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Strategic Leadership Behaviours that Develop Organisational Resilience in NHS Trusts in England: A Multiple-Case Study

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Abstract

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The provision of quality health care and standards of leadership in the National Health Service in England have been of concern for many years. To address falling standards and institutional failures external regulation of the service was introduced. However, despite the scrutiny of regulators, concerns regarding organisational culture, quality and leadership in the NHS prevail.

Research in organisations that have improved their performance as evidenced by the health care quality regulator, Care Quality Commission, has mainly focussed on the organisational changes that have occurred. However, little has been studied as to whether organisational objectives go beyond delivering quality improvement and there is a lack of examination of the strategic leadership behaviour that underpins organisational performance improvement and resilience.

Furthermore, there is little research into how the focus of organisational change may alter following a second inspection that demonstrates quality improvement, as evidenced by the Care Quality Commission. Thus it is unclear whether improvement is the result of corporate strategy that intends to deliver long-term, sustainable improvement, short to mid-term improvement to satisfy the regulator, or a mixture of both. This research set out to explore these issues.

A multiple-case study design of two non-typical NHS Foundation Trusts were researched to identify the strategic leadership behaviours that enabled organisational performance improvement and underpinned the development of sustained organisational resilience. The research questions were explored through the multiple methods of interviews, secondary documents, non-participant observations and NHS Staff Survey data. Thematic analysis of interview data and analysis of documents were complemented by analysis of summary aggregated percentages of staff survey data.

The research offers new insights into leadership behaviour that goes beyond a focus on quality improvement and presents a new theoretical framework regarding the development of organisational resilience. Five strategic leadership behaviours underpinned the development of sustained organisational resilience: responsible leadership, a values-led culture, being people-focussed, applying rigorous governance and a commitment to organisational learning. A new paradigm of leadership in the NHS is proposed, that of responsible leadership. This will benefit the health and social care sectors as they move into a model of integrated care.

CONTENTS

LIST OF APPENDICES

LIST OF TABLES

LIST OF FIGURES

DECLARATION OF AUTHORSHIP

I, Barbara Caroline Bradbury, declare that this thesis and the work presented in it is my own and has been generated by me as the result of my own original work.

Title of thesis:

Strategic leadership behaviours that develop organisational resilience in NHS hospitals in England: a multiple-case study

I confirm that:

1. This work was done mainly while in candidature for a research degree at the University of Southampton;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the source of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission.

Date: 25 May 2022

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GLOSSARY

British Medical Association: Representative organisation that supports and negotiates terms and conditions on behalf of all UK doctors and medical students

Clinical Commissioning Group: A group of GP practices that commission most planned hospital care, rehabilitation services, urgent and emergency care, most community health services, mental health and learning disability services in the English National Health Service

Care Quality Commission: Organisation responsible for monitoring and regulating the quality of health and social care provided by the English NHS, private, social and charity sectors

Datix: Electronic incident reporting system for risk management, capturing patient safety incidents: used in NHS organisations to report clinical incidents and near misses

Integrated Care System: Integration of NHS health providers, local government and other wider delivery partners (e.g. charities) working collaboratively to meet the health and social care needs of their community. These will become statutory organisations following new legislation, proposed to begin in 2022

Just Culture: An organisational culture that supports consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

National Health Service: The health service of the UK, funded centrally through taxation and free at the point of delivery for all UK residents

National Health Service Trust: A hospital in the NHS in England that has opted out of local authority control and is managed by a Trust. An NHS Trust may comprise a group of several hospitals under the management of one Board of Directors

National Reporting and Learning System: Central record of all incidents and near misses reported through local risk management systems (e.g. Datix)

NVivo: Computer software programme for qualitative data management and analysis

Organisational Resilience: An organisation that responds positively to a challenging event, recovers and emerges stronger

People: Employees of the National Health Service

Royal College: Medical Royal Colleges are professional bodies responsible for specialty training and GP training in the UK, with oversight of curricula and assessment for each training programme

Serious Incident: An unexpected or avoidable death or injury that results in serious harm, and must be investigated to understand the cause and ensure organisational learning from the event to avoid repetition

Sustainable Transformation Partnership: In 2016, NHS organisations, local councils and other organisations came together to form sustainable transformation partnerships in all areas of England. They set out proposals to improve health and social care and are taking collective responsibility for managing resources and delivering NHS care: they are evolving into Integrated Care Systems

Values and Behaviours Framework: A document that sets out an organisation's values, expectations and standards of behaviour, and how colleagues should work together

ABBREVIATIONS

AR	Annual Report
BMA	British Medical Association
BP	Board Paper
CEO	Chief Executive Officer
CHI	Commission for Health Improvement
COVID-19	Coronavirus Disease (2019)
CQC	Care Quality Commission
CQCSR	Care Quality Commission Summary Report
CS	Case Study
DHSC	Department of Health and Social Care
DoH	Department of Health
ED	Executive Director
ERGO	Ethics and Research Governance Online
GP	General Practitioner
HSCA 2012	Health and Social Care Act 2012
ICS	Integrated Care System
ID	Identity Number
IRAS	Integrated Research Application System
NED	Non-Executive Director
NHS	National Health Service
NHSI	National Health Service Improvement
NRLS	National Reporting and Learning System
PBS	Preliminary Briefing Sheet
PIS	Participant Information Sheet
R&D	Research and Development
RCA	Root Cause Analysis
RQ	Research Question
SI	Serious Incident
STP	Sustainable Transformation Partnership
UK	United Kingdom
VBF	Values and Behaviours Framework

Chapter 1

INTRODUCTION

1.1 Context and chapter overview

Health systems globally are stretched, struggle to provide quality services and face spiralling costs (Heavin, 2017), with the COVID-19 pandemic highlighting their fragility in many countries (Deloitte, 2021; Haque, 2021). The maintenance of a functioning National Health Service (NHS) was central to the United Kingdom (UK) government's lockdown requirement to stay at home, protect the NHS and save lives (Tonkin and Whitaker, 2021). Prior to the pandemic, sustainability plans were being drawn up throughout England to address on-going financial pressures in the health and social care sectors, initially to be implemented by April 2021 (Alderwick *et al.*, 2016). However, whilst closer collaboration has been exhibited during the current pandemic (Gray and Sanders, 2020; DHSC, 2021b), change in legislation is required for true integration between the sectors following the Health and Social Care Act 2012 that promoted greater competition (Allen *et al.,* 2017). A recent UK government White Paper from the Department of Health and Social Care (DHSC) that sets out proposals for legislative change (DHSC, 2021b) estimates its implementation will commence in 2022.

It is assumed for the purposes of this research that the legislative changes will be enacted and the formation of Integrated Care Systems (ICS) will be formally incorporated in due course. In order to sustain the future delivery of safe, effective health care, free at the point of delivery, the NHS will need to adapt and contribute to whole system working, engaging with partners to provide effective services. This will require a nuanced understanding of corporate leader behaviours that maintain resilience of an organisation whilst adapting to change and challenge. This chapter sets out the background to the research study, followed by the rationale for its undertaking. The research questions are then identified and an account of how they are addressed is set out in the thesis structure that follows. The chapter concludes with a summary.

1.2 Background

The provision of safe, high quality health care has been an on-going concern for the UK government over several decades (Donald and Southern, 1978; Department of Health, 1998; Leatherman and Sutherland, 2004; Darzi, 2008; Fulop and Ramsay, 2019).

Various reported scandals of health care practice and outcomes in the NHS in England (Hunter, 2001; Walshe and Higgins, 2002; Kirkup, 2015; Iacobucci, 2020a) have been examined through public inquiries (Ritchie *et al.*, 2000; Kennedy, 2001; Francis, 2013). Institutional failures were frequently attributed to their culture and leadership, and organisations were usually left to address concerns without government oversight (McLachlan, 1976; Horton, 2016). External regulation of the health care sector was introduced to monitor quality and safety of health care (Alaszewski, 2002; Dewar and Boddington, 2004; Alvarez-Rosete and Mays, 2014; Newdick and Danbury, 2015) and, despite becoming a driver for change, concerns of NHS organisational culture, quality of health services and standards of leadership remain (Walshe and Chambers, 2017; Bailey and Burhouse, 2019).

Globally, health care spending has steadily climbed over the past 20 years (Levit *et al.*, 2003; Lostao *et al.*, 2007; Appleby, Galea and Murray, 2014; Onn, 2015). The average annual increase in the health care budget in England from the establishment of the NHS in 1948 until 2008 was 3.7%. This has slowed since the financial crash in 2008 to an average of 1.4% per annum. In 2019/20 the national budget for health and social care was £143 billion, accounting for just over 6% of Gross National Product. However, Trusts in England are struggling to remain within budget and, with a deficit overall (Appleby, Galea and Murray, 2014; Dunn, McKenna and Murray, 2016; Anandaciva, 2020), ensuring the NHS delivers value for money is an issue for government.

Health care pressures are changing. A rising elderly population, health conditions that are frequently the result of poor lifestyle choices and an under-funded health and social care system are putting health services under strain (Caley and Sidhu, 2011; Scarborough *et al.*, 2011; Hex *et al.*, 2012; Dall *et al.,* 2013; Keaver *et al.*, 2018). The rapid global spread of the COVID-19 pandemic revealed stretched health care resources: anticipated costs to health care and the macro-economy are significant (Bartsch *et al.,* 2020; McKibbin and Fernando, 2020), with early UK modelling estimates of an additional health cost burden of £39.6 billion and a total economic cost of £308 billion (Keogh-Brown *et al.,* 2020). In managing viral spread, the UK has focussed on protecting the NHS from being completely overwhelmed, highlighting its vulnerability (Burman *et al.,* 2020; Chowdhury, 2020; Moore, 2020; Willan *et al.*, 2020; Yano, 2020). The importance of developing resilience in the UK health system has, arguably, never been more important (Chada, 2018; Lancet, 2020; Haque, 2021).

1.3 Rationale for the research

Having had a career in health care as a nurse clinician and Trust Board director, held service quality roles at regional and national level, and as an organisational development consultant and executive coach to the health, social care and health charity sectors, the researcher is deeply concerned about the quality of patient care, leadership and sustainability of the NHS. She was involved in the development of organisational audit programmes for these sectors at the King's Fund (Pitt, 1990) and more recently has observed organisations preparing for inspection by the Care Quality Commission (CQC), the regulator of quality in health and social care organisations in the NHS in England.

The CQC commenced a programme of comprehensive inspections in 2013 in response to serious concerns of the government regarding service failures in the NHS (Kennedy, 2001; Francis, 2013). The regulatory process has been adapted over time (Beaussier *et al.,* 2016) changing from a focus on monitoring performance against government targets, patient safety and reliance on information from patient surveys, infection rates and waiting times (CQC, 2010) to the current inspection process using a team of CQC employees and NHS experts who assess quality using their professional judgement (Boyd *et al.,* 2017). The current approach is time-consuming and opinions vary regarding its value for money and the impact that inspection has on health care quality (Walshe *et al.,* 2014; Castro, 2018).

In addition to activities applicable to all organisations, such as bureaucratic paperwork and survey logistics, preparations for a CQC inspection can vary markedly. For example, the researcher has observed considerable expenditure on temporary agency nursing staff where vacancy levels were high; a long overdue programme of painting and signposting of the estate; and an emphasis on 'business as usual': generally an indication that the organisation felt confident regarding what the inspectors would find.

The CQC aims to improve quality of health care and develop organisational resilience (CQC, 2016a) through its regulatory programme. Following an inspection it rates the organisation as underperforming *(Inadequate/Requires Improvement),* performing *(Good)* or highly performing *(Outstanding)*. According to the CQC, a high performing NHS organisation is one that ensures a safe environment to patients, delivers effective treatment and responds in a timely way to their needs. It is well-led, governed to ensure an open and fair culture, provides high quality care that is based on individual patient need and encourages learning and innovation. Patients are cared for with

compassion and treated with respect and dignity (CQC, 2013a). Resilience is demonstrated when an organisation improves its CQC rating (CQC, 2018a). Whilst these domains are indisputably important for health care provision it is suggested they will not be enough to guarantee sustainability of an organisation, as demonstrated in other sectors.

Private companies have failed despite being industry giants and sector leaders, due to poor decisions and inability to innovate (Lucas and Goh, 2009; Gershon, 2013). For example, Blockbuster Inc. failed to see how the film industry and people's screen preferences were changing and poor business decisions created its downfall (Davis and Higgins, 2013). For similar reasons, Kodak failed to adapt to emerging digital technology and, despite having been the industry leader in camera production and film for a century, the company folded (Ho and Chen, 2018). On the other hand, with a similar business model and Kodak's closest rival for fifty years, Fujifilm recognised the need to change, adapted and continued to grow exponentially (Ho and Chen, 2018).

Ryanair also altered its business model in order to save a rapidly failing business. Having tried to compete on cost with other airlines, it was soon undercut and made rapid losses. Company leaders made the decision to become a low budget service in order to survive: minimising quality standards without compromising safety has enabled the company to flourish (Box and Byus, 2007; Thomas, 2015). These examples from industry indicate that organisational survival is nuanced and nothing can be assumed. Flexibility and adaptability to an emerging environment is essential to sustainability. With NHS services that can be delivered by non-NHS providers (Walumbe, Swinglehurst and Shaw, 2016), nothing should be taken for granted regarding future health service provision and the NHS would do well to learn from private industry.

A Trust that has been rated as underperforming by the CQC undergoes stringent scrutiny by health care regulators, causing additional pressure to an already challenged organisation. The focus for the CQC is to help drive performance improvement but not all organisations do improve their subsequent CQC rating, some improve temporarily and others deteriorate (CQC, 2015; CQC, 2018c; CQC, 2019b). In organisations that do improve, the CQC reports that the organisations typically focus on quality improvement, shared values and culture change, frequently described as moving from a punitive to a non-bullying, compassionate culture that is patient-centred (CQC, 2017c). Other authors

(Fulop *et al.,* 2020) have also reported a focus on quality improvement and culture change, and highlighted the importance of developing a listening culture.

The CQC consistently reports high levels of compassionate care throughout NHS Trusts, even in those that underperform (CQC, 2017a; CQC, 2017b; CQC, 2018a; CQC, 2019a). Compassionate leadership in health care has been widely promoted (Mannion, 2014; Shea, Wynyard and Lionis, 2014; West and Chowla, 2017), particularly for the benefits to patient care. However, the theory does not always meet with reality (Cole-King and Gilbert, 2014) and not all staff experience compassion in the workplace. Annual NHS Staff Survey data reveal that discrimination, bullying and harassment are experienced by 25% of the survey-responding workforce (Bailey and Burhouse, 2019).

Hospitals are high-pressure work environments and the demand to produce higher quality care with fewer resources is constant (Jones, 2010; Gainsbury, 2017; Harlock *et al.*, 2017). As organisations move into closer working with social care and other partners the NHS will need to be resilient to withstand new pressures and adapt appropriately to remain relevant and viable (Darzi, 2008; Akhtar *et al.*, 2016; Bridges *et al.*, 2017; O'Hara, Canfield and Aase, 2019). It will need leaders who are focussed on improvement and who can demonstrate sustained organisational resilience. The leaders of organisations that are underperforming as evidenced by the CQC could learn from those who have transformed their organisations and moved into the performance space. Organisations that are already performing may learn how to sustain organisational resilience and not slide back. Against this backdrop the researcher aimed to understand how NHS leaders have developed organisational resilience in Trusts.

The organisational resilience literature is considerable and has grown exponentially over the past twenty years (Linnenluecke, 2017), as scholars have become increasingly interested in the subject in the wake of natural disasters due to climate change, and crisis events prompted by the terrorist attack on the New York World Trade Center on 11 September, 2001 (Burnard and Bhamra, 2011). Studies have been undertaken in a variety of disciplines such as supply chains (Sheffi and Rice, 2007), ecological systems (Holling, 1973) and crisis management (Comfort, Boin and Demchak, 2010), giving rise to a disparate and highly contextual body of literature.

The influence of the various research disciplines on scholars of organisational resilience in organisational management and health care research is apparent. Research in health care has been highly influenced by the field of resilience engineering

(Braithwaite, Wears and Hollnagel, 2015), which has a strong focus on safety culture. Studies have mainly been focussed on the resilience of the workforce and in discrete departments and services within the organisation. Research at the macro level is lacking (Berg *et al.,* 2018), highlighting the need for organisation-wide study.

There is no agreed definition of the construct of organisational resilience, either within or between disciplines (Ma, Xiao and Yin, 2018). There are several concepts and many components that have been identified in the theoretical literature (Chen, Xie and Liu, 2021), which frequently guide empirical studies. The many definitions of the construct can be seen to influence the emphases that various scholars place on the concepts. However, it is not clear how transferable the concepts are within contexts and this is not adequately addressed in the literature (Linnenluecke, 2017).

The literature corpus has been very well developed theoretically but there is an appreciable lack of empirical study in the organisational management and health care fields. Theoretical contributions are largely unsupported by empirical evidence (Rahi, 2019), which has led to a disjointed body of literature (Duchek, 2020). Researchers have identified a range of leader behaviours that affect organisational resilience, which are not always then adequately qualified in the literature: for example, Gracey (2019) writes that leaders should develop the correct organisational culture, without further elaboration of what is correct.

In the face of a disparate and imprecise body of literature, there is a need for inductive, empirical work that will identify specific leadership behaviours that have developed organisational resilience. This will be of use to practitioners and scholars alike, providing evidence of leadership behaviour and further insights into the actual development of organisational resilience.

The impact of toxic behaviours in health care and other organisations has been well documented (Walton, 2007; Chu, 2014; Kline, 2019; Labrague *et al.,* 2021) and the researcher sought to identify the most impactful positive behaviours of NHS leaders in Trusts that were performing well. Getting clarity on who is influential and how that influence is manifested was another objective of the research, in order to understand at what level leaders reside in a performing organisation. A third objective of the research was to identify the organisational behaviours, systems and processes to encourage and discourage in order to maintain sustainability of an NHS Trust.

The research has the potential to be of benefit to health care through sharing of new knowledge, which may influence the overall strategic leadership direction of NHS organisations. It aims to provide useful, meaningful and robust evidence, to leaders within the health care sector, on behaviours that will benefit the NHS and enable sustainable organisational resilience of organisations in the health and care system. It is also suggested that it may provide useful insights to organisations in other sectors that are striving to remain sustainable in their sector.

In order to learn from achieving organisations there needs to be clarity on how leaders have brought about performance improvement that develops sustained organisational resilience. It is important to learn from organisations that have sustained resilience over time and not reverted following a temporary improvement. The strategic leadership approach of NHS leaders to performance improvement and organisational resilience development was not clear from the literature. Further empirical study is required to understand how leaders of successful NHS Trusts approach an organisational performance improvement programme. This led the researcher to ask the questions:

What has enabled organisational performance improvement and thus developed organisational resilience, as evidenced by the Care Quality Commission?
What strategic leadership behaviours underpinned the development of sustained organisational resilience?

The research has identified five strategic leadership behaviours that inter-relate and developed sustained organisational improvement and resilience in two NHS Trusts in England. The primary behaviour was that of responsible leadership. A new theoretical framework that identifies five core factors of responsible leadership and its inter-relating strategic leadership behaviours situated within staff and organisational development present new insights to the field of organisational resilience with respect to its development in organisations under significant challenge. The research also proposes a new paradigm of NHS leadership: responsible leadership is considered essential for the sustainability of health and social care. This thesis records how these research questions were addressed and its structure is now presented.

1.4 Thesis structure

Following this first chapter in which the context, background and rationale for the

research has been presented and research questions identified, Chapters 2 and 3 report the literature that has been reviewed relevant to the research study. Chapter 2 reviews the background context of the NHS in England, including the influence of the medical profession from inception to the present day, the rise of clinical governance and the CQC. Leadership literature relevant to the NHS is also reviewed. Chapter 3 reviews organisational resilience literature and its relevance to health care. The researcher's definition of organisational resilience is discussed and the research questions identified.

The fourth chapter sets out the research methodology and methods and reveals the pragmatist epistemology and subjectivist ontology of the researcher. The research case study design is discussed and the rationale for selection of two non-typical cases is made: organisational profiles of each case study are presented. The research methods are discussed: semi-structured interviews, document reviews, non-participant observations and analysis of elements of the NHS Staff Survey. The impact of the COVID-19 pandemic on the research fieldwork is also discussed.

Chapter 5 presents the process of analysis of the interview data. It describes the thematic analysis technique described by Braun and Clarke (2013) and discusses the value of NVivo software used in the data analysis. A second analytic process of Gioia, Corley and Hamilton (2012), used to finesse the analysis and demonstrate further rigour, is also presented. Data analysis and findings from the data corpus are presented in Chapter 6 and a discussion of the findings follows in Chapter 7. The contribution this research makes to organisational resilience and leadership theory, practice and policy is also discussed in Chapter 7. The final Chapter 8 identifies the limitations of the research study, offers directions for future research and concludes the thesis.

1.5 Chapter summary

This chapter has introduced the research study that set out to identify how leaders behaved strategically to improve the performance of their organisation and develop sustained organisational resilience, as evidenced by the CQC. The context, background, rationale and theoretical motivation for the research were discussed and the research questions introduced. The structure of the thesis was then presented and the chapter concluded with a summary. The following two chapters review the literature that is relevant to the research study.

Chapter 2

LITERATURE REVIEW
PART I: LEADERSHIP AND THE NHS

2.1 Introduction and chapter overview

This research seeks to understand how two NHS organisations in England have developed and maintained resilience in a changing and challenging environment. The literature reviewed in this thesis pertains to leadership and leader behaviour, organisational culture, governance and regulation, performance and organisational resilience, contextualised to research in the health care sector and hospital Trusts in the NHS, in England in particular. The literature review is reported in two chapters: Part I is focussed on literature relating to leadership and the NHS. In Chapter 3, Part II reviews the organisational resilience literature and related leadership behaviours.

This chapter commences with a brief background to the inception of the NHS in the UK, relating the influence of the medical profession on its establishment and continuity. There follows an overview of the key milestones in the organisation, administration and management of English NHS hospital health care. The introduction and on-going clinical governance and regulation in English hospitals is examined in Section 2.3, reviewing the impact this has had on organisational performance, safety and quality. An overview of leadership, leader behaviour and organisational culture literature is then presented, and their influence on contemporary culture and styles of leadership in the NHS are explored: this concludes the chapter and Part I of the literature review.

2.2 The National Health Service of the United Kingdom

2.2.1 Background

The NHS was established in the UK in 1948. It was a radical and globally unique delivery model, based on the principles of providing comprehensive health care to all, funded through taxation and free at the point of access (Bloor, 1998); these founding principles remain relevant today (DHSC, 2021a). There have been several significant reorganisations with respect to government oversight and management of the NHS throughout its 72-year history (Petchey, 1986; Harrison and Wood, 1999; Sausman, 2001; Nuffield Trust, 2018). Having knowledge of its history enables greater understanding of the governance, cultural issues and management complexities that the service faces

today. Hence, an overview of the key themes will now be reported.

2.2.2 The medical profession and the NHS

Doctors in the UK have their financial and professional interests overseen by their professional bodies. The British Medical Association (BMA) acts on behalf of General Practitioners (GP), whilst the various Royal Colleges represent the interests of hospital consultants. The medical profession was unhappy with the potential impact of the NHS upon their autonomy following the NHS Act of 1946 (Lancet, 1946) and the presidents of the Royal Colleges worked hard to ensure that the Minister of Health granted concessions to consultants (Newdick, 2014). The Royal Colleges successfully defended the profession's assumed rights for clinical autonomy and self-regulation, and were granted highly privileged positions as consultants in NHS hospitals, which overcame their opposition (Digby, 1998; Macpherson, 1998).

General Practitioners were also concerned about their remuneration and perceptions of loss of clinical freedom and the BMA lobbied hard on their behalf to maintain their position as independent business owners, paid through a capitation fee per registered patient rather than a salary. Further concessions from the government won over the GPs and terms were agreed finally three weeks before the 'Appointed Day' of 5th July 1948 (Bloor, 1998; Sheard, 2011).

The profession retains a powerful base and this adversarial position with government surfaces periodically (Harrison and Lim, 2003; Bevan, 2008; Ruiz, Bottle and Aylin, 2013; Goddard, 2016; Horton, 2016). In England doctors have consistently resisted change, clinical and managerial accountability (Horton, 2016) and poor clinical practice has frequently been left unchallenged, often for many years, before an individual practitioner, service or organisation has been formally investigated (Walshe and Higgins, 2002; Walshe and Shortell, 2004; Holmes, 2013; Price *et al.*, 2020).

The NHS is not unified in its organisational systems and governance throughout the four UK countries (England, Northern Ireland, Scotland and Wales). This research has been conducted in England and the remaining literature review relates specifically to that country, commencing with an overview of its organisational structure and management.

2.2.3 Organisational structure and management of the NHS in England

There have been three distinct phases regarding the organisation and management of the NHS, fuelled by governments' desires to have greater service

efficiency, effectiveness and accountability of the medical profession (Stewart and Walshe, 1992; Harrison, 1994; Laing and Shiroyama, 1995; Peckham, 2014; Beaussier *et al.,* 2016). A fourth phase is now being implemented, driven by increasing financial problems in the public sector: it aims for greater integration of the NHS with other partners in social care and local government (NHS England *et al*., 2014; Exworthy, Mannion and Powell, 2016; DHSC, 2021b). These phases are described below, chronologically.

2.2.3.1 The administration era: 1948 — 1983

Until the first significant bureaucratic change in 1974, NHS hospitals were led by a triumvirate of hospital secretary, chairman of the medical staff committee and a senior nurse - the matron (Learmonth, 2017). This administrative bureaucracy ran alongside a powerful medical hierarchy (Sausman, 2001; Harrison and Lim, 2003). Teaching hospitals with medical schools were exempt from this triumvirate senior team model and created their own organisational structures. By the 1970s it was felt that there should be greater consistency of hospital administration throughout the service.

A reorganisation in 1974 created a unified management structure in all NHS hospitals, with a strategic tier of managers (Elkind, 1998). Consensus management was introduced whereby a team of administrator, matron, finance officer, hospital medical consultant, community physician and a GP were required to agree a course of action before it could be implemented (Harrison, 1982; Learmonth, 2017). Hospital administrators were considered to be holding a prestigious role and were usually male (Learmonth, 2017). In practice, the medical professionals were the key decision makers, with the administrators acting more as ‘diplomats’, smoothing the path for the physicians (Harrison, 1982).

From its inception, NHS finances came under pressure. Estimated costs were exceeded in the first two years and income to the Treasury from national insurance contributions was inadequate, causing additional sources of funding to be sought. Within three years the public were charged for some dental and ophthalmic services and the introduction of prescription charges followed in 1952 (Digby, 1998). Financial pressures continue to be a feature of the contemporary NHS (Woolf and Henshall, 2000; Street, 2016; Lafond, Charlesworth and Roberts, 2016; Rodriguez-Santana *et al.*, 2020).

2.2.3.2 The general management era: 1984 — 1997

The next major shake up came in 1983 after Roy Griffiths, then the Managing Director of Sainsbury's supermarkets, was tasked by the Conservative government to lead an inquiry into NHS management (Harrison, 1994). Griffiths was scathing about how the NHS was run (Griffiths, 1983, p. 8) stating its issues were a result of poor general management, defined as "the responsibility drawn together in one person, at different levels of the organisation for planning, implementation and control of performance". Griffiths (1983, p. 4) also recommended strongly that doctors should become more involved in hospital management, commenting "clinicians must participate fully in decisions about priorities in the use of resources". The outcome following the Griffiths Report was the introduction of general management in 1984.

The thrust of the reforms was to increase financial accountability and have a clear system of management responsibility, with one person in overall charge (Pollitt *et al.,* 1991; Marnoch, 2008). Managers and not administrators were in charge and placed at all levels throughout the organisation. The emphasis began to move away from the authoritative power of doctors towards a focus on quality and finance (Sausman, 2001), altering the balance of medical power at the head of the organisation. Whilst there was little change in the tense relationship between doctors and managers, there began to be an acceptance of managerial legitimacy and in NHS management/ government relationships (Harrison and Lim, 2003; Learmonth, 2017).

The Thatcher government tackled the problems of spiralling costs and lack of accountability head on. With a macro-economic policy objective to reduce public spending, the NHS was expected to become more efficient and effective, producing more for less (Pollitt, 1996). The contemporary NHS continues to be required to make efficiency savings year on year and there has been a great deal of merger activity to try and rationalise spending (Cereste, Doherty and Travers, 2003; Gaynor, Laudicella and Propper, 2012).

In 1990 the government brought in changes designed to bring in competition to the NHS, with the introduction of an internal market. The intent was to drive up quality and efficiency of hospital services and to drive out those offering sub-standard or costly care. General hospitals were re-named hospital Trusts and entered into contractual arrangements with purchasers: the district health authorities and newly established GP Fundholders (Woolf and Henshall, 2000). Subsequent governments have continued to

reorganise the NHS, including the dismantling of GP Fundholding in 1998 (Exworthy, Mannion and Powell, 2016).

2.2.3.3 The leadership era: 1997 — 2010

The notion of NHS leadership began to gain prominence in the early term of Blair's New Labour government of 1997 (O'Reilly and Reed, 2010). The term leadership was initially used interchangeably with the word management (Harrison and Lim, 2003; Learmonth, 2017). Towards the end of the century leadership and leaders became the consistent terms used when referring to NHS chief executive officers (CEO).

The introduction of clinical governance in 1999 required NHS organisations for the first time to formally account for patient safety and clinical quality (Price *et al.,* 2020). The CEO and Board became responsible for clinical quality improvement and standards of their organisation, which had previously been the domain of doctors (Sausman, 2001; Salter, 2007). This further changed the relationship between medical consultants and managers, breaking the dominant influence of consultants and placing the CEO firmly as the organisation's leader. With this additional responsibility of clinical governance, CEOs also became accountable for organisational, clinical and financial failures (Sausman, 2001).

2.2.3.4 The transformation era: 2010 onwards

The Coalition government of 2010 created another major NHS reorganisation (Exworthy, Mannion and Powell, 2016), with accountability of hospitals changing from the government directly to an arms-length, newly formed organisation, NHS England. The UK entered a decade of under-investment in public services with a significant impact on health and social care services (Charlesworth and Johnson, 2018; Iacobucci, 2020b).

In 2014, organisations with oversight of health and social care provision published their Five Year Forward View of the NHS (NHS England *et al.,* 2014), outlining plans for health service providers to work in partnership with other sectors to address funding, quality and care gaps in the health and social care system. It was envisioned that by April 2021, NHS Trusts would be working in collaboration with other health service providers, social care and local authorities in Sustainable Transformation Partnerships (STP) within an ICS, implementing sustainable transformation plans that had been developed during the preceding years (Ham *et al.,* 2017; NHS England and NHS Improvement, 2018).

The focus for the NHS has moved from internal competition to collaboration, that rationalises resources and transforms services to meet local community need (Alderwick and Raleigh, 2017; Walshe, 2017; DHSC, 2021b). However, a controversial Health and Social Care Act 2012 (HSCA 2012) introduced by the Coalition government created a barrier to true integration due to statutory competition law that can challenge organisations for anti-competitive practices (Davies, 2013; Timmins, 2018). Therefore, integration of organisations designed to improve service quality, patient outcomes or greater efficiency can be blocked if the action is deemed to remove market competition (Spencelayh and Dixon, 2014; Sanderson, Allen and Osipovic, 2017).

New legislation is required to remove the contestability enshrined in the HSCA 2012, enabling operationalisation of an ICS: this is now in process, with a projected implementation date of 2022 (DHSC, 2021b). Integration of health and social care services will, arguably, require different leader behaviours and attitudes to those dominant in a climate of competition. Therefore, a nuanced understanding of the most desirable leader behaviours will be essential for its success: these are explored in Section 2.5. A review of regulation of clinical governance in the NHS now follows.

2.3 Regulation of clinical governance in NHS hospitals in England

Statutory regulation of clinical governance in the UK health care sector was preceded by a number of public reviews into serious health service failures that demonstrated the inadequacy of self-regulation of medical care (Scally and Donaldson, 1998; Walshe, 2002; Walshe and Higgins, 2002; Millar *et al*., 2013). The New Labour government under Blair set out a direction of travel for the NHS to address clinical governance (DoH, 1997). It established a commission in 2001, the Commission for Health Improvement (CHI), which was the first statutory regulatory organisation to assess the performance of NHS hospitals. Prior to its inception there were a number of voluntary accreditation programmes in the UK: most notably those that focussed on improving clinical quality in hospitals were the King's Fund Organisational Audit and the Hospital Accreditation Programme (Bohigas *et al.*, 1998; Walshe, 1999).

The primary aim of CHI was to "help bring about demonstrable improvement in the quality of NHS patient care" (Benson, Boyd and Walshe, 2006, p. 214). It did this by conducting clinical governance reviews and then making recommendations to a Trust following their CHI visit. These recommendations tended to be more oriented towards management practices than on direct patient care and outcomes. In their review of the

process, Benson and colleagues (2006, p. 213) recommended “any future review or inspection processes should place a greater focus upon patient outcomes if such reviews are to demonstrate their value in making a contribution to improving health”. The Healthcare Commission replaced CHI in 2004, followed by the CQC in 2009, which remains the inspection body today and is now discussed.

2.3.1 Care Quality Commission

The Coalition government of 2010 — 2015 was concerned about the quality and safety of patient care following a number of high-profile reviews into service failures (Kennedy, 2001; Walshe and Higgins, 2002; Francis, 2013; Kirkup, 2015). A demanding inspection process by CQC was established (Exworthy, Mannion and Powell, 2016), which has been revised periodically (Beaussier *et al.,* 2016). Substantial changes were introduced in 2013 following investigation into the widely-reported failings at the Mid Staffordshire NHS Foundation Trust (Francis, 2013; James, 2020).

In NHS non-specialist acute and mental health hospitals, the CQC inspection results in a rating of *Inadequate, Requires Improvement, Good* or *Outstanding* for each of five quality domains: leadership, safety, effectiveness, caring and responsiveness to patient need; and an overall rating on the same scale for the organisation (CQC, 2015). These quality domains developed further Darzi’s definition of clinical quality relating to patient experience, patient safety and effectiveness of care (Darzi, 2008; Walshe *et al.*, 2014).

The CQC undertook an in-depth review of all health services in England during 2013-2016 to establish the state of health care in the country and provide a baseline of each organisation (CQC 2017a; CQC, 2017b). Of the one hundred and thirty-six NHS non-specialist acute Trusts, five were rated *Outstanding*, thirty-nine were rated *Good*, eighty were *Requires Improvement* and twelve Trusts were *Inadequate* (CQC, 2017a) (Table 1, p. 36). The latter were placed in special measures, received additional regulatory scrutiny and given between six and twelve months to improve. All fifty-four NHS mental health Trusts were also inspected. Overall, two Trusts were *Outstanding*, thirty were rated *Good*, twenty-one were *Requires Improvement* and one Trust was *Inadequate* (CQC, 2017b) (Table 1). Following this baseline assessment, CQC has continued to undertake periodic assessment visits to Trusts in England and aims to improve the overall quality of health care in the country (CQC, 2018b).

Table 1: Overall Trust CQC Ratings of NHS Non-specialist Acute Trusts and NHS Mental Health Trusts in England, December 2016 (Source: CQC, 2017a; CQC, 2017b)

Non-specialist Acute Trusts (n=136)	INADEQUATE	REQUIRES IMPROVEMENT	GOOD	OUTSTANDING
	12 (9%)	80 (58%)	39 (29%)	5 (4%)
Mental Health Trusts (n=54)	1 (2%)	21 (39%)	30 (55%)	2 (4%)

2.3.2 Core clinical service areas of CQC inspection

Non-specialist acute and mental health NHS Trusts in England are complex organisations and can comprise a number of hospitals delivering a range of services distributed over large geographical areas. In order to bring more rigour and consistency to benchmarking Trusts, CQC identified eight core clinical service areas in the acute sector and eleven in the mental health sector (Table 2), which it estimated would account for the majority of clinical quality experiences of patients (CQC, 2017a; CQC, 2017b).

Table 2: Core Services Assessed by CQC in NHS Non-specialist Acute and Mental Health Trusts in England (Source: CQC, 2017a; CQC, 2017b)

Core Services in NHS Non-specialist Acute Trusts	Core Services in NHS Mental Health Trusts
Urgent and emergency services	Child and adolescent mental health wards
Medical care, including older people	Acute wards for adults of working age and psychiatric intensive care units
Surgery	Long stay/rehabilitation mental health wards for working age adults
Intensive and critical care	Wards for older people with mental health problems
Maternity and gynaecology	Wards for people with a learning disability or autism
Services for children and young people	Forensic inpatient/ secure wards
End of life care	Specialist community mental health services for children and young people
Outpatients and diagnostic imaging	Community-based mental health services for adults of working age
	Community-based mental health services for older people
	Mental health crisis services and health-based places of safety
	Community-based mental health services for people with a learning disability or autism

Each hospital within a Trust is inspected in each of the individual core services it provides, which are rated independently for each of the five quality domains noted above and given an overall service rating. Each hospital within the Trust is also given an overall quality rating, which is an aggregate of the overall service ratings. The final Trust rating is an aggregate of the overall hospital ratings. This gives a detailed picture of quality at service, hospital and organisational level (CQC, 2017a).

The CQC publishes an annual report that includes the overall ratings of all core health and care sector services it regulates. Tables 3 and 4 show the ratings of all core services in the NHS non-specialist acute and mental health Trusts in England since the comprehensive oversight process was introduced. Services are commissioned and others de-commissioned in-year, therefore service numbers fluctuate.

Table 3: CQC Ratings of All Core Services in NHS Non-specialist Acute Trusts in England, 2016-2020 (Source: CQC, 2017a; CQC, 2018a; CQC, 2019a; CQC, 2020)

Non-specialist Acute Trust Core Services	INADEQUATE	REQUIRES IMPROVEMENT	GOOD	OUTSTANDING
2016 (n= 1,649)	81 (5%)	620 (38%)	868 (53%)	80 (5%)
2017 (n= 1,758)	57 (3%)	643 (37%)	960 (54%)	99 (6%)
2018 (n= 1,752)	48 (3%)	545 (31%)	1,054 (60%)	105 (6%)
2019 (n= 1,773)	43 (2%)	452 (26%)	1,151 (65%)	127 (7%)
2020 (n= 1,777)	30 (2%)	406 (23%)	1,193 (67%)	148 (8%)

Table 4: CQC Ratings of All Core Services in NHS Mental Health Trusts in England, 2016-2020 (Source: CQC, 2017a; CQC, 2018a; CQC, 2019a; CQC, 2020)

Mental Health Trust Core Services	INADEQUATE	REQUIRES IMPROVEMENT	GOOD	OUTSTANDING
2016 (n= 506)	7 (1%)	125 (25%)	344 (68%)	30 (6%)
2017 (n= 540)	7 (1%)	130 (25%)	369 (68%)	34 (6%)
2018 (n= 515)	6 (1%)	107 (21%)	360 (70%)	42 (8%)
2019 (n= 543)	15 (3%)	91 (17%)	383 (71%)	54 (10%)
2020 (n= 514)	15 (3%)	77 (15%)	365 (71%)	57 (11%)

2.3.3 CQC core service quality: domain definitions and trends 2016-2020

Since the comprehensive CQC inspection regime was introduced, the quality of core health services across all domains has been rated consistently higher in the mental health sector than non-specialist acute Trusts. Quality ratings in both sectors and across all domains have improved annually overall (Tables 5 and 6). However, there are relatively small changes in the mental health sector compared to some noticeable changes in acute hospital services across the five-year span. The greatest change is observed in services moving from *Inadequate* and *Requires Improvement*. Re-inspections have identified services that have maintained quality, improved and also deteriorated (CQC, 2015; CQC, 2018a; CQC, 2020).

Table 5: CQC Quality Domain Ratings (%) for NHS Non-specialist Acute Trust Core Services in England, 2016-2020 (Source: CQC,2017a; CQC,2018a; CQC,2019a; CQC,2020)

	2016				2017				2018				2019				2020			
DOMAIN	**I**	**RI**	**G**	**O**	**I**	**RI**	**G**	**O**	**I**	**RI**	**G**	**O**	**I**	**RI**	**G**	**O**	**I**	**RI**	**G**	**O**
Safe	11	70	19	0	5	42	52	1	3	40	57	1	3	36	61	1	2	34	63	1
Effective	2	42	54	2	1	24	72	3	1	21	75	4	1	19	77	4	1	16	79	4
Caring	0	7	78	15	0.5	3	88	8	0.5	2	89	8	0.5	2	87	11	0.5	1	86	13
Responsive	7	60	29	4	2	35	58	4	2	30	64	5	1	25	68	6	1	25	67	7
Well-led	10	47	38	6	5	29	61	6	4	24	65	7	1	21	68	7	2	19	70	8

TABLE KEY	**I** - Inadequate	**RI** - Requires Improvement	**G** - Good	**O** - Outstanding

Table 6: CQC Quality Domain Ratings (%) for NHS Mental Health Trust Core Services in England, 2016-2020 (Source: CQC, 2017b; CQC, 2018a; CQC, 2019a; CQC, 2020)

	2016				2017				2018				2019				2020			
DOMAIN	**I**	**RI**	**G**	**O**	**I**	**RI**	**G**	**O**	**I**	**RI**	**G**	**O**	**I**	**RI**	**G**	**O**	**I**	**RI**	**G**	**O**
Safe	4	36	59	1	3	36	60	1	2	37	60	1	4	30	66	1	4	29	67	1
Effective	1	24	71	4	1	24	71	3	0.5	21	74	5	1	17	77	6	1	13	80	6
Caring	0	4	87	9	0	3	88	9	0	2	86	12	1	3	83	14	0.5	3	81	16
Responsive	1	16	78	5	1	16	78	5	1	13	80	6	2	11	80	7	2	12	78	8
Well-led	1	21	74	4	1	20	75	4	1	17	75	7	3	13	75	8	3	12	75	10

TABLE KEY	**I** - Inadequate	**RI** - Requires Improvement	**G** - Good	**O** - Outstanding

By the term ‘safe’, the CQC means that patients are protected against all forms of abuse (physical, mental, discriminatory, institutional, psychological, neglect, financial), or avoidable harm (CQC, 2015). Since 2015, it has consistently reported concern for the quality of patient safety in both non-specialist acute and mental health Trust core services in England (CQC, 2015; CQC, 2017a; CQC, 2017b; CQC, 2018a; CQC, 2020). Whilst Trust staff consistently assert that safety is their top priority, CQC inspectors often do not find evidence of safe practices or embedded systems and processes that safeguard patients

adequately (CQC, 2017a; CQC, 2017b; CQC, 2020). Table 5 shows a considerable increase over the timeframe in *Good* and *Outstanding* ratings for this domain in the non-specialist acute sector; Table 6 shows there has been little improvement in 5 years in mental health Trusts, with both sectors having one-third of Trusts currently rated as *Inadequate* or *Requires Improvement*.

A patient's care is judged to be effective when their "treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence" (CQC, 2017a, p. 25). Services that demonstrate a focus on quality improvement and on-going evaluation are key features contributing to *Good* and *Outstanding* effective care ratings (CQC, 2017a). A *Good* responsive service is one where "services are organised to meet patient's needs" (CQC, 2017a, p. 30). Services are assessed on their ability to show flexibility to individual patient needs, listen and respond to complaints in a timely manner and make improvements as a result of feedback. Patient access and cancellations are also assessed within this quality domain. Both mental health and non-specialist acute services have improved annually in these domains (Tables 5 and 6).

There has been a considerable focus on providing compassionate and respectful health care, both in the NHS and abroad (Darzi, 2008; Lown, Rosen and Marttila, 2011; Mannion, 2014; West and Chowla, 2017; Bridges *et al.*, 2017; Bleiker *et al*., 2020). Treating patients with respect, dignity, kindness and compassion are the elements that the CQC look for when assessing whether a service is caring (CQC, 2015). The results in this domain are striking for their consistently high ratings in both sectors (Tables 5 and 6). Where services have fallen short, this reportedly has been largely due to low staffing levels and the ensuing strain this puts on a service (CQC, 2015).

The relationship between leadership quality, hospital performance and patient outcomes are well documented (Firth-Cozens and Mowbray, 2001; Shipton *et al.*, 2008; Francis, 2013; West *et al.,* 2014; Kline, 2019). Examination of several NHS organisational failures has identified poor leadership practices as a contributory factor (Kennedy, 2001; Redfern, Keeling and Powell, 2001; Francis, 2013) and establishing the quality of leadership is the fifth domain scrutinised by the CQC. This domain continues to decrease in the unacceptable ranges over time in both mental health and non-specialist acute services (Tables 5 and 6). The CQC reports a positive correlation between the quality of leadership and quality of health care in NHS Trusts (CQC, 2017a; CQC, 2017b). The impact

of regulation on NHS Trusts is now reviewed through research which is independent of the CQC.

2.3.4 The impact of CQC regulation on NHS Non-specialist Acute and Mental Health Services in England

There are a large number of regulatory bodies that hold the English NHS to account, with no one body having complete overall responsibility (Peckham, 2014; Edwards, 2016; Oikonomou *et al.*, 2019). The CQC requires Trusts to provide annual data and periodically inspects organisations to assure quality. However, despite duplication in the regulatory system, safety from poor clinical practices in English NHS hospitals is not guaranteed (Beaussier *et al.,* 2016; Iwami *et al.,* 2017; James, 2020). As noted above, patient safety has been a constant concern for CQC since 2014 (CQC, 2015; CQC, 2017a; CQC, 2017b; CQC, 2018a; CQC, 2020). As Edwards (2016) remarks, the financial and time-consuming burden of regulation and the numbers of regulators in the UK health system can cause confusion as to who is monitoring what. Paradoxically, regulatory overload might force organisations to focus more on quality assurance rather than quality improvement in order to satisfy inspectorates (Fulop and Ramsay, 2019).

The CQC aims to encourage and contribute to quality improvement of NHS services through its regulatory process (CQC, 2016a): it seeks to influence organisations through collaboration with other regulators and stakeholders that have a development responsibility to the NHS (Smithson *et al.,* 2018). Its intentions were to raise standards by sharing best practice information across organisations, identifying areas for improvement and holding Trusts to account through inspection. It was also envisaged that the new system would achieve this aim if more Trusts over time were rated *Good* and *Outstanding*, and less were *Inadequate* or *Requires Improvement* (Walshe *et al.,* 2014). An evaluation of the pilot phase of the new regulatory model reported impact in a number of ways, both positive and negative (Walshe *et al.,* 2014). These are summarised in Table 7.

On completion of the first round of inspections, Smithson and colleagues (2018) evaluated the impact that the revised CQC regulatory framework had on the inspected NHS acute and mental health hospitals in England. They identified eight potential "impact mechanisms" (Smithson *et al.,* 2018, p. 13) and reported positive and negative impacts on Trust respondents using this devised framework. Examples of impacts are shown in Table 8, below.

Table 7: Pilot Phase Evaluation of Impact of CQC Comprehensive Inspection Process
(Source: Walshe *et al.,* 2014)

Positive Impact	Negative Impact
Inspections identified few unknown areas for improvement and validated existing concerns, giving impetus for change	Not all staff saw the process as a development opportunity, but punitive
Trust staff were positive that the approach could provide a credible assessment of their organisation	There was concern over the consistency and reliability of ratings and reports
A post-inspection quality summit of key stakeholders was an opportunity to gain commitment for development support from those stakeholders. This was particularly useful for lower-performing Trusts	There was concern over the time commitment of preparation and inspection and costs of the process
The inspection gave opportunity for Trust staff to voice concerns that were usually supressed, such as a bullying culture and staff morale	A vast quantity of data, of questionable value to the process, was requested by the CQC
The inspection provided an opportunity for reflection and strategic planning	

Using the impact mechanism framework, Boyd, Moralee and Ferguson (2020) investigated the CQC's impact on quality through its relationships with Trust staff and the use of its guidance documents and assessment frameworks. They also focussed their analysis on the registration remit of the CQC, which is outside the scope of this research. They concluded that the CQC does impact quality of services through supportive relationships with staff, providing feedback, facilitating development by other stakeholders and through provision of relevant guidance products. They also acknowledged that Trust staff need intrinsic motivation to improve and may need to develop capability in order for quality improvement to be self-sustaining (Boyd, Moralee and Ferguson, 2020).

In an evaluation of the impact of regulation on NHS acute hospitals, Castro (2018) reported a mixed effect on organisational performance and clinical outcomes. In assessing the effect of CQC inspection on two measures of quality of care, Castro-Avila and colleagues (2019) found little evidence to support a positive link and concluded that external regulatory oversight did not contribute significantly to improvement in care quality. They also reported that improvements made prior to a CQC inspection were actually reduced following an inspection. The reason for the downturn is unclear but may

Table 8: Impact Mechanisms with Examples of Positive and Negative Impact on NHS Acute and Mental Health Trusts in England (Source: Smithson *et al.,* 2018)

Impact Mechanism	Description	Positive Impact Examples	Negative Impact Examples
Anticipatory	Regulator sets clear standards and expectations. Trust prepares in advance of an inspection to comply	Raised awareness; improved staff engagement; aids prioritising quality issues	Actions focussed on getting through the inspection, not raising quality of care; frenzy of bureaucracy; staff anxiety raised
Directive	Trust takes actions directed or guided by the regulator, including enforcement actions	Implementation of more robust tools and systems for monitoring quality	Implementing requirements that were not agreed with or seen to be of high priority
Organisational	Organisational development arising from non-directive discussions with the regulator, stimulating reflection and change	Culture change; leadership development; changes in leadership	Increase in reporting turned the focus away from patients, towards administrative tasks
Relational	Relationship between regulator's inspectors and Trust staff, which influences behaviour through credibility of regulatory staff	Valued characteristics include consistency, experience, fairness, credibility, objectivity and service-user focussed. Having time to interact informally enables sharing of ideas and soliciting advice	Negative perceptions of CQC include their being aggressive, nit-picking, critical and confrontational. Lack of mutual respect hinders opportunity to share ideas and seek advice
Informational	Regulator collates information on Trust performance and makes it publicly available so others can make decisions and choices	Stakeholders have relevant information to inform decision-making on services	Impact is negated when information on website is out of date or publication is delayed
Stakeholder	Other stakeholders influenced or mandated to work with Trust as result of regulator action	Trust actively engages with stakeholders that can help with quality improvement	Stakeholders not always engaged proactively with Trust, unless poorly rated
Lateral	Regulatory action and encouragement stimulates Trust members to work with other organisations or peers to share learning and develop mutually	Use of networks and external relationships to share learning and obtain support	Use of existing networks not focussed on addressing CQC concerns
Systemic	Regulator shares themes identified across organisations, stimulating action of other sectors in the system	Some evidence of CQC thematic work being used by health and social care providers and other stakeholders	Model not well suited to organisations working in partnerships or networks

be a result of the shock and denial that some experience following a poor CQC rating (CQC, 2017a). It also suggests that improved performance following an inspection is the result of internal rather than external motivation.

The findings of Castro (2018) contrast with those of the CQC, who state their feedback implies that inspection does contribute to performance improvement (CQC, 2017c; CQC, 2018c). Pratt (2015) described how staff in one Trust had responded to being in special measures following the first CQC comprehensive inspection with optimism and a determination to make improvements. The inspection was a precipitant for the resulting internal motivation to change and focus on Trust governance, safety, quality improvement and listening to patient feedback, which enabled the Trust to come out of special measures within two years (Pratt, 2015). These conflicting results make it difficult to get a clear picture of how regulation might contribute to performance improvement in NHS hospitals.

Hovlid and colleagues (2020) performed a systematic review on health care studies that addressed change in organisations subject to external inspections, to identify mediators of change. Reviewed studies included organisations in various settings and with different regulatory processes, mainly accreditation, including NHS regulation in hospitals in England. They found that external inspections can promote change, dependent on how they are conducted: the process impacts how the findings are received and followed up by the inspected organisation. The process and inspectors must be perceived as credible and their findings valid for change to occur.

Mediators of change included planning, implementation and evaluation of activities aimed at continuous quality improvement, improved communication between the organisation and external partners, and opportunities for internal discussion and greater staff engagement to agree and focus on areas for development (Hovlid *et al.,* 2020). Their findings suggest that an inspection perceived to lack credibility might contribute to the downturn in performance post-inspection that was reported by Castro-Avila and colleagues (2019), noted above.

The CQC reports consistent annual improvements in numbers of services rated *Inadequate* and *Requires Improvement*, but also notes that some services deteriorate in quality (CQC, 2015; CQC, 2018c; CQC, 2019b). There was no significant difference in improvement overall in the NHS reported recently, particularly in maternity, mental health and emergency services from the previous year (CQC, 2020), highlighting the

difficulty that some organisations have in providing quality services despite regulation. This raises an issue as to whether the CQC regulatory process should also seek to improve organisational resilience, which will be explored further in Section 3.7.1.

A mark of a resilient organisation is its ability to improve whilst under pressure (Boin and van Eeten, 2013), emerging stronger following external challenge (Vogus and Sutcliffe, 2007; Crichton, Ramsay and Kelly, 2009). That some health care organisations decrease their performance and resilience under regulatory scrutiny is a concern and an area for further investigation (Leistikow and Bal, 2020). Organisational resilience in health care organisations will be addressed in Section 3.7. Internal governance of NHS organisations is now discussed.

2.4 Internal governance processes

Clinical governance has been described as an overarching concept for the combined clinical activities aimed at quality improvement (Som, 2009; Travaglia *et al.,* 2011). Brennan and Flynn (2013) note that clinical governance systems are both external regulatory and internal managerial processes, as in the case of the English NHS. This can create an ambiguity of understanding. Braithwaite and Travaglia (2008) identified four components of clinical governance: activities that promote quality and safety, creating structures for their improvement, utilisation of data and evidence, and developing a patient-centred approach. They also commented that it should strengthen links to corporate governance with respect to its aspects of effective management, fiscal responsibilities and accountability for service delivery. In mapping the rise of clinical governance in healthcare, Travaglia and colleagues (2011) observed a growing number of terms that have become associated with the concept, including risk which includes the themes of staff, audit, service, care and clinical. Quality and performance, patients and safety are also dominant themes.

There are various statutory regulations that set out the areas of accountability and governance for NHS Foundation Trusts. An NHS Trust Board is required to hold its organisation to account for its performance and delivery of its strategy through seeking assurance that systems of control are robust and reliable (Monitor, 2014). The Foundation Trust regulator, Monitor (under the operation of NHS Improvement since April 2016), requires Trusts to demonstrate compliance in the areas of quality, safety, financial stewardship and risk management through effective corporate governance (Monitor, 2014).

The statutory areas governing quality are ensuring that essential standards of quality and safety, as laid down by the CQC, are met; striving for continuous quality improvement; and enabling staff to deliver safe, effective, person-centred care (National Quality Board, 2011). Accountability for quality assurance and clinical governance is managed statutorily through a Trust's Quality Committee (Ramsay *et al.,* 2013). As reported in Section 2.2.3.2, Griffiths (1983) recommended that medical clinicians became more involved in hospital management and took greater accountability of their practice, heralding a more formal approach to clinical risk management (Lawton and Parker, 1999).

Alongside rising costs of medical negligence claims, Trusts have been required to demonstrate improved risk management processes. The NHS Litigation Authority introduced a Clinical Negligence Scheme for Trusts in 1995 (Towse and Danzon, 1999) and helped Trusts monitor and analyse causes of risk and learn from incidents. Managing risk remains an important aspect of organisational safety (Zinn, 2008; Parker, 2009) and overall sustainable performance (Pojasek, 2013). As part of the governance framework and codes, NHS Trusts are required to have a Board Assurance Framework in place that provides an effective and comprehensive process by which all risks are identified, monitored and addressed (Ramsay *et al.,* 2013).

Trust Boards are required to shape a positive culture for the Board and their organisation (Ramsay *et al.,* 2013). Accountability for financial probity and compliance is statutorily overseen by an Audit Committee (Ellwood and Garcia-Lacalle, 2016). Trust Board papers freely available on the Internet reveal these topics are regularly discussed at Trust Board meetings, reported through various committees and 'Governance' agenda standing items. Trust culture and NHS leadership is discussed in Section 2.6.1 and follows the review of specific leadership literature now presented.

2.5 Leadership and leader behaviour

Study of leadership has a significant history and an extensive literature. Plato communicated his views on leadership and the qualities of leaders in his fourth century BC writings, whilst the work of Carlyle in the 1840s catalysed the proliferation of modern day leadership research (Iszatt-White and Saunders, 2014). An overview of its theoretical development is now presented to provide the context for its influence on health care leadership. An extensive review or critique of each major theory is not provided and it is recognised that there are many other contributions to the leadership literature of import: their exclusion does not imply insignificance to the body of knowledge. Rather, this

literature review has been deliberately focussed on that which has had most influence on the NHS and situates the contemporary position of its leadership and leader behaviour.

2.5.1 Overview of leadership theory development

There has been considerable variety in the approach of scholars to the study and definitions of leadership (Northouse, 2016). Yukl (2012) asserts that such a variety makes it difficult to make comparisons or integrate the findings. King (1990) identified nine evolutionary eras in the development of leadership theory, with researchers focussed on different themes in each era: five of these are reviewed below in chronological order, identifying their influence on NHS leadership. The behaviour era gave rise to leadership styles theories, which are dominant today (Halliman, 2014). The styles most influential in the NHS over the past two decades are then discussed. Additionally, responsible leadership is reviewed for its potential significance in the contemporary NHS.

2.5.2 The personality era

Carlyle posited a 'great man theory' based on his views that historical leaders were heroic and only those men born with heroic potential would become leaders (Perruci and McManus, 2013). The dogma of leaders being 'born and not made' persisted and led researchers to identify the characteristics of leaders, giving rise to trait theory. These theories were eventually discredited when empirical research was unable to identify a single or group of traits exclusively associated with good leadership (Khan *et al.,* 2016). King (1990) refers to this phase of theory as the personality era, which preceded the influence era.

2.5.3 The influence era

Kort (2008) reviewed two hundred and twenty-one definitions of leadership collated by Rost in the 1990s and identified a thread that ran through them: that leadership was about one person, i.e. the leader, to get another - a follower, to do something. Other reviews of the subject at that time concurred with the view that an aspect of leadership is relational between individuals and relates to the ability to influence (Mullins, 1999). However, different theories proposed how this influence was achieved (Rost and Smith, 1992), including the emergence of studies focussed on the relational nature between leadership and power dynamics (Clark and Harrison, 2018).

Leader influence through positional or legitimate power, with autocratic leaders exerting authority and control over subordinates was one explanation and, although it is

recognised that this style of top-down influence is inappropriate in the contemporary workplace (King, 1990), it still lingers in the NHS to the detriment of its employees (Lewis and Kline, 2019). Expert power, vested in the person through their knowledge base, was another of five types in the initial taxonomy of power identified by French and Raven in 1959 (Clark and Harrison, 2018), to which they later added further theory (Elias, 2008). Expert power is clearly featured in a health care system, where professional groups have a distinct knowledge base according to their discipline. Also, within a profession there are specialised experts with an advanced level of educational achievement and clinical expertise, such as medical and nurse consultants.

A more subtle hierarchy also pervades the NHS, whereby one professional group cedes expert power to another, such as nurses to doctors, creating a professional power dynamic: intra- and inter-professional power plays out in health care organisations, a result of both expert and positional power, which has been wielded with negative effect (Currie and Suhomlinova, 2006; Hutchinson and Jackson, 2015). It was also noted in Section 2.2.2 that historically, the balance of power of medical consultants over senior management had led to a clinical autonomy that did not necessarily put the needs of patients first (Mannion and Goddard, 2001; Currie and Suhomlinova, 2006). Whilst this position is considerably improved today, relationships between doctors and managers can be difficult and remains periodically problematic in some organisations (Rundall *et al.,* 2004; Bhaidkar and Goswami, 2016).

