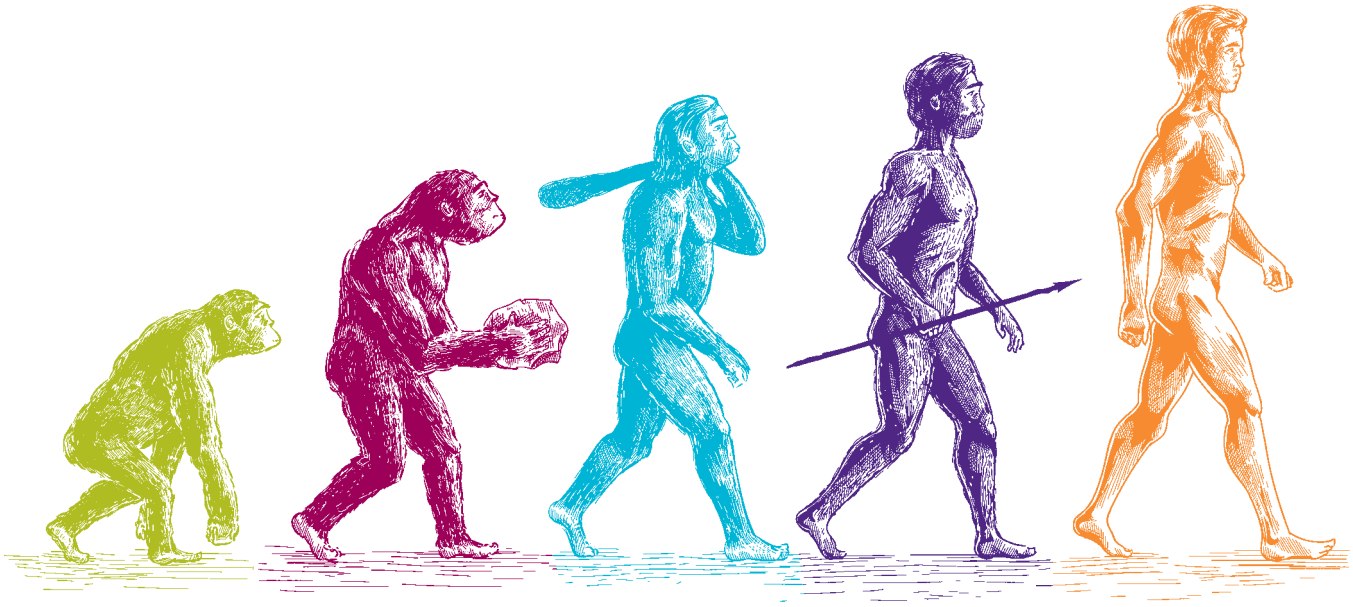
Chartered Institute of Internal Auditors



ORGANISATIONAL CULTURE

Evolving approaches to embedding and assurance

Foreword

Organisations are taking an interest in culture like never before; not because they are being forced to, but because they know a healthy culture is integral to their bottom lines, even their survival. Furthermore public and regulatory scrutiny of ethics and behaviour has become even more intense.

Organisations on the cutting edge of culture aren't just articulating a set of values; they are ensuring that those values are embedded at all levels of the organisation. They also know that the culture debate doesn't end with values. They are utilising a range of tools and techniques that aim to 'hard-wire' culture into underlying systems to help ensure the appropriate behaviours of their employees.

This paper was produced as the result of our involvement in the Financial Reporting Council's culture project, a market-led initiative which aims to gather insight into corporate culture and the role of boards; to understand how boards can shape, embed and assess culture; and to identify and promote good practice. The Institute has led the embedding and assurance workstream, looking at measuring and monitoring culture, the role of internal audit, risk management and public reporting of cultural indicators.

We are grateful to all those organisations that shared their experiences with us. We hope that this report will be useful to the FRC as it looks to help boards take action on culture and to the profession as a standalone piece on the future of culture assurance.

Dr Ian Peters MBE
Chief Executive
May 2016

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Executive summary

Boards and senior management have the prime responsibility for defining and analysing organisational culture by promoting the values and the behaviours they wish to see across their organisations.

Boards need assurance that a culture of learning from mistakes, rewarding the right behaviour and systems and processes that produce the desired behaviours are being embedded across their organisations. A statement of values is not sufficient on its own; boards need to know that 'espoused' values are the same as actual values on the ground. Providing assurance to boards around values on the ground, however, is just part of the picture as culture is not merely the articulation of an organisation's values.

The use of gut feel can play a part in the audit of culture but in the digital age, assurance providers can make much greater use of hard as well as soft indicators to reduce the subjectivity of their findings. Data from internal reporting systems can be aggregated and used to identify trends and reveal issues of which the board may be unaware. The emergence of 'big data' provides scope for internal auditors to develop specific skills and work with data analysts to provide insight.

Who owns culture in an organisation is an issue that boards and senior management need to resolve. It is unclear, otherwise, whom board committees charged with cultural issues should turn to for advice and guidance.

Internal audit is one of the assurance providers that boards and senior management have turned to with some success; but there is still a long way to go. The positioning and reach of internal audit and the ability to 'tell it how it is' are as important as the ability to audit cultural issues. Its role as the inside-outsider is the key to success when providing culture assurance. But audit committee members and senior executives must be open to the idea that, at present, there may be less hard evidence compared to more traditional audits and accept the likelihood of grey areas with differences of opinion. This may entail a change in culture and behaviour at the audit committee itself.

Done well, internal audit has a key part to play in assuring boards around culture. But this should not be confused with the idea that internal audit should be the board's sole assurance provider. This is because internal auditors need to have much more than the traditional skillset to succeed in this area. Furthermore, others have a role to play in embedding and assurance. It is critical for internal audit to have strong relationships with other functions across the organisation.

Scope and structure

This report has four sections:

- The bigger picture – culture and the need for assurance
- Approaches to embedding culture
- Providing assurance on culture – snapshots of existing practice
- Conclusions and recommendations

The approaches to providing assurance around culture are evolving and some promising examples of new approaches are beginning to emerge. But this is the beginning, rather than the end, of the process. Internal auditors, like all other functions involved in the management and governance of organisations, have much to learn if a step-change is to be achieved. For its part, the Institute is committed to supporting the collective effort.

Against this backdrop, there is much work to be done – for internal auditors, for audit committees and boards, for senior management teams, and others. In particular, we recommend:

- The board should articulate the expectations around values and behaviours and should seek assurance that staff at all levels are effectively 'living the values' that the board deem are conducive to a healthy organisational culture.
- The board and the head of internal audit (HIA) should review whether it is appropriate to incorporate into the audit plan the better use of available data and technology in relation to culture assurance, in addition to traditional surveys, interviews and observations.
- The board and the HIA should review the skill set of the internal audit function, and make provision for any deficiencies to be addressed, as required by the HIA and the audit plan. Where organisations have the resource to do so, this may involve including internal audit in a multidisciplinary team working on cultural issues.

- Boards should try to embed a 'just culture' which distinguishes between: simple mistakes/errors; risky behaviours; and recklessness. A 'just culture' promotes an atmosphere of trust but makes clear where the line must be drawn between acceptable and unacceptable behaviour.
- The audit committee should encourage the HIA to sit as an observer on various senior-level boards and committees and key project steering groups. This enables the HIA to glean insight into organisational behaviour and culture through being able to see and hear not only what is being discussed but also the way it is being discussed.
- HIAs and boards should agree to make space for a 'meta-audit' i.e. the chance for the HIA to stand back and think about what the experiences of all standard audit activity say about culture.
- Internal audit needs to be conscious of its own culture/behaviours and how it is perceived by the rest of the organisation. Internal audit should audit its own culture to help convince others in the organisation of the value of its involvement.
- HIAs should engage with those functions that are involved in the embedding, enforcing and assessing of culture to reduce the risk of gaps or duplication of work. The board and senior management should support this.

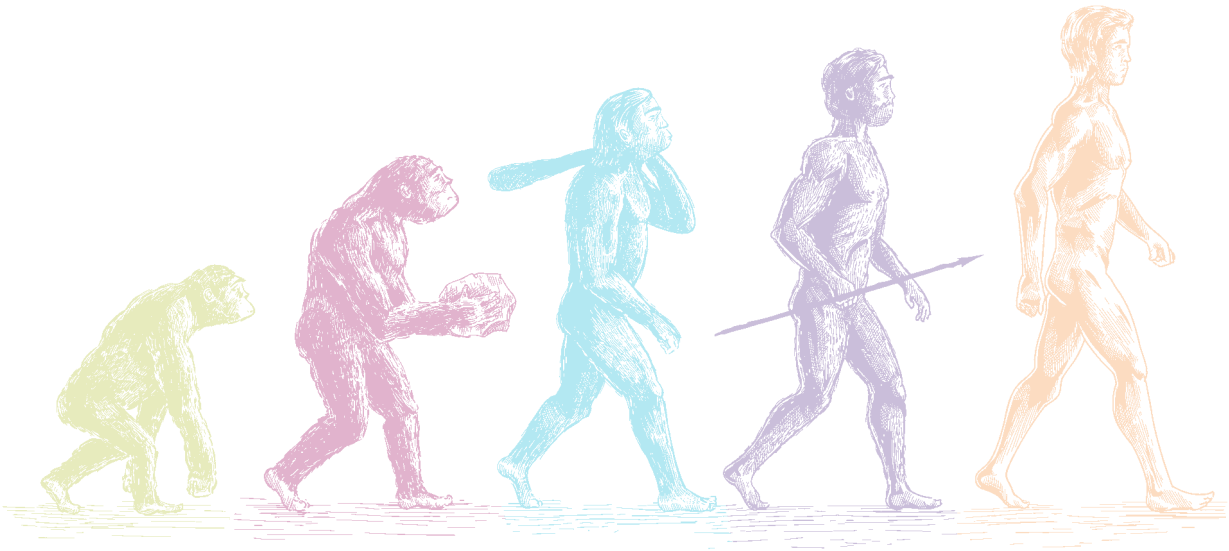
Methodology

The research which underpins this report was carried out in the context of the Financial Reporting Council's 'culture coalition' project, which sought to take a broad look at corporate culture in the UK and how it might be improved.

