Changing leadership, management and culture in mental health trusts

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DOI:
10.1108/MHRJ-03-2022-0018

Document Version
Peer reviewed version

Citation for published version (Harvard):
Konteh, F, Mannion, R & Jacobs, R 2022, 'Changing leadership, management and culture in mental health trusts', *Mental Health Review Journal*. https://doi.org/10.1108/MHRJ-03-2022-0018

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Abstract

Purpose

To explore how leadership, management practices and organisational cultures have changed in low and high performing mental health providers between 2015 and 2020 in the English National Health Service (NHS).

Design/methodology/approach

We used a qualitative case study design comprising a purposeful sample of two low performing and two high performing mental health providers, based on ~~. The main form of data collection was~~ semi-structured interviews with 60 key informants (mostly internal to the organisation with some external informants from local Clinical Commissioning Groups).

Findings

We found major differences regarding leadership, management and organisational culture between low and high performing mental health providers in 2015/2016, and that the differences had diminished considerably by 2019/20. In 2015/16, low performing providers were characterised by a 'top-down' style of leadership, centralised decision-making, and 'blame cultures'. In contrast, the high performing providers were characterised as having more distributed, collaborative and inclusive styles of leadership/management, with open and supportive cultures. As the low performing providers changed and adapted their styles of leadership and management and organisational culture over the five-year period, they more closely resembled those of the high performing trusts.

Originality/value

This is the first study to explore the relationship between changing organisational factors ~~(leadership, culture, management practices)~~ and the performance of mental health care providers. It provides evidence that it is possible for radical changes in leadership, management and organisational culture to be enacted over a relatively short period of time and that such changes may help low performing providers to turnaround their underperformance.

Key words: mental health providers, leadership, culture, management, performance,

Introduction

The growing focus on performance in healthcare and the need for improved health service delivery against the backdrop of tight budgetary constraints has led provider organisations to search for new and more innovative and efficient ways of managing resources and delivering ~~-~~services (Som, 2009; Health Foundation, 2015; Meehan *et al.*, 2017). The international literature highlights the critical role of effective leadership and management practices in leveraging improved organisational performance in healthcare organisations (Taylor *et al.*, 2015; Bloom *et al.* 2014; Mannion *et al.* 2017; Sfantou *et al.*, 2017; Fulop and Ramsay, 2019; De Brún *et al*, 2019; Asaria *et al.* 2021). There is also growing empirical evidence to suggest that specific cultural attributes can drive improvements in the quality of care (Jacobs *et al.* 2013; Mannion *et al.* 2005; Kumar and Khiljee, 2015; Fulop and Ramsay 2019; Vindrola-Padros *et al.* 2020).

Healthcare providers are complex and dynamic organisations, and a range of external factors and internal drivers combine to influence provider performance (Helmig *et al.* 2014; Fulop and Ramsay, 2019; Al-Sawai, 2013; Boyne *et al.* 2010). While providers may have limited control over external factors, their performance is largely a function of how well the organisation is led and managed as well as its underlying culture (Fulop and Ramsay, 2019). Empirical research has demonstrated that high performing health care providers share ~~a number of~~several common characteristics. These include effective leadership and management and a supportive organisational culture where senior staff act on staff concerns about quality and promote desirable change. Other common organisational factors associated with high performing providers include involving staff in strategy and decision-making and collaborating with partner organisations ~~in order to~~to learn from and share best practice (Vindrola-Pedros *et al.* 2020; Fullop and Ramsay, 2019). Indeed, Taylor *et al.* 2015 (p 7) in their review of the literature distil seven key attributes associated with high performance in healthcare organisations, namely "a positive organisational culture, senior management support, effective performance monitoring, building and maintaining a proficient workforce, [having] effective leaders across the organisation, expertise-driven practice, and interdisciplinary teamwork". Empirical studies have also highlighted the complex and dynamic inter-relationships between organisational culture and performance in healthcare organisations (for example, Mannion *et al.* 2005; 2010; Fulop and Ramsay, 2019; Goldman and Casey 2010; Jacobs *et al.* 2013). A range of virtuous cultural attributes have been linked to high performance in healthcare organisations. For example, a strong feeling of belonging, trust and cohesion, being 'outward looking', a focus on quality and patient safety, and promoting values which embrace change in working practices. Conversely, underperforming organisations have been found to exhibit cultural values which are more inward looking, a general unwillingness of senior managers to listen to and act on concerns raised by staff and being averse to adapting to changing

roles and responsibilities (Braithwaite *et al.* 2017; Vaughn *et al.* 2019). The inextricable linkage between organisational culture and leadership has long been established. As Schein (2010 p 4) suggests, "the creation and management of culture" are "uniquely associated with leadership". While it has been difficult for empirical research to disentangle the degree of influence that leadership versus organisational culture has on quality and performance (Braithwaite *et al.*, 2017), both appear to have an important influence on the performance of health care providers.