Linstead, Fulop and Lilley (2004, p. 183) contend that there is always a power dynamic in a relationship, which is "one of the most controversial aspects of organisations". However, Moss Kantor (1979) argues that power is manifested through connections in an organisation, both formal and informal, and not derived from a leader's style or skill. She defines power as "the ability to mobilise resources (human and material) to get things done" (1979, p. 66) and asserts that it is through their power that the leader is able to exert influence on individuals or groups.

Moss Kantor's (1979) definition underlines the importance of building personal relationships in organisations and promotes a positive notion of power, a view supported by Iszatt-White and Saunders (2014). The need to develop good relationships between leaders, managers and clinicians has been recognised in the NHS, acknowledging particularly the positive benefits to patient outcomes, staff well-being and improved performance (Firth-Cozens and Mowbray, 2001; Edwards, 2005; Collins, 2006).

2.5.4 The behaviour era

The focus of leadership studies moved from sources of power or traits towards their behaviour (Clark and Harrison, 2018), emphasising what they do to make them effective leaders. The importance of initiating structure to accomplish tasks and showing consideration for group cohesion were important behaviour traits identified in early studies of this era (King, 1990). Later theories included the idea that leaders create an environment for subordinate behaviour, generating intrinsic motivation through improving expectations as well as extrinsic motivation through reward systems (Russ, 2013).

McGregor's 'Theory Y' offered an alternative to the contention that leaders who exerted control and rewards generally extrinsically motivated employees. The application of 'Theory Y' concepts and assumptions regarding intrinsic motivation (Carson, 2005; Russ, 2013) is evident in the NHS: when leaders provide the appropriate environment, employees are committed to organisational goals, are self-directed when empowered, seek responsibility, find satisfaction in their work and contribute to decision-making and problem-solving (Frankel, Leonard and Denham, 2006).

Argyris (1976) asserted that command and control leadership behaviour inhibits learning in organisations due to unwillingness of employees to offer powerful leaders, or those leaders to request, feedback on their actions. He posited that alternative behaviour would promote feedback and "double-loop learning" (Argyris, 1999, p. 68) and proposed a model view whereby leaders would identify people most competent to make decisions. This requires power-sharing with anyone competent to undertake a task, openness to learning from others and a lack of defensiveness. He suggested this would result in improved problem-solving, decision-making, a greater possibility that errors would be discussed openly and that learning would take place through discussion and feedback (Argyris, 1976).

Argyris (1999) also proposed that errors occur through system design rather than ignorance and that organisational learning takes place when people accept rather than cover up errors. Establishing an open and blameless approach to reporting errors and promoting a learning organisation has been shown to have a positive impact on patient outcomes (Frankel, Leonard and Denham, 2006; Jones and Woodhead, 2015; Fulop and Ramsay, 2019) and has been on the NHS agenda for many years (Mayor, 2000; Lilleyman, 2005; West *et al*., 2014; CQC, 2017c).

2.5.5 The transactional and transformational eras

Transactional leadership, whereby the leader with clear authority motivates by punishment and reward, is a distinct era in the development of leadership theory (King, 1990). Clark and Harrison (2018) argue that it advanced the influence era, as there was greater expectation of reciprocity in the leader-follower relationship. Still visible in the NHS (Kumar, 2013), it is a model that emphasises organisation and planning of resources, resolving problems and monitoring outcomes and achievement of objectives (Alimo-Metcalfe, 1999). Firth-Cozens and Mowbray (2001) have suggested this is the style of leadership descended from the UK government's management of the NHS, which has percolated through to NHS commissioners and clinical team leaders. There has been an acknowledgement by NHS leaders that this style of behaviour is not best suited to health care quality improvement (Kumar, 2013).

The appeal for a transformational leadership style (Alimo-Metcalfe, 1999; Alimo-Metcalfe and Alban-Metcalfe, 2005) has gained traction in the NHS, characterised by leaders who are able to inspire enthusiasm, identify a clear vision and sense of organisational purpose, develop staff to become intrinsically motivated to work effectively and focus on improving performance (Storey and Holti, 2013). Transformational leadership has a moral dimension, with leaders showing "concern for the greater good" (Alimo-Metcalfe, 2013, p. 22). The leader develops their team colleagues, increases their confidence and develops leader behaviours in others (Yammarino and Dubinsky, 1994). The positive impact of transformational leadership on team performance (Dionne *et al.,* 2004) underlines the importance of such an approach for the NHS.

Over time, ideas on leadership and leader behaviour have changed and altered the ways that work is managed and channelled (Gronn, 2002). Leadership has been reconstructed as something that can be shared throughout teams, departments and the organisation and not left to an elite cadre of executives and senior employees (Beirne, 2017). In a review of leadership theory, Alimo-Metcalfe (2013) reported additional ideas of leadership beyond those of the evolutionary eras set out by King (1990). She suggests that leadership has become more focussed on working with people rather than doing to others and described three models to illustrate the point, namely ethical, authentic and distributed leadership. Of these, the latter has become one of considerable discussion in the NHS and is now introduced.

2.5.6 Distributed leadership

Distributed or collective leadership replaces an heroic head at the top of an organisation with a broader base of leadership development running throughout organisational tiers (Linstead, Fulop and Lilley, 2004; King's Fund, 2011): leadership power is distributed to wherever expertise, motivation and capability reside in the organisation. The call for NHS leaders to adopt a distributed model (McKee *et al.,* 2013; West, 2015; West and Chowla, 2017) arose partly to address the quality and safety failures in NHS hospitals referred to in Section 2.3. Public inquiries have concluded that poor leadership practices and negative organisational cultures have been at their root (Kennedy, 2001; Francis, 2013; Dixon-Woods *et al.,* 2014).

West and colleagues (2014) have argued that collective leadership is required to nurture the right culture for healthcare and ensure that all staff from ward to Board are involved in decision-making and innovation: there is evidence of this model working in the NHS (Willcocks and Wibberley, 2015; Fulop and Ramsay, 2019). In addition to this approach to leadership, West (2020) has also promoted the concept of compassionate leadership for NHS leaders, which is now addressed.

2.5.7 Compassionate leadership

Dutton, Workman and Hardin (2014) assert that employee stress is inevitable in an organisation and that compassion is shown when it is met with concern and care by another who notices the stress, attempts to understand it, feels empathy and takes action to relieve it. This conforms to a definition of compassion that it includes emotion and motivation to act (Vrtička, Favre and Singer, 2017). West and Chowla (2017) describe a model for compassionate leadership involving four components: paying attention to staff through active listening; understanding another's cause of distress; showing empathy; and helping and supporting the other. These are similar to the components of compassion identified by Dutton and colleagues (2014) and suggest their concept of compassionate leadership describes behaving compassionately towards stressed colleagues.

A requirement for compassion in care was a defining value written into the original NHS Constitution in 2009 (Bleiker *et al.,* 2016). A report into the effectiveness of the Constitution stated: "Treating all patients with compassion should be hard wired into every organisation and individual member of staff's behaviour" (DoH, 2012, p. 26). Compassionate leader behaviour has been widely promoted in the NHS to deliver

compassionate caring and avoid the poor practices examined through public inquiries noted in Section 2.3 (West, 2013; Newdick and Danbury, 2015; Tomlinson, 2015).

The challenge to do this consistently whilst working in a stressful environment (Vrtička, Favre and Singer, 2017; Bleiker *et al.,* 2020) is discussed in Section 2.6.1; compassion may be felt but not always accompanied by compassionate behaviour (Gilbert, 2017). The focussed attention on compassion is also discussed in Section 2.6.1. It is suggested that an alternative overarching leadership style such as that of responsible leadership, with its intention of doing the right thing towards others, may be a more appropriate goal for NHS leaders.

2.5.8 Responsible leadership

The notion of responsibility incorporates the idea of accountability towards someone for something (Voegtlin *et al.*, 2019). In leadership literature this generally refers to responsibility for the accountability of organisational performance (Cameron, 2011). Maak and Pless (2006, p. 104) describe responsible leadership as "the art of building and sustaining good relationships to all relevant stakeholders". They contend that responsible leaders value building and cultivating ethically sound relationships with all stakeholders to create a values-based identity between them based on a moral sense of justice, care and accountability for a wide range of social, economic, ecological and human responsibilities (Pless and Maak, 2011). These two authors suggest the mindset of a responsible leader shifts away from accountability solely to the organisation's shareholders (or internal stakeholders), towards a total stakeholder society.

Freeman, Wicks and Parmar (2004) assert that responsible leaders view organisational values as significant to organisational success. Other authors acknowledge the economic responsibility that leaders have to shareholders (Lynham and Chermack, 2006; Siegel, 2009; Voegtlin *et al.*, 2019). Doh and Quigley (2014) state the responsible leader builds an open and inclusive organisational culture by sharing and disseminating knowledge whilst building strong, external relationships with stakeholders; at a team level they provide psychological safety and performance learning, leading to improved decision-making and outcomes. Stahl and Sully de Luque (2014) assert that managers, and senior leaders in particular, have an impact on the social performance and long-term viability of their organisation, a theme implied in these various definitions.

Waldman and Galvin (2008) assert that a leader must be responsible in order to be effective. They contend that responsible leadership is highly strategic, geared

specifically to others, with an obligation to be held accountable for one's actions; a responsible leader is motivated to do the right thing towards others. They suggest the 'others' are shareholders and stakeholders (Waldman and Galvin, 2008). Working in a publicly funded health care system, leaders of NHS Trusts are accountable to central government for the use of public funds. Other Trust stakeholders include its staff, service users, other NHS providers, higher education establishments, local authorities and social services; these stakeholders collectively create a system (Akhtar *et al.*, 2016; Manley *et al.*, 2016).

Responsible leaders are aware of their impact on others and focus on doing what is right, through building relationships and serving stakeholder needs (Cameron, 2011; Freeman and Auster, 2011; Pless and Maak, 2011). Stahl and Sully de Luque (2014) emphasise the importance of environment on leader behaviour, identifying organisational context as an antecedent of how people actually behave as opposed to how they should behave. They suggest that responsible behaviour is also affected by a leader's personal characteristics including their values and philosophy, an intention to do good and avoid harm. Crilly and colleagues (2008) also state that responsible leaders align the varied interests of multiple stakeholders, taking ethical decisions within the situational context.

Whilst responsible leadership behaviour has not been strongly associated in the literature with NHS leaders to date, the shifting focus towards collaboration among various providers of health and social care discussed in Section 2.2.3.4 may require a change in leadership style, for example to ensure success of an ICS. Balancing the various objectives of individual stakeholders in the ICS will require system leaders to have well developed communication skills, be firm negotiators, active listeners and have a strong moral compass to do that which is right for the community they serve. The result is likely to have organisational winners and losers in the system and, whilst the system leaders may feel compassionate, they may not be able to behave compassionately to all system players whilst delivering the most benefit to their user stakeholders. A responsible leadership model offers a logical alternative for consideration due to its focus on multi-agency system players and organisational viability and resilience.

2.5.9 Summary of the reviewed leadership literature

Leadership scholars have sought to identify what makes an effective leader (Yukl, 2012), whether certain styles and behaviours are more effective and under what

circumstances they produce better results (Gilmartin and D'Aunno, 2007). Various theories have emerged through decades of research, resulting in a lack of cohesion in the use of terms and concepts (Yukl, 2012). The influence of many theories is present in the NHS today, from a top-down, command and control style to a shared model of distributed leadership.

Health care leadership has been influenced by research both specific to its sector and in general management studies (Gilmartin and D'Aunno, 2007). Leadership has been studied at various levels of organisational hierarchy (Yukl, 2012) and the focus of behaviour is affected accordingly: for example, in a hospital, a ward manager is likely to be more internally focussed than the CEO. The argument for compassionate and distributed forms of leadership have been dominant in the extant health care literature (Fotaki, 2015; de Zulueta, 2016; West, 2020), desirable for their positive impact on patient outcomes. A link between leadership and culture is also evident in the literature and is now introduced, followed by a more in-depth review of NHS leadership and culture.

2.6 Leadership and organisational culture

The relationship between leader behaviour and organisational culture has been researched globally in various sectors (Lok and Crawford, 2004; Dartey-Baah, Amponsah-Tawiah and Sekyere-Abankwa, 2011; Bell, Chan and Ne, 2014; Jordan, Werner and Venter, 2015), including health care (Parker *et al.,* 1999; Gilmartin and D'Aunno, 2007; Jacobs *et al*., 2013; Dixon-Woods *et al.,* 2014; Nica, 2015). Schein (2004, p. 17) defines culture as "a pattern of shared basic assumptions that was learned by a group as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think and feel in relation to those problems". Schein's premise is that a new leader begins to impose onto a group their personal vision, values, beliefs and assumptions about how things should be; once accepted they become the shared culture, which is embedded and passed on to new employees.

Schein (2004) asserts that culture formation is always striving towards patterning as we seek stability, consistency and meaning; he views culture and leadership as two sides of one coin. Common themes running through the various definitions and meanings that describe organisational culture (Brown, 1992; Masood *et al*., 2006; Jacobs *et al.,* 2013) are: a reflection of what is valued; dominant leadership styles; visible symbolism

(dress code, for example); unconscious learned behaviour; and beliefs which justify action. Employees will often describe organisational culture in behavioural terms and "how things are done around here" (Lowndes, 2014, p. 688). A review of culture and leader behaviour in the NHS now follows.

2.6.1 Culture and leader behaviour in the NHS in England

There has been a considerable focus on the culture of the NHS for over two decades (Ball, 1996; Mayor, 2000; Wise, 2001; Sprinks, 2012; Jacobs *et al.*, 2013; Pope, 2019). Key areas researched are: staff bullying and its impact on health professionals and patient care (Randle, 2003; Lilleyman, 2005; Randle, 2011; Timm, 2014; Gerada *et al*., 2018); leadership style and leader influences on staff well-being and patient care quality (Firth-Cozens and Mowbray, 2001; Collinson, 2006; Powell *et al*., 2014; Bailey and Burhouse, 2019; Best, 2020); and safety and organisational learning (Mayor, 2000; Mannion *et al.,* 2015; Newdick and Danbury, 2015; Fulop and Ramsay, 2019).

A recent study by the British Medical Association (BMA, 2018) reported that bullying and harassment emanating from senior leaders in the workplace was experienced by 40% of doctors; a strong blame culture persisted in the NHS and 95% of doctors were anxious about making a mistake (Wise, 2018). The high level of stress among the profession has become compounded by the COVID-19 pandemic, with staff shortages jeopardising patient safety and quality of care (Propper, Stoye and Zaranko, 2020). The trend appears unabated despite a government commitment that goes back two decades to addressing a blame culture in the NHS (Wise, 2001) and knowledge of the impact on patient care that results from working in a blaming environment, including the deliberate cover-up of poor practice (Mayor, 2000; Waring, 2005; Frankel, Leonard and Denham, 2006; Sprinks, 2012; Kirkup, 2015; Glasper, 2016; Wise, 2018).

The Francis review (Francis, 2013) of one NHS Trust in England identified some significant cultural issues: neglectful patient care; a culture of staff bullying, fear and cover-up of mistakes; disregard to patient and relative's complaints; a lack of learning from incidents; denial of poor managerial practices; leaders more focussed on delivering government financial targets than prioritising patient needs. Francis criticised a system whereby multiple NHS regulators either overlooked or ignored such poor standards of care and leader behaviour. He recommended that the NHS in England took a complete system-wide approach, from the Department of Health down to frontline clinicians and support workers, to address the serious failings that, he believed, would be more

entrenched than isolated to the one organisation he reviewed.

The culture described by Francis was similar to that reported in previous high-profile NHS inquiries (Ritchie *et al.*, 2000; Kennedy, 2001; Walshe and Higgins, 2002). The scale and nature of care failures that he found were a catalyst to address the significant changes required to NHS leadership, organisational culture, healthcare quality, patient safety, regulation and governance, including the revised comprehensive inspections by the CQC as noted in Section 2.3.1 (Holmes, 2013; DoH, 2015; Walshe and Chambers, 2017; Oikonomou *et al.,* 2019). The CQC (2017c, 2018d) has subsequently asserted that a feature of NHS organisations that have attained a *Good* or *Outstanding* CQC grade is the sense of humility and lack of complacency exhibited by their leaders.

Compassionate leadership has been called on to address the failings identified by these inquiries. The concept of compassionate leadership described by West and Chowla (2017) in Section 2.5.7 is promoted as a leadership culture by the authors, who also call for a style of collective leadership in the NHS. They conclude that "collective leadership creates the culture in which high quality, compassionate care can be delivered" (West and Chowla, 2017, p. 252). It is argued that compassionate care can be given in a hierarchical leadership structure such as in a military hospital. Therefore, collective leadership is not essential to promoting compassion.

Health care professionals are not always in a position to act compassionately, despite understanding the cause of stress and a desire to help alleviate it: a lack of compassionate behaviour is not necessarily indicative of a lack of compassionate feeling (Gilbert, 2017). Barriers to acting with compassion in a health care environment can be physical, emotional and administrative (Bleiker *et al.*, 2020), and when caregivers are frequently exposed to the suffering of others they can experience compassion burnout or fatigue (Vrtička, Favre and Singer, 2017), rendering them unable to show compassion.

Additionally, not all health professionals are operating in an environment that is particularly suited to displaying compassion (Bleiker *et al.,* 2020), such as in radiography. Here, safety measures include maintaining a physical distance between patient and professional, and the focus is on delivering an efficient, effective service (Hendry, 2019). It is also reported that patients do not routinely expect compassion from radiographers (Bleiker *et al*., 2016). A positive correlation has been shown between patient experience and a compassionate workforce (Ward *et al.,* 2018; West, 2020). However, there are differences in the understanding of what it means to be compassionate (Bleiker *et al*.,

2016) and, whilst it has a positive impact on the therapeutic relationship (Gilbert, 2007), compassion should not be relied upon to give responsive, quality care (Fotaki, 2015).

In a large study within the NHS, Dixon-Woods and colleagues (2014) reported that leaders at all levels in Trusts stated the values of compassion and care was a priority for their organisation and personally felt as a professional commitment. However, there was a challenge to turning that commitment into achievable goals. There has been increasing concern that global health care has lost its moral compass in providing compassionate care (de Zulueta, 2016) and the evidence suggests that progress towards greater compassion in the NHS is being made but that much is still to be done (Bailey and Burhouse, 2019; Kirkup, 2019; Kline and Lewis, 2019). This is particularly evident in the high incidence of bullying and harassment that affects staff of all professions and levels (Randle, 2003; Illing *et al.,* 2013; Timm, 2014; Lewis and Kline, 2019). It is suggested that a stronger focus on eliminating these negative behaviours as opposed to the promotion for compassionate leadership may result in greater compassion from the workforce. It is argued that acting responsibly towards colleagues at all times would develop compassion in the workforce.

Bevan (2008) argues that NHS Trust failures were a result of the clinical autonomy and professional self-regulation that doctors had fought hard to maintain at the inception of the NHS (Lancet, 1946; Digby, 1998; Macpherson, 1998). The Blair government also acknowledged that widespread quality failures in the NHS were attributable to a service demonstrating behaviours and operating practices largely unchanged from 1948. It sought to modernise the NHS with less central interference and greater public accountability (DoH, 1997; DoH, 2000). The policy direction then taken by the UK government received very limited input from the dominant medical profession (Alvarez-Rosete and Mays, 2014). The focus became putting patient interests at the heart of decision-making, sharing best practice and learning from mistakes, demonstrable safety and quality care, and improved leadership (DoH, 2000; Freeman and Walshe, 2004).

A key objective of the government in 1997 was for the NHS to develop an open culture and enable widespread learning by sharing safety information across organisations (DoH, 1997; DoH, 2000). In 2003, a national system for reporting patient critical incidents and near misses - the National Reporting and Learning System (NRLS) - was introduced into the NHS (Shaw *et al.*, 2005; Howell *et al*., 2015). Data on all accidents and near misses that are reported via a Trust's risk management system are updated

monthly on a central register and available for the general public to scrutinise (https://report.nrls.nhs.uk/nrlsreporting/). The public also has access to report online any safety concerns they have regarding a hospital Trust in England. More recently, the Secretary of State for Health stated an ambition was for the NHS "to become the first healthcare system in the world that truly embraces the standards of safety common in the airline, nuclear and oil industries" (DoH, 2015, p. 3) by enabling a culture of staff freely speaking out on concerns regarding safety or care quality.

Learning from errors requires a commitment to learning (Cho *et al.,* 2013). Schein (2004) purports that developing an organisational learning culture requires employees to hold a shared belief that learning is a good thing. The key to learning is to get feedback, reflect, absorb the implications and implement change (Schein, 2004). Schein also asserts the task of a leader is to create a culture of a perpetual learning organisation in order for its survival. Argote and Miron-Spektor (2011) share this view: they state the ability to learn and adapt is critical to organisational performance and long-term sustainability. In healthcare, enhancing organisational learning can improve quality, clinical and organisational outcomes (Carroll and Edmondson, 2002). It should also contribute to the development of organisational resilience through the delivery of sustainable and appropriate systems and processes. In addressing resilient health care, Robson (2013) states that a system to promote effective, continual learning is vital to organisational resilience.

According to Argyris (1999), organisational learning is a competence that all organisations should develop in order to better detect and correct errors, change systems and processes as required, and understand their limits of innovation. Senge (2006, p. 4) asserts that excelling organisations of the future will be those that "discover how to tap people's commitment and capacity to learn at all levels in an organisation". He identified five components to a learning organisation: personal mastery of one's subject, a mind that is open to challenge, building a shared vision, team learning and systems thinking. Senge states that systems thinking underpins the learning organisation, as people shift their thinking from the individual to a connected whole and understand the impact of their actions on others. This literature review identifies systems thinking as a theme that connects culture, organisational commitment to learning and responsible leadership to organisational resilience, but these do not appear in the literature in a directly linked framework. This is discussed further in Section 7.4.

Successful NHS senior leaders spend considerable time outside of their organisations engaging with their external community, cognisant of the role that health care plays in the wider social system (Ferlie and Pettigrew, 1996; Shipton *et al.*, 2008; Exworthy, Mannion and Powell, 2016; Walshe and Smith, 2016; Fulop and Ramsay, 2019). This leaves less time for them to be available to Trust staff, particularly those who are several tiers removed from them in the hierarchy. Research suggests that there is a link between employee satisfaction, patient outcomes and staff perceptions of senior management, especially related to their support, communications, a shared value system, attitudes towards their health and well-being and responsiveness to their needs (Firth-Cozens and Mowbray, 2001; Collinson, 2006; King's Fund, 2011; Kline, 2019).

Data from the NHS Staff Survey, discussed in Section 4.4.6, show a distinct difference in the experience of line manager and senior leader support (Appendix I). A perception of inconsistent behaviour between immediate and senior managers may cause staff to feel less valued by organisational leaders, with implications for staff engagement and patient outcomes. In a longitudinal analysis over the four years 2006-2009, of the NHS Staff Survey scores and predictors of Trust outcomes, Topakas and colleagues found that patient satisfaction was positively related to employee satisfaction with the support of their line manager (Topakas, Admasachew and Dawson, 2010). Health care managers contribute to successful organisational performance and quality of patient care through direct people management that supports team building, facilitates staff development and persuades by influence (Shipton *et al.*, 2008; King's Fund, 2011; Dixon-Woods, McNicol and Martin, 2012; Powell *et al.,* 2014; Kline, 2019). Therefore, the apparent prioritising of line management support taken by Trusts appears appropriate.

Whilst line managers provide the immediate support and encouragement to staff, senior leaders are able to inspire and psychologically strengthen colleagues to cope with daily pressures and changes in the workplace (Cooke, Wang and Bartram, 2019). As the psychological well-being of staff has an impact on patient outcomes (Firth-Cozens and Mowbray, 2001) it is in the interests of the organisation, employees and service users for senior leaders to maintain meaningful communication with all employees (Damschroder *et al.*, 2009). Communication in NHS organisations has long been a point of concern and many patient complaints refer to poor internal communications between NHS staff (Pincock, 2004).

Effective two-way communication is essential for leaders to influence effectively

for organisational success (Tourish and Hargie, 1998; Collinson, 2006; Dixon-Woods, McNicol and Martin, 2012; Men and Jiang, 2016). Inadequate communication has been cited as the cause of failure of major NHS projects that require culture change to support their implementation (Bowns, Rotherham and Paisley, 1999; Frame, Watson and Thomson, 2008). Darling and Beebe (2007) argue that communication based upon key values and a concern for people is required for the successful execution of those values.

In today's digital environment CEOs and senior leaders have various channels available to communicate and inspire their employees, foster staff engagement and show empathy. Media such as podcasts, webinars, email and video enable virtual connection in real time and via recordings. Senior leaders who communicate with staff across hierarchical levels on organisational goals promote their effective implementation (Damschroder *et al.*, 2009; Dixon-Woods, McNicol and Martin, 2012). For widespread culture change it is incumbent on senior leaders to engage with all employees to encourage their commitment and lead behaviour change, in whatever media is available to them. This will not only enhance change readiness but also promote their resilience (Horne and Orr, 1997; Parsons, 2010).

Work-related stress in the NHS has been steadily rising, exacerbated by the continuing resource pressures in the health system (Andrews and Thorne, 2015; Kline, 2019; Alderwick *et al.,* 2021). Consideration to the health and well-being of staff has seen greater focus in Trusts in recent years following a review of the health of NHS staff (Boorman, 2010). Trusts are responsible for providing health and well-being services (Quirk *et al.,* 2018) and a focus on developing resilience of the workforce, particularly nurses, has been advised and introduced in some organisations (Jackson, Firtko and Edenborough, 2007; Sergeant and Laws-Chapman, 2012).

2.7 Chapter summary

This chapter has presented a brief history of the NHS followed by an account of clinical governance and regulation of hospitals in England. The impact of the current regulatory process on organisational performance, safety and quality was explored. An overview of leadership, leader behaviour and organisational culture literature was then presented, and their influence on styles of leadership in the NHS and contemporary culture were discussed. A chapter summary concluded the chapter and Part I of the literature review.

In the following chapter organisational resilience literature is reviewed, including

its relationship with personal resilience. Organisational resilience in health care and the relationship between health care regulators and organisational resilience is also discussed. A synthesis of the complete literature review (Parts I and II) is presented in Section 3.8, followed by identification of the research questions.

Chapter 3

LITERATURE REVIEW
PART II: ORGANISATIONAL RESILIENCE

3.1 Introduction and chapter overview

Following a review of the NHS and leadership literature, this chapter sets out a review of organisational resilience literature. The chapter first reports the method taken to review the research field and undertake a systematic search of the organisational management and health care literature. Search terms and the screening process are recorded, followed by an overview of the resilience literature. Organisational resilience definitions, concepts and components are then discussed. Leader behaviours that affect organisational resilience are presented and a summary of the organisational resilience literature concludes with the researcher's rationale for her definition of organisational resilience.

The chapter continues with a brief discussion on organisational resilience in health care and health care regulation. Following synthesis of the two literature review chapters (Parts I and II), the emerging research questions are identified. This concludes the chapter.

3.2 Literature review method

A review of the organisational resilience literature was conducted in two stages. An initial analysis of systematic literature reviews was undertaken in order to determine the breadth of the resilience research field. A total of thirteen systematic literature review papers in the organisational management and health care disciplines were identified (Table 9), published between 2011 and 2022. Examination of these papers evidenced seven major disciplines in the resilience research field with a variety of concepts, foci and definitions (Table 10, p.65). Systematic literature reviews of these disciplines, such as supply chain resilience (López-Castro and Solano-Charris, 2021), resilience engineering (Bergström, van Winsen and Henriqson, 2015) and disaster resilience (Tiernan *et al.,* 2018) were also analysed to ensure the subject matter was explored fully. An overview of this literature is discussed in Section 3.3.

The second stage of the organisational resilience literature review involved analysis of screened literature identified through a systematic search of the

Table 9: Systematic Literature Reviews of Organisational Resilience

Author (s)	Date	Area of Focus
Bhamra *et al.*	2011	Organisation
Annarelli and Nonino	2016	Organisation
Linnenluecke	2017	Organisation
Barasa *et al.*	2018	Organisation
Berg *et al.*	2018	Health Care
Ruiz-Martin *et al.*	2018	Organisation
Øyri and Wiig	2019	Health Care
Rahi	2019	Organisation
Conz and Magnani	2020	Business
Iflaifel *et al.*	2020	Health Care
Hillmann	2021	Business
Ahmed *et al.*	2022	Organisation
Evenseth *et al.*	2022	Organisation

organisational management and health care literature. Four databases were searched: Scopus and Web of Science Core Collection were selected for their comprehensive coverage of peer-reviewed literature, scientific journals and conference proceedings in the fields of social sciences, health and humanities. These two databases identified the large majority of papers for screening. Due to the research being undertaken in the NHS, an additional two databases specific to the health care sector were searched: the Cumulative Index of Nursing and Allied Health Literature (CINAHL) and MEDLINE (Ovid), which identified a smaller but appreciable number of additional papers (Figure 1).

3.2.1 Literature search terms and screening process

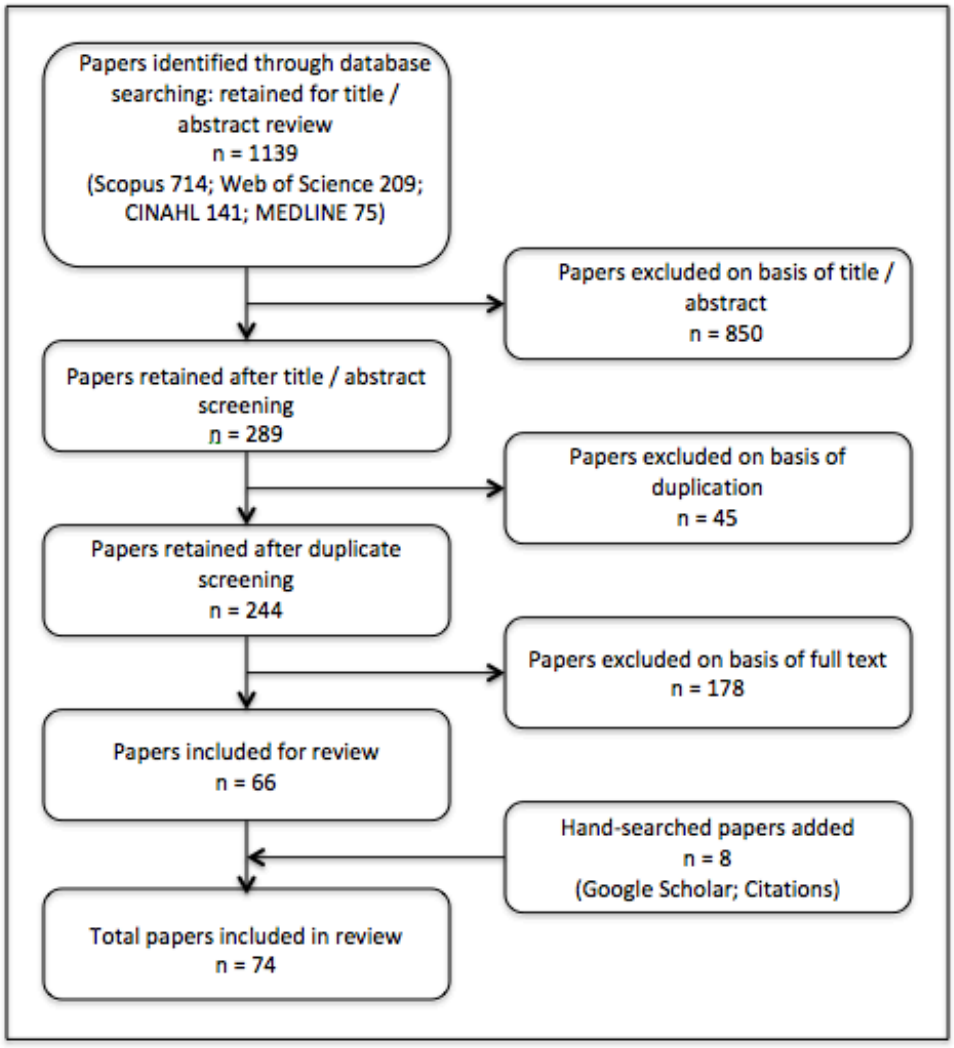
The keywords "Organisational Resilience" and "Organizational Resilience" were searched to ensure that articles with the linked words in both British and American forms were identified. Included in the search were the keywords combined with organi*ational culture, health care and personal resilience. Exclusions to the search were terms that related to other fields of resilience research such as supply chain, disaster management, crisis management, engineering and ecological resilience. Specific to the health care sector, studies of health care providers in developing countries and references to COVID-19 were also excluded. A total of 1,139 research papers and conference proceedings were identified through the database searches and retained for review (Figure 1).

The 1,139 papers were screened by title, keywords and/or abstract. Papers were excluded from this search if they related to: environmental disasters and emergency management; individual resilience exclusively; organisations in financial crisis; climate

change; technical infrastructure; small and medium enterprises; family businesses; market turbulence and competition. These exclusions were on the basis that they do not relate to, compare or impact directly on the resilience of NHS Hospital Trusts that were responding to non-crisis turbulence, the subject of this research. Of the remaining papers, 45 duplications were removed and 244 papers were retained for full text reading.

The final inclusion criteria were papers that identified one or more of: organisational resilience concepts and components, leadership behaviours that affect organisational resilience, definitions of organisational resilience or a systematic literature review. Of the 66 papers included for the review, a manual search for frequently cited texts that fell outside the initial searches, papers and books listed on Google Scholar and texts known to the researcher resulted in an additional 8 papers and a total of 74 texts included in the literature review (Figure 1), covering a wide range of subject areas (Table 12) and discussed in Section 3.4.

Figure 1: Literature Search Screening Process



3.3 Overview of the resilience literature

Resilience refers to the ability of a system to resist and respond to a shock, recover from it and cope with change (Annarelli and Nonino, 2016; Chen, Xie and Liu, 2021). It has been researched by scholars from various disciplines, resulting in multiple definitions and concepts (Wied, Oehmen and Welo, 2020): examples are summarised in Table 10. Whilst there is overlap of ideas across some fields, a review of definitions indicates there is no unified opinion on what constitutes resilience (Linnenluecke, 2017; Chen, Xie and Liu, 2021), even among scholars of the same discipline (Bergström, van Winsen and Henriqson, 2015).

Resilient behaviour has been studied for several decades in the field of positive psychology (Maier and Seligman, 1976; Rutter, 1985; London, 1993; Luthans *et al.*, 2007; Robertson *et al.,* 2015) and has its roots in science: it originally defined the capacity of a metal to recover its initial shape after, for example, thermal stress (Ollier-Malaterre, 2010). This led to the resilience concept of an individual's ability to adapt to stress and rebound from adversity (Luthans, 2002; Kossek and Perrigino, 2016).

Holling (1973) initiated the concept of organisational resilience from the field of ecology (Barasa, Mbau and Gilson, 2018), taking his insights regarding the capacity of actors to affect the resilience of a system and extrapolating his theory to organisational systems and management. This marked a turning point in the study of ecosystems and systems research (Wied, Oehmen and Welo, 2020). Resilience studies have grown considerably in number over the past two decades (Ma, Xiao and Yin, 2018), becoming more important in the fields of disaster and crisis management as frequency of natural and man-made disasters have increased along with people's awareness of their consequences (Ruiz-Martin, López-Paredes and Wainer, 2018). These fields of resilience studies share definitive ideas with ecological systems resilience, around the capacity of a system to respond positively to a disturbance so that they can continue to function (Walker *et al.,* 2004; Comfort *et al.,* 2010).

The goal of resilience engineering is to bring about organisational resilience (Hollnagel, 2013) and seeks to understand why things go right as opposed to analysing the cause of failure (Wiig *et al.,* 2020). Resilience engineering concepts have built on the ecological perspective, focussing on a system's adaptive capacity prior to and following a disturbance, enabling it to keep within its functional limits (Nemeth and Herrera, 2015).

Table 10: Resilience Research Field Perspectives

Research Field	Ecology	Engineering	Supply Chain	Crisis and Disaster Management	Positive Psychology	Health Care	Organisation Theory
Influential Authors	Holling (1973) Linnenluecke and Griffiths (2010) * Walker *et al.* (2004)	* Hollnagel *et al.* (2006) Nemeth and Herrera (2015) Woods (2015)	* Ambulkar *et al.* (2015) Carvalho *et al.* (2012) Ponomarov and Holcomb (2009) Sheffi and Rice (2007)	Boin and Lodge (2016) * Comfort *et al.* (2010) Drennan *et al.* (2015) Weick and Sutcliffe (2015)	* Luthans *et al.* (2006) Masten (2001) Werner and Smith (2001)	* Braithwaite *et al.* (2015) Carthey *et al.* (2001) Hollnagel *et al.* (2015) Meyer (1982)	Coutu (2002) Hamel and Välikangas (2003) Horne and Orr (1997) * Lengnick-Hall *et al.* (2011) Mallak (1998b) Vogus and Sutcliffe (2007)
Resilience Concepts and Components	Absorb change and maintain stability.	Anticipation, adaptive capacity, asorb change and recovery.	Strategic initiative, redundancy, risk management and flexibility.	Improvisation and sense-making.	Response to risk and adaptive ability.	Organisational learning and adaptation.	Recovery and improvement.
Resilience Focus	Ability of a system to return to its original state following a disturbance.	The resistance of a system to shocks and speed of its return to equilibrium.	Business continuity.	Urgent response to a unique problem.	Individual resilience.	Safety of operational systems.	Capacity to emerge stronger from a crisis event.
Resilience Definition **(* Influential Author Source)**	The capacity of a system to absorb disturbance and re-organise while undergoing change so as to retain essentially the same function, structure, identity and feedbacks.	The ability to sense, recognise, adapt and absorb variations, changes, disturbances, disruptions and surprises.	The capability of a firm to be alert to, adapt to and quickly respond to changes brought about by a supply chain disruption.	The capacity of a social system to proactively adapt and recover from disturbances that fall outside the range of normal and expected disturbances.	The developable capacity to rebound from adversity, and even go beyond, to attain success.	The provision of safe health care, defined as the ability to make things go right and not merely the absence of failures or adverse outcomes.	The ability to effectively absorb, develop situation-specific responses to and ultimately engage in transformative activities to capitalise on disruptive surprises.

Hollnagel (2013) argues that it is necessary to understand how systems operate successfully in order to determine what happens when they go wrong. Hollnagel and colleagues (2015) refer to this approach as Safety-II logic, relating to an organisation's ability to adapt successfully in changing circumstances. Safety-I logic is defined as "a state where as few things as possible go wrong" (Hollnagel, Wears and Braithwaite, 2015, p.1) due to analysis of error, identification of causal factors and making changes to avoid a repeat incident.

The impact on an organisation's ability to function in an increasingly global market, with supply chains more exposed to disruptions, has led to a rise in studies of supply chain resilience (Annarelli and Nonino, 2016). In their review of supply chain resilience literature, Ribeiro and Barbosa-Povoa (2018) identified a variety of definitions and numerous elements that contribute to supply chain resilience (Sheffi and Rice, 2007; Ponomorov and Holcomb, 2009; Ponis and Koronis, 2012; Heckmann, Comes and Nickel, 2015). These include the concept of speed – recovery from a disturbance in a timely manner; strategic planning and network design; response to a disruption; adaptive ability to reduce the probability of a disturbance; identifying, anticipating and preparing for events; returning to a steady state or to a position better than the original (Ribeiro and Barbosa-Povoa, 2018). The authors concluded there is a need globally for a clear definition of supply chain resilience and proposed "a resilient supply chain should be able to prepare, respond and recover from disturbances and afterwards maintain a positive steady state operation in an acceptable cost and time" (Ribeiro and Barbosa-Povoa, 2018, p.116).

Resilient health care systems are considered an essential aspect of health system strengthening and performance (Koeva and Rohova, 2020). Theory of health care resilience has developed from other disciplines, particularly resilience engineering (Jeffs *et al.*, 2009), with a focus on strengthening safety practices (Braithwaite *et al.*, 2015). In a review of health care resilience studies, Berg and colleagues (2018) reported an absence of studies at the organisational level, with a preponderance of field research focussed on individual or departmental resilience. They argue that studies should include macro-level data to study the resilience of the whole health care system to avoid resilient health care becoming a discipline centred on an individual's resilience ability within the system. They also call for comparative and longitudinal studies in health care resilience research (Berg *et al.,* 2018).

Organisational resilience definitions, concepts and components identified from analysis of the organisational management and health care management literature are now discussed.

3.4 Organisational resilience definitions, concepts and components

As noted in Section 3.2, seventy-four texts were retained for analysis from the organisational management and health care literature screened (Figure 1): these are listed in Table 12. At an organisational level the study of resilience has been influenced by research in the disciplines reported in Section 3.3 (Annarelli and Nonino, 2016; Ruiz-Martin, López-Paredes and Wainer, 2018). This is evident in the main concepts and components of organisational resilience (Table 12, p. 70) and its various definitions, examples of which are presented below in Table 11. The subject remains predominantly conceptual despite the interest of significant numbers of researchers (Barasa, *et al.,* 2018), with studies frequently focussed on developing theories unsupported by empirical evidence (Rahi, 2019) that has led to a fragmented body of literature (Ma, Xiao and Yin, 2018; Duchek, 2020).

3.4.1 Definitions

Despite the considerable growth of organisational resilience studies over the past two decades, the construct comprises numerous and diverse themes (Duchek, 2020). Organisational resilience has been broadly conceptualised from three positions: proactive preparation, adaptive capacity, and recovery and growth (Hills and Allen, 2018; Koronis and Ponis, 2018; Bell, 2019; Duchek, 2020; Chen, Xie and Liu, 2021). The many definitions of the construct reflect the various emphases that scholars place on these three main concepts. Table 11 lists a variety of definitions from the analysed literature with their main emphases, selected for their influence in the discipline as evidenced by large numbers of citations. Exceptions were the publications by Gracey (2019) and Chen, Xie and Liu (2021): these were included as examples of definitions that arose from recent empirical research, something which remains under-represented in the mainly conceptual field of organisational resilience.

These various definitions evidence the divergent thinking of the organisational resilience construct, with the concept of adaptation as a sole point of convergence. Many authors consider it an ability to deal with internal and external disturbance (Meyer, 1982; Mallak, 1998b; Coutu, 2002). Others define it as a capacity to deal with them (Fiksel,

2003; Koronis and Ponis, 2018; Wiig *et al.,* 2020). Yet other authors understand organisational resilience as a capability to deal with these issues (Reinmoeller and van Baardwijk, 2005; Gracey, 2019). What is not clear is how these terms capacity, ability and capability are defined or why an author has chosen a specific definition (Ruiz-Martin, López-Paredes and Wainer, 2018).

Table 11: Definitions of Organisational Resilience

Author (s) and Year	Area of Focus	Resilience Concept	Definition
Meyer 1982	Health Care	Adaptation and recovery	The ability to absorb a discrete environmental jolt and restore prior order.
Horne and Orr 1997	Business	Adaptation and recovery	A fundamental quality to respond productively to significant change that disrupts the expected pattern of events without engaging in an extended period of regression.
Mallak 1998b	Organisation	Adaptation	The ability of an individual or organization to expeditiously design and implement positive adaptive behaviours matched to the immediate situation, while enduring minimal stress.
Coutu 2002	Business	Adaptation	The ability to adapt to the requirements of the surrounding environment and to effectively develop new capabilities to absorb and manage environmental variability.
Hamel and Välikangas 2003	Business	Proactivity and adaptation	Continuously anticipating and adjusting to deep, secular trends that can permanently impair the earning power of a core business.
Reinmoeller and van Baardwijk 2005	Business	Adaptation	The capability to self-renew over time through innovation.
Vogus and Sutcliffe 2007	Organisation	Adaptation, recovery and growth	The maintenance of positive adjustment under challenging conditions such that the organisation emerges from those conditions strengthened and more resourceful.
McManus *et al.* 2008	Organisation	Proactivity, adaptation and recovery	A function of three abilities or capabilities: adaptive capacity, situation awareness and management of keystone vulnerabilities.
Burnard and Bhamra 2011	Organisation	Proactivity and adaptation	An emergent property that relates to the inherent and adaptive qualities that enable an organisation to take a proactive approach to threat and risk mitigation.
Lengnick-Hall, Beck and Lengnick-Hall 2011	Organisation	Adaptation, recovery and growth	A firm's ability to effectively absorb, develop situation-specific responses to, and ultimately engage in transformative activities to capitalise on disruptive surprises that potentially threaten organisation survival.
Koronis and Ponis 2018	Organisation	Proactivity and adaptation	The accumulated cultural capacity of an organisation to make sense of risks and negative events, to absorb the pressure and ultimately protect the organisation's social capital and reputation.
Gracey 2019	Organisation	Proactivity and adaptation	A people-centric capability based on the strategic coordination of organisational resources, adaptive leadership, intelligence, communication and staff development which enables the identification and analysis of strategic threats through shared situational awareness.
Wiig *et al.* 2020	Health Care	Adaptation	The capacity to adapt to challenges and changes at different system levels, to maintain high quality care.
Chen *et al.* 2021	Organisation	Adaptation, recovery and growth	The ability of an organisation to reconfigure organisational resources, optimise organisational processes, reshape organisational relationships in a crisis, recover quickly from the crisis, and use the crisis to achieve counter-trend growth.

Other issues arise in the conceptualisation of the construct. For example, it is sometimes viewed as an emergent property in response to an organisational setback

(Burnard and Bhamra, 2011), whilst other authors have asserted it is a quality in response to a significant event (Horne and Orr, 1997). A further interpretation is that organisational resilience is a function of various components (McManus *et al.,* 2008). It has been described as bouncing back from a crisis and returning to pre-crisis stability (Horne and Orr, 1997; Bhamra, Dani and Burnard, 2011) and, alternatively, the adaptive capacity to evolve to a new stability (Fiksel, 2003) and improve functioning (Vogus and Sutcliffe, 2007; Lengnick-Hall, Beck and Lengnick-Hall, 2011; Duchek, 2020).

Organisational resilience has been conceptualised in relationship to time: showing proactive resilience before an event, an adaptive attribute during an event and/or a reactive attribute in response to an event. It has also been considered a dynamic attribute before, during and after an event (Conz and Magnani, 2020). Scholars who advocate a process approach to organisational resilience report different elements of the process depending on their definition of the construct (McManus *et al.,* 2008; Lengnick-Hall, Beck and Lengnick-Hall, 2011; Koronis and Ponis, 2018; Chen, Xie and Liu, 2021).

Some view organisational resilience as an outcome of an organisation's activities, when organisations respond positively to adverse circumstances or return to a steady equilibrium following a disruption (Horne and Orr, 1997; Duchek, 2020). It has also been understood as a measure of how much disturbance an organisation can tolerate and still function (Limnios *et al.,* 2014). This broad range of theoretical positions underlines the complexity of the construct and the need for clarity by each researcher of their particular understanding of organisational resilience.

3.4.2 Theoretical concepts and components

As reported in Section 3.4.1, three main concepts of organisational resilience were identified in the literature: proactive preparation, adaptive capacity, and recovery and growth. A number of components that enable resilience are evident in the literature: some are more aligned to one of the main concepts (Table 12). However, it is recognised that these components are not individually situated under one sole concept of the organisational resilience construct, but may be dynamic components. For example, risk management has a proactive component that enables an organisation to anticipate potential problems (Dahms, 2009; Burnard and Bhamra, 2011; Koronis and Ponis, 2018). It is also important during recovery of an identified problem (Carthey, de Leval and Reason, 2001; McManus et al., 2008). The full range of risk management aims to protect

against potential risks and capitalise on recovery after an impactful event (Hopkin, 2014; Petruzzi and Loyear, 2016).

Table 12: Typologies, Concepts and Components of Organisational Resilience within Organisational Management and Health Care Literature

Author(s)	Year	Typology: Theory Development	Typology: Empirical Research	Typology: Literature Review	Area of Focus	Organisational Resilience CONCEPTS and Components: PROACTIVE PREPARATION: Financial resource	Organisational culture	Shared core values	Preparedness / anticipation	Redundancy / slack	Contingency planning	Situational awareness	Process focussed	ADAPTIVE CAPACITY: Organisational change	Cognition & behav. ability	Innovation / improvisation	Adaptation / adjustment	Capability	Performance	Improvement	Flexibility / agility	Organisational planning	RECOVERY AND GROWTH: Corporate governance	Organisational learning	Strategic management	Leadership	Effective communication	Risk management	Shared decision-making	Staff support / development	Multi-stakeholder network	Relationship building	Readjustment
Meyer	1982		✓		Health Care	✓		✓	✓	✓	✓	✓					✓							✓	✓							✓
Weick and Roberts	1993	✓	✓		HRO							✓	✓								✓											
Acar and Winfrey	1994	✓			Organisation	✓	✓							✓			✓					✓		✓	✓							
Bartlett and Goshall	1995	✓			Organisation											✓		✓		✓							✓					
Horne and Orr	1997		✓		Business		✓	✓						✓	✓	✓		✓	✓			✓		✓	✓							✓
Mallak	1998b	✓			Organisation	✓							✓	✓	✓	✓										✓			✓			
Carthey *et al.*	2001	✓			Health Care								✓		✓		✓											✓				
Coutu	2002	✓			Business									✓	✓	✓	✓							✓						✓		
Fiksel	2003	✓			Business		✓									✓	✓															
Hamel and Välikangas	2003	✓			Business			✓							✓	✓	✓	✓														
Reinmoeller and van Baardwijk	2005	✓	✓		Business				✓							✓								✓	✓					✓		
Woods and Hollnagel	2006	✓			Organisation				✓			✓					✓						✓									
Vogus and Sutcliffe	2007	✓			Organisation							✓	✓		✓					✓	✓			✓				✓				
McManus *et al.*	2008		✓		Organisation	✓	✓		✓		✓	✓			✓										✓			✓				
Dahms	2009	✓			Organisation	✓			✓								✓						✓	✓	✓			✓				
Jeffs *et al.*	2009	✓	✓		Health Care		✓					✓	✓						✓					✓		✓		✓				
Somers	2009		✓		Public Works				✓			✓	✓		✓										✓			✓				
Braes and Brooks	2010	✓			Organisation		✓	✓				✓						✓					✓		✓	✓	✓					
Gibson and Tarrant	2010	✓			Organisation		✓	✓	✓												✓			✓		✓	✓					
Bhamra *et al.*	2011			✓	Organisation																											
Burnard and Bhamra	2011	✓			Organisation							✓					✓							✓								
Lengnick-Hall *et al.*	2011	✓			Organisation			✓	✓				✓		✓	✓	✓				✓						✓			✓	✓	
Luo and Shi	2011	✓			Organisation							✓		✓	✓	✓	✓				✓				✓							
Kantur and İşeri-Say	2012	✓			Business			✓	✓	✓			✓	✓	✓	✓			✓		✓			✓	✓		✓					

Author(s)	Year	Typology			Area of Focus	Organisational Resilience CONCEPTS and Components																												
						PROACTIVE PREPARATION									ADAPTIVE CAPACITY										RECOVERY AND GROWTH										
		Theory Development	Empirical Research	Literature Review		*Financial resource*	*Organisational culture*	*Shared core values*	*Preparedness / anticipation*	*Redundancy / slack*	*Contingency planning*	*Situational awareness*	*Process focussed*	*Organisational change*	*Cognition & behav. ability*	*Innovation / improvisation*	*Adaptation / adjustment*	*Capability*	*Performance*	*Improvement*	*Flexibility / agility*	*Organisational planning*	*Corporate governance*	*Organisational learning*	*Strategic management*	*Leadership*	*Effective communication*	*Risk management*	*Shared decision-making*	*Staff support / development*	*Multi-stakeholder network*	*Relationship building*	*Readjustment*
Boin and van Eeten	2013	✓			Organisation		✓		✓					✓					✓						✓								
de Oliveira Teixeira and Werther	2013		✓		Business		✓		✓		✓					✓	✓				✓			✓									
Hollnagel	2013	✓			Organisation				✓			✓					✓		✓					✓									
Robson	2013	✓			Health Care										✓		✓							✓									
Hopkin	2014		✓		Organisation		✓				✓	✓	✓				✓	✓	✓		✓			✓	✓	✓				✓	✓		
Limnios *et al.*	2014	✓			Organisation	✓			✓			✓					✓							✓			✓						
Winnard *et al.*	2014	✓			Business	✓			✓		✓					✓	✓							✓		✓							
Sawalha	2015		✓		Insurance		✓										✓							✓						✓			
Annarelli and Nonino	2016			✓	Organisation																												
Cheese	2016	✓			Business		✓										✓				✓			✓									
Kuntz *et al.*	2016	✓			Organisation	✓	✓		✓								✓		✓					✓									
Ortiz-de-Mandojana and Bansal	2016	✓			Organisation				✓			✓					✓			✓	✓								✓				
Petruzzi and Loyear	2016	✓			Organisation						✓									✓										✓			
Witmer and Mellinger	2016		✓		Health Care	✓	✓	✓																	✓				✓	✓			
Espiner *et al.*	2017	✓			Tourism		✓		✓		✓	✓													✓					✓			
Linnenluecke	2017			✓	Organisation																												
Barasa *et al.*	2018			✓	Organisation																												
Berg *et al.*	2018			✓	Health Care																												
Bouaziz and Hachicha	2018		✓		Organisation				✓					✓	✓		✓							✓					✓				
Gover and Duxbury	2018	✓	✓		Health Care	✓	✓	✓					✓	✓							✓				✓	✓				✓	✓		
Hatton *et al.*	2018	✓			Organisation											✓	✓							✓			✓						
Hills and Allen	2018	✓			Higher Educ.		✓	✓	✓			✓		✓			✓		✓					✓			✓						
Ishak *et al.*	2018	✓			Organisation			✓					✓	✓			✓							✓				✓		✓			
Koronis and Ponis	2018	✓			Organisation		✓						✓			✓	✓				✓			✓	✓					✓			
Ma *et al.*	2018	✓			Organisation				✓		✓				✓	✓	✓				✓												

Author(s)	Year	Typology			Area of Focus	Organisational Resilience CONCEPTS and *Components*																												
						PROACTIVE PREPARATION								ADAPTIVE CAPACITY									RECOVERY AND GROWTH												
		Theory Development	Empirical Research	Literature Review		*Financial resource*	*Organisational culture*	*Shared core values*	*Preparedness / anticipation*	*Redundancy / slack*	*Contingency planning*	*Situational awareness*	*Process focussed*	*Organisational change*	*Cognition & behav. ability*	*Innovation / improvisation*	*Adaptation / adjustment*	*Capability*	*Performance*	*Improvement*	*Flexibility / agility*	*Organisational planning*	*Corporate governance*	*Organisational learning*	*Strategic management*	*Leadership*	*Effective communication*	*Risk management*	*Shared decision-making*	*Staff support / development*	*Multi-stakeholder network*	*Relationship building*	*Readjustment*
Ruiz-Martin *et al.*	2018	✓		✓	Organisation				✓	✓		✓				✓					✓					✓		✓					
Andersson *et al.*	2019		✓		Finance		✓														✓									✓			
Bell	2019	✓			Organisation		✓																✓	✓		✓	✓	✓		✓			
Bui *et al.*	2019	✓			Organisation														✓	✓	✓				✓					✓			
Gracey	2019		✓		Army		✓					✓					✓				✓	✓		✓	✓	✓	✓		✓				
Morales *et al.*	2019		✓		Manufacture		✓	✓						✓	✓	✓		✓							✓						✓			
Øyri and Wiig	2019			✓	Health Care																												
Rahi	2019			✓	Organisation																												
Suryaningtyas *et al.*	2019		✓		Hotel		✓												✓					✓	✓								
Conz and Magnani	2020	✓		✓	Business	✓				✓	✓						✓				✓			✓									
Cotta and Salvador	2020		✓		Manufacture																		✓			✓					✓		
Cruickshank	2020	✓			Organisation					✓						✓	✓				✓		✓										
Duchek	2020	✓			Organisation				✓						✓		✓	✓																
Gilson *et al.*	2020		✓		Health Care		✓	✓				✓			✓		✓				✓		✓		✓	✓						✓	✓
Iflaifel *et al.*	2020			✓	Health Care																												
Koeva and Rohova	2020	✓			Health Care									✓		✓	✓	✓															
Mitsakis	2020	✓			Organisation												✓				✓		✓						✓				
Mousa *et al.*	2020		✓		Higher Educ.		✓																✓						✓	✓			
Wiig *et al.*	2020	✓			Health Care											✓	✓			✓			✓				✓						
Chen *et al.*	2021		✓		Organisation	✓	✓																✓	✓							✓		
Hillmann	2021			✓	Business																												
Kantabutra *et al.*	2021	✓			Organisation	✓	✓	✓								✓	✓		✓		✓		✓		✓	✓				✓			
Ahmed *et al.*	2022	✓		✓	Organisation				✓		✓						✓			✓		✓											
Evenseth *et al.*	2022	✓		✓	Organisation																	✓											
Lyng *et al.*	2022	✓			Health Care												✓					✓			✓	✓							

Similarly, effective communication can enable organisations to prepare for and respond adaptively to disturbances (Gibson and Tarrant, 2010), and contribute to recovery and growth after a critical event by ensuring personnel are kept appraised of strategic plans and supported through any change processes (Bartlett and Goshall, 1995). Open communication regarding potential critical events, response to an event and sharing learning from experiences (Hopkin, 2014) clearly align to proactive, adaptive and recovery concepts of the organisational resilience construct. Thus, the layout of components in Table 12 should be noted as illustrative.

3.4.2.1 Proactive preparation

Proactivity enables an organisation to anticipate disruption, take steps to ensure it can thrive in the face of adversity and prevent problems escalating into crises (Somers, 2009; Boin and van Eeten, 2013; Ortiz-de-Mandojana and Bansal, 2015). Empirical researchers assert that organisations which proactively prepare for a threat to business continuity plan strategically to adapt prior to a disruption, rather than to react following a disruptive event (Meyer, 1982; McManus *et al.,* 2008; de Oliveira Teixeira and Werther, 2013). A number of components are considered to contribute to proactive preparation for resilience.

Some scholars state the importance of establishing an organisational culture that promotes organisational resilience. There are a number of interpretations however, such as: a culture that is prepared to act decisively, move forward and overcome potential adverse circumstances following a disruption (Acar and Winfrey, 1994); a culture of diversity and integration to help empower people in adversity (Braes and Brooks, 2010); a culture that adapts well to change (Gover and Duxbury, 2018); a learning-oriented organisational culture (Kuntz, Näswall and Malinen, 2016); a culture aligned to shared core values (Morales *et al.,* 2019); a culture of heightened risk awareness (Hopkin, 2014). Whilst other scholars concur that organisational culture is a component of organisational resilience (Horne and Orr, 1997; Boin and van Eeten, 2013; Witmer and Mellinger, 2016; Koronis and Ponis, 2018), perspectives differ on the precise nature of this component.

Many of these cultural perspectives in relation to organisational resilience are proposed from a theoretical standpoint (Acar and Winfrey, 1994; Braes and Brooks, 2010; Boin and van Eeten, 2013; Kuntz, Näswall and Malinen, 2016; Koronis and Ponis, 2018). The empirical literature is also divided in its view on the culture that is required to develop organisational resilience (de Oliveira Teixeira and Werther, 2013; Gracey, 2019;

Sawalha, 2015). Further empirical studies that confirm its relevance and identify the type of organisational culture affecting organisational resilience would bring more clarity to the issue and strengthen the assertion of a relationship between the two.