We conducted a survey[1] of HIAs from all sectors of the economy, to collect factual data on the extent to which the profession is involved in auditing culture; the methods it is using; who else it is working with; and how it is reporting on issues raised. The bar charts in this report are based on this survey (referred to in this report as the Institute's survey). (The full results are available on the Chartered IIA website).

During the period from November 2015 to March 2016, we held in-depth discussions and interviews with auditors, academics, regulators and safety directors from a range of sectors including aviation, insurance, banks and healthcare providers, to get deeper insights.

We also held roundtables with senior executives and audit committee chairs to obtain their perspectives; facilitated discussions with the Institute's group of FTSE 100 HIAs; and ran presentations and webinars to discuss the issues with members across the UK.



1 *Survey of 922 HIAs in all sectors conducted in November/December 2015.* We received 220 responses. Results available at https://www.iia.org.uk/culturereport

Section One: The bigger picture – culture and the need for assurance

When organisations fail, any subsequent review or post-mortem tends to attribute the failure to culture. Almost every major corporate scandal of the last century will, in part, be due to certain cultural weaknesses – either by having the wrong tone at the top, or by individuals not acting in accordance with the organisation's ethics and values. A harmful corporate culture can be detrimental to the long-term health of the company and its employees. Failures are very visible to customers, shareholders and the wider community and can seriously erode confidence and trust. Culture can be the difference between a business that lasts and one that crumples under pressure.

All observers have their own interpretation of what the term 'culture' means. It is commonly interpreted as "*the way we do things around here*"[2]. The term itself is off-putting for some as it is such a nebulous concept. An organisation's culture develops over time and is influenced by external factors and pressures as well as the ways that internal systems, processes and roles inter-relate (or do not). Problems can occur when that interaction between external drivers, aspects of the organisation's internal system (such as incentives) and individual behaviours become significantly misaligned. So perhaps the question to ask is what can be done to improve the control environment at the point of interaction between these elements? Further, assurance providers need to devise a way to generate respect for controls (and the management of risk) as a value so that they are not seen as something to be circumvented.

The point about the power of the interaction of the system, incentives and behaviours was brought to life by UBS's 'rogue trader', Kweku Adoboli, in an interview with the Financial Times[3] in which he said, "*There are bound to be similar failings while the chasm between profit demands of management and the rules of compliance remain*". He added that he believes that holding up those, such as himself, as 'rotten apples' in an otherwise clean industry is enabling the banks to move on without considering what happened to allow or even encourage their misconduct.

Values

A number of organisations use values as a shorthand for the overall culture they are looking for. That said, values do not tell the whole story about culture; and we must be careful to distinguish between 'espoused' values and actual values on the ground. Some corporate values statements and their development have been specifically engineered by boards. Other organisations have developed values, which are not necessarily stated, organically over time.

> **"It seems to me that the problem in 2008 was so systematic that putting people in jail was almost beside the point. We need to change the system. It isn't that you had a couple of bad guys. You had a whole system that was rotten; thousands and thousands of people behaving very badly because the system basically instructed them to do it."**
>
> *Quote from Michael Lewis, author and financial journalist*[4]

Simply adopting formal values statements makes no difference in itself. Values need to be translated, to be communicated, and to have an impact on behaviours, in order to be able to influence the way business is done.

The need to provide assurance around culture

Boards and senior management need to understand whether the culture they want for their organisation is actually the one that exists in practice. Many believe that 'what gets measured gets managed'. In a large number of organisations, the human resources function is charged with measuring the organisational culture (through surveys and other tools), while employees are responsible for the actions and behaviours that create the culture. Assurance providers primarily need to assure boards that the culture they have set is reflected in practice throughout the organisation. Assurance providers can also advise on the robustness of the control framework. Internal auditors can, indirectly, help to embed the culture

2 *Corporate Cultures: the Rites and Rituals of Corporate Life,* Deal and Kennedy, 1982
3 *Kweku Adoboli: a rogue trader's tale,* Financial Times, October 2015
4 *Why only Britain's bankers can save the world from another Big Short,* The Times, 23 January 2016

through the way they conduct audit activity; the advice and insight they provide to boards; and through the ways they flag up where the culture is not as expected. This way, the assurance provider can play a role in supporting (or 'carrying') positive cultural traits, or calling out traits that are not helpful. On the flipside, the internal audit function needs to ensure that its own culture does not negatively influence behaviours in the wider organisation.

There are a number of assurance providers who can provide such assurance to boards on culture. So far, we have found that much of this work tends to fall to internal audit (both in-house and outsourced) or external consultants. It is worth noting that who assesses culture in an organisation is an issue that needs resolving by boards and senior management teams. Lack of clarity on assessment can make it difficult for the audit committee, or other board committee charged with cultural issues, to decide who to turn to for support and advice.

The role of internal audit

Internal audit's role as the 'inside-outsider' – being inside the organisation but ostensibly independent and objective – is key to succeeding in the culture assurance sphere. Internal auditors' knowledge and expertise in the organisation's internal controls and its compliance programmes mean that over time, they can build a well-informed perspective on practices right across the organisation. No other function has a mandate to move across the organisation in the same way that internal audit does. Internal auditors know which departments experience recurring problems and ones that don't act on, or are sluggish to respond to, audit recommendations. This means that internal auditors are well placed to assess the organisation's culture, based on the practices and behaviours they observe. More information on organisational culture and controls can be found at Appendix B.

It is crucial for the audit committee and any other board committees which are tasked with responsibility for organisational culture to give internal audit a clear mandate, and to write that mandate formally into the audit charter for the organisation.

The Institute's Financial Services Code[5] recommends that internal audit should have the right to attend and observe all or part of Executive Committee meetings. A number of HIAs told us that they glean insight into organisational behaviour and culture not just through auditing per se, but also through sitting as an observer on various senior-level boards and committees and key project steering groups. This enables them to see and hear not only what is being discussed but also the way it is being discussed. For example, one is able to see for oneself whether or not it is just good news that is being shared upwards. Such behaviour can give clues as to the style and tone of management and therefore the culture of the organisation.

We should not underestimate the fact that any employee has insight into the culture of their organisation. It is not difficult to have an inkling if there are problems with the corporate culture. Internal auditors can get a sense of culture by being alert to everyday behaviours and keeping attuned to the way the place feels as they walk around the corridors. It is a more organic and informal, but no less valuable, way to keep an eye out for cultural issues. Although, as with any employee, auditors themselves are prone to certain biases. So a robust view from the auditor will rely on analysing a range of data as well as these 'corridor' observations.

The success of internal audit's role in culture will hinge on convincing others in the organisation of the value of its involvement. This perhaps speaks to the culture of internal audit itself. Ultimately, this value will rely on the quality and honesty of conversations internal audit is able to have with management. Internal audit, despite ostensibly being independent, is part of the culture/sub-cultures itself, so it needs to be aware of and try to overcome its own biases. The function also needs to demonstrate sufficient accountability, and to have effective mechanisms for communicating their concerns about culture to board members. Therein lie the real challenges.

[5] *Effective Internal Audit in the Financial Services Sector,* Chartered Institute of Internal Auditors, 2013

Section Two: Approaches to embedding culture

This section of the report considers different approaches to embedding culture focusing in particular on the aviation sector and explores more fully the concept of 'just culture'. We also move the debate forward through exploring the concept of 'technoculture', which aims to capture the way in which a specific notion of corporate culture becomes hard-wired into reporting and managerial systems.

In sectors such as aviation and the NHS, organisations are harnessing technology and revolutionising their use of big data. This in turn can be capitalised on by assurance providers and audit, who can leverage the data tools to provide more objective and robust insights about culture. Internal audit is already starting to tackle the role of data analytics in its work. It will however need to expand on this to apply such techniques to other data. Here we outline the broad aspects relating to assurance provision in aviation and the NHS. It is worth noting that the amount and complexity of the information that the NHS holds has taken time to turn into something that is useful for analysis. Sir Ian Kennedy, former head of the Care Quality Commission, commented back in 2001 that one hospital was awash with data from one source or another – what was lacking was information[6]. Appendix B provides more detail on embedding and assessing culture in the NHS.

Aviation and safety culture

For those who provide assurance around culture, there are lessons to be learned from industries where safety is a strategic business risk, such as oil/gas, aviation and nuclear. Safety issues, injuries, deaths and environmental disasters have provided the impetus to tackle culture head-on. These industries have developed sophisticated tools and techniques to understand the behavioural aspects of such risks, helping to safeguard employees and the public as well as their reputations.

A fundamental element of safety culture in the aviation industry is 'just culture'. Professor James Reason has studied in depth the question of human error and how organisations can be designed to take account of this, rather than assuming people will get everything right first time. He wanted to promote an organisational culture that accepts human weaknesses and fallibilities but that has processes, checks and balances to reduce the possibility of errors arising. Building on this, he also developed the notion of a 'just culture', which distinguished between:

- **Simple mistakes or errors** – where the system needed to look for this, and individuals should not be blamed for things going wrong;
- **Risky behaviours** – where the system needed to be improved but also where individuals should be coached and educated to be more careful;
- **Reckless behaviours** – where systems and processes were set up to encourage people to comply but they were deliberately over-riding these controls, in which case those individuals should be punished.

This 'just culture' that only punishes individuals for reckless actions is intended to promote an atmosphere of trust in which people are encouraged, even rewarded, for providing essential safety-related information, but in which they are also clear about where the line must be drawn between acceptable and unacceptable behaviour.