Although there is now a burgeoning evidence base documenting the factors which influence the performance of healthcare providers, there has been a dearth of studies exploring the organisational drivers of performance in mental health (MH) providers. For example, Asaria and others (2022) surveyed 129 acute NHS hospital trusts (none from mental health hospital trusts) and found an association between higher-quality management and better organisational performance. Where research has focused on mental health, this has tended to have less robust research designs. ~~it was likely to be limited in scope, dimensions explored, range of informants, and/or method used.~~ For example, a study exploring ~~which explored~~ the discrepancy between actual and desired organisational culture in public mental health hospitals in Cyprus used quantitative data derived from a survey of ~~from~~nursing staff only ~~only~~ (Prodromou and Papageorgiou, 2022). ~~, without exploring the dimensions of leadership and management practices.~~ To the best of our knowledge, this is the first study to explore the relationship between a range of changing organisational factors (leadership, culture, management practices) and the performance of mental health care providers.

Methods

We used a multiple qualitative case study design~~,~~ to explore the interplay between organisational factors and performance in ~~mental health (~~MH~~)~~ trusts (providers) in England. As part of a larger study, we constructed a composite performance indicator for each provider in England using administrative and patient survey data (paper being submitted to *SSM*, information redacted). Estimates from a discrete choice experiment eliciting the UK general population's preferences were used as a valuation for the relative weighting of mental healthcare quality attributes (Rowen *et al*, forthcoming). Quality attributes were expressed in a single metric in terms of Quality Adjusted Life Years (QALYs) to allow summation into a composite measure of quality. MH~~ental health~~ provider costs were also estimated in QALY terms. We quantified the relative performance of providers as composite quality minus cost (expressed as QALYs). We then compared providers in terms of the composite performance indicator and ranked them. We ~~also~~ checked our performance rankings against the rankings ~~produced~~ by the Care Quality Commission (CQC) – the UK hospital sector regulator ~~– (the Care Quality Commission~~

~~(CQC))~~ to ensure consistency. CQC rates NHS providers based on five criteria/dimensions, namely safe, caring, effective, responsive, and well led, providing an overall rating as 'inadequate', 'requires improvement', 'good', or 'outstanding'. The CQC periodically assesses specific services and/or the trust as a whole and provides a rating for each of the above dimensions as well as an overall rating.

From the rankings we produced, we purposefully selected four providers: two of which were categorised as high performing and two low performing. We ensured that the two trusts in each category were similar in terms of local population characteristics, rurality, size, and levels of local competition. This enables us to attribute any differences in performance largely to internal organisational factors (leadership, culture, management practices) rather than external factors over which trusts have limited control. We have labelled the two lower performing trusts as A and B, and the ~~two~~ higher performing trusts, as C and D for the purpose of anonymity.

Trust A is a Foundation trust ~~which is~~ based in a mostly rural setting in the East Midlands in England, serves a population of more than 700,000 and employs approximately 2400 staff. ~~The trust~~It covers more than 30 (mostly small) localities, including one city, operates from almost 60 ~~-~~locations and provides the full range of mental health services and support for people with learning disabilities. In its first inspection in 2015, the CQC rated Trust A overall as 'requires improvement', with the 'well led' being among the criteria recording the same rating.

Trust B is a Foundation trust in the South-west of England and serves mostly rural settlements with a population of more than 500,000. It covers 40 settlements, including two small cities, several towns and few villages, and operates from more than 20 locations. The trust provides a full range of community health, mental health and learning disability services and ~~a number of~~several regional specialist services and employs approximately 4000 staff. In 2015 the CQC assessment covered older people's mental health services in both the community and ~~in~~ the inpatient wards and rated the community services overall as 'good' and the inpatient services as 'requires improvement'. In both assessments, the leadership dimension recorded a requirement notice.

Trust C is a non-Foundation Trust serving a major city in England, covers more than 74,000 square miles across five geographic zones and a population of 1.2 million. It provides a range of integrated mental health and social care services to people of all ages in several localities, as well as specialist services nationally. It operates from mainly 12 locations and employs approximately 2000 staff. CQC's inspection visits in 2015 focused on wards, which provided a specialist eating disorder service and acute wards for adults of working age. The CQC ~~provided an overall rating rated for~~ the services ~~assessed~~ overall as 'requires improvement'; however, among the five assessment criteria, the well led and caring stood out as 'good'.

Trust D is a Foundation trust in the south of England, which works with six unitary local authorities and two Clinical Commissioning Groups (CCGs), providing specialist mental health, learning disability and community health services for a population of more than 900,000 people. It operates across more than 70 localities, comprising mostly small communities, one big town and a major town and operates from close to 100 locations. Following a series of inspections of various services at Trust D in 2015, the CQC in its comprehensive report rated the trust overall and on all five quality dimensions as 'good'.

