policies for decades, were unofficially fast-tracked during the global pandemic without political, financial, disciplinary, or contractual roadblocks. These included access to Universal Healthcare Insurance (albeit generally covid related), the introduction to telemedicine (virtual GP visits) and multi-disciplinary work practices and behaviours which may have ultimately placed the dominant hierarchal culture of community healthcare under attack.
9.3 Direction for Future Research

The results of this study have shown that there is scope to improve and build on the research in organisational culture as it relates to healthcare reform and community healthcare reform specifically. The mixed methods approach offers a consistent, contextual understand of the unobservable elements of organisational culture through the exploration of firsthand experiences. The lack of reform evaluation has been previous identified as a deficit which could be filled by baseline and post-reform data collection. Implementation science research in the sector could incorporate this short comprehensive framework, which could also be applied to post-reform case studies.

It is recommended that further research is undertaken in the community healthcare area to identify and evaluate the level, if any, cultural change has taken place with a view to re-testing the organisational culture in 2022-2023, being 3 years since the research data collection was undertaken. A benchmark of the various organisational cultures should also be catalogued to establish what, if any, correlation exists between the organisational culture in the community sector and the acute sector of healthcare. Working in collaboration with other institutes and organisations, organisational culture in the healthcare sector could also be benchmarked across other sectors with a view to accruing additional knowledge about this unique and complex service provider which effects daily life globally.

9.4 Reflection on the Research Process

This section offers a critical reflection on the research process as experienced by me, as the researcher. My previous professional and academic experiences have undoubtedly influenced the methodology and other elements of the study design and delivery, accepting, as previously cited, that no research is truly value-free. To reduce this inherent bias, I have maintained a reflexive course, remaining cognisent at all times of my identity, role, and experience, which I suggest ultimately enhanced the research enquiry.

Initially the investigated literature revealed a complexity to organisational culture research which I had not fully anticipated. The most challenging aspect of the research
process was the ambiguity surrounding both the research theme of organisational culture and the lack of uniformity in the literature, which was also unexpected. For me at this point consistency and pragmatism replaced the lack of cohesion and certainties. From this viewpoint the research is based on a practical, reliable, robustly documented process, with a firm focus on the application of “what works” in answering the research questions.

However, the scale and layers of management and governance within the organisation appeared to total eliminate all elements of personal authority and responsibility, ever at the most senior national level. Having worked as CEO of PLC companies and in other senior roles, I found this frustrating. The idea of collective decision making is not uncommon but, in this instance, it appeared to be used as a decision avoidance strategy. The excessive access negotiations were protracted and challenging. Striking the balance between consistent professionalism and stalking was difficult. Notes recorded in October 2018 indicate senior management meetings had been cancelled three consecutive times (at short notice). Referring to my journal entry in November 2018 it was noted “that no one is really in charge of making decisions, which move up and down the organisation. In May 2019, following an employment statute change of two members of the national management team, the journal entry suggested “it is nearly impossible to keep track of decision makers and ever-changing role”. When the research journey commenced in September 2018 this level of negotiation could not have been anticipated.

The “sense making” of communication in the organisation was particularly challenging including the underutilisation of technology and the lack of interest and access to general information concerning the strategy plans in the organisation. Visiting a slow responding site on 1st July 2019, a straw poll was taken from 12 employees in the canteen. None of those present knew the name of their CEO or remembered receiving their notification of survey email. The sense of apathy in the building was tangible. Two days later when visiting a semi-decommissioned mid 1900 hospital complex, it also became apparent that the building consisted of a type of “shared office arrangement”, no one was responsible for the common areas (introduction and notification about poster).

Despite the challenges, the journey has been a learning and an insightful one, the fact that I had previously conducted evaluations and implementation science projects in the same
geographical areas ensured that I was not viewed as an “agent of the management”, which could have presented a roadblock at interviews. On the contrary individually the qualitative participants were very honest and frank about their personal experiences of culture in the organisation. Those who participated brought a wealth of knowledge and experience and were very willing to share and explain. In the absence of “red tape” the experience has been incredibly positive and enlightening, individual managers and team members were helpful, supportive, and engaged in the process. This, if nothing else, has demonstrated to me that the “group think” or collective culture of an organisation can differ significantly from the individual willingness and cooperation of individual team members independently.