An effective reporting culture depends on, among other things, how the organisation handles blame and punishment. A 'no-blame' culture is neither feasible nor desirable. Most people desire some level of accountability when a mishap occurs, but they also want to ensure people are not scapegoated for things that were not their fault. In a just culture environment the culpability line is more clearly drawn. A 'just culture' is, therefore, not the same as a 'no-blame' culture.

That said, safety may be an easier object of managerial intervention than, say, risk culture. The reason is that it might be easier to identify what 'strong' safety culture is about and linking it directly to error reduction and improvements in performance. Note also that a fundamental aspect of the safety culture is the ability to carry out robust root cause analysis – the more a proper root cause analysis is done, the less likely a politically acceptable scapegoat is going to be found. In safety-critical industries such as aviation, errors can have life-or-death consequences, whereas in banking, for example, the downside of poor risk outcomes – such as losing the bank's or its customers' money – is not as clear-cut and emotive as people dying as a result of error.

6 *The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984–1995,* July 2001

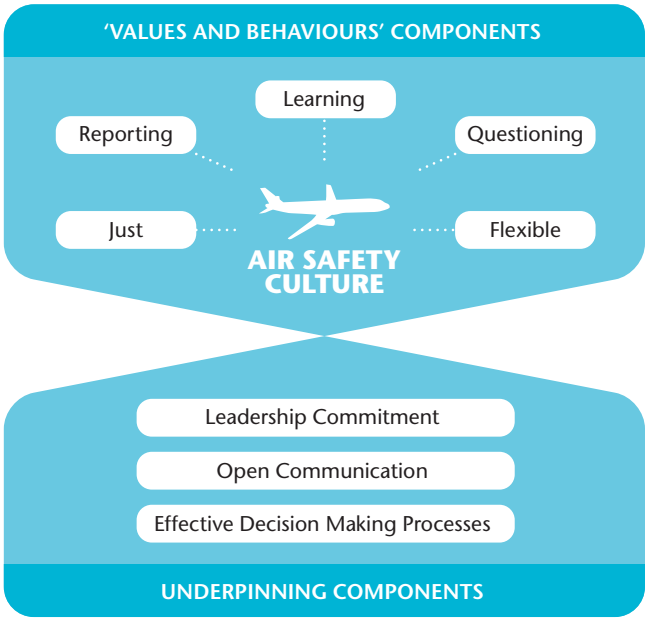
Airlines have access to enormous amounts of information (data generated by the systems in the cockpit) which they can analyse after each flight to detect events that deviate from the norm. One airline we spoke to said that in addition to the monitoring of data, there are flight monitoring liaison officers who encourage all ground and crew staff to report safety-related issues themselves. These officers are employees of the airline or are operational experts. The technical data may not give a complete picture as to how or why an event occurred so the officers elicit this kind of information from the crew and establish whether information relating to the event requires highlighting to other crews to help prevent a repeat of the incident. They also act as an interface with the crew to reinforce company procedures and where applicable impart knowledge. The aim is to improve safety and manage the performance of any individual around any issue of re-training in a confidential and non-punitive manner. This system works well as the crew members trust the officers. Trust is crucial to 'just culture', as it hinges on the assurance that if you report something in the common interest, it won't be frowned upon.

The Civil Aviation Authority (CAA), the UK's aviation industry regulator, commented that, as testament to the maturity of the airlines' internal reporting systems, the regulator receives relatively few 'whistleblows'. This is corroborated by the authors of a forthcoming book chapter[7] who quoted one of the airline senior safety managers as saying: "*If they get into the whistleblower line then they've gone too far; you don't need the whistle, we give them the whole orchestra to play with, the whistle's the last thing on our list*". This is in contrast to the financial services sector where, according to the Financial Times[8], there was a 28 per cent rise in whistleblowing reports to the regulator in the 2014-2015 financial year, with 1,340 tip-offs, compared with 1,040 the preceding year.

Assessing culture – The Military Aviation Authority

The Military Aviation Authority (MAA), the independent organisation responsible for regulating air safety across defence, developed its own model of an engaged safety culture which is made up of a number of components: 'just culture'; reporting culture; learning culture; questioning culture; and flexible culture. These are underpinned by leadership commitment, open communication and effective decision-making processes.

An engaged Air Safety Culture



Source: Military Aviation Authority

To complement this model, the MAA has usefully defined what 'good' looks like to aid the assessment of culture. The air safety culture framework[9] can be used to make the assessment. Assurance providers in any sector can adapt this framework to their own organisations to assess culture. This can be found at appendix A.

7 *'Technoculture: Risk reporting and analysis at a large airline'*, T.Palermo. In M.Power (Ed.) *Riskwork: Essays on the Organizational Life of Risk Management.* Oxford University Press, forthcoming, 2016

8 *FCA publishes new rules on whistleblowing,* Financial Times, 6 October 2015

9 *Manual of air safety,* Military Aviation Authority, 2015

Other sectors e.g. banks could adapt safety culture tools and techniques replacing safety with, for example, customer service or another core value. This was demonstrated in a recent blog by PwC[10]:

The story of culture change at global steel manufacturer Alcoa and the implications for banking culture

The basis of culture change in any sector is to pick a critical few routines that influence organisational health, identify the cue, standardise the required response and reward it. The CEO, Paul O'Neill, at Alcoa (global steel manufacturer) focused all efforts on one routine: reducing days lost through injury. O'Neill's focus on safety culture had two consequences: Alcoa went from 1.86% lost work days (already well better than average) to 0.1%. Profits grew from $264m to $1.4bn (with a 10x rise in market cap).

At Alcoa, focusing on days lost to injury drove improvement in all the cultural dimensions that banks would also want to fix: MDs had to supervise line managers more closely, line managers had to communicate with their teams, team members saw that suggestions for improving operational conduct were embraced not ignored, investment went to initiatives that improved overall outcomes, those who ran the 'machine' too hot were identified and sanctioned while those who shared lessons with peers in other teams were the heroes.

The blog's author suggested that in banks you need to set a goal, such as product suitability (although this goal would be different for different areas of the bank); aim for zero errors (the cue); handle any breach with appropriate learning and remediation (the response); and reward those whose lessons learnt from the error help the bank (reward). In other words, identifying and reporting dozens of measures may be a hindrance when it comes to culture change. On the other hand, just focusing on one or a few key routines to 'fix' culture can drive performance improvement and have a knock-on effect on all cultural dimensions.

Source: A quick fix on banking culture, Mark Dawson, PriceWaterhouseCoopers, February 2016

Implementing a 'just culture'

Implementation of a 'just culture' is far from straightforward and hinges on ensuring that front-line staff won't be punished as a result of making honest mistakes or reporting safety hazards or high-risk occurrences – and that staff believe this to be true. Yet as Matthew Syed, author of Black Box Thinking, pointed out[11], and this gets to the heart of the matter on culture: "*In business, politics, aviation and healthcare, people often make mistakes for subtle situational reasons. Increasing punishment in this context, doesn't reduce mistakes, it reduces openness. It drives the mistakes underground. The more unfair the culture, the greater the punishment for honest mistakes and the faster the rush to judgement, the deeper this information is buried. This means that lessons are not learned, so the same mistakes are made again and again*".

'Just culture' needs both the employer and the employee to co-operate. It is incumbent on employees to report near-misses and safety-related incidents; but employers need to facilitate the reporting mechanism and structure. Organisations need to have clear reporting processes and organisation-wide communication, and to provide all staff with effective training initiatives.

We heard from the CAA that implementing a just culture requires sustained effort. Employees need to understand that if they make a mistake they won't be punished and, furthermore, it is valuable to the company and possibly others in the industry to learn from that mistake. Staff need to feel safe but also to see what they are reporting is not going unheard otherwise they will question why they bother. Individuals can be encouraged to be open and honest about their mistakes but they need to be completely assured that it is safe to do so. Staff perception is critical – they also need to know that what they have reported has made a difference.

10 *A quick fix on banking culture,* Mark Dawson, PriceWaterhouseCoopers, February 2016
11 *Black Box Thinking,* Matthew Syed, 2015

Applying 'just culture' to other industries and sectors

Going wrong is a part of life — and of work, whichever sector you are in. One can think that the 'just culture' concept is only applicable to safety industries but it goes wider than that. Mistakes happen even in the best-run organisations. Traders take foolish risks. Bankers make questionable deals. Doctors make mistakes – an incision may be made in the wrong place. 'Just culture' could be relevant to every industry, as it is about learning from mistakes rather than those mistakes being hidden. The key thing is what happens when things go wrong, and how to learn from mistakes.

All industries could benefit from the underlying concepts of 'just culture', namely:

- The need to differentiate between wilful or reckless misdemeanours and well-intentioned mistakes.
- The importance of applauding messengers. When the messenger is shot, learning stops.
- Asking what went wrong, rather than who is to blame.

'Just culture' and an open reporting culture are inextricably linked, in that an effective reporting culture is underpinned by the way that blame is handled in the organisation. In aviation, the concept of just culture is central to ensuring that safety is paramount. 'Just culture' is one where employees feel free to speak up if something goes wrong. More information on organisational failure, blame and 'just culture' can be found at Appendix B.

Technology and culture

As previously mentioned, a 'just culture' and a reporting culture are closely linked. A forthcoming book chapter by academics at the London School of Economics (LSE)[12], explores the relationship between control technologies and organisational culture and how their interrelationship influences the flow of information between front-line staff functions and senior managers at an airline. The paper develops the concept of 'technoculture', which aims to capture the way in which specific aspects of a desirable corporate culture become hard-wired into reporting and managerial systems. The airline spent a long time and committed significant organisational resources to develop and make operational this idea of 'just culture', including its hard-wiring in a range of reporting and monitoring technologies.

The chapter focuses on:

- When and how do (and can) people feel free to 'speak up' and report risks?
- What technologies and culture enable risk reporting and analysis?