We obtained research ethics approval from the NHS Health Research Authority and local approval from the research governance office in each participating organisation, which enabled us to recruit and interview 60 participants, purposefully selected across the four sites. We purposefully selected informants to comprise executive team members, senior managers and service directors/clinicians, patient representatives and Clinical Commission Groups (CCGs) – responsible for commissioning services for each provider. These included: 3 chief executives; 4 medical/clinical directors; 3 directors of nursing; 36 board directors and service managers with a range of organisational roles; 6 senior managers from local CCGs (responsible for commissioning services for each provider); 4 consultant psychiatrists; and 4 patient representatives. Each participant was provided with an information sheet in advance and asked to complete and sign a consent form, countersigned by the interviewer. The interviews were conducted between November 2019 and August 2021. Most interviews were conducted face-to-face with a small number (following the outbreak of COVID-19 in March 2020) completed virtually (via Zoom and Microsoft Teams). Interviews generally lasted for about 60 minutes. Consent, particularly their permission to record, was confirmed with every informant before the interview would commenced.

Data analysis

The topic guide and method of questioning encouraged informants to provide a retrospective perspective of how things have evolved in their organisation over the period 2015/16 and 2019/20. The topic guide (of particular relevancerelevance to this paper) covered the following topics:

- The organisation's Style style of leadership of the organisation: in the period around 2015/16 and currently (period of interview); and any continuity or /changes in leadership style over this period.
- The prevailing culture: in the period around 2015/16; and any continuity and change in culture over the period 2015/16 to 2019/20.

- Other major organisational and management factors, for example: investment in the use of information technology; and relationships with partner organisations in the local health community.

NVivo was used to organise, structure, code and analyse the data (transcripts) which a professional transcriber had transcribed from the interview audio files. We followed the five stages of the Framework method for analysing the data (familiarisation, theme identification, indexing, charting and interpretation) (Gale *et al*. 2013). Based on abductive theorizing (Awuzi and McDermott, 2017) and pattern matching we explored the perspectives of informants ~~with regard to~~regarding our research questions, and how these converged or diverged between low and high performing providers over the period 2015/16-2019/20.

Results

Tables 1 and 2 provide a summary picture of how the low performing organisations (A and B) and high performing organisations (C and D) compared across key organisational factors in 2015/16 and 2019/20. From the retrospective enquiry approach used, it was possible to explore how for each provider ~~has evolved with regard to its~~ leadership, culture and organisational processes evolved over the ~~5 year~~5-year period. It should be noted that the patterns evident in the data are more nuanced than the synthesised results in the tables might suggest. However, there was a high degree of commonality in terms of organisational factors between the two low performers (A and B) and the two high performers (C and D). Taken together this indicated a marked divergence between the low performing providers and their high performing counterparts, particularly in 2015/16. Additional quotes from study informants relating to changes in leadership, culture, technology, and relationships are presented as Multimedia appendix 1.

Table 1: 2015/2016 Comparison of low and high performing trusts based on key organisational dimensions

Dimension	Low performing trusts	High performing trusts
Leadership style	• Command and control/dictatorial • Less visible • Transactional • Detached, less inclusive, and less empowering • Less trusting of staff • Reactive and less proactive	• Distributed, devolved and collaborative; some elements of command and control • Visible • Inclusive, engaging and empowering • Trusting of staff • Proactive
Organisational culture	• Target-oriented; cost-cutting • Fault-finding & punitive, less focus on issues and learning • Less empowering or supportive • Lacking in staff & service user engagement (coproduction) • Weak on Equality Diversity and Inclusivity (EDI)	• Quality and efficiency focused (less focus on cutting cost) • Focus on issues & learning (not blaming) • Open, empowering, mentoring and supportive • Evidence of staff engagement; less service user engagement (coproduction) • Some EDI concerns
Approach to strategy	• Ad hoc approach to strategy – less coherent strategy • More focus on cost than quality	• Relatively measured approach to strategy • A codified strategy with a strong focus on quality
Technology	• Very basic technology infrastructure • Limited use of digital technology	• Technology infrastructure on a sound footing, though with few challenges • Some innovation and use of digital technology
Relationship with partners	• Challenging relationships	• Manageable relationships

On all ~~of~~ the dimensions, ~~it is clear that the~~the providers, particularly the low performers, have evolved during the period under review, to the extent that by 2019/2020 the differences between the low performing and high performing trusts have become less distinct.

Table 2: 2019/2020 Comparison of low and high performing trusts based on key organisational dimensions

Dimension	Low performing trusts	High performing trusts
Leadership style	• Relatively distributed, devolved and collaborative • Some command and control elements • Relatively visible	• Typically distributed, devolved and collaborative • Highly visible
Organisational culture	• Relatively open, empowering and supportive • Yet some elements of fault finding • Some staff and service user engagement • Issues with EDI	• Embedding open, empowering and supportive culture • Strong focus on issues as a basis for learning • Good staff and service user engagement • Focus on addressing EDI issues
Approach to strategy	• More coordinated and measured approach to strategy • Codified strategy with staff involvement	• Coordinated and collaborative approach to strategy • Quality Improvement (QI) strategy developed and updated
Technology	• Relatively developed technology infrastructure, yet lagging • Reasonable use of digital technology	• Enhanced technology infrastructure • Digitally mature (as Global Digital Exemplar/Fast Follower) • Use of digital technology in QI effort
Relationship with partners	• Improved relationships	• Healthy and productive relationships