The use of financial resources is considered in various ways to contribute to organisational resilience. Some studies report that holding financial reserves enables an organisation to weather a challenging event and remain resilient and sustainable (Meyer, 1982; Conz and Magnani, 2020). Meyer illustrated the relevance of this in his research of the private health care sector, where a disruptive event can cause financial loss and organisational closure if there are no financial reserves to support the organisation through a prolonged disruption (Meyer, 1982). Dahms (2009) suggests that effective management of financial resources, which is linked to risk management, promotes organisational resilience. An alternative view is offered by Limnios and colleagues (2014), who suggest that resilience is affected by an organisation's ability to reconfigure its resources and adapt to changing circumstances.

For some authors, building slack or redundancy into an organisation is a proactive strategy for resilience (Meyer, 1982; Kantur and Íşeri-Say, 2012; Conz and Magnani, 2020). The influence from the field of engineering resilience is evident (Cruickshank, 2020), where redundancy enhances resilience by ensuring back-up systems are available in the event of a disruption. Other components that may contribute proactively to organisational resilience include an organisation's situational awareness (Woods and Hollnagel, 2006; McManus *et al.,* 2008; Burnard and Bhamra, 2011; Petruzzi and Loyear, 2016) and having a strong focus on organisational processes (Weick and Roberts, 1993; Mallak, 1998b; Espiner, Orchiston and Higham, 2017).

As shown in Table 12, most scholars perceive there to be an element of proactive behaviour that contributes to organisational resilience. It is also noted that the majority of these views are offered from a theoretical perspective, giving rise to a diversity of thinking that may not be validated by research findings. Therefore, in drawing conclusions from the literature, one should be alert to where more testing of theory is required and how the body of knowledge would be strengthened from more empirical study.

3.4.2.2 Adaptive capacity

Many authors assert adaptive capacity is a central concept of organisational resilience (Horne and Orr, 1997; Hamel and Välikangas, 2003; Hopkin, 2014; Ma, Xiao and Yin, 2018), enabling an organisation to move beyond survival and thrive in a turbulent

environment (Vogus and Sutcliffe, 2007; Lengnick-Hall, Beck and Lengnick-Hall, 2011; Duchek, 2020). Key components to this concept are the ability to adapt and adjust (Carthey *et al.,* 2001; Gibson and Tarrant, 2010; Robson, 2013), be strategically flexible and agile (Luo and Shi, 2011; Hopkin, 2014; Cheese, 2016), improvise and innovate (Winnard *et al.,* 2014; Hatton *et al*., 2018; Koeva and Rohova, 2020) in response to challenging circumstances in order to maintain performance and improve outcomes (Horne and Orr, 1997; Mallak, 1998b).

Some scholars argue that resilience is enabled by organisation-level cognitive and behavioural routines and capabilities (Coutu, 2002; McManus *et al.,* 2008; Somers, 2009) through the development of human resource management (Lengnick-Hall, Beck and Lengnick-Hall, 2011). Cognitive elements may include the development of a strong set of shared core values, regular organisational communication and the ability to innovate and improvise with available resources (Lengnick-Hall, Beck and Lengnick-Hall, 2011). Ruiz-Martin, López-Paredes and Wainer (2018) assert that resilient employees contribute to the development of organisational resilience.

Mallak (1998b) argues that an individual's sense of self-efficacy is an example of the cognitive aspect of resilience: those that have a strong sense in their abilities to problem solve and create adaptive solutions under duress contribute to organisational resilience. This perspective supports the notion that organisational resilience is state-like, affected by employee strength and can be developed through the behavioural and cognitive abilities of individuals, teams and leaders (Hillmann, 2021).

It is interesting to note that many more theoretical scholars (n=16) than empirical researchers (n=3) identified innovation as a component of organisational resilience. Whilst it may seem apparent theoretically that innovative practice would be advantageous to an organisation responding to a challenging or disruptive event, in practice it was not identified to the same degree of importance (Table 13). This illustrates the need to be cautious of drawing conclusions from the theoretical literature without further testing of the concepts and components.

Other adaptive components of resilience that have been identified by theorists and empirical researchers are the ability of an organisation to plan, manage change and adjust in response to environmental disruptions in order to maintain performance (Hills and Allen, 2018; Ishak *et al.,* 2018; Gracey, 2019). These capabilities enable an

organisation to maintain functioning and contribute to its sustainability (Morales *et al.,* 2019).

In their interpretation of adaptive capacity, some authors refer to this concept as a coping reaction to a disruption, based on the view of organisations as complex, adaptive systems (Barasa, Mbau and Gilson, 2018). The concept is also referred to as adaptation post-disruption, when new capacities are developed in response to an event, thus enabling recovery, growth and organisational sustainability (Duchek, 2020). This duality in interpretation of the concept provides another area of divergence within organisational resilience literature and a potential confusion of the meaning of the construct. Whilst it is clear from Table 12 that most scholars concur with the notion of adaptive capacity, it should be recognised that there is a difference in perception of the concept's function.

3.4.2.3 Recovery and growth

Organisations have been classed as resilient having recovered from a disturbance (Horne and Orr, 1997; Ruiz-Martin, López-Paredes and Wainer, 2018). Furthermore, some authors perceive adversity as an opportunity for organisational growth, thus becoming stronger (Vogus and Sutcliffe, 2007; Lengnick-Hall, Beck and Lengnick-Hall, 2011; Ma, Xiao and Yin, 2018). Some components that are reported to enable recovery and growth include organisational learning (Burnard and Bhamra, 2011; Chen, Xie and Liu, 2021), collaboration or strengthening links with stakeholders (Reinmoeller and van Baardwijk, 2005; Sawalha, 2015), sound corporate governance (Dahms, 2009; Hopkin, 2014) and developing and supporting staff (Cheese, 2016; Bouaziz and Hachicha, 2018).

The impact that resilient employees have on developing a resilient organisation is emphasised by some scholars (Mallak, 1998b; Ruiz-Martin, López-Paredes and Wainer, 2018). Building personal resilience can be facilitated through development programmes for staff. Coutu (2002) contends that resilient workers cope with reality, make meaning of it without despairing and create solutions that contribute to organisational survival. Kantur and İşeri-Say (2012, p. 764) state that, whilst there is no consensus amongst researchers of organisational resilience, "resilient individuals, as part of the whole organisational system, are expected to be a positive factor for organisations to develop their resilience capacity".

Some scholars refer to strategic management as a key component of organisational resilience (Kantur and İşeri-Say, 2012; Kuntz *et al.,* 2016). Central to this is

a concern with strategic decision-making in response to changes in their environment to ensure successful growth (Hillmann, 2021). It has been argued that organisations need to change and transform following disruption, requiring different approaches to create new options for growth (Lengnick-Hall, Beck and Lengnick-Hall, 2011).

Andersson and colleagues (2019) observed that leadership is rarely mentioned in the organisational resilience literature. Of the studies reviewed, six theoretical papers (Table 12) addressed leadership as a component of the construct. However, almost half (n=9) the research papers identified leadership as an enhancer of organisational resilience (Table 13), a further example of the mismatch between theory and empirical findings in the discordant corpus of organisational resilience literature.

Researchers differ considerably in their analysis of leadership within the construct: for example, there are references to adaptive leadership (Gracey, 2019), resilient leadership (Morales *et al.*, 2019; Suryaningtyas *et al.*, 2019), servant and transformational leadership (Witmer and Mellinger, 2016) and leadership that is outward-focussed (de Oliveira Teixeira and Werther, 2013; Gilson *et al.,* 2020). Hopkin (2014, p. 258) remarked that the Board had an important leadership role in "setting the tone" for employees, whilst Gover and Duxbury (2018, p. 489) concluded that the CEO had "enhanced the hospital's ability to cope with change". A greater clarity on leadership style that enables organisational resilience would be useful for organisational leaders to apply theory to practice. Leader behaviours that affect organisational resilience are reported in Section 3.5.

Thus, it can be concluded from the organisational management literature that organisational resilience is understood by scholars to be a complex construct, comprising various concepts and multiple components. The literature is diverse, a result of the various disciplines from which authors have been influenced. Concepts and components are not used uniformly: the same word may have a different interpretation between reporters. These anomalies negate clarity of the subject and underline the relevance for researchers to state their positioning of the construct within their resilience studies. Furthermore, the highly theoretical nature of the literature should be noted as a contributor to its diversity, with many of the components requiring further testing of their validity. Agreed amongst authors is that organisational resilience is influenced and achieved through a mixture of abilities and actions. Gibson and Tarrant (2010) assert it is the mix that makes an organisation resilient.

3.5 Leader behaviours affecting organisational resilience

Empirical research studies within the screened literature (n=21) were analysed for leader behaviours that have affected organisational resilience: these are presented in Table 13. Five studies were conducted within the health care sector, all outside of the UK (Meyer, 1982; Jeffs *et al.,* 2009; Witmer and Mellinger, 2016; Gover and Duxbury, 2018; Gilson et al., 2020). There was considerable variation amongst researchers as to which behaviours contribute to the development of organisational resilience. It is suggested this may be, at least in part, due to the wide range of organisations studied: the range included the army, health care, hotel sector, manufacturing and finance (Table 13).

All researchers identified a range of actions and a majority (n=14) agreed that effective, organisation-wide communication is an essential ingredient. Open communication should ensure that organisational values, progress and strategy information flow freely throughout the organisation (Horne and Orr, 1997; Andersson *et al.,* 2019). Cotta and Salvador (2020) argue that open communication, both internally and externally, ensures that all stakeholders are appraised of the organisation's response to a disruptive event.

Remaining connected and building relationships with external stakeholders was observed leader behaviour by many researchers (n=12). Meaningful discussion with external partners helps an organisation to build resilience through awareness of stakeholder limitations and expectations, future possible obstacles, impacts and available resources (McManus *et al.*, 2008). Similarly, Mousa and colleagues (2020) reported the importance of building relationships with multiple stakeholders and maintaining meaningful communication to identify risks and assess readiness to face those threats. Chen and colleagues (2021) refer to this as cultivating relationship resilience that, they assert, helps the organisation to overcome a crisis event. These authors also comment on the importance of developing good relationships internally, to foster a community of valued staff and loyal employees, which will help with staff retention and to overcome a company crisis (Chen, Xie and Liu, 2021).

Other authors (n=12) also noted that organisational resilience was enhanced by a focus on building positive staff relationships. This can be achieved through actions such as mentorship, creating a no-blame culture, providing opportunities for staff development and encouraging innovation (de Oliveira-Teixeira and Werther, 2013). One study reported that staff felt supported by their servant leaders and an attitude to improve, whatever

Table 13: Research Study and Method - Leader Behaviours that affect Organisational Resilience

Author (s) / Year	Area of Focus	Method				Internal relationship building	Environmental surveillance	Risk awareness / management	Effective org.- wide communication	Financial accountability	Development of a learning organisation	Encourage innovation	Staff development / support	Development of a strong value system	Attention to organisational processes	Organisational preparedness	Creative problem-solving	Leadership	Effective governance	Adaptation / agility	Development of a strong orgl. culture	System monitoring / awareness	Stakeholder connectivity / rel. building	Flexible use of resources	Contingency planning	Organisational change
		Survey	Case Study	Action Research	Secondary Data Analysis																					
Andersson *et al.*, 2019	Finance		✓			✓		✓	✓				✓	✓			✓				✓		✓			
Bouaziz and Hachicha, 2018	Organisation	✓				✓							✓				✓			✓						
Chen *et al.*, 2021	Organisation		✓			✓					✓										✓		✓	✓		
Cotta and Salvador, 2020	Manufacture	✓				✓			✓		✓		✓										✓			
de Oliveira Teixeira and Werther, 2013	Business				✓	✓	✓		✓			✓	✓			✓		✓			✓		✓			
Gilson *et al.*, 2020	Health Care			✓		✓				✓	✓		✓				✓	✓	✓		✓		✓			✓
Gover and Duxbury, 2018	Health Care		✓			✓			✓	✓					✓			✓			✓			✓		✓
Gracey, 2019	Army		✓				✓	✓	✓		✓							✓			✓					
Hopkin, 2014	Organisation		✓			✓	✓	✓	✓		✓		✓	✓	✓	✓		✓	✓	✓	✓		✓	✓		
Horne and Orr, 1997	Business		✓			✓			✓		✓										✓		✓	✓		✓
Jeffs *et al.*, 2009	Health Care		✓					✓	✓	✓					✓			✓	✓		✓					
McManus *et al.*, 2008	Organisation		✓				✓	✓	✓								✓				✓		✓			
Meyer, 1982	Health Care		✓				✓		✓					✓		✓				✓		✓		✓	✓	
Morales *et al.*, 2019	Manufacture	✓							✓			✓	✓	✓			✓	✓			✓					✓
Mousa *et al.*, 2020	Higher Ed.	✓							✓		✓		✓								✓		✓			
Reinmoeller and van Baardwijk, 2005	Business	✓						✓			✓	✓											✓			
Sawalha, 2015	Insurance	✓						✓	✓		✓		✓						✓		✓		✓			
Somers, 2009	Public Works	✓				✓	✓	✓							✓	✓						✓			✓	
Suryaningtyas *et al.*, 2019	Hotel	✓																✓			✓					
Weick and Roberts, 1993	HRO		✓			✓			✓		✓				✓					✓		✓				
Witmer and Mellinger, 2016	Health Care		✓			✓				✓				✓			✓	✓			✓		✓	✓		

obstacles might be in their way, so fostering a resilient mindset (Witmer and Mellinger, 2016). Horne and Orr (1997) assert that when staff feel connected with colleagues this enables resilience through their joint flexibility in response to pressure.

Most scholars (n=15) commented that leaders were committed to developing a strong organisational culture in order to promote organisational resilience. However, in keeping with that discussed in Section 3.4.2.1, there were differing observations of prevalent cultures in the organisations researched. Andersson and colleagues (2019) noted a culture of informal relationships in a distributed leadership power base that supported open communication and the observance of organisational values. Chen, Xie and Liu (2021) examined culture through a specific lens of community spirit and concluded that corporate culture can shape organisational commitment among employees. From a health care perspective, Jeffs and colleagues (2009) reported a focus on developing a safety culture, whilst a different study in health care observed how leaders sought to bring about a change from a hierarchical, performance-driven culture to one that supported improvement, built trust between managers and subordinates and developed proactive decision-making (Gilson *et al.,* 2020). Alternatively, Sawalha (2015) reported a culture that facilitates information exchange and organisational learning. These various outcomes emphasise the contextual nature of organisational resilience studies.

Some authors (n=10) have commented that leaders have developed systems or processes to encourage organisational learning (Weick and Roberts, 1993; Hopkin, 2014; Gracey, 2019). The relevance of leadership in enhancing organisational resilience was identified by nine researchers (Jeffs *et al.,* 2009; Witmer and Mellinger, 2016; Gover and Duxbury, 2018), as discussed in Section 3.4.2.3. A number of other leader behaviours that have been observed to affect organisational resilience have been recorded by fewer numbers of researchers, as identified in Table 13. The variety of actions highlights the disparate nature of the organisational resilience construct, how it is researched according to the understanding of its concepts and components, the context of the organisation and the influence that other research disciplines have had on individual scholars.

3.6 Summary of organisational resilience literature review

The study of organisational resilience has developed across several disciplines, resulting in a variety of definitions and concepts. Inconsistencies among scholars, both intra- and inter-disciplinary, make it difficult to draw conclusions on absolute components

of resilience, its development and how it may be sustained, as studies are not necessarily comparing or reporting on similar concepts. Studies that have researched leader behaviours affecting organisational resilience reflect the disparate views of resilience researchers. Research is influenced by their definition and understanding of the concepts and components of organisational resilience, which result in what the scholars seek to confirm from their research.

Knowledge development of the organisational resilience construct through research has been highly context-dependent and there has been little attempt to address how different conceptualisations and approaches may be relevant in a different context (Linnenluecke, 2017). The construct has been researched for almost fifty years, since Holling (1973) was credited with its introduction to the field of ecology (Burnard and Bhamra, 2011). Although it has received increasing scholarly attention over the last thirty years (Chen, Xie and Liu, 2021) and particularly has burgeoned this century (Gibson and Tarrant, 2010; Ma, Xiao and Yin, 2018; Ruiz-Martin, López-Paredes and Wainer, 2018) it is frequently criticised for its lack of clarity, fragmented and disjointed approach to research (Hillmann, 2021).

The majority of papers reviewed are conceptual and many accounts in the literature are repetitive. Recent authors frequently remark on the disparate nature of the organisational resilience literature (Mitsakis, 2020; Kantabutra and Ketprapakorn, 2021; Lyng *et al.,* 2022) and state their aim is to contribute to the theoretical discussion by summarising the current corpus, offering a new theory or adapting a definition (Hatton, 2018; Cruickshank, 2020; Koeva and Rohova, 2020). Arguably, the burgeoning literature of this nature is not advancing considerably the body of knowledge in the construct of organisational resilience but mainly adds to the theoretical account by frequent repetition of what is known, creating new models that may never be tested and adding ever more complex definitions, as evidenced in Table 11. There is a clear need for more inductive, empirical research in the organisational resilience field, underlining the relevance of this researcher's work.

3.6.1 Researcher's definition of organisational resilience

Working from a diverse and inconsistent knowledge base requires a researcher in this field to clarify their understanding and application of organisational resilience concepts and definition. The current research is focussed on two case studies of NHS Trusts that have improved and maintained their higher performance over the course of

four years. The researcher concurs with the theoretical position that organisational resilience is a combination of the concepts of adaptation, recovery and growth. She asserts these concepts map to the adaptive response by an NHS Trust to a negative regulatory inspection, which ultimately results in recovery and growth, demonstrated by a positive inspection that identifies organisational improvement.

Three definitions of organisational resilience from the reviewed literature (Table 11) identify the concepts of adaptation, recovery and growth (Vogus and Sutcliffe, 2007; Lengnick-Hall, Beck and Lengnick-Hall, 2011; Chen, Xie and Liu, 2021). In their definition, Chen and colleagues (2021) refer to recovery from a crisis. A crisis is a high-impact event that causes sudden disruption to organisational function, affects usual organisational networks and communication channels (Teo, Lee and Lim, 2017) and threatens the organisation's survival (Carmeli and Schaubroeck, 2008). Whilst a negative regulatory report may be psychologically impactful to staff, the event could not be considered an organisational crisis that required swift decisions to be made (Pearson and Clair, 1998) to ensure its survival. Similarly, in their definition of organisational resilience, Lengnick-Hall and colleagues (2011) refer to the recovery from an event that potentially threatens the organisation's survival. The NHS Trusts in this research were responding to a more routine disturbance that did not directly threaten their continuity. Consequently, the researcher rejected these definitions.

The third definition, that of Vogus and Sutcliffe (2007), was adapted by its authors from an engineering resilience perspective and was considered by the researcher to be in alignment with the position of the two case studies: organisations challenged for poor performance, that previously had been under public scrutiny following adverse events, and had subsequently been assessed as performing organisations. Due to the alignment, this researcher accepted the definition proposed by Vogus and Sutcliffe (2007) and thus defined organisational resilience as "the maintenance of positive adjustment under challenging conditions such that the organisation emerges from those conditions strengthened and more resourceful" (Vogus and Sutcliffe, 2007: p. 3418). Vogus and Sutcliffe (2007) include scandals, shocks, disruption to routines and risk of competition as challenging conditions, which directly relate to the challenges of the case study NHS Trusts.

3.7 Organisational resilience and health care organisations

As noted in Section 3.3, the field of resilience engineering has influenced the

application of organisational resilience theory to health care organisations (Anderson *et al.,* 2016; Berg *et al.,* 2018). Both Safety-I and Safety-II (Section 3.3) approaches to organisational safety are evident in the NHS: clinicians are encouraged to report near miss events and clinical incidents on a Trust's clinical management system (Griffin, 2009; Walsh, Burns and Antony, 2010). Examination of near misses enables review of potential threats, adaptation of processes and avoidance of future incidents: learning from near misses implies learning from success – an accident that did not happen. Robson (2013) asserts that learning from incidents is essential to organisational resilience, which is partly facilitated in the NHS by a Trust's incident reporting system and root cause analysis of serious incidents (Mengis and Nicolini, 2010).

Studies of organisational resilience in health care globally and the NHS vary in focus such as employee resilience (Mallak, 1998a; Sull, Harland and Moore, 2015; Brunetto *et al.,* 2020), departmental research (Jeffs *et al.*, 2009), community settings (Gover and Duxbury, 2018; Gilson *et al.,* 2020), mental health (Witmer and Mellinger, 2016) and organisation-wide studies (Meyer, 1982). A recent multiple-case study of NHS Trusts in special measures for quality by Fulop and colleagues (2020) identified eight areas of focus that had contributed to their improvement, namely: governance and clinical leadership, service delivery, data monitoring, organisational culture and staff engagement, work force, quality improvement strategy, quality improvement interventions and estates. The study identified the importance of a listening culture, a focus on continuous learning and a quality improvement mindset.

Improvements to the staff survey data were also reported by Fulop and colleagues (2020), although specific areas were not described other than increased staff engagement. In their report they commented on the lack of studies that have considered factors which may have influenced improvement and organisational resilience, such as internally driven versus externally driven interventions and those operating at a system-wide level (Fulop *et al.,* 2020). They identified collaborating with external partners and establishing good relationships with regulators as external interventions, along with having time to embed change.

As noted in Section 1.1, since early 2020 the COVID-19 pandemic has caused unexpected pressure on global health systems (Deloitte, 2021; Haque, 2021) and maintaining a functioning NHS was central to the UK government's lockdown strategy (Tonkin and Whitaker, 2021). Evaluation of the early response of the NHS to the

pandemic has identified its lack of preparedness with an over-reliance of just-in-time and lean management principles, which threatened operations due to supply chain disruption (Bryce *et al.*, 2020). Lack of personal protective equipment and reserves of ventilators were the result of apparent policy decisions rather than lack of foresight (Bryce *et al.,* 2020).

Notwithstanding a difficult start, which was exacerbated by years of underfunding and considerable staff shortages, the NHS has demonstrated some system resilience. Staff were rapidly retrained and redeployed system-wide and temporary hospitals were set up to help alleviate pressure in mainstream hospitals. The system, whilst remaining under severe strain and facing significant challenges, has not collapsed (Willan *et al.,* 2020; Alderwick, *et al.,* 2021; Anderson *et al*., 2021; Wise, 2021). It will be important to learn lessons from recent history to build greater preparedness for future disruptive events and maintain a resilient, sustainable health care system.

3.7.1 Organisational resilience and health care regulation

In a review of studies that researched the relationship between health care regulators and organisational resilience, Øyri and Wiig (2019) identified resilience-promoting and resilience-hindering themes. Those promoting resilience included anticipation, learning, adaptation and flexibility, facilitated by a local sense of responsibility. They also concluded that those same themes could hinder resilience if the organisational focus was solely on compliance. They reported a need for more research in this area to advance knowledge in the relationships between safety, regulation and resilience (Øyri and Wiig, 2019).

As noted in Section 2.3.4, NHS Trusts regulated by the CQC may reduce performance over time, demonstrating a reduction in organisational resilience. This raises a question as to whether the regulatory process should have an objective to facilitate the development of organisational resilience: Trusts spend considerable time and public funds preparing for inspections by the CQC (Castro, 2018). It is argued that the immense use of resources should have a positive benefit and deliver performance improvement for the organisation and its stakeholders. There is little research into the organisational objectives of NHS Trusts following a CQC inspection, so it is unclear as to whether those that do improve their CQC grading and develop organisational resilience have had a focus solely on compliance or whether other factors are at play.

The unintended negative consequences of regulation are also of concern. These

can include difficulty to attract staff, a focus on compliance, decreased staff morale which can affect quality of care and staff retention, public concern over the services they have to access and an increase in staff costs in order to induce people to work in a challenged environment (Rendel, Crawley and Ballard, 2015). Additionally, the focus on preparatory work and then on regulatory compliance can distract staff from a focus on excellence, towards only attaining minimum standards (Sutherland and Leatherman, 2006), which defeats the objectives of a regulatory organisation that purports to promote resilience and an improvement mindset (CQC, 2016a). The benefit of regulation to organisations is unclear: Sutherland and Leatherman (2006) claim that any benefit is likely to be associative rather than causal, and more research is required to determine the value of regulation to health care organisations (Marsden *et al.,* 2020).

NHS hospital Trusts that have been publicly reviewed for serious failings and those rated as underperforming by the CQC are under challenge to improve significantly and speedily (Berwick, 2013; CQC, 2013b; Keogh, 2013). Organisational leaders are required to engage their employees on a journey of culture change and improvement at a time when low morale may be abundant (CQC, 2017c; CQC, 2018d). The Trust must continue to function whilst addressing dysfunctional processes, requiring the development of organisational resilience to absorb change and not just focus on its systems (Horne and Orr, 1997) if it is to improve and be ultimately sustainable. Having a nuanced understanding of how NHS Trust leaders have developed organisational resilience would be of benefit to the whole system in which they operate. It would also benefit leaders of underperforming Trusts, who may learn how to accelerate resilience development from those that have succeeded.

A synthesis of the complete literature review will now follow, from which the research gap and resulting research questions are identified.

3.8 Synthesis of literature review (Parts I and II)

Health care organisations in the UK are subject to external regulation by the CQC. Following an extensive inspection process, a Trust will be judged as underperforming (*Inadequate* or *Requires Improvement*), performing (*Good*) or highly performing (*Outstanding*). This research seeks to understand how senior leaders have responded to an underperforming CQC grade and subsequently improved organisational performance whilst under external challenge and scrutiny, within two years. The improved grade was maintained following a further inspection two years later, thus demonstrating sustained

organisational resilience.

An overview of the introduction and development of the NHS identified a series of significant reorganisations, as successive governments aimed for greater control and accountability for clinical performance and spending. The most recent change has impacted plans for greater collaboration between health, social care and local authorities to rationalise resources and improve services in ICSs. Legislative change to enable effective partnerships is required and should be implemented in 2022.

The latest decade has been one of austerity in response to a global financial crisis and the health service has struggled from years of under-investment and increasing staff shortages. The impact of these measures was evident at the beginning of the COVID-19 pandemic, with inadequate supplies of equipment and appropriate protection for front line staff. Despite its unpreparedness, the NHS responded with resilience and, whilst still under strain, it continues to adapt and deliver services.

The medical profession has had a history of self-regulation and resistance to loss of autonomy and management oversight. This has contributed to a number of significant service failures and subsequent public inquiries, eventually leading to the regulation of clinical governance. As more Trust failures emerged the regulatory system was challenged and the CQC developed a comprehensive inspection process. A review of the current process identified that many services do improve over time but that others deteriorate.

There is varied opinion as to the benefits of regulation, with some authors concluding there are none and others seeing it as a catalyst for improvement. The CQC and some academics report that better leadership accompanies performance improvement, but the key behaviours of senior leaders and objectives set by the CEO and Board following an underperformance CQC rating are not identified. This may be due to an assumption by researchers that the major goal would be to achieve an improved performance rating. A focus on quality improvement, culture change, governance and values are evident but details of specific values or desired culture are limited.

A review of leadership literature suggests that NHS leaders have been influenced by a style of autocratic leadership. Expert and professional hierarchical power are also present and have had a negative effect, particularly in relation to the medical profession: this is changing but not extinct. Transactional and transformational leadership has also been influential in the NHS; the most recent espoused behaviours are transformational, including compassionate and distributed leadership models. A stakeholder approach, that

of responsible leadership, offers an alternative style to those principally argued for in the NHS and may be more relevant to leaders of future ICSs.

In examining leadership and culture of the NHS, autocratic leadership has led to a pervasive bullying culture. This has been of concern for over two decades and cited as a cause of organisational failures. A culture of compassion has been promoted by some academics to address institutional bullying. Also, a key governmental objective has been to promote an open culture, encouraging staff to report incidents and near misses without fear of retribution, and to learn by sharing safety information across organisations. A learning organisation is considered critical to improving organisational performance and long-term sustainability.

Resilience has been researched in a range of disciplines, resulting in various definitions, concepts and components. The organisational resilience management literature is diverse and inconsistent, requiring a researcher of the subject to state clearly their positioning of the construct. Research into leader behaviours that affect organisational resilience is limited and shaped by the theoretical perspective of each researcher. The range of behaviours reported by researchers reflects the variety of resilience components identified in the literature, giving rise to diverse conclusions.

Resilience research in health care has been strongly influenced by the field of resilience engineering, with its focus on safety. The majority of studies have occurred at the departmental and individual level and a limited number of studies at the organisational level was apparent. There was a call for comparative and longitudinal studies at the organisational level, a gap that this research fills.

3.8.1 Identification of research questions

Clearly some NHS Trusts are more successful than others and those that have been unable to sustain improvement can learn from the best. However, whilst it is clear that there has been a focus of ensuring a compassionate workforce with a model of distributed leadership and an open, non-blame culture, what is lacking is knowledge of the senior leadership strategy and behaviours required to take an organisation from underperformance to an achieving organisation. Furthermore, it is not clear whether all underperforming organisations require a culture change and change of values and, if so, what culture and values will best facilitate development of organisational resilience.

For the NHS to learn from achieving, resilient organisations the following research questions (RQ) need to be addressed:

RQ1: What has enabled organisational performance improvement and thus developed organisational resilience, as evidenced by the Care Quality Commission?

RQ2: What strategic leadership behaviours underpinned the development of sustained organisational resilience?

The following chapter sets out the methods used to answer these research questions.

Chapter 4

METHODOLOGY

4.1 Introduction and chapter overview

The methodology chapter describes the process that identified the strategic leadership behaviours that underpinned the development of sustained organisational resilience, to determine how organisational performance improvement was enabled in two NHS Trusts in England. The chapter addresses the philosophical paradigm of the researcher followed by an explanation of the research design and methods. Issues of research reliability, validity, quality and triangulation of data are then addressed. Ethical considerations for the study are discussed, followed by analysis of the impact on fieldwork and the research study of the COVID-19 pandemic in March 2020. The final section outlines the methods of data analysis and precedes a chapter summary.

4.2 Researcher's philosophical paradigm

This qualitative research focussed enquiry on understanding process and meaning to enable learning for improvement, utilising reflexivity in analysis. A pragmatist philosophy underpinned the work, centred on the consequences of action (Denzin and Lincoln, 2018) and its practical application (Saunders, Lewis and Thornhill, 2016). The research aims to contribute practically to the NHS, providing insights on strategic leadership behaviours that develop organisational resilience, using an inductive approach (Blaikie, 2009; Mason, 2018).

The epistemological premise of pragmatism views knowledge as dynamic: what is truth today may be different in the future and, therefore, seeking an absolute truth is a "hopeless cause" (Denscombe, 2017, p. 173). According to pragmatism, there is no single 'best' research approach that can lead to irrefutable knowledge. Rather, knowledge has specificity and that which is 'true' enables successful action (Saunders, Lewis and Thornhill, 2016). Thus logically, various methods can be utilised to understand the phenomenon being studied as knowledge development "is linked to participation, intervention and learning" (Mjøset, 2009, p. 49).

The researcher reflected a subjectivist ontology (Wahyuni, 2012), seeking to understand how the participants in the study interacted with their environment and interpreted its events (Mason, 2018). She acknowledges her inability to be entirely

objective as her perceptions are subjective (McQueen and Knussen, 2002; Silverman, 2013), influenced by her NHS experience, conscious and unconscious biases and unconscious influence during data analysis, which is discussed in Section 4.6.4. Scholars argue the importance of the social researcher being aware of their epistemological and ontological positions, as these influence the choice of methodology and enable cross-referencing for consistency (Huff, 2009; Symon and Cassell, 2012; Mason, 2018). The ontological and epistemological philosophies held are congruent with pragmatism (Wahyuni, 2012; Saunders, Lewis and Thornhill, 2016) and the multi-methods chosen to research the subject (Mjøset, 2009; Thomas, 2011), which are addressed in Section 4.4.

4.3 Research design

A multiple-case study design was chosen for the research. Yin (1999) asserts that a case study approach is relevant when researching phenomena in today's health organisations as they are in constant flux and part of increasingly complex systems. He defines case study as "an empirical enquiry that investigates a contemporary phenomenon in depth and within its real-world context, when the boundaries between phenomenon and context may not be clearly evident" (Yin, 2014, p. 16). Stake (1995) posits an alternative view, that precise definitions of a case study or case are not possible as there are many interpretations according to various disciplines. For him, the case study is the choice of object to be studied, be that an individual person or department, and is a specific, complex and functioning thing.

A similar position is taken by Schwandt and Gates (2018), who comment that use of the terms vary considerably across disciplines and fields of study, which include references to: an in-depth exploration from multiple perspectives of the uniqueness and complexity of a particular institution or system in real-life context; whose primary purpose is to generate an in-depth understanding of a social phenomenon; using several data sources. These authors suggest that, rather than seeking a universal definition, a more critical question for researchers using cases is "What is this a case of?" (Schwandt and Gates, 2018, p. 342). The research object, they argue, may be unknown until much of the empirical work is complete.

According to Thomas (2011) a case study comprises analysis of a subject that is an example of a phenomenon, the object. The object is the unit of analysis, that which the researcher seeks to understand as a whole (de Vaus, 2001). This research aims to discern the strategic response to challenge in two NHS hospital Trusts - the cases - by identifying

specific strategic behaviours of their leaders: therefore, it is asserted that a case study design was the most appropriate to address the research questions in these discrete organisations, aligned to other examples in health care research in the NHS (Bamford and Daniel, 2005; Allen *et al.,* 2012; Dixon-Woods *et al.,* 2014; Fulop *et al.,* 2020) and globally (Gorli, Kaneklin and Scaratti, 2012; Poksinska, Fialkowska-Filipek and Engström, 2017; Forrest-Lawrence, 2019).

Case studies have been criticised for their lack of generalisability, particularly in comparison with survey research (Gomm, Hammersley and Foster, 2000). In his foreword to Yin's text (Yin, 2014, p. xviii), Campbell stressed the scientific laboratory method as superior to the "out-of-doors social science" case study approach due to the "inability to replicate at will". Some case study researchers suggest this misunderstands the purpose of elucidating the uniqueness of the case (Stake, 1995; Thomas, 2011; Gorard, 2013). Scholars purport protestations from the scientific community regarding the unscientific nature of organisational studies stem not from concerns of design or method but their conflicting epistemologies and ontologies (Byrne and Ragin, 2009; Huff, 2009; Buchanan, 2012).

Some researchers assume that all studies should follow the same process (Thomas, 2011). But, a quantitative paradigm is not appropriate for researching all phenomena and there is no one right way to conduct research (Lichtman, 2014). Silverman (2013) argues that there are no right or wrong methods, only those appropriate to the researcher's topic and model. As a pragmatist, this researcher chose multiple qualitative methods to illuminate what happened and why (Dubois and Gadde, 2002) in the organisations studied.

Byrne and Ragin (2009) distinguish between generalisability and universality. They assert the importance of developing an understanding of causation, which goes beyond the individual case, whilst acknowledging the boundaries of that generalisation. Yin (2014, p. 40) suggests that the case should be viewed as "the opportunity to shed empirical light about some theoretical concepts or principles" rather than a "sampling unit". The case study is "likely to strive for generalisable findings or lessons learned – that is, analytic generalisations – that go beyond the setting for the specific case that had been studied" (Yin, 2014, p. 40).

Stake (1995) stresses particularisation of the case study, coming to understand the case well, not for its difference but what it is and does. This implies knowledge of others that the case is different from and contributes to naturalistic generalisation. Schwandt and Gates (2018) assert that typicality is not the purpose of a case study but that the case

may have utility beyond itself, particularly if a trend emerged in other studies of the same phenomenon. Similarly, Gerring (2004) refers to a case study as an intensive examination of a single case whose aim is to illuminate a larger set of cases.

Flyvbjerg (2006, p. 3) reported "five misunderstandings" regarding case studies. He examined and demonstrated that it was possible to generalise from a single case, using examples of Darwin, Newton and Einstein, but not always desirable to do so. Debunking the view that case study is unsuitable for theory building, he stated it has usefulness for generating and testing hypotheses. He also argued "predictive theories and universals cannot be found in the study of human affairs. Concrete, context-dependent knowledge is therefore more valuable than the vain search for predictive theories and universals" (Flyvbjerg, 2006, p. 7). These case studies will contribute to the development of organisational resilience theory in health care organisations, generalisable to a theoretical proposition and not to the population (Yin, 2014).

Campbell later reversed his opinion, becoming a strong proponent for the case study and agreed that human learning and expertise resulted from context-dependent knowledge (Flyvbjerg, 2006). Hammersley and Gomm (2000) argue the significance of case study research is the use that others make of them. Through the examination and analysis of two cases the researcher aims to provide new data that other NHS Trust leaders may draw on to develop organisational resilience and sustainability.

4.3.1 Case selection

Multiple cases were selected to provide some comparison for analysis, leading to greater insights (Thomas, 2011). The rationale was to identify whether findings were replicated across the cases, enabling extrapolation to broader theories (de Vaus, 2001; Saunders, Lewis and Thornhill, 2016) and strengthening the possibility that findings will be useful for other NHS Trusts. As de Vaus (2001) posits, multiple cases will be more compelling than a single case and provide a tougher test for a theory. The two Trusts were a non-specialist acute (case study one) and a mental health Trust (case study two), located in different health regions.

The phenomenon under study was strategic leadership behaviour that developed organisational resilience following external challenge. As noted in Section 2.3.1, the NHS health regulator CQC has conducted rigorous assessments of NHS hospitals in England since 2013. The first round of baseline inspections identified significant numbers of hospitals that were underperforming and rated *Inadequate* or *Requires Improvement*,

particularly in the acute sector (Table 1, p. 36). The researcher chose two Trusts of similar size and diversity within their specialisms: characteristics that demonstrate their similarity whilst maintaining anonymity are listed in Table 14 below. Profiles of the cases studied are presented in Section 4.3.2.

Table 14: Characteristics of Case Study Organisations

Case Study 1 **Non-specialist Acute Foundation Trust**	**Case Study 2** **Mental Health Foundation Trust**
Multiple sites; large geographical spread	Multiple sites; large geographical spread
Multiple clinical specialties	Multiple clinical specialties
Previous external scrutiny	Previous external scrutiny
University associated teaching Trust	University associated teaching Trust
CQC significant improvement in 2 years	CQC significant improvement in 2 years
CQC maintained improvement after further 2 years	CQC maintained improvement after further 2 years

Another selection criterion was that both Trusts were underperforming on their first CQC comprehensive inspection and improved significantly on their inspection after a timeframe of two years. On a subsequent inspection they maintained their improved grade, again within a further two-year timeframe. Both Trusts have also had significant adverse publicity to overcome, unrelated to CQC inspections.

Stake (1995) argues for three types of case study, with different considerations for selection. The intrinsic case is one where the researcher may have been given a particular case to study; an instrumental case study is chosen to understand a specific phenomenon. Choosing more than one instrumental case constitutes a collective case study. He asserts that the cases are studied primarily independently and selection should first be driven by what can be learned. This might best come from a typical or an unusual case.

Yin (2014) describes five case types, including the representative or typical case. Schofield (2000) states that studying the usual, or typical, organisation is an appropriate aim for a researcher as it elucidates the normal. If another organisation wants something different to the typical, it can plan change accordingly (Schofield, 2000). As reported in Section 2.6.1 the NHS is widely known for a dominant culture, quality and safety record. Arguably, researching NHS organisations that are *not* representative should yield more

useful data. Two non-representative cases for study were considered manageable by the researcher within her timeframe and resources (Saunders, Lewis and Thornhill, 2016).

Studying an extreme or unique case (Yin, 2014) enables the researcher to study phenomena that are unusual to the representative cases and probe possible reasons for these differences (Seawright and Gerring, 2008; Bryman, 2012). The two selected Trusts fall into this category. George and Bennett (2005) purport that outlier case studies provide greater opportunity for developing new theories through unexpected insights during fieldwork. Authors assert that cases should be selected for their potential to yield relevant data (Schwandt, 2001; Creswell, 2013; Silverman, 2013). Due to their difference from many NHS Trusts the two selected should offer greater opportunity for learning how leaders developed organisational resilience and sustainability, which can be shared with the sector.

The researcher sought access to Trusts that have demonstrated resilience through withstanding external pressure and emerging stronger. The cases were purposefully selected for meeting this criterion (Emmel, 2013). According to Blaikie (2009), Lincoln and Guba assert that transferability between contexts is possible provided they are judged to be similar. The two selected Trusts have several similar features: size; geographical spread; complexity of services; number of employees; CQC assessment history; previous negative publicity (Table 14). This increases the possibility of drawing analytical generalisations from the data (Robson and McCartan, 2016).

Negotiating access into an organisation for research purposes can be difficult. There may be issues of perceived researcher credibility, competence and integrity, communication skills, their understanding of the environment and intrinsic value of the research (Silverman, 2013; Mason, 2018). As noted in Chapter 1, the researcher has had a successful NHS and health consultancy career, with established credibility in the sector (Appendix V). From personal experience, the researcher is aware of sensitivity within the NHS to admitting external researchers for reasons including patient confidentiality, safety, defensiveness and adverse publicity fears. She was heedful the selection criteria made for greater sensitivity: the organisations would neither wish to garner more negative publicity nor personnel be reminded of past history that may still be manifest.

The upper management tiers in hospitals can be difficult to access (Taylor and Bogdan, 1998) and, avoiding the prospect of gatekeepers (Emmel, 2013; Silverman, 2013), the researcher contacted the CEOs directly to establish their interest. In one Trust

she had a personal connection to the CEO and made contact by telephone. The second CEO she approached at a health care conference, where she attended as a delegate and the CEO was a speaker. Both CEOs gave immediate permission in principle to their organisation becoming a case study. The researcher is neither a stakeholder nor has worked in either organisation.

4.3.2 Case Study organisational profiles

In accordance with ethical approval requirements, the case study organisations are anonymous and their participants' identification confidential. The profiles of the case study organisations are reported so as to maintain these requirements.

4.3.2.1 Case Study 1

Case Study 1 (CS1) is a large non-specialist acute NHS Foundation Trust. It provides a range of services to its cosmopolitan population including acute medicine and surgery, emergency, trauma and orthopaedics, cardio-thoracic and critical care, maternity, paediatrics and ophthalmology. It is a teaching hospital with strong links to its local university. The Trust manages a number of hospitals, most of which have a long history. There has been significant investment in modernising the estate in recent years. The Trust's history of comprehensive CQC inspections is reported in Table 15.

Table 15: Care Quality Commission Comprehensive Inspection History - Case Study 1

Year	Inspection Number	Outcome
2015	Comprehensive Inspection 1	Under-performance (Inadequate / Requires Improvement)
2017	Comprehensive Inspection 2	Improved performance (Good / Outstanding)
2019	Comprehensive Inspection 3	Retained grade of Inspection 2

4.3.2.2 Case Study 2

Case Study 2 (CS2) is a large mental health and learning disability NHS Foundation Trust providing in-patient and community services to adults, children and adolescents. The population, mainly urbanised, has a diverse ethnicity and demographic. The Trust has teaching status and works closely with its local university. Its services are wide-ranging and include street triage, perinatal mental health, crisis resolution, neurodevelopmental services, forensic mental health services and specialist treatment to older adults with moderate to severe mental health problems. Much of the Trust estate is old and there is

a modernisation plan in progress, refurbishing community and in-patient facilities. The Trust's history of comprehensive CQC inspections is reported in Table 16.

Table 16: Care Quality Commission Comprehensive Inspection History - Case Study 2

Year	Inspection Number	Outcome
2015	Comprehensive Inspection 1	Under-performance (Inadequate / Requires Improvement)
2016	Comprehensive Inspection 2	Retained under-performance grade of inspection 1 (Inadequate / Requires Improvement)
2017	Comprehensive Inspection 3	Improved performance (Good / Outstanding)
2019	Comprehensive Inspection 4	Retained grade of inspection 3

4.4 Research methods

Case studies may incorporate multiple methods including interviews, document reviews and observations to generate data (Berg and Lune, 2012; Creswell, 2013; Yin, 2014; Robson and McCartan, 2016; Mason, 2018). Consistent with a pragmatist, who frequently seeks multiple sources of data to solve the research problem (Saunders, Lewis and Thornhill, 2016; Denscombe, 2017), all three of the above-named methods were used. The selection of methods was informed by the researcher and case intuition, making use of sources of knowledge that were available within the organisations (Hyett, Kenny and Dickson-Swift, 2014). In addition, NHS Staff Survey data were included for analysis. The rationale for choice of each method is given in Subsections of 4.4 below.

4.4.1 Fieldwork overview

Fieldwork was planned to take place over six months. Consideration was given to spending three months sequentially in each site. This was impractical due to the availability of Trust staff and the existing schedules of internal meetings. As Yin (2014) observes, the case study researcher does not have control over their research environment and may need to adjust their research plan. The flexibility of the researcher and qualitative research design (Braun and Clarke, 2013) facilitated concurrent data collection from multiple methods and both case study sites. This ensured efficiency of fieldwork, in consideration to the Trusts as well as the researcher. The majority of fieldwork was completed before access to the case study sites was curtailed by COVID-19 pandemic restrictions in March 2020.

The researcher was given access to Trust buildings and freedom to walk corridors unaccompanied. She did not visit clinical areas unescorted. Interviews were held with staff at their convenience and various meetings and events were attended and observed by request or invitation. The majority of fieldwork was completed in nineteen weeks, before access to the case study sites was withdrawn on 23rd March 2020 due to COVID-19 pandemic restrictions. The impact of this interruption to fieldwork and the research study is discussed in Section 4.7.

Observations and reflections were documented longhand in a fieldwork notebook whilst on Trust premises. Aware of personal influences, the researcher tried to maintain objectivity throughout (McQueen and Knussen, 2002), particularly through reflexivity and reflection, noting down thoughts and feelings of the research process and findings (Cole *et al*, 2011; Haynes, 2012). These written field notes were frequently referred to and reflection continued during data analysis.

4.4.2 Sample selection

The researcher did not know either organisation or their structure and selected an extensive snowball sampling technique (McQueen and Knussen, 2002; Berg and Lune, 2012), in keeping with other research studies in health care organisations (Sheu *et al.,* 2009; Witmer and Mellinger, 2016) including the NHS in England (McGivern and Fischer, 2012; McKee *et al.,* 2013). An executive director (ED) was initially interviewed at one Trust, following introduction by the CEO. The CEO was the first interviewee in the second Trust. Both Trust Chairs were introduced to the researcher by the CEOs and were interviewed early in the process.

The researcher asked each participant interviewed for introductions to their colleagues who were senior leaders and might be interested in contributing to the research (Patton, 2014), establishing a chain of referrals (Saunders, 2012). This introduced an element of purposive sampling (Robson and McCartan, 2016) to ensure the participants were at a sufficiently senior level to relate adequately to the interview questions (Silverman, 2013). Referred staff were sent a standardised email (Appendix IV), with an attached one-page preliminary briefing sheet (PBS) (Appendix V) regarding the study. This enabled the recipient to make a decision in principle and formed the first stage of providing informed consent to participate in the study. The PBS gave an overview of all salient points, which could be read quickly. The volume of emails sent to NHS managers and leaders was well known to the researcher, informing the decision after the

interviews commenced to provide a research briefing sheet: pragmatically, the researcher felt this would have more chance of being read initially than the four-page Participant Information Sheet (PIS).

Once the researcher received their agreement in principle to participate in the study she sent the prospective participant the detailed PIS (Appendix VI) prior to arranging the interview. The ethical considerations of this approach are reported in Section 4.6.3. All recipients of the PIS consented to interview, which suggests the PBS provided adequate and accurate information. A participant consent form (Appendix VII) was completed and signed by the interviewee and researcher prior to conducting each interview; a paper copy was left with the participant and a digital copy retained by the researcher.

The sampling method provided a wide cross-section of participants in both Trusts (Table 17, p. 101) including executives, senior and middle managers, clinicians and non-clinicians from introductions made across and down the organisations. The participant sample was purposive (Bryman, 2012) with respect to the level of staff seniority to ensure relevance to the research questions (Saunders and Townsend, 2018), but not selected by the researcher to eliminate an element of unconscious bias and potentially narrowing the field for selection (Braun and Clarke, 2013). The gender of the CEOs of both Trusts is undisclosed to further aid anonymity of the organisations.

4.4.3 Interviews

Interviews were considered to be the most appropriate method to determine how leaders reacted emotionally and behaviourally to challenge from the CQC and other events. The interview conversation enables the researcher to ask about and hear the experiences of the interviewee in their own words (Kvale, 2007). The researcher can elicit data on things such as feelings, opinions, understanding, attitudes, memory and interpretation, focussed on distinctive features of events (Arksey and Knight, 1999; Peräkylä and Ruusuvuori, 2018). Semi-structured interviews gave the researcher flexibility to follow up on issues raised by the participant (Rubin and Rubin, 2012). They also enabled the researcher to be viewed “as a knowledge-producing participant in the process itself, rather than hiding behind a preset interview guide” (Brinkmann, 2018, p. 579).

The interview framework of questions (Appendix II) provided an aide memoire to the researcher and their rationale is explained in Appendix III. The first and last questions

were consistently asked in the same sequence. The initial question was designed to relax the interviewee (Aurini, Heath and Howells, 2016), enabling them to settle quickly to facilitate a quality interview (Schostak, 2006). The final question was a 'catch all' to ensure the participant had provided all the information they wished to impart. The framework ensured all topics were covered during the interview, but not necessarily addressed in the same order or questions posed verbatim. The researcher was guided by the interviewee's answers, facilitating a conversational flow (Gillham, 2005; Kvale, 2007). A summary of the substantive issues explored through the interview process is presented in Section 4.4.3.1.

Interviews were recorded for accuracy of data collection (Gillham, 2005; King and Horrocks, 2010). The researcher maintained good eye contact throughout the meeting, established rapport early and gained participant trust, monitoring and responding to the participant's response to questions (Rubin and Rubin, 2012). The researcher thoroughly prepared prior to commencing interviews, ensuring she had clarity on the issues (Section 4.4.3.1) she wished to discuss (Mason, 2018). This facilitated the conversation by ensuring minimal reference to the interview framework (Appendix II), so maintaining good rapport and ensuring the participant remained at ease (Edwards and Holland, 2013).

Interviews were held on Trust premises at a time and venue convenient to the interviewee. The digital recordings were transcribed verbatim and checked manually for accuracy: transcripts were uploaded into NVivo software (Bazeley and Jackson, 2013), analysed using thematic coding as defined by Braun and Clarke (2013) and refined by the Gioia architecture (Gioia, Corley and Hamilton, 2012). The process of analysis is introduced in Section 4.8 and described in detail in Chapter 5. The face-to-face interviews took between sixty and ninety minutes. Four interviews were rescheduled to a telephone call due to the COVID-19 pandemic lockdown. These interviews took between fifty and eighty minutes, in line with those previously conducted face-to-face. The quality of the interviews was not compromised by this change of method, the impact of which is discussed further in Section 4.7.3.

Researchers differ in opinion as to how many participants should be interviewed in a study and suggest various sample sizes for different methods (Mason, 2010; Dworkin, 2012; Braun and Clarke, 2013; Creswell, 2013; Silverman, 2013; Mason, 2018). Some academics agree that in-depth interviews should be held until saturation has been reached (Bryman, 2012; Creswell, 2014; Saunders, Lewis and Thornhill, 2016), described

by Creswell (2014) as gathering fresh data that yields no new properties or insights, though this is also contentious (Braun and Clarke, 2013; O'Reilly and Parker, 2013).

In a comprehensive review of published organisational and workplace studies between 2010 and 2013, Saunders and Townsend (2016) found a lack of transparency in reporting participant numbers in 23.4% of studies. They reported a median of 32.5 participants to reach saturation and recommend that, whilst thirty people may be a credible sample for an organisation or single group analysis, it is only an estimate and the researcher should provide their own evidence of saturation (Saunders and Townsend, 2016).

Thirty-nine participants were interviewed across both cases from a range of managers and clinicians at various levels in the organisation (Table 17), sixteen in CS1 and twenty-three in CS2. The researcher had intended to interview a similar number of participants in both Trusts and analyse the data per case before drawing any comparison. Pragmatically, this approach changed for two reasons: firstly, data from both cases were remarkably similar, despite the difference in Trust specialties, and saturation had been reached across cases around thirty-four participants.

The COVID-19 pandemic in March 2020 became a critical factor for the Trusts, creating the second reason for change. The researcher did not think it either justifiable or necessary to even up the case participant numbers whilst the organisations were in crisis and saturation had been reached. By participant request, one interview was rescheduled to early evening and a second was postponed twice, evidence of the pressure that Trust staff were under in both organisations. One prospective participant, an Emergency Department medical consultant, cancelled their interview due to time pressures caused by the pandemic, further evidence of staff pressure and inappropriateness of requesting referrals.

4.4.3.1 Substantive issues explored during interview

Seven substantive areas were explored through the interview to identify the strategic leadership behaviours that underpinned the development of organisational resilience in both case studies. These are now addressed in the following order: organisational culture, impact of the inspections on staff morale, organisational strategic priorities, influential leader behaviour, risk management, organisational learning and organisational resilience. The questions are set out in Appendix II and the rationale for them is presented in Appendix III.

Table 17: Participant Demographic Data

ID	Gender Male / Female	Case Study	C: Clinical Role N: Non-clinical role Clinical Background ***	Grade *	Tenure in Role (Years)	Years in Trust	Other NHS Trust **
1	M	1	N	E	2.25	2.25	No
2	M	1	N	E	2	2	No
3	F	2	N	M	3	10	No
4	M	2	N	E	3	10	Yes
5	F	2	N ***	E	1.5	1.5	Yes
6	F	1	N ***	E	6	6	Yes
7	M	2	C ***	S	10	20	No
8	M	2	N	S	2	11	Yes
9	M	1	N ***	S	3	3	Yes
10	M	1	N	S	5	22	Yes
11	F	2	N ***	M	2	17	Yes
12	M	2	N	E	1.5	1.5	Yes
13	M	2	C ***	S	5	15	Yes
14	F	2	N ***	S	1	15	Yes
15	F	2	N	M	3	6	No
16	F	2	N ***	S	2	5	Yes
17	M	2	N ***	S	17	17	Yes
18	M	2	N	E	2	2	Yes
19	F	1	N ***	M	5	23	No
20	M	1	N ***	S	1	16	Yes
21	F	1	N ***	S	9	20	Yes
22	M	2	N	E	6	6	Yes
23	F	2	C ***	S	1	3	Yes
24	F	2	C ***	S	4	8	Yes
25	M	2	C ***	S	4	15	Yes
26	F	2	N ***	S	9	15	Yes
27	M	2	C ***	E	3	9	Yes
28	F	1	N ***	M	15	30	No
29	F	1	C ***	S	15	32	Yes
30	M	1	N ***	S	0.5	17	Yes
31	F	2	N ***	S	10	26	No
32	M	2	N ***	S	2.75	2.75	Yes
33	F	1	N ***	S	2	30	Yes
34	F	2	N ***	S	5	18	Yes
35	F	1	N	E	4	4	Yes
36	F	1	N ***	S	2	28	Yes
37	F	1	N ***	S	4	24	No
38	F	2	N ***	S	2.5	20	Yes
39	M	1	N ***	S	2.5	2.5	Yes

LEGEND		
	Grade *	E: Executive; S: Senior Manager; M: Middle Manager
	Other NHS Trust **	Participant has experienced working in another NHS Trust

Leader behaviours and organisational cultures that affect organisational resilience were discussed in Section 3.5. The researcher aimed to identify the organisational culture in the case studies, whether culture change had been a strategic priority and, if so, whether this was a response to the Trust's CQC rating. Identifying whether this was a priority and the reasons for it may illuminate leadership behaviour that underpinned organisational resilience.

The CQC has had negative reviews, with some organisations reporting a sense of unfairness at their overall grade (Beaussier *et al.*, 2016; CQC, 2017c; Purohit, 2020). Staff may feel negative following a poor CQC rating (Smithson, *et al.,* 2018), whilst others are able to maintain an optimism and commitment to improve (Pratt, 2015). It is suggested that staff responses to challenge from the CQC may be affected by the organisation's leadership and this was explored during the interviews. The impact on staff morale and well-being, and consistency of mood throughout the Trust following each consecutive CQC inspection, was examined. As some scholars assert, (Mallak, 1998a; Coutu, 2002; Bustinza *et al.*, 2016), resilient employees contribute to the development of organisational resilience.

It is not clear from the literature whether CQC-challenged Trusts are focussed on short-term priorities aimed at improving their CQC rating, have a longer-term vision for sustainability, or maintain a mixture of both. The Trusts' strategic priorities were discussed during the interview. In each case the researcher aimed to understand what the organisation's priorities were before the first comprehensive CQC inspection and whether they changed following it. She also sought to elucidate how the Trust's strategic priorities changed after the second CQC rating and whether staff perceived the priorities might be different without CQC oversight. This may illuminate the impact of the CQC on organisational strategic direction, culture and resilience.

Having insight into positive leadership actions will draw out desirable behaviours that impact staff well-being and culture. Leading by example is an important aspect of leadership, particularly in a rapidly changing environment (Porter-O'Grady and Malloch, 2007). As previously evidenced, leadership impacts culture and organisational resilience and participants were asked to identify positive standout leadership behaviour, which was analysed for leadership style, consistency and patterns across the cases. The researcher also looked for evidence of distributed leadership and whether influence was held at particular levels in the organisation.

Managing risk effectively is essential to organisational resilience and sustainability (Burnard and Bhamra, 2011). A feature of a resilient organisation is its attention to horizon scanning and managing potential risks before they become critical to sustainability (Louisot, 2015). Information was gathered on the Trusts' approach to risk management and patient safety, identifying their significance to organisational strategic priorities and consequent resilience.

Organisational learning is essential for sustainability (Franco and Almeida, 2011). Resilient organisations learn from past experiences, adapting processes and systems to avoid repeat errors (Weick and Sutcliffe, 2015). They also learn from what has gone well to proactively prevent incidents (Hollnagel, 2013). The Trusts' approach to organisational learning from error and best practice was probed during the interview to establish their processes and focus.

Organisational resilience in the NHS is less discussed in the literature, possibly because it is difficult to close an NHS hospital even when one is considered for closure (Moon and Brown, 2001; Brown, 2003; Timmins, 2007). However, the health care landscape is changing (Jones, 2015), hospitals and major services have closed (Lehman, 2006; Dyer, 2013) and the significant pressures in the system require leaders to be mindful of the resilience of both staff and the organisation for future sustainability (Levey and Levey, 2019). In order to identify leadership behaviour that has developed organisational resilience it was necessary to explore how resilience is addressed and the perceived future direction for the cases.

4.4.3.2 Implications and mitigation of the retrospective study

This research study required interview participants to recall information relating to their career and current organisation, a qualitative design utilised by other researchers (Hart and Baruch, 2022). Senior managers and executive leaders are expected to be cognisant of factors that affect their organisation's external environment (Mmobuosi, 1988). Therefore, it is suggested they are likely to remember significant issues that impact the organisation and will have greater recall of those issues than their subordinates. For that reason the researcher deliberately chose to interview senior leaders in both Trusts.

Throughout their interview, the researcher asked participants to recall their reactions to events that had occurred up to four years earlier. As indicated in Section 4.4.3.1, questions included recollections of feelings following the adverse CQC inspection in 2015 and emotions experienced following the first positive inspection in 2017. The

lapse in time created a potential for inaccurate accounts due to loss of memory of the immediate impact the participants had felt following both CQC reports. It has long been asserted that emotionally stimulating situations, from both positive and negative experiences, are more likely to be accurately recalled over time than similar, non-emotionally provoking events (Hamann, 2001). LaBar and Cabeza (2006) suggest that emotional events hold a privileged position in one's memory, with new insights from neuroscience research offering more understanding of the latent emotional associations and recall of personal episodes from the remote past. Memories of emotional experiences may be endured due to their ability to focus attention, are novel or are rehearsed (Cahill and McGaugh, 1998). Reisberg and Heuer (1992) assert that emotional memories are relatively consistent over time and state we can largely trust our memories of emotional events.

