Title: Competing Values Framework: a useful tool to define the Predominant Culture in a Maternity Setting in Australia

Abstract

Objective: To identify the predominant culture of an organisation which could then assess readiness for change.

Design: An exploratory design using the Competing Values Framework (CVF) as a self-administered survey tool.

Setting: The Maternity Unit in one Australian metropolitan tertiary referral hospital.

Subjects: All 120 clinicians (100 midwives and 20 obstetricians) employed in the maternity service were invited to participate; 26% responded.

Main Outcome Measure: The identification of the predominant culture of an organisation to assess readiness for change prior to the implementation of a new policy.

Results: The predominant culture of this maternity unit, as described by those who responded to the survey, was one of hierarchy with a focus on rules and regulations and less focus on innovation, flexibility and teamwork. These results suggest that this unit did not have readiness to change.

Conclusion: There is value in undertaking preparatory work to gain a better understanding of the characteristics of an organisation prior to designing and implementing change. This understanding can influence additional preliminary work that may be required to increase

the readiness for change and therefore increase the opportunity for successful change. The CVF is a useful tool to identify the predominant culture and characteristics of an organisation that could influence the success of change.

Key words: organisation, culture assessment, change readiness, competing values

Background and Context for the study

Summary of Relevance	
Problem or Issue	Implementation of significant change in healthcare can be challanging.
What is already known	Prior to the implementation of innovations in health care settings, there is often little consideration of the cultural characteristics of the organisation that may determine their readiness to change.
What this paper adds	This paper describes a methodology to determine the predominant culture using the Competing Values Framework. The assessment process at the study site revealed characteristics that would need to be considered if change was to be effective and sustainable. This process can assist in change management strategies.

This paper describes the process that one maternity service undertook to gain a better understanding of the predominant culture and characteristics of the organisation prior to the implementation of a mandatory government policy.

The effectiveness of implementing innovations in healthcare was the focus of an important systematic review in 2004[1]. The review confirmed that prior to implementation of innovations in health care settings there was often little consideration of the characteristics of the organisation that may determine their readiness to change. Failure to recognise or understand the organisational characteristics has been described as the root cause of the mediocre success of programs designed for quality improvement in diverse disciplines [2-9]. The literature warns of the consequences of not assessing the powerful influence of organisational cultural on efforts to bring about change [6,10,11]

The focus of change processes is often on the practical and material change requirements. The less visible and tacit characteristics of the people who will be involved in the change are often over looked [12-14]. These characteristics include participants' self-efficacy, the congruence between values and attitudes of the individual and the organisation, the personal and organisational valence, the leadership style and support and the perception of the value of the proposed change [2,3,15-18].

The impetus for assessing the readiness for change in one maternity service was the mandatory implementation of a government policy that would require significant adjustments in order to meet the key deliverables? In this paper we will use this policy as an example to demonstrate why examination of the organisation may be beneficial as preparatory work.

In 2010, the government of New South Wales (NSW), Australian, issued a public health policy, “Maternity – Towards Normal Birth” [19]. The policy required all NSW public maternity services to implement strategies to reduce a range of potentially unnecessary interventions in birth. Target measures were to be achieved over a five-year period, with each health service accountable for outcomes. For a majority of the services this was the first time such targets had been set and it was recognised that this would require a significant reorganisation of systems to achieve improvements. For example, the target for women having a vaginal birth after a previous caesarean section (CS) operation was set at greater than 60% and in 2010 the State average was 12% (range 2.9 – 26%) [20]. At the research site the success rate of vaginal birth after CS in 2010 was 12%. Therefore, a five-fold improvement in current practices would need to occur to achieve the target outcomes.

In addition, outcome data in Australia demonstrates variations in intervention rates in childbirth that cannot be explained by either the demographics or clinical history of the women [21,22]. This literature suggests that the context and cultural characteristics of organisations may influence intervention in birth, rather than the clinical variables of the woman or her baby. Possible explanations for variations that have been cited in the literature are the effectiveness of collaboration between care providers and aspects of team work. [23-30]. The evidence suggests there is a direct link between teamwork and patient outcomes including mortality rates[31]. Where there is effective interprofessional collaboration, based on

mutual trust and respect with shared decision making and engagement at all levels, the quality and safety of care is improved [32-35].