9.5 Conclusion of Research

The original contribution of this research has been outlined under the various sections which includes the policy and practice in the healthcare community sector, in addition to the theoretical and methodology implications. The study has explored the collective organisational culture in a community healthcare setting, being the unit of analysis for the study. The research design has facilitated a deep dive into the complex construct of organisational culture and the forces which shape its composition in healthcare. Distinct for other studies in the field, the findings from this research have indicated a single overarching culture, with all the corresponding dimensions of that culture being congruent. This provides a strength and a penetration of a unilateral culture across the whole organisation. The identified gap between the current culture and the desired culture is common across all departments and disciplines, suggesting that employees are themselves sending a clear unambiguous signal, that change is needed. It may also be sending a signal that the complex adaptive system of healthcare needs a comparable organisational culture, one that reflects a modern, learning, and inclusive organisation.

This thesis attempts to move the debate on organisational culture from theory and concept to policy and practice, placing it center stage of healthcare reform. It is hoped that the research findings will provide leverage to change champions and leaders in the participating and other healthcare organisations. Facilitating open discussions the CVF
conceptual framework could enable practices to bridge the identified gap between the culture the employees have and the culture they want. It is hoped this research will improve the understanding of what organisational culture is and demystify its impact on the behaviors and assumptions of the collective culture. This study provides a rare opportunity for collaborate sustainable reform for the participating organisation, which is not born from a top down “consultations” or strategic directives, but from a statistically robust investigation and in-depth personal contributions in a natural setting.
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Appendix i  Hard Copy of OCAI Survey (p. 3 & 4)
Appendix ii Poster 1 & 11
Appendix III Participants Information Leaflet (PII)

More about the Trinity Centre
Practice for Healthcare Innovation (TCPHI)

The Trinity Centre for Practice and Healthcare Innovation (TCPHI) is a research centre based in the School of Nursing & Midwifery, Trinity College Dublin.

The mission of the centre is to work collaboratively with healthcare staff, industry and the public to improve healthcare services and develop, implement and evaluate new innovative healthcare interventions and models of care. The expertise of the TCPHI team in implementation science, healthcare knowledge and experience is available for sharing and supporting research capacity between academic staff, post-doctoral researchers, postgraduate research students and staff in affiliated healthcare providers and industry.

The centre has successful collaborated with a large network of clinical, industry and research partners and are actively engaged in the synthesis and translation of evidence into every day healthcare. The TCPHI research team and associated academics serve on local, regional and national policy and care planning committees, taskforces, nursing and midwifery professional associations, and regulatory bodies.

If you are interested in working with us and would like to discuss ideas or potential collaborations, please do not hesitate to contact the researcher or the centre Director.

Dr. Catherine McCabe
Director of Trinity Centre for Practice for Healthcare Innovation.
Email: cmmccabe@tcd.ie
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Introduction to Research:

Organisational culture is recognised as being at the heart of successful private business operations but has failed to date to performance and delivery in the Irish Public Sector. The World Economic Forum has extended their Health Care Review to now include the developed world as the ageing demographic and financial restrains are having public sector transformation.

While the global need for health care reform often focuses on structure, strategy and staffing, little emphasis is placed on the cultural resistance which accounts for 50-75% of organisational change failures.

Some public-sector research in Ireland has cited failure of culture as being responsible for failed change, but as research has been made to measure or identify the organisational culture in the Health Service Executive, 

Research Procedures:

This research seeks to identify and measure the organisational culture in two Community Health Organisations (CHO) in the Health Service Executive. The two CHO’s: 5 and 6 have been selected as they offer contracting service users and providers, Area 6 (population 464,350) and Area 5 (population 497,560) are a mix of urban and rural service users. Area 5 includes Celbridge, Killiney Waterford, Wexford and as far as South Tipperary, while area 6 is more compact and includes the areas of Wicklow, Dublin South and Dun Laoghaire.

The researcher will conduct a survey with employees in both areas, and will also interview senior managers on a one-to-one basis. The information gathered will allow the researcher to establish the type of culture that operates in both area, and will also evaluate that type of culture preferred by staff to deliver the required changes.

Identifying and exploring the culture will enable better planning and inclusion of this critical element in transformation and reform.

Researcher/ Doctoral Candidate:

Debra O’Neill holds a first class MBA and is a first year PhD candidate and a 20132 Scholar with the Trinity Centre for Practice and Healthcare Innovation, in the School of Nursing and Midwifery. She has a wealth of practical experience in the commercial sector in change management and organisation culture, skills which she hopes to bring to her research.
Appendix iv Introductory Letter to Influencers

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Trinity Centre for Practice and Healthcare Innovation
School of Nursing and Midwifery,
Faculty of Health Sciences, Trinity College Dublin,
24 D’Olier Street, Dublin 2.