Notwithstanding, the researcher was aware of the potential for participant hindsight bias (Roese and Vohs, 2012) from memory distortion, apparent prediction or a sense of inevitability (Nestler, Blank and Egloff, 2010). In order to address the potential for inaccuracies she listened carefully throughout the interviews and followed up with clarification questions on responses that suggested participant recollections following hindsight. The researcher was also constantly mindful of the data she had collected from previous participants in the case study Trusts and sought to gather further evidence and clarify findings when necessary, during interviews with later participants.

Other substantive issues that were explored during the interviews and noted in Section 4.4.3.1 related to organisational strategies regarding culture, learning, priorities and risk management. The interview data was triangulated by secondary data sources of Board Papers, Annual Reports and CQC Summary Reports. In this way the researcher was able to confirm interview findings. Interview data regarding the impact on staff morale was further explored and corroborated through analysis of the NHS Staff Survey data. Utilising these methods, the researcher addressed and confirmed accuracy of interview data.

4.4.4 Meeting observations

Observation of meetings provided complementary field data to the interviews to answer the research questions from a different perspective (Hennink, Hutter and Bailey, 2011). The researcher was a non-participant observer (Creswell, 2013): following introductions, no interaction occurred between the researcher and meeting attendees

during formal session proceedings. This enabled her to maintain focus on observing, listening and reflecting, including the personal impact whilst trying to maintain objectivity (McQueen and Knussen, 2002; Haynes, 2012; Creswell, 2013). The researcher also recognised the value her health care experience brought to the research: being relaxed in an unfamiliar environment and among senior leaders enabled her to be open to observation and enquiry, free of anxiety.

Meetings were attended to observe unconscious organisational culture behaviour (Hinshelwood and Skogstad, 2000): how leaders interacted with staff, Board members and other stakeholders, including the general public. Their behaviour to each other such as active listening, support and challenge, response to challenge and use of time were noted. The level of challenge by non-executive directors (NED) and governors to the executive team, and the response of the EDs and Chair of the Board were also of interest to the researcher. The responsibility of a NED is to contribute to strategic governance and promote accountability of the EDs, focussed on areas of risk (Sheaff *et al.,* 2015). It is suggested that development of organisational resilience and sustainability is enhanced by a culture of high-level challenge.

Deciding what to record from the array of interactions during an extended meeting is an issue for the observer (McQueen and Knussen, 2002; Barbour, 2008). She chose an unstructured format (Creswell, 2013), enabling the recording of interactions, behaviours and reflections as they occurred on a bespoke recording sheet (Appendix VIII), unobtrusively making handwritten field notes (Bryman, 2012; Lichtman, 2014). A structured format would have required preconceived ideas of what was important to note and a prepared recording schedule against which to observe (McQueen and Knussen, 2002; Barbour, 2008), which was incompatible with the researcher's preference for subjectivist pragmatism (Morgan, 2014) and intuitive awareness (Hinshelwood and Skogstad, 2000).

In observing leaders, the researcher was interested to compare them in various settings and with different attendees, including the presence of external stakeholders. She requested an invitation to observe a Board meeting, governor meeting and a Quality meeting; others she attended following spontaneous invitation from participants. The researcher was invited to attend a stakeholder engagement meeting, one-day staff conference and an evening staff award ceremony in one Trust. In the second Trust she was invited to an afternoon CEO briefing event attended by managers, governors and the

public, and an evening stakeholder engagement meeting. She conversed informally with attendees at the invitation events and described her role. The Quality Committee meeting in CS2 was rescheduled and held online due to COVID-19 restrictions: the researcher was invited to dial-in by telephone and this is discussed further in Section 4.7.2. The meetings observed during fieldwork are recorded in Table 18 below.

Table 18: Meetings Observed in Case Studies during Fieldwork

Case Study 1	Case Study 2
Board meeting (Open to general public) *(Researcher request)*	Board meeting (Open to general public) *(Researcher request)*
Stakeholder engagement meeting: evening meeting attended by two EDs, Chair and 62 service users, to contribute to the development of the Trust's quality strategy for 2020/21 *(Invitation)*	Stakeholder engagement meeting: morning meeting attended by Board, 44 governors and service users, to contribute to the development of the Trust's strategic objectives for 2020/21 *(Invitation)*
Clinical Quality Group meeting: attended in person *(Researcher request)*	Quality Committee meeting: dialled in by phone *(Researcher request)*
Governor meeting with Board *(Researcher request)*	Staff conference: one day; attended by approx. 300 staff of all grades and roles *(Invitation)*
CEO briefing: afternoon meeting attended by approx. 100 managers of all grades, governors and general public to brief and take questions on strategic plans for 2020 *(Invitation)*	Staff annual awards ceremony: evening event attended by approx. 600 staff *(Invitation)*

4.4.5 Document review

Lee (2012) defines documents as including visual records, films and digital recordings as well as written texts. Various information documents, for communication with the general public and the Trust's service users and available in public spaces around the Trusts, were photographed or collected and reviewed. These documents offered additional contextual material to the researcher, opportunistically and intuitively gathered (Hyett, Kenny and Dickson-Swift, 2014).

Annual reports (AR) and Board papers (BP) for the years 2015-2019 are available on the case study websites and were reviewed. These years span the time of the CQC comprehensive inspections for each case study, therefore mapping behaviours and culture during the time of underperformance, initial and sustained improvement. In CS1, a further ten years of ARs were accessible and provided additional contextual data to the dataset. The secondary data sources were analysed following interview data analysis to

avoid any unconscious influence or bias in identifying data codes and themes (Diefenbach, 2009). The reviewed secondary source reports and papers are listed at Appendix IX.

The secondary datasets were analysed for evidence of organisational culture, quality assurance, risk management, preparation for regulatory inspections and other leader behaviours. The documents provided a valuable record (Denscombe, 2017) of strategic decisions and insights into organisational culture, priorities and leader behaviour. The secondary data was not recorded for the purposes of research, which could be considered a drawback (McQueen and Knussen, 2002). However, analysis of BPs (Brewerton and Millward, 2001; Aurini, Heath and Howells, 2016) and ARs enabled the researcher to identify change in trends and provided evidence to contrast the findings from the interview data. This is discussed further in Section 4.8.2.

Inspection reports from the CQC are available on their website (www.cqc.org.uk) and the summary reports following the inspections in 2015, 2017 and 2019 for both cases were accessed (Appendix IX). Content related to organisational culture, risk management and governance, Trust values, organisational learning and feedback, staff resilience, communication and engagement, leadership and leader behaviour, clinical quality and patient-centred care was reviewed. Additionally, each CQC domain (Section 2.3.1) was analysed for evidence of change between inspections. Analysis of these various document datasets provided the researcher with additional data to compare, validate and triangulate her findings and is discussed further in Section 4.5.

4.4.6 NHS Staff Survey data

Staff survey data have been collected annually in the NHS since 2003 (Pinder *et al.*, 2013). Trusts consider the results an important dataset, used to help drive organisational development and resilience (Burnard and Bhamra, 2011; Lalonde, 2011; Robson, 2013) and inform understanding of the state of staff well-being (Andrews and Thorne, 2015; Chada, 2018). Specific survey data were selected for analysis: aggregated percentage data relating to safety culture, environmental culture, morale and well-being, leader and manager experience and quality of care were analysed for changes over the years 2015-2019 inclusive (Appendix X: CS1 and Appendix XI: CS2). The data analysed were mapped to the relevant questions on the NHS Staff Survey 2019 (Appendix XIV). It is posited that these categories of the dataset are indicators of organisational culture, personal resilience and leader behaviour, and may show a correlation to the

organisations' resilience and culture from the perceptions of their staff. The findings are presented in Chapter 6.

The survey is an indicator of staff engagement, which is important for staff morale and performance (Fletcher *et al.,* 2014; Wake and Green, 2019). Researchers report positive change on staff survey data in organisations that have improved their CQC grade (Fulop *et al.,* 2020). Survey data are used by the CQC in support of judgements on service quality, as evidenced in Chapter 6. The CQC asserts the data is a reliable predictor of the effectiveness of a Trust's leadership and quality of care (CQC, 2015), with questions relating to bullying (safety), stress (well-being) and discrimination (morale) as specific indicators (CQC, 2017a). It follows that these indicators should reflect positive change in Trusts that have improved and developed organisational resilience.

Staff survey data have frequently been analysed in both longitudinal and single year data analysis studies (Raleigh *et al.*, 2009; West and Dawson, 2012; Powell *et al.,* 2014; Priest *et al.,* 2015; Dawson, 2018; Ravalier, McVicar and Boichat, 2020; Teoh, Hassard and Cox, 2020). In a multi-method longitudinal, multi-case study Dixon-Woods and colleagues (2014) triangulated staff survey data along with historic BPs, interviews, observations, CQC reports and other methods of collection in order to research NHS culture and behaviour, synthesising interpretive and narrative data analyses. Pinder and colleagues (2013) suggest a longitudinal analysis of the data, tracking changes in staff satisfaction over time, may well be valuable indicators to both lay and professional audiences.

The survey is administered both online and on paper. Online responses have been steadily rising since 2015, from approximately 160,000 to 470,000 in 2020; paper response rate is gradually declining, from 150,000 to 100,000 over the same period (NHS Staff Survey, 2020). Saunders and colleagues predict a likely response rate of 30-50% from postal and web-based surveys (Saunders, Lewis and Thornhill, 2016), which is in line with the results of the annual NHS Staff Survey as shown in Appendix I.

Overall, the increase in response rate may be due to staff perceptions that their organisation is listening and acting more on their feedback, which is evident from the data (Appendix I). There is an upward positive trend in how supported staff feel by their manager and the involvement in decision-making they experience, which may induce a desire to reciprocate especially if a manager makes a personal request to complete the survey: this is likely in an organisation that values staff survey feedback. It is also possible

that there is greater opportunity for people to access the online survey than previously, increasing completion rates.

Survey data collection in the Trusts overlapped with fieldwork and the researcher considered staff engagement with it was likely to be a focus for the cases. Therefore, a specific question relating to the survey was not asked of interview participants. The researcher chose to analyse the importance to the cases of this dataset through BPs, ARs and unprompted references by participants during interview. According to previous research findings and CQC assertion, analysis of the selected sections of the staff survey should show an improvement in organisations that have moved from underperforming to performing as rated by the CQC. They may indicate staff and organisational resilience and prevailing organisational culture.

4.4.7 Subsidiary data

Communications to the staff and public were present in all Trust buildings in the forms of posters, brochures, display boards, leaflets and reports. They were collected or photographed opportunistically and provided complementary, contextual data to the formal datasets (Peräkylä and Ruusuvuori, 2018). These are discussed in context in Chapters 6 and 7.

4.5 Research reliability and validity, data triangulation and research quality

Scholars differ in their views on social research validity and reliability, data triangulation and quality (Spencer and Ritchie, 2012; Creswell, 2013; Silverman, 2013; Yin, 2014; Robson and McCartan, 2016; Flick, 2018). These issues are now addressed in order.

4.5.1 Reliability and validity

Reliability refers to the consistency of results: that a finding can be replicated at another point in time when studied by the same methods of data collection (Mason, 2018). Validity refers to the appropriateness of the measures used and their accurate analysis (Saunders, Lewis and Thornhill, 2016). Issues of reliability and validity are fundamental to quantitative researchers and have to be proved as objectively achieved (Symon and Cassell, 2012) to demonstrate research integrity. Quantitative researchers are critical of social scientists that question their relevance (Armstrong *et al.*, 1997; Denscombe, 2017; Mason, 2018). They argue that non-standardisation of qualitative methods of data collection make it unfeasible to perform reliability tests.

Denzin and Lincoln (2018, p. 20) observe that some researchers have "replaced criteria of reliability, validity, generalisability and objectivity with the terms dependability, credibility, transferability and confirmability", respectively, with the goal to build trustworthiness and place rigour in the methods (Morse, 2018). Mason (2018, p. 236) argues the researcher should demonstrate reliability, achieved by evidencing their data generation and analysis are appropriate to the research questions and are "thorough, careful, honest and accurate (as distinct from true or correct)".

Morse (2018) asserts that rigour is attained through appropriate validation and verification strategies to hard and soft data. She argues descriptive, hard data are facts that can be checked and validated with an external data source. Interview data comprising feelings, beliefs, opinions and reported behaviours are soft, interpretive data that may be verified with others' experiences, or reconfirmed by the participant, but cannot be validated. Mason (2018) purports that validity can be addressed through validity of interpretation, questioning the validity of the data analysis and the interpretation on which it is formed. This is dependent on validity of method, as the interpretation cannot be valid if the research methods have not enabled the researcher to arrive at the concepts they set out to understand.

Morse (2018) also argues that having confidence in the validity of interpretation demonstrates quality and rigour of data analysis and its interpretation. The challenge is for the researcher to demonstrate their interpretation is valid by reporting how they arrived at that interpretation (Mason, 2018). Justification for the research design was presented in Section 4.3 and appropriateness of methods and sources of data addressed in Section 4.4. The rigour of data analysis is demonstrated in Chapter 5 and Chapter 6 and interpretation of data analysis discussed in Chapter 7. It is posited that these sections and chapters provide evidence of the reliability and validity of the research study.

4.5.2 Data triangulation

Triangulation is a form of validation supported by some authors (Brewer and Hunter, 1989; Stake, 1995; Berg and Lune, 2012; Creswell, 2013), utilising multiple methods and data sources to understand a phenomenon from various perspectives. Flick argues a "strong program of triangulation" (Flick, 2018, p. 450) extends the research, from extra knowledge made known about a phenomenon rather than used as a second source to replicate what is already known from the first method.

Stake (2006) argues the importance in seeking out and presenting multiple perspectives on activities and issues in case study work, stating that it is seldom necessary to resolve contradictory evidence: he asserts that contradictions might aid understanding of the issues. Brewer and Hunter (1989) warn that the former use of one method might influence the next. For example, a participant who has been interviewed may react to the researcher differently (and vice versa) the next time they are observed in a meeting. The researcher was aware of this and tried to keep distance and be unobtrusive when observing meetings. She also remained reflexive and reflective on this issue to maintain objectivity.

Mason (2018) argues that different methods and data sources will illuminate different research questions or levels of answer. She asserts that the researcher who uses multiple methods should be encouraged to approach their research questions from different angles. This will enhance validity in the sense that social phenomena are more than uni-dimensional and the study will grasp more than one of those dimensions (Mason, 2018). Various data sources have been used to address the research questions and validate the analysis. These include secondary sources internal and external to the cases and the multiple methods reported in Section 4.4. It is argued these data from multiple sources and times extend the study (Flick, 2018) and confirm the integrity of data analysis (Spencer and Ritchie, 2012).

4.5.3 Research quality

Concerns regarding the quality of social research frequently arise from a philosophical standpoint (Spencer and Ritchie, 2012) and criticism from quantitative researchers (Henry, 2015). Frameworks and checklists defining quality criteria (Spencer *et al.,* 2003; Johnson *et al.,* 2006; Tracy, 2010) of qualitative research are not universally accepted among the research community (Seale, 1999; Easterby-Smith, Golden-Biddle and Locke, 2008; Cassell and Symon, 2011). However, researchers are required to produce a report that demonstrates quality of the research process (Kitto, Chesters and Grbich, 2008).

Symon and Cassell (2012) reviewed a number of lists and concluded that some criteria are more relevant for reviewing journal articles and others suited to informing research practice. They argue that researchers should be aware of these criteria lists and how they may be applied to their own work. They identified from the research community a number of shared beliefs of what constitutes good quality social research

and concluded that the research should be convincing and interesting, have a logical argument, be technically competent, reflexive, acknowledge its limitations and contribute to knowledge (Symon and Cassell, 2012).

Mason (2018) argues against prescriptive lists but agrees with Seale (1999) that quality matters. She asserts that research should be rigorous and worthwhile, with researchers making a convincing case for their arguments and conclusions. She condones the principle of demonstrating research quality through evidence of validity and reliability. Appropriate methods, careful data analysis and a wider application of findings are hallmarks of quality research to Mason. Easterby-Smith and colleagues (2008) agree with Mason that researcher reflexivity contributes to research quality.

Henry (2015) suggests member checking as a way of establishing quality, whereby participants provide feedback to the researcher on their findings prior to production of a final report. Stake (1995) notes how participants may not agree with the researcher's account and Hallett (2013) argues that member checking is not always desirable. The researcher had considered focus groups for member checking in the initial research design. She discarded the idea prior to undertaking fieldwork for two reasons: interviews were recorded and accurately transcribed and, though a participant on recollection may question accuracy of the account, this would not invalidate the data. Secondly, each person approaching the research data will interpret it differently (Bazeley and Jackson, 2013). Therefore, the participant may question a researcher's findings without compromising the rigour of the analysis and quality of the research.

Robson and McCartan (2016) refer to the personal qualities required of the researcher to conduct a quality investigation: these include adaptability and flexibility in the field, asking good questions, sensitivity and responsivity to contradictory evidence, an open and enquiring mind, showing empathy and being a good listener. They argue that these are skills of any professional working with people in whatever capacity and are likely to provide the researcher with a firm grasp of the issues being studied.

The researcher has had a successful career in the field under study, is a qualified executive coach and an experienced healthcare management consultant, all of which arguably require the use of these professional skills for success. Adaptability, flexibility and empathy were demonstrated, particularly in response to the COVID-19 pandemic. Participants frequently remarked, "that's a good question" during interviews and several

participants stated the researcher was a good listener, evidence of the quality of the researcher's interview skills.

Seale (1999) asserts that any value to consideration of methodological standards should benefit research quality through reflection on decisions made during the research study, thus developing intellectual rigour. The researcher has demonstrated reflection during her choice of research design and methods (Sections 4.3 and 4.4) and throughout fieldwork and data analysis, and has argued that reliability and validity have been evidenced (Section 4.5.1). Triangulation of data has added to the rigour of data analysis (Section 4.5.2) and it is posited that collectively these elements have contributed to a research study of high quality.

4.6 Ethical considerations

The ethical considerations of social research can raise moral dilemmas for the researcher (Kimmel, 1988). Miles and colleagues (2014) identify core ethical issues that must be addressed. These include participant informed consent, confidentiality and anonymity, harm and risk, trust and honesty, worthiness and benefits of a project, research integrity and quality. Ethical considerations arise at all stages of a research study, from conceptualisation through to data analysis and report writing (Birch *et al.,* 2002) thus requiring a researcher to maintain an internal ethical dialogue throughout the process. Addressing moral dilemmas and taking accountability for decisions strengthens the integrity of a researcher and models good behaviour to the research community and research subjects (Israel, 2015).

Research in the UK is subject to regulation and ethical approval by research ethics committees (Wiles, 2013). Research in the NHS requires additional approvals (Richardson and McMullan, 2007) and must be granted before any fieldwork can commence. Issues of research quality were addressed in Section 4.5.3. As noted in the PIS (Appendix VI) there were no risks to participants and it was stated that the research aims to be of benefit to the cases and the wider NHS.

King and Horrocks (2010) suggest that formal ethical guidelines are the basic requirements for addressing research ethics and advise the researcher to think broadly of the ethical implications for their study. The researcher addressed a number of ethical considerations in addition to those considered for formal ethical approval: anonymity of cases and confidentiality of participants; participant recruitment, informed consent and experience; researcher subjectivity; storage of data; researcher integrity. These issues are

discussed below following evidence of University ethical committee and NHS approval to proceed and will demonstrate research integrity.

4.6.1 Ethical approval to proceed

An application was made to undertake research in the NHS via the Integrated Research Application System (IRAS Reference Number 248763). This included submission of the researcher's curriculum vitae, description of the study and justification for the research and was approved unequivocally. NHS clinical ethical committee approval was not required as research participants were NHS staff. The research protocol was approved in both Trusts, added to their research database and monitored regularly. An application for ethical approval was made to the University of Southampton research ethics committee (ERGO Number 47300). Documents presented included the PIS (Appendix VI), consent form (Appendix VII), interview schedule (Appendix II) and CEO acceptance emails from both Trusts. Prior to approval the PIS was revised to account for changes in research methods: shadowing was included (Section 4.7.1) and focus groups removed, as discussed in Section 4.5.3.

4.6.2 Anonymity of cases and confidentiality of participants

Preserving the anonymity of the Trusts was an ethical consideration (Mason, 2018). Evidence of their uniqueness (Section 4.3.1) would identify them to anyone knowledgeable about NHS Trusts in England. For example, NHS organisations that have been reported for poor quality performance are well known in the field; the reputations of Trusts and leaders are also well known, standing out as examples for their CQC performance, patient and staff survey data. Thus, geographical regions have been omitted from the research account, the gender of the CEOs has been undisclosed and cases are reported in deliberately broad terms: the researcher defends this ethical decision.

Participants were guaranteed anonymity and confidentiality during recruitment to the study (Appendix V; Appendix VI) and confirmed by the researcher prior to the start of each interview. To maintain confidentiality and anonymity, all participants were given an identifying code and no names of individuals or organisations other than the CQC are reported. Factors that would readily identify the Trust and therefore personnel have been omitted from the thesis.

4.6.3 Participant recruitment, informed consent and experience

Selecting a snowball method for participant recruitment (Section 4.4.2) required ethical consideration. Both Trust CEOs were engaged from the outset, which displayed powerful support for the researcher: their direct introductions to colleagues almost guaranteed a positive response. Subsequent participants were either introduced to the researcher via email or, more frequently, she was given contact details of staff members and made the initial approach. A standardised email was sent (Appendix IV), with an attached one-page PBS that acknowledged the support of the Trust CEO and research and development (R&D) department (Appendix V). It also included a brief biography, setting out the researcher's NHS background to establish credibility.

Mentioning CEO support in the PBS may have affected participant recruitment to the study. Employees can feel pressurised to participate once a CEO has become involved in an organisational study (Israel, 2015), influencing their decision. A potential referrer may also feel obliged to the researcher on the request for referrals (Biernacki and Waldorf, 1981), affecting whom they refer to the study. The researcher was mindful of her resource constraints, particularly time and finances. In addition, the cases had invested trust in the researcher to complete the study.

It was considered ethical to mention CEO and R&D support. This provided additional integrity to the study and recruitment of participants was essential to complete the fieldwork. Some email invites were ignored, which suggests that recipients did not feel obliged to their referral colleague or organisation to participate. Those involved showed enthusiasm, expressed interest in the research topic and referred two or more colleagues to the researcher, which suggests they valued their contribution and trusted the research. All participants provided signed consent prior to interview. They were given the opportunity to withdraw at any time: no participant requested their data be retracted, which suggests they were comfortable with the interview and the data they had given.

Barbour (2008) notes that conducting research within a familiar cultural environment can be beneficial to a researcher: being comfortable on all premises visited enabled the researcher to feel relaxed and put participants at ease, an important part of the interview process (Gillham, 2005; Kvale, 2007). She was cognisant that her career background helped to build rapid rapport with all participants: once reassured of confidentiality they readily opened up to the researcher. Many participants assumed her

level of knowledge regarding their organisational world, which enabled them to speak freely. She was mindful not to abuse the position of trust readily afforded to her by ensuring that she maintained strict focus on the research topic (Creswell, 2013; Wiles, 2013).

The interview researcher is in a powerful position, extracting information that the interviewee may not usually tell them (Creswell, 2013; Brinkmann, 2018). This researcher asked participants to share potentially sensitive information regarding colleagues and other organisations in the health sector. She was mindful that her questions would ask participants to recall feelings of previous events that may evoke unpleasant memories. As an ex-clinician she was acutely aware of the need to maintain confidentiality, be factually observant and an active listener, show empathy, make accurate notes, write respectfully about individuals and take accountability for her actions.

It was important to the researcher that interviewees felt their participation had been a worthwhile experience. Considerable preparation went into making the interview a "conversation with a purpose" (Mason, 2018, p. 116), ensuring good use of available time. She was mindful of participant needs: for example, she checked with each interviewee at the outset how much time they had available and adapted accordingly. She made explicit that the interview schedule was a guide and that questions would not be asked in a set order or specifically phrased. Active listening was employed to ensure a logical sequence to the conversation, no repetition and all areas addressed. Coaching skills of summarising, clarifying and reframing were used to minimise subjective interpretation and ensure understanding (Whitmore, 2017; Van Nieuwerburgh, 2020). These skills helped her to conduct her research ethically and courteously.

4.6.4 Researcher subjectivity

Having had a career in health care, the researcher has considerable experience of hospital and Trust cultures, regulators and leader behaviours. She has insight into clinical and managerial tensions and potential clashes of values, perspectives and objectives. She also feels at ease in the environments she was studying. Therefore, she was mindful on reflection and through reflexivity to identify any unconscious bias that may have been present during fieldwork. For example, whether a particular observed situation had unconsciously reminded her of a past experience that may have had a positive or negative affect and influenced her observations and subjective feelings. Field notes and

meeting observations were reflected on to ensure objectivity and quality of data (Denscombe, 2017).

Lichtman (2014) asserts the qualitative researcher does not try and eliminate subjectivity, but acknowledges it through reflexivity and moves with it. Haynes (2012) describes theoretical reflexivity as the process through which the researcher recognises their preconceptions and interpretations that affect the outcome of their research. This researcher believes that theoretical reflexivity develops objectivity by minimising conscious biases. Subjectivity also comes in the form of unconscious bias, those views and opinions that we are unaware of (Atewologun, Cornish and Tresh, 2018; Nixon, 2019) and therefore difficult to address. The researcher repeatedly questioned and checked for subjectivity and sought to elicit unconscious opinions.

Stake (2006) argues that case study research is often subjective as the researcher relies on their experience and personal values. Silverman (2013) advises researchers to consider how the organisations they study differ from those they are familiar with. Unfamiliarity with the case study Trusts made it easier to avoid instant assumptions. However, the researcher was conscious of the ease with which these could be made and theoretical reflexivity was considered by her to be essential. Haynes (2012) asserts that emotion is a valuable source of reflexive insight. The researcher's feelings and impressions were recorded in her field notes (Saunders, Lewis and Thornhill, 2016) and frequently reflected on.

4.6.5 Storage of data

Electronic transcripts of all interviews were stored on a password-protected computer, accessible only to the researcher, to maintain confidentiality and compliance with the University of Southampton's code of ethics. (The University of Southampton's Data Management Policy can be accessed via: http://www.calendar.soton.ac.uk/sectionIV/research-data-management.html). Only the researcher and a member of her supervision team accessed the interview transcripts during thematic analysis, the latter to check for reliability of coding: this is further addressed in Section 5.2.2. Handwritten field notes and observation records were stored in a locked desk, accessible only to the researcher. Other data is in the public domain, available online. However, the identity of case organisations is not reported.

4.6.6 Researcher integrity

Clark and colleagues (2010) warn of the ethical dilemmas that qualitative researchers can face during fieldwork in health care organisations, particularly if working undercover. At meetings and when walking anonymously around Trust premises staff and public attendees were not always aware of the researcher's role and she took care to focus her observations on people and objects relevant to the research. Mason (2018) argues that researchers have an on-going obligation to address ethical considerations throughout a study. The researcher was conscious of the privilege extended to her by the Trust CEOs and ensured she maintained professionalism throughout the time she spent on Trust premises. It is argued that addressing these ethical considerations have further evidenced research integrity.

4.7 Impact of COVID-19 on fieldwork and the research study

Meetings on Trust premises were halted on 23rd March 2020 due to COVID-19 restrictions. The impact on fieldwork and implications for the research study are discussed below.

4.7.1 Shadowing

The initial research design included prospective shadowing for some interview participants, evidenced in the consent form (Appendix VII) and PIS (Appendix VI). This would have allowed the researcher to observe behaviours of leaders in alternative settings (Brinberg and McGrath, 1985; Denscombe, 2017). Leaders are frequently shadowed in the NHS as a form of staff development, role learning, career planning and job induction (Punukollu, 2009; Pathiraja and Outram, 2011) and most interviewees agreed to be shadowed.

Shadowing enables the researcher to gain insights from the expert opinion of the person being followed as well as obtaining data that might be difficult to articulate (McDonald, 2005). It is widely used in management studies to observe and understand the content of another's work and how it is performed (Johnson, 2014). No dates had been scheduled with participants prior to the pandemic lockdown in March 2020, rendering this unviable. However, prior to this time the researcher had been reflecting on whether shadowing would be a good use of her and participants' time, hence no participants had been approached for a potential date. The impact on the study is discussed in Section 4.7.4.

4.7.2 Meeting attendance

As noted in Section 4.4.4, a Quality Committee due to be attended was postponed and conducted online. The researcher did not have a video link to this meeting but was able to attend via a telephone link. The meeting extended to three hours with no break. Maintaining active listening without visual contact for that time brought its own challenge and concentration was aided by note taking. Lack of visibility of the speakers was considered a disadvantage, although impressions of how the committee interacted were still ascertainable, as was following the content of their discussion. From the minutes of previous meetings the researcher was able to identify the names of committee members and their roles.

Due to the virtual meeting space the committee Chair consistently identified the speaker, enabling the researcher to follow which member of the committee was addressing the meeting. With non-participant observation it is possible that people being observed may change their behaviour, even when observed from a distance (Mason, 2018). Listening to the meeting without a video link had the benefit of negating this potential drawback. The researcher was able to obtain data on meeting content and formed an impression of leader behaviours and style and, therefore, attendance had been of some benefit. However, she was mindful that leader behaviour might have been out of character due to the novelty of the situation, which limits the reliability of findings.

4.7.3 Interviews

Reported in Section 4.4.3, four scheduled face-to-face interviews were subsequently held by telephone. One was postponed twice and another rescheduled to the evening at the request of the participants; one participant cancelled their interview. Quality of conversations was not compromised by the medium and rapport was quickly gained at the start of interviews. The telephone interviews took between fifty and eighty minutes, in line with those previously conducted face-to-face. The participant consent form was emailed to each participant, who electronically scanned the signed copy and emailed it to the researcher for her records. The data collected by telephone was as comprehensive as that gathered face-to-face and had no adverse effect on the dataset. As data saturation had been reached (Mason, 2018) no further participants were recruited to the study and fieldwork was concluded.

4.7.4 Implications for the research study

One notable exception to the participants was the CEO of CS1, who had requested a meeting later in the researcher's process due to a busy work schedule. The Trust Chair and three EDs were interviewed in CS1 (Table 17, p. 101) and significant data had been obtained through the CEOs executive colleagues. Therefore, it is not considered to have had a negative impact on the research study as saturation had already been reached and new data may not have been elicited through another interview. However, it would have been interesting to have their insights and reflections and to hear first hand their ambitions for the Trust. From that perspective it was a loss to the study.

With respect to shadowing, the researcher had considered omitting this method prior to the lockdown. She had observed many members of staff from various levels of management and leadership during several meetings and events, and informally whilst observing on Trust premises. All EDs had been observed in at least one formal setting, and several at two or more events including both CEOs and Chairs. Many other senior leaders had attended the Quality meetings. The participants likely to have been shadowed spent much of their working day in similar meetings. The researcher felt that she had enough data to inform her analysis on matters of Trust culture, unconscious behaviour and staff interaction. She concludes that shadowing would not have generated significant additional data to the research and therefore omission did not adversely affect the study.

4.8 Methods of data analysis

The methods of data analysis for the data corpus are presented below. The process for analysis of the interview data is described in detail in Chapter 5.

4.8.1 Analysis of interview data

Interview data were analysed thematically using the six-phase process established by Braun and Clarke (2006), using NVivo software (Bazeley and Jackson, 2013). On completion of this process the researcher did a final analysis of the identified codes and themes using the Gioia methodology (Gioia, Corley and Hamilton, 2012), which provided nuance and additional rigour to the data analysis. These are presented in detail in Chapter 5.

NVivo software enables the researcher to create analytical memos relating to ideas and themes, which can be directly linked to coded text (Lewins and Silver, 2007). A

memo list was created in the software by the researcher, which facilitated a systematic capture of thoughts, ideas and concepts, linked to coded data nodes. Memos provided an additional rigour to data analysis through the tracking of ideas and concepts represented by the coded node, ensuring these were reviewed and reflected upon (Bazeley and Jackson, 2013).

4.8.2 Analysis of secondary data

Trust documents that related to the years 2015-2019 inclusive were reviewed for both cases: these included BPs and ARs. In CS1, ARs were available online back to 2005-2006, and were reviewed to further evidence the research findings. In total, papers were reviewed for fifty Board meetings in CS1 and thirty-nine in CS2. The three summary reports prepared by the CQC (CQCSR) following Trust comprehensive inspections in 2015, 2017 and 2019 were reviewed for the same time period. Reviewed BPs, ARs and CQCSRs are listed in Appendix IX. Secondary data were analysed on completion of interview data analysis to ensure the researcher was not unconsciously looking for themes in the interview data that were evident in other sources. This enabled greater validation of the interview data analysis through triangulation from other datasets.

Whilst meeting minutes are formally reviewed and 'accepted as a true record' at the commencement of the following meeting, they may not be completely accurate (Bryman, 2012). For example, things get said in meetings that are 'not for minuting' or "off the record" (Denscombe, 2017, p. 251). Nuance of behaviour is difficult to analyse from a meeting account: a discussion may be accurately recorded but the feelings and tone of the speakers must be interpreted. In their observations of NHS Board meetings, Endacott and colleagues (2013) noted omissions of Board dynamics in the reported minutes. These limitations to the document review of BPs are acknowledged.

As discussed in Section 4.4.4, the role of a NED is to bring challenge to a Board and hold it to account for delivery against strategic priorities or objectives and matters of governance (Sheaff *et al*., 2015). Chambers and colleagues (2017) suggest that a health care Board should be focussed on patient safety, organisational sustainability, innovation and improved reputation. However, the quality of Board governance is variable and dependant on the interpersonal dynamics of Board members (Veronesi and Keasey, 2010). Through analysis of the BPs the researcher was able to detect the level of challenge from NEDs and gauge the dynamic by the response from the ED. Whilst this is an interpretation of feeling, it was relevant to the researcher to understand the

effectiveness of the challenge and perceived defensiveness or acceptance by the Board executives. Challenge is a form of feedback, which is essential for organisational learning (Senge, 2006). The response of EDs to challenge is likely to set the culture for learning throughout the organisation.

Board papers and ARs were systematically analysed for content relating to strategic priorities, Trust values, organisational culture, attitude towards staff development and welfare, organisational learning and feedback, Trust resilience and sustainability, risk management and governance. These encompassed the strategic behaviours that had been identified through analysis of interview data. The datasets were also scrutinised for evidence of a patient focus, which had been observed by the researcher but had not been identified as strongly in the interview data. During the analysis, changes in emphasis and trends on any of these dimensions were noted. The findings of the analysis of BPs and ARs are reported in Chapter 6.

The CQC summary reports were analysed for content related to organisational culture, leadership and leader behaviour, clinical quality, risk management and governance, organisational learning and feedback, staff resilience, communication and engagement, Trust values and patient-centred care. Each CQC domain (Section 2.3.1) was analysed for evidence of change between inspections. Analysis of these datasets provided additional data and enabled comparison and triangulation (Section 4.5.2) of the data corpus. The findings are presented in Chapter 6 and discussed in Chapter 7.

4.8.3 Analysis of NHS Staff Survey data

As identified in Section 4.4.6, aggregated percentage data of the NHS Staff Survey relating to safety culture, environmental culture, morale and well-being, leader and manager experience and quality of care were analysed for changes over the years 2015-2019 inclusive. The data were compared between cases and against all NHS Trust summary aggregated percentage data (Appendix XII) for the same period. The trend differentials between 2015 and 2019 for all Trusts, CS1 and CS2 are presented in Appendix XIII. The data findings are presented in Chapter 6 and discussed in Chapter 7.

4.8.4 Analysis of subsidiary data

As reported in Section 4.4.7, the researcher collected opportunistically various brochures, reports and leaflet literature that were freely available to the general public and staff. She also photographed various information boards and posters. These texts

formed a complementary or subsidiary role in the research; Peräkylä and Ruusuvuori (2018) assert that an unsophisticated, informal approach to the analysis of such texts is acceptable and the data are discussed in context in Chapters 6 and 7. This chapter now concludes with a summary.

4.9 Chapter summary

The methodology chapter has described how the researcher examined the leadership behaviours of leaders in two NHS Trusts that have enabled organisational performance improvement and underpinned the development of organisational resilience. An overview of the chapter was followed by an explanation of the researcher's philosophical paradigm that identified pragmatist philosophy and subjectivist ontology. The multiple-case study design and selection of cases was then presented, justifying the approach to health care organisational research. The research methods, their relevance, fieldwork and participant sampling method were then reported. The implications of the retrospective study and how they were mitigated were then discussed. Issues of research reliability and validity, triangulation of methods and research quality were addressed and ethical considerations for the study then discussed. This was followed by a discussion on the impact of the COVID-19 pandemic on fieldwork and the research study. The final section provided an overview of methods of data analysis and preceded the chapter summary. The data analysis and findings are presented in Chapter 6 and discussed in Chapter 7. The process of analysis of interview data is now presented in Chapter 5.

Chapter 5

PROCESS OF ANALYSIS OF INTERVIEW DATA

5.1 Introduction and chapter overview

This chapter describes the process of data analysis that addressed the research questions: "What has enabled organisational performance improvement and thus developed organisational resilience, as evidenced by the Care Quality Commission? What strategic leadership behaviours underpinned the development of sustained organisational resilience?" Thematic analysis of interview data followed the six-phase process defined by Braun and Clarke (2013) and introduced in Section 4.8.1. An additional level of analysis, using the architecture illustrated by Gioia, Corley and Hamilton (2012), is then reported and evidences the rigour of data analysis undertaken by the researcher.

5.2 Thematic analysis of interview data after Braun and Clarke (2013)

Thematic analysis is a process of encoding and theming qualitative data: themes may be initially generated inductively from the data or deductively from prior research and theory (Boyatzis, 1998). The researcher used inductive reasoning to address the research questions, using the six-phase process established by Braun and Clarke (2006). As advised by these authors, the analysis was not conducted linearly as the outline suggests but using a dynamic, recursive approach (Braun and Clarke, 2006; Braun and Clarke, 2013).

5.2.1 Phase 1: Familiarisation with data

The first phase of data analysis required a total immersion in the data in order to become familiar with it, which began by transcribing each interview. Data software was used for the initial transcription of the digital audio recording and the resultant Word document was assiduously checked against the recording to ensure accuracy. This required the researcher to listen several times to each interview recording. Printed transcripts facilitated ease of access to the dataset, were read through and initial ideas noted on them. Searching for meaning and patterns in the data at this stage was the foundation for the remaining analysis (Braun and Clarke, 2006). The completed Word document transcripts were uploaded to NVivo prior to coding. The use of NVivo assisted the management of a large dataset and contributed to a more rigorous qualitative data analysis (Bazeley and Jackson, 2013).

5.2.2 Phase 2: Generating initial codes

Saldaña (2016, p. 4) describes a code as "a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data". Codes are usually attached to data segments ranging from a single word to an entire page of text (Miles, Huberman and Saldaña, 2014). The first transcript was encoded in NVivo, coding sections of data and recording their description in a codebook. This enabled other data with similar features to be appropriately coded. The second and subsequent interview transcriptions were similarly coded, using an iterative process and adding codes to the codebook as new features arose.

As stressed by Coffey and Atkinson (1996), codes are organising principles that are not set in concrete and can be expanded, altered or scrapped as ideas are developed through iteration. Codes were refined during this activity and there was constant checking and reflection of previously coded transcripts to ensure consistency of application: when appropriate, data were un-coded and re-coded. All data relevant to the research questions were coded and collated to each related code. Data were assigned multiple codes if more than one concept was identified in the text. The final Nvivo codebook (Appendix XIX) contained one hundred and sixteen substantive codes (Appendix XV). An example of a code was "uncomplacent", which was coded each time a participant made a comment that described lacking complacency, for example:

> *"There's a very real recognition that **we've got more work to do**, and that the work will never be done. You've got to continue paying attention to it, and it just feels very energising: it feels very healthy, mature" (ID 22: CS2).*

Another code was "living the Trust values", which was coded each time there was a reference to the Trust values being an important focus for the organisation and matched by staff behaviour, for example:

> *"They (Trust Board) are very, very focussed on us living our values, being true to our fundamental constitution, and so on. So we talk about diversity and inclusion, we talk about well-being and what our people are going through, leadership and so on" (ID 1: CS1).*

At the request of the researcher, a member of her supervision team also coded four transcripts, amounting to 10% of the dataset. This was performed to assess reliability

of the researcher's coding. Bazeley and Jackson (2013) question the relevance of a second person checking for reliability of a solo investigator on the basis that each person will see and code the data differently. They suggest it may be valuable in order to have a discussion with the second reviewer about one's findings. What was useful to the researcher was the ensuing conversation with her supervisor, gaining insights into another perspective on the data: subsequently, coding became more nuanced. For example, data that had been initially coded as 'culture' was re-coded to various aspects of organisational culture that identified old and new behaviours. This became significant when identifying themes, as will be evidenced further in Section 6.3.

5.2.3 Phase 3: Searching for themes

Following completed development and definition of codes, these were then collated into potential themes by identifying repeated patterns in all data relevant to each potential theme. Braun and Clarke (2013, p. 227) refer to the themes at this stage of analysis as "candidate" themes, for revision during further analysis. Themes were determined by their saliency to answer the research questions and advance understanding, not frequency of occurrence (Buetow, 2010; Braun and Clarke, 2013; Javadi and Zarea, 2016). Twenty-nine candidate themes were identified from the data.

5.2.4 Phase 4: Reviewing themes

The interview dataset was revisited and themes reviewed against all coded data. The themes were then compared for distinctiveness between each theme - external heterogeneity - and relatedness of the data within each theme - internal homogeneity (Boyatzis, 1998). This led to integration of some themes and formation of other sub-themes, producing nineteen themes and thirty-four sub-themes (Appendix XV) relevant to addressing the research questions. Following this stage of analysis, themes were organised into five overarching themes (Braun and Clarke, 2013). The relationship of themes and sub-themes to the overarching theme were presented in five thematic maps (Figures 3-7, Sections 6.3.1 – 6.3.5 inclusive), following the example of Braun and Clarke (2013, p. 233).

5.2.5 Phase 5: Defining and naming themes

Further iteration with the dataset was conducted during which themes were defined and named, identifying each for its uniqueness. Brief definitions of each theme

within its overarching theme were developed, following the illustrated example of Braun and Clarke (2013, p. 250).

5.2.5.1 Overarching Theme I: Responsible Leadership

An overarching theme that demonstrates responsible leadership behaviour was used to address performance improvement. Participants described responsible leadership in a number of ways. The theme 'Collective Leadership Model' refers to the approach by executive leadership to influence overall organisational leadership culture. A corresponding theme 'Proactive Accountability' explores explicit actions and responses to organisational situations through the sub-themes *'Acting Responsibly'*, *'Responding to Challenge' and 'Actions'.* Running through both themes is 'Positive Distributed Influencing', relating to key influencers who set the tone and direction of the organisation. This theme is explored through the sub-theme '*Role Model',* which illustrates how people influence. How leaders plan for organisational resilience is explored through the themes 'Strategic Organisational Development' and 'Whole System Involvement'. The impact of whole system pressures and the desire to be a responsible leader is explored through the sub-themes *'Taking Responsibility' and* '*Impact on Trust'.*

5.2.5.2 Overarching Theme II: Values-Led Culture

This overarching theme describes the organisations' culture which leaders have introduced and embedded in response to external challenge. Frequent references to a previous culture, the new culture and how change has been introduced and embedded are explored through the theme 'Delivering Culture Change', differentiating old and new behaviours and attitudes. Alignments of personal and organisational values and the impact on patients and staff of a caring culture are illustrated through the themes 'Aligned Staff and Trust Values' and 'Compassionate Caring'. These themes show how a values-led culture has been embedded in the Trusts.

5.2.5.3 Overarching Theme III: People-Focussed

This overarching theme describes the attention that leaders have paid to their staff in order to improve performance and develop organisational resilience. Deliberation to attract people with a particular mindset and retain personnel is explored through the theme 'Recruitment and Proactive Retention'. The overlap between being 'People-Focussed' and the overarching theme of a 'Values-Led Culture' is discussed in Section 6.3.3. The importance that leaders placed on connecting with staff is illustrated through

the theme 'Effective Communication' and evidenced more deeply through the sub-themes *'Building Staff Relationships'* and *'Investing in Communication'.*

In parallel with staff recruitment and retention are the themes 'Staff Development' and 'Effective Team Work', which identify the attentiveness to career progression within the organisations. The theme 'Resilience-Building Programmes' is explored through two sub-themes, *'Perspectives on Organisational Resilience'* and *'Personal Resilience'*. Participant views on the relationship between personal and organisational resilience, and how resilience has been formally addressed in the organisations, are identified through this theme. The theme 'Acting on Feedback' evidences the proactivity of leaders to understand what is important to staff and monitor progress of intentional change to address concerns. This theme is replicated in overarching theme five, 'Commitment to Learning' and their linkage is discussed in Section 6.5.

5.2.5.4 Overarching Theme IV: Rigorous Governance

This overarching theme evidences that leaders have prioritised governance of internal systems and processes in order to improve performance and build organisational resilience. Frequent participant references to a strong governance approach, building a firm foundation on which to practice, the Trusts' attitudes to risk and their risk management processes are illustrated through the themes 'Delivering Strategic Priorities' and 'Robust Risk Management'. The influence and impact of the CQC regulator on the Trusts' governance procedures are examined through the theme 'Effective Response to Regulatory Feedback'. The three themes are laterally related.

5.2.5.5 Overarching Theme V: Commitment to Learning

This overarching theme identifies that leaders have embraced a learning mindset to improve performance and develop organisational resilience. A willingness and requirement to learn is evidenced through the theme 'Organisational Learning Imperative', which describes the processes utilised in the organisations to understand what goes wrong, works well and how learning is shared throughout the organisations. The learning mindset is further evidenced through the theme 'Acting on Feedback', which illustrates sources of feedback and resultant actions taken by leaders. The duality of this theme, also an element of the overarching theme 'People-Focussed', is discussed in Section 6.5. A commitment to learning is evidenced by the frequent comments made by

participants that there is always room for improvement and there is more to be done, explored through the theme 'Lack of Complacency'.

5.2.6 Phase 6: Producing the report

Analysis of data continued during this final phase of thematic analysis. As Braun and Clark (2013) make explicit, producing a written report forms part of the analytic process and is not a standalone activity after analysis has been concluded. The researcher continued to refine themes, sub-themes and codes within themes throughout the six phases of analysis, illustrating her continuation of data analysis during report production.

5.3 Analysis utilising structure by Gioia, Corley and Hamilton (2012)

An additional analytic process was then undertaken, using the structure illustrated by Gioia, Corley and Hamilton (2012). The Gioia method is an appropriate analytical tool for an inductive approach to qualitative data analysis (Azungah, 2018). It has been used in organisational research studies (Suleiman and Othman, 2021) including application as a further analytical step following thematic analysis using the method of Braun and Clarke (2013) (Donald, 2017).

This provided a final opportunity to analyse and nuance the data codes and themes and added greater rigour to the data analysis: this is discussed further in Section 6.2. On completion of the analysis, thematic maps (Figures 3 - 7) for each overarching theme were produced as described by Braun and Clarke (2013, p. 233) and are presented in Sections 6.3.1 – 6.3.5. An overview of findings (Figure 2, Section 6.2) is also presented using the Gioia structure (Gioia, Corley and Hamilton, 2012).

5.4 Chapter summary

This chapter has described the six-phase process of thematic analysis (Braun and Clarke, 2013) of the interview data to address the research questions: "What has enabled organisational performance improvement and thus developed organisational resilience, as evidenced by the Care Quality Commission? What strategic leadership behaviours underpinned the development of sustained organisational resilience?" A brief definition of each identified overarching theme - the strategic leadership behaviours - and their themes were presented and an additional stage of analysis was then reported, followed by a chapter summary. Data analysis and findings are now presented in Chapter 6.

Chapter 6

DATA ANALYSIS AND FINDINGS

6.1 Introduction and chapter overview

Interview data were analysed using the thematic analysis method described by Braun and Clarke (2013) and finessed using the Gioia architecture (Gioia, Corley and Hamilton, 2012) as detailed in Chapter 5. A synopsis of the findings is followed by a presentation of the evidence for each overarching theme, incorporating the remaining data corpus to triangulate (Boyatzis, 1998) the interview dataset. These datasets include Trust BPs and ARs, NHS staff surveys, CQC summary inspection reports and subsidiary data. The researcher's field notes and reflections are also reported during the chapter. The strategic priorities/objectives for both cases during the years 2015-2020 are then presented, followed by a synthesis of the data analysis. A summary concludes the chapter.

6.2 Synopsis of the findings

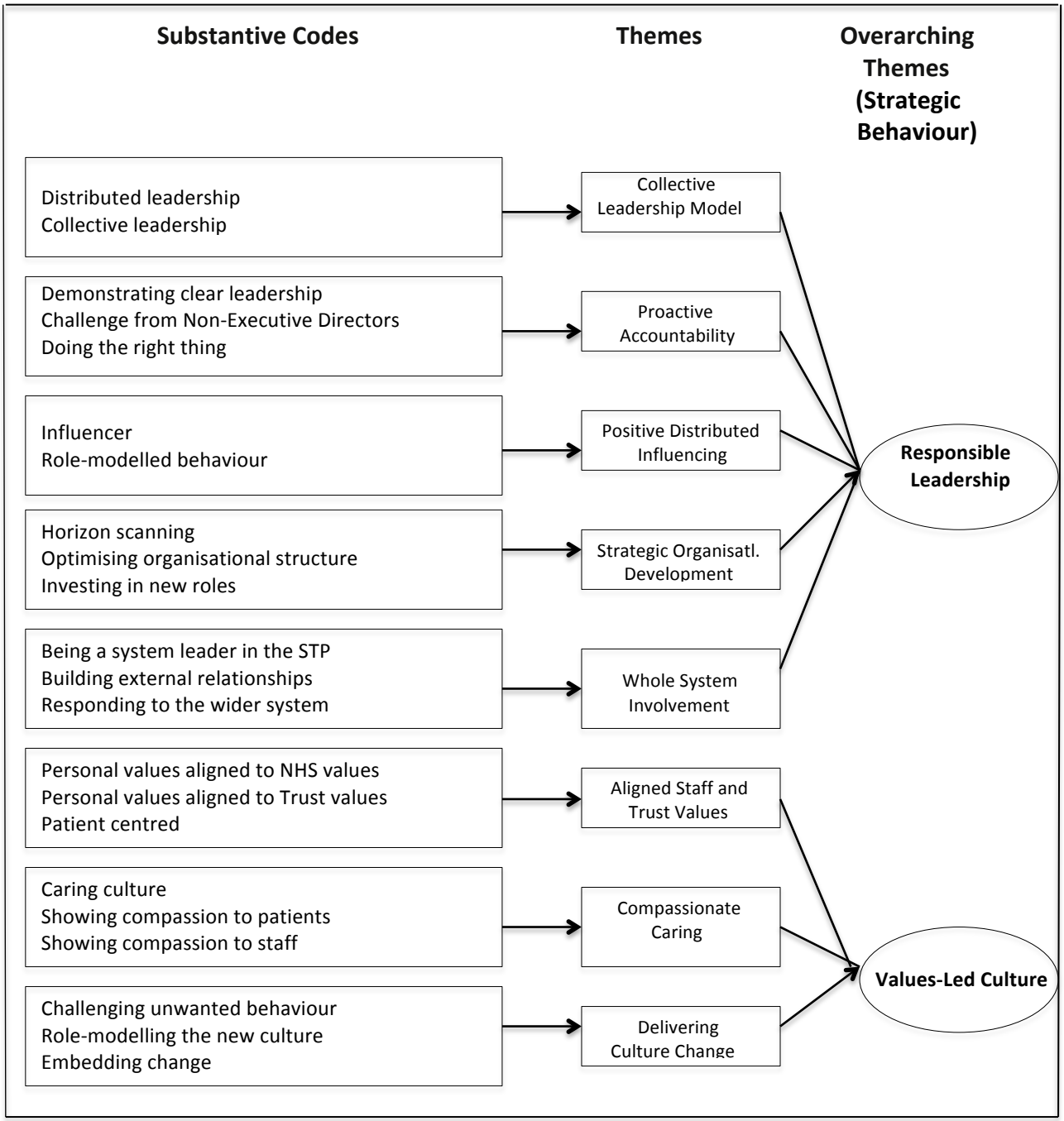
Thematic analysis of the interview data identified five strategic behaviours - the overarching themes - where leaders had focussed in order to improve organisational performance and thus develop organisational resilience (Vogus and Sutcliffe, 2007; Bhamra, Dani and Burnard, 2011; Boin and van Eeten, 2013). Behaving responsibly was the primary driver and underpinned the other actions. These included establishing and living a new organisational culture based on Trust values, and having a strong focus on staff: supporting their development, building resilience, encouraging respect for others, working collaboratively and acknowledging their contribution. Practicing rigour around governance and maintaining processes that enable learning from success and failure were other significant behaviours identified through the analysis.

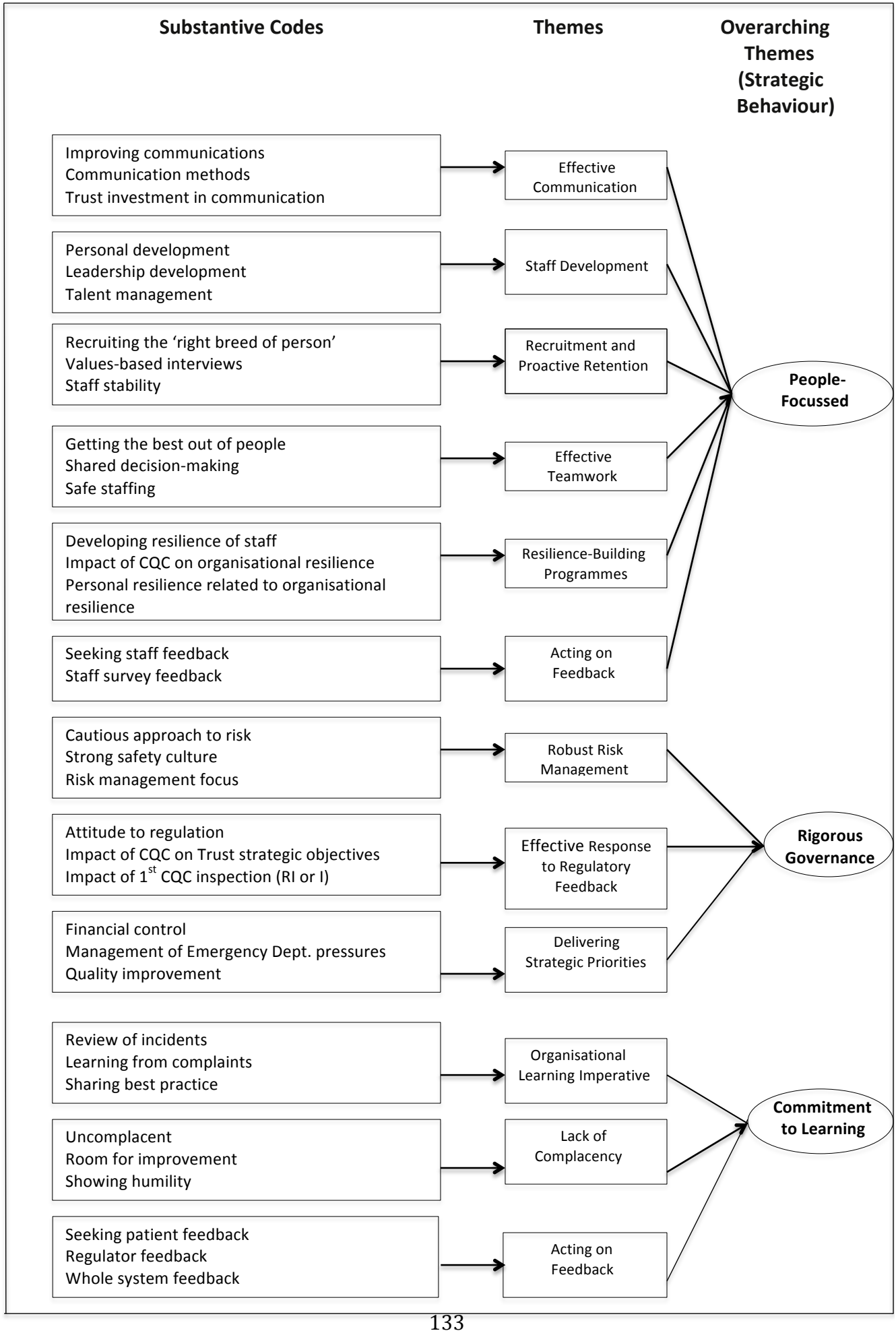
An overview of findings is presented diagrammatically in Figure 2 using the structure illustrated by Gioia, Corley and Hamilton (2012). As observed by Saldaña (2016), a pragmatist may choose to select different tools for a job. The Gioia architecture offered the researcher an alternative framework to review the substantive codes, themes and overarching themes, which resulted in further nuance towards the final data analysis. This additional analytic step is further evidence of the iterative approach and research rigour performed by the researcher. Utilising the structure of Gioia and colleagues (2012) data is

presented in an alternative form to the thematic maps of Braun and Clarke (2013) and provides readers an opportunity to 'digest at a glance' the data analysis.

Figure 2: Overview of Interview Data Analysis

Architecture after Gioia, Corley and Hamilton (2012)




Substantive Codes
Themes
Overarching Themes (Strategic Behaviour)
Improving communications
Communication methods
Trust investment in communication
Effective Communication
Personal development
Leadership development
Talent management
Staff Development
Recruiting the 'right breed of person'
Values-based interviews
Staff stability
Recruitment and Proactive Retention
Getting the best out of people
Shared decision-making
Safe staffing
Effective Teamwork
Developing resilience of staff
Impact of CQC on organisational resilience
Personal resilience related to organisational resilience
Resilience-Building Programmes
Seeking staff feedback
Staff survey feedback
Acting on Feedback
People-Focussed
Cautious approach to risk
Strong safety culture
Risk management focus
Robust Risk Management
Attitude to regulation
Impact of CQC on Trust strategic objectives
Impact of 1st CQC inspection (RI or I)
Effective Response to Regulatory Feedback
Financial control
Management of Emergency Dept. pressures
Quality improvement
Delivering Strategic Priorities
Rigorous Governance
Review of incidents
Learning from complaints
Sharing best practice
Organisational Learning Imperative
Uncomplacent
Room for improvement
Showing humility
Lack of Complacency
Seeking patient feedback
Regulator feedback
Whole system feedback
Acting on Feedback
Commitment to Learning

6.3 Evidence for the five strategic leadership behaviours

6.3.1 Strategic Leadership Behaviour I: Responsible Leadership

Acting as responsible leaders was the dominant leader behaviour manifest in both Trusts. As noted in Section 2.5.8, Pless and Maak (2011) suggest the mindset of a responsible leader shifts away from accountability solely to the organisation's shareholders, towards a stakeholder society, based on a moral sense of justice, care and accountability for a wide range of social, economic, ecological and human responsibilities. Working in a publicly funded health care system, leaders of NHS Trusts are accountable to central government for the use of public funds. Amongst other Trust stakeholders are its staff, service users, other NHS providers, higher education establishments, local authorities and social services. The stakeholders collectively create a system (Akhtar *et al.*, 2016; Manley *et al.*, 2016).