In accepting this to be the case, gaining a better understanding of the characteristics of the organisation and using this information to facilitate the development of strategies for change may have a positive impact on the success rate overall and including the mandated government policy. The policy requires a reduction in the overall intervention rates which could be achieved through work focused on work place culture, rather than exclusively on the development of practices and procedures.

Study Location

The research site for this study was an Australian, tertiary level, maternity service in a major city. The service cares for around 2,500 women and babies per year; employs 120 obstetric and midwifery clinicians and is a major teaching hospital, affiliated with two universities.

Study Design and Methods

An exploratory design using a self-administered, staff survey was used. Ethical approval for the study was provided by the New South Wales Health Human Research Ethics Committee (0911-313M), as part of a larger study investigating a change management process in the maternity service.

Competing Values Framework (CVF)

The tool selected to assess the culture of the organisation and its readiness for change was the CVF. This is a validated instrument that has been described in the literature in over 1000 studies, across disciplines, to describe the typology of organisational culture [18].

The results of a systematic review [36] of the instruments available for cultural assessment specifically suitable for healthcare services was used to select the most appropriate instrument for use in this study; the Competing Values Framework. This instrument had the strength of examining the values and beliefs of the participants that informed their opinions about their working environment. CVF was also cited as the most frequently used to measure organisational culture in health services research [37]

Description of the CVF

The CVF was developed empirically in the early 1980s based on Jung's model of psychological archetypes and research on indicators for organisational effectiveness [18]. The framework has a typological design that identifies four *types* of cultures that exist within an organisation: Clan, Adhocracy, Hierarchy and Market with each describing the values, basic assumptions and attributes that are recognised within a team or organisation.

Each of the culture types are described as follows by Cameron *et al* (Table 1) with the competing values in opposite quadrants of the table and hence the origin of the name of the framework.

Table 1 Competing Values Framework (Cameron & Quinn, 2006)

1. Dominant Characteristics		Now	Preferred
Clan Predominant feeling of teamwork and trust amongst colleagues with an orientation towards collaboration and cohesion. The glue of this organisation is a sense of commitment and loyalty.	**Adhocracy** Emphasis on innovation and risk taking and is a dynamic and creative workplace which encourages individuality and flexibility. The glue of this organisation is a commitment to innovation and experimentation.		
Hierarchy A very structured place to work with success defined in terms of smooth and efficient operations. Adherence to rules, regulations, policies and procedures is the glue of this organisation	**Market** A focus on results and outputs in a controlled and stable environment where leaders are hard driving producers. An emphasis on winning is the glue of this organisation.		

The predominant culture is determined by the participants' rating of six specific dimensions of the organisation: the dominant characteristics, organisational leadership, management of employees, organisational glue, strategic emphasis and the criteria of success. There are four descriptors for each of the six dimensions and the participant provides a score in rank order of preference. The options are listed as A, B, C and D and the responses provide an indication of the culture type: A=Clan, B=Adhocracy, C=Market and D=Hierarchy for each dimension as described in Table 2 for the dimension of "Dominant Organisational Characteristics.

Table 2 CVF Dominant Organisational Characteristics (Cameron & Quinn 2006)

A.	The Maternity Service is a very personal place. It is like an extended family. People seem to share a lot of themselves	**10**	**40**
B.	The Maternity Service is a very dynamic and entrepreneurial place. People are willing to stick their necks out and take risks	**20**	**30**
C.	The Maternity Service is very results-orientated. A major concern is with getting the job done. People are very competitive and achievement-orientated.	**40**	**20**
D.	The Maternity Service is very a controlled and structured place. Formal procedures generally govern what people do.	**30**	**10**
	Total	**100**	**100**

Although not explicitly described in words, the responses to the dimensions assess characteristics of the organisation that include congruence of values between the individual and the organisation, the perception of individual value of participants' in the organisation and their self-efficacy (or how effective the individual believes they can be).

The participant is invited to divide 100 points between each option in rank order providing the highest score to the descriptor that best fits their impression of the organisation as it is today. After completing the scores relevant to “now”, the participant is invited to score how they would “prefer” the organisation to be in five years if there was to be successful change. A summative calculation of the scores is performed using the Organisational Cultural Assessment Instrument (OCAI) [18]. The results are then graphically represented in a table divided into four quadrants, one for each culture type. The final graph provides a visual representation of the results which is intuitively appealing and has greater explanatory value than written descriptors. The predominant culture can be identified at a glance. Specific

attention should be given to where the difference between the scores for now and the preferred is greater than ten points [18].