The overlapping nature of leadership, management practices and culture in each organisation was borne out in the interviews (See Multimedia Appendix 1, ~~in particular~~ Sections B and C). There was a convergence of views among the informants from all case study sites that leadership was the most critical determinant of the provider's performance. Thus, the findings, ~~and in~~ particularly the divergence in leadership style and managerial approach between the low performers and high performers in 2015/16, aligned closely with the CQC assessment report at the time. As noted above, on the 'well led' dimension the CQC rated Trusts C and D as 'good', and Trusts A and B as 'requires improvement.' ~~In addition~~However, more recent CQC assessments identify each of the providers as doing well on the leadership dimension, with one of the low performers, Trust A, being rated as 'outstanding' on the 'well led' dimension. This suggests how much the underperforming providers~~, in particular, have~~ have improved since 2015 ~~to the extent~~so that they now closely resembled their high performing counterparts on some of the quality assessment criteria.

It appears that external regulatory influence, most notably the CQC, ~~also had an influence on~~helped to ~~shaping~~ shape the leadership and management practices of the MH providers. In the interviews, ~~informants, especially~~ executive directors~~, referred to~~mentioned the CQC repeatedly, linking some of their management strategies and practices to earlier CQC assessments, for example, engaging staff about future strategy development and service redesign. There is evidence to suggest that the low

performing providers in our case studies were ~~initially~~, in the period leading to 2015/16, less proactive (in responding to the ~~external environment (including~~ regulatory agencies); and ~~. Both providers showed evidence of a~~ lacked ~~of~~ creativity in strategy formulation and ~~in~~ the design and delivery of quality health care. In contrast, the leadership of the high performing providers was more proactive and innovative in responding to external drivers and internal organisational issues, such as the results of staff surveys.

~~Perspectives on l~~Leadership style and approach

In reflecting on the period around 2015/2016 many informants in the low performing trusts (A and B) were critical of ~~the~~ their organisation's style of leadership ~~of their organisation~~, describing it ~~in such terms~~ as 'command and control' 'dictatorial', and 'punitive'. The style of leadership ~~at the time~~, according to the Chair, of one of the low performing providers, was "quite an old school" and one that did not place enough trust in staff and therefore did not believe "in delegating authority down through the organisation." ~~It was clear that the m~~Management of the organisation, including key decision-making, was described as highly centralised and controlled at the top (board level) with little attempt to devolve autonomy over ~~decision making~~decision-making to service level and frontline teams. Not only did the leadership of the low performing providers appear to display low levels of trust in staff but they also provided little organisational support and resources for staff development. In addition, as ~~an informant~~ a clinician and service lead in Trust B~~, (a clinician and service lead)~~ suggested, the executive team was rather "detached"~~, adding they~~and "~~were~~ very remote from the directorate and ~~from the~~ clinical workforce"; this perspective was shared by other informants (for example: see quote below and LPT_1, LPT_2 and LPT_3 in Multimedia Appendix 1). Thus, not only was the leadership perceived as being less inclusive and lacking visibility, ~~,~~ but there also appeared to be little attempt to promote clinical leadership. Some executive members were very conscious about how poorly the CQC had rated them as a provider in 2015/16, including on the leadership dimension.

The [CQC] report, published in April 2016, highlighted that improvements were needed in the areas of Effective and Well-led, with a particular focus being required on Safe where we were rated as Inadequate [reference being made to CQC ratings] [Board Member_1, Trust A]

When I joined [in 2014] at board level there was an almost command and control leadership style [Board member_2 Trust A]

The leadership style was, previously, quite dictatorial and punitive… It has been quite punitive and quite a difficult leadership style. [Service Level Director (Clinician)_1, Trust B]

Until four or five years ago, it very much was that [top-down] and had been that for at least ten years prior to that [CCG Informant_1 Trust B]

I think there's a greater disconnect between our clinical services and the executive team from the point of view that they're less visible within the organisation. [Service level Director (Clinician)_2, Trust B]

In contrast, ~~to the low performing trusts (A and B),~~ the leadership style of the two high performing trusts (C and D) were, as of 2015/2016, described as largely collaborative and inclusive with a commitment to devolving responsibility and authority over ~~decision making~~decision-making down to service level, while remaining visible, connected, and maintaining robust oversight of service quality (example HPT_2 in Multimedia Appendix 1). This leadership was also viewed as willing to adapt when needed, for example reverting to a command-and-control style when this was required to address potential areas of underperformance (example HPT_3 in Multimedia Appendix 1). The perspectives of informants demonstrated that the high performing providers sought to embed those leadership qualities that reflected well on the organisation's performance. For example, the high performers wanted to improve staff engagement, ~~– in the areas of~~ coaching/mentoring, and equality, diversity and inclusivity (EDI). These providers were driven largely by the desire to continuously improve on key performance measures, including annual staff surveys. ~~In order to~~To avoid complacency, the leadership of the high performers had also taken a number of 'reality checks' which allowed space for critical reflection using a range of hard data and soft intelligence to understand how they could maintain and improve their performance. For example, with respect to EDI, informants in both Trusts C and D noted that the leadership had seen the need for meaningful strategies for improvement and the organisation was making changes to that end. This included encouraging more black and minority ethnic staff members to be mentored and supporting them to take up leadership roles within the organisation. Another example concerned the adaptation of mentoring and leadership support for frontline staff, focusing on basic management and operational skills relevant to their area of productivity. This marked a shift away from all staff undertaking routine leadership training.