The theme 'Whole System Involvement' refers to both case study Trusts working with external stakeholders in local STPs to improve and sustain health and care services (Walshe, 2017), as mentioned in Section 2.2.3.4. Participants from both cases indicated their Trust's commitment towards the whole system and described incidences of mindset change from competition to collaboration and partnership. There was acknowledgement of their sense of responsibility to take a leadership role within their STP, as expressed in the following extract. It was also reported that the CEO of CS1 leads the STP in that Trust's partnership group.

> *"(The Board) are ahead of the curve … they've been thinking for five years that CCGs (Clinical Commissioning Groups) are going; there's going to be a new way of learning; there's going to be Integrated Care Systems coming. And (the CEO)'s been saying right from the start: 'We're going to lead it'. There's that ahead of the curve thinking that has really, really helped our organisational resilience. […] If they continue to see these waves coming it really does make us even more resilient" (ID 14: CS2).*

This extract also illustrates how the Trust leaders are future-focussed, working strategically with other system leaders to maintain organisational resilience, evidencing a relationship with the theme 'Strategic Organisational Development'. Commenting on different perspectives of responsible leadership, Miska and colleagues (2014) concluded that business leaders increase engagement with stakeholders the greater their long-term

view of organisational sustainability and, therefore, its resilience (Ortiz-de-Mandojana and Bansal, 2016; Bui *et al.*, 2019). Active membership in the whole system was reported as essential for on-going organisational resilience by a number of participants. There was a perception that resilience of the Trust relied on a collaborative mentality that would enable the whole system to flourish, as illustrated in the following comment:

> *"I think we've also got to think about recruitment in the **system**, not for our organisation. That's a really important part of resilience. […] I think organisational resilience: we have to think outside our own boundaries, because we can't keep this a resilient organisation. We cannot do it with just what we've got under **our** control, we do have to think differently" (ID 2: CS1).*

A stakeholder perspective suggests the needs and interests of employees are addressed by responsible leaders, as are those of the wider community in which the organisation operates (Waldman and Galvin, 2008). Working in whole system partnership has been evident in CS1 since 2015. For example, BP 2 (p. 150) included a report that provided an update to the Board on their then recently commenced partnership working with a closely located Acute Trust *"with the aim of promoting highly effective joint working between the partner Trusts for the benefit of patients and staff within the two organisations"*. This pre-dates the existence of an STP and was established to address challenges in Urgent Care provision across their location.

In the same year, a report for Board approval of the Trust's learning and development strategy 2015-2020 was included in BP 6 (p. 145): this had *"been subject to extensive consultation with key stakeholders and partners"* and noted how they would ensure that *"not only we develop our own staff but how we will play our part in ensuring the NHS continues to train some of the most exceptional professionals global healthcare has to offer".* This is a clear reference to making a contribution that goes beyond their Trust requirements.

There was evidence in the most recent CQC reports from both Trusts of collaborative working with external stakeholders to ensure sustainability of local services. For example, in CS1 it reported: *"There was a clear interconnected vision and strategy for the Trust which recognised quality alongside sustainability. The strategy was aligned with local plans for delivery of care in the wider health and social care economy. The Trust was active in developing relationships in the community with partners and stakeholders to drive the goal of providing better and more integrated care in (their location) and the*

surrounding areas" (CQCSR 3, p. 4). Similarly in CS2, a Board report (BP 83) noted how they were working to develop sustainability in the NHS through closer working with partners in their STP.

There has been a clear focus on partnership working in CS2 for the five years since 2015, evidenced in the reviewed organisational documents. It was reported in the minutes of the first Board meeting (BP 50, p. 4) in 2015 that a partnership day had been attended by a clinical director, who had observed strong clinical and managerial leadership emerging and evidence of partnership working. In the corresponding AR for the Trust the CEO wrote how future plans for delivering a better system of care for local communities would be shaped by their values and require on-going engagement with stakeholders, who had already met to discuss a five-year strategy. These references indicate the organisational future for CS2 was considered as rooted in collaboration with system partners in order to serve their community more effectively. These data illustrate the external-facing, relationship-building priorities of the CEOs and senior leaders in both case studies that signify responsible leadership (Maak and Pless, 2006; Pless and Maak, 2011).

The theme *'*Proactive Accountability' encompasses a number of sub-themes that referred to explicit actions and behavioural responses to organisational situations. A leader behaviour particularly noted by the researcher and captured under the sub-theme *'Acting Responsibly'* was flagged by thirty-four *in vivo* references from nineteen participants at all levels regarding *"doing the right thing"* and *"the right thing to do"* (Appendix XV). Waldman and Galvin (2008) state that responsibility is based on a leader's broad moral standards to do the right thing towards others, a sense of obligation to act on those standards and be held accountable for the consequences of their actions. Tennyson and Strom (1986, p. 298) state that acting responsibly is a result of "careful, reflective thought about which response is professionally right in a particular situation".

Recording several entries in her field notes, the concept of responsible leadership as a strategic behaviour was considered by the researcher very early in her fieldwork. She observed the frequency that participants stated "*it's the right thing to do*". Also, she noted the phrase was mentioned in connection with both strategic business decisions and linked to Trust values. One respondent (ID 23) in CS2, for example, commented that Trust leaders would discuss risks associated with potential business decisions and question: *"Is this the right thing to do for our patients or staff"*? This also reflected the patient focus

observed by the researcher (Section 6.3.2).

The researcher reflected that the theme appeared to have a moral/ ethical dimension in terms of responsibility to their entire community, as illustrated in a comment by ID 6 in CS1 regarding a recent strategic decision: "*It's a (business) risk and an opportunity and I think the moral imperative to do the right thing".* Pless and Maak (2011) assert that being responsible can stem from a leader's recognition that it is simply the right thing to do. Lynham and Chermack (2006) concur that ethical thinking is a component of responsible leadership. Many participants from both Trusts appeared to act from this sense of ethical responsibility, as the researcher's reflections acknowledged.

As reported in Section 2.6.1, there has been considerable emphasis in recent years for leaders in the NHS to practice compassionate and distributed / collective leadership. It has been argued that these are appropriate styles of leadership for the NHS due to the positive impact on staff and patient care (Firth-Cozens and Mowbray, 2001; Jønsson *et al.*, 2016; West and Chowla, 2017; Kline, 2019). Cameron (2011) asserts that responsibility is frequently associated with empowerment and freedom of action, which implies discretion and authority: it is suggested these are actions associated with distributed leadership.

Cameron also associates caring and compassion with responsible leadership, "promoting goodness for its own sake" (Cameron, 2011, p. 26). Compassionate caring was identified as an aspect of both Trusts' culture, evidenced in Section 6.3.2. The theme 'Collective Leadership Model' was identified as a result of the frequent references to collective and distributed leadership mentioned by participants in both cases, thus evidencing different aspects of responsible leadership. For example, one leader described her compassion for a colleague through the following recollection:

> *"I also remember attending a meeting where a manager shared a story, and I remember thinking: 'Wow, I never knew that! I never knew you were in that situation'. […] He's got a whole journey that he's been on and (I now have) a small window of why he feels that" (ID 21: CS1).*

The theme 'Positive Distributed Influencing' references a variety of staff holding roles at executive, senior and middle management who were identified as organisational influencers, reflecting a distributed leadership model in both cases. Almost all participants -thirty-five in total - singled out their CEO as the most influential person in their Trust. The CQC commented on this in their latest report of CS2: *"The chief executive*

was well respected by all staff and stakeholders. (Their) visibility across services was highly valued and appreciated by staff. Staff found (him/her) to be very approachable, responsive, decisive and understanding of the daily challenges they faced in their work" (CQCSR 6, p. 9).

The strength of feeling among participants, including both Chairs, regarding their CEO was remarkable and consistent. The researcher reflected during her fieldwork how the CEOs influenced through their behaviour, were an inspiring role model and showed an exemplary leadership style. She noted they shared qualities of modesty and non-complacence, were approachable and accessible, frequent communicators, they balanced aspiration with realism, were Trust-values driven and patient centred. Some of these observed traits have been reported as responsible leadership characteristics (Maak and Pless, 2006; Cameron, 2011; Patzer, Voegtlin and Scherer, 2018), at organisational and individual levels (Miska and Mendenhall, 2018).

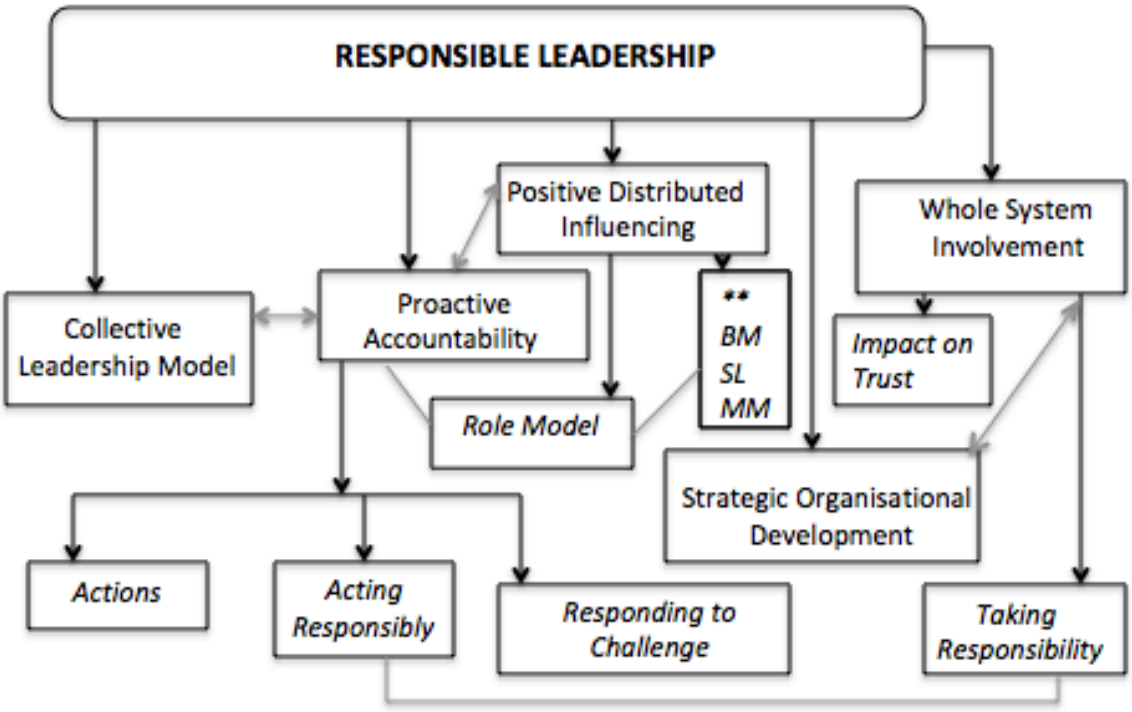
By role-modelling certain behaviours, responsible leaders can demonstrate a commitment to the actions they wish to influence and perpetuate in their colleagues (Waldman and Galvin, 2008). Participants cited many examples of positive influential behaviour. One participant described how his current and former managers were people who listened, showed they valued his opinions and contributions, challenged and provided opportunities for personal growth and career development, did not accept mediocrity and *"enabled me to continue to develop my own moral compass in a sense of what is the appropriate thing to do" (ID 10: CS1).* These behaviours correlate to the researcher's reflections and analysis noted above.

The relationship of responsible leadership themes is presented in the thematic map (Figure 3) below. The map identifies a close lateral relationship between the themes 'Whole System Involvement' and 'Strategic Organisational Development': the contribution of the Trusts to the whole system was a responsible, strategic decision to actively engage and play a leadership role. There is a tentative relationship observed between the two sub-themes '*Taking Responsibility'* and '*Acting Responsibly'*. Taking responsibility was a sub-theme of 'Whole System Involvement', which demonstrated responsible leadership thinking and behaviour; similarly, acting responsibly was the outcome of the responsible leader behaviour of being proactively accountable. The close lateral connection between the themes 'Proactive Accountability' and 'Collective Leadership Model' is also demonstrated on the map: leadership behaviour is influenced

by their style.

These themes and sub-themes illustrate various aspects of responsible leadership. Other behaviours that signal responsible leadership are evidenced in the remaining four strategic behaviours identified through this analysis, underlining it as the primary behavioural driver to organisational change and sustainability. This is explored further in Section 6.5. This strategic behaviour of leaders has been identified by interview data analysis and further evidenced through secondary data sources. The implications of these findings will be discussed in Chapter 7.

Figure 3: Thematic Map for Overarching Theme Responsible Leadership



TYPEFACE KEY: OVERARCHING THEME; Theme; *Sub-theme*

LEGEND: Single arrow represents direction of hierarchical thematic relationship

Bi-directional arrow indicates a close lateral relationship between themes

Single line represents a tentative relationship between theme and sub-theme, or sub-themes of different themes

** *BM: Board Member; SL: Senior Leader; MM: Middle Manager*

OVERARCHING THEME = STRATEGIC LEADERSHIP BEHAVIOUR

6.3.2 Strategic Leadership Behaviour II: Values-Led Culture

Following their research into successful companies, Waterman and Peters assert an organisation will not be successful without a considered approach to developing, having clarity on and living the right sort of values (Waterman and Peters, 2004). Values reflect a sense of what ought to be (Schein, 2004) and shape the culture of an organisation. Following significant negative feedback from external reviews unrelated to CQC regulation both case study Trusts revised their organisational values. These were developed with their staff through a comprehensive engagement strategy: Board leaders were committed to embedding the values and promoting a new organisational culture. The changes began in both Trusts after the appointment of a new CEO: it is suggested their personal values of responsible leadership started the process of culture change.

Culture is a key determinant of organisational behaviour (Newdick and Danbury, 2015). Both organisations chose a values-led culture, which is in keeping with the theory of responsible leadership (Freeman, Wicks and Parmar, 2004). Culture change is difficult to achieve and takes time to embed and become a new normal (DeJoy, 2005; Atkinson, 2012). The involvement of staff in identifying the Trust values would have considerably enhanced their willingness to become engaged in and implement culture change (Beckerman and Fontana, 2001).

The current CEO of CS1 took up post in January 2010 and reported in the Trust's annual report (AR 5, p. 27): *"The new values, it was agreed, should have real meaning, be memorable and staff must be able to live and work by them. […] They will become central to organisation change, effective leadership and define what we expect from our staff. […]. Going forward, it is vital that the values underpin 'how we do things around here' and work will continue with staff throughout 2010/11 to look at different behaviours that define the values, which will allow staff to take personal responsibility for their own behaviour and challenge unacceptable behaviours in others".* The comment reflects a call for responsible behaviour in everyone.

The previous Trust values in CS1 were reported once in the five preceding annual reports and included statements of purpose rather than values, such as: *"We are accountable for our use of public resources"* and *"We promote innovation and improvement" (AR 3, p. 4).* The refreshed values were intended to herald a new organisational culture in CS1. They have been mentioned substantially in every subsequent AR and have appeared on all Trust documents since late 2016

(BP 19, p. 1), serving as a continual reminder of their centrality to Trust culture.

In 2015, the then recently appointed CEO of CS2 began a process of culture change. He/she signalled in the AR: *"Our plans for the future will be shaped by our values and beliefs about working in a way which improves patient care. […] We want to establish and sustain a culture based upon compassion where people consistently feel valued and supported" (AR17, p. 3).* A new values and behaviours framework (VBF) was considered central to this work. At the launch of the framework in March 2016 the CEO wrote: *"[W]e've developed a new set of organisational values and a description of what they mean in practice. […] What matters most is that you and I use them to guide the way we work" (VBF, 2016, p. 2 - CS2)*. The importance of living the Trust's values has been mentioned in each subsequent AR in CS2.

The importance of the Trust values was evidenced in the NHS Staff Survey data. Over the years of analysis there was an increase of 8.6% in CS1 and 11.4% in CS2 in reported discussions of Trust values at annual appraisal meetings. This followed the trend in all Trusts, which reported an increase of 8.4% over the five years (Appendix XIII). This suggests a stronger focus on organisational values has been embraced by the NHS, and is possibly a reflection on the drive towards compassionate caring which has been noted previously (West and Chowla, 2017) in Section 2.5.7.

It is notable that both organisations clearly stipulated the behaviours that accompanied the values. This would ensure clarity of meaning and, therefore, no excuse for non-compliance. It also underlined the message they had purpose, real meaning and must be lived. In shaping their organisational strategy for 2020-2025, both Trusts consulted with staff on their values, which remained unchanged (AR 15; AR 21). There is considerable overlap between their Trust values: both reflect a culture based on desirable behaviours towards staff and intentionally complement NHS values (DHSC, 2021a), which are based on behaviours towards patients. The Trusts' values are reported in Table 19 below, in themes and not as specifically stated in documents to preserve anonymity. The NHS values are as described in literature (DHSC, 2021a).

The theme 'Aligned Staff and Trust Values' evidences two sub-themes identified in both Trusts. The first reflected the Trusts' focus on staff and the importance of employing people with personal values that aligned to those of the Trust (Section 6.3.3). The consequences of having a mismatch of values was articulated in the following comment:

"[W]here I've had challenging times in teams with personnel, it's always fundamentally come down to values in one way or another. Whether that's fundamentally a moral compass or whatever it is, but it would be about values rather than competencies. You can teach people the role and yes, people do change, but it's much harder to reset people's values" (ID 10: CS1).

The second sub-theme related to the value of putting patients first: it was apparent that patients were central to decision-making in both organisations and is discussed further in Section 6.4. As commented in Section 2.6.1, Francis (2013) reported an NHS culture whereby finances frequently were prioritised over patient need. Whilst accountability of public funds is a requirement for the NHS (Monitor, 2014), there were many references to leaders considering primarily what was best for patients and their relatives. Of interest to the researcher and discussed in Section 6.4 was the omission of a patient-centred approach in the Trust values as appears in those of the NHS, shown in Table 19.

Table 19: Organisational Values: Case Study 1, Case Study 2 and NHS
(Source: AR15; AR21; DHSC, 2021a)

CASE STUDY 1 *(Launched 2010; Reviewed 2019/20)*	**CASE STUDY 2** *(Launched 2016; Reviewed 2019/20)*	**NHS** *(Launched 2009; Reviewed 2019)*
Respect everyone	Respect everyone	Respect and dignity
Everyone counts	Everyone counts	Everyone counts
Work together	Work together	Working together for patients
Encompass change	Encompass change	Improving lives
Acknowledge success	Staff first	Compassion
	Future focus	Commitment to quality of care
KEY: *Similar values identified in print of same colour*		

The CQC observed that: *"Staff were highly motivated to work with patients and carers to ensure that the care was what they needed and they had a good patient experience. Patients said the staff tried to meet their needs, that they worked hard and*

had patients' best interests and welfare as their priority. Staff treated patients with compassion and kindness, respected their privacy and dignity and understood the individual needs of patients" (CQCSR 6, p. 9). The strength of organisational values was also observed in both Trusts by the CQC. For example, in the latest report for CS2 it was noted: *"Staff knew and understood the Trust vision and values and how they applied in the work of their team and influenced objectives at service level. There was a strong, visible person-centred culture" (CQCSR 6, p. 4).*

The theme 'Delivering Culture Change' was identified through data analysis. Many participants (n=26) referred to how embedded the Trust values were in their organisation. Culture was reported to have changed significantly over the past five years in both Trusts, and particularly since the first positive CQC inspection that created a real purpose for celebration. Participants in CS1 commented on the length of time it had taken to bring about a sustained change and some attributed this to the legacy of the adverse publicity they had previously endured and which had highlighted a culture of bullying and inappropriate senior leader behaviour. Whilst culture change takes time and requires trusted leaders (Schein, 2004; Schraeder, Tears and Jordan, 2005; Yukl, 2013), one participant described it as a reluctance to put the past behind them. In driving culture change he had challenged his colleagues to reframe their thinking:

> *"This place does fantastic stuff that a lot of places in the UK don't. But historically it would be an ostrich and stick its head in the sand and that's what we've been working hard to change, and it **is** changing. […] We can't keep living in the past and harping on about the past. It happened. We've learned, we've made the changes. [...] **We have to move on**" (ID 9: CS1).*

In CS2 there had been a further change of CEO in March 2017, after the new values had been introduced. This was an internal appointment of a Board member, who continued to build on the innovations of their predecessor and brought a marked openness and accessibility to the role that hastened the change of culture throughout the organisation. This Trust had also had a damaging external report that exposed a bullying culture and the new CEO was keen to accelerate change to a no-blame, fair and just culture. This recent change was acknowledged in the following participant comment:

> *"[C]ertainly you do feel if something went wrong, that the Trust would back you, whereas before you felt the Trust would scapegoat you because we were*

so paranoid about our reputation, and doctors were often at the receiving end of that. […] (The CEO) said (to a partner organisation colleague) "I want my staff to be open and able to say what they think", and that's a positive thing. That wouldn't have happened before" (ID 13: CS2).

Participants frequently reported an observed change in their organisational culture. It was not embedded totally and change was still in progress. Medical consultants were most frequently mentioned in connection with inappropriate behaviours that remain and continue to be challenged. It was interesting to note that one participant (ID 1), in his second year of appointment and first NHS role following a career in the private sector, held a different perception to his colleagues. For example, all participants mentioned experiencing a reduced hierarchy with respect to command and control compared to his contrasting view. It felt to him that Trusts thought only about "*consultants and bullying behaviours*" and he thought that frequently they were "*just inappropriate behaviours" (ID 1: CS1).* He also stated the nurses were very hierarchical and that the old-fashioned structures he considered were in evidence led to more bullying, command and control behaviour.

It is suggested that the NHS has a distinct corporate culture (Edwards and Kleiner, 1988) that will be recognised by those who have worked in other NHS organisations. It is that familiarity with the culture that put the researcher at ease when conducting her work in both organisations. It is argued that idiosyncratic elements of this unfamiliar corporate culture will stand out to the uninitiated, to whom small but significant change may not be apparent. Thus, it is the NHS outsider who had seen the old culture and was unable to perceive the change that was in progress and reported by the employees of longer standing.

It is also possible that there was a more marked change before ID 1 took up post, as culture change had been on-going for almost ten years in CS1. This underlines the length of time it takes to embed culture change. Participants with NHS experience who were recent appointees in either Trust, or those who had left and subsequently returned, referred to their awareness of a previous organisational reputation and negative culture that did not match their current experience of the Trust. This is another indication of culture change in progress in these organisations.

Attitudes that developed as a result of the new culture were described by many participants and included a new pride in their organisation, a positive atmosphere and a

desire to do well. In CS1 the CQC observed *"care to be outstanding with people reporting that staff went the extra mile and their care and support exceeded their expectations" (CQCSR 6, p. 7).* Some participants linked a new culture to the development of staff and organisational resilience. For example, it was felt that greater fairness in CS2 gave people strength, knowing that they were not going to be blamed when things went wrong. It was also stated by a participant in CS2 that they celebrate "*the good stuff*" which was considered critical and gave people more confidence, enabling them *"to deal with those difficult days" (ID 12: CS2).*

Showing compassion to staff and patients was on-going for the Trusts, evidenced through the theme 'Compassionate Caring' and supported by examples of specific instances. There were fifty-two references to compassionate caring for both staff and patients. As participant ID 29 (CS1) reported: *"I'm always so humbled by some of the most junior staff nurses being so kind and showing such compassion. Not in a disingenuous way … they really* ***care****, and […] I hope that comes from role-modelling and leadership in the department and […] the whole team, saying 'this is what's important to us' ".* The annual report of 2012-2013 (AR 8) in CS1 reported a direct link to their values and this compassionate approach to care, stating how the Trust was working to embed its values, further evidencing the longevity of a compassionate, caring culture in that organisation.

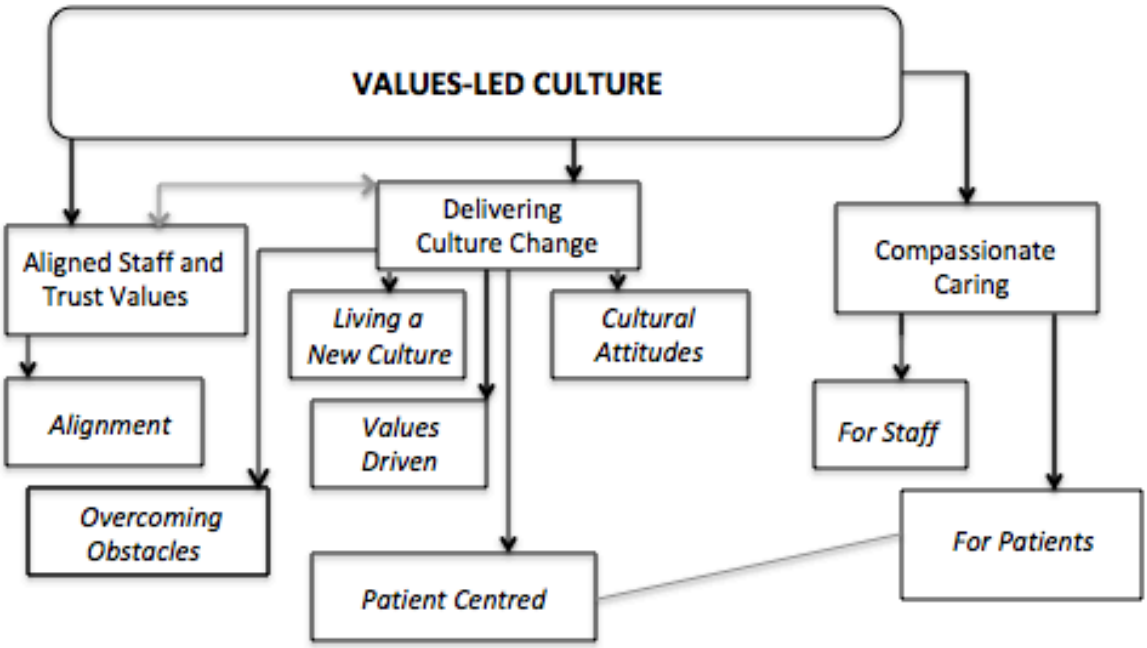
Participants also stated that being compassionate could be difficult, as the following quote illustrates:

> *"We're acutely aware that we sometimes say to people: 'We understand how much pressure you're under, we are listening', and then we don't do anything. […] We must sit down with colleagues and actually think about what we can actually do. Because, otherwise, we can sit here nodding and looking sympathetic and then go away and forget all about it, because it's too difficult" (ID 18: CS2).*

On the same theme, a participant in CS1 spoke of the need for people to perform, despite not always getting what they want: "*In order to run a service there needs to be give and take, with a balance of listening and empathy on one hand and being prepared to do your job, even though you may feel disadvantaged" (ID 28: CS1).* This suggests that a manager can be a good listener, understand the situation and show empathy, but may not be able to resolve a situation and remove another's suffering, which is the act of compassion (Dutton, Workman and Hardin, 2014). This is discussed in Section 7.3.7.

The strategic leadership behaviour of working to promote a values-led culture has been identified through interview data analysis and further evidenced from various datasets. The relationships of the themes and sub-themes relating to a values-led culture are presented in the thematic map below (Figure 4). The thematic map depicts the close lateral relationship between the themes 'Delivering Culture Change' and 'Aligned Staff and Trust Values'. The theme 'Compassionate Caring' defines the hierarchical relationship to both sub-themes *'For Staff'* and '*For Patients',* illustrating that the behaviour was applied to both groups of stakeholders. This is also reflected in the hierarchical relationship between the theme 'Delivering Culture Change' and sub-theme *'Patient Centred'*, which was visible in the Trusts and identified through data analysis. The relevance of this strategic behaviour is discussed in Chapter 7.

Figure 4: Thematic Map for Overarching Theme Values-Led Culture



TYPEFACE KEY: OVERARCHING THEME; Theme; *Sub-theme*

LEGEND: Single arrow represents direction of hierarchical thematic relationship

Bi-directional arrow indicates a close lateral relationship between themes

Single line represents a tentative relationship between sub-themes of different themes

OVERARCHING THEME = STRATEGIC LEADERSHIP BEHAVIOUR

6.3.3 Strategic Leadership Behaviour III: People-Focussed

Creating a positive work environment and attending to staff needs became a focus for leaders as they sought to bring about culture change and improve organisational performance. Evidenced through the corresponding themes, the areas of particular focus were recruitment and proactive staff retention, listening to and acting on feedback, enhanced relationship building through improved communication, effective teamwork, staff development and developing personal resilience. The importance of these areas was underlined in CS2 in the annual report of 2014-2015 (AR 16), where four of the five strategic priorities for the following year related to developing a listening and responsive culture to improve staff engagement, addressing skills and behaviours that aligned with Trust values, recruitment and proactive retention of skilled staff and improving the working environment and well-being of staff (Table 20, Section 6.4).

Organisations rated as underperforming by the CQC can have difficulty attracting or keeping staff (Rendel, Crawley and Ballard, 2015), with a potential negative impact on organisational resilience. The researcher explored why participants had come to work at the Trust (Appendix II; Appendix III) and compared the length of time they had worked there (Table 17, p.101) to analyse whether previous negative publicity and CQC ratings, or current reputation, may have affected staff recruitment and retention in the cases.

Twenty-three participants had worked in the organisations for over ten years, including the CEO of CS2. It is also noted that the CEO of CS1 had held that role for ten years and had been an internal Board appointment. All EDs (n=10) interviewed had held post for six or less years, with the majority (n=6) employed in their organisation for three or less years. The CEO of CS2 has held that post for three years. Both Trust Chairs and all the latest Board appointees commented that they were attracted to the Trust because of the CEO; all the EDs also cited current national reputation as a positive influence. One participant (ID 22) had held his ED post prior to the appointment of the CEO: the remaining EDs were current CEO appointments.

Three senior managers had previously worked at CS2, left the Trust and then returned following the current CEOs appointment, cited as their reason for return. There were many participants who stated their longevity in their organisation was due to the career enhancing opportunities that had been available. This is evidenced in Table 17 (p. 101): there were twelve employees who had held the same post throughout their tenure in either organisation, with the remainder (n=27) having changed roles. All non-

director post holders (n=8) that had held one post in the Trust had been in their role for three or less years. These figures indicate that both organisations are able to recruit and retain staff and are currently considered attractive places to work. They also evidence the opportunities in both cases for staff development, which is addressed below.

As mentioned in Section 6.3.2, the Trusts considered it important to recruit staff with aligned personal values to the desired new culture. Both Trusts have incorporated a values-based interview process (Patterson *et al.*, 2016) that addresses idiosyncratic values in addition to professional qualifications and experience. Also reported in Section 6.3.2, consultant behaviour was singled out as the most challenging. It was recognised that, historically, the balance of power of medical consultants over management had led to a clinical autonomy that did not necessarily put the needs of patients first (Mannion and Goddard, 2001; Currie and Suhomlinova, 2006), as noted in Section 2.2.3.2. A similar view of consultant recruitment was held in both Trusts and was being actively addressed, as the following quote suggests:

> *"I've made it very clear here the type of people that we should be employing to consultant posts should be technically very good. They should have professional experience. They should be the best in their trade […] but they should also have the right moral compass and if they haven't got that then I don't want them here" (ID 2: CS1).*

As noted in Section 4.4.6, an annual survey of NHS staff has been distributed since 2003 (Pinder *et al.,* 2013) and aims to provide organisations with data that can be used to improve staff experience and, therefore, patient care (Appendix XIV). Saunders and colleagues (2016) assert that surveys from government and large, well-known organisations are likely to be trustworthy and reliable as their reputation relies on credible data. Participants from both Trusts reported paying significant notice to the NHS staff survey results, which are viewed as a critical source of staff feedback. Both organisations present key findings to their Board in an internal interpretive report, identifying areas of focus and an action plan to address them during the following year. Examples of how each Trust report the findings are presented at Appendix XVI (BP 13: CS1) and Appendix XVII (BP 69: CS2). Following up on staff survey results, responding and monitoring progress was evident and consistent in the cases, as the following comment illustrates:

> *"I think the feedback loop is there. The staff survey helps, reacting to the staff*

survey, being clear on your outcomes from that, what we need to work on, what we do really well.[…] Something we do really well is feeding back when people do well and reflecting and debriefing on all those things that are going well, or things that have gone not so well" (ID 21: CS1).

Data for the past five years on six survey themes that are indicators of organisational culture, personal resilience and leader behaviour (Section 4.4.6) have been reported for each case study (Appendix X: CS1; Appendix XI: CS2) and collated against the overall Trust data (Appendix XII). The five-year trend differentials for all Trusts, CS1 and CS2 are presented in Appendix XIII, providing a ready reference for data comparison. The analysis and findings of these data are now presented.

Effective internal communication between managers and staff is essential to organisational success (Tourish and Hargie, 1998; Men and Jiang, 2016). Darling and Beebe (2007) argue that communication based upon key values and a concern for people is required for the successful execution of those values. Communication in NHS organisations has long been a point of concern and many patient complaints refer to poor internal communications between NHS staff (Pincock, 2004). Ineffective communication has also been cited as the cause of failure of major NHS projects that require culture change to support their success (Bowns, Rotherham and Paisley, 1999; Frame, Watson and Thomson, 2008).

Maintaining effective communication throughout the organisation was an on-going challenge for the case Trusts and observed by the CQC: in its first comprehensive inspection of CS1 the CQC had observed *"effective involvement and communication with staff was an issue. There was evidence that significant changes were being introduced without staff being aware of them" (CQCSR 1, p. 15).* Significant improvement had been observed during the inspection two years later, as evidenced in the report: *"Staff felt leadership was good and accessible. Staff told us they felt supported and heard. There were high levels of constructive engagement with staff. Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture and to motivate staff to succeed" (CQCSR 2, p. 6).*

Both executive teams were reported to have increased their reach through various communication channels. Senior leaders were perceived to be more approachable, accessible and active listeners, and many participants (n=26) referred to an improvement in communications, particularly over the last three years. Improved

communications was also corroborated through staff survey data, which showed more effective communication was being experienced in both Trusts. It was reported to have increased by 9.2% in CS1 and 10.8% in CS2 over five years. This compared to an average increase in all Trusts of 4% (Appendix XIII). Staff also reported an increase in confidence that their organisation will address their concerns: 10.5% of people in CS1 and 13.1% in CS2 over the five years compared to an increase of 3.8% in all Trusts (Appendix XIII). These data suggest a successful communication strategy in the cases.

The Chair of the Board of CS1 was reputed to be "*very, very people oriented, very people-focussed"* (ID 1: CS1). The Chair personally told the researcher that, shortly after taking up post he spoke to the CEO about internal communications and said: *"whatever (he/she) was doing, (he/she) must communicate times ten"* (ID 2: CS1). On their appointment, the CEO in CS2 began to use social media platforms regularly to connect with all staff, which was a departure from a more controlled communication culture. The CEO was reported to have *"a completely different way of doing things. It's more of a dial-in blog and vlog and a conversation where (he/she) will update generally and then (he'll/she'll) just get into a conversation with whoever happens to be on the call. It's open to everyone: some clinicians dial in, some managers dial in, some estate staff dial in … there's no restriction" (ID 14: CS2).*

There was recognition that social media had the potential to communicate positive messages but also, present a vision of the Trust that may not be experienced by all staff. A change in culture in CS2, driven by the CEO and ED for communications, had resulted in a vibrant social media presence and staff feedback that, as well as the "*shiny*" things, "*it's really important to attend to the basics at the same time" (ID 22: CS2).* Discussions were being held about this potentially negative aspect of social media communication and provides an example of culture change and a willingness to respond to staff feedback, further evidenced in Section 6.3.5.

A focus on teamwork was evident in both organisations. The strength of team spirit was overt to the researcher at the staff annual awards ceremony she attended in CS2. The team awards for clinical and non-clinical teams (AR 21, p. 112) were keenly contested and the researcher chatted to a number of team members during the evening. Considerable team loyalty and concern for each other was apparent. Staff also spoke of the importance of senior relationships: they reported that managers and leaders they trust, which included the CEO, are available, approachable, supportive, accommodating,

listen and are willing to facilitate change. Following the event the researcher recorded a field note and reflected on these observations, the generosity of applause and genuine pleasure shown to those that received awards. They demonstrated a strong supportive culture among those present, which may be indicative of a widespread corporate supportive culture.

Greater staff engagement and effective team-working have been linked to improved patient experience and clinical outcomes in health care organisations (Catchpole *et al.,* 2007; West and Dawson, 2012; Studer, Hagins and Cochrane, 2014). Feeling a sense of meaning and community at work, having an opportunity to make a contribution to their organisation and sharing an alignment of values will increase employee engagement (Markos and Sridevi, 2010). There has been an increasing effort to improve levels of staff engagement in the NHS in recent years through a greater understanding by leaders of its importance (Lowe, 2012; Dromey, 2014).

It was reported in CS1 that during the last four years leaders had become more focussed on improving staff engagement through providing greater support and a more empowering style to develop staff, implemented through their quality strategy. There was a change of focus towards "*getting the people who do the job to come up with the ideas about how we can make it better and different, and dealing with that supportively"* (ID 19: CS1). This had *"helped to increase the focus on the need for effective staff engagement"* (ID 10: CS1). Staff survey data confirmed this improvement on all dimensions analysed (Appendix XII).

In 2018, a newly appointed member of staff introduced a similar engaging style in CS2. The post holder took an appreciative enquiry approach, "*valuing whatever good practice and then being able to help and support and get teams to self-identify where they needed to develop and work"* (ID 32: CS2). They focussed on *"developing a rapport with staff, increasing engagement and making sure people felt supported"* (ID 32: CS2). This was reported as a departure from a previous culture that had less interaction and engagement. The above-average response rate to the annual NHS Staff Survey (Appendix XII) in the cases may be a further reflection of increased staff engagement.

Some participants reported that having a good role model and observing behaviours that could be emulated were an important contribution to their development. Being a role model was something others aspired to. Also a sub-theme evidenced in responsible leadership (Section 6.3.1), this indicates an overlap of the strategic leader

behaviour themes and is discussed in Chapter 7. Many participants spoke of opportunities for career advancement provided in the Trust, which is evident in the interview participant's demographic data presented in Table 17 (p. 101). Participant ID 19 (CS1) spoke of how leadership development had altered her style of staff support from "*let me do that for you*" to a coaching, facilitative approach that talent-spotted and developed staff. She also spoke of the importance of role-modelling a supportive culture to her colleagues.

The five years of analysed NHS staff survey data reveal that staff from both organisations reported marked improvement in their experiences of management from both immediate and senior managers. The responses in these Trusts are a considerable increase over the average all-Trust data (Appendix XII) and suggest a successful outcome to their behaviour and culture change strategies. Compared to the national picture, both cases show notable improvements to staff morale in levels of reported enthusiasm, enjoyment of work and satisfaction with level of colleague support. Of particular note are the data related to how staff feel their organisation values their work (CS1: +12.5%; CS2: +14.7%) and recommend their Trust as a place to work (CS1: +12.2%; CS2: +15.3%). These two scores had the highest increases of all the survey questions (Appendix XIII). The Trusts have also made slight reductions in the number of staff reporting work-related stress, compared to the overall NHS Trust trend of annual increases (Appendix XIII).

As noted in Section 2.3.1, patient safety has been a subject of concern for the NHS for many years (Ham, 2003; West and Lyubovnikova, 2013) and is a key area of focus for the CQC (CQC, 2015). Encouraging openness and reporting of adverse events in a no-blame organisational culture increases patient safety (White, 2006; Davies and Mannion, 2013). Over the five-year time frame, staff from both organisations reported considerable improvement in the safety culture and how they felt treated when involved in an incident. These data on the NHS Staff Survey were markedly greater to those from all Trusts (Appendix XIII). Interview participants acknowledged an emphasis on safety, which in CS1 was described as *"five star according to the British Safety Council"* (ID 1: CS1).

Both Trusts have made progress on equality compared to a national picture of regression, despite a slight increase of experiencing discrimination in CS2. Bullying and harassment by managers has reduced; by other colleagues and the public this has increased slightly in CS2. Experiences of bullying by the public, patients and relatives have been consistently higher in CS2 than all Trusts over the five years (Appendix XII). This may

be a reflection on the high levels of violence and bullying reported in mental health hospitals (Spector, Zhou and Che, 2014), which has been a concern in the NHS for many years (Bond and Brimblecombe, 2003; Dhumad, Wijeratne and Treasaden, 2007).

Levels of bullying in the NHS and the cases remain relatively high and both Trusts took a new approach to tackle the issue in 2019. A priority for 2019/20 in CS1 included "*a new approach to diversity and inclusion and tackling bullying and harassment" (BP 44, p. 7).* Bullying and harassment was an on-going concern in CS2 and addressed in 2019/20 through a *"revised health and well-being plan aimed to reduce bullying and harassment from any source'"*(BP 85, p. 37). These evidence a rapid response to staff survey feedback.

Positive relationships between managers and staff have been shown to benefit employee well-being (Van Bogaert *et al*., 2012; Guest, 2017). The NHS Staff Survey results show a consistent annual increase in staff perceiving the interest their manager and their organisation have taken in their health and well-being. The overall improvement in both cases is higher than the recorded national increase (Appendix XIII). As reported by a participant: *"People's well-being is really important. It's a **real** priority. I think it's become even more so over the last couple of years" (ID 11: CS2).* In CS1 a well-being manager with a psychology background had been employed to take forward their agenda. It was reported that: *"He's done great things, all sorts of programmes. We have six hundred managers going through them. All sorts of interventions, guides, signposting people to all sorts of help, professional, clinical and so on" (ID 1: CS1).* A continued focus on well-being was evident in both Trusts, as noted by *in vivo* references to *'well-being'* by twenty-three participants.

In seeking to understand the meaning ascribed to the concepts of personal and organisational resilience in the case Trusts, the researcher asked direct questions of the participants (Appendix II; Appendix III). The term 'resilience' was frequently raised in connection with a focus on staff well-being in their Trust. Some participants linked this to personal resilience, in keeping with some authors as previously noted in Section 3.4.2.3 (Wright and Cropanzano, 2004; Holmberg, Larsson and Bäckström, 2016): *"I think it's (resilience) about staff well-being and staff feeling valued" (ID 29: CS1).* In CS2 a participant observed: *"I think that a lot is talked about the resilience of staff, and I think that we talk about well-being and we talk about how we're making sure that people are looking after themselves" (ID 18: CS2).*

Both Trusts have had staff training programmes related to building personal

resilience for many years, evidencing the theme 'Resilience-Building Programmes'. A programme was established in 2015 in CS1 (AR 11, p. 60), incorporating a series of "*resilience building modules*" (BP 2, p. 121). Training programmes "*designed to build resilience*" (AR 16, p. 59) and help staff deal with stress and develop active listening skills were started during 2014 in CS2. These initiatives were linked to the organisations' health and well-being programmes, thus it is understandable why the topics of resilience and well-being were frequently connected by participants during interviews. Other participants commented on an ability to utilise internal resources and skills such as *"the ability to be **steely …** internally **steely** about what you're doing: it's like a core strength" (ID 16: CS2),* emphasising some positive behaviours of personal resilience (Luthans, Vogelgesang and Lester, 2006; Kossek and Perrigino, 2016).

It was noted in Section 3.4.1 a lack of consensus in the literature on the definition of organisational resilience (Coutu, 2002; Kantur and İşeri-Say, 2012; Chen, Xie and Liu, 2021). Participants had diverse definitions, which can be grouped into three broad areas: people's resilience, the individual Trust and the wider system. Participants acknowledged all, one or two of these as aspects contributing to the organisation's resilience. Aligning with some authors (Coutu, 2002; Ruiz-Martin, López-Paredes and Wainer, 2018), some participants stated the resilience of an organisation is determined by the resilience of its workforce:

> *"A resilient organisation is one that knows its business, that has a very good well-being strategy for all of its staff, that is forgiving when things go wrong, but is there for you, alongside you. […] A resilient organisation enables teams to stand up on their own … that allows development of its staff, that feels confident, that feels that they've developed people who, when new people come in, can go through that cycle, and tolerate disharmony, tolerate difference" (ID 25: CS2).*

An alternative view was that of the organisation operating as a successful unit *"that can demonstrate it uses its resources appropriately and efficiently and effectively; they're both important. And also, one that is able to hear the hard things it has to hear when things don't go well, and maintain a sense of moving forward" (ID 34: CS2).* Also: *"A resilient organisation is one that can fundamentally focus on its core purpose of really delivering safe, good care every day. And that means an understanding of the risks to be able to do that and an openness to what can and can't be addressed, and how we do have*

to do something to work around those risks" (ID 35: CS1). The latter participant continued that the resilience of the organisation also comes from the individual resilience of those who work in it and who feel a strong connection to it, which resonates with the assertions of Kantur and Işeri-Say (2012).

The third perspective of organisational resilience was that of acknowledging being in a wider system and contributing to that system. This is described by Linnenlueke (2017) as an organisation's perspective and response to the external environment, as was articulated by a participant: *"I think one of the things that makes for resilience is a desire and a commitment to collaboration, both internally and within the local health system, because if you're serious about collaboration,* ***really*** *serious about it, it means having a genuine curiosity of other perspectives, a commitment to on-going dialogue, a willingness to compromise, and that ultimately makes you more resilient as an organisation" (ID 22: CS2).*

The Trusts' sense of responsibility and contribution to resilience of their whole system is evidenced in papers presented at most Board meetings and in their ARs. The most recent AR in CS1 reported: *"As one of the largest organisations in (location), we have a significant role to play to help protect the environment. We have developed a sustainable development strategy which sets out how we intend to manage and reduce our environmental impact, improve efficiency and resilience and control the cost of delivering our services" (AR 15: CS1).* A previous AR in CS1 had made references to developing whole system resilience of emergency services with local partners (AR 10, p. 18) and preparing for sustainability of services during the winter pressures (AR 10, p. 30) that are experienced in the NHS (Fisher and Dorning, 2016; Scobie, 2018).

Contributing to whole system resilience was evidenced in CS2, reporting on their work with local partners on developing a new model of service delivery "*to improve demand and capacity and strengthen resilience within the whole system" (BP 51, p. 104).* More recently they reported engagement with partners, working "*to ensure that system-wide issues are addressed" (BP 60, p. 109).* Both organisations produce an Emergency Preparedness Resilience and Response Annual Report which is scrutinised by their Audit Committee (BP 38; BP 48).

It is evident that both Trusts actively prepare for and monitor organisational resilience through the lenses of staff resilience, organisation processes and the whole system in which they operate. Assurance of organisation systems and processes was

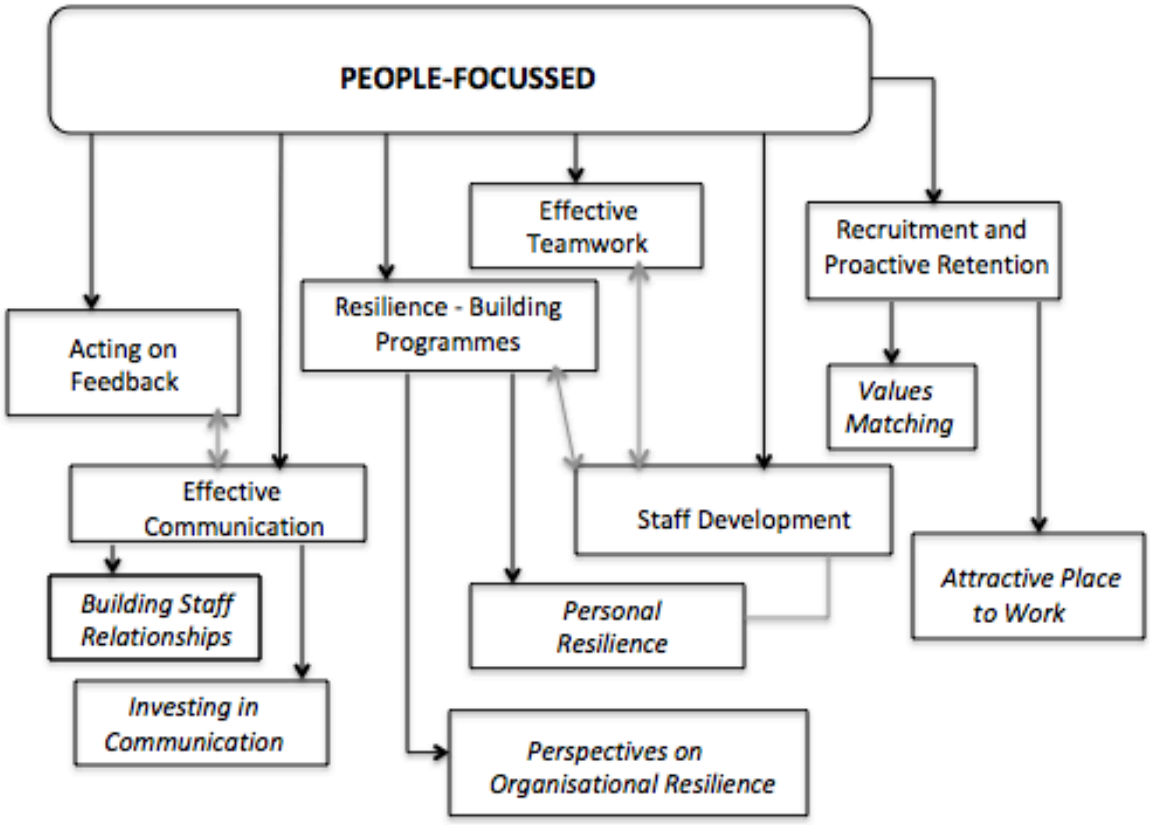
identified as a sub-theme of rigorous governance and will be further evidenced in Section 6.3.4. This focus on organisational resilience and sustainability is arguably further evidence of responsible leadership and will be discussed in Chapter 7.

One of the main pillars of the 2020-2025 organisational strategy for CS2 is a focus on their staff (AR 21, p. 14), underscoring the on-going centrality of people-focussed behaviour for the Trust. Many staff had been consulted during its development and the new strategy resonated with Trust employees. One participant expressed their strong support by stating: "*People is what we do. We're out there all the time in the community, working with providers, up-skilling them. […] So I think the Trust is about looking after our staff, so that they're able to be as good as they can be, in terms of care, […] keeping our staff safe, supported, understood, […] and staff feeling you genuinely listen" (ID 31: CS2).*

In the introductory remarks in the latest AR, there was a clear statement from the CEO of CS1 that staff were valued and remained an important focus for their Trust. The message underlined that supporting staff well-being and stamping out discrimination, bullying and harassment remained a top priority. With reference to the challenges placed on staff through the COVID-19 pandemic, the CEO stated: "*I want to commend them for their resilience, their bravery and their professionalism at all times. […] Our staff are very special people, doing an exceptional job to provide the best possible care for those who need our services" (AR 16, p. 9).*

Thus, the evidence for leaders being people-focussed has been presented through a variety of datasets following analysis of interview data. The relationships of the themes and sub-themes relating to this strategic behaviour are presented in a thematic map below (Figure 5). The close lateral relationship between the themes 'Acting on Feedback' and 'Effective Communication' is identified on the map, depicted by the bi-directional arrow. 'Effective Communication' is hierarchically related to the sub-themes *'Building Staff Relationships'* and *'Investing in Communication',* both identified from the data as important aspects of developing communication in the Trusts. The thematic map illustrates that the themes 'Recruitment and Proactive Retention' and 'Staff Development' were also a focus for the leaders, the latter of which was laterally related to the theme 'Effective Teamwork'. This strategic behaviour is discussed in relation to other strategic behaviours in Section 6.5. The findings are discussed in Chapter 7.

Figure 5: Thematic Map for Overarching Theme People-Focussed



TYPEFACE KEY: OVERARCHING THEME; Theme; *Sub-theme*

LEGEND: Single arrow represents direction of hierarchical thematic relationship

Bi-directional arrow indicates a close lateral relationship between themes

Single line represents a tentative relationship between sub-themes of different themes

OVERARCHING THEME = STRATEGIC LEADERSHIP BEHAVIOUR

6.3.4 Strategic Leadership Behaviour IV: Rigorous Governance

Governance reforms in the NHS have been influenced by successive government demands for greater accountability. As reported in Section 2.4, the statutory areas of governance for an NHS Trust are quality, safety, finance and risk (Brennan and Flynn, 2013; Monitor, 2014) and they are required to demonstrate effective risk management processes (Ramsay *et al.*, 2013). Leaders of both Trusts took a robust approach to ensuring compliance in all areas of governance as they sought to improve performance. This is evidenced through the themes identified during data analysis of 'Delivering Strategic Priorities', 'Robust Risk Management' and 'Effective Response to Regulatory Feedback'.

Maintaining rigorous oversight of the systems and processes that assure leaders of appropriate management of risks, quality and safety has been identified as a leader behaviour affecting organisational resilience (Table 13, p. 79) and was a strategic priority in both Trusts. Several participants made *in vivo* references to '*getting the basics right',* which was also stated in the AR in CS2 following the underperformance rating from the CQC inspection in 2015. The CEO wrote that the Trust needed to get better at '*getting the basics right*, *including issues of staff training and learning from incidents' (AR 16, p. 7).* This focus was evident in the Trusts.

One participant in CS1 described the regulatory standards as being "*in the business as usual space. […] The CQC standards are basic, minimum standards of quality and safety and that's how we would communicate them in the organisation. After all, Good is not a mark of fantastic-ness! This is the basics, getting the basics right. What we want to do is go above and beyond that, […] but, I always say to my team […] you have* ***got*** *to keep those basics right" (ID 6: CS1).*

Another participant in CS1 recalled the strategic priorities to address the Trust's shortcomings in 2015. She remarked how the first CQC report was accepted in her Division as a fair reflection: staff acknowledged the areas they needed to improve and evidence their activities. They required better processes to capture data and show how they were learning, and focussed on "*Datix (risk management system) […] and Quality (Committee) meetings" (ID 28: CS1).* Addressing the issues identified by the CQC in this way evidences the themes of 'Delivering Strategic Priorities' and 'Effective Response to Regulatory Feedback'.

Having a belief that one can influence effectively one's surroundings and circumstantial outcomes, and a conviction that one can learn from positive and negative events, helps to develop resilience (Bonanno, 2004). Resilience was demonstrated in both Trusts following the first comprehensive inspection by addressing the issues identified by the CQC, learning from regulatory feedback and ensuring they influenced behaviour and future outcome. It was acknowledged in CS1 that *"they were things that we'd known about, anticipated and should have made sure that all those bases were covered and* ***are*** *covered on an on-going basis, and we let ourselves down in the inspection, and we didn't make that mistake twice in terms of 2017" (ID 10: CS1).*

A similar attention to feedback was reported in CS2*:*

"So one of the key things now, and I've touched on it several times, is consistently

having the basics in play, because when you read the (CQC) report, […] what you can see in practice are small things that actually, when you aggregate them up, can cause you issues and regulatory breaches, so I'm making sure that we're checking the basics and we're doing that routinely" (ID 5: CS2).

Resilience can be developed through acceptance of a situation and responding positively to it (Hanson, 2018). Tugade and Frederickson (2004) suggest that resilience is built by thinking positively when confronting challenge. Another participant in CS1, who had initially felt overwhelmed by the inspection process, evidenced personal resilience. Following a period of reflection she adjusted her thinking and became more positive about its potential to improve standards. She reported:

"When the CQC first came around and we were being assessed, it all felt very unwieldy. […] You just kind of thought: oh my God, how are we going to get all this into … ? […] And how do we do it? And there was an element of fear when we first thought we were getting assessed by CQC. But then, once you really understood the domains and what it was that the CQC were checking, I think very quickly we all felt: actually, this is not unreasonable. It is not anything we wouldn't want for ourselves, or our relatives, or our patients. So therefore, let's not see it as being a threat that the CQC are coming: let's see this as work in progress and, if we're not doing it, let's not hide the fact that we're not doing it, but let's think about what we can do to make it better, to achieve the standard" (ID28: CS1).

As was discussed in Section 3.4.2.3, resilient employees cope with reality and create solutions that contribute to organisational survival (Coutu, 2002) and enhance organisational resilience (Mallak, 1998b; Ruiz-Martin, López-Paredes and Wainer, 2018). Resilient leaders demonstrate a capacity to respond positively and address challenge whilst acting under pressure (King, Newman and Luthans, 2016). Critical to their resiliency is an ability to learn from failure and see it as a learning opportunity (Holmberg, Larsson and Bäckström, 2016). Leader behaviours of positivity, being focussed and proactive are characteristics of the resilient leader (Wilson, 2013) and were evident in the case study Trusts as these quotations above illustrate.

A more controlled data-driven approach to monitoring and process assurance was initially taken in CS2 after their first underperforming CQC report in 2015. A number of systems and processes were introduced to monitor and assure quality. It was noted in the

first reviewed AR that a new data quality team would "*work on cleaning poorly recorded data as well as delivering the data quality message to all services across the Trust".* They also ensured processes were established *"to reduce the amount of errors being made in the new clinical information system"* (AR 16, p. 90). The current CEO was appointed in 2017 and altered the direction, focussing on culture and people as evidenced in Sections 6.3.2 and 6.3.3. There was also evidence of the strong leadership example of the CEO reported in Section 6.3.1. One participant who was not a Board member at the time recalled from his perspective:

> *"It seemed like the way we were going to get through this is to get more data, to get more control, to get more assurance. […] So it became reporting and people having to report upwards and it was a flurry of assurance and data. […] And then there was some changes in leadership […] and I think that from the outset, with (current CEO) leading, there was that strong kind of focus on culture, on people, on openness, transparency, on a kind of respect that everyone counts, let's bring people with us. And those messages were just played and replayed, and people get on board with that; people link and connect with those sorts of messages which are values-based" (ID 27: CS2).*

According to many participants (n=24), a key approach to building organisational resilience in both cases was a stringent approach to risk management. It was stated that *"one of the big things in the organisation over the last five years has been the focus on understanding risk, and responding using risk to drive the business of the organisation" (ID 10: CS1).* Some participants thought leaders were too risk-averse, impacting the speed of decision-making and taking action, which caused frustration. In both organisations this was explained as a result of previous negative reputational publicity and they were being cautious to ensure that avoidable errors were not made. Both Trusts review two detailed BPs at each meeting, one from the statutory Quality Committee and the other, a quality performance report.

Participant ID 1 thought that governance in CS1 was *"extreme"* and stated his experience of the private sector had been less intense. He described the Trust as having a strong safety culture and functioned through a risk management mechanism. This is core to how they are governed, which "*suits quality very well because, at the end of the day, you're looking at the outcomes of quality, particularly of patient care. And, if you make a mistake you dive into that detail and you rectify things and you don't judge" (ID 1: CS1).*

He stated they were a very open and honest organisation with good reporting, responses and action plans. His comments suggest a no-blame culture exists in the Trust, also reported by other participants and a sub-theme of a values-led culture (Appendix XV).

There were opposing views on the impact of both Trusts' approach to managing risk. In CS2 the risk management system was reported by ID 12 to be sophisticated and very effective in monitoring and managing key risks. However, the intensity of monitoring was thought to provoke anxiety. It was also observed in CS1 that having a more risk-averse culture can be disabling for staff because *"it can sometimes drive decision-making upwards and make people feel you've got to seek permission all the time, rather than have a sense of control. And that can be quite comfortable for people sometimes, as well as disempowering" (ID 35: CS1).*

Trying new approaches to health care service delivery has inherent risks (Fenn and Egan, 2012; Simsekier *et al.,* 2015) and there was acknowledgement in both organisations they *"need clinicians to be exercising their expert judgement and* ***taking risks,*** *and feel able to make these decisions with the organisation's backing" (ID 22: CS2).* This was seen as a culture change in CS2, where they are *"talking about just culture, so we look at how we take responsibility as a system and not just as individuals" (ID 23: CS2),* and echoes the non-judgemental attitude cited by ID 1 (CS1) above. Similarly, it was viewed as a required culture change in CS1: a participant felt at times that the organisation was "*over-governing*" and "*needed to understand risk and then you can accept it, you can do something about it or we'd need to take immediate action" (ID 35: CS1).* These attitudes link with the previously evidenced themes of responsible leadership and values-led culture, reported in Sections 6.3.1 and 6.3.2.