The design of the tool facilitates an overall assessment of the predominant culture, as well as assessment of the individual dimensions. This information is valuable if the organisation wishes to scrutinise potential areas for change that will result in an overall cultural shift.

Identification of the current culture type and the preferred type is also essential for change management. Where there is significant divergence in the desired predominant culture types there can be variation in perceptions in espoused values, aspirations and direction [18]. The energy, motivation and engagement by members of the organisation can be affected by this incongruence and risks the organisation's ability to achieve the desired change [18]. The degree of incongruence provides an indication of the readiness of the organisation to undergo change. In addition, there is an indication of which dimensions of the organisation may require the most attention for the change to be implemented successfully.

Administration of the CVF Tool

The tool was tested at a local university prior to implementation at the study site and minor amendments made. The university students and academic staff recommended that the scores should be out of 10 rather than 100 for greater ease of division for nominating a score. Communication with the authors of the Competing Values Framework provided reassurance that changing the scoring in the proposed manner may alter the variance in

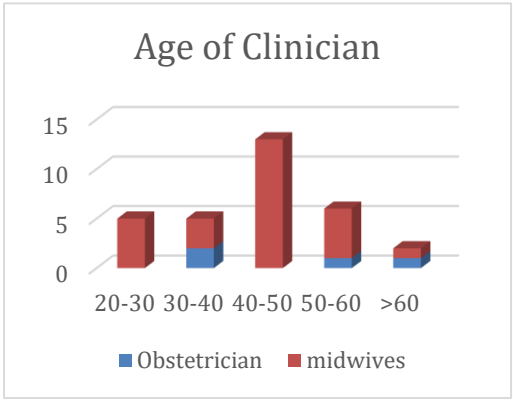
147 scores but would not make a difference to the reliability of the sum scores. The authors were
148 supportive of customising the format for the users' preference.
149 For the purpose of the research some of the language in the descriptors was changed to
150 better fit the context of a maternity service. For example, "the organisation" was changed to
151 "the Maternity Service". The amendments were not considered to change the meaning of the
152 questions but rather described in language that would have greater face validity for the
153 participants.
154 Clinicians were informed of the proposed survey at strategic opportunities such as education
155 sessions and scheduled multidisciplinary forums. As all clinicians (100 midwives and 20
156 obstetricians) were to be invited to complete the tool, one hundred and twenty CVF tools
157 were printed on distinguishable purple paper. The majority of clinicians received this in
158 person from the researcher. Some forms were provided to the midwifery managers in each
159 of the clinical areas to reach clinicians working on evening shifts and weekends. Survey
160 boxes were placed in all clinical areas and clinicians were invited to post the completed form
161 which was conducted over a four-week period.
162 The front page of the tool described the purpose of the survey and instructions for
163 completion. In addition to the survey, demographic information about the participant was
164 collected that indicated the discipline (midwifery or obstetric), age, predominant area of

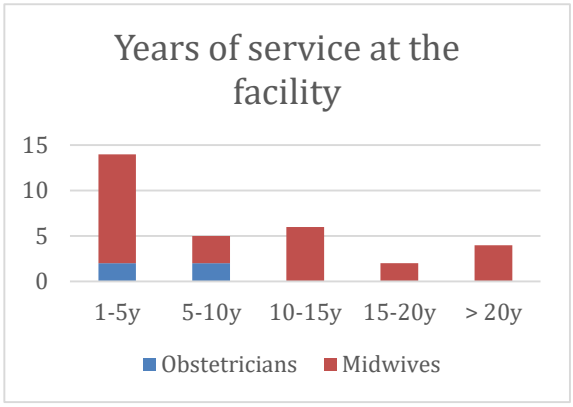
practice (antenatal, birth, postnatal) and length of time employed in the service. The survey was anonymous.

Results

Of the 120 surveys distributed 31 were returned (25.8%). Four of the 20 Obstetricians (20%) responded and 27 of the midwives (27%). The largest group of participants were clinical midwives (71%). The majority of the participants had been working within the organisation for 1- 5years (42%) and were aged between 40-50 years (Table 4).

Table 3 Demographic Characteristics of Participants





The survey respondents described the predominant culture of their organisation as one of Hierarchy with a focus on Market (Figure 1). They identified that the prevalence of teamwork and collaboration was low and of even less prevalence was a culture that encouraged innovation and flexibility. Respondents expressed their preference for a culture that was different to the current one, with a preference for a Clan culture and an increase in Adhocracy with less control, regulation and less focus on outputs.