It has been quite a listening type of leadership and I'll give you one evidence. In our staff survey, we score very highly…compared to national criteria. One of the questions is 'how much do the senior leadership listen to staff'? And we come out quite well on that. [Board member_1 trust D]

I guess that goes back to the empowerment, so that is about listening, because that's about the frontline having the solutions and recognising they've got the solutions…I mean, we don't become an outstanding organisation in well led with the CQC for no reason [Board member_2 trust D]

I think we have slightly forgotten about actually grounding people in managerial skills so that they're confident to then become more senior leaders...We are really trying to do that, but haven't quite worked out the system for doing it and…understandably, these processes can take a bit of time [Board member_1 Trust C]

I think we've started to really look at our leadership behaviours and particularly move more into a coaching style of leadership… [Board member_3 Trust D]

As noted above, the low performing providers have adapted and evolved their leadership style and approach since 2015. In both organisations, this transformation coincided with significant changes in

board composition, including a change of trust chief executive (see ~~for example~~ LPT_3 and LPT_6 in Multimedia Appendix 1). A divisional director in Trust A, for example, reflected on an 'unequal partnership', which previously existed between their organisation and the ~~Clinical Commissioning Group~~CCG. He noted that "over the past three years" they have "become more of a system leader and try to lead the commissioners with our expertise and therefore influence the commissioning far more" leading "the design of the broader strategy as the system experts." ~~Both of the low~~Both low performing providers began to mirror the style of leadership that Trusts C and D have exemplified since 2015/16. Accordingly, informants from Trusts A and B used words such as devolved, trusting, delegating, empowering and inclusive to describe their organisation's leadership style in 2019/2020 (see also Multimedia Appendix 1 Sections A through C under Low performing trusts).

…the staff feedback is we are rated outstanding by the CQC for leadership for being well led; so we pride ourselves on that and we pride ourselves on our exec and non-exec visibility and engagement…from board to ward to team the engagement, listening, understanding and acting [Board member_3 Trust A].

I think it's shifted quite a bit so first and foremost I think a key bit is that we now have a leadership style which is about trusting people to be able to do their jobs and therefore delegating authority down through the organisation [Board member_2 Trust A].

It was a fairly punitive environment where people were frightened to speak out and were anxious about dealing with higher management, and I think that's changed. It's changed in the last couple of years, there's been a change of managers, and there's quality change [Service level Director (Clinician)_3 Trust B]

~~Perspectives on c~~Changing cultures and strategy

As noted above, the intimate linkage between leadership style and organisational culture was reflected throughout the interviews (for example Multimedia Appendix 1 Section C). In the low performing trusts, informants' perspectives about culture change closely reflected their thoughts about its leadership. In addition, it is apparent that both leadership and culture were directly linked to managerial processes and practices, including strategy formulation, coproduction, use of technology and relationships with partners. As with styles of leadership, there is evidence that organisational culture change at each of the low performing sites has been driven, at least in part, by less than favourable internal staff survey results, and by external regulatory demands, most notably ~~the negative~~ CQC assessments. For example, in one of the low performing trusts, the Associate Director of Operations for Older People recalled that trust-wide consultation regarding strategy development was limited in the past. The Director of Strategy also confirmed ~~also~~ that as an organisation, they started making a concerted attempt at ~~coproducing the~~engaging staff at different stages of strategy ~~(with staff engagement~~development ~~at different stages)~~ following the unfavourable CQC assessment findings in 2015, which "called for improvement in key areas, including being 'well led'". While Trusts A and B

lacked a coherent or codified strategy in 2015/16, Trusts C and D had developed a quality strategy, albeit with limited staff and service user engagement. Unlike A and B, the quality strategy documents for Trusts C and D were available on their respective website as of 2016. Subsequently, all NHS mental health trusts in England have developed a five-year quality improvement strategy as mandated in the NHS Five Year Forward View (NHS, 2014; Ham and Murray, 2015). By now, each organisation has made some effort to consult with staff and service user representatives regarding strategy formulation and the co-design of services. However, the high performing providers appeared to have more developed processes for engaging staff and service users, with one provider also consulting partners in their local health system (including the Clinical Commissioning Group and local authorities).