Foundation Trusts are required to publish a governance statement in their AR (Monitor, 2014) that includes an externally audited Quality Account on patient safety, patient experience and clinical effectiveness for all service users. Feedback on the year's performance against quality objectives and identifying those set for the following financial year are detailed in the report. Processes for monitoring in-year quality performance in CS1 were set out in detail and involved staff reporting into various groups relevant to the objectives. These include the Trust's transformation Board, patient experience group, clinical quality group and the Quality and Outcomes Committee of the Board. Organisational risks are monitored by the Board through the Board Assurance Framework (AR 9, p. 147), demonstrating a variety of governance routes and mechanisms

for assuring clinical quality, safety and patient experience.

In CS2 various groups monitor quality and patient experience and report regularly to the Board including a clinical quality Board, strategic governance groups, the Trust Quality Committee and patient safety peer groups; risks to quality were reported to the Board through the Board Assurance Framework. Monitoring patient experience through various mechanisms was frequently mentioned in Board reports, which may be a reflection on the mental health specialism of the Trust where it is increasingly recognised as an important factor for clinical excellence in the NHS (Gilburt, Rose and Slade, 2008; McAndrew *et al.,* 2014). A participant commented to the researcher that the Trust has *"got an internal assurance process where we have quality and safety reviews, and on the Quality and Safety Review team we have people with lived experience, governors, directors, who go on them. We have a whole programme of those: our services go through them all the time" (ID 4: CS2).*

The Clinical Quality Group in CS1 meets bi-monthly and provides oversight to the Board Quality and Outcomes Committee of serious incident (SI) reviews, regulatory compliance, patient safety, clinical audit, the medicines advisory group, clinical risk, relevant policies and the Trust quality strategy. The researcher attended a meeting of this group (Section 4.4.4) during which she recorded observations (Appendix VIII) and noted rigorous attention to quality and safety during the meeting. It was a lengthy meeting (2.5 hours) with a packed agenda, chaired by the Chief Nurse. The researcher later recorded in her field notes that anything reported such as low-risk falls or near misses were scrutinised for anything that can be learned across the organisation. The focus on organisational learning is further evidenced in Section 6.3.5.

Various personnel presented a paper to the group and members were previously briefed in writing on the paper. Due process was uncompromised: if the briefing sheet was inadequate or not provided the paper was deferred for presentation at the following meeting, ensuring the agenda ran efficiently and all details were reviewed and discussed. This was reported by some participants to be an example of risk aversion and a source of frustration due to delay. The researcher reflected that this extreme attention to detail ensured there were no loose ends and the group maintained a high level of scrutiny. The CQC had previously reported similar observations: *"The clinical quality group, chaired by the chief nurse, provided scrutiny and ensured proper closure of incident actions and learning" (CQCSR 2, p. 13).* These are evidence of the theme 'Robust Risk Management'.

The researcher dialled in by telephone to a rescheduled Trust Quality Committee meeting of CS2, which was conducted online due to COVID-19 restrictions (Section 4.7.2). This was a three-hour meeting, chaired by a NED and usually held bi-monthly. Prior to the meeting she was sent relevant papers by email. The impact of the pandemic and management of identified risks to patients and staff were discussed; feedback to the committee on senior staff preparations for dealing with future scenarios that were "*at this stage academic*" (ID 5: CS2) demonstrated the Trust's readiness to adapt to unknown risks, a feature of organisational resilience (Boin and van Eeten, 2013; Weick and Sutcliffe, 2015). The agenda included SI reviews and sharing learning from them, feedback on Quality and Safety Reviews, regulatory compliance, oversight of the Board Assurance Framework, excellence and complaints reporting, medication incidents, monitoring of the quality strategy and partnership working.

The researcher recorded observations during the meeting (Appendix VIII) and noted that all committee members sought assurance on all subjects presented and were diligent with detail. Following the meeting she reflected on how the committee was keen to ensure good governance oversight and wanted to be assured that due process was being carried out. She also perceived it was a protracted meeting, possibly due to it being held virtually, and that sitting around a table may facilitate shorter proceedings. It was possibly a longer meeting due to its postponement, plus the additional agenda items of scenario planning for future COVID-19 risks. Therefore, the representativeness of the observed meeting is questionable. However, the general style of inclusivity was probably usual.

The CQC stated in its latest report for CS2 that *"improvements were needed to ensure that the premises and equipment continued to be safe across the acute wards for adults of working age and psychiatric intensive care units. Medicines and clinic room management needed to be improved across some core services to ensure that medicines and medical equipment was safely monitored for use" (CQCSR 6, p. 4)*. The latter comments provide evidence of the need for stricter risk management processes in some areas in CS2, which might account for the researcher's perception that proceedings were protracted at the Quality Committee meeting. It would be appropriate in light of the CQC comments that greater assurance should be sought and provides further evidence for the theme 'Effective Response to Regulatory Feedback'.

Discussed in Section 2.6.1, the NHS has been accused of making decisions based

on finances rather than patient need (Francis, 2013). It was reported that both Trusts managed their financial duties with a patient centred approach. Participants stated the Trusts aimed to ensure that patient safety and quality were not compromised when making financial resource decisions. One participant spoke of potentially difficult conversations with EDs regarding finances and safe staffing levels. He stated a clear emphasis that patient safety and quality should not be compromised over a challenge for greater efficiency: "*It's (the message is) delivered here consistently and that quality - patient safety thread goes through the organisation" (ID 20: CS1).*

The most recent audited Annual Accounts for both organisations (AR 15; AR 21) show a positive financial position, whilst acknowledging the ever-increasing demands on budgets and the challenging financial and operational environments (Gainsbury, 2017; Robertson *et al*., 2017; Chowdhury, 2020; Lancet, 2020). Complementary notes to the accounts demonstrate leaders acknowledgement of responsibility to their Trust's organisational resilience and sustainability. For example, the report in CS1 stated: *"In light of the COVID-19 pandemic the Trust undertook a further detailed financial assessment considering the impact of changes to the financial regime for NHS Trusts and applying sensitivity analysis. This provided assurance that the Trust's cash flow was sufficient to support its services for the 12 months from the date of signing of these accounts. […] The Trust has adequate resources to continue in operational existence for the foreseeable future" (AR 15, p. 108).* However, the 'foreseeable' timeframe was not quantified.

A year-end surplus was reported in CS2 and additional assurances were also sought and reported: *"The Board of Directors performs an integral role in maintaining the system of internal control, supported by the work of its committees, internal and external audit and its regulators. […] Over the last five years we have made considerable savings against the Service Improvement Plans, demonstrating sustainability and improvements in economy and efficiency" (AR 21, p. 106).* Accountability for financial resources and organisational sustainability is clear, demonstrating responsible leadership within the Trusts.

The researcher sought to understand the emotional impact that the CQC had on Trust staff following the first comprehensive inspection that resulted in them rated as underperforming. Various reactions were reported and several participants from both Trusts expressed disappointment in their rating but stated it was a just outcome and not unexpected, as illustrated by the following quote:

*"There was disappointment, there was definitely disappointment. But I think people, actually looking around, thought it was probably fair and reasonable. I think there has always been a sense of the **caring** has always been really good, and the one-to-one interactions have always been really good. But our processes and our systems are very laborious, and then we've got all the environmental issues. And I think that's the focus people took: that it wasn't necessarily that our patient contact was the issue; it was everything else that was the issue. And it was the ways of working and sometimes it was the lack of the right environment, or the lack of tools. So I don't think people actually thought it was the **actual care** we delivered" (ID 33: CS1).*

The participant's (ID 33) comment above suggests that they had reflected and justified the CQC rating with a positive explanation. Jackson, Firtko and Edenborough (2007) argue that reflection and positivity are strategies that develop protective factors for resilience. This was also a resilience factor evidenced by a number of participants (n=6) who spoke of a disconnection between their own service and the entire Trust: they felt the Trust rating was not attributable to them, as summed up by one participant: *"We saw ourselves as a different kind of part of everything else because we're a discrete specialist service and we felt **we're doing grand**" (ID 27: CS2).*

A disparity of CQC ratings between services within the organisation also affected how staff felt about the overall Trust rating, as reported by a participant in CS2:

"I think some teams were really disappointed and I think the challenge in the Community rather than In-Patients was that they didn't get (RI/I); they were rated as (G/O) in a lot of those areas, so there was a different level. So it was disappointing that overall there was an (RI/I) rating. But, actually, some of the Community Teams were rated as (G/O) with (G/O) for Caring. So for those teams, I think there was a lot of disappointment: the fact that they had worked really, really hard and were functioning in the best way they could with the pressures, but actually the Trust still got (RI/I)" (ID 14: CS2).

There were references in CS1 to staff feeling *"irritated, frustrated, cross with themselves, some of those said it was own goals" (ID 6: CS1)* and that they had shot themselves *"in the foot in a number of places with just not getting some*

of the basics right, regarding things that they'd known about, anticipated and should have made sure that all those bases were covered" (ID 10: CS1). A similar sentiment was expressed in CS2*:*

> *"I think probably the more optimistic people in the Trust were disappointed. I think the more realistic people felt that was probably true. I wasn't surprised. I think we were caught out […] we were caught out, particularly around RT (Rapid Tranquilisation) and stuff on wards, which was one of the big things and it wasn't just the only thing, but it was one of the biggest things. And I think the Trust was completely caught out by that" (ID 13: CS2).*

Another participant noted: *It wasn't that we didn't know what we should be doing; it wasn't like we were suddenly introducing new things. It was just, we know we should be doing it, so we should be doing it all the time" (ID 37: CS2).*

The impact of historic events in the Trusts appeared to have a bearing on some staff. This was expressed as an acceptance of the rating due to low expectations: *"It felt normal. We weren't a successful Trust: we didn't have success. And if we did, it was in pockets and we didn't celebrate it. […] I think we were already battle-weary then, and it was just like: 'Well, that was expected!' " (ID 29: CS1).* Following the first CQC report the same participant described:

> *"[A] move to more obvious transformational leadership, the development and investment in the transformation team, and also a decentralisation of managing the Trust. The Divisions became much more autonomous and self-sufficient. [...] One clear advantage was that services did not feel done to, and took responsibility for decisions and workforce planning, etc." (ID 29: CS1).*

Distributed leadership and promoting empowerment were leader behaviours noted in Section 3.5 that enable recovery and growth and enhance organisational resilience. Building personal resilience appears to have been enabled in CS1 by collective leadership, staff taking control and being involved in decision-making (Luthans *et al.,* 2006), which then enhanced the organisation's resilience.

A similar acceptance was reported in CS2, with one interviewee stating: *"It felt to me like what we were expecting. That's how it felt, it felt like we deserved, I think. I would say, if we were giving a very honest answer, that's what we'd have expected it to be" (ID 26: CS2).* He went on to state that there was a change of Chief Nurse following the first CQC inspection and:

> *"She really, really focussed our minds. […] You just need to be constantly prepared and it needs to be about the way that you provide care. […] So there is certainly a big change to our approach. […] So, kind of understanding how do you manage that process of improvement, identifying what's going wrong; and the shared ownership across, so it's not just the responsibility of one person. […] Certainly, the assurance and making sure that things are going through the right reporting mechanisms, that's really changed" (ID 26: CS2).*

This participant has identified leader behaviours of leading organisational change, preparedness and attention to organisational processes (Section 3.5) as factors that affected organisational resilience in CS2 following their first CQC inspection.

Some participants commented that their underperformance rating was a catalyst for change and improvement. It was also reported that personal resilience was required to deliver improvement and influence change, as indicated by the following comment:

> *"(M)oving from (RI/I) to (G/O) and showing resilience through that, it is really hard, really hard work and really difficult. I think, probably one of the things that has helped was being really clear about what is it we're going to target to improve and why.[…] So being able to link in the areas where we were (RI/I) to: 'Actually, this will improve clinical quality and outcomes for families', I think was a different type of conversation […]. So it's changing that narrative, which yeah, it's really hard work; it's* ***really*** *hard work" (ID 24: CS2).*

Of the twenty-nine participants working in the Trusts at the time of the first CQC comprehensive inspection, only one participant stated a sense of unfairness with the Trust rating. Describing the shock she experienced, she said that she *"felt it was the wrong decision. I remember vividly because our Division definitely got (RI/I) and I thought: 'God, we are* ***better*** *than that'! I really felt that was an unfair measurement of our performance" (ID 28: CS1).* She also recalled that the negative rating was a call to action:

> *"But in **many** other ways, I do remember in myself thinking: right, that's going to change. And it made us **more** determined and more resilient in terms of looking at … really breaking down what the elements were and what is our process in our Division, but not doing it as a one-man band. We also realised that we had to very much get the wards engaged, because we weren't the ones … yes, we might have been questioned, but it was definitely: if the weakest member of the team hasn't got it, then it's not happening! So, yes, I did feel it was **unfair**, but it was what they found. So yeah, it made us more determined, definitely" (ID 28: CS1).*

These quotations report a variety of responses by participants to the first CQC comprehensive inspection including disbelief, inevitability and disappointment. The leaders also accepted the decision and took positive action collectively, demonstrating leadership and personal resilience in response to a challenging situation (Matheson *et al*., 2016).

The level of the participant's seniority in the organisation at the time of the first inspection made a difference to their recall of the event: this was discussed in Section 4.4.3.2. It also made a difference to the impact on the participant, as indicated by the following comment: *"(I felt) pretty bad. I was just going into a Ward Manager role and I don't think it would have had the same level of impact as it would now. If that happened today I'd be very upset about that" (ID 11: CS2).* In questioning the participant why she thought she would feel different, she offered the insight that she had experienced a change in the responsibility she feels towards the well-being of her colleagues as she has gained seniority:

> *"Because of my role and a greater understanding of what that means. I think my main thinking really back then would have been coming to work, delivering day to day care and going home again, doing as best as I could and then going home. As you progress in your career you have, I've had, a very different way of looking at things - the bigger picture, and a greater understanding of what that might mean for people that use the service potentially, and those that are using it right now; on staff morale: how it feels, whereas I don't think I really understood it in the same way. I'm looking at it through a different lens, whereas I think a lot of the staff that*

I'm responsible for come to work just to do their job, and they do it very well, and go home again" (ID 11: CS2).

This participant's reflection suggests that a greater responsibility for organisational performance may be felt at senior levels of the organisation and underlines the importance of active leadership in delivering organisational change, sustained improvement and organisational resilience as noted in Section 3.5.

There was a view that a poor CQC rating had an impact on organisational reputation and, therefore, influenced organisational objectives, as this participant articulated: *"The CQC does have a huge bearing on reputation and how you're viewed within your local system, how you're viewed nationally. So, there's undoubtedly a significant impact" (ID 22: CS2).* This was consistent with the need for Trusts to manage reputational risk and it was recognised that a firm handle on risk management would contribute to the organisation's reputational success and positive perception by external regulators. As stated by one participant, *"in common with every NHS organisation in the land, there's always reputation risk and you always have to be mindful of the regulator's view of your organisation" (ID 22: CS2).*

Participants spoke of considerable scrutiny by regulators following the first CQC comprehensive inspection, including *"a lot of assurance meetings about what's going on with improvement" (ID 11: CS2).* This was echoed in CS1, where there was a history of scrutiny by regulators over a number of years, as commented on by the CQC: *"There was a sense within the Trust that it had been under exceptionally high levels of external scrutiny for a number of years; this was evident among some of the executive team" (CQCSR 1, p. 16).* These findings are consistent with the assertions of authors (Berwick, 2013; Keogh, 2013) reviewed in Section 2.3.4.

As reported in CS1, they now have *"a very light touch from NHSI. […] [T]hey just don't bother us, they leave us alone. And I think that gives you resilience because you can get on with some of the transformation stuff and you can be in charge of your own destiny. And you can stop; you can take your foot off the pedal and think: 'Right, how do we take it to the next level?' " (ID 6: CS1).* However, this "light touch" came only after the second inspection of being a performing organisation: i.e. both organisations continued to have strict regulatory oversight after their first CQC rating of acceptable performance (*Good/Outstanding).* This suggests the CQC could have a more nuanced approach to regulatory oversight of performing organisations, which is discussed in Section 7.6.

The CEO in CS2 also referred to the burden of regulatory monitoring as a real driver for getting out of the underperformance space. A CQC comprehensive inspection notice was served to CS2 shortly after the CEO was appointed and they made clear to their executive team the goal was to improve on their previous grading in order to avoid having excessive scrutiny and their credibility questioned. They commented that this would then enable the Trust to find capacity to make the developments important to them. Several participants agreed that moving into a CQC performance grading had enabled the Trusts to take a more strategic view and plan for improvement, important for organisational resilience and sustainability (Boin and van Eeten, 2013). This implies that stringent oversight impedes organisational resilience as the focus is on getting the organisation up to a standard, which can limit strategic thinking and action. This was noted by Marsden and colleagues (2020) and is discussed in Chapter 7.

The CQC asserts it promotes organisational resilience, evidenced when an organisation improves its inspection grading (CQC, 2018a). This is consistent with the definition that organisational resilience is demonstrated through responding to challenge and emerging stronger (Vogus and Sutcliffe, 2007; Bhamra, Dani and Burnard, 2011; Boin and van Eeten, 2013), as discussed in Section 3.4.2.3. The researcher sought to understand the participants' perspectives on CQC regulation and its impact on organisational objectives and resilience (Appendix II; Appendix III). There was consistent agreement amongst participants that the regulatory process was most impactful when the organisation was underperforming, partly due to the very close examination by various regulators the Trust then receives. It was noticeable that a more corporate feel was reported in both Trusts since their first inspection, a reflection on the values-led culture change that had been implemented.

A participant in CS2 thought the CQC comprehensive inspection process undermined the resilience of an organisation due to it being too onerous, stressful and a lengthy process that takes about six months if all runs smoothly. He was more in favour of the unannounced visits undertaken in mental health Trusts, whereby feedback is given on the day and reported on fairly quickly. He did acknowledge the CQC had been a catalyst for change but thought *"the speed of improvement was a result of leadership and the quality of leadership in the organisation rather than close oversight of regulators and the regulatory standards" (ID 4: CS2).* It is suggested that a regulatory process that produces a heavy burden on an already overstretched service, and particularly in a performing

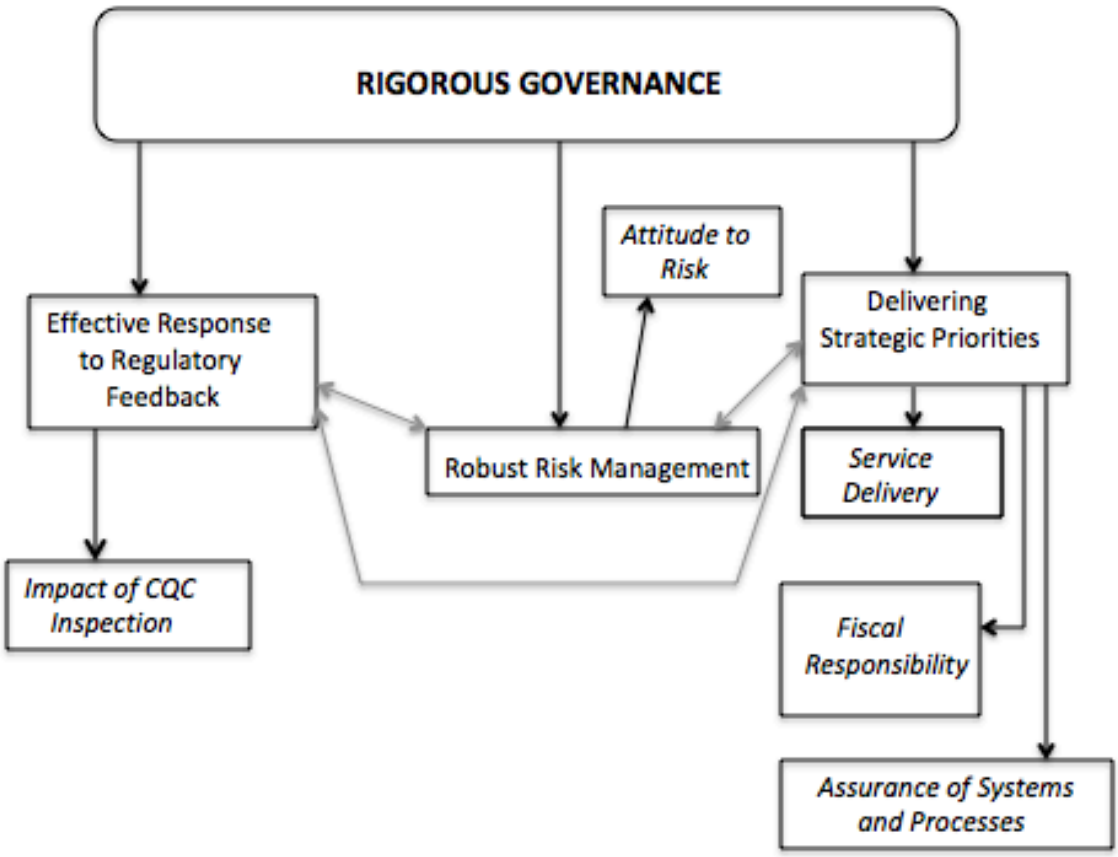
organisation, should be re-examined and this is discussed in Section 7.6.

The attention paid by the Trusts to assurance, governance and resilience was recently acknowledged by the CQC, as evidenced in the latest comprehensive inspection reports. In CS1 it reported: *"There was a clear interconnected vision and strategy for the Trust which recognised quality alongside sustainability. There were structures, processes and systems of accountability to operate a governance system designed to monitor the service and provide assurance. There was an effective and productive governance team at the trust with comprehensive roles and responsibilities. There were good arrangements to ensure the trust executive team discharged their specific powers and duties" (CQCSR 3, p. 4).*

Regarding CS2 the CQC noted: *"The trust had clear structures for overseeing performance, quality and risk to enable oversight of what was happening across the trust, themes and potential issues. The trust was proactively engaged in working with others and were key partners in the local sustainability and transformation plans" (CSQSR 6, p. 14).* These comments confirmed the findings and observations of the researcher, reported in this section. It has been evidenced through participant interviews, BPs, ARs and CQC summary inspection reports that leaders focussed rigorously on governance to enable performance improvement.

The relationships of the themes and sub-themes relating to this strategic behaviour are illustrated in the thematic map below (Figure 6). The close lateral relationship between the three themes 'Robust Risk Management', 'Effective Response to Regulatory Feedback' and 'Delivering Strategic Priorities' are illustrated on the map: risk management was identified strategically as a priority for the Trusts, and is also a requirement of governance that is monitored by NHS external regulators. The sub-theme *'Attitude to Risk'* of the theme 'Robust Risk Management' illustrates how risk is viewed in the Trusts. *'Assurance of Systems and Processes'* is a sub-theme of the theme 'Delivering Strategic Priorities', demonstrating the strategic behaviour of rigorous governance in the Trusts. The relevance of this leadership behaviour is discussed in Chapter 7.

Figure 6: Thematic Map for Overarching Theme Rigorous Governance



TYPEFACE KEY: OVERARCHING THEME; Theme; *Sub-theme*

LEGEND: Single arrow represents direction of hierarchical thematic relationship

Bi-directional arrow indicates a close lateral relationship between themes

OVERARCHING THEME = STRATEGIC LEADERSHIP BEHAVIOUR

6.3.5 Strategic Leadership Behaviour V: Commitment to Learning

According to Argyris (1999), organisational learning is a competence that all organisations should develop in order to better detect and correct errors, change systems and processes as required and understand their limits of innovation. Senge (2006, p. 4) asserts that excelling organisations of the future will be those that "discover how to tap people's commitment and capacity to learn at all levels in an organisation". He identified five components to a learning organisation: personal mastery of one's subject, a mind that is open to challenge, building a shared vision, team learning and systems thinking. Senge states that systems thinking underpins the learning organisation, as people shift their thinking from the individual to a connected whole and understand the impact of their actions on others (Senge, 2006). These components overlap with some components of organisational resilience reported in Table 12, particularly those of effective

communication, capability, shared core values, flexibility, staff support and development. This is discussed further in Chapter 7.

Having a commitment to learning is an enabler of organisational learning (Cho *et al.*, 2013). Schein (2004) also argues developing a learning culture requires people to be committed to acquiring new knowledge: employees must hold a shared belief that learning is a good thing. The key to learning is to get feedback, reflect, absorb the implications and implement change. Schein asserts the task of a leader is to create a culture of a perpetual learning organisation in order for its survival (Schein, 2004). Argote and Miron-Spektor (2011) share this view: they state the ability to learn and adapt is critical to organisational performance and long-term sustainability. In healthcare, enhancing organisational learning can improve quality, clinical and organisational outcomes (Carroll and Edmondson, 2002).

Some authors (Carroll and Edmondson, 2002; Schein, 2004; Välikangas, 2010; Argote and Miron-Spektor, 2011) imply that organisational resilience is affected by an organisation's commitment to learning, aligning with the assertions of scholars (Horne and Orr, 1997; Hopkin, 2014) reviewed in Section 3.4. Developing a learning organisation was a leader behaviour identified in the literature as affecting organisational resilience (Table 13). A commitment to learning and becoming a learning organisation was a strategic behaviour of leaders in the case study Trusts as they sought to change culture, improve safety and performance and so develop organisational resilience. This finding is evidenced through the themes identified during data analysis: 'Lack of Complacency', 'Acting on Feedback' and 'Organisational Learning Imperative'.

As noted in Section 2.6.1, the CQC (2017c; 2018d) asserts that a feature of NHS organisations having attained a *Good* or *Outstanding* CQC grade is their sense of humility and lack of complacency. This view was also shared by a participant in CS2, who stated that CQC *Outstanding* organisations acknowledge they are not outstanding everywhere and can always develop: *"so it's more of a kind of a philosophy and a mindset that they bring and demonstrate … better everyday, always room for improvement" (ID 4: CS2).* Many participants (n=22) in the study referred to a lack of complacency in their current CQC grade, the need to continuously improve and recognition that continuation of their status cannot be taken for granted. This supports the assertion of the CQC (2017c, 2018d) that leaders of *Good* or *Outstanding* Trusts show humility and lack complacency, as reported in Section 2.6.1.

Both Trusts have maintained their improved grading twice in succession, proof they have at least maintained the progress made after being rated a performing organisation. Scrutiny has now significantly reduced, as reported in Section 6.3.4, which suggests that improved standards and processes are perceived by regulators to be more embedded in the organisations. It may also be an indicator that a culture of learning and improvement is evident in the Trusts. A participant in CS1 commented that they work to improve, not maintain their position. He described being "*really disappointed*" with getting a *Goo*d for Caring and had challenged the CQC on this result. The CQC had replied to him that: " '*Good is good'. But no, Good is not good enough! It should really be business as usual" (ID9: CS1),* evidencing a clear indication of a lack of complacency.

Addressing feedback and learning from regulators, other external and internal stakeholders was apparent in both organisations and demonstrates an overlap with the theme 'Effective Response to Regulatory Feedback' discussed in Section 6.3.4. As has been evidenced in Section 6.3.3, considerable attention is paid to staff feedback via the annual NHS Staff Survey (Appendix XVI, Appendix XVII). Additional staff feedback is gathered throughout the year in CS1 via quarterly internal surveys; they also use an electronic app that enables staff mood and concerns to be monitored and addressed in real time and which is also used in CS2. Seeking, listening to and acting on feedback from various stakeholders is further evidenced below and the overlap of this theme with the strategic behaviour 'People-Focussed' is addressed further in Section 6.5.

Participants spoke of the direct electronic access staff have to both CEOs, who may be sent complaints, requests for help, service updates and communication on other matters. The CEOs were reported to respond quickly and supportively to email communication. This was also the experience of the researcher: emails sent from her to the CEOs were always responded to promptly, which was markedly different to her experience in other organisations. Almost all staff throughout both organisations responded promptly to the researcher's emails, demonstrating the mirroring and role modelling of considerate leader behaviour.

There was evidence of managers empowering staff to innovate, identify areas for improvement and implement change. A participant (ID 19) in CS1 described her current support and coaching of two new staff members, acting as their sounding board as they found their feet and identified the changes they wished to make. A participant in CS2 spoke of how leaders had become more enabling than controlling through culture

change. She described how leader behaviour had changed from: *" 'You must do it, you must just get it done', to: 'We've got to really understand it quite quickly. And, if you're saying you need resource we're going to give it to you. We then expect you to perform but, actually, we understand more that some of your ideas are really good and we've got to give you the chance to put those into play and we'll give you the support mechanism to do it' " (ID 14: CS2).*

Participants spoke of how they were introducing new clinical roles, partly in response to a lack of available doctors and nurses. In CS2 they reported having many new roles for graduate mental health practitioners who entered the Trust with a psychology degree and one year of training in mental health. These non-traditional NHS practitioners were questioning patient management practices and taking a lead on reviewing processes, implementing change and improving quality. This is a clear example of strategic thinking for organisational resilience and sustainability, first evidenced as responsible leadership in Section 6.3.1, facilitated by culture change (Section 6.3.2) to a more listening and learning organisation. It is also an example of innovation, a leader behaviour affecting organisational resilience (Table 13).

Seeking feedback from patients and relatives was clearly evident in both organisations. Both Trusts collect feedback regularly and patients provide feedback to the National Patient Survey. Patient experience in CS1 is in the top quartile compared to participating NHS Trusts (AR 15, p. 9). In CS2 they publicise patient feedback and how they have responded on posters that are prominent throughout their buildings. Patient feedback was also sought through open meetings, such as the two stakeholder engagement meetings observed by the researcher (Table 18, p. 106). Board meetings in both Trusts start with a patient story (Lee, Baeza and Fulop, 2018), evidenced in the agenda and minutes of all BPs: a patient is invited to give an account of their experience of care, that includes providing feedback on what went well, not so well and what needs to be improved or changed from their perspective.

Reflecting on her observation of the Board meeting in CS1, the researcher noted how the patient was welcomed by the Board, remained relaxed in an environment that could have been intimidating (Rhodes *et al.,* 2002) and was not hurried, despite going beyond the time allocated on the agenda. The breadth of questions Board members asked of the patient who presented their story and the close attention paid to the answers was also notable. The Board enquired what changes would make a positive

difference to the patient experience and promised to let the patient know in writing which of their ideas were taken forward. The CEO, Chair, some EDs and NEDs took notes and it was observed to be an authentic listening experience. The observed Board meetings in both Trusts were totally patient-focussed; the Board frequently asked any presenter of a paper how patients and relatives were or would be affected by the topic under discussion. The researcher again (Section 6.3.2) reflected on the lack of a patient focus written in the Trust values when it was clearly central to both Trusts; this is discussed in Section 6.4.

'*Learning from feedback*' was a sub-theme of the theme 'Organisational Learning Imperative'. Most participants (n=33) referred to systems, processes and an attitude of learning in their organisation, which permeated down from the top. It was noted in Section 6.3.4 that there are various mechanisms by which data is collected and monitored. It was also evident that there was shared learning from the collected data. For example, in response to an SI in CS2 a participant (ID 12) told the researcher how the Board had reviewed the learning from the directorate to discuss what else they could learn. Another emerging situation that had taken place very recently in another part of the Trust had avoided becoming an SI as a result of the learning from the previous incident. The NHS Staff Survey data also pointed to a commitment to organisational learning: over the years of data analysed, there was an improvement of 8.1% in CS1 and 6.5% in CS2 of people reporting that the Trust took action to ensure an incident was not repeated. This compared to a slight downturn in all Trusts of -0.2%.

Participants described various approaches to shared learning. One spoke of how they would review data, identify learning points and then talk to relevant people across the Trust to embed the learning: "*My colleagues – my peers, the other clinical lead nurses or general managers, we would definitely talk about it […] and ensure the ward managers knew about it" (ID 11: CS2).* A participant in CS1 described their use of external regulators to help them learn and improve practice in the organisation. For example, whether it was learning from incidents, complaints or best practice, the Trust would seek to understand what an upper-quartile organisation would look like in the particular field, seeking information from the CQC to be able to make national comparisons and understand why another organisation had superior outcomes, demonstrating a "*willingness to say we can do better" (ID 10: CS1).*

Sharing best practice was evident in both cases. Both organisations had developed

systems for acknowledging and sharing good practice across their Trust, recognising the importance of celebrating success and learning from positive events (Gryna, 1992). A system for reporting excellence had been developed in CS2 and was accessed via the Trust intranet, to enable sharing of best practice and learning. The initiative was started by a participant (ID 3), who explained how she had wanted to shift the focus away from solely learning from negative incidents after finding *"a fantastic graph that says 3% of what people do in the NHS lead to negative incidents. **3%**! What about the 97% when people are doing things well?" (ID 3: CS2).* She observed there was nowhere to record positive improvements to patient outcomes following innovation other than the individual patient record. Having recognised that an accessible record of positive incidents could enable shared learning and dissemination of best practice ID 3 designed a bespoke system. The aim was to create a database of excellence in the Trust. The Quality department in CS2 produce monthly Quality sheets that highlight both excellence and learning from incidents.

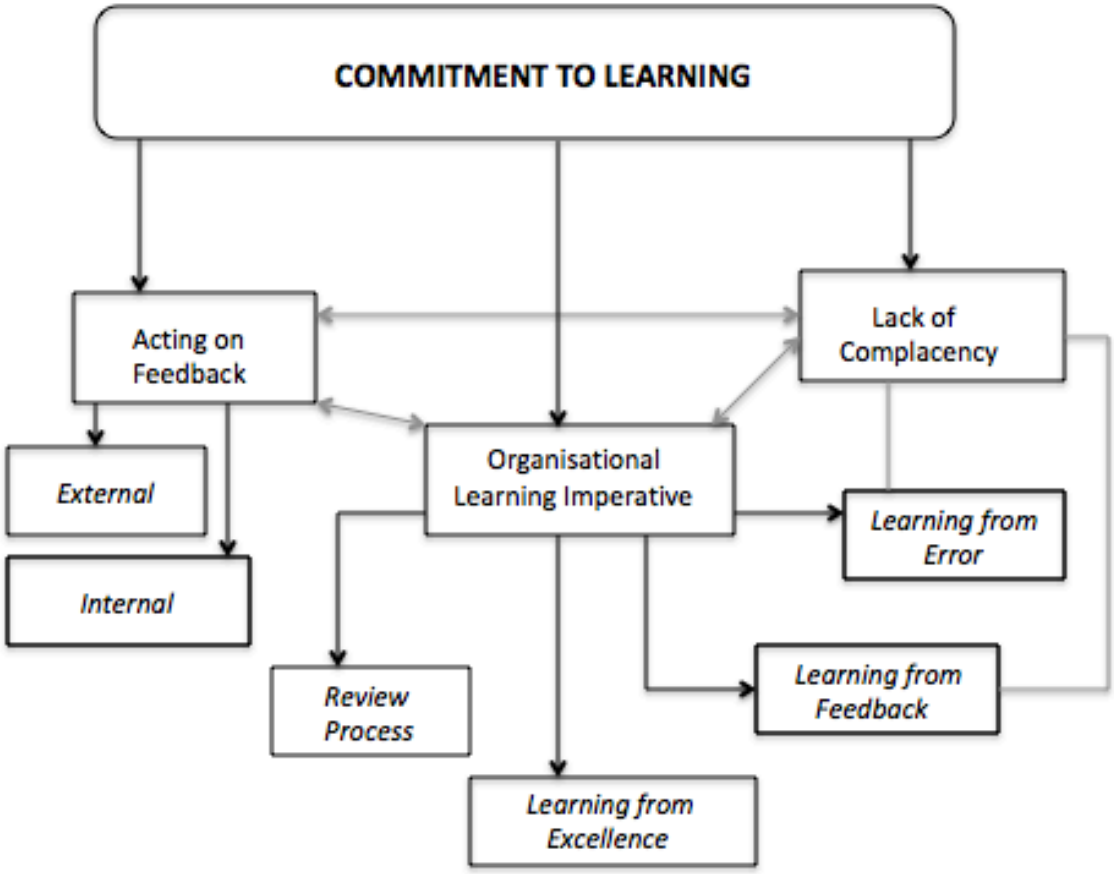
Organisational learning is facilitated by a monthly message shared throughout CS1. Learning points from an incident are distributed by email and presented on an A4 poster in a readily digestible form so that people can extract key points in a short space of time. The poster enables emerging themes to be picked up and addressed. Divisions are encouraged to also share weekly messages and to report frequently "*as it means they are picking up stuff and near misses" (ID 29: CS1).* The focus is on making improvements for patients.

The CQC latest reports on both Trusts made references to their observation of organisational learning, corroborating the findings of the researcher. In the report for CS1 they noted that: *"During our core services inspection we found numerous examples of how feedback from patients and those close to them shaped the way in which services were delivered. […] There was a strong culture of reporting incidents to learn and improve" (CQCSR 3, pp. 4-5).* The report also acknowledged that staff understood the importance of learning, provided feedback to those who reported incidents and assured follow-up action had been taken.

Having a commitment to learning was a strategic leadership behaviour identified from the interview data and has been further evidenced through various datasets. The relationship of the themes and sub-themes to this strategic behaviour are presented in the thematic map (Figure 7) below. The map indicates that a close lateral relationship

exists between the three themes 'Lack of Complacency', 'Organisational Learning Imperative' and 'Acting on Feedback': learning was achieved through the requirement placed on leaders to seek, analyse, accept feedback and act on it. An uncomplacent mindset ensured that leaders were open to continuous learning and acknowledgement that improvement is always possible, even when high standards are exhibited. The four sub-themes of the theme 'Organisational Learning Imperative' illustrate that learning is a process and identify the sources taken by the Trusts to fulfil their self-obligation for on-going learning: feedback, excellence and causes of error. This finding complements the theme 'Acting on Feedback', the sources of which are both *'Internal'* and *'External'* to the organisation as the sub-themes indicate. This strategic leadership behaviour is discussed in Chapter 7.

Figure 7: Thematic Map for Overarching Theme Commitment to Learning



TYPEFACE KEY: OVERARCHING THEME; Theme; *Sub-theme*

LEGEND: Single arrow represents direction of hierarchical thematic relationship

Bi-directional arrow indicates a close lateral relationship between themes

Single line represents a tentative relationship between theme and sub-theme

OVERARCHING THEME = STRATEGIC LEADERSHIP BEHAVIOUR

6.4 Strategic priorities 2015-2020: Case Study 1 and Case Study 2

Following interview data analysis, BPs and ARs were reviewed to identify the strategic objectives or priorities of both cases for the five financial years between 2015-2016 and 2019-2020 inclusive. These were compared to the strategic leadership behaviours identified through data analysis and references to organisational resilience, to establish any correlation between what was to be achieved – the goals/priorities – with the behaviours associated with how they would be achieved. Documents from both organisations repeatedly stated the importance of goal and priority achievements being guided by Trust values. The summarised findings are presented in Table 20 and Table 21 below.

Table 20: Strategic Priorities 2015-2020: Case Study 2 (Source: BP 53, 62, 70, 84; AR 19)

	Strategic Objectives 2014/15	**Strategic Goals 2015/16 - 2019/20**
1	Improving staff engagement through a listening, responsive culture PEOPLE-FOCUSSED	Safe, effective, quality care (PATIENT CENTRED CARE) RESPONSIBLE LEADERSHIP
2	Development of appropriate skills and behaviours in line with Trust values VALUES-LED CULTURE	Local, joined up patient care RESPONSIBLE LEADERSHIP
3	Recruiting and retaining the right people with appropriate skills PEOPLE-FOCUSSED RESPONSIBLE LEADERSHIP	Put research, innovation and learning into practice COMMITMENT TO LEARNING
4	Improving the environment and well-being of staff RESPONSIBLE LEADERSHIP PEOPLE-FOCUSSED PERSONAL RESILIENCE	Be the provider, employer and partner of choice PEOPLE-FOCUSSED RESPONSIBLE LEADERSHIP
5	Delivering intelligence of workforce, quality and finance to determine trends/risks RESPONSIBLE LEADERSHIP RIGOROUS GOVERNANCE	Live within means RIGOROUS GOVERNANCE RESPONSIBLE LEADERSHIP ORGANISATIONAL RESILIENCE

Table 21: Strategic Priorities 2015-2020: Case Study 1 (Source: BP 4,14, 25, 35, 43)

	Strategic Objectives 2015/16 **Strategic Priorities 2016/17; 2017/18**	**Strategic Priorities 2018/19; 2019/20**
1	Delivery of high quality, individual care delivered with compassion (PATIENT-CENTRED CARE) RESPONSIBLE LEADERSHIP	Excel in consistent delivery of high quality, patient-centred care, delivered with compassion (PATIENT-CENTRED CARE) RESPONSIBLE LEADERSHIP
2	Employ the best and help staff fulfil their potential PEOPLE-FOCUSSED	We will invest in our staff and their well-being, supporting, educating and developing the workforce PEOPLE-FOCUSSED
3	Provide leadership to partners in network, for the benefit of all stakeholders RESPONSIBLE LEADERSHIP	Lead, collaborate and co-create sustainable integrated models of care with partners to improve the health of all stakeholders RESPONSIBLE LEADERSHIP
4	Deliver pioneering, efficient practice at the leading edge of innovation, learning and transformation COMMITMENT TO LEARNING	Be at the leading edge of research and transformation and translate rapidly into exceptional clinical care and embrace innovation COMMITMENT TO LEARNING
5	Be financially sustainable to safeguard quality for the future and ensure strategic direction supports this goal RIGOROUS GOVERNANCE RESPONSIBLE LEADERSHIP ORGANISATIONAL RESILIENCE	Deliver financial sustainability and contribute to financial recovery of the health system to safeguard future service quality RIGOROUS GOVERNANCE RESPONSIBLE LEADERSHIP ORGANISATIONAL RESILIENCE
6	Ensure sound governance and regulatory compliance RIGOROUS GOVERNANCE	Consolidate and grow specialist clinical services, focussing on core areas of excellence and pursue appropriate, effective out of hospital solutions RESPONSIBLE LEADERSHIP
7	Ensure a safe, friendly environment for patients and staff (PATIENT and) PEOPLE-FOCUSSED	

Table 20 and Table 21 show a strong correlation between the strategic behaviours of leaders identified through data analysis and the Trusts' strategic goals/ priorities. The strategic goals in CS2 (Table 20) changed significantly in 2015-2016, and were standardised for the five years until 2020. This was a result of a five-year strategy and

vision developed by the Board and launched in April 2015 (AR 17).

As was previously reported (Sections 6.3.2 and 6.3.5), the researcher observed the absence of a patient focus in the Trusts' values: in her experience many NHS Trusts state their first organisational value as being patient-focussed. Her field observations indicated a strong patient focus in both organisations, which was a sub-theme of the theme 'Delivering Culture Change', further evidence that it was considered an important value. This was also evident in the secondary data analysed. As shown in Tables 20 and 21 above, the first strategic priority/goal in both cases was the delivery of high quality, patient-focussed care. This explains its absence from the Trust values and, arguably, is more appropriately placed as a primary goal for a health care provider.

The NHS Staff Survey data showed a marked improvement regarding patient focus over five years: in CS1 an increase in 7.7% and in CS2, an increase of 11.4% of respondents agreed that patient care was the Trust's top priority, which compared to an overall Trust increase of 4%. There was also an improvement in staff reporting satisfaction with the standards of care in their Trust: CS1 increased by 8.7% and CS2 by 6.5%, compared to a national average of 2.1% (Appendix XIII). This would indicate a successful achievement against their first organisational strategic goal/priority as perceived by staff.

It was noted that CS2 was behind the national average in total: 60.2 % of staff were satisfied with Trust standards whilst 85.4% of staff were satisfied with levels of care in CS1; these compared to 71.4% overall. This may be a reflection on the mental health sector generally. The CQC reported concerns of bed reductions, inadequate staffing levels, lack of skilled staff and access to localised care in mental health in a recent report (CQC, 2019a). Therefore, these pressures in the system are likely to impact the staff in CS2. Against this backdrop it is considered that survey results evidence that CS2 has made significant progress over time.

6.5 Synthesis of data analysis

Responsible leadership behaviour has been seen to encompass a number of qualities that are threaded throughout the five strategic behaviours identified through interview data analysis. For example, the code 'role-modelled behaviour' overlaps with the code 'role modelling the new culture' identified in the strategic behaviour of a values-led culture. Taking responsibility and acting responsibly link to the sub-themes of *Fiscal Responsibility* and *Assurance of Systems and Processes* that are evident in rigorous

governance behaviour. Being uncomplacent was associated with having a commitment to learning and is a quality of responsible leaders. Similarly, improving communications is associated with being people-focussed and responsible leadership. Consequently, it is argued that responsible leadership is the fundamental leadership behaviour that has been used to improve performance, with the remaining four strategic behaviours closely related to it.

Having laid the foundations of responsibility, delivering culture change was evidenced in both Trusts as a fundamental approach by new CEOs to address poor behaviour and bring about performance improvement. A set of values and corresponding behaviours to live the values were developed in both organisations in consultation with a large body of staff. These values have driven the recruitment process and ensure that staff are employed with personal values that align with those of the organisation. Therefore, a values-led culture is suggested as the second leadership behaviour that was developed to underpin organisational improvement and resilience in both cases.

The values of both organisations are strongly focussed on staff. Caring for their well-being, having regular communication throughout the Trusts, enabling staff development, building staff relationships and seeking and responding to feedback were all features of being strategically focussed on their people. Acting on feedback was also a theme of a commitment to being a learning organisation, drawing together elements of responsible leadership, a commitment to learning and being people-focussed. It is suggested that a commitment to learning is also associated with governance through the management of risk, analysis of incidents and responding to the outcome of analysis.

It is posited these behaviours are interconnected and not set in a hierarchical relationship, as seen in the related threads and overlapping of codes and themes. It is suggested that responsible leadership is the foundation for the other four strategic behaviours and is, therefore, fundamental to the development of organisational resilience and sustainability. This will be discussed in Chapter 7.

6.6 Chapter summary

This chapter presented the analysis and findings of interview data following the six-phase thematic data analysis method described by Braun and Clarke (2013) and finessed through the structure of Gioia and colleagues (2012) as detailed in Chapter 5. This analytical process identified five strategic leadership behaviours that enabled

organisational performance improvement and underpinned the development of organisational resilience in the two cases. A synopsis of these findings and their presentation using the Gioia architecture followed the chapter introduction and facilitated a 'summary at a glance' of the relationship of codes, themes and strategic behaviours identified through data analysis.

The evidence for each of the five strategic behaviours was then presented in sequence: responsible leadership, values-led culture, people-focussed, rigorous governance and commitment to learning. The themes and sub-themes of each strategic leadership behaviour were evidenced from interview data and substantiated through analysis of secondary data sources: Trust ARs, BPs, CQC summary inspection reports and NHS Staff Survey data. Researcher reflections and observations were also reported in the chapter. Reference was made to the subsidiary data that had been opportunistically gathered. A thematic map demonstrating the relationships between themes and sub-themes to the overarching strategic leadership behavioural theme were presented at the end of each section.

The strategic priorities of the Trusts for the years 2015-2019 were presented and mapped to the five strategic leadership behaviours identified from the interview data analysis, showing a close correlation between strategic priorities and behaviours. The first strategic priority for both cases was the delivery of high quality, patient-centred care, which accounted for the absence of a strong patient-focussed approach in the data analysis. This was followed by a synthesis of the data analysis and a concluding chapter summary. A discussion of the findings follows in Chapter 7.

Chapter 7

DISCUSSION AND CONTRIBUTION

7.1 Introduction and chapter overview

This research sought to establish what enabled organisational performance improvement and developed organisational resilience, as evidenced by the CQC, in two NHS Trusts in England. Specifically, it set out to identify the strategic leadership behaviours that underpinned the development of sustained organisational resilience. The research also aimed to provide meaningful and robust evidence to leaders within the health care sector on behaviours that will enable sustainable performance improvement. Understanding how this was brought about in successful Trusts may provide a foundation for the development of sustainable organisational resilience within other health care organisations, the NHS and the wider system in which health care is delivered.

Through the identification and sharing of new knowledge with other leaders, the research has the potential to influence the overall service, quality, safety, leadership and sustainability of health care organisations. The chapter commences with a summary of this research thesis, followed by a discussion of the research findings. The contribution of the research to theory, practice and policy is then discussed. The chapter concludes with a summary.

7.2 Summary of the research thesis

It was noted in Chapter 1 that health care systems globally are struggling with increasing costs and demands on services (Heavin, 2017), further exacerbated by the COVID-19 pandemic (Haque, 2021). The NHS in England continues to be stretched and remains under-resourced, both financially and in its workforce (Alderwick *et al.,* 2021) and will require organisational resilience to remain a sustainable health system fit for purpose. Closer collaboration between health and social care providers and other system partners has commenced but requires legislative change to enable full implementation: this is anticipated to progress in 2022 (DHSC, 2021b).

A review of the literature established that the NHS health care regulator, the CQC, aims to contribute to quality improvement (CQC, 2016a) and the development of organisational resilience (CQC, 2015) through its regulatory framework. However, scholars differ in their opinion as to how successfully the organisation achieves these

aims (Beaussier *et al.,* 2016; Castro, 2018; Fulop and Ramsay, 2019). Whilst some NHS organisations do improve, others deteriorate or remain underperformers (CQC, 2018a) and the impact of the regulator is not unequivocally positive (Walshe *et al.,* 2014; Smithson *et al.,* 2018; Castro-Avila, Bloor and Thompson, 2019). This suggests that other factors contribute to organisational improvement and sustained resilience, which is likely to be a consequence of its leadership and internal motivation (Pratt, 2015; Boyd, Moralee and Ferguson, 2020).

The leadership of the NHS has been influenced by its history. A powerful medical body has shaped delivery of health services in the UK and continues to oppose change and influence organisational reform (Goddard, 2016; Horton, 2016). Doctors have been slow to adopt leadership roles (Akhtar *et al.,* 2016) and were opposed to being managed: the role of the CEO was initially contentious (Sausman, 2001). However, the importance of clinical leadership and particularly of doctors has been underlined (Darzi, 2008; Jonas, McCay and Keogh, 2011; Swanwick and McKimm, 2011; West, 2015) and opinion and practice among doctors is changing (Nicol, Mohanna and Cowpe, 2014; Akhtar *et al.*, 2016), although there is still much more for them to embrace (Bailey and Burhouse, 2019).

Poor leadership was frequently cited as the cause of poorly performing NHS hospitals and negative organisational culture (Ritchie *et al.,* 2000; Kennedy, 2001; Francis, 2013). There has been a concerted push for compassionate and distributed leadership in the NHS (Darzi, 2008; King's Fund, 2011; West, 2020) to overcome a command and control style and promote a non-bullying culture. The CQC reports widespread consistent, compassionate care in NHS hospitals (Tables 5 and 6, p. 38). However, the NHS Staff Survey suggests a different picture, with one in four staff reporting experience of bullying, harassment and discrimination from colleagues (Bailey and Burhouse, 2019).

Although compassionate caring is a goal for many leaders (Dixon-Woods *et al.,* 2014) it is not always possible to enact (Bleiker *et al.,* 2020) and showing less compassion does not equate to feeling uncompassionate (Gilbert, 2017). It is suggested that compassion will not contribute to long-term organisational sustainability without an additional approach to leadership. Responsible leadership was proposed as a more appropriate leadership behaviour, focussed on doing the right thing to all stakeholders in a whole system.

Organisations that improve performance as evidenced by the CQC have focussed

on quality improvement, culture change, governance and values (CQC, 2017c; Fulop *et al.,* 2020). The CQC (2017c) identified improved organisations as having a values-based culture that is patient-centred and addresses staff bullying. Recent research by Fulop and colleagues (2020) stated the importance of a listening, continuous learning culture and a quality improvement mindset. A commitment to learning was also identified by Dixon-Woods and colleagues (2014) as an important element of quality improvement. In studying organisations aiming to address quality of care, Dixon-Woods and colleagues found staff more focussed on compliance than a genuine need for better quality or safer systems (Dixon-Woods *et al.,* 2014).

Resilience has been studied in a variety of fields including positive psychology (Werner and Smith, 2001; Luthans *et al.,* 2006), supply chains (Sheffi and Rice, 2007; Ponomarov and Holcomb, 2009), crisis and disaster management (Boin *et al.,* 2005; Comfort *et al.,* 2010) and engineering (Hollnagel *et al.,* 2006; Woods, 2015). Holling (1973) observed resilience in ecological systems and applied the principles to organisations, thus initiating academic interest in organisational resilience. Organisational resilience in health care has been strongly influenced by the field of resilience engineering (Braithwaite *et al.,* 2015; Hollnagel *et al.,* 2015) with its attention on safety systems.

Organisational resilience management literature is diverse and inconsistent (Ma, Xiao and Yin, 2018; Chen *et al.,* 2021). There has been a proliferation of interest in the discipline over the last twenty years but the subject remains highly conceptual and requires more empirical research in order to test and develop theory that is supported with evidence (Duchek, 2020). Many definitions of organisational resilience exist, reflecting the theoretical resilience concepts of proactive preparation, adaptive capacity, recovery and growth.

The definition accepted by this researcher is that of an organisation that has responded positively to challenge, continued to function whilst adapting under pressure and emerged stronger (Vogus and Sutcliffe, 2007). The researcher asserts this definition aligns with an NHS Trust that was rated as underperforming (*Inadequate/Requires Improvement*) by the CQC, subjected to considerable scrutiny by regulators and subsequently judged as a performing (*Good/Outstanding*) organisation.

Values, leadership and management style impact the development of organisational resilience (Braes and Brooks, 2010; Bouaziz and Hachicha, 2018). There is a need for alignment of organisational culture, risk management strategy and staff

behaviours that support organisational survival (Pojasek, 2013; Costanza *et al.,* 2016) so as to develop sustainable organisational resilience. Leaders have the ability to reshape organisational culture and enhance organisational resilience (de Oliveira Teixeira and Werther, 2013), which is required for long-term sustainability (Bhamra, Dani and Burnard, 2011). Thus it is essential that leader behaviour and strategic priorities create the climate for sustained organisational resilience. However, theoretical contributions are not validated by empirical findings (Rahi, 2019) and it is not clear from the literature what leader behaviours or organisational culture best enhance organisational resilience: there is a need for more empirical study in this field.

The strategic priorities in Trusts following a CQC judgement of underperformance have not been evident in the literature. Subsequent organisational improvement may be the result of a short-term objective to achieve an improved CQC grading, or a longer-term strategic objective aimed at organisational resilience and sustainability. For under-achieving organisations to learn from higher performers there needs to be greater clarity on which strategic leadership behaviours enable performance improvement and underpin the development of sustained organisational resilience. This research set out to identify those strategic leadership behaviours.

It was suggested that studying organisations demonstrating sustained improvement over time will generate more significant data: some NHS organisations have improved from one CQC comprehensive inspection to another, only to then relapse at a sequential inspection, raising concern for sustainable improvement (CQC, 2018a) and authentic organisational resilience. A case study design was considered to be the most appropriate to study strategic leadership behaviour and the choice of two non-representative cases argued as providing a greater opportunity for learning and application to the sector. A significant change in performance in the two cases selected was demonstrated to the CQC during two consecutive regulatory inspections over a period of four years. Qualitative methods and secondary data were employed to study leadership behaviour including semi-structured interviews, non-participant observations, document analysis and analysis of specific NHS Staff Survey data.

The majority of fieldwork was conducted over nineteen weeks and site visits were halted due to the COVID-19 pandemic restrictions implemented on 23rd March 2020. The remaining data collection of interviews and meeting observations were completed via telephone. The impact of these changes were discussed and considered to

not adversely affect the data corpus or quality of the research study. Interview data were analysed thematically using the method described by Braun and Clarke (2013), using NVivo software (Bazeley and Jackson, 2013), and finessed using the Gioia methodology (Gioia, Corley and Hamilton, 2012), demonstrating rigour in data analysis. Secondary data sources were analysed on completion of interview data analysis to avoid unconscious bias and influence in selection of data codes, themes and strategic leadership behaviours (Diefenbach, 2009).

Five strategic leadership behaviours were identified from the interview data and further evidenced through triangulation of the secondary data sources. These leadership behaviours comprise: responsible leadership; implementation and embedding a values-led culture based on staff behaviours; being people-focussed; maintaining rigorous governance; and an organisational commitment to learning. The dominant behaviour was that of responsible leadership, creating the foundation for the remaining four behaviours. A discussion of these research findings now follows.

7.3 Discussion of the research findings

As noted above, five strategic leadership behaviours underpinned the development of sustained organisational resilience and enabled organisational performance improvement, as evidenced by the CQC. There were various lateral relationships between the five behaviours, with responsible leadership connecting to all four others behaviours. Responsible leadership was therefore identified as the dominant strategic leadership behaviour present in both case studies and fundamental to the development of sustainable organisational resilience, and is discussed in Section 7.3.1.

Two strategic behaviours are situated within staff development: a values-led culture based on staff behaviour and being people-focussed. These are discussed in Sections 7.3.2 and 7.3.3. The remaining two strategic behaviours, a focus on rigorous governance and an organisational commitment to learning, are situated within organisational development. These are discussed in Sections 7.3.4 and 7.3.5. The impact on NHS Trusts of the CQC and regulation is discussed in Section 7.3.6. A recommendation of a new paradigm for NHS leadership is discussed in Section 7.3.7.

7.3.1 Responsible Leadership

Leadership has been identified by a number of scholars as a behaviour that affects organisational resilience, in both health care (Jeffs *et al.,* 2009; Gover and Duxbury, 2018;

Gilson *et al.,* 2020) and other organisational settings (Hopkin, 2014; Gracey, 2019; Morales, *et al.,* 2019). However, leadership styles were infrequently made explicit with the exception of Witmer and Mellinger (2016), who identified servant and transformational leadership styles. Responsible leadership was an original finding of this research. Five core factors that contribute to responsible leadership were identified in the findings. These are discussed in Sections 7.3.1.1 - 7.3.1.5 below.

7.3.1.1 A strong moral compass

Having a strong moral compass is a fundamental attitude of responsible leaders (Pless, 2007): morals that go beyond economical growth and self-interest to showing responsibility to society (Stahl and Sully de Luque, 2014). Waldman and Galvin (2008) assert that an individual must feel an internal obligation to do the right thing towards others in order to be considered responsible. These findings show that decisions were guided by a moral conscience to do the right thing, whether that was towards an individual, a service, an organisation or a strategic business decision.

Morality refers to a social code of conduct that individuals and groups adopt as normative to guide their behaviour (Carlo *et al.,* 2016). In both case studies there was a process for recruiting staff with a strong moral compass and personal values congruent to those of the organisation. This is important to ensure consistency of staff behaviour in an organisation and maintain a measure of equality.

A strong moral compass came from Board leaders and filtered down to other levels in the case organisations through role-modelling, with mirroring of prosocial behaviour and communication. This identifies how senior leaders can influence behaviour in Trusts, which are complex organisations functioning simultaneously on three levels: the macro or whole system level; meso level, that of the individual Trust; and the micro, departmental or divisional level (Health Foundation, 2010).

Staff can be affected by pressures and unexpected situations, becoming thrown off course: the current pandemic is such an example. There will be many difficult choices and decisions that need to be taken that go beyond the usual competing of resources and prioritising as a result of the unique circumstances the NHS is currently operating within. Being guided by answering the fundamental question “What is the right thing to do?” will help to ensure morally responsible decisions are made.