Combining the two results onto the same plot provides a clear indication of the incongruence between the participant's assessment of the culture now and what would be preferred.

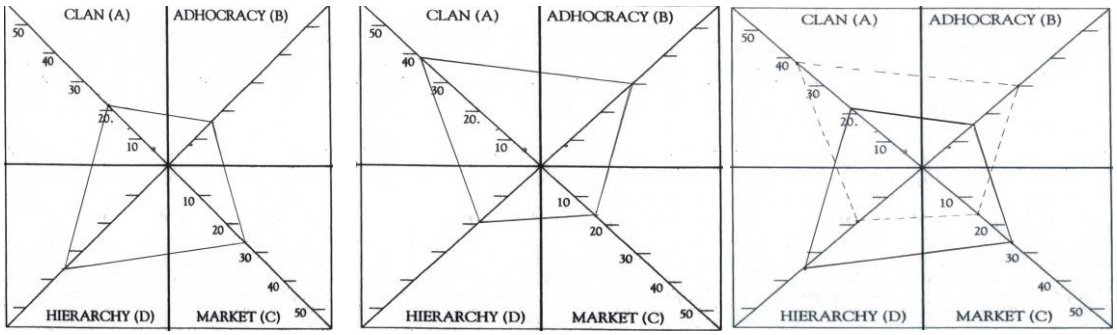


Figure 1 CVF Result Now, Preferred and Combined

The results of the six dimensions are expressed in Figure 2 as a combined result of the "now" and "preferred" cultures. Each demonstrates incongruence between the predominant cultures "now" to what is preferred. In each dimension there is a preference for an increase in both Clan and Adhocracy cultures with a decrease in both Hierarchy and Market. For a majority of the dimensions there is a difference of greater than ten points.