An example of hard-wiring 'just culture' into reporting and monitoring technologies is flight monitoring, where pilots' performance is monitored in real time. If there is a safety-related event, the pilot would usually file a report to investigators, which would trigger a risk analysis of the system data. Even if the pilot does not file a report, the flight monitoring system would enable the investigators to pick the issue up, as the data enables the reconstruction of all the actions taken by the pilot.

The relationship between culture and the outlined control technologies shows us how organisational culture does not need to be separate from technology; in fact the use of technology in such ways can helpfully lead to an improvement in culture. So the concept of 'technoculture' leads us away from seeing technology and culture as opposing concepts, and prompts us to start exploring where the two become entwined.

The point here is that the 'just culture' concept becomes enhanced through the use of data and technology. It relies on two elements rather than just one: employee encouragement and technological leverage. So 'just culture' is based on a system of hard and soft controls, i.e. the combination of monitoring technologies with management attention to safety issues and facilitation of a safe environment for people to speak up if there are problems. In other words, as the LSE report authors say, "'*Just culture' does not float around in a set of principles or corporate values, but gets hard-wired into control technologies*". The systems and subsequent risk reporting do not allow anywhere to hide, and the 'belt and braces' approach means that problems staff members report are likely to be picked up by the technology anyway. In a subtle way, the technology helps them to be honest.

The concept of 'technoculture', has positive potential for assurance provision in all sectors. We think that assurance providers can harness this level of risk reporting, which makes much better use of hard controls – formal rules and activities that are common place, are tangible and reinforce the usual elements of desired culture such as codes of conduct/ethics – to provide more robust assurance and reduce the subjectivity of their findings.

[12] '*Technoculture: Risk reporting and analysis at a large airline*', T.Palermo. In M.Power (Ed.) R*iskwork: Essays on the Organizational Life of Risk Management*. Oxford University Press, forthcoming, 2016

Section Three: Providing assurance on culture – snapshots of existing practice

In this section we describe internal audit's current practices in providing assurance around culture and behaviours, both through the function's position in the organisation and through incorporating cultural aspects into its routine audits. We outlined a number of challenges in our earlier report[13] on culture and the role of internal audit relating to values assessment; methods; skills; and reporting.

We are now seeing clear, if primarily anecdotal, evidence that the profession is starting to address these challenges but there is still some way to go. So boards need to be aware of the limitations of current assurance provision.

The insightful internal auditor

In order to audit culture and behaviours, internal audit must become more insightful by developing a deep understanding of the organisation and the environment in which it operates. IIA Global's new Mission Statement for the internal audit profession now includes the need to provide *insight*. This requirement aligns closely with auditing culture in that in order to develop an audit methodology that is insightful, auditors need to understand the prevailing culture within the organisation.

To help facilitate the delivery of insight perhaps some time and space needs to be made in audit plans for some kind of 'meta-audit' whereby auditors include observations about culture and behaviour in each audit, and stand back and think about what the experience of all their specific audits says about culture. In this way, auditors can explore the kinds of assurance narratives that they are comfortable with themselves and would share with boards. Over time, more discipline and metrics could be developed for this exercise: but the first thing needed is to create the space in audit plans for a 'meta-audit', and for audit committees to agree to it, agree on the form it should take, and approve it.

Insight and internal audit

Developing insight comes with experience. Developing the following habits and characteristics are key to both becoming more insightful as well as being able to assess organisational culture effectively:

Find parallels –relate what you see and hear during an audit and compare these to similar situations. For example, reflect on what is good and bad in the organisation's approach to customer complaints compared to others you have experienced (benchmarking). Insights can also be gained from more remote parallels such as the way Great Ormond Street Children's Hospital learnt how to transfer sick children more safely to intensive care from Formula 1 motor sport.

Ask more questions – this will help to gain a full appreciation of how and why things are done in a particular way. Ask plain (content free) questions that encourage people to share their view of the world and do not impose your perspective on them. It is also very important to listen to other people, really listen – remember the origin of the word auditor comes from the Latin for 'listener'. To delve more deeply into specific issues apply a simple method that you feel comfortable with and one that works.

Don't take things for granted – discussing how procedures work and talking about the risks and issues that arise with different people is a good way to obtain a diverse set of viewpoints but don't accept everything on face value. Focus audit testing to substantiate what is actually happening, particularly around the management of key risks or where there are differences of opinion about what is happening and why. Build evidence as well as the results of interviews and discussions to support audit recommendations.

Identify trends and, connections – use audit software and reporting tools that enable statistical analysis to reveal issues people may not be aware of. Traditionally this has been used to identify gaps or duplications in records but the existence of huge quantities of data and powerful analytical tools now makes it possible to mine data and assess the results from different angles and perspectives to establish new relationships, patterns and correlations. This is a very technical field but the emergence of 'big data' provides scope for internal auditors to develop specific skills and/or work with IT experts to provide insight.

Change the way you get the message across – look critically at audit reports to ensure both the structure and language helps to get the key messages and opinions across. Are reports short, clear and to the point? Consider what you want the readers to know that they are perhaps not aware of, what this means and what needs to be done to mitigate the risks.

Source: Chartered Institute of Internal Auditors, 2015

13 *Culture and the role of internal audit – looking below the surface*, Chartered Institute of Internal Auditors, 2014

Values assurance

Internal audit's role in auditing culture is to provide independent advice and assurance to the board that the culture and values it has set are (i) appropriate given the organisational risk context and (ii) being lived throughout the organisation. Obtaining a realistic view of the cultural situations on the frontline is a seemingly intractable problem to overcome for boards in all sectors. This is because the information that boards receive tends to be filtered; or simplified to a point where 'red flags' and nuances are removed, or buried deep in the reporting packs.

In the Institute's survey, 60% of HIAs reported that their boards have established and articulated the culture they want – which means, of course, that two out of five have not. However, even if boards have not formally set the culture they want, they do need awareness of the culture and sub-cultures 'on the ground'. So how can boards be made aware of what the cultural situation is at all levels of the organisation?

Where organisations do have values statements, the key question for internal audit is how to gather evidence and demonstrate that the values are being lived at every level throughout the organisation. Providing assurance around values, however, is by no means straightforward. According to the Institute's survey, only a minority of HIAs (20% across non-financial services organisations and 42% financial services) have been asked to assess the extent to which the company's values are manifested in the behaviour of all staff in the organisation. This is clearly a potentially serious gap. So if the audit committee chair feels that the HIA and their team have the skills to undertake the task, he/she should make sure that values assessment is incorporated into the audit plan. This is likely to be an area where internal audit would benefit from working in a multidisciplinary team in order to properly assess how well values are embedded throughout the organisation.

In relation to the banking sector, the G30 report[14] on banking conduct and culture said that focusing on values and conduct are the building blocks of culture and the 'what to aspire to' is largely in place in banks, through the bold statements that they have made about the way that they intend to behave going forward. The report pointed out, however, that failing in implementation and embedding these values remains a serious issue for the banks.

GlaxoSmithKline (GSK) carries out a values assurance programme across all operations internationally. A multidisciplinary team spends four to five weeks on site, interviewing employees at different levels in the organisation, which enables the company to see where leaders communicate the values and how people are demonstrating them in the way they work. The case study is available on the Institute's website[15].

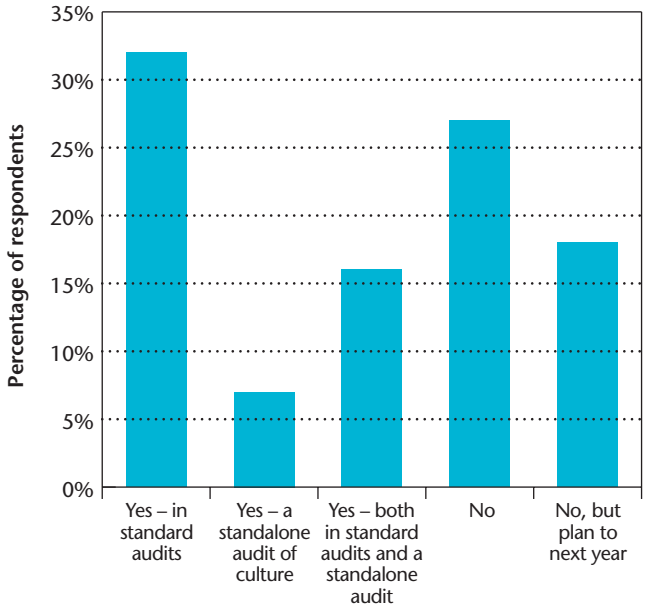
[14] *Banking conduct and culture, a call for sustained and comprehensive reform*, G30, July 2015. The G30 is a private, nonprofit, international body composed of very senior representatives of the private and public sectors and academia. It aims to deepen understanding of international economic and financial issues.

[15] The case study is available on our website at https://www.iia.org.uk/culturereport

Culture assurance – methods

Many auditors feel that there is more mileage to be had in looking at the cultural aspects in their standard audits than in separating out culture itself. The chart shows that about one-third of respondents to the Institute's survey incorporate cultural matters into their standard audits, whereas conducting standalone audits of culture was much less prevalent. This echoes the Institute's finding from its 2014 report on auditing culture. Across all sectors, around a quarter of organisations say that they do not audit culture. As expected, given the prominence of poor culture and behaviour as an issue in banks before, during and since the global financial crisis, the equivalent figure for the financial services sector is much lower, at only 10%.