4th June 2019

Dear Ann,

I hope you are well. Over the coming week all HSE employees in your areas will be invited to complete a short 5-7 minute survey on-line which will enable me to measure the organisational culture in your Community Healthcare area. The link to the survey will be received in an email from your Chief Officer.

The Senior Management in the HSE and the regional Management Team have agreed to support the research and it is important that all categories of staff are represented. For example, in the pilot test of the research last year, only 1% of nurses in a Community Healthcare area completed the survey versus 40% of nurses who make up employees in the area.

I include some hard copies and return envelopes for those who may not be on-line. Alternatively, you may complete the survey at home / on your smartphone / iPad or tablet by visiting www.culturechange.ie

Can I please ask you to place the enclosed poster in your department or offices, where staff members can see it (Canteen/ Hallway/TeaRoom/ Office) Can you please ask your team members to complete the survey once the link is emailed in the coming weeks? I really appreciate your assistance with this small task, which will make the whole project possible.

If you have any questions, I can be contacted on 086 3856565 or email donella9@tcd.ie

Kindest Regards

Debra O’Neill MBA MMII
Doctoral Candidate
1252 Scholar Trinity College Dublin.

School of Nursing & Midwifery,
Faculty of Health Sciences,
24 D’Olier Street,
Dublin 2, Ireland

T 353 (0) 1 8962892
F 353 (0) 1 8963001
nursing_midwifery@tcd.ie
www.tcd.ie/Nursing_Midwifery
Colleagues,

From previous correspondence, you will be aware of the focus on change in the health services generally and the culture in our own Community Healthcare organisation in particular.

The senior management team, with the aim of encouraging further attention on community healthcare innovation and organisational culture, is pleased to co-operate with Debra O’ Neill in her research on such subjects.

Debra is currently conducting PhD research at the Trinity College Dublin Centre for Practice and Healthcare Innovation (www.tcd.ie/cphhi/) and is linking with as part of that centre’s collaboration with health service providers. As a result, has approved of an opportunity for Debra to help measure organisational culture in our community healthcare area by means of a voluntary, confidential survey.

The opportunity to participate in Debra’s survey will be available to all employees across counties over the next few weeks.

The online survey will take about six minutes to complete. As understanding culture in the workplace is important, I would be very grateful if all staff categories could contribute – in order that this independent survey will be representative.

Further information on Debra’s project entitled “Diagnosing culture: a mixed methods exploration of organisational culture in community healthcare reform in Ireland” is available at www.culturechange.ie (which also contains a link to the survey).

Debra will be visiting sites around the over the coming weeks and will be available to address any questions you have or to assist in the event of paper copies of the survey being sought. Debra can be contacted by phone at (086) 385 6565 or by e-mail at DONeill9@tcd.ie

Organisational culture in community healthcare impacts on quality, safety and satisfaction for you as an employee and in respect of patients and stakeholders. I look forward to Debra’s research, guided by your responses to the survey, helping to define organisation culture – especially at a time of change.

Thanking you in anticipation.

Regards,
Appendix vi Communications Officer Survey Distribution

For attention of all employees of Community Healthcare

My thanks to Chief Officer and the senior management team of Community Healthcare for their interest in my research for the Trinity College Dublin Centre for Practice and Healthcare Innovation.

You will have received the below e-mail in recent days from the Chief Officer as regards the voluntary, confidential survey that features in this independent project focused on organisational culture in community healthcare reform.

I would be very grateful if you could take some six minutes to complete the survey, by clicking the link to https://www.surveymonkey.com/r/Culture2015.

All answers are confidential and you are required to tick boxes only, read the statements and select a number.

Thank you for your time.

Debra O’Neill,
Tel. (086) 386 6565, e-mail at DONeill9@tcd.ie

Appendix vii Reminder Posters No 111
Appendix ix Semi-structured Interview Protocol

Introduction:
Firstly, I want to thank you for taking the time out of your busy schedule to meet with me. (As you know) My name is Debra O Neill, and I am a 2nd year PhD student in the Centre for Practice and Healthcare Innovation at Trinity College Dublin. You will have previously received the project information leaflet and a copy of the consent form which we have both now signed and which I will keep on file as a record of your consent. I want to remind you again that this interview is being recorded on both these devices (pointing to digital recorder and iPad), this will enable me to record your answers and comments for accurate transcription. It also means I do not have to take notes throughout the interview.