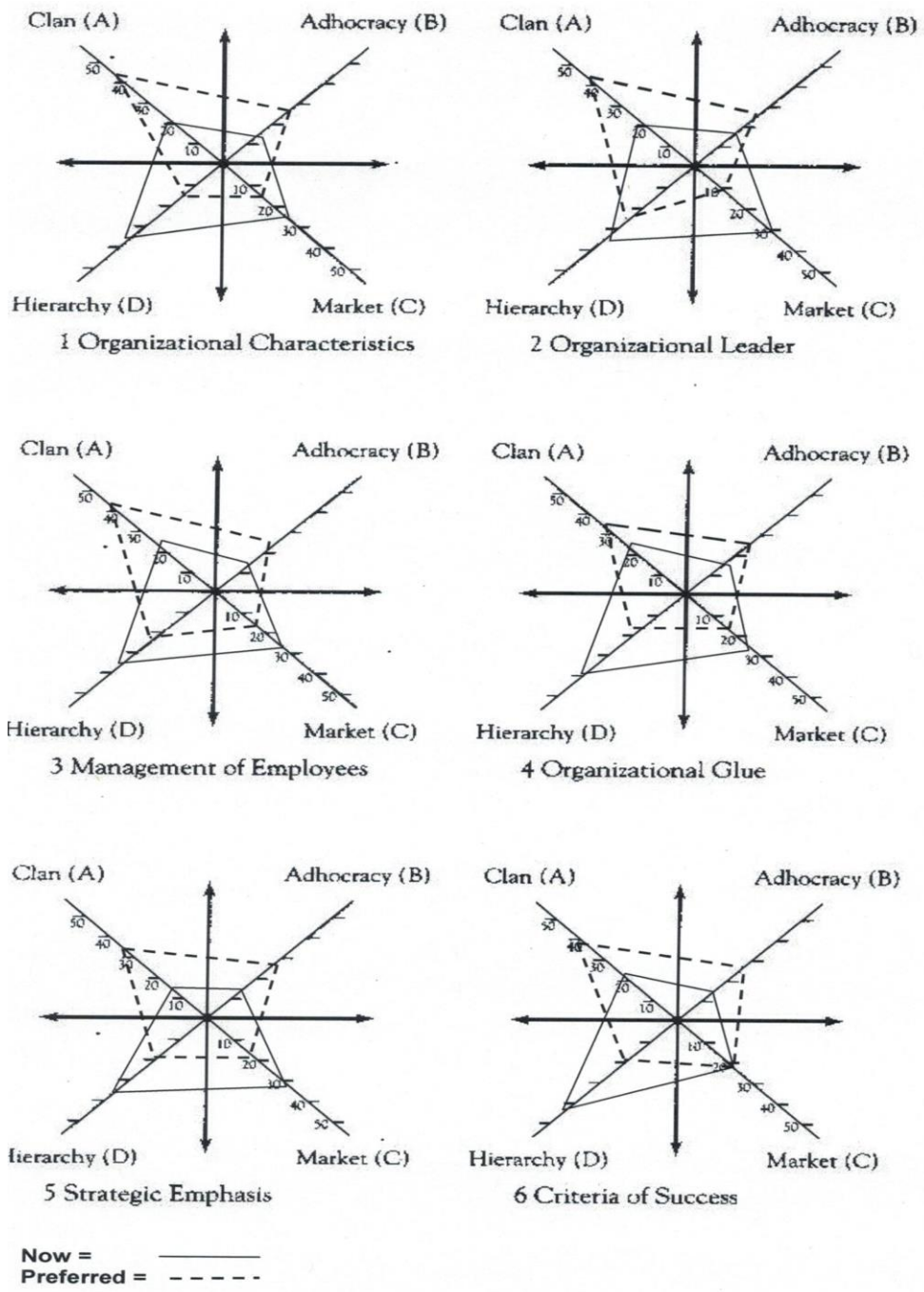


Figure 2 CVF Results for six Dimensions, Now and Preferred

Discussion

The response rate to the survey was 26% and the results must be considered in this context. The predominant culture, as expressed by the results, is the impression of the small percentage of respondents which may limit the inferences that can be drawn. Coincidently,

196 in the same year another survey was generated by the state government also exploring
197 workplace characteristics and attributes. The research site had a response rate of 18% with
198 a confidence interval of 3% which the authors describe as being a representative sample of
199 the facility population [38]. The low response rates may, however, suggest more about the
200 organisation by the silence and non-engagement in the process and is in itself noteworthy.
201 The majority of respondents were those aged 40-50 years (42%) and those who had worked
202 for the organisation for 1-5 years (45%). Midwives were more likely to respond with 27% of
203 the potential cohort returning a survey as opposed to 20% of the obstetricians.
204 The results demonstrated that the majority of the respondents perceived the predominant
205 culture of the organisation to be a hierarchical type with a focus on rules, regulations and
206 control. The Adhocracy culture scored the lowest value of all four culture types. There are
207 opposing values between the two cultures of Hierarchy and Adhocracy which would result in
208 less opportunity for innovation, flexibility or implementation of new ideas in the organisation.
209 Considering the requirement for this organisation to implement significant changes to meet
210 the mandated policy it is important to recognise that the respondents do not perceive there
211 to be an environment that is ready to accept innovation.
212 Market culture scored the second highest and Clan third. The suggestion here is that the
213 maternity service has a focus on meeting performance indicators and target measures, with
214 less focus on collaborative engagements with members of the team who are participating in

the performance. The overall result indicates that at present the characteristics of this maternity unit are not consistent with that of a high performing organisation [39]. That is, an organisation that requires interprofessional collaboration and team work in order to meet performance indicators. As mentioned previously, the inferences that could be drawn from a low response rate is limited, however, those who did respond have stated that there is lack of team work and engagement and if this is prevalent across the service then this may indicate a lack of motivation to be involved in activities including this survey.

The results of the hypothetical scoring for the future culture indicated that respondents would prefer an organisation with characteristics that were opposite to that of today. The graph depicts almost a mirror image of the results in the opposite quadrants. Respondents would prefer the organisation to have a collaborative, cohesive team where innovation is encouraged in an environment of flexibility and risk taking. There are greater than ten points difference in each of the quadrant scores between the now and preferred cultures, which according to this framework design, warrants attention. The results demonstrate that there is a need for cultural change within the maternity service if the planned implementation of the government policy is to be successful and sustained.

The results also show greater than 10 points difference for each of the six dimensions with a predominance of cultures in the lower quadrants and a preference for the opposite cultures in the future. In each of the dimensions respondents had a desire for the Clan culture which

may indicate the perception of their value to, and within, the organisation. Some of the descriptors for this culture are feelings of teamwork and trust, an orientation towards collaboration and cohesion; a sense of commitment and loyalty where work is done together. If this is the workplace respondents would prefer, then by deduction, this is not how the current environment is viewed.