There has been sufficient history of poor leadership in the NHS (Kennedy, 2001; Francis, 2013) to be aware there is ample opportunity to act without integrity or

responsibility. The NHS is under-recruited in many professional and leadership roles (Janjua, 2014; Moberly, 2017; Oliver, 2020), creating pressures daily that can make it difficult to do the right thing. Meeting national targets can help drive up quality but can also influence gaming activity (Castro, 2018), whereby actions to avoid punitive outcomes are taken, which are not in the best interests for patients (Bevan, 2006). Acting with a strong moral compass and consciously doing the right thing will help responsible leaders develop organisational resilience.

7.3.1.2 Caring for staff

Scholars have discussed that caring for staff is an important aspect of achieving high organisational performance (Frankel, Leonard and Denham, 2006; Cameron, 2010). This implies that a focus on staff is the right thing to do and is the action of responsible leadership: leaders would recognise that caring for their people was essential to their well-being and ability to care for others effectively, improving the outcomes for their service users (Firth-Cozens and Mowbray, 2001) and the greater community.

Caring for staff is a factor of responsible leadership (Pless, 2007) and can be examined through the lens of how leaders behave when things go wrong. In an organisation that is led through command and control, bullying and blame, reactions to incidents can be severe, such as firing someone after an incident where blame had been apportioned to a perpetrator or accountable person. This induces a climate of wariness and fear (Razzaghian and Shah, 2011; Ekici and Beder, 2014), the opposite to a caring environment. The findings of this research have identified that responsible leadership can bring about change: exploring the circumstances surrounding an incident and acknowledging that accidents are inevitable in health care environments but are not perpetrated willfully, encourages a just and fair culture and demonstrates care.

Staff can find it difficult to raise issues of concern and, when they do, their organisation does not always respond appropriately (Mannion *et al.,* 2018). Difficult discussions are often avoided and poor behaviour can be left unchallenged (Patterson, *et al.,* 2002). Showing due care to staff, providing support, ensuring inappropriate behaviour is challenged and appropriately dealt with, is guided by doing the right thing and acting morally as a responsible leader.

7.3.1.3 Horizon scanning

Horizon scanning is an essential feature of a resilient organisation (Louisot, 2015),

with leaders maintaining awareness of potential risks and managing them before they become critical (Somers, 2009). Having an awareness of what may be coming can also create opportunities (Sutherland and Woodroof, 2009). The research findings showed the case Trusts had a number of leaders who were looking out for potential changes in direction, new approaches and opportunities to collaborate with partners and innovate. Horizon scanning and taking appropriate action helps develop sustained organisational resilience.

Horizon scanning is a discipline and requires regular activity to avoid losing out on potential opportunities or being caught unawares (Amanatidou *et al.,* 2012). It relies on a commitment to being well informed, with leaders proactively discussing the big picture (Rodríguez-Sánchez and Perea, 2015). Anticipating and continually preparing for future developments takes effort and was found to benefit the case Trusts in positioning their organisations in the STP and partnership collaborations. This enhanced their reputation within their local partnerships and developed a more positive perception of the Trusts.

Engaging multiple stakeholders in horizon scanning from different specialties and with diverse expertise provides richer observations of the environment (Könnölä *et al.,* 2012). The research findings underline this importance of looking forward, ensuring that various leaders take responsibility for horizon scanning in their specialist area and encouraging this activity at various levels in the organisation. This ensured clinical leaders at various levels of seniority were encouraged to remain aware of clinical innovation outside of their locality, create opportunities for advancement in clinical service design and delivery and maintain a leadership position in clinical practice. These are actions that promote performance improvement and contribute to organisational resilience (Kantur and İşeri-Say, 2012).

7.3.1.4 Whole system involvement

Responsible leaders are concerned about the sustainability, and therefore the resilience, of the whole system in which they operate (Crilly, Schneider and Zollo, 2008) and are not focussed solely on their own organisation's survival. The whole system in the context of this research comprises the Trust and partners in the STP of which they form part. Thus, the system spreads beyond their own organisational boundaries. The importance of this finding is particularly relevant as the NHS moves to working in close collaboration with system partners.

It has been recognised that sustainability of the NHS within the principles of its

foundation - free at the point of delivery to anyone in need of health care - will only be viable if the whole system works more collaboratively for the community it serves (DHSC, 2021b). Primary, secondary and tertiary health services, social care, local authorities and the voluntary sector need to be better aligned and finite resources need to be managed effectively (Humphries, 2015) within a more integrated care system.

Responsible leaders seek to ensure their organisation and people are contributing appropriately to the needs of their community (Useem, 2005). The case study Trust leaders regarded taking responsibility and making a positive contribution to the future delivery of an ICS as important. There are unknown risks involved in these ventures and potential downturn for NHS Trusts as they balance their priorities with those of other organisations in the system. However, the research findings identified that leaders were clear that this was the right thing to do for the communities they serve and aimed to raise standards in other areas and not theirs alone. They were also clear that acting responsibly in the whole system and embracing system-wide thinking was critical to the sustainability of the NHS.

An ICS will rely on leaders acting responsibly towards all stakeholders in the whole system, working for the greater good of the community. System leaders will need to put in a degree of effort to ensure the smooth running of parts of the system that may not yield a particular benefit to their organisation. As budgets and resources get shared and reallocated there will be winners and losers in the system (Pless, Maak and Waldman, 2012). Putting aside personal and individual organisational gain will require all leaders to be guided by a strong moral compass to do what is right for the community and develop sustainable system and organisational resilience.

7.3.1.5 Reaching out

Building relationships with senior leaders and staff is essential to enable effective influencing for organisational success (Collinson, 2006; Dixon-Woods, McNicol and Martin, 2012). Proactively reaching out to their organisational community and taking the initiative in communication with all staff was a priority for the CEOs of both case study Trusts. They established a variety of methods to engage with all employees, including live video calls whereby any member of staff could speak directly to them, thus making themselves accessible and approachable. The CEOs were highly influential and garnered respect for their leadership, which was evident throughout both Trusts.

The strength of feeling towards the CEOs underlined the significance of a visible

and respected leader of an organisation. This was an interesting finding: there has been a significant emphasis on the role of distributed leadership in the NHS, with the implication that the charismatic or heroic leader is no longer an appropriate model of leadership (King's Fund, 2011; West *et al.*, 2014; Beirne, 2017). However, the CEOs were considered inspirational role models through their exemplary leadership style, qualities of transformational leaders (Alimo-Metcalfe and Alban-Metcalfe, 2005; Hay, 2006; Robbins and Davidbizar, 2020).

Leaders distributed throughout an organisation encourage a more equitable and diverse distribution of power and authority, greater staff engagement and opportunity for innovation (Harris, 2008; Bush and Glover, 2012); these are important for service improvement. Distributed leadership will be essential in partnership working (Beirne, 2017). In both case Trusts there was evidence of distributed leaders acting responsibly. Moreover, these findings underline the importance of distributed leadership that is led by a responsible, highly influential and respected CEO.

7.3.2 Values-led culture

Both organisations developed a set of values that centred on staff behaviours. The values set out how staff were expected to work together and behave towards each other and the organisation. There was recognition that they needed to be embedded and lived if they were to have real meaning (Speculand and Chaudhary, 2008) and considerable work went into assuring they were known and discussed regularly. Significant numbers of staff at all organisational levels contributed to their development. Staff involvement would have considerably enhanced their willingness to become engaged in and implement culture change (Beckerman and Fontana, 2001).

The values drove a culture change in both Trusts. The significance of this finding is in the content of the values-led culture: the focus being squarely on staff as opposed to patients, which is frequently reported in NHS Trusts (Dixon-Woods *et al.,* 2014). They included an organisational element of embracing change. The organisations recognised that when staff work within a framework of appropriate behaviours, underpinned by responsible leadership and a morality that guides them to do what is right, patients will automatically be better looked after. However, a strong patient focus was also evident in both Trusts and was the first strategic priority/goal for both case study organisations.

It is interesting to note that many underperforming organisations are reported to have subsequently focussed on developing a compassionate and values-based culture

that is patient-centred and addresses staff bullying (CQC, 2017c; Fulop *et al.,* 2020). This is in direct contrast to the findings of this study. This may be a reflection on the timing of the culture change in the case studies and contemporary influence of the system: the current rhetoric is to have patient-focussed values and a compassionate culture (de Zulueta, 2016; West and Chowla, 2017).

The case study Trusts developed their ideas outside of this influence. There is no one right set of organisational values that will deliver patient-centred care (Mannion, 2014). The individual approach taken by the case study Trusts could be a significant learning for other organisations: it is important to develop a values-led culture based on values that are authentic to the organisation and not to an idealised model that is considered applicable to all (Mannion, 2014).

Both cases had a history of bullying and a controlling culture under previous leadership. Destructive, toxic behaviours can affect the organisation as well as an individual (Pelletier, 2010) and has a negative effect on staff satisfaction and organisational commitment (Mehta and Maheshwari, 2013). As both CEOs were internal appointments they would have experienced that negative culture and observed its effect on their colleagues. It is argued that leaders with a strong moral compass would desire to change a toxic culture to one based on a set of behaviour-based values.

Logically, driving out a toxic culture would be a priority for a responsibly oriented CEO and a positive change in culture was widely reported in the organisations. Analysis of the NHS Staff Survey data showed there was a significant increase in the percentage of staff who perceived patient care to be the Trusts' top priority. These are important findings: they indicate that having a strong values-led culture based on staff behaviours, together with the primary strategic priority to deliver high quality patient care, results in a significant improvement to patient outcomes.

7.3.3 People-focussed

A focus on people is a strategic leadership behaviour that is closely related to caring for staff. Taking a personal interest in staff circumstances is another example of responsible leadership (Maak and Pless, 2006), manifested through being people-focussed. A leader who is aware of the life issues affecting the people they manage can then make decisions that take staff needs into consideration. Acting with care is a factor of responsible leadership and will contribute to the development of organisational resilience through supporting the well-being of staff.

Another aspect of being people-focussed was evident in the opportunities for staff development in both Trusts. This resulted in their ability to retain staff for significant lengths of time (Table 17, p. 101) and is likely to have contributed to the development of organisational resilience. An organisation unable to retain staff loses its capacity for organisational memory (Randall *et al.,* 1996; Balmer and Burghausen, 2015). Resilient organisations learn from past experiences, adapting processes and systems to avoid repeat errors (Weick and Sutcliffe, 2015). They also learn from what has gone well to proactively avoid incident (Hollnagel, 2013). It is suggested that organisational memory, aided by the long tenure of many staff, has contributed to the development of organisational resilience in the cases studied.

7.3.4 Rigorous governance

Rigour implies a close attention to detail and the adherence to a clear set of guidelines. Both Trusts had robust risk management systems for recognising, reporting and monitoring the risks to personnel, the organisation and system-wide environment. A strong focus on safety was evident in both Trusts and staff were encouraged to report issues of minor import, near misses and serious incidents without fear of blame. Managing risk within a robust system is an essential component of strengthening organisational resilience (Dahms, 2009; Mitchell and Harris, 2012).

A finding of the research was a propensity for risk aversion in both Trusts. This was attributed to previous negative history and a concern for managing reputational as well as clinical risk. NHS organisations that have been publicly vilified can take many years to recover: reputations can be destroyed (Purohit, 2020) and public confidence lost (Oliver, 2015). Avoiding further reputational loss may account for the rigorous approach to governance and risk aversion noted in both cases. Ensuring public confidence and being assured that risks are rigorously monitored and managed are also the actions of responsible leadership.

Whilst a strong focus on risk management is essential to organisational resilience (Section 3.4.2) and ultimate sustainability (Louisot, 2015), risk aversion can hinder its development (Bell, 2019). Being able to adapt to change quickly is important for the development of resilience and a resistant organisation can lower its resilience (Bhamra, Dani and Burnard, 2011). Senior leaders in both organisations accepted that risks are present and that they may need to reassess their tolerance to risk taking. However, the punitive actions of regulators (Castro, 2018) and increase in litigation (Section 2.4) with its

associated rising costs (Lawton and Parker, 1999) are inhibitors of change.

Research in non-NHS organisations found that traditional risk management practices alone did not create a culture of resilience (Hopkin, 2014). Non-NHS CEOs focussed on applying flexibility, learning from experience and adapting to improve (Hopkin, 2014). It is asserted that adopting these principles in the Trusts would enhance their organisation's resilience without compromising governance. Relaxing rigour is likely to involve departure from established processes, potentially introducing carelessness and inadvertent errors. It is suggested that having a system that identifies potential risk, takes calculated decisions and employs flexibility without carelessness would enable a less rigid but equally robust system of governance that ensured organisational resilience was maintained. This is described by Collins (2001) as being flexible and responsible within a rigorous framework.

Some underperforming NHS organisations alter their focus to quality improvement in order to raise their performance (CQC, 2017c; Fulop *et al.,* 2020). This is logical as the CQC is the regulator of health care quality (CQC, 2015). This was not found to be a strategic focus in the cases studied, although quality improvement was evident. It is asserted that quality improvement was achieved through the model of responsible leadership, which ensured systems and processes were appropriately managed and maintained through the oversight of rigorous governance. By focussing on doing the right thing and getting the basics right, quality improvement was achieved without it being identified as a strategic focus for change.

7.3.5 Commitment to learning

Both organisations had developed systems for acknowledging and sharing good practice across their Trust, recognising the importance of celebrating success and learning from positive events (Gryna, 1992). These are also elements of responsible leadership and essential for organisational resilience and sustainability (Carroll and Edmondson, 2002; Robson, 2013). These learning initiatives were recent additions to both Trusts. It was acknowledged that the systems were not as developed or embedded as those that monitored incidents and near miss events.

A commitment to learning was observed in both organisations, ensuring that negative events were not repeated and that best practice was shared and replicated. For an organisation and its employees to learn there must be effective processes to communicate new knowledge (Nutley and Davies, 2001). An interesting finding was the

speed at which information was shared among the staff. Managers at ward level were encouraged to take the initiative and immediately share relevant information on clinical safety issues to avoid repetition elsewhere in the organisation.

Distributed leadership encouraged such initiatives, ensuring immediacy and currency of information sharing and promoting individual and organisational learning (Hailey and James, 2002). Avoiding bureaucracy and facilitating innovation helped avoid repetition of negative events. It is suggested that this is evidence of responsible leadership contributing to organisational resilience, which potentially could be duplicated by other organisations.

7.3.6 Impact of CQC regulation

There was general agreement in the Trusts that external regulation by the CQC had been a catalyst for quality improvement. However, this was felt most keenly after a CQC judgement of underperformance and an acceptance that the verdict was not good enough. It was considered that a CQC performance grade was a mark of basic standards, of which the Trust had fallen short. A message was instilled in Trust staff that they needed to improve because it was the right thing to do for patients, not in order to tick CQC boxes. This message was successfully embedded in both organisations.

Both Trusts spoke of being inward-looking whilst they were under greater scrutiny by regulators, limiting their ability to innovate until they were re-assessed as a performing organisation *(Good / Outstanding)* by the CQC two years later. However, they continued to have frequent regulatory meetings for a further two years until the subsequent inspection demonstrated sustained organisational improvement. It was only then that close regulatory scrutiny was removed.

Both organisations had embarked on culture change prior to a comprehensive CQC rating in their organisation, underlining the fact that this had not been driven by, or in response to, an underperforming CQC rating. This suggests that responsible leaders take initiative, know what to do and act proactively. It was felt in the Trusts that their improvement had been a result of the Trust's leadership rather than the CQC, whose process was considered to undermine organisational resilience. It was stated that the regulation rating provided a useful benchmark, enabling them to assess their performance against other similar Trusts. However, it was not a process to drive organisational strategy.

The CQC can motivate underperforming organisations to improve their

performance. However, many organisations do not improve or do not sustain improvement. It was considered by the Trusts that the CQC limits thinking and detracts an organisation from strategic innovation during periods of their intense scrutiny, which can prevail over several years. This would hinder organisational development and resilience building. This was the opinion in the case studies, and strongly suggests that sustained performance improvement and organisational resilience had been achieved through the responsible leadership that was evident in both cases. Leaders of both Trusts accepted that a health care organisation should focus on higher quality performance because it is the morally right thing to do.

7.3.7 A new paradigm for NHS leadership

Compassionate health care is widely accepted to be a strong moral good that should be sustained (de Zulueta, 2016). The elements of a compassionate response have been defined as listening with attention, understanding the cause of distress, empathising and taking action to help (West and Chowla, 2017). However, having compassion does not always equate to acting compassionately (Bleiker *et al.*, 2016): there are a number of authentic reasons why people may not display the compassion they feel. For example, they may be feeling stressed and unable to cope with the stresses of another; they may feel overwhelmed by the suffering of another and internalise the pain rather than be able to separate from it (Vrtička, Favre and Singer, 2017). There may be a shortage of personnel or time to devote to the person who is suffering, despite what would be preferable.

There is evidence that many clinicians in the NHS experience compassion fatigue (Walker, 2011; Dasan *et al.,* 2015) or are unable to give the level of care that they would desire (Appendix I). This suggests a level of distress in the workforce and genuine barriers to acting with compassion (Gilbert, 2017; Mascaro and Raison, 2017), which does not equate to a lack of it. However, it does demonstrate authentic difficulty in providing a consistent style of idealised behaviour.

Showing compassion is characterised by recognising another's distress followed by a desire to help (Goetz, Keltner and Simon-Thomas, 2010). 'Doing' compassion is the action taken to help alleviate another's pain (Atkins and Parker, 2012; Dutton, Workman and Hardin, 2014; Kanov, Powley and Walshe, 2017). It can be difficult to always act with compassion towards staff, particularly when their needs conflict with those of the service: a manager can show empathy, but may not be able to resolve a situation and remove

another's suffering, which is the act of compassion (Dutton, Workman and Hardin, 2014). However, a leader can show empathy, concern and negate bullying or uncaring attitudes towards staff, whilst ensuring service demands are met.

The relentless call for compassion in the NHS can be stressful for practitioners, especially among those who are working in fast-paced environments that require distancing from patients for safety, such as radiography departments (Bleiker *et al.*, 2016). Whilst it is important to show respect and kindness, there is little time to show genuine compassion in such an environment. However, compassion is not required for quality care (Fotaki, 2015).

It is argued that a new paradigm for NHS leadership, applicable to all circumstances and settings, is now required: that of responsible leadership. Responsible leaders are guided by a strong moral compass to do the right thing for all. Behaving with compassion when it is appropriate and realistic is the act of a responsible leader. However, it is not always possible to alleviate another's pain, only acknowledge it. This is not to advocate for less optimal behaviour but that which is realistic, achievable and authentic. Acting with morality is a choice and it is argued that a responsible leadership paradigm will steer people to do the right thing, act with integrity, respect, care and professionalism.

7.4 Contribution to theory

7.4.1 Contribution to organisational resilience theory

There is a vast body of organisational resilience literature, which has grown expansively over the past twenty years. Scholarly interest has spanned several fields including crisis and disaster management, ecological systems, supply chain and engineering resilience. In the field of positive psychology, research has focussed on individual resilience. Resilience within health care organisations has been heavily influenced by engineering resilience due to its focus on safety, but a safe organisation is not necessarily sustainable, as was discussed in Section 1.3. Organisational resilience literature in the fields of management and business is diverse and informed by studies in the various disciplines previously mentioned. Scholars have also been interested in the impact of personal resilience on organisational performance and change.

Examination of the organisational resilience management and health care literature exposed a highly theoretical body of work, with a relative dearth of empirical research. Studies in health care are mainly focussed on the resilience of staff and

organisational departments, with few organisation-wide studies. As noted in Section 3.3, Berg and colleagues (2018) called for comparative and longitudinal studies at the macro organisational level, which this research addresses.

Three main concepts of organisational resilience were identified in the reviewed literature: those of proactive preparation, adaptive capacity, and recovery and growth. However, there is no unified agreement on what constitutes organisational resilience, which is evident from its many definitions (Table 11) that were discussed in Section 3.4.1. All empirical researchers and theorists agree that adaptive capacity is an element of organisational resilience. Research suggests it is an amalgam of this and the other two concepts, but in a variety of combinations.

Many components that enhance organisational resilience were identified within the literature analysed. However, there is an imbalance between what is conceptually formulated and research findings. It is important to be mindful, therefore, that what may be claimed theoretically is not necessarily empirically evidenced, as discussed in Sections 3.4.2.2 and 3.4.2.3. Of the wide-ranging organisational studies reviewed, researchers have collectively identified twenty-one leader behaviours that affect organisational resilience (Table 13). The findings of this research are mapped against these behaviours in Table 22. Where there is not a direct match, they have been aligned to a similar behaviour where possible, to enable a comparison of established and original contributions.

Leadership was identified by a number of authors but most were not explicit as to the style of leadership or specific elements of leadership behaviour required to affect organisational resilience. Two studies (Morales *et al.,* 2019; Suryaningtyas *et al.,* 2019) referred to resilient leadership, a style ill-defined in the literature: it refers to leaders being resilient (Dartey-Baah, 2015; Eliot, 2020). A further study identified leadership behaviour that was focussed on being outward facing towards their external environment, fostering links with stakeholders and partners and remaining future-focussed (de Oliveira Teixeira and Werther, 2013). The current research identified whole system involvement as a leader behavioural theme, confirming the behaviour of outward-focussed leadership.

Witmer and Mellinger (2016) identified servant and transformational leadership in the health care organisation they researched. Qualities of transformational leaders include gaining the trust and respect of their colleagues, encouraging creativity, inspiring

them with optimism and enthusiasm, and recognising their contributions (Yammarino and Dubinsky, 1994). These were observed in both case study Trusts as noted in Section 7.3.1 and link to the findings of the behavioural themes of collective leadership, positive distributed influencing and caring for staff.

Table 22: Leadership Behaviours - Organisational Resilience Literature and Research Findings

Empirical Literature: Leader Behaviour	Frequency (n) Identified in Literature (Total n=21)	Research Findings: Leader Behavioural Themes	Strategic Leadership Behaviour
Leadership	9	Collective leadership model	RESPONSIBLE LEADERSHIP
Financial accountability Flexible use of resources	4 6	Proactive accountability	
		Positive distributed influencing	
Environmental surveillance Organisational preparedness	6 4	Horizon scanning	
		Strong moral compass	
Organisational change Contingency planning	4 2	Strategic organisational development	
Stakeholder connectivity / relationship building	12	Whole system involvement	
Development of a strong value system	5	Aligned staff and Trust values	VALUES-LED CULTURE
		Compassionate caring	
Development of a strong organisational culture	15	Delivering culture change	
Effective organisation-wide communication	14	Effective communication	PEOPLE-FOCUSSED
Staff development / support	9	Staff development Caring for staff	
		Recruitment and proactive retention	
Internal relationship building	12	Effective teamwork	
Creative problem-solving	6	Resilience-building programmes	
Risk awareness / risk management	8	Robust risk management	RIGOROUS GOVERNANCE
Attention to organisational processes System monitoring / awareness	3 3	Effective response to regulatory feedback	
Effective governance	4	Delivering strategic priorities	
		Lack of complacency	COMMITMENT TO LEARNING
Development of a learning organisation	10	Organisational learning imperative	
Adaptation / agility	4	Acting on feedback	
Encourage innovation	3		

Less specific in their observations were Gover and Duxbury (2018) who commented that, in their case study, the CEO enhanced people's ability to cope with

change due to their management style and capacity to get along with people. Gilson and colleagues (2020) reported that leaders worked at breaking down professional silos in order to encourage change, whilst Gracey (2019) referred to the need for adaptive leadership and dynamic decision-making when faced with a complex problem.

Active leadership is therefore an acknowledged behaviour that affects organisational resilience. However, specific leadership behaviour is not clearly identified in the literature. Responsible leadership was a finding of this research and offers a new contribution to the field. Specific behaviours that contributed to responsible leadership were identified. Having a strong moral compass was one such leader behaviour and this has not previously been associated with the development of organisational resilience: this provides a new insight.

Developing a strong organisational culture has been identified by the majority (n=15) of researchers reviewed and was also observed in the case study Trusts. As noted in Section 3.5, there is little homogeneity amongst previous research as to what the prevailing culture might be, and some descriptions of the established organisational culture are imprecise. For example, Gracey (2019) calls for a corporate cultural identity and having the correct culture in place; Gover and Duxbury (2018) reported that staff felt the culture had enhanced the organisation's ability to overcome change. Neither of these studies further elucidated what culture had been observed. A no-blame culture was identified in Hopkin's (2014) study. He also referred to the researched organisation having shared values regarding the building of strong relationships, both internally and externally.

Similarly, Andersson and colleagues (2019) spoke of having shared organisational values that promoted internal relationships and encouraged staff retention in their case study. They observed a culture that supported informal relationships and a preference for co-operation. Alternatively, Gilson and colleagues (2020) reported a customer-centric culture in their organisational study. Therefore, it is widely accepted that a leader who develops a strong organisational culture will enhance organisational resilience. What is less clear is what culture leaders should aim to foster in their organisation.

The case study Trusts revealed a culture that was based on their organisational values. Furthermore, the values were staff-focussed and behaviourally explicit to enable those values to be lived. Recruitment was structured to ensure that prospective staff had personal values that aligned with those of the Trust. Therefore, the identification of a

values-led culture, specifically aimed at staff behaviours, is a new research finding and offers a contribution to organisational resilience theory.

A third strategic leadership behaviour identified through data analysis was that of being people focussed. Leader behavioural themes that contributed to this strategic behaviour include effective communication and teamwork, staff development and delivering resilience-building programmes. These behaviours support the findings of other researchers: many identified effective organisation-wide communication (Horne and Orr, 1997; Cotta and Salvador, 2020), staff development and support (Bouaziz and Hachicha, 2018; Mousa *et al.,* 2020) and internal relationship building (Somers, 2009; Chen *et al.,* 2021).

Other studies have reported the behaviour of creative problem-solving (Andersson *et al.,* 2019; Gilson *et al.,* 2020) which, it is suggested, aligns with the delivery of resilience-building programmes. In addition, the research findings have linked recruitment and proactive retention to the development of organisational resilience. Although this had not been identified as a significant finding in previous research, it does support the shared organisational value of promoting internally to retain staff (Andersson *et al.*, 2019) that was noted in the literature and mentioned above.

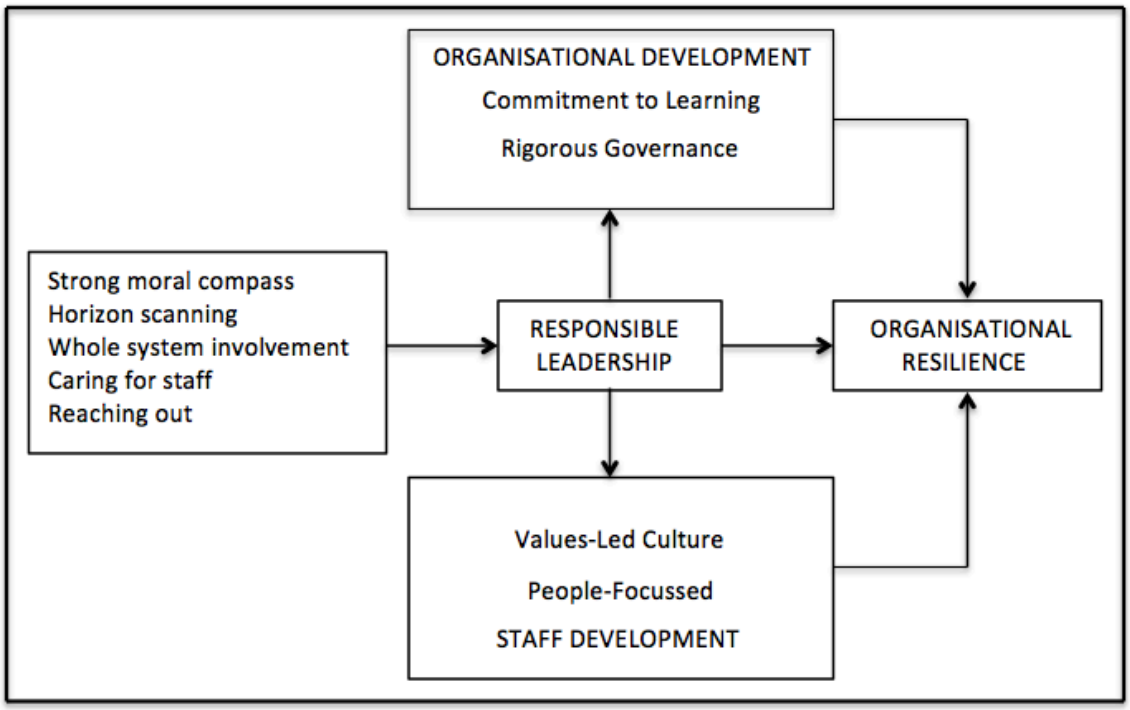
The strategic leadership behaviour of rigorous governance supports the findings of other scholars. The behaviours of robust risk management (Reinmoeller and van Baardwijk, 2005; McManus *et al.,* 2008), delivering on strategic priorities (Hopkin, 2014; Gilson *et al.,* 2020) and providing an effective response to regulatory feedback (Somers, 2009; Gover and Duxbury, 2018) have all been similarly identified by previous research. Jeffs and colleagues (2009) assert it is important that leaders keep good communications with regulatory bodies, discuss practice standards and work together to enable a collaborative approach to regulation. This behaviour was evidenced in the two case study Trusts.

The development of a learning organisation was identified in many studies (Weick and Roberts, 1993; Horne and Orr, 1997; Sawalha, 2015; Chen *et al.,* 2021) and is therefore not a new finding. A leader behaviour that was found as a result of the current research was that of a lack of complacency, which has not been specifically linked to the enhancement of organisational resilience and is thus a new finding. Encouraging innovation was not a finding of the current research, as has been identified in previous studies (Reinmoeller and van Baardwijk, 2005; Morales *et al.,* 2019) but was noted: for

example, the Trusts were being creative with their originality in appointing staff with non-clinical backgrounds and creating new roles to deal with the recruitment issues faced in the NHS.

The current research offers three major contributions to the organisational resilience literature: strategic leadership behaviours of responsible leadership; a values-led culture based on putting staff first; and the identification of five strategic leadership behaviours that work concurrently to enable performance improvement and underpin the development of organisational resilience. This offers new insights and a theoretical framework of organisational resilience development, which is presented in Figure 8.

Figure 8: Development of Organisational Resilience — A Theoretical Framework



The research identified that responsible leadership underpinned the development of organisational resilience. This offers a new insight to the organisational resilience literature. Five core factors constituted responsible leadership: having a strong moral compass; horizon scanning; whole system involvement; caring for staff; and reaching out.

A strong moral compass was a significant factor that guided the behaviour of responsible leaders, driven by a focus on doing the right thing. This directly links having a strong moral compass to the development of organisational resilience for the first time and provides clarity on how leaders think and act when planning for organisational performance improvement and sustainable resilience. Their goals are long-term and activity is shaped to achieving long-term sustainability.

Organisational resilience was understood and developed in the context of the whole system within which the organisation operated. The responsible leadership strategic behaviours connected whole systems activity, organisational culture and a commitment to learning to the development of organisational resilience. This offers new understanding of strategic thinking and concurrent behaviours that underpin the development of organisational resilience. Whilst they are standalone behaviours, they have an internal relationship: by prioritising concurrent action in each of these areas an organisation can improve its performance and develop sustainable organisational resilience.

The framework offers clarity on the strategic leadership behaviours that will develop sustainable organisational resilience. Organisational systems and processes that enable assurance and on-going learning, whilst maintaining a strong focus on staff development, relationship building, values and behaviours, contribute to organisational resilience development. This provides an unambiguous message and further develops organisational resilience theory by confirming that staff development and organisational development are contributors to the development of organisational resilience. It is asserted that concurrent actions of responsible leadership and those strategic behaviours situated within staff and organisational development will promote sustainable organisational resilience in challenged organisations.

7.4.2 Contribution to leadership theory

Responsible leadership positively affects employee satisfaction, motivation and individual performance (Gomes, Marques and Cabral, 2022) through its influence on values and trust (Marques, Reis and Gomes, 2018). Such leadership has been associated with improving organisational commitment (Eisenberger *et al.,* 2001; Sobhani, Haque and Rahman, 2021) and enhancement of employee well-being (Haque, Fernando and Caputi (2021) and personal resilience (Forgeard *et al,* 2011).

As previously discussed in Section 2.5.8, another focus for responsible leaders is their accountability of organisational performance (Cameron, 2011) and on building strategic relationships with stakeholders (Waldman and Galvin, 2008). The research findings support all these aspects of responsible leadership. Scholars have also studied the impact of responsible leadership on the sustainability of the surrounding environment, such as improving employee's green behaviour (Han, Wang and Yan, 2019).

However, the leadership literature has not identified the link between responsible

leadership and organisational resilience. Thus, in addition to its contribution to organisational resilience theory this study has added to the literature of responsible leadership. For the first time it has been identified that five specific elements of responsible leadership: those of having a strong moral compass, horizon scanning, whole system involvement, caring for staff and reaching out, together with the mediating factors within organisational development and staff development, enable responsible leaders to develop organisational resilience. This is an original contribution to leadership theory.

7.5 Contribution to practice

Many NHS organisations are struggling to deliver sustained performance improvement and develop organisational resilience. The theoretical framework developed through this research provides a clear structure to leaders of the strategic behaviours that facilitate organisational improvement and underpin sustainable organisational resilience. Adopting the principles of responsible leadership identified in the five core factors, and applying the remaining four strategic behaviours situated in organisational and staff development, NHS leaders can create a path to sustainable organisational improvement and resilience.

The primary strategic leadership behaviour is that of responsible leadership: it is suggested this should become the new paradigm that directs NHS leadership for the future. The five identified core factors of responsible leadership are fundamental to the strategic behaviours of leaders and are essential to the development of sustainable organisational resilience. Leaders must adopt a whole systems mindset and act with a strong moral compass in order to bring sustainability to the NHS and their partnership organisations. This will require a change in outlook from competition to collaboration and will only be achieved by thinking and acting responsibly, doing the right thing for all.

Developing an organisational culture that focuses on staff behaviours, and building relationships with staff to encourage them to contribute to organisational change, will create firm foundations for organisational sustainability. Synchronously, a robust focus on organisational governance and learning is required. Combining these behaviours will build a sustainable organisation and system. These behaviours can and should be replicated throughout an organisation at whatever level of leadership: formal and informal leaders in a distributed leadership model can practice responsible leadership and contribute to the development of sustained organisational resilience.

The behaviours identified through this research can contribute immediately to the NHS and the whole system in which it operates. It is in the middle of a deep crisis caused by the COVID-19 pandemic, the long-term effects of which will cause considerable additional pressure to a corporate system already severely strained. It will be essential that organisations plan for a sustainable future, applying these strategic leadership behaviours in a systematic way. Having a short-term focus will not deliver sustainability. It will be essential that leaders learn from successful organisations that have survived significant challenge and emerged more strongly, having led with a strong moral compass, a desire to do the right thing, support the whole system and develop long-term organisational sustainability.

This new framework for the development of sustained organisational resilience is the result of empirical research conducted in NHS Trusts in England. This provides significant insights to the health care sector, which is currently undergoing significant change (Section 1.1) and pressure, compounded by a contemporary pandemic. It is going to require organisational resilience that is sustainable to remain flexible and adaptable to new demands and partnership working: this new framework can provide a road map to organisations. The CQC, currently operating a heavily bureaucratic and time-consuming regulatory process, can also use the framework as a guide to the development of a more nuanced approach to health care quality regulation: this is discussed in Section 7.6.

The theoretical framework might also be applied in a variety of organisational sectors: it is not limited to the NHS or the public sector. It is also relevant in organisations of different sizes. The principles remain the same: for an organisation to be sustainable it must be future-focussed, led responsibly, committed to learning, robustly governed, have a strong focus on its people and a culture that unequivocally values its staff. Combining these five strategic leadership behaviours will guide organisations to a sustainable future.

7.6 Contribution to policy

Whilst this research did not set out to evaluate the CQC or its regulatory system, it has been evident that the value of the CQC to health care organisations in England is debatable and controversial. Comprehensive inspection is a costly, lengthy, bureaucratic process that does not always result in a positive outcome. It can hinder innovation, strategic development and organisational resilience, which is at odds with CQC aims. Poor CQC ratings can destabilise an organisation and have adverse unexpected effects, again at odds with CQC organisational aims. It has been evidenced in this research that

organisations can be excessively scrutinised, despite having achieved improvement to a level of acceptable quality performance. This would suggest that the CQC process is applied to all organisations without consideration to individual need.

The CQC acknowledges it needs to become more fit for purpose (CQC, 2016b; 2019b) and reports it is looking into its processes, particularly in preparation for inspecting an ICS of the future. However, it could become more flexible in its approach to working with organisations currently, assessing in the first instance whether they are being responsibly led. Irrespective of their CQC rating, a responsible leader striving to continuously improve organisational performance and sustainability may require different support and scrutiny to a leader focussed on a short-term goal to satisfy regulators.

The framework developed in this research could contribute to a more nuanced assessment of organisational leadership. By assessing the motivation of leaders and their strategic leadership behaviours, the CQC would be able to identify which organisations might benefit from additional regulatory oversight and those that are on a trajectory to becoming a sustainable, resilient organisation. Sustainable resilience takes time to develop and if this was acknowledged by the CQC, they could be assured that strategic development would be enhanced with less of their input.

It is suggested that the regulatory process is re-examined. In an already overstretched health system such as the current state of the NHS, it is arguably unethical to be providing excessive oversight to organisations that are on an improvement trajectory. This research suggests it is counter-productive in a responsibly led organisation and, therefore, an unnecessary use of CQC time which could be re-directed to organisations that would benefit most from their input. The theoretical framework developed through this research is recommended as a more nuanced approach to aid assessment of responsible leadership and prospective organisational performance improvement and sustainability in NHS Trusts. This would enable a more targetted approach to scrutiny of NHS Trusts, and other organisations the CQC inspects, and remove unnecessary stringent oversight that detracts from strategic innovation. It would also free up valuable CQC resources to provide more support to organisations in greatest need.

7.7 Chapter summary

This chapter has discussed the research findings and identified its contribution to theory and practice. Following an introduction and overview to the chapter, a summary of the research thesis was presented. The context for the research was reported followed by a summary of the literature review and the emerging research questions. The methodology and research methods, process of data analysis and the findings were then summarised. A discussion of the findings then followed: the five strategic leadership behaviours were discussed following examination of the five core factors that contributed to responsible leadership. The impact of regulation by the CQC was also discussed and a new paradigm for NHS leadership was proposed, that of responsible leadership.

Contribution of the research to both organisational resilience and leadership theories was then presented, including a new theoretical framework of organisational resilience development. This connects the core factors of responsible leadership and the four remaining strategic leadership behaviours that underpin the development of sustained organisational resilience, providing new insights to organisational resilience theory and leadership theory.

The framework provides a clear pathway to the development of sustainable organisational resilience and identifies clear strategic leadership behaviours to underpin the process. These behaviours can be applied at all levels of an organisation and in a variety of organisational settings, not exclusive to the NHS. It was suggested the behaviours are immediately applied in the NHS to help develop sustainability of a corporate organisation that is experiencing severe stress. The contribution of this research to practice was then identified.

Finally, the contribution to policy was presented. The theoretical framework was suggested as an aid to assess responsible leadership by the CQC during their regulatory oversight, provide a more nuanced approach to inspection and enable the CQC to direct their support to organisations in greatest need. The chapter concluded with a summary. The limitations of the research will now be discussed in Chapter 8.

Chapter 8

STUDY LIMITATIONS, FUTURE RESEARCH AND CONCLUSION

8.1 Introduction and chapter overview

This research has identified five strategic leadership behaviours that enabled organisational performance improvement as evidenced by the CQC, which underpinned the development of sustained organisational resilience in two NHS Trusts in England. The research was conducted in two non-representative NHS Trusts using qualitative research methods and analysis of secondary data. Limitations to the research study will now be discussed, followed by directions for future research. A conclusion will draw the chapter and thesis to a close.

8.2 Limitations of the study

Undertaking an empirical research study is not a perfect process and it is incumbent on a researcher to recognise the limitations of their work (Mason, 2018). The research case study design is of itself a limiting factor in the choice and number of cases studied. It was argued (Section 4.3.1) that studying extreme cases was the most appropriate for this research study and two organisations providing very different health care services (mental health and non-specialist acute services) were purposefully selected for comparison.

The CEOs of the case study Trusts were interested in the research for both the learning that could be shared with the wider NHS and also for insights that may illuminate areas for development in their own organisation. This strongly indicates the case studies were organisations that seek feedback and have an improvement mindset. A significant finding of the research study was that of the organisations having a strong commitment to learning. The attitude from the outset of the CEOs may have unconsciously biased the researcher to look for confirmatory evidence in the data corpus.

The considerable overlap in the cases of leadership style and strategic behaviours in both cases strengthens the reliability and generalisability of the research findings (de Vaus, 2001). However, comparing a performing organisation with an underperforming one may have highlighted behaviours that hindered the development of organisational resilience, eliciting different insights. This may be useful to underperforming organisations, especially if they were practicing an identified adverse behaviour: it is as

useful to know what to do less of as it is to be clear on practices that are beneficial. The choice of unique case studies has not enabled such insights. However, the research aimed to identify whether behaviours were replicated across the cases (Section 4.3.1) and, therefore, it is argued the selection was appropriate for the study.

The retrospective nature of the study is a limitation of the work. Participants were required to recall events that had occurred up to four years previously. This introduced the potential element of hindsight bias (Roese and Vohs, 2012) and unreliable memory recall. It was considered that senior leaders were more likely to have an accurate recollection of events due to the strategic nature of their role and the response they would be required to make (Mmobuosi, 1998) following a negative CQC rating: consequently, the researcher requested introductions to senior managers to minimise possible inaccuracies in the data.

Senior leaders appeared confident in their responses and there was considerable similarity in their recollections. Whilst emotion predominantly benefits memory, particularly in conditions of moderately high arousal (LaBar and Cabeza, 2006) it is also acknowledged that memories can be inaccurate, especially if the emotion was heightened by a negative event (Jang and Huber, 2008). Therefore this may have an impact on the data referring to emotional recall collected through interview. Interview data regarding organisational issues were triangulated with secondary data and confirmed the interview findings. Participants who had been in more junior roles at the time of the first CQC comprehensive inspection reported they could not accurately recall how they felt at the time of receiving the negative CQC rating: this substantiates the decision of the researcher's selection of participants.

Both case studies comprised a number of hospitals and discrete services within their Trust. Therefore it is likely that each divisional area or hospital had its own organisational culture. A Divisional culture within a Trust-wide culture was not explored explicitly with participants. In aiming to establish the Trust's culture, it is possible that participants were reflecting unconsciously on the culture of their own service within the organisation, introducing a potential misunderstanding between participant and researcher. This could have been clarified through member checking (Saunders, Lewis and Thornhill, 2016) with participants following transcription of their interview. This was not feasible after the onset of COVID-19 and therefore it introduces a potential anomaly in the data analysis. This has been partially addressed through triangulation of interview

data with secondary datasets.

The researcher sought to interview senior staff working in all areas of the organisations in order to establish a Trust-wide response to the research questions. Whilst this was achieved (Table 17, p. 101) the effect of the senior leadership behaviours on front line clinicians was mainly unexplored - six of the thirty-nine participants had a clinical role, each with a substantive senior managerial component. Exploring the research questions with grass roots clinicians would have elicited data on how distributed the leadership was in the organisations and whether the strategic leadership behaviours were mirrored throughout. Thus the impact of the identified strategic leadership behaviours at grass roots level was not examined and leaves a gap in the research.

A criticism of all case study research, it is acknowledged that a final limitation lies in the difficulty to replicate exactly the study (Bettis, Helfat and Shaver, 2016; Brandt *et al.,* 2014). Researcher observations are unique and it cannot be guaranteed that a different researcher would share observations, interpretations and insights. However, it is argued that for this very reason it strengthens the research study: it has enabled fresh insights on the strategic leadership behaviours that enable organisational performance improvement and underpin the development of sustainable organisational resilience. Furthermore, the research has been conducted at a uniquely insightful time in the history of the NHS which cannot be replicated and which makes the study distinctly valuable for future researchers and practitioners.

8.3 Directions for future research

This research has provided new insights into how organisational resilience is developed in organisations that are significantly challenged but not in crisis. It is recommended that further research is undertaken to examine the strategic leadership behaviours of leaders in other challenged organisations and compared against the theoretical framework developed from the current research. This may validate the theory and provide further insights. Organisations that apply the theory in practice should be studied and its impact on organisational resilience be assessed through rigorous research.

The study was undertaken within the NHS in England. It is suggested that further research using the same research questions and research design is applied in other NHS organisations: this would enable the theory to be applied and tested, strengthening further the body of knowledge and understanding of the strategic leadership behaviours that develop and sustain organisational resilience in health care organisations. It is also

suggested the theory is tested in other sectors and industries aiming to sustain organisational resilience. It is argued that responsible leadership with simultaneous attention to staff and organisational development is equally as relevant in other sectors as to health care.

A question left unanswered is: What are the strategic behaviours of leaders in underperforming organisations? These should be examined and compared with those of higher performing organisations. This would facilitate further learning for leaders and guide them to identifying the organisational behaviours that are hindering improvement.

8.4 Conclusion

The world is in the throes of the COVID-19 pandemic, which has overstretched health care provision internationally and underlined the severe tensions that exist in many health services (Deloitte, 2021; Haque, 2021). Managing viral spread in the UK has had its challenges and the UK government has focussed on protecting the NHS from complete overwhelm, highlighting its vulnerability (Burman *et al.,* 2020; Chowdhury, 2020; Moore, 2020; Willan *et al.*, 2020; Yano, 2020). Whilst it has continued to function, the NHS has been pushed to the brink (Lancet, 2020) and the importance of developing resilience in the UK health system is now essential if it is to improve on pre-pandemic performance (Thomas, 2020) and maintain sustainability. Furthermore, leaders will be challenged to make difficult decisions, allocating finite resources to the competing priorities of multiple clinical specialists (Macdonald *et al.,* 2020; Morris *et al.*, 2020; Oussedik *et al.,* 2021; Patel, Thomas and Quilter-Pinner, 2020) whilst balancing the treatment of new cases and reducing a record waiting list (Griffin, 2020).

Within this context, this research has set out to identify the most impactful strategic leadership behaviours that leaders of successful NHS Trusts in England have employed to improve organisational performance and underpin the development of organisational resilience. There are many NHS establishments that are underperforming as evidenced by the CQC (CQC, 2020). A nuanced understanding of the strategic leadership behaviours, systems and processes that lead to sustained performance improvement can provide useful information to other leaders and guide performance improvement in less successful organisations.

The research thesis documents the research journey and comprises eight chapters. The theoretical motivation for the research was laid out in Chapter 1 and confirmed the area of interest for the researcher, which resulted from a career in the

health care sector and a concern for the standards of leadership, quality and sustainability of the NHS. The impact on quality that the UK health care quality regulator, the CQC, makes is questionable (Walshe *et al*., 2014; Flodgren, Gonçalves-Bradley and Pomey, 2016; Castro-Avila, Bloor and Thompson, 2019), as is the assertion that it improves the resilience of organisations through its inspection process (CQC, 2016a). The researcher sought to understand further these issues relating to the CQC.

Literature that pertains to leadership, and specifically that which has influenced leadership development and behaviour in the NHS in England, was reviewed in Chapter 2. A strong focus on compassionate and distributed leadership was identified. In the third chapter the field of organisational resilience was explored. The researcher accepted a definition of organisational resilience that closely relates to an underperforming NHS Trust, which is then subjected to close scrutiny by health care regulators before emerging as a performing organisation. The authors (Vogus and Sutcliffe, 2007) assert that organisational resilience is defined by an organisation that has been challenged by a significant event, continues to perform whilst adapting to change and emerges stronger. The literature review identified gaps in knowledge of the strategic behaviours of leaders in NHS organisations following a CQC inspection that rates the organisation as underperforming (*Inadequate/ Requires Improvement*). This led to the identification of two research questions:

RQ1: What has enabled organisational performance improvement and thus developed organisational resilience, as evidenced by the Care Quality Commission?

RQ2: What strategic leadership behaviours underpinned the development of organisational resilience?

The fourth chapter identified the methods used to explore the research questions. A multiple-case study of two non-representative NHS Trusts in England were selected as the most useful to elicit understanding. The organisations were purposefully selected for their proven sustained organisational resilience. Using a pragmatic, inductive approach, a variety of methods were selected to study the cases. Semi-structured interviews, secondary data including Trust documents and the NHS Staff Survey, non-participant observations and collection or photographic evidence of documents opportunistically available contributed to the data corpus. Analysis of these various datasets enabled triangulation of the findings that resulted from the analysis of interview data.

The process of analysis of interview data was presented in Chapter 5. The thirty-

nine interviews conducted in the two case studies were recorded and subsequently analysed following a verbatim transcription. The thematic analytical process described by Braun and Clarke (2013) was used as the primary method of data analysis, utilising NVivo software. A further analysis using the Gioia methodology (Gioia, Corley and Hamilton, 2012) enhanced analytical rigour.

Data analysis and findings were reported in Chapter 6. Analysis of the interview data identified five strategic leadership behaviours; these were confirmed through analysis of the remaining datasets. Evidence for each strategic leadership behaviour was presented together with a thematic map that described the hierarchical and lateral relationships between sub-themes, themes and the overarching theme that described the strategic leadership behaviour. A presentation of the data analysis following the Gioia methodology (Gioia, Corley and Hamilton, 2012) was also provided. The strategic priorities / goals for both case study Trusts during the relevant years pertaining to the research study were presented and mapped to the strategic leadership behaviours. There was a close correlation between the strategic priorities and behaviours.

The data were discussed in Chapter 7. The impact of regulation by the CQC on performance improvement and contribution to resilience building was also discussed in this chapter. There followed a discussion on the impact of a long discourse that has centred on the delivery of compassionate care in the NHS. An alternative leadership paradigm that will contribute to the development of sustainable organisational resilience was proposed. Contributions of the research to theory, practice and policy were presented in this chapter. The limitations of the research study were then set out in Chapter 8 and directions for future research were suggested, prior to the research conclusion.

8.4.1 Research contribution

Returning to the research questions identified through the literature review:

RQ 1: What has enabled organisational performance improvement and thus developed organisational resilience, as evidenced by the Care Quality Commission?

RQ 2: What strategic leadership behaviours underpinned the development of organisational resilience?

Five strategic leadership behaviours were identified through analysis of interview data and confirmed through triangulation with the remaining datasets. One behaviour, that of responsible leadership, connected to the remaining four behaviours and was

identified as the primary strategic leadership behaviour that underpinned the development of organisational resilience in the two case studies. Five core factors of responsible leadership were identified: being guided by a strong moral compass; caring for staff; horizon scanning; having active involvement in the whole system; reaching out proactively to staff. Comparing these factors to extant literature contributes to the understanding that responsible leaders are committed to both internal and external stakeholders as proposed by Maak and Pless (2006) and are driven by strong moral values (Stahl and Sully de Luque, 2014).

Responsible leadership as a primary strategic leadership behaviour that underpins the development of organisational resilience is a significant finding of the research and provides a new contribution to organisational resilience theory: it explicitly links having a strong moral compass to the development of organisational resilience. This provides new insights into responsible leadership motivation. It also suggests the performance improvement strategy for the Trust leaders was achieved through long-term goals aimed at sustainable improvement and organisational resilience, in line with scholarly thinking (Lynham and Chermack, 2006).

The research also offers a novel contribution to leadership theory: it is the first time that the link has been made between responsible leaders and the development of organisational resilience. Specific elements of responsible leadership, working synchronously on identified elements of organisational and staff development, have been identified as mediators that enhance organisational resilience.

Organisational leaders were proactive in reaching out to their staff, communicating frequently. Regular opportunities were provided for all staff to interact with the CEO in real time via video link, which enhanced accessibility and built staff-leader relationships. The CEOs in both case study Trusts were highly respected by all staff for their inspirational leadership and exemplary style. The finding concurs with Wang and Hackett (2016) who assert the importance of having a strong, transformational leader who acts responsibly and role-models exemplary behaviour.

The research found that both case studies had developed a values-led culture based on staff behaviours and which embraced organisational change. This is an interesting finding: most studies report that NHS organisations generally develop cultures that are focussed on patients and compassion (Dixon-Woods *et al.,* 2014). There has been a significant discourse in extant literature regarding compassionate leadership and caring

(de Zulueta, 2016; West and Chowla, 2017; West, 2020), which suggests a cause for the frequency with which these appear in Trust values. Furthermore, the CQC looks for signs of compassion during their routine inspections, another logical reason for organisations to herald compassion.

The case studies had developed their values prior to the CQC comprehensive inspections and before the proliferation of the compassionate leadership literature. A recent review of values in both organisations has led them to retain their staff-based values, which suggests they are content with them and that they are effective. Mannion (2014) advises against a uniform approach, asserting that there are different ways to achieving quality, patient-centred care. Speculand and Chaudhary (2008) underline the importance of developing organisational values that are meaningful to staff and are lived. The case study Trusts developed values that were authentic to them, were being embedded and guided staff behaviour. This could be a significant learning for other organisations: it is important to develop values that are relevant and authentic to a specific organisation rather than try to conform to an idealised norm.

A strong patient focus was palpable in the Trusts and document analysis revealed that, in both organisations, their first strategic priority/goal was to deliver high quality, patient-focussed care. Analysis of NHS Staff Survey data identified a significant increase over five years in the perceptions of staff that patient care was the Trust's primary concern. This suggests that the organisations were successful in achieving their first strategic priority/goal and supports Mannion's (2014) view for a bespoke focus on the approach to providing patient-centred care.

The Trusts spoke of difficulties associated with the strong messaging around compassion. Whilst they spoke of compassion being present, it was acknowledged that it was not always possible to be compassionate whilst trying to balance service delivery and staff preferences. The findings also revealed that leaders were at times unable to resolve the pressures and stress felt within the workforce, despite understanding and empathising with them. This finding is in keeping with the observations of Vrtička, Favre and Singer (2017) who identify authentic reasons why people may be unable to show compassion.

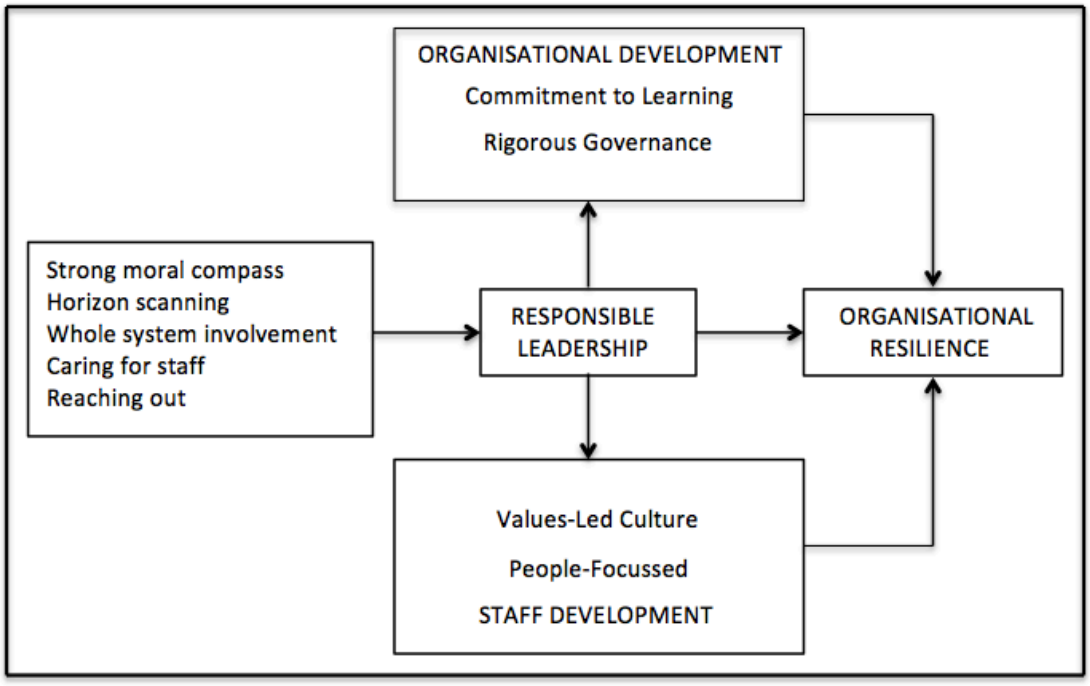
Leaders were motivated to do the right thing, a core quality of a responsible leader (Waldman and Galvin, 2008): this extended beyond their organisation. The research identified that the case study leaders were actively involved in the whole system

in which they operated. This finding supports the assertion that responsible leaders are networked to stakeholders in multiple sectors (Miska and Mendenhall, 2018). Trust leaders were clear that sustainability of their organisation relied on the sustainability of the whole system of which they formed part, and for which they had a responsibility to contribute. These findings are concordant with the views of Maak and Pless (2006) who assert that responsible leaders consciously aim to balance various stakeholder interests.

Trust leaders were aware of issues that were likely to impact their organisation and were constantly looking for opportunities to innovate and contribute to the whole system by regular horizon scanning. Horizon scanning aims to identify emerging issues and events that can disrupt an organisation (Schultz, 2006). This was encouraged at all levels of the organisation and was not held in one particular department. This finding supports the assertion of Bustinza and colleagues (2016) that staff at all levels in an organisation should be encouraged to engage in intelligence gathering.

Further insights into the development of sustainable organisational resilience in challenged organisations have enabled the development of a new theoretical framework, discussed previously in Section 7.4 and re-presented in Figure 8 below.

Figure 8: Development of Organisational Resilience — A Theoretical Framework



Two strategic leadership behaviours were situated within staff development: a values-led culture and being people-focussed. These form a lateral link to the core factors within responsible leadership of reaching out and caring for staff. Two strategic leadership behaviours were situated within organisational development: an

organisational commitment to learning and rigorous governance of the organisation. These provide a lateral link to two core factors of responsible leadership: a strong moral compass and horizon scanning. Both staff and organisational development relate to the whole system.

The theoretical framework links the three elements of responsible leadership, staff and organisational development to the development of organisational resilience. These findings present a new contribution to the organisational resilience and leadership literatures: responsible leadership has been found central to the development of organisational resilience. There is an overlap in concepts with the relationships of staff and organisational development to responsible leadership, which are stated by Miska and Mendenhall (2018) in the extant literature. These authors relate staff development and robust governance processes to responsible leadership research; they also refer to having a culture that supports responsible leadership. The research has confirmed these associations.

The research findings evidence the suggestion of other scholars that the development of organisational resilience is associated with the development of employee resilience (Luthans *et al.,* 2007; Ruiz-Martin, López-Paredes and Wainer, 2018). The research also offers new understanding of strategic thinking and concurrent leadership behaviours that underpin the development of organisational resilience. The discrete strategic leadership behaviours identified in this research have an internal relationship: prioritising concurrent action for each behaviour enables an organisation to improve performance and develop sustainable organisational resilience.

Responsible leadership and whole system involvement, organisational culture and a commitment to learning are linked to the development of organisational resilience. This is a significant finding for the NHS as it moves into closer collaboration with system partners. Health care organisations and integrated care systems of the future will require responsible leadership to develop organisational resilience and system sustainability. A knowledge of the culture that is predominant in a successfully performing organisation, and a commitment to keep learning from each other, sharing good practice and avoiding repetition of errors will be essential as they adapt to new ways of working.

The ICS will bring together people from various organisational cultures with different professional values, models of performance management and regulatory systems (Peck and Dickinson, 2009). These provide barriers to change and partnership

working. The differential power relationships that already exist in the NHS will be tested (Glendinning, 2003) and relationships will need to be built to develop trust in the system. Health care organisations working within an Integrated Care System will need leaders who are good communicators, can influence people at different organisational levels and inspire partners to do what is morally right for their communities, possibly at their own expense.