Your identity will always remain confidential and your will not be identified by your answers or your participation. Your interview will be recorded as interview 1 / interview 2 / interview 3 etc. If you wish to stop the interview at any point please just say so. If you do not wish to answer a question, please just say so.

The interview will take approximately one hour, are you happy to proceed? So, I will just start the recording. As you know the research is about organizational culture in this Community Healthcare Area. So, we will start with some questions about the culture.

1) Characteristics of Culture:

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<thead>
<tr>
<th>Interview Topic</th>
<th>Explanatory Question</th>
<th>Additional Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>The survey found that the culture in the community healthcare was</td>
<td>What's it like to work here?</td>
<td>Can you explain that further?</td>
</tr>
<tr>
<td>Hierarchy or controlling, what do you think about that?</td>
<td>Can you tell me about the culture in your department?</td>
<td>Can you give me an example of that?</td>
</tr>
<tr>
<td>Can you tell me about the culture in the disability/ mental health service?</td>
<td>What is the most pressing thing now?</td>
<td>What do you mean?</td>
</tr>
</tbody>
</table>

2) Leadership

<table>
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<th>Explanatory Question</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Why do you think leadership might be important to culture?</td>
<td>Can you tell me about the leadership style in your area?</td>
<td>Can you explain further?</td>
</tr>
<tr>
<td>Can you tell me about the leadership style in the organisation?</td>
<td>What do you think are the important qualities for future Leaders?</td>
<td>What do you mean?</td>
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<tr>
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<td>Can you give me an example?</td>
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### 3) Organizational Glue

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<th>Explanatory Question</th>
<th>Additional Question</th>
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<tbody>
<tr>
<td>What do you think is valued here?</td>
<td>What’s important to everyone?</td>
<td>Can you explain further?</td>
</tr>
<tr>
<td>What holds everything together? (keeps people going)</td>
<td>What’s important to you?</td>
<td>What do you mean?</td>
</tr>
<tr>
<td></td>
<td>What will be important in the future?</td>
<td>Can you give me an example?</td>
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### 4) Management of Employees:

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<td>How do you think employees are treated or managed / motivated?</td>
<td>Can you tell me about how the team interact together?</td>
<td>Can you explain further?</td>
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<td></td>
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<td>What do you mean?</td>
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<td>What’s the biggest challenge in the management of employees?</td>
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<td>Can you give me an example?</td>
</tr>
<tr>
<td>How do you incentivise collaboration and creativity in lone workers?</td>
<td>What about part-time workers?</td>
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### 5) Strategic Emphases:

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<td>What plans or initiatives are in place to change the strategic emphases?</td>
<td>Can you tell me about the current plans and culture?</td>
<td>Can you explain further?</td>
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<td>What will influence the change?</td>
<td>What do you mean?</td>
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<tr>
<td></td>
<td>What will the challenges be?</td>
<td>Can you give me an example?</td>
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<td>How do you contribute to that change or challenges?</td>
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### 6) Criteria for Success

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<tr>
<td>Can you tell me about measuring and redefine success?</td>
<td>What’s gets rewarded?</td>
<td>How?</td>
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<tr>
<td>What does success look like for you personally and the organisation.</td>
<td>How would a person get on around here?</td>
<td>Can you give me an example?</td>
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<td></td>
<td></td>
<td>Can you explain?</td>
</tr>
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Is there anything else you would like to add?

Do you have any questions?

So, I’m going to stop the recording there, thank you again.
Appendix ix Consent Form

Appendix x Ethical Approval
Appendix xii Literature review search strategy

1. Work package 1: organisational culture
   Concept 1: Organisational culture
   Medline: (MH "Organizational Culture")
   CINAHL: (MH "Organizational Culture")
   EMBASE: 'organizational culture'/exp
   PsycINFO: no appropriate term
   Global Health Library:
   Web of Science: keyword search only on title and topic
   Authors of papers were contacted to request missing or additional data as previously noted

ASSIA: MAINSUBJECT.EXACT.EXPLODE("Organizational culture") OR MAINSUBJECT.EXACT.EXPLODE("Corporate culture")

Keywords: “Organization* Cultur*” OR “Organisation* Cultur*” OR “corporat* culture*” OR “Organisation* climate” OR “Organization* climate” OR “Organization* Change*” OR “Organisation* Change*”