The second preferred culture was Adhocracy with a dynamic and creative workplace where individuality and flexibility is encouraged and a preference to be leaders in innovation. These characteristics were not recognised in their workplace today. The majority of the dimensions have greater than ten points difference between respondents' assessments of the current culture and their preferred culture.

The overall results of this study indicate a lack of readiness to change but a strong preference from respondents for the culture to be different. Acknowledging this incongruence and harnessing the desire to be different may influence a change in the culture to one where change is valued. According to Jones et al. in a workplace that is perceived to have strong human relations values (Clan) or open systems values that encourage flexibility (Adhocracy), there are more positive views towards change and a greater willingness to be engaged in change processes [39]. These authors (2005) further describe such an organisation having "reshaping capabilities" that are dynamic and responsive to external need or internal desire. Reshaping capabilities include attributes such

as individual responsiveness, engagement, a commitment to personal and professional development and a willingness to perform. These attributes can positively affect workers' overall competence and thereby increase efficacy in change processes. There is therefore a direct correlation between the reshaping capabilities and the rate of successful change [39].

When reshaping capabilities are low and change is required, such as in the case of the implementation of government policy, organisational tension can develop which can jeopardise the change process. Respondents in this study suggest they do not have a strong sense of trust, cohesion or collaboration in their team. In addition the findings show that respondents believe that there is an under appreciation of their individuality and potential for creative participation in an environment focused on performance. Tension may result from such unmet needs and the inability to meet personal potential can lead to disengagement and reduced efficacy [2,17,32,40-42].

Tensions have also been historically evident in maternity care between obstetricians and midwives where professional boundaries have become territorial and fiercely contested [25,43-45]. In Foucauldian terms, the scientific knowledge of childbirth was traditionally held by obstetricians and hence professional power was held by them to the exclusion of other disciplines and in particular midwifery[46]. Reforms in maternity care in recent times, however, have resulted in changes in the roles and responsibilities for maternity carers. These changes have been most evident with the development of midwifery-led models of care with

midwives regaining the responsibility for women of normal risk and collaborating with obstetricians where risk is identified. Despite sound evidence for the effectiveness of midwifery-led models of care, [47,48] the translation into practice and the transition to collaborative models of care continues to be challenged by the inability, or reluctance, to relinquish, or modify, former roles and responsibilities [25,45,49-51].

Appreciating the existence of historical tensions between healthcare teams and the difficulties with translation of evidence into practice, gaining an understanding the predominant culture of an organisation and its readiness for change is critical. Such knowledge will enable decision makers to design appropriate strategies so that change can be effectively implemented. For this midwifery service the follow up plan is for an action research project where the clinicians will be invited to contribute to the development of strategies to implement the government policy. Respondents have nominated that they would prefer to be included in teamwork, they would prefer to have the opportunity to be creative and to develop new ideas and that they would like some direction but not to be overly controlled. The cyclical nature of action research methodology may be the key to the successful implementation of this government policy.

It is not possible to determine whether behaviours or organisational characteristics require change if there has been no measurement of the current situation. The CVF provides a way of measuring a baseline; the information can then be used to design interventions to

influence the desired changes. The CVF tool would then be used to reassess the predominant and preferred culture over time. It is not possible to report on changing culture in the research site here as the processes leading towards changing the culture are continuing. What this paper offers is a way forward for maternity clinicians facing one of the most common challenges in practice.

Conclusion

In healthcare systems where interprofessional collaboration is not evident and where tensions continue between professional boundaries of responsibility there is a threat to the delivery of safe and effective care. In order to change what may be an historical legacy of hierarchical structures there first needs to be recognition of the situation; an intention to change the status quo and then purposeful strategies to support change towards interprofessional collaboration.

The CVF is a valuable tool to assess the predominant culture of an organisation as part of preparatory work prior to the implementation of change to increase the opportunity for success.

Limitations

The response rate to this process was lower than anticipated and the results may not be an indication of the overall assessment of the predominant culture.

Acknowledgements

There has been no financial assistance received for this work.