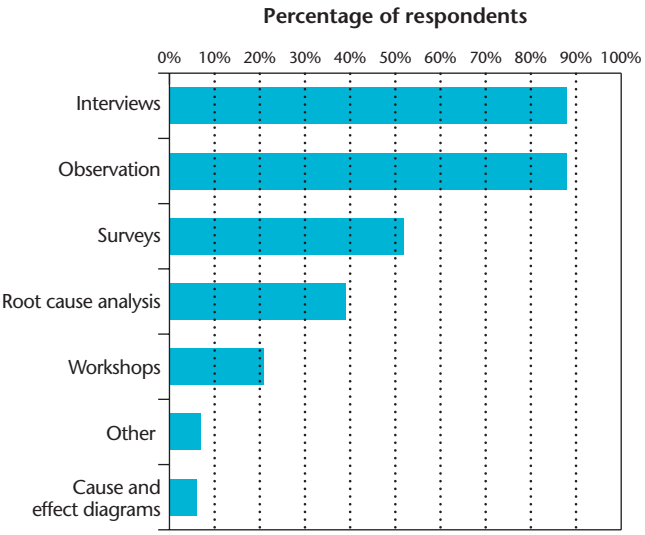
Does your audit plan include any aspect of culture either in your standard audits or as a standalone audit of culture?



The Institute's survey revealed that staff surveys, whistleblowing activity and governance structures are the most common proxies HIAs use to audit culture. Other proxies include HR grievance data and exit interviews; management of customer complaints; values statements and their incorporation into recruitment and performance management; and pay, reward and incentive structures. Supplier feedback can also be a useful gauge of culture as highlighted by the Groceries Code Adjudicator's investigation into Tesco[16].

The chart below shows the range of methods used to audit culture from the Institute's survey. The most popular methods by far were interviews; and observation – nearly 9 in 10 auditors use each of these methods. Other methods include: focus groups; reputational analysis; and capturing reviews and lessons from near misses. As the Institute has pointed out previously[17], surveys need to be used with caution as they only provide indirect observations of behaviour at best. Furthermore, both surveys and interviews may be skewed if employees do not feel able to speak openly and honestly.

What methods do you use to audit behaviours and culture? (tick all that apply)



One HIA told us that she was making much greater use of observation and work shadowing to assess whether what she and her team see and hear aligns with the policies and processes. She commented that there was some resistance from management to begin with regarding these techniques. Managers became more accepting once they could see the value of such methods, but there was a bedding-in period.

16 *Groceries Code Adjudicator – Investigation into Tesco plc,* January 2016
17 *Culture and the role of internal audit,* Chartered Institute of Internal Auditors, 2014

Root cause analysis

Root cause analysis (RCA) was cited by 39% of the Institute's survey respondents as a method to better understand the culture of the organisation. RCA is an important way to get underneath the skin of the behavioural/cultural issues. This is about looking at not just what has happened in terms of compliance with expectations, but why things happened. Often this approach uncovers organisational and process factors that may have contributed to an issue, for example, how targets and incentives are set and communicated, and how appraisals are conducted.

Leeds Building Society conducted a standalone audit of culture using a mixture of the methods outlined above. The case study is available on the Institute's website[18].

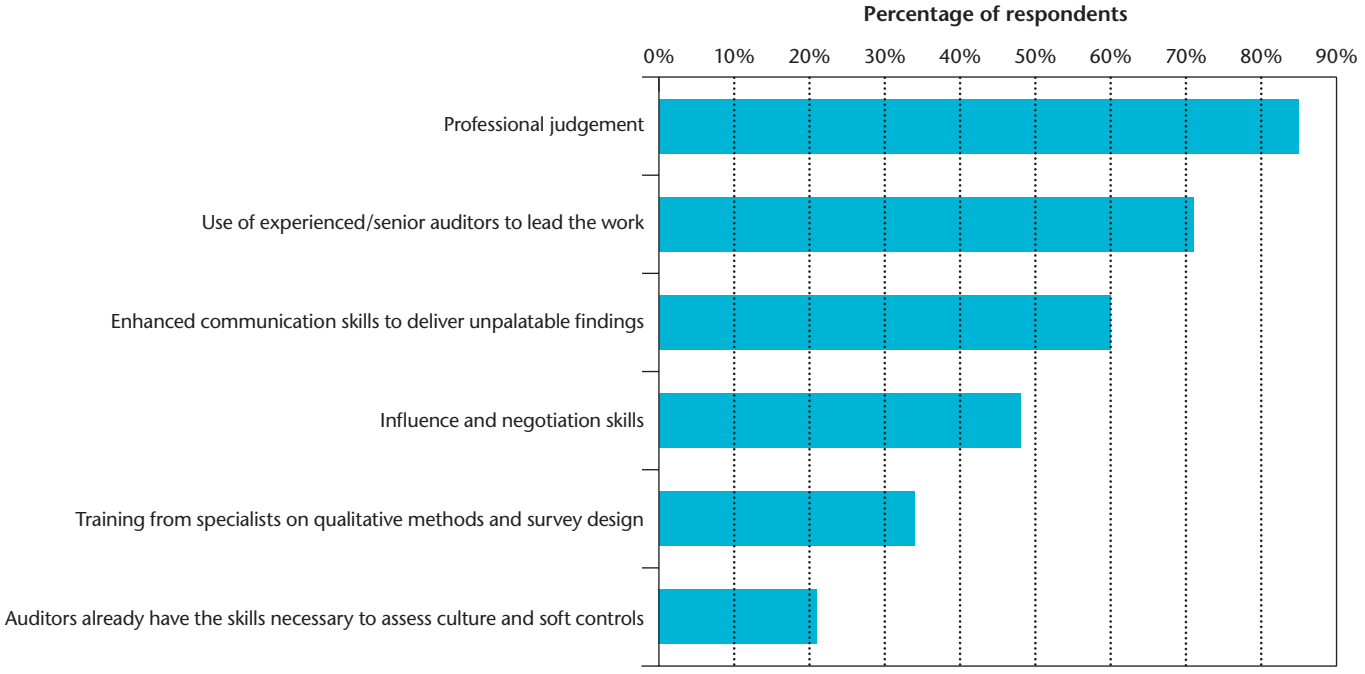
Skills and training

Internal auditors need to have the competencies, credibility and confidence to engage in meaningful discussion of behaviour, culture and 'soft controls'. 'Soft controls' are difficult to describe as they are not tangible. There is no strict definition of the term although; The Auditor's Dictionary (David O'Regan, John Wiley & Sons, 2004) defines a soft control as, "an internal control based on intangible factors like honesty and ethical standards". Those outside the profession have, understandably, questioned whether internal auditors have the right mindset, emotional intelligence and skills to work in this sphere. This remains a key challenge for the profession.

The chart shows that the Institute's survey respondents felt that professional judgement and experience were the top requirements in terms of skills and competencies they needed to audit culture. This echoes the wider discussions we had, where most HIAs told us that assigning experienced senior auditors who understand the organisation and have sound working relationships in place with managers is key to succeeding in this sphere.

We can see why some think that the traditional skillset of internal auditors does not equip them well to provide assurance on organisational culture and behaviours. For example, while they can perceive the results of behaviour, they are not behavioural experts and may not fully understand 'defensive routines', which may lead to encouragement of audit's work because it is coming up with politically acceptable answers, but ones that miss the 'elephant in the room'. As outlined earlier in the section on methods, they need to make much more use of interviews, behavioural observations, data analysis (including management information) and other means. Internal audit teams' skills are necessary but, in the main, not sufficient as yet. Building the skills and capability in audit teams will be essential to making progress in this sphere.

What skills and competencies does internal audit need to audit culture and in particular soft controls? (tick all that apply)



[18] The case study is available on our website at https://www.iia.org.uk/culturereport

Multidisciplinary teams

Given that internal audit teams may not have the complete skillset, some are proponents of the use of multidisciplinary teams. In our survey, just under half of the HIAs we asked said that bringing a multidisciplinary team together, including, for example, organisational psychologists, ethnographers, sociologists and staff from operations, would enhance the quality of participation in and the acceptance of audit findings. Over a third of respondents were, however, undecided. This makes sense, given that auditing culture is still relatively new ground but multidisciplinary working is probably what auditors will have to embrace if they want to have greater success in auditing culture and behaviours. Such an approach may not be the cultural norm for internal audit, but it is likely to be required to provide real insight and independence. It is important for internal audit, audit committees and boards to be aware of this issue.

Reporting methods: the objective and the subjective

In relation to reporting, the challenge is conveying results based on the combination of hard data and gut feel. Results can be reported verbally to managers or more formally within internal audit reports as cultural issues. The gut feel issues tend to be reported verbally. While perceptions are valuable, they may not necessarily be accurate, and there is a risk that internal audit will give management a sense of misplaced security or could even be wrong. Moreover, if internal audit's opinion is not sufficiently validated then internal audit may end up simply trading opinions with those to whom they are reporting. Therefore, the need to obtain audit evidence around soft control issues is critical.

Comments concerning 'tone at the top', the organisation's ethical climate, and management's philosophy and operating style must be approached with care and rigour to reduce the subjective dimension. Audit committee members and senior executives, however, must be open to the idea that this is an area that will not have the same hard evidence to underpin conclusions, compared to more traditional areas: and they must accept the likelihood that there will be grey areas with differences of opinion.

Scoring and opinion

Providing assurance opinions or the use of scoring does not seem to be prevalent when reporting on culture and risk culture. We heard from a number of HIAs that when using methods such as observation they do not give an assurance opinion or specific recommendations but just use narrative and assert that they are observations. Indeed the use of scoring as per traditional audits was not seen as beneficial in the area of culture and 68% of the survey respondents said that they either don't use scoring or use a different way of scoring.

An HIA from the health sector told us that in terms of reporting you need to be cautious what you put down in writing but if you describe what is going on in as much detail as possible then there is enough for you to present at audit committee. Some reporting is bound to be quite narrative in nature. It is more thoughtful and discursive. Sometimes this does extend to giving opinions based on informed views but not necessarily so. Rather than focusing on red-amber-green (RAG) ratings or scores, one needs to give clear messages that get the point across with enough factual evidence to back up what you are saying.