Health Care Reform:
   Medline: (MH "Health Care Reform")
   CINAHL: (MH "Health Care Reform")
   EMBASE: 'health care policy'/exp
   PsycINFO: DE "Health Care Reform"
   Global Health Library:
   Web of Science: keyword search only on title and topic
   ASSIA: no appropriate term
   Keywords: reform* or change* or improv* OR transform* OR “organisational reform*” OR “organizational reform*” OR “culture* reform*” OR “reforming culture*”
Concept 3: community health sector

Keywords: "Community Health Service*" OR "Community Healthcare service*" OR "Community Health Care Service*" OR "community health care" OR "community healthcare" OR "primary health network*" OR "district healthcare" OR "district health care" OR "community health centre*" OR "community health center*" OR "Rural Health Center*" OR "Rural Health Centre*" OR "primary health care" OR "primary care" OR "primary care trust*"

Global Health Library Search: tw:("organisational culture" OR "organizational culture") AND (instance:"ghl") AND ( mj:("Organizational Culture" OR "Surveys and Questionnaires" OR "Organization and Administration" OR "Psychology, Industrial" OR "Reproducibility of Results" OR "Health Management" OR "Culture" OR "Psychology, Social" OR "Health Systems" OR "Organizational Objectives" OR "Psychometrics" OR "Social Behavior" OR "Cultural Characteristics" OR "Health Policy" OR "Interpersonal Relations" OR "Primary Health Care" OR "Research" OR "Strategic Planning" OR "Program Evaluation" OR "Data Collection" OR "Statistics as Topic" OR "Organizational Policy" OR "Climate" OR "Health Care Reform" OR "Evidence-Based Practice" OR "Interprofessional Relations" OR "Weights and Measures" OR "Unified Health System" OR "Local Health Systems" OR "Health Centers" OR "Anthropology, Cultural" OR "Rural Settlements" OR "Comprehensive Health Care" OR "Informatics" OR "Health Organizations" OR "Cultural Competency" OR "Rural Population")

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**Accessibility Information and Tips** Revised Date: 07/2015

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Centre*" OR "primary health care" OR "primary care" OR "primary care trust*"") OR ti("Community Health Service*" OR "Community Healthcare service*" OR "Community Health Care Service*" OR "community health care" OR "primary health network*" OR "primary health care" OR "district healthcare" OR "district health care" OR "community health centre*" OR "community health center*" OR "Rural Health Center*" OR "Rural Health Centre*" OR "primary health care" OR "primary care" OR "primary care trust*"))) AND ((MAINSUBJECT.EXACT.EXPLODE("Organizational culture") OR MAINSUBJECT.EXACT.EXPLODE("Corporate culture")) OR (ab("Organization* Cultur*" OR "Organisation* Cultur*" OR "corporate culture*" OR "Organisation* climate" OR "Organization* climate" OR "Organisation* climate" OR "Organization* Change*" OR "Organisation* Change") OR ti("Organization* Cultur*" OR "Organisation* Cultur*" OR "corporate culture*" OR "Organisation* climate" OR "Organization* climate" OR "Organisation* climate" OR "Organization* Change*" OR "Organisation* Change") AND (ab(reform* OR change* OR improv* OR transform* OR "organisational reform*" OR "organizational reform*" OR "culture* reform*" OR "reforming culture") OR ti(reform* OR change* OR improv* OR transform* OR "organisational reform*" OR "organizational reform*" OR "culture* reform*" OR "reforming culture")) AND (MAINSUBJECT.EXACT.EXPLODE("Community health services") OR MAINSUBJECT.EXACT.EXPLODE("Community health care") OR MAINSUBJECT.EXACT.EXPLODE("Community health") OR MAINSUBJECT.EXACT.EXPLODE("Community health councils") OR MAINSUBJECT.EXACT.EXPLODE("Community health centres") OR MAINSUBJECT.EXACT(""Public health") OR (ab("Community Health Service*" OR "Community Healthcare service*" OR "community health care" OR "community healthcare" OR "primary health network*" OR "district healthcare" OR "primary health care" OR "primary care" OR "primary care trust") OR ti("Community Health Service*" OR "Community Healthcare service*" OR "community health care" OR "community healthcare" OR "primary health network*" OR "primary health care" OR "primary care" OR "primary care trust*))

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S6 ab("Community Health Service*" OR “Community Healthcare service*” OR “Community Health Care Service*” OR “community health care” OR “community healthcare” OR “primary health network*” OR “district healthcare” OR “district health care” OR “primary health care” OR “primary care” OR “primary care trust*”))

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