References

1. Greenhalgh T, Robert G, MacFarlane F, Bate P, Kyriakidou O. Diffusion of innovation in service organisations: Systematic review and recommendations. *The Milbank Quarterly* 2004; **82**(4): 581-629.
2. Weiner BJ. A theory of organizational readiness for change. *Implementation Science: IS* 2009; **4**: 67-.
3. Blackman D, O'Flynn J, Ugyel L. A Diagnostic Tool for Assessing Organisational Readiness for Complex Change. Australian and New Zealand Academy of Management. Hobart; 2013.
4. Dopson S, Fitzgerald L, Ferlie E. Understanding Change and Innovation in Healthcare Settings: Reconceptualizing the Active Role of Context. *Journal of Change Management* 2008; **8**(3): 213-31.
5. Igo T, Skitmore M. Diagnosing the organizational culture of an Australian engineering consultancy using the competing values framework. *Construction Innovation* 2006; **6**: 121-39.
6. Lakos A, Phipps S. Creating a culture of assessment: a catalyst for organizational change. *Libraries and the academy* 2004; **4**(3): 345-61.
7. Miller D. Building sustainable change capability. *Industrial and Commercial Training* 2004; **36**(1): 9-12.
8. Nazir N. Person-culture fit and employee committment in banks. *Vikalpa* 2005; **30**(3): 39-51.
9. Yong K, Pheng L. Organizational culture and TQM implementations in construction firms in Singapore. *Construction management and economics* 2008; **26**: 237-48.
10. Fawcett S, Brau J, Rhoads G, Whitlark D. Spirituality and organizational culture: cultivating the ABCs of an inspiring workplace. *International Journal of Public Administration* 2008; **31**: 420-38.
11. Hemmelgarn A, Glisson C, James L. Organizational culture and climate: Implications for services and interventions research. *Clinical Psychology: Science and Practice* 2006; **13**(1): 73-89.
12. Allen R, Kraft C. Discovering your hospital's unconscious. *Hospital Forum* 1983; (January/february): 11-7.
13. Allen R, Kraft C. Transformations that last: a cultural approach. Alexandria, Vancouver: Miles River Press; 1984.

14. Linnenluecke M, Russell S, Griffiths A. Subcultures and Sustainability Practices: the Impact on Understanding Corporate Sustainability. *Business Strategy and the Environment* 2007; **10**.
15. Rogers E. Diffusion of Innovations. 5th ed. New York: Free Press; 2003.
16. Armenakis A, Harris S. Crafting a Change Message to Create Transformational Readiness. . *Journal of Organizational Change Management, 15(2), 169-83* 2002; **15**(2): 169-83.
17. Paré G, Sicotte C, Poba-Nzaou P, Balouzakis G. Clinicians' perceptions of organizational readiness for change in the context of clinical information system projects: insights from two cross-sectional surveys. *Implementation Science* 2011; **6**(15): 1-14.
18. Cameron S, Quinn R. Diagnosing and Changing Organisational Culture: based on the Competing Values Framework. San Francisco: : Jossey-Bass; 2006.
19. Department of Health NSW. Towards Normal Birth. In: Primary & Community Partnerships Branch Department of Health NSW, editor. Sydney; 2009.
20. Centre for Epidemiology and Evidence. New South Wales Mothers and Babies 2010. In: Population and Public Health Division, editor. Sydney: NSW Ministry of Health; 2012.
21. Lee Y, Roberts C, Patterson J, et al. Unexplained variation in hospital caesarean section rates. *MJA* 2013; **199**: 348-53.
22. Women's Healthcare Australasia. Benchmarking Maternity Care Individual Report 2012/13. Canberra, Australia, 2014.
23. Simpson K, James D, Knox G. Nurse-physician communication during labour and birth: implications for patient safety. *Journal Obstetrics Gynaecology Neonatal Nursing* 2006; **35**: 547-56.
24. Downe S, Byrom S, Finlayson K, Fleming A, Edge E. East Lancashire Childbirth Choices Project: Choice, safety and collaboration. Lancashire, England.: University of Central Lancashire 2009.
25. Hastie C, Fahy K. Inter-professional collaboration in delivery suite: A qualitative study. *Women and Birth* 2011; **24**(2): 72-9.
26. Monari F, Di Mario S, Facchinetti F, Basevi V. Obstetricians' and midwives' attitudes toward cesarean section. *Birth* 2008; **35**(2): 129-35.
27. Australian Department of Health and Aging. Improving Maternity Services in Australia The Report of the Maternity Services Review. In: Australian Government Department of Health and Ageing, editor. Canberra: Commonwealth of Australia; 2009.
28. Kvarnstrom S. Difficulties in collaboration: A critical incident study of interprofessional healthcare teamwork. *Journal of Interprofessional Care* 2008; **22**(2): 191-203.