Scorecards and dashboards

One HIA from the insurance sector uses a risk culture framework, based on the Financial Stability Board (FSB) framework on supervising financial institutions on risk culture (see appendix B for more detail about culture/risk culture; and the FSB framework), to assess indicators of a sound risk culture. They incorporate this assessment into every audit they do. The HIA and her team use a mix of observation and interviews to build a scorecard of culture for each department using a traffic light system. She said that in terms of reporting, the audit opinion stays as it would have done without the risk culture framework. What is different is that they would call it out if the function was operating in a too risky way or if there was a 'sea of red' in the scorecard. This causes management to be less defensive or likely to argue the findings.

She pointed out, however, that the framework also has its drawbacks in that it is a 'point in time' assessment, so the observations may have been different at different times. It might be worth revisiting at other points in the year to get a more accurate picture. No survey or model can adequately capture the true culture of an organisation, given that there are sub-cultures and ad-hoc behaviours. Such a framework can be the start of a process, and an ongoing dialogue between internal audit and the audit committee, rather than providing a definitive view.

Another reporting method that auditors use is a dashboard of culture indicators to present to the audit committee or a committee that is charged with culture in its remit. Dashboards can be helpful in that they provide the relevant information all in one place and enable longitudinal tracking but some senior executives highlighted to us that they need to be used with caution as they may end up just providing a veneer on culture.

Assessing culture in the NHS

We have heard about one safety-critical sector – aviation – going from unacceptably low levels of safety in the 1960s and '70s to such high, measurable levels that safety is now taken for granted by the public. Another sector – the NHS – has been dogged by safety-related crises over the same time period, yet system-wide learning does not seem to have improved over time. Furthermore, the NHS operates under intense financial pressure which can be exacerbated by cultural issues. This was most recently highlighted by an independent report[19] which identified the need for a big overhaul in culture and working practices e.g. staff were 60 per cent more likely to be absent because of sickness at the worst Trust compared with the best.

The regulators in the health sector – Care Quality Commission (CQC), Monitor, and the Trust Development Authority – all make assessments of whether organisations within their remit are well-led. In their model, the characteristics of a well-led organisation are: delivery of sustainable high quality person-centred care; support for learning and innovation; and promotion of an open and fair culture.

In that context, they recommend that NHS Boards should ask themselves the following[20]:

- Is there alignment from the board to the ward on the vision and goals of the organisation?
- Do staff understand the values and behaviours that reflect the culture of the organisation?
- Have we undertaken an assessment of the culture within the organisation and acted on the results?

Such questions are clearly applicable to boards in all sectors.

19 *Operational productivity and performance in English NHS acute hospitals: unwarranted variations, An independent report for the Department of Health,* Lord Carter of Coles, 2016

20 *Exploring CQC's well-led domain – how can boards ensure a positive organisational culture?* The King's Fund, 2014

Mersey Internal Audit Agency – follow-up case study on auditing culture

In the Institute's previous report on auditing culture[21], we highlighted the evolving role of internal audit in the NHS in relation to assessing culture, which is strongly influenced by the regulatory environment. We outlined the work being done by the Mersey Internal Audit Agency (MIAA) – a major provider of internal audit and consultancy services to over 50 NHS organisations. We followed up with them, to find out how their work on culture has progressed in the last couple of years.

The key findings were as follows:

- MIAA are continuing to build on much of the work outlined in the previous case study. There is an even greater expectation from the audit committee that they should be doing this work. This attitude has culminated from a number of 'watershed' moments over the decades in the NHS. The terms of reference of NHS audit committees mean that their remits and roles are very broad. All the methods internal audit use are accepted by management because they see the added value.
- MIAA still conduct the Disconnect Survey, which assesses the differing perceptions of safety and quality at both Board and Ward level. The questions are based on the five areas which are now part of the CQC fundamental standards and include statements such as:
    1. In my organisation, I feel my voice is listened to.
    2. I am happy to raise any concerns I have with safety or quality with my organisation.
    3. If staff are busy, we sometimes have to cut corners.
    4. I feel that my organisation is well led.
- Internal audit carries out 'Quality Spot Check' work. Organisations can choose a variety of metrics which internal audit test and observe. These could include infection prevention and control; medicines management and/or controlled drugs; and recording of safety thermometer data.
    - As part of this work, they observe the staff and patients when arriving on the ward. Similar to the 'First 15 Steps'[22], this gives the auditor a flavour of the ward culture. When this is reported, they would mention if they were made to feel welcome; if staff made eye contact; if they introduced themselves; how busy the ward seemed, and if it was busy, how the staff seemed to be coping; whether the patients seemed happy; and the patients' impressions of the ward. They have been to organisations where different wards have quite a different 'feel' and, in some cases, this has been clearly attributable to different leadership styles.
- The challenge for auditors is to observe behaviour and triangulate what they see and hear with available data. In the NHS context, they might see patients being cared for, but if the answer to the question '*What happened last time staff raised a concern about patient care?*' is '*Nothing*', then that would be of concern. Such contradictory signals between observations and data should prompt auditors to delve more deeply into the true culture.

21 *Culture and the role of internal audit,* Chartered Institute of Internal Auditors, 2014

22 The 15 Steps Challenge is a series of toolkits which help look at care in a variety of settings through the eyes of patients and service users based on their first impressions, to help capture what good quality care looks, sounds and feels like.

Section Four: Conclusions and recommendations

Our research shows that internal auditors in different sectors are beginning to get to grips with the challenge of assessing culture and behaviours in their organisations; and are developing some promising approaches to tackling the complexities and ambiguities that this represents. It is plain, however, that there is still some way to go in order to provide robust assurance, advice and insight to boards on organisational culture.

Approaches to organisational culture have evolved and the evidence shows that organisations are now utilising new tools and techniques to embed good behaviours into systems of governance. Organisations at the forefront of embedding and providing assurance are doing much more than simply releasing a statement of values into the ether. Simple values statements, whilst useful, are just part of the picture. Organisations on the cutting edge of developing appropriate culture are ensuring that values are embedded at all levels.

Organisations that embody the new approach to culture are shifting the focus to rewarding the right behaviours. Safety-critical industries such as aviation have tackled issues relating to speaking up and blame and are using new techniques to develop, monitor and, most importantly, embed good behaviours. They emphasise learning and rewarding rather than apportioning blame.

Obtaining reliable information about soft controls is a challenge and internal auditors find it harder to meet that challenge in quite the same way as with hard controls because a degree of subjectivity is involved. Although gut feel is still relevant, hard-wiring culture into reporting and managerial systems to help remove some of that subjectivity will have significant implications for assurance in this area. New technology has allowed organisations to manipulate and analyse large quantities of customer and client data like never before. Internal auditors can leverage powerful data tools to provide more objective and robust insights about culture and thus provide boards with assurance that internal audit's opinion on culture is being supported by hard data.

Against this backdrop, there is much work to be done – for internal auditors, for audit committees and boards, for senior management teams, and others. In particular, we recommend:

- The board should articulate the expectations around values and behaviours and should seek assurance that staff at all levels are effectively 'living the values' that the board deem are conducive to a healthy organisational culture.
- The board and the head of internal audit (HIA) should review whether it is appropriate to incorporate into the audit plan the better use of available data and technology in relation to culture assurance, in addition to traditional surveys, interviews and observations.
- The board and the HIA should review the skill set of the internal audit function, and make provision for any deficiencies to be addressed, as required by the HIA and the audit plan. Where organisations have the resource to do so, this may involve including internal audit in a multidisciplinary team working on cultural issues.
- Boards should try to embed a 'just culture' which distinguishes between: simple mistakes/errors; risky behaviours; and recklessness. A 'just culture' promotes an atmosphere of trust but makes clear where the line must be drawn between acceptable and unacceptable behaviour.
- The audit committee should encourage the HIA to sit as an observer on various senior-level boards and committees and key project steering groups. This enables the HIA to glean insight into organisational behaviour and culture through being able to see and hear not only what is being discussed but also the way it is being discussed.
- HIAs and boards should agree to make space for a 'meta-audit' i.e. the chance for the HIA to stand back and think about what the experiences of all standard audit activity say about culture.
- Internal audit needs to be conscious of its own culture/behaviours and how it is perceived by the rest of the organisation. Internal audit should audit its own culture to help convince others in the organisation of the value of its involvement.
- HIAs should engage with those functions that are involved in the embedding, enforcing and assessing of culture to reduce the risk of gaps or duplication of work. The board and senior management should support this.

Appendix A
Military Aviation Authority – Air safety culture framework

COMPONENT	THEMES/INDICATORS
Values and Behaviours	
Just Culture	
Goal: *An atmosphere of trust where people are encouraged, and even rewarded, for providing safety related information and where it is clear to everyone what is acceptable and unacceptable behaviour.*	The distinction between acceptable/unacceptable behaviour (The 'line in the sand') is appropriately defined and communicated.
	Unsafe behaviour is dealt with appropriately.
	Safe behaviour is rewarded appropriately.
	Human error is treated consistently and in line with policy.
	The perception throughout the organisation is that human errors and unsafe acts are dealt with fairly and consistently.
	Investigations are carried out using a formal process and by appropriately trained personnel.
	There are sufficient numbers of trained (and current) investigators.
	There is a willingness to admit that people make errors.
	Investigations cut across all levels of the organisation.
Reporting Culture	
Goal: *An organisational climate where people readily report problems, errors and near misses.*	There is a functioning and effective Air Safety Reporting System.
	There is a functioning and effective '4-worlds' Error Management System.
	There is appropriate awareness of the Air Safety reporting and Error Management systems at all levels.
	There is effective management of Air Safety related reports.
	The number of reports is commensurate with the size/type of the organisation.
	The 'age' of reports is appropriate for the organisation.
	The Air Safety/Error Management reporting system is fully inclusive and available to everyone who needs access (access to contractors etc).
	Sufficient people are trained on the Air Safety/Error Management reporting system and new arrivals are trained/briefed in an appropriate timeframe.