With a reactive leadership approach and transactional leadership style, as noted above, both Trusts A and B in 2015/16 promoted a target-oriented culture and a culture that was more focused on cutting cost and balancing the books, than on assuring and improving quality and efficiency.

In the same vein, Trusts A and B, unlike their high performing counterparts, had not promoted a listening culture or encouraged staff to speak up or raise legitimate concerns about quality of care. Rather, what prevailed in the two organisations was a blame (or fault-finding) culture. Informants in both ~~the~~ low performing trusts suggested that there ~~had been~~was a conscious effort to change aspects of the organisational culture to beneficial effect. For example, the manager for improving access to psychological therapies (IAPT) in one of the low performing trusts suggested how his trust's culture has evolved. He contrasted the "previous regime", which he described as "business-like and standoffish" to the current one, noting that it "was no coincidence that with the change to a more inclusive culture, our CQC ratings improved, and our staff survey results improved". Informants in both low performing trusts highlighted some of the culture change programmes being implemented. These included ~~a number of new initiatives including~~ education and learning programmes, coaching and mentoring opportunities and supporting leaders to better model the organisation's expected values through their behaviour and actions. For example, this included effort to listen to and act on staff concerns and "to contribute to our standard operating procedure" (Home Treatment Service Manager, Trust B); as well as the development of a strategy around bespoke training for suicide prevention (Medical Director, Trust A) (See also below).

It almost seemed to be, like I said, that because our Commissioners were working in a purely performance-based manner that that's what we were responding to just trying to hit the targets and, as I say, often missing the point [Associate Director (Operations) _1 Trust A]

Training, it's about leadership development based around those values and we've had about 1,000 people, 1,000 colleagues go through that leadership programme in the last year or so. [Board member_1 Trust B]

As with their high performing counterparts, both Trusts A and B had recently encouraged more clinicians to take up leadership roles. In Trust A, for example, it was reported that unlike previous practice, by 2019 senior managers, including clinicians, had been encouraged to apply for positions when the substantive holders had moved. Thus, ~~during the~~in recent period, there has been greater staff empowerment in both Trust~~s~~ A and B, ~~similar to~~like what had largely characterised Trusts C and D. There were suggestions of a shift away from a culture that blamed individuals for mistakes to a no blame or 'just' culture, which encouraged staff to report incidents and learn from ~~past~~ mistakes.

… *In their service lines, they feared getting something wrong, they feared the blame culture of being disciplined for making a mistake whereas now, what our staff say is they do feel empowered to make changes in their services which is absolutely right and the blame culture is a thing of the past. [Board Member_1, Trust A]*

We're working hard to develop a culture that learns from when things go wrong, and being a just culture… I think it's more about being a just culture where we're not scapegoating people, but we absolutely hold people to account for their own behaviours. [Director (Service Level) _2 Trust A]

I think we do listen now. I think people have to – we try and make sure that we have regular business meetings, reflective practice, all of those models of supervision and giving people a voice … [Service level Manager (Clinician)_1 Trust B]

The organisational culture and strategic decision-making in both Trusts C and D has since 2015 prioritised patient safety and quality over purely cost~~-~~-cutting considerations. In these organisations quality improvement had been more about effective service delivery through 'removing waste' and judicious/efficient use of resources. These cost reductions ~~have~~ included, minimizing inpatient stays, reducing out of area placements, redeploying staff, and replacing external agency staff with internal banking staff.

~~A number of i~~Informants from both Trusts C and D described their organisation's culture as one that ~~has~~ always strived to create the right environment for staff to work in and deliver high quality services. For example, the Chief Operating Officer ~~(COO)~~ of Trust C noted that the organisation has always promoted an open, compassionate, and listening culture; ~~. He suggested,~~ however, ~~that~~ their challenge was that some staff members were less proactive to act on concerns raised. Some informants from the high performing trusts highlighted the influential role of their organisation's Chief Executive Officer (CEO) in promoting the organisation's core values and focus~~ing~~ on continuous quality improvement.

I think it is a listening culture. So, I think it is, yes; and I think the engagement in staff to help shape strategies and service redesign- not just staff, I think also service users – so, I think it's got increasing drive for involvement. We've got a big involvement team and I think that having the service user voice at the core of everything is really important. [Board member_2 Trust C]

The culture, I would say, is empowering and supportive of staff…I think it's probably what I've said about leadership, to be honest, it's inclusive, it is supportive, it's compassionate, it's a caring organisation. I think that's

always been like that. I think so, but I would say it's more now. I think it's more now than before. [Board member_3 Trust C]

I think since we've had our existing chief exec, who's been in post for eight or nine…eight years now, I think, it's always been very participative, it's always been emphasis on supporting our staff on morale, on looking after our staff. I think it is about those relationships, about that loyalty, about that continuity of leadership. [Board member_4 Trust D]

~~Perspectives on t~~Technology innovation and partnership

There was also divergence between the low and high performing trusts, with respect to how developed their technology infrastructure ~~was~~ and ~~how much they were~~enhanced their ~~using~~ use of digital technology in 2015/16 (see for example, Multimedia Appendix 1 Section D). Similarly, the providers differed in the nature of partnership within their local healthcare economy, especially in 2015/16 (see Multimedia Appendix 1 Section E).