29. Raab CA, Will SEB, Richards SL, O'Mara E. The Effect of Collaboration on Obstetric Patient Safety in Three Academic Facilities. *JOGNN: Journal of Obstetric, Gynecologic & Neonatal Nursing* 2013; **42**(5): 606-16 11p.
30. Kear T, Ulrich B. The role of interprofessional collaboration in supporting a culture of safety. *Nephrology News & Issues* 2015; **29**(8): 21.
31. Wheelan S, Burchill C, Tilin F. The link between teamwork and patients' outcomes in intensive care units. *American Journal of Critical Care* 2003; **12**: 527-34.
32. Kennedy H, Lyndon A. Tensions and teamwork in nursing and midwifery relationships. *Journal Obstet Gynecol Neonatal Nurs* 2008; **37**(4): 426-35.
33. Corwin L, Corbin J, Mittelmark M. Producing Synergy in Collaborations: A Successful Hospital Innovation. *The Innovation Journal: The Public Sector Innovation Journal* 2012; **17**(1).
34. Reina M, Reina D, Rushton C. Trust: The Foundation for Team Collaboration and Healthy Work Environments. *AACN Advanced Critical Care* 2007; **18**(2): 103-8.
35. Rice K, Zwarenstein M, Conn L, Kenaszchuk C, Russells A, Reeves S. An intervention to improve interprofessional collaboration and communications: A comparative qualitative study. *Journal of Interprofessional Care,* 2010; **24**(4): 350–61.
36. Scott T, Mannion R, Davies H, Marshall M. The quantitative measurement of organizational culture in health care: a review of the available instruments. *Health Services Research* 2003; **38**(3): 923-45.
37. Helfrich C, Li1 Y, Mohr D, Meterko M, Sales A. Assessing an organizational culture instrument based on the Competing Values Framework: Exploratory and confirmatory factor analyses. *Implementation Science* 2007; **2**(13): 1-14.
38. ORC International. 2011 YourSay Workplace Survey. 2011.
39. Jones R, Jimmieson N, Griffiths A. The Impact of Organizational Culture and Reshaping Capabilities on Change Implementation Success: The Mediating Role of Readiness for Change. *Journal of Management Studies* 2005; **42**(2): 361-86.
40. West E, Barron DN, Dowsett J, Newton JN. Hierarchies and cliques in the social networks of health care professionals: implications for the design of dissemination strategies. *Social Science & Medicine* 1999; **48**(5): 633-46.
41. Veronesi J. Is your workforce engaged to be satisfied? *Home Health Care Management & Practice* 2009; **21**(2): 124-6.
42. Manley K. 'The way things are done around here'—Developing a culture of effectiveness: A pre-requisite to individual and team effectiveness in critical care. *Australian Critical Care* 2008; **21**(2): 83-5.
43. Benoit C, Zadoroznyj M. Medical dominance and neoliberalisation in maternal care provision: the evidence from Canada and Australia. . *Social Science & Medicine* 2010; **71**: 475-81.

44. Vernon L. A Brief Overview of How Male Medicine Co-Opted the Midwife's Role in the Birth Process *Open Journal of Nursing* 2015; **5**: 758-64.
45. Reiger K, Lane K. Working together: collaboration between midwives and doctors in public hospitals. *Australian Health Review* 2009; **33**(2): 315-24.
46. Foucault M. Power/knowledge: Selected interviews and other writings 1972–77. New York: Pantheon Books; 1980.
47. Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. . Cochrane Database of Systematic Reviews Wiley; 2016.
48. Tracy S, Hartz D, Tracy M, et al. Caseload midwifery care versus standard maternity care for women of any risk: M@NGO, a randomised controlled trial. *Lancet* 2013; **382** (9906): 1723-32 10p.
49. Lane K. The plasticity of professional boundaries: A case study of collaborative care in maternity services. *Health Sociology Review* 2006; **15**(4): 341-52.
50. Newnham E. GENERAL SECTION: Midwifery directions: The Australian maternity services review. *Health Sociology Review* 2010; **19**(2): 245-59.
51. Newnham E. Birth control: Power/knowledge in the politics of birth. *Health Sociology Review* 2014; **23**(3): 254-68.