COMPONENT	THEMES/INDICATORS
Reporting Culture (continued)	
Goal: *An organisational climate where people readily report problems, errors and near misses.*	There is willingness to report Air Safety occurrences/ near misses/errors.
	There is a positive attitude within the organisation, at all levels, towards Air Safety/Error Management reporting.
	There is confidence, at all levels, in the Air Safety/Error Management reporting system.
	The value of reporting is understood.
	There are no unjust negative consequences towards those who have submitted reports.
	There is no perception that there will be unjust negative consequences for those who have submitted reports.
	Those submitting reports are given appropriate and timely feedback.
Learning Culture	
Goal: *Organisational willingness and competence to draw the right conclusions from its safety information and to take appropriate actions based upon those conclusions.*	Reported occurrences are dealt with appropriately.
	Follow up actions are monitored at an appropriate level.
	Follow up actions are timely/robust/effective.
	Follow up actions are tracked through to completion.
	Lessons identified are appropriately disseminated.
	There is evidence of trend analysis (undertaken and effective?).
	There is an appetite within the organisation for learning from experience (from both good and bad experiences).
Questioning Culture	
Goal: *A culture where people are engaged and ready to ask "what if?" and "why?" questions that provide the antidote to assumptions and reduce the possibility of incubated mistakes.*	The organisation works proactively to attempt to prevent occurrences before they happen.
	There is a positive attitude towards the identification of new risks.
	Challenging of processes and assumptions is encouraged.
	The danger of 'organisational norms' is understood and managed.

COMPONENT	THEMES/INDICATORS
Flexible Culture	
Goal: *An organisation that can adapt to changing circumstances and demands while maintaining its focus on safety.*	There is a clear appetite for and evidence of Continual Improvement within Air Safety. Organisation change programmes are appropriately scrutinised for Air Safety implications.

Underpinning Elements

Leadership Commitment	
Goal: *An organisation where leadership commitment to Air Safety exists without question.*	There are clearly defined leadership/management responsibilities for Air Safety. There is clearly demonstrable leadership/management commitment towards Air Safety. There is an appropriate understanding of Air Safety risks within levels of management. Air Safety is sufficiently resourced (Established, manned, trained).
Open Communication	
Goal: *An environment where Air Safety issues are openly and effectively communicated throughout the organisation.*	Management is 'connected' to workforce on Air Safety related issues. Management is understanding of the workforce's view of Air Safety. Individuals understand their particular role in Air Safety. Workforce feels that Air Safety concerns are taken seriously by management. Workforce has inclusive and appropriate involvement in Air Safety related meetings? Air Safety related communication is effective throughout all levels of the organisation.
Effective Decision Making	
Goal: *An environment where the consideration of any impact on Air Safety is clearly embedded within any decision-making process.*	Air Safety plays a fundamental role in day to day decision making. Air Safety has an appropriate priority against output. Any evidence of a 'can do' attitude is appropriate and risk based.

Appendix B

This appendix provides more detailed information on some specific aspects of organisational culture touched on in the main report:

- Risk culture
- Culture and the control environment
- Organisational failure, blame and 'just culture'
- Sectoral approaches – The NHS and financial services

Culture and risk culture

Risk culture is a term describing the values, beliefs, knowledge and understanding about risk shared by a group of people with a common purpose, in particular the employees of an organisation or of teams or groups within an organisation[23]. Organisations in all sectors need to take risks to achieve their objectives. The prevailing risk culture within an organisation will significantly affect its ability to manage these risks. An effective risk culture is underpinned by enabling and rewarding individuals and groups for taking well-informed risks. An inappropriate risk culture will lead to activities that are totally misaligned with stated policies and procedures or operate completely outside these policies. At best this will hamper the achievement of strategic, tactical and operational goals. At worst it will lead to serious reputational and financial damage.

It is difficult to separate out organisational culture and risk culture and just focus on one or the other. Organisational culture both determines and is influenced by risk culture. There has been much debate in the assurance world about the distinction between the two and perhaps, although not the final word on the matter, the risk culture framework developed by the Institute of Risk Management presents a neat depiction of the relationship. The framework attempts to distil the complex and interrelated set of relationships that influence risk culture. Risk culture is the sum of multiple interactions between these levels. At the lowest level, each individual's personal predisposition to risk contributes to their ethical stance, how they behave and make decisions. Group behaviours and the underlying organisational culture also influence risk culture.

IRM's Risk Culture Framework

Culture and the control environment

Models of culture – hard and soft controls

There are many models that look at the components of organisational culture. None can definitively capture the culture of an organisation, nor be a predictor of specific behaviours. Most models make a distinction between what many people describe as hard and soft controls. 'Hard controls' are familiar as they refer to formal rules and activities that are common place, are tangible and reinforce the desired culture.

The COSO framework for Internal Control refers to the 'Control Environment' which incorporates both hard and soft controls. Senior leaders should sponsor activities and initiatives that define, drive and monitor culture. They should seek to improve the control environment this area. 'Hard controls' are the bread and butter of internal audit's remit; procedure, policy, and processes. 'Soft controls' are harder to define, but concern accompanying culture, behaviours, unwritten rules and attitudes. It is considering both types controls together that auditors can start to get a good picture of the culture. Key (hard) culture controls include:

- The objectives that are set and how they are communicated throughout the business.
- The success or failure of employees to complete relevant training.
- Data management and analytics.
- Timeliness of reporting of information.

[23] *Under the Microscope – Guidance for Boards,* Institute of Risk Management, 2012

For example, late reporting of a control failure or hostility to a critical internal audit report doesn't say anything explicitly about ethics, but it does indicate a state of mind where things that cause discomfort are likely to be swept under the carpet.

'Soft controls' are more difficult to describe as they are less tangible than 'hard controls'. They can be best explained by giving some examples of 'soft controls':

- **Competence** – being adaptable and a willingness to learn.
- **Trust and openness** – teamwork, helping and relying on one another to solve problems.
- **Strong leadership** – direction and leading by example.
- **High expectations** – striving to improve, to raise the bar.
- **Shared values** – doing the right thing in the right way.
- **High ethical standards** – honesty, equality and fairness.

Providing assurance

While some boards are turning to internal audit or external consultants to audit culture, external audit can also play a role although it is early days and the profession is still considering the extent to which it should be involved. Henry Irving, head of ICAEW's Audit and Assurance Faculty, questions whether culture could explicitly be covered by statutory audit. "*You would have to have a public statement in place to say what companies report on their culture first,*" he says. "*The management reporting would have to use robust, neutral and measurable criteria to be measured against, and these would need to be consistently applied. It would be difficult to audit these robust criteria without having a tick-box culture.*" Instead he prefers the approach already being used by some companies in which audit firms undertake private engagements to give some kind of assurance to management over culture[24]. In the future, there is, perhaps, the potential for internal audit and external audit to collaborate in this area as they do in relation to assurance around financial and non-financial controls, but our survey shows that only 6% collaborate on culture at present. Some external auditors we spoke to felt that as companies move towards integrated reporting that culture would be at the heart of that. Furthermore, the challenges around skills apply to external auditors as much as they do internal auditors.

The role of internal audit

There are still questions over where exactly internal audit fits in in relation to culture. While internal audit clearly has a role, some argue that the assessment of culture should be performed by management – specifically by the Human Resources function. Internal audit might add more value if it worked with that function and helped them not only assess culture periodically but also advise on building detective controls to identify potential problems on a real-time basis.

Norman Marks' blog – Assessing the Organisation's Culture, August 2015:

- All internal auditors should be aware and alert to any indicators of inappropriate behaviour of any kind: from ethical lapses, to excessive risk-taking, to disregard for compliance, to poor teamwork, to ineffective supervision and management, to bias or discrimination, to – you name it.
- Internal auditors should not be afraid of bringing these issues to the attention of management and Human Resources so they can take action.
- The CAE (HIA) and the CEO should discuss the organisation's culture and its condition with the board (or committee of the board) on a regular basis. My preference is for the CEO to take the lead, with additional information provided by the CAE on internal audit's related activities and opinion.

So, organisational culture is an important area for internal audit to incorporate into its work. If the appropriate checks and balances are put in place, and there are cultural issues bubbling up in an organisation, then there are ways to identify and address these before they become a major front page story or the subject of a negative social media campaign.

Effective work in relation to culture should help to correct internal control failings before they go awry. Internal audit can play both a key advisory role, and assurance role as part and parcel of their role in evaluating the risk and control environment with access right across the organisation.

24 *Auditing Corporate Culture,* Economia, May 2015

Internal audit can play an important role in prompting and widening organisational discussions about the cultural aspects that may be impacting performance and risk. Internal audit's role is to understand/advise/assure how the other lines of defence are or should be measuring and managing cultural issues. As a result internal audit should be engaging with senior leaders with regard to questions of awareness, ownership and oversight of corporate culture and how and when independent and objective assurance can be provided.

> **"Internal audit, acting as the eyes and ears of the board but independent of management, is in a unique position to judge and advise whether the tone from the top is being adhered to across an organisation. Through internal audit, a board can satisfy itself not only that the tone at the top represents the right values and ethics but more importantly, that this is being reflected in actions and decisions throughout the organisation."**

Dr Ian Peters, Chief Executive CIIA, quoted in *Checking Culture: A new role for internal audit, Institute of Business Ethics,* July 2015

The Institute's survey revealed that the two departments that internal audit works with the most on culture are risk management and HR. The survey findings were not borne out by our discussion in that we were not able to find much evidence of how, indeed if, internal audit works with other functions in this area. A number of functions across organisations have a contribution to make around the assessment of culture so internal audit will need to embrace working with other functions in order to be more effective in this area. One HIA at one of the major banks we spoke to said that a board reputation committee had recently been formed to review, on behalf of the Board, management's recommendations on conduct and reputational risk. HR, risk, internal audit, conduct and compliance were going to submit a joint report to the committee which was likely also to go to the full board. This will help the committee develop a dashboard to monitor progress on culture and values and facilitate debate and challenge between the board and the executive.