Investments in and the use of up-to-date technology appeared to be limited in both Trusts A and B in 2015/16. However, both organisations increased their use of digital technology over the intervening period. The adoption of QI models in service delivery, such as the PDSA (Plan, Do, Study and Act), also emerged as a recent development. Digital technology has, however, not yet fully developed in the low performing trusts; for example, some services are still lagging behind in the effort to transition to a paperless system of communication.

I think they've been slow to embrace new technology especially around digital stuff and they seem to constantly have issues with their information systems… When it gets down to an operational level and operationalising it, the internal IT department in the trust needs to increase the pace and be a bit more ambitious, and as commissioners we are incentivising the trust to embrace the digital offer. [CCG Informant_1 Trust A]

In contrast, the view from Trusts C and D was that use of IT was fairly well developed by 2015. Trust D was selected (among ~~seven~~ ~~mental health~~MH trusts in England) as a global digital exemplar~~s~~ (GDE) in 2017 and C as a 'fast follower' (collaborating and sharing experience with a ~~global digital exempla~~GDE~~r~~). Thus, compared to Trusts A and B, who lagged ~~behind~~ in terms of digital maturity, both Trusts C and D have since 2015 invested more and advanced further in the use of technology and innovation to support the quality and efficiency of service delivery. For example, while all four providers have been using QI tools to improve quality, there was evidence that Trusts C and D have been making more innovative use of QI models and data. This included evaluating services, making projections in specific areas, ~~in order~~ to keep improving quality and patient outcomes.

~~Perspectives on relationships with partners~~

Relationships with partner organisations in the local health economy, especially in 2015/16, is another area in which the low performing trusts differed ~~sharply~~ from their high performing counterparts. ~~Relationships with other local~~ Local economy partnerships/relationships have not always been smooth for all the providers, especially based on a common feeling across the organisations that the mental health sector had historically been disadvantaged when it came to funding. However, the relationships were more manageable in Trusts C and D ~~whereas they were~~and more challenging in Trusts A and B. ~~It is important to note, h~~Nevertheless, ~~owever,~~ ~~that~~ each organisation has seen its relationships with partners improve especially with the recent shift toward integrated health care delivery within the framework of an integrated care system (ICS) (Sanderson *et al.* 2021).

I said before I think there are really good relationships now with commissioners, and that was definitely not the case not even that many years ago. Maybe five or six years ago, there was a very standoffish relationship with our commissioners… I've had opportunity to engage with commissioners, which was never a thing previously – they didn't let people like me in managing services anywhere near the commissioners…[Service level Manager (Non-clinician)_1 Trust A].

Discussion

As one would expect from a qualitative case study of this nature, the perspectives of informants within and across the sites did not always reflect a consistent patterning. This is not surprising given the dynamic nature of leadership and culture in a complex health care setting in which failure and success may not be considered as distinct opposites (Vindrola-Padros *et al.* 2020). However, we found strong evidence to suggest in 2015/16 that there was a marked difference between high and low performing providers in terms of their style of leadership, management, and organisational culture as well as their willingness to invest in information technology and the quality of relationships with partners. Our ~~case study~~ findings support the notion that leadership and culture are so interlinked that it is almost impossible to separate them ~~two~~ in analysing the factors, which influence provider performance (Schein, 2010; Mannion *et al.* 2005). We found the style of leadership and dominant culture to bear the most important influence on performance for all four providers in our case study. The features of each provider's leadership and culture were crucial in leveraging internal factors, for example ~~with regard to~~regarding job satisfaction (as reflected in staff surveys), and external drivers (notably the influence of regulatory bodies). Empirical research has shown that ~~particular~~ certain leadership behaviours predict organisational outcomes in the English NHS. For example, in a recent quantitative study, West, *et al.* (2021) found that supportive leadership, mediated through management behavioural practices such as engaging staff in decision-making and listening to and giving staff feedback, was significantly associated with patient satisfaction as well as the ability of staff to cope with work pressure.

In the case studies, the divergent terms in which informants in the low performing trusts and those in the high performing trusts generally described their organisation's leadership style and approach in 2015/16 suggests that effective leadership matters for the performance of mental health providers. Previous research has found that specific attributes of leadership, for example command and control, detached, and less visible (A and B) and collaborative, inclusive, visible, engaging, consultative, trusting of staff (C and D) are associated with low and high performing healthcare organisations, respectively (Vindrola-Padros *et al.* 2020; Fulop and Ramsay, 2019; Mannion *et al.* 2005). Data from these case studies demonstrates how leadership in healthcare, including mental health, has also evolved from the traditional individualised (heroic) notion to more of a 'collectivistic' team view of leadership (De Brún e*t al.,* 2019; Konradt, 2014; Fulop and Mark 2013), which is associated with performance improvement. We found evidence that the leadership of the high performing providers was willing and able to adapt and switch to a ~~command and control~~command-and-control style when the situation demanded. Within the kind of complex and dynamic system in which mental health providers operate, flexibility and ability to adapt appears to be a hallmark of successful leadership (Tourish, 2019).

Our findings have revealed first, there was a good degree of congruence between leadership and culture across the case study sites. Second, ~~similar to~~like leadership, it was possible to distinguish between the low performing and high performing providers based on certain features of their organisational culture in 2015/16. It was possible to differentiate between the low and high performing providers based on, for example, an undue focus on bearing down on costs and meeting targets as against enhancing quality and safety~~,~~ and promoting a blame culture as against a just and supportive culture. Furthermore, empirical research has suggested that having an overall organisational strategy, which in 2015 was the case in Trusts C and D but not in A and B, does appear to make a difference to being a successful organisation (Walker, 2013; Gupta, 2011; Goldman and Casey, 2010; Fulop and Ramsay, 2019). Adequate infrastructure has also been associated with successful organisations (Vindrola-Pedros *et al.* 2020). To this end, the high and low performing providers ~~in the case studies~~ were distinguishable ~~with regard to~~regarding the maturity of their information technology. There is a growing recognition that involving service users, as well as frontline staff, in the coproduction of strategy and service design is pivotal to improving health care outcomes (Palumbo, 2015). Leadership and culture, among other contextual factors, are central~~pivotal~~ to effective coproduction (Gheduzzi *et al.* 2019). While there was evidence of better staff engagement in the high

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performing trusts than the low performing ones at the outset, service user engagement is one area in which all four MH providers did not follow best practice.~~could be doing better~~ Another important feature of successful health care organisations is ~~to develop and nurture~~ nurturing strong relationships with partners based on shared learning (Fulop and Ramsay, 2019; De Brún *et al.* 2019; Vindrola-Pedros *et al.* 2020). The findings are consistent with the literature, suggesting that the dynamic interaction between the internal factors (of leadership, culture and managerial practices) and the external environment (including regulatory and policy-making bodies) was also a key ingredient in mental health provider's performance (Schein, 1994; Mannion et al. 2005; Jacobs; 2013; Vindrola-Pedros et al 2020; Fulop and Ramsay, 2019; De Brún *et al.* 2019; Asaria, *et al.* 2022). Regulatory agencies are crucial in influencing performance improvement and accountability in healthcare, yet regulation may also generate a range of deleterious consequences for organisations, staff and patients. ~~Yet, one or two unhelpful aspects of regulation have been reported in the literature.~~; ~~F~~for example, 'regulatory overload' may occur due to too many overlapping regulators and regulations ~~in England~~ (Fullop and Ramsay, 2019); and adherence to regulatory requirements may result merely in 'tick boxing' rather than lead to genuine improvements in the quality of service delivery ~~lacking in flexibility and relying too much on a tick box exercise~~ (Oikonomou *et al.* 2019). In our case study, ~~across the board,~~ the CQC was the most influential regulatory agency, with the high performing trusts being more responsive and adaptive than their low performing counterparts to regulation ~~regulatory~~ especially in 2015/16. ~~Thus, the underperforming providers, in an attempt t~~To improve their performance, ~~– for example the low~~ including staff survey scores and poor CQC ratings, the underperforming providers ~~–~~ embarked upon purposeful leadership and culture change:, ~~. These changes were~~ sometimes becoming radical in approach~~.~~, ~~–F~~for example by replacing the CEO~~,~~; becoming more assertive in their engagement with commissioners~~,~~; ~~, for example in engaging with the CCG,~~ ~~and sometimes more incremental, for example~~ moving from a centralised command and control style of leadership to a more devolved approach to leadership; ~~style approach~~ and shifting from a blame culture to a just culture.

Limitations

Given the case studies are drawn from four purposefully selected English mental health trusts, it is only with caution that the findings can be generalised beyond mental health providers in England. Another limitation relates to the narrow coverage of study participants - drawn from senior managers and executive team members and not including frontline staff and local authority representatives. However, the benefit of having informants from the provider's top hierarchy is that they can provide a more strategic overview of the organisation and its performance. Study informants also included representatives of local commissioning groups and patient representatives, who provided useful outsider perspectives on the internal and external drivers of performance.

Conclusions

Our case studies of four mental health trusts in England provide evidence to suggest that leadership, management practices and culture are associated with organisational performance. In addition, mental health providers ~~are capable of evolving~~can evolve in response to both external factors and internal drivers. We found evidence to suggest that radical changes in leadership and organisational culture are possible to enact over a relatively short period of time and that such changes may help support low performing MH providers to turnaround their underperformance and thus become more similar in organisational characteristics to their high performing counterparts.

Acknowledgments

This study was funded by the Health Foundation as part of their quality and efficiency project. The authors are also grateful to the participating mental health providers, especially to the staff members who were interviewed and the R&D staff who supported the recruitment.

Conflicts of interest

None

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