Organisational failure, blame and 'just culture'

To start to get to the nub of culture we need to unpick what causes organisations to fail. Harvard Business School's Professor Amy Edmonson[25] highlighted that learning from organisational failure is far from straightforward. This is because the blame game gets in the way. Furthermore, the human tendency to hope for the best and try to avoid failure is exacerbated by organisational hierarchy. Professor Edmonson asked executives how many of the failures in their organisations are truly blameworthy and they estimated 2%-5%. Then when asked how many are treated as blameworthy, they say 70%-90%. This results in failures not being reported and lessons are lost.

> **"...Think about what happens in most lines of professional work when a major failure occurs. To begin with, we rarely investigate our failures. Not in medicine, not in teaching, not in the legal profession, not in the financial world, not in virtually any other kind of work where the mistakes do not turn up on cable news. A single type of error can affect thousands, but because it usually only touches one person at a time, we tend not to search as hard for explanations."**

The Checklist Manifesto, Atul Gawande, 2009

Despite the particular characteristics and complexities of different industries, there is much of value in relation to organisational culture that can be gleaned each others' experience about the nature of both failure and learning.

25 *Strategies for learning from failure, Professor Amy Edmonson,* Harvard Business Review, April 2011

Professor Edmonson went on to say that serious failures can be averted, in theory, through the use of good risk management but small process failures are inevitable. Considering these as blameworthy is counterproductive and the focus should be identifying and correcting small failures. For example, most accidents in hospitals result from a series of small failures which unfortunately line up in the wrong way (the "Swiss cheese" model of failure described below). When things go wrong, organisations should develop a clear understanding of "what happened" not "who did it". To fix failures and learn from them requires consistently reporting small and large failures and systematically analysing them for the real root causes.

James Reason, Professor of Psychology at the University of Manchester, has encapsulated this thinking in the "Swiss cheese" model (1990) which purports that accidents happen when a connected series of factors occurs in unpredictable ways, like the holes in a block of cheese lining up. He formulated this model to develop a theory of how accidents happen in large organisations. Human error may sometimes be the factor that immediately precedes a serious failure, but there are usually deeper, systemic factors at work which if addressed would have helped to prevent or mitigate the consequences of the error.

James Reason's underlying thesis is that human beings are fallible and will always make operational mistakes, so it is the responsibility of managers to ensure that those mistakes are anticipated, planned for and learned from. Without seeking to do away altogether with the notion of culpability, he shifted the emphasis from the flaws of individuals to flaws in the system/organisation, from the person to the environment, and from blame to learning.

Sectoral approaches – the NHS and financial services

The NHS

> **"Organisational culture is central to every stage of the learning process – from ensuring that incidents are identified and reported through to embedding the necessary changes deeply into practice. There is evidence that 'safety cultures', where open reporting and balanced analysis are encouraged in principle and by example, can have a positive and quantifiable impact on the performance of organisations. 'Blame cultures' on the other hand can encourage people to cover up errors for fear of retribution and act against the identification of the true causes of failure, because they focus heavily on individual actions and largely ignore the role of underlying systems."**

An organisation with a memory, A report by a group chaired by the Chief Medical Officer for England, 2000

Many NHS Public Inquiries, going back as far as the first modern Inquiry in 1969[26], produce similar findings about the causes or reasons for failure, even when they are focused on quite different clinical areas[27]. Five common themes are:

- Inadequate leadership, lacking vision and unwilling to tackle known problems
- Organisational or geographic isolation which inhibits the transfer of innovation and inhibits peer review and constructive critical exchange
- System and process failure – in which organisational systems and processes are either not present at all or not working properly
- Poor communication both within the NHS organisation and between it and patients or clients, which means that problems are not picked up
- Disempowerment of staff and patients/clients which means that those who might have raised concerns were discouraged or prevented from doing so.

Mike Bell from Reputability LLP[28] argues that there are two principal factors involved in aviation's success, which are yet to be developed in the NHS:

- There is an independent regulator, with a clearly defined role, staffed and led by experts (with actual experience in the industry and technical competence), accountable to parliament, and funded by those it regulates; and
- There is a culture of openness, with timely and honest reporting of all untoward occurrences whether or not they cause harm and widespread dissemination of the lessons to be learnt.

He says that, in contrast, health regulators have not been free from political influence, and that the views of its own experts have been ignored or suppressed. He goes on to say that the NHS needs a regulatory framework and a culture whose aims are to promote NHS-wide learning from mistakes. It needs to get rid of the current pattern of cover-up and fear that prevents system-wide learning. As we outline below there are signs that this is beginning to change.

Technological innovation in healthcare

Being able to audit in a big data world, as we saw in aviation, is critical to providing assurance to boards. We are also seeing evidence of the NHS starting to innovate in its use of big data. One hospital's use of data and indicators provides a rich seam for assurance providers to mine. This can them help provide more robust assurance to boards around cultural issues.

A Guardian article[29] highlighted how one Scottish hospital is leading the way in technological innovation and using data transparency to drive up standards. This has parallels with the use of big data and data monitoring systems in aviation.

In the wards of Clydebank's Golden Jubilee hospital, there are screens on the wall displaying data. The screens are the public presence of a unique digital framework – which collates more than 300 measures of quality of care, from complaints to compassion. The data is interactive, predictive, accessible by every staff member, from ward to board level, on desktops and as an app.

The dashboard includes patient experience indicators include death rates and complaints but also indicators of compassion of staff towards patients. Golden Jubilee was the first hospital to use the new values dashboards based on the caring behaviours assurance system. Here, patients are asked to pick key words on a tablet screen to describe how they were greeted when they first arrived, or how scared they felt on the way to their operation.

Every ward has its own local indicators as well as those national targets that need to be measured across the hospital. Nursing staff have weekly audits to analyse the results. The framework is actually lighter on bureaucracy and paperwork because staff designed it and trust it.

The transparency of the data and indicators also helps to promote a sort of peer pressure to improve. The technology has been utterly transformative, explains the hospital's chief executive, Jill Young. "The product we have now is interactive but also predictive and analytical. Staff can see trends coming through, and it gives you that healthy competition because it's in public for all to see. Ward managers will ask each other: how do you manage to get 98% in that competency?"

26 *Report of the Committee of Inquiry into allegations of ill-treatment of patients and other irregularities at the Ely Hospital,* Cardiff, March 1969
27 *Inquiries: learning from failure in the NHS* – Kieran Walshe, 2003
28 *Reputability blog, NHS culture: lessons from flight safety,* July 2013
29 *Sharing is caring – how one hospital is leading the way on transparency,* The Guardian, January 2016

Financial services and risk culture

The Financial Stability Board (FSB) guidance on supervising financial institutions on risk culture recommends supervising the following elements:

- **Tone from the top:** The board and senior management are the starting point for setting the financial institution's core values and expectations for the risk culture of the institution, and their behaviour must reflect the values being espoused. A key value that should be espoused is the expectation that staff act with integrity (doing the right thing) and promptly escalate observed non-compliance within or outside the organisation (no surprises approach). The leadership of the institution promotes, monitors, and assesses the risk culture of the financial institution; considers the impact of culture on safety and soundness; and makes changes where necessary.
- **Accountability:** Relevant employees at all levels understand the core values of the institution and its approach to risk, are capable of performing their prescribed roles, and are aware that they are held accountable for their actions in relation to the institution's risk-taking behaviour. Staff acceptance of risk-related goals and related values is essential.
- **Effective communication and challenge:** A sound risk culture promotes an environment of open communication and effective challenge in which decision-making processes encourage a range of views; allow for testing of current practices; stimulate a positive, critical attitude among employees; and promote an environment of open and constructive engagement.
- **Incentives:** Performance and talent management encourage and reinforce maintenance of the financial institution's desired risk management behaviour. Financial and non-financial incentives support the core values and risk culture at all levels of the institution.

Source: Financial Stability Board Guidance on Supervisory Interaction with Financial Institutions on Risk Culture – A Framework for Assessing Risk Culture. April 2014

It can be argued that these four elements are as equally relevant to risk culture as they are to culture and can be applied to all organisations of any size including private companies, public bodies, government departments and not-for-profits.

Michael Lewis, author and financial journalist, argues that in the financial services sector the key question to ask is what has been done to fix the incentives? He asserts that while there has been some change in compensation practices since the financial crisis, not enough has been done to attack the incentive problem. In other words, without changing the incentives you can't expect to have changed the behaviour. He goes further to say that institutions making big bets should be partnerships rather than public companies as shareholders are very bad at monitoring the risks whereas partnerships are incentivised with a view for the long-term as they lose everything if things go wrong. These criticisms have also been asserted by Andrew Haldane, chief economist and executive director monetary analysis at the Bank of England, who said, "Challenges to the shareholder-centric company model are rising, both from within and outside the corporate sector. These criticisms have deep micro-economic roots and thick macro-economic branches. Some incremental change is occurring to trim these branches. But it may be time for a more fundamental re-rooting of company law if we are to tackle these problems at source. The stakes – for companies, the economy and wider society – could scarcely be higher"[30].

[30] *Who owns a company?,* speech by Andrew Haldane, Bank Of England, May 2015

About the Chartered Institute of Internal Auditors

First established in 1948, the Chartered Institute of Internal Auditors (IIA) obtained its Royal Charter in 2010. It is the only professional body dedicated exclusively to training, supporting and representing internal auditors in the UK and Ireland. It has over 9,000 members in all sectors of the economy including private companies, government departments, utilities, voluntary sector organisations, local authorities and public service organisations such as the National Health Service.

Over 2,000 members of the institute are Chartered Internal Auditors and have earned the designation CMIIA. Over 800 of our members hold the position of head of internal audit and the majority of FTSE 100 companies are represented amongst the institute's membership.

Members of the Chartered Institute of Internal Auditors are part of a global network of over 180,000 members in 170 countries. All members across the globe work to the same International Standards and Code of Ethics.

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