Those leaders will need to influence not only their system partners but also their financial stakeholders, the government. A focus on doing the right thing for health and social care is something spoken about in government but little action has taken place to date to turn the rhetoric into reality. There will undoubtedly be difficult decisions to be made, with system winners and losers an inevitable consequence (Pless, Maak and Waldman, 2012); it is essential for the health and care of the population of England that those decisions are taken by responsible leaders.

The research found the CQC to be considered an inhibitor to organisational resilience. The process of regulation and scrutiny was seen to impede the ability for organisations to innovate and think beyond achieving basic standards. This finding concurs with the work of Marsden and colleagues (2020), who refer to this as an unintended consequence of regulation and is in direct conflict with the aims of the CQC.

To return to the question of Schwandt and Gates (2018, p. 342) posed in Section 4.3, "What is this a case of?": these are two cases of sustainable, organisationally resilient NHS Trusts that have improved organisational performance through responsible leadership, a values-led culture based on staff behaviours, are people-focussed, rigorously governed and committed to learning. Furthermore, they demonstrate exemplary leadership.

It is time for leaders in the health sector to look at their reflection and observe a new style of heroic, responsible leader: a leader who is modest, uncomplacent, is approachable and accessible, who balances aspiration with realism and frequently communicates with stakeholders; a leader who is values-driven, staff and patient-centred, shows humility and is continuously learning; a leader who ensures systems and processes are robust to manage safety, quality and risk; a leader who is future-focussed and works effectively with whole system partners. In short, a responsible leader with a strong moral compass and who is motivated to do the right thing for their community. This responsible leader will develop a sustainable, resilient organisation.

APPENDIX I

NHS Staff Survey Results in England, 2015-2019: All Trusts

(Source: NHS Staff Surveys 2015-2020)

Survey Theme	NHS Q No.	2015	2016	2017	2018	2019
Safety Culture: Reporting of incidents, near misses and errors		**%**	**%**	**%**	**%**	**%**
Staff encouraged to report incidences, near misses or errors	17b	85.0	85.0	85.0	86.0	85.0
Staff feel fairly treated when involved in an incident	17a	52.2	51.0	54.0	58.3	59.7
Staff feel secure raising concerns of safety	18b	68.0	70.0	70.0	70.7	71.7
Staff feel confident that their organisation will address their concern	18c	56.0	58.0	57.6	58.0	59.8
Staff have reported witnessed incidents	16c	94.0	94.7	94.6	94.9	95.0
Action is taken by Trust to ensure incident is not repeated	17c	72.0	70.0	70.0	70.5	71.8
Staff are given feedback on changes made in response to incident	17d	54.1	56.2	58.7	60.0	61.1
Safe Environment: Experience of incidences of bullying, abuse or harassment from:		**%**	**%**	**%**	**%**	**%**
Managers	13b	13.0	13.0	12.8	13.2	12.3
Other colleagues	13c	19.0	19.0	18.0	19.1	19.0
Patients, relatives or other members of the public	13a	28.8	28.1	28.2	28.5	28.5
Staff member or colleague reported last incident of bullying	13d	41.0	45.0	44.0	42.0	45.0
National level of reported staff abuse		44.7	47.5	47.8	47.0	48.6
Management Experiences: Immediate manager		**%**	**%**	**%**	**%**	**%**
Satisfaction with amount of support from manager	5b	66.8	69.0	69.0	69.8	71.0
Staff feel their work is valued by their manager	8g	70.5	71.0	71.0	72.0	73.3
Manager gives clear feedback on their work	8c	60.0	61.8	62.0	61.4	62.9
Manager is supportive in a personal crisis	8e	74.0	74.7	75.0	74.0	77.0
Feel trusted to do their job	3b	91.0	91.0	91.0	91.0	91.0
Can count on manager for help with difficult task	8b	71.0	71.0	72.0	71.0	73.0
Trust values discussed at appraisal meeting	19e	30.8	33.0	34.0	37.0	39.2
Manager asks staff's opinion before making decisions that affect their work	8d	53.6	54.1	54.6	55.3	56.2

Senior managers		**%**	%	%	%	%
Awareness of who the senior managers in the Trust are	9a	82.0	82.2	82.0	83.0	83.0
Senior managers act on staff feedback	9d	30.0	31.1	32.0	32.7	34.5
Effective communication between senior managers and staff	9b	38.0	39.2	40.0	41.0	42.0
Try to involve staff in important decisions	9c	32.0	33.1	33.0	34.0	36.0
Teamwork						
Team has a set of shared objectives	4h	72.0	72.0	72.0	72.8	72.4
Team meets often to discuss its effectiveness	4i	59.3	60.3	60.4	60.6	60.7
Involved in change decisions that affect team	4c	52.0	52.0	52.0	52.2	52.0
Quality of Care		**%**	**%**	**%**	**%**	**%**
Agree that patient care is the organisation's top priority	21a	73.3	74.0	75.0	76.0	77.3
Satisfied with the quality of care they give patients	7a	82.2	82.7	84.0	80.7	81.1
Feel able to give the care they aspire to	7c	67.0	69.0	66.8	67.1	68.5
Satisfied with standards of care in their Trust	21d	69.0	69.0	70.0	71.0	71.4
Trust acts on concerns raised by patients	21b	73.0	73.0	73.0	73.4	73.8
Health and Well-Being		**%**	**%**	**%**	**%**	**%**
Staff has felt unwell as a result of work-related stress	11c	37.0	36.8	38.0	39.8	40.3
Trust takes positive action on staff health and well-being	11a	30.0	32.0	31.8	28.6	29.3
Immediate manager takes a positive interest in staff's health and well-being	8f	65.8	68.0	69.0	68.4	69.7
Staff Morale		**%**	**%**	**%**	**%**	**%**
Staff feel enthusiastic about their job	2b	74.0	74.0	73.6	75.0	74.8
Staff look forward to going to work	2a	58.0	59.0	57.7	59.0	59.5
Satisfied with level of colleague support	5c	82.0	82.0	82.0	82.0	82.0
Staff recommend their organisation as a place to work	21c	58.7	59.8	59.6	61.6	63.3
Satisfied with the extent to which the Trust values their work	5f	41.8	43.0	43.0	46.0	48.0
Feels Trust acts fairly on promotion/career progression against protected characteristics (Equality Act)	14	86.0	85.0	86.8	83.4	83.9
Has experienced discrimination by patients/relatives/public	15a	6.8	6.0	6.6	7.0	7.2
Has experienced discrimination by Trust staff	15b	7.0	7.0	8.0	8.1	7.7
Survey Response Rate		**%**	**%**	**%**	**0%**	**%**
		41.0	44.0	45.0	46.0	49.8

APPENDIX II

Semi-Structured Interview Framework Questions

1	Please tell me about your career and how long you've worked here.
2	Why did you come to work in this Trust?
3	How would you describe the culture of the organisation?
4	Has it (the culture) changed over the last 5 years? If so, how is it different? **
5	Reflecting back, was there a particular time when you recognised things had changed and why?
6	How did it feel when the Trust was rated *XXX* by the CQC in 2015? **
7	When you achieved *YYY* the following inspection, how did that feel in the organisation?
8	And then, after you maintained that grading recently, how did it feel?
9	What were the Trust's strategic priorities following the first CQC inspection? **
10	How does the CQC impact the organisation's strategic priorities? Would you focus on different priorities if you weren't inspected by the CQC?
11	Who are the key influencers in the organisation, and why?
12	Please tell me about a leader behaviour that has stood out for you for a positive reason during the past 2-3 years, and why that was memorable for you.
13a 13b	How does the organisation learn from incidents or errors? And how does it share good practice?
14	What does organisational resilience mean to you?
15	What do people do here to help build organisational resilience?
16	How does the CQC contribute to the resilience of the NHS?
17	What is the organisation's attitude to risk?
18	How is horizon scanning managed in the Trust?
19	How do you see the future for the Trust?
20	Is there anything else that you think is significant or that you'd like to tell me?

*** Adapted for participants working in Trust for less than 5 years*

APPENDIX III

Rationale for Interview Framework Questions

KEY: ** Questions were adapted according to length of time the participant had been employed at the Trust.

1. Initial question: Please tell me about your career and how long you've worked here.

This provided contextual data on participants, an indication of staff turnover, the organisation's approach to talent management and staff development. Indication of organisational memory in the Trust is significant as the data reflects on operations over the previous 4-5 years. Asking this question first was designed to relax the interviewee: enabling a participant to settle quickly is essential to facilitating a quality interview (Schostak, 2006). Thus, the initial question had a dual purpose of putting the interviewee at ease (Aurini, Heath and Howells, 2016) and providing contextual data.

2. Why did you come to work in this Trust?

This question was asked to elicit the motivation of the participant to join the Trust staff, which may provide insights into the current reputation of the Trust and the impact of previous widely publicised negative events. It may also indicate whether any organisational change, such as to leadership or culture, has affected recruitment and retention.

3. How would you describe the culture of the organisation?

Both case study Trusts had historical external reports that highlighted a bullying culture. Improved organisational performance as evidenced by the CQC is likely to have been accompanied by a changing culture, as the literature suggests (Smithson *et al*., 2018). The question sought to identify the current culture of the organisation to establish whether there had been a change from previous reports.

4. Has it (the culture) changed over the last 5 years? If so, how is it different?**

This question was asked of all participants who had worked in the Trust throughout the timeframe. It was adapted appropriately for those who had worked at the Trust for less than five years. The question was asked to unearth behaviour change that accompanied any difference in culture and identify what the previous culture had been..

5. Reflecting back, was there a particular time when you recognised things had changed and why?**

The researcher aimed to identify if culture change had been a distinctive priority for the Trust, what had driven the change and whether it was part of a planned strategy. Exploring when a participant was feeling the impact of change may have illuminated when the change process had started and whether this was the result of an underperforming CQC rating or linked to a different priority. It would also identify what behaviours had changed and the perceived results following the changes.

6. How did it feel when the Trust was rated XXX by the CQC in 2015? **

The CQC has had negative reviews, with some organisations reporting a sense of unfairness in their overall grade (Beaussier *et al.*, 2016; Care Quality Commission, 2017; Purohit, 2020). Implementation of regulator recommendations is affected by the perceived credibility of the inspection process (Hovlid *et al.,* 2020) and this question was aimed at understanding whether Trust employees felt that their grade was justified, how they viewed the feedback given by the regulator and what bearing this may have had on how they approached follow-up and the next inspection. It was also asked to ascertain whether some Trust departments felt differently than others and how collective or disparate the Trust is as an entire organisation. This may have an impact on organisational resilience.

7. When you achieved YYY the following inspection, how did that feel in the organisation?**

This question was asked to identify the organisation's response to achieving an improved performance rating. This would give insight regarding the reaction of the Trust to success – how it celebrated success and the meaning assigned to the successful outcome. This may be an indicator of organisational culture and potential complacency.

8. And then, after you maintained that grading recently, how did it feel?

This question probed any difference felt from receiving a successive, unchanged performance grade, personally and in the organisation; how a second successful improvement grade was marked; the attitude of leaders to the process and on-going priorities. The response may reveal an attitude to the regulator, motivation of participants and the organisation, a sense of momentum and perceived value of the regulatory process. It may also draw out views on personal and organisational resilience.

9. What were the Trust's strategic priorities following the first CQC inspection?**

This question was asked to determine the impact of the CQC on the strategic priorities of the organisation following an underperformance rating. It sought to identify whether organisational priorities changed as a result of the CQC grade. More specifically, did they become less strategically focussed on the organisation's sustainability towards an inward focus of performance improvement as assessed by the CQC. Understanding Trust objectives and priorities may shed light on how the organisation views regulation and how beneficial the inspection process and regulators are to developing an organisation's resilience and ultimate sustainability.

10. How does the CQC impact the organisation's strategic priorities? Would you focus on different priorities if you weren't inspected by the CQC?

This question was asked to determine whether Trust strategic priorities were impacted by any CQC inspection and enabled further probing on a number of issues. For example, did priorities alter after a positive inspection rating? How did this compare with the response from question 9 above? If there were changes, what were they, what was the reason for the change and how significant might that be to organisational resilience and performance? Without a CQC inspection, would strategic priorities be different? Exploring these additional issues was facilitated by this initial question.

11. Who are the key influencers in the organisation and why?

Leaders are influential and, as reported in Section 2.6.1, the NHS has focussed on distributed leadership and its impact on organisational culture. This question sought to identify where influence is located in the case study Trusts. This would indicate a style of leadership, such as an hierarchical or distributed leadership pattern, in the organisation. This would also be an indicator of organisational culture, which can be cross-referenced for consistency with questions 3 and 4 above.

12. Please tell me about a leader behaviour that has stood out for you for a positive reason during the past 2-3 years and why that was memorable for you.**

The research aimed to identify the strategic leadership behaviours that have accounted for or contributed towards the performance improvement noted by the CQC. Responses to this question may identify particular behaviour patterns or standout individuals, which may be significant. The question would elicit positive behaviours that

may contribute to performance improvement and the development of organisational resilience. The responses can also be compared to the influential people identified in question 11 above to identify any pattern or correlation.

13a. How does the organisation learn from incidents or errors?

13b. And how does it share good practice?

These questions were designed to understand the organisation's systems and processes for recording and monitoring accidents, incidents and best practice; identify how lessons from these positive and negative incidents are determined and how learning is then shared throughout the organisation. They were also aimed at eliciting the Trust's attitude to learning from accidents and sharing best practice and whether there is an imbalance of acknowledging positive and negative experiences. It may also indicate a Trust culture. Accelerating learning throughout an organisation by sharing reflections from both positive and negative experiences will help develop and embed a quality culture (Schein, 2004), important for organisational performance and resilience of a health care organisation.

14. What does organisational resilience mean to you?

The researcher was interested to discover what the research participants understood from the term organisational resilience, having agreed to participate in the study. The researcher also sought to find out whether there was a collective definition of organisational resilience in the Trust, as definitions in the literature vary (Horne and Orr, 1997; Burnard and Bhamra, 2011; Hopkin, 2014). Therefore, a shared definition of organisational resilience was likely to indicate that it was discussed by organisational leaders and disseminated throughout the organisation.

15. What do people do here to help build organisational resilience?

Personal resilience has gained traction in the NHS and is frequently linked to health and well-being programmes (Sull, Harland and Moore, 2015). This question aimed to identify at which level organisational resilience was discussed and the extent to which a formal commitment to organisational resilience in the Trust was addressed. Awareness of participants to organisational resilience initiatives in their Trust was explored through this question. Their knowledge of such initiatives may be an indicator of their appreciation of the relevance of organisational resilience and the need for a corporate

approach to plan for organisational sustainability.

16. How does the CQC contribute to the resilience of the NHS?

Identified in the literature, the CQC perceives it has a role contributing to the development of organisational resilience in the NHS (CQC, 2015; CQC, 2020). The question sought to determine how participants perceive the NHS regulator as a contributor to the Trust's resilience. The perceived potential influence and credibility of the CQC to develop sustainability in health and social care may be illuminated through this question.

17. What is the organisation's attitude to risk?

A hospital Trust is required to assess risks and maintain a risk register. There are two broad areas of risk, those of patient safety and financial risks (Monitor, 2014). This question was left open for participants to address from the perspectives they felt most knowledgeable. Managing risk effectively is essential to organisational resilience and sustainability (Burnard and Bhamra, 2011). The question was asked to elicit information on the Trust's approach to and management of risk, identifying its significance to strategic priorities and contribution to organisational resilience and sustainability.

18. How is horizon scanning managed in the Trust?

Horizon scanning is a key requirement for organisational resilience, especially in times of organisational change (Louisot, 2015). The NHS is in a significant change process, with Trusts now in formed Sustainable Transformation Partnerships, working towards an Integrated Care System (Section 2.2.3.4). A Trust's ability to place itself within the wider system will be highly relevant to its resilience and sustainability. An understanding of the Trust's approach to this external-facing task may illuminate how it plans for resilience and organisational sustainability in the long term, and aims to contribute to the sustainability of the system in which it operates.

19. How do you see the future for the Trust?

This question sought to understand how widely Trust goals are communicated throughout the organisation and whether there is a shared vision from the Board to clinicians and non-clinical managers. Staff commitment may be indicated, with potential impact on organisational resilience. The question sought to identify the future focus for the Trust – longevity vs. short-term goals.

20. Final question: Is there anything else that you think is significant or that you'd like to tell me?

This question enabled participants to share any information with the researcher that they may have anticipated would be asked and was not, or anything that came to mind during the course of the interview that was important to them.

APPENDIX IV

Introductory Email to Referred Prospective Participants

Email Subject Heading: PhD Research

cc: Referrer

Dear (First Name)

I am interviewing a number of people in the Trust as part of my research into leadership and organisational resilience. The Trust's CEO and R&D department are supporting the research and your colleague (Name 2) has suggested that you may be interested in being involved, and has given me your email address.

It is entirely voluntary for you to participate and the confidential interview will take a maximum of 90 minutes. I attach a brief overview of the project to give you some context. I have a detailed information sheet for prospective participants (4 pages) should you be interested in participating, to read before finally consenting to be interviewed.

In the first instance I would greatly appreciate it if you would give consideration to being interviewed as I think your input would be invaluable. I would be very happy to have a conversation with you about it should you want more details at this stage. I have interviewed (Name 2) and you may also wish to talk to him/her about the work.

I look forward to hearing from you.

Kind regards,

Barbara

Barbara Bradbury
Tel: (Landline Number)
Mob: (Number)

APPENDIX V

Preliminary Briefing Sheet for Prospective Participants

PhD RESEARCH OVERVIEW

Research questions:

"What has enabled organisational performance improvement and thus developed organisational resilience, as evidenced by the CQC? What strategic leadership behaviours underpinned the development of sustained organisational resilience?"

Context:

Resilience has been defined as the ability to continue to positively adjust under challenging circumstances, with the organisation eventually emerging more strongly and better resourced. This research sets out to determine the impact that NHS leadership has on the resilience of their organisation. Specifically, how did the organisation go from a CQC rating of *XXX* to *YYY*?

Research objectives:

- Identify the strategic behaviours of leaders which impact the resilience of their organisation
- Gain clarity on which leader behaviours relate most positively to staff
- Provide evidence to other healthcare leaders and potentially enable greater resilience throughout the NHS.

Benefit to the Trust:

- Gaining greater insight into the most impactful strategic behaviours of leaders
- Getting clarity on who is influential and how that influence is manifested
- Identifying which behaviours, systems and processes to encourage and discourage in order to maintain organisational resilience and sustainability.

Participant involvement:

- Face-to-face interview, 60-90 minutes. Recorded for accuracy
- Possible shadowing – 1 day
- Possible observation in meetings

Confidentiality:

All data will be kept strictly confidential. Each participant will be allocated an identification code, which will be securely held in a separate encrypted file and place to other data and stored on the University of Southampton's data research repository. The PhD thesis will not identify individual participants or the Trust.

Consent:

Participants will be asked to sign a consent form when they agree to participate in the research.

Right to withdraw:

Participants have the right to change their mind and withdraw at any time without giving a reason and without their participant rights being affected. If they decide to withdraw after 30 days following their interview their data may be included in the data analysis. Should they choose to withdraw during a period of shadowing, all written field notes previously taken that day will be destroyed immediately by shredding and will not form part of the data analysis.

Researcher: Barbara Caroline Bradbury TD, MPhil, BSc (Hons), RGN

PhD student, University of Southampton – Southampton Business School

Barbara has worked for 30 years in the field of personal and organisational development (OD). Following her clinical experience in ITU and as a surgical ward Sister, Barbara moved into the OD field, initially at Regional Health Authority level and then to the role of Director of Development (Organisational Audit) at the King's Fund. She returned to the health service as an executive director of OD in an NHS Community Trust before establishing an OD consultancy in 1999, working with healthcare organisations.

APPENDIX VI

Participant Information Sheet

UNIVERSITY OF Southampton

Participant Information Sheet

Study title: The Impact of Leaders on Organisational Resilience

Researcher name: Barbara Bradbury
ERGO number: 47300
IRAS Reference Number: 248763

You are being invited to take part in the above research study. To help you decide whether you would like to take part or not, it is important that you understand why the research is being done and what it will involve. Please read the information below carefully and ask questions if anything is not clear or you would like more information before you decide to take part in this research. You may like to discuss it with others but it is up to you to decide whether or not to take part. If you are happy to participate you will be asked to sign a consent form.

What is the research about?
I am Barbara Bradbury, a PhD student at the University of Southampton and funding my own research. I have an NHS career background, and worked clinically as a nurse in hospitals before moving into the field of organisational development. I have worked at the King's Fund and been a director of Nursing and Organisational Development in an NHS Trust. For the last 20 years I have worked independently with NHS professionals, focussing on leadership and management development and I am keen to understand how leaders impact the resilience of the NHS organisation in which they work. The findings of this research may be of benefit to you and your Trust through:

- Gaining greater insight into the most impactful behaviours of leaders
- Getting clarity on who is influential and how that influence is manifested
- Identifying which behaviours, systems and processes to encourage and discourage in order to maintain high reliability within the Trust.

The research has the potential to be of wider benefit to the NHS and other organisations through sharing of new knowledge with other leaders, which may influence the overall service, quality, safety and leadership of organisations. It aims to provide useful, meaningful and robust evidence, to leaders within the health care sector, on behaviours that will benefit the NHS and enable greater resilience of organisations in the health care system.

Why have I been asked to participate?
You have been asked to be involved in this research because it focuses on leaders at all levels in the Trust. Approximately 25 leaders in your Trust will be participating in the study.

What will happen to me if I take part?
You will be requested to have a face-to-face interview with me for 60-90 minutes, which will be digitally recorded for accuracy and which I will later transcribe. The transcription will have all identifiable information removed. Your information will be kept confidential and anything reported will be anonymised – i.e. you will not be identified by name. The digital audio recording will be destroyed immediately after it has been transcribed and within three months of your interview. Prior to transcription and deletion, digital audio recordings will be kept in a separate encrypted file and place to other data and stored securely on the University of Southampton's data research repository.

I may also observe you as you undertake your usual work: for example, I shall be observing open Board meetings and, with permission from the CEO and committee meeting Chairs on behalf of their committee members, other management meetings such as the Risk Management Committee. I shall be observing unobtrusively from a distance and noting specifically the conversation subject matter, behaviour of leaders and interactions between the meeting membership. I will record the names and job titles of the meeting participants electronically and keep this information secure in an encrypted file, accessible by the researcher only, and stored on the University of Southampton's data research repository. This information will not be shared with anyone. I will allocate each meeting participant an identification code number and this code will be kept in a separate encrypted file and place to other data and stored on the University of Southampton's data research repository.

I may ask your permission to shadow you for part of your working day, to a maximum of 7.5 hours, to observe you in your role. This is completely optional and your signed consent will be required should you agree to this request. You will have full control over what aspects of your working day I may shadow you and when you would like me to be absent. The observation will not involve me collecting any sensitive or identifiable data. Observation field notes will hold no identifiable data and will be stored in a locked desk accessible only by the researcher. On completion of the research they will be shredded.

Are there any risks involved?
There are no risks anticipated with your involvement, aside from mild fatigue. You can choose to withdraw during the interview at any time without needing to explain yourself and without prejudice. You can also choose to request I stop shadowing you at any time during the working day without needing to explain yourself and without prejudice.

What data will be collected?
I will record your name and job title electronically and keep this information secure in a separate encrypted file and place to other data, accessible by the researcher only, and stored on the University of Southampton's data research repository. This information will not be shared routinely with anyone. In the event that my data management system is audited for compliance against applicable regulations, certain individuals may request access to your data.

Only my supervisor (Prof Amy Fraher: A.L.Fraher@soton.ac.uk) and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may also require access to your

data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

Your email address will be kept for the duration of the study in order that I can maintain contact with you as necessary. Any emails will be sent from a device that is password protected.

Will my participation be confidential?
Your participation and the information I collect about you during the course of the research will be kept strictly confidential. I will allocate you an identification code number and this code will be kept in a separate encrypted file and place to other data and stored on the University of Southampton's data research repository.

You will be asked to sign a consent form when you agree to participate in the research. Your signed consent form will be immediately scanned digitally by a password-protected device and stored securely in a separate encrypted file and place to other data on the University of Southampton's data research repository. The original document with your handwritten signature will be left in your possession for your own record and eventual disposal.

The PhD thesis will not identify individual participants or the Trust.

All electronically stored data, including interview transcripts, observation field notes and consent forms, will be securely stored in separate encrypted files, accessible by the researcher solely. It will be stored on the University of Southampton's data research repository. Identifiable data will be removed from all electronically stored data.

In the event of an audit or research governance monitoring, only my supervisor (Prof Amy Fraher: A.L.Fraher@soton.ac.uk), responsible members of the University of Southampton or an individual from a regulatory authority may be given access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

Do I have to take part?
No, it is entirely up to you to decide whether or not to take part. If you decide you want to take part, you will need to sign a consent form to show you have agreed to take part.

What happens if I change my mind?
You have the right to change your mind and withdraw at any time without giving a reason and without your participant rights being affected, by emailing me at B.C.Bradbury@soton.ac.uk
If you decide to withdraw after 30 days following your interview your data may be included in the data analysis, but you will not have further involvement in the research. Should you choose to withdraw during a period of shadowing, all written field notes previously taken that day will be destroyed immediately by shredding and will not form part of the data analysis.

What will happen to the results of the research?
The research will be written up in a PhD thesis. Other publications may be subsequently developed for professional outlets. Your personal details will remain strictly confidential. Research findings made available in any reports or publications will not include

information that can directly identify you. The Trust will not be identified without the specific consent of the Chief Executive Officer.

What happens if there is a problem?
If you have a concern about any aspect of this study, you should speak to me and I will do my best to answer your questions. If you remain unhappy or have a complaint about any aspect of this study, please contact the University of Southampton Research Integrity and Governance Manager (Tel: 023 8059 5058; Email: rgoinfo@soton.ac.uk).

Data Protection Privacy Notice
The University of Southampton conducts research to the highest standards of research integrity. As a publicly-funded organisation, the University has to ensure that it is in the public interest when we use personally-identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, 'Personal data' means any information that relates to and is capable of identifying a living individual. The University's data protection policy governing the use of personal data by the University can be found on its website (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the researcher if you have any questions or are unclear what data is being collected about you.

Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at http://www.southampton.ac.uk/assets/sharepoint/intranet/ls/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 2 years after the study has finished after which time any link between you and your information will be removed.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

Thank you for reading this information sheet and considering taking part in the research.

12 August 2019_v3

APPENDIX VII

Consent Form

UNIVERSITY OF Southampton

CONSENT FORM

Study title: The Impact of Leaders on Organisational Resilience

Researcher name: Barbara Bradbury
ERGO number: 47300
IRAS Reference Number: 248763
Participant Identification Number:

Please initial the boxes if you agree with the statements:

I have read and understood the information sheet (12 August 2019, v3) and have had the opportunity to ask questions about the study.	
I agree to take part in this research project and agree for my data to be used for the purpose of this study.	
I understand my participation is voluntary and I may withdraw at any time for any reason without my participation rights being affected.	
I understand that I may be quoted directly in reports of the research but that I will not be directly identified (e.g. that my name will not be used).	
I understand that I may be asked to be shadowed for a maximum of 7.5 hours during one working day and agree to be observed in this way.	
I understand that taking part in the study involves audio recording. The recording will be transcribed and then the audio file will be destroyed. The transcribed notes will be securely held in the University of Southampton research data store for the purposes set out in the participation information sheet.	

Name of participant (print name) ……

Signature of participant ……

Date……

Name of researcher (print name) ……

Signature of researcher ……

Date……

12 August 2019_v3

APPENDIX VIII

Meeting Observation Recording Sheet

Case Site ID: **Meeting Title:** **Date:**

Start Time: **End Time:** **Meeting Length:**

Attendees:

Observation	Reflection

APPENDIX IX

Secondary Data Sources

CASE STUDY 1

Year	BP No.	AR No.	CQCSR No.
2006		1	
2007		2	
2008		3	
2009		4	
2010		5	
2011		6	
2012		7	
2013		8	
2014		9	
2015	1-10	10	1
2016	11-21	11	
2017	22-31	12	2
2018	32-41	13	
2019	42-48	14	3
2020	49	15	

TABLE KEY:

BP No.	Board Paper Number
AR No.	Annual Report Number
CQCSR No.	Care Quality Commission Summary Report Number

CASE STUDY 2

Year	BP No.	AR No.	CQCSR No.
2015	50-59	16	4
2016	60-68	17	
2017	69-76	18	5
2018	77-82	19	
2019	83-89	20	6
2020	90	21	

TABLE KEY:

BP No.	Board Paper Number
AR No.	Annual Report Number
CQCSR No.	Care Quality Commission Summary Report Number

APPENDIX X

NHS Staff Survey Results 2015-2019: Case Study 1

(Source: NHS Staff Surveys 2015-2020)

Survey Theme	NHS Q No.	2015	2016	2017	2018	2019
Safety Culture: Reporting of incidents, near misses and errors		**%**	**%**	**%**	**%**	**%**
Staff encouraged to report incidences, near misses or errors	17b	86.9	88.4	88.7	89.3	90.7
Staff feel fairly treated when involved in an incident	17a	53.5	57.7	57.4	64.0	65.8
Staff feel secure raising concerns of safety	18b	64.7	67.0	67.5	71.7	72.7
Staff feel confident that their organisation will address their concern	18c	52.7	56.3	57.5	61.4	63.3
Staff have reported witnessed incidents	16c	94.3	94.9	95.3	95.3	95.3
Action is taken by Trust to ensure incident is not repeated	17c	66.8	70.6	71.1	74.6	74.9
Staff are given feedback on changes made in response to incident	17d	54.3	58.2	61.3	62.8	64.0
Safe Environment: Experience of incidences of bullying, abuse or harassment from:		**%**	**%**	**%**	**%**	**%**
Managers	13b	13.9	12.0	11.8	11.7	10.5
Other colleagues	13c	20.1	17.9	18.4	18.5	18.1
Patients, relatives or other members of the public	13a	28.6	27.6	26.9	24.5	25.4
Staff member or colleague reported last incident of bullying	13d	40.9	42.7	44.6	45.4	46.3
National level of reported staff abuse		44.7	47.5	47.8	47.0	48.6
Management Experiences: Immediate manager		**%**	**%**	**%**	**%**	**%**
Satisfaction with amount of support from manager	5b	66.0	67.2	68.4	69.7	71.8
Staff feel their work is valued by their manager	8g	68.5	71.6	71.5	73.2	75.0
Manager gives clear feedback on their work	8c	55.7	59.3	58.8	59.0	61.9
Manager is supportive in a personal crisis	8e	70.9	73.7	73.4	74.5	77.0
Feels trusted to do their job	3b	91.7	92.8	92.7	92.1	92.4
Can count on manager for help with difficult task	8b	68.5	70.2	70.4	68.9	73.5
Trust values discussed at appraisal meeting	19e	27.9	29.9	31.9	34.5	36.5
Manager asks staff's opinion before making decisions that affect their work	8d	51.0	53.9	54.5	55.9	57.4

Senior managers		%	%	%	%	%
Awareness of who the senior managers in the Trust are	9a	78.6	80.9	83.9	85.5	83.4
Senior managers act on staff feedback	9d	27.3	31.7	34.0	35.9	38.9
Effective communication between senior managers and staff	9b	35.4	39.0	41.3	42.9	44.6
Try to involve staff in important decisions	9c	29.1	32.9	34.3	36.5	39.0
Teamwork						
Team has a set of shared objectives	4h	70.6	74.7	74.6	73.2	73.3
Team meets often to discuss its effectiveness	4i	52.9	56.7	57.0	56.9	58.2
Involved in change decisions that affect team	4c	52.0	54.5	54.7	54.9	53.6
Quality of Care		**%**	**%**	**%**	**%**	**%**
Agree that patient care is the organisation's top priority	21a	76.8	79.8	81.3	83.2	84.5
Satisfied with the quality of care they give patients	7a	80.1	81.9	80.9	80.3	81.8
Feel able to give the care they aspire to	7c	64.8	67.4	65.6	65.2	68.1
Satisfied with standards of care in their Trust	21d	76.7	80.9	83.1	84.9	85.4
Trust acts on concerns raised by patients	21b	72.5	75.0	76.8	78.5	78.1
Health and Well-Being		**%**	**%**	**%**	**%**	**%**
Staff has felt unwell as a result of work-related stress	11c	36.1	34.0	35.3	37.0	35.9
Trust takes positive action on staff health and well-being	11a	29.4	34.4	34.9	28.4	32.3
Immediate manager takes a positive interest in staff's health and well-being	8f	64.6	67.0	67.0	68.8	71.0
Staff Morale		**%**	**%**	**%**	**%**	**%**
Staff feel enthusiastic about their job	2b	72.8	74.3	73.9	75.7	76.7
Staff look forward to going to work	2a	55.9	57.2	57.1	58.7	59.3
Satisfied with level of colleague support	5c	79.6	82.1	83.1	82.5	83.4
Staff recommend their organisation as a place to work	21c	60.7	66.9	68.8	70.8	73.9
Satisfied with the extent to which the Trust values their work	5f	38.1	44.0	44.9	47.8	50.6
Feels Trust acts fairly on promotion/career progression against protected characteristics (Equality Act)	14	87.4	89.3	88.1	84.7	87.5
Has experienced discrimination by patients/relatives/public	15a	5.8	5.9	6.3	5.1	5.6
Has experienced discrimination by Trust staff	15b	7.6	7.2	8.2	7.3	6.5
Survey Response Rate		**%**	**%**	**0%**	**%**	**%**
		44.2	42.1	42.9	52.5	55.2

APPENDIX XI

NHS Staff Survey Results 2015-2019: Case Study 2

(Source: NHS Staff Surveys 2015-2020)

Survey Theme	NHS Q No.	2015	2016	2017	2018	2019
Safety Culture: Reporting of incidents, near misses and errors		**%**	**%**	**%**	**%**	**%**
Staff encouraged to report incidences, near misses or errors	17b	80.8	85.6	86.2	88.1	88.6
Staff feel fairly treated when involved in an incident	17a	47.3	51.6	53.5	58.2	61.7
Staff feel secure raising concerns of safety	18b	64.6	70.7	71.3	71.4	71.8
Staff feel confident that their organisation will address their concern	18c	47.4	56.0	56.8	58.7	60.5
Staff have reported witnessed incidents	16c	92.8	94.9	95.8	93.4	94.6
Action is taken by Trust to ensure incident is not repeated	17c	63.7	68.9	69.1	70.8	70.2
Staff are given feedback on changes made in response to incident	17d	53.9	63.2	67.1	66.4	62.6
Safe Environment: Experience of incidences of bullying, abuse or harassment from:		**%**	**%**	**%**	**%**	**%**
Managers	13b	15.2	12.1	12.1	12.5	10.7
Other colleagues	13c	18.4	16.2	17.2	17.4	18.9
Patients, relatives or other members of the public	13a	35.2	32.5	34.0	36.2	36.5
Staff member or colleague reported last incident of bullying	13d	50.1	55.4	56.2	56.2	58.2
National level of reported staff abuse		44.7	47.5	47.8	47.0	48.6
Management Experiences: Immediate manager		**%**	**%**	**%**	**%**	**%**
Satisfaction with amount of support from manager	5b	70.7	73.4	73.5	74.7	78.1
Staff feel their work is valued by their manager	8g	75.4	78.3	78.5	78.7	81.5
Manager gives clear feedback on their work	8c	62.9	67.5	69.4	68.4	71.1
Manager is supportive in a personal crisis	8e	78.1	79.1	79.6	78.1	83.3
Feels trusted to do their job	3b	89.9	90.3	91.5	91.2	92.0
Can count on manager for help with difficult task	8b	73.6	76.0	76.5	76.4	78.6
Trust values discussed at appraisal meeting	19e	32.4	43.5	40.0	42.8	43.8
Manager asks staff's opinion before making decisions that affect their work	8d	57.7	60.5	61.9	61.7	64.8

Senior managers		%	%	%	%	%
Awareness of who the senior managers in the Trust are	9a	85.2	86.1	88.2	86.8	87.5
Senior managers act on staff feedback	9d	31.2	33.8	37.2	37.6	40.7
Effective communication between senior managers and staff	9b	36.7	41.2	43.9	44.1	47.5
Try to involve staff in important decisions	9c	35.3	38.2	42.5	41.1	44.2
Teamwork						
Team has a set of shared objectives	4h	71.8	74.3	76.1	75.3	75.1
Team meets often to discuss its effectiveness	4i	62.9	66.6	68.9	67.1	68.2
Involved in change decisions that affect team	4c	50.3	55.3	55.6	57.3	56.1
Quality of Care		**%**	**%**	**%**	**%**	**%**
Agree that patient care is the organisation's top priority	21a	68.6	73.3	74.9	79.3	80.0
Satisfied with the quality of care they give patients	7a	74.0	77.6	75.2	74.5	76.2
Feel able to give the care they aspire to	7c	54.7	58.1	57.1	57.8	59.9
Satisfied with standards of care in their Trust	21d	53.7	57.8	56.6	60.9	60.2
Trust acts on concerns raised by patients	21b	68.2	74.7	74.3	77.0	75.2
Health and Well-Being		**%**	**%**	**%**	**%**	**%**
Staff has felt unwell as a result of work-related stress	11c	44.9	42.9	45.4	44.0	44.3
Trust takes positive action on staff health and well-being	11a	24.7	28.8	33.4	31.1	33.6
Immediate manager takes a positive interest in staff's health and well-being	8f	71.9	74.0	75.5	75.5	79.3
Staff Morale		**%**	**%**	**%**	**%**	**%**
Staff feel enthusiastic about their job	2b	68.8	74.2	70.8	73.9	73.2
Staff look forward to going to work	2a	52.6	58.7	56.7	57.2	58.6
Satisfied with level of colleague support	5c	80.5	85.5	84.1	83.9	84.4
Staff recommend their organisation as a place to work	21c	48.6	54.4	56.1	62.6	63.9
Satisfied with the extent to which the Trust values their work	5f	40.3	46.1	48.5	51.7	55.0
Feels Trust acts fairly on promotion/career progression against protected characteristics (Equality Act)	14	84.7	88.2	88.2	85.5	88.1
Has experienced discrimination by patients/relatives/public	15a	6.6	7.5	7.9	9.0	8.5
Has experienced discrimination by Trust staff	15b	7.1	6.1	8.2	8.3	7.4
Survey Response Rate		**%**	**%**	**%**	**0%**	**%**
		50.5	53.3	54.9	54.5	56.5

APPENDIX XII

NHS Staff Survey Results in All Trusts, Case Study 1 and Case Study 2, 2015-2019: Collated Data

(Source: NHS Staff Surveys 2015-2019)

TABLE KEY: Trust* All: All Trusts *CS1: Case Study 1* CS2: Case Study 2

Survey Theme	Trust*	2015	2016	2017	2018	2019
Safety Culture: Reporting of incidents, near misses and errors		**%**	**%**	**%**	**%**	**%**
Staff encouraged to report incidences, near misses or errors	**All**	**85.0**	**85.0**	**85.0**	**86.0**	**85.0**
	CS1	*86.9*	*88.4*	*88.7*	*89.3*	*90.7*
	CS2	80.8	85.6	86.2	88.1	88.6
Staff feel fairly treated when involved in an incident	**All**	**52.2**	**51.0**	**54.0**	**58.3**	**59.7**
	CS1	*53.5*	*57.7*	*57.4*	*64.0*	*65.8*
	CS2	47.3	51.6	53.5	58.2	61.7
Staff feel secure raising concerns of safety	**All**	**68.0**	**70.0**	**70.0**	**70.7**	**71.7**
	CS1	*64.7*	*67.0*	*67.5*	*71.7*	*72.7*
	CS2	64.6	70.7	71.3	71.4	71.8
Staff feel confident that their organisation will address their concern	**All**	**56.0**	**58.0**	**57.6**	**58.0**	**59.8**
	CS1	*52.7*	*56.3*	*57.5*	*61.4*	*63.3*
	CS2	47.4	56.0	56.8	58.7	60.5
Staff have reported witnessed incidents	**All**	**94.0**	**94.7**	**94.6**	**94.9**	**95.0**
	CS1	*94.3*	*94.9*	*95.3*	*95.3*	*95.3*
	CS2	92.8	94.9	95.8	93.4	94.6
Action is taken by Trust to ensure incident is not repeated	**All**	**72.0**	**70.0**	**70.0**	**70.5**	**71.8**
	CS1	*66.8*	*70.6*	*71.1*	*74.6*	*74.9*
	CS2	63.7	68.9	69.1	70.8	70.2
Staff are given feedback on changes made in response to incident	**All**	**54.1**	**56.2**	**58.7**	**60.0**	**61.1**
	CS1	*54.3*	*58.2*	*61.3*	*62.8*	*64.0*
	CS2	53.9	63.2	67.1	66.4	62.6
Safe Environment: Experience of incidences of bullying, abuse or harassment from:		**%**	**%**	**%**	**%**	**%**
Managers	**All**	**13.0**	**13.0**	**12.8**	**13.2**	**12.3**
	CS1	*13.9*	*12.0*	*11.8*	*11.7*	*10.5*
	CS2	15.2	12.1	12.1	12.5	10.7
Other colleagues	**All**	**19.0**	**19.0**	**18.0**	**19.1**	**19.0**
	CS1	*20.1*	*17.9*	*18.4*	*18.5*	*18.1*
	CS2	18.4	16.2	17.2	17.4	18.9
Patients, relatives or other members of the public	**All**	**28.8**	**28.1**	**28.2**	**28.5**	**28.5**
	CS1	*28.6*	*27.6*	*26.9*	*24.5*	*25.4*
	CS2	35.2	32.5	34.0	36.2	36.5
Staff member or colleague reported last incident of bullying	**All**	**41.0**	**45.0**	**44.0**	**42.0**	**45.0**
	CS1	*40.9*	*42.7*	*44.6*	*45.4*	*46.3*
	CS2	50.1	55.4	56.2	56.2	58.2
National level of reported staff abuse		**44.7**	**47.5**	**47.8**	**47.0**	**48.6**

Management Experiences:		%	%	%	%	%
Immediate manager						
Satisfaction with amount of support from manager	**All**	**66.8**	**69.0**	**69.0**	**69.8**	**71.0**
	CS1	*66.0*	*67.2*	*68.4*	*69.7*	*71.8*
	CS2	70.7	73.4	73.5	74.7	78.1
Staff feel their work is valued by their manager	**All**	**70.5**	**71.0**	**71.0**	**72.0**	**73.3**
	CS1	*68.5*	*71.6*	*71.5*	*73.2*	*75.0*
	CS2	75.4	78.3	78.5	78.7	81.5
Manager gives clear feedback on their work	**All**	**60.0**	**61.8**	**62.0**	**61.4**	**62.9**
	CS1	*55.7*	*59.3*	*58.8*	*59.0*	*61.9*
	CS2	62.9	67.5	69.4	68.4	71.1
Manager is supportive in a personal crisis	**All**	**74.0**	**74.7**	**75.0**	**74.0**	**77.0**
	CS1	*70.9*	*73.7*	*73.4*	*74.5*	*77.0*
	CS2	78.1	79.1	79.6	78.1	83.3
Feel trusted to do their job	**All**	**91.0**	**91.0**	**91.0**	**91.0**	**91.0**
	CS1	*91.7*	*92.8*	*92.7*	*92.1*	*92.4*
	CS2	89.9	90.3	91.5	91.2	92.0
Can count on manager for help with difficult task	**All**	**71.0**	**71.0**	**72.0**	**71.0**	**73.0**
	CS1	*68.5*	*70.2*	*70.4*	*68.9*	*73.5*
	CS2	73.6	76.0	76.5	76.4	78.6
Trust values discussed at appraisal meeting	**All**	**30.8**	**33.0**	**34.0**	**37.0**	**39.2**
	CS1	*27.9*	*29.9*	*31.9*	*34.5*	*36.5*
	CS2	32.4	43.5	40.0	42.8	43.8
Manager asks staff's opinion before making decisions that affect their work	**All**	**53.6**	**54.1**	**54.6**	**55.3**	**56.2**
	CS1	*51.0*	*53.9*	*54.5*	*55.9*	*57.4*
	CS2	57.7	60.5	61.9	61.7	64.8
Senior managers	**All**	**82.0**	**82.2**	**82.0**	**83.0**	**83.0**
Awareness of who the senior managers in the Trust are	*CS1*	*78.6*	*80.9*	*83.9*	*85.5*	*83.4*
	CS2	85.2	86.1	88.2	86.8	87.5
Senior managers act on staff feedback	**All**	**30.0**	**31.1**	**32.0**	**32.7**	**34.5**
	CS1	*27.3*	*31.7*	*34.0*	*35.9*	*38.9*
	CS2	31.2	33.8	37.2	37.6	40.7
Effective communication between senior managers and staff	**All**	**38.0**	**39.2**	**40.0**	**41.0**	**42.0**
	CS1	*35.4*	*39.0*	*41.3*	*42.9*	*44.6*
	CS2	36.7	41.2	43.9	44.1	47.5
Try to involve staff in important decisions	**All**	**32.0**	**33.1**	**33.0**	**34.0**	**36.0**
	CS1	*29.1*	*32.9*	*34.3*	*36.5*	*39.0*
	CS2	35.3	38.2	42.5	41.1	44.2
Teamwork	**All**	**72.0**	**72.0**	**72.0**	**72.8**	**72.4**
Team has a set of shared objectives	*CS1*	*70.6*	*74.7*	*74.6*	*73.2*	*73.3*
	CS2	71.8	74.3	76.1	75.3	75.1
Team meets often to discuss its effectiveness	**All**	**59.3**	**60.3**	**60.4**	**60.6**	**60.7**
	CS1	*52.9*	*56.7*	*57.0*	*56.9*	*58.2*
	CS2	62.9	66.6	68.9	67.1	68.2

Involved in change decisions that affect team	**All**	**52.0**	**52.0**	**52.0**	**52.2**	**52.0**
	CS1	*52.0*	*54.5*	*54.7*	*54.9*	*53.6*
	CS2	50.3	55.3	55.6	57.3	56.1
Quality of Care		**%**	**%**	**%**	**%**	**%**
Agree that patient care is the Trust's top priority	**All**	**73.3**	**74.0**	**75.0**	**76.0**	**77.3**
	CS1	*76.8*	*79.8*	*81.3*	*83.2*	*84.5*
	CS2	68.6	73.3	74.9	79.3	80.0
Satisfied with the quality of care they give patients	**All**	**82.2**	**82.7**	**84.0**	**80.7**	**81.1**
	CS1	*80.1*	*81.9*	*80.9*	*80.3*	*81.8*
	CS2	74.0	77.6	75.2	74.5	76.2
Feel able to give the care they aspire to	**All**	**67.0**	**69.0**	**66.8**	**67.1**	**68.5**
	CS1	*64.8*	*67.4*	*65.6*	*65.2*	*68.1*
	CS2	54.7	58.1	57.1	57.8	59.9
Satisfied with standards of care in their Trust	**All**	**69.0**	**69.0**	**70.0**	**71.0**	**71.4**
	CS1	*76.7*	*80.9*	*83.1*	*84.9*	*85.4*
	CS2	53.7	57.8	56.6	60.9	60.2
Trust acts on concerns raised by patients	**All**	**73.0**	**73.0**	**73.0**	**73.4**	**73.8**
	CS1	*72.5*	*75.0*	*76.8*	*78.5*	*78.1*
	CS2	68.2	74.7	74.3	77.0	75.2
Health and Well-Being		**%**	**%**	**%**	**%**	**%**
Staff has felt unwell as a result of work-related stress	**All**	**37.0**	**36.8**	**38.0**	**39.8**	**40.3**
	CS1	*36.1*	*34.0*	*35.3*	*37.0*	*35.9*
	CS2	44.9	42.9	45.4	44.0	44.3
Trust takes positive action on staff health and well-being	**All**	**30.0**	**32.0**	**31.8**	**28.6**	**29.3**
	CS1	*29.4*	*34.4*	*34.9*	*28.4*	*32.3*
	CS2	24.7	28.8	33.4	31.1	33.6
Immediate manager takes a positive interest in staff's health and well-being	**All**	**65.8**	**68.0**	**69.0**	**68.4**	**69.7**
	CS1	*64.6*	*67.0*	*67.0*	*68.8*	*71.0*
	CS2	71.9	74.0	75.5	75.5	79.3
Staff Morale		**%**	**%**	**%**	**%**	**%**
Staff feel enthusiastic about their job	**All**	**74.0**	**74.0**	**73.6**	**75.0**	**74.8**
	CS1	*72.8*	*74.3*	*73.9*	*75.7*	*76.7*
	CS2	68.8	74.2	70.8	73.9	73.2
Staff look forward to going to work	**All**	**58.0**	**59.0**	**57.7**	**59.0**	**59.5**
	CS1	*55.9*	*57.2*	*57.1*	*58.7*	*59.3*
	CS2	52.6	58.7	56.7	57.2	58.6
Satisfied with level of colleague support	**All**	**82.0**	**82.0**	**82.0**	**82.0**	**82.0**
	CS1	*79.6*	*82.1*	*83.1*	*82.5*	*83.4*
	CS2	80.5	85.5	84.1	83.9	84.4
Staff recommend their organisation as a place to work	**All**	**58.7**	**59.8**	**59.6**	**61.6**	**63.3**
	CS1	*60.7*	*66.9*	*68.8*	*70.8*	*73.9*
	CS2	48.6	54.4	56.1	62.6	63.9
Satisfied with the extent to which the Trust values their work	**All**	41.8	43.0	43.0	46.0	48.0
	CS1	38.1	44.0	44.9	47.8	50.6
	CS2	40.3	46.1	48.5	51.7	55.0

Feels Trust acts fairly on promotion/ career progression against protected characteristics (Equality Act)	**All**	**86.0**	**85.0**	**86.8**	**83.4**	**83.9**
	CS1	*87.4*	*89.3*	*88.1*	*84.7*	*87.5*
	CS2	84.7	88.2	88.2	85.5	88.1
Has experienced discrimination by patients/relatives/public	**All**	**6.8**	**6.0**	**6.6**	**7.0**	**7.2**
	CS1	*5.8*	*5.9*	*6.3*	*5.1*	*5.6*
	CS2	6.6	7.5	7.9	9.0	8.5
Has experienced discrimination by Trust staff	**All**	**7.0**	**7.0**	**8.0**	**8.1**	**7.7**
	CS1	*7.6*	*7.2*	*8.2*	*7.3*	*6.5*
	CS2	7.1	6.1	8.2	8.3	7.4
Survey Response Rate		**%**	**%**	**%**	**0%**	**%**
	All	**41.0**	**44.0**	**45.0**	**46.0**	**49.8**
	CS1	*44.2*	*42.1*	*42.9*	*52.5*	*55.2*
	CS2	50.5	53.3	54.9	54.5	56.5

APPENDIX XIII

NHS Staff Survey Results in All Trusts, Case Study 1 and Case Study 2 2015 and 2019: Trend Differentials

(Source: NHS Staff Surveys 2015-2020)

TABLE KEY: Trust* All: All Trusts *CS1: Case Study 1* CS2: Case Study 2

Survey Theme	Trust*	2015	2019	Trend
Safety Culture: Reporting of incidents, near misses and errors		**%**	**%**	**%**
Staff encouraged to report incidences, near misses or errors	**All**	**85.0**	**85.0**	**=**
	CS1	*86.9*	*90.7*	*+3.8*
	CS2	80.8	88.6	+7.8
Staff feel fairly treated when involved in an incident	**All**	**52.2**	**59.7**	**+7.5**
	CS1	*53.5*	*65.8*	*+12.3*
	CS2	47.3	61.7	+14.4
Staff feel secure raising concerns of safety	**All**	**68.0**	**71.7**	**+3.7**
	CS1	*64.7*	*72.7*	*+8.0*
	CS2	64.6	71.8	+7.2
Staff feel confident that their organisation will address their concern	**All**	**56.0**	**59.8**	**+3.8**
	CS1	*52.7*	*63.3*	*+10.5*
	CS2	47.4	60.5	+13.1
Staff have reported witnessed incidents	**All**	**94.0**	**95.0**	**+1.0**
	CS1	*94.3*	*95.3*	*+1.0*
	CS2	92.8	94.6	+1.8
Action is taken by Trust to ensure incident is not repeated	**All**	**72.0**	**71.8**	**-0.2**
	CS1	*66.8*	*74.9*	*+8.1*
	CS2	63.7	70.2	+6.5
Staff are given feedback on changes made in response to incident	**All**	**54.1**	**61.1**	**+7.0**
	CS1	*54.3*	*64.0*	*+9.7*
	CS2	53.9	62.6	+8.7
Safe Environment: Experience of incidences of bullying, abuse or harassment from:		**%**	**%**	**%**
	All	**13.0**	**12.3**	**-0.7**
Managers	*CS1*	*13.9*	*10.5*	*-3.4*
	CS2	15.2	10.7	-4.5
Other colleagues	**All**	**19.0**	**19.0**	**=**
	CS1	*20.1*	*18.1*	*-2.0*
	CS2	18.4	18.9	+0.5
Patients, relatives or other members of the public	**All**	**28.8**	**28.5**	**-0.3**
	CS1	*28.6*	*25.4*	*-3.2*
	CS2	35.2	36.5	+1.3
Staff member or colleague reported last incident of bullying	**All**	**41.0**	**45.0**	**+4.0**
	CS1	*40.9*	*46.3*	*+5.4*
	CS2	50.1	58.2	+8.1
National level of reported staff abuse		**44.7**	**48.6**	**+3.9**

Management Experiences:		**%**	**%**	**%**
Immediate manager				
Satisfaction with amount of support from manager	**All**	**66.8**	**71.0**	**+4.2**
	CS1	*66.0*	*71.8*	*+5.8*
	CS2	70.7	78.1	+7.4
Staff feel their work is valued by their manager	**All**	**70.5**	**73.3**	**+2.8**
	CS1	*68.5*	*75.0*	*+6.5*
	CS2	75.4	81.5	+6.9
Manager gives clear feedback on their work	**All**	**60.0**	**62.9**	**+2.9**
	CS1	*55.7*	*61.9*	*+6.2*
	CS2	62.9	71.1	+8.2
Manager is supportive in a personal crisis	**All**	**74.0**	**77.0**	**+3.0**
	CS1	*70.9*	*77.0*	*+6.1*
	CS2	78.1	83.3	+5.2
Feel trusted to do their job	**All**	**91.0**	**91.0**	**=**
	CS1	*91.7*	*92.4*	*+0.7*
	CS2	89.9	92.0	+2.1
Can count on manager for help with difficult task	**All**	**71.0**	**73.0**	**+2.0**
	CS1	*68.5*	*73.5*	*+5.0*
	CS2	73.6	78.6	+5.0
Trust values discussed at appraisal meeting	**All**	**30.8**	**39.2**	**+8.4**
	CS1	*27.9*	*36.5*	*+8.6*
	CS2	32.4	43.8	+11.4
Manager asks staff's opinion before making decisions that affect their work	**All**	**53.6**	**56.2**	**+2.6**
	CS1	*51.0*	*57.4*	*+6.4*
	CS2	57.7	64.8	+7.1
Senior managers				
Awareness of who the senior managers in the Trust are	**All**	**82.0**	**83.0**	**+1.0**
	CS1	*78.6*	*83.4*	*+4.8*
	CS2	85.2	87.5	+2.3
Senior managers act on staff feedback	**All**	**30.0**	**34.5**	**+4.5**
	CS1	*27.3*	*38.9*	*+11.6*
	CS2	31.2	40.7	+9.5
Effective communication between senior managers and staff	**All**	**38.0**	**42.0**	**+4.0**
	CS1	*35.4*	*44.6*	*+9.2*
	CS2	36.7	47.5	+10.8
Try to involve staff in important decisions	**All**	**32.0**	**36.0**	**+4.0**
	CS1	*29.1*	*39.0*	*+9.9*
	CS2	35.3	44.2	+9.1
Teamwork				
Team has a set of shared objectives	**All**	**72.0**	**72.4**	**+0.4**
	CS1	*70.6*	*73.3*	*+2.7*
	CS2	71.8	75.1	+3.3
Team meets often to discuss its effectiveness	**All**	**59.3**	**60.7**	**+1.4**
	CS1	*52.9*	*58.2*	*+5.3*
	CS2	62.9	68.2	+5.3

Involved in change decisions that affect team	**All**	**52.0**	**52.0**	**=**
	CS1	*52.0*	*53.6*	*+1.6*
	CS2	50.3	56.1	+5.8
Quality of Care		**%**	**%**	**%**
Agree that patient care is the Trust's top priority	**All**	**73.3**	**77.3**	**+4.0**
	CS1	*76.8*	*84.5*	*+7.7*
	CS2	68.6	80.0	+11.4
Satisfied with the quality of care they give patients	**All**	**82.2**	**81.1**	**-1.1**
	CS1	*80.1*	*81.8*	*+1.7*
	CS2	74.0	76.2	+2.2
Feel able to give the care they aspire to	**All**	**67.0**	**68.5**	**+1.5**
	CS1	*64.8*	*68.1*	*+3.3*
	CS2	54.7	59.9	+5.2
Satisfied with standards of care in their Trust	**All**	**69.0**	**71.4**	**+2.1**
	CS1	*76.7*	*85.4*	*+8.7*
	CS2	53.7	60.2	+6.5
Trust acts on concerns raised by patients	**All**	**73.0**	**73.8**	**+0.8**
	CS1	*72.5*	*78.1*	*+5.6*
	CS2	68.2	75.2	+7.0
Health and Well-Being		**%**	**%**	**%**
Staff has felt unwell as a result of work-related stress	**All**	**37.0**	**40.3**	**+3.3**
	CS1	*36.1*	*35.9*	*-0.2*
	CS2	44.9	44.3	-0.6
Trust takes positive action on staff health and well-being	**All**	**30.0**	**29.3**	**-0.7**
	CS1	*29.4*	*32.3*	*+2.9*
	CS2	24.7	33.6	+8.9
Immediate manager takes a positive interest in staff's health and well-being	**All**	**65.8**	**69.7**	**+3.9**
	CS1	*64.6*	*71.0*	*+6.4*
	CS2	71.9	79.3	+7.4
Staff Morale		**%**	**%**	**%**
Staff feel enthusiastic about their job	**All**	**74.0**	**74.8**	**+0.8**
	CS1	*72.8*	*76.7*	*+3.9*
	CS2	68.8	73.2	+4.4
Staff look forward to going to work	**All**	**58.0**	**59.5**	**+1.5**
	CS1	*55.9*	*59.3*	*+3.4*
	CS2	52.6	58.6	+6.0
Satisfied with level of colleague support	**All**	**82.0**	**82.0**	**=**
	CS1	*79.6*	*83.4*	*+3.8*
	CS2	80.5	84.4	+3.5
Staff recommend their organisation as a place to work	**All**	**58.7**	**63.3**	**+4.6**
	CS1	*60.7*	*73.9*	*+12.2*
	CS2	48.6	63.9	+15.3
Satisfied with the extent to which the Trust values their work	**All**	**41.8**	**48.0**	**+5.0**
	CS1	38.1	50.6	*+12.5*
	CS2	40.3	55.0	+14.7

Feels Trust acts fairly on promotion/ career progression against protected characteristics (Equality Act)	**All**	**86.0**	**83.9**	**-2.1**
	CS1	*87.4*	*87.5*	*+0.1*
	CS2	84.7	88.1	+3.4
Has experienced discrimination by patients/ public/ relatives	**All**	**6.8**	**7.2**	**+0.4**
	CS1	*5.8*	*5.6*	*-0.2*
	CS2	6.6	8.5	+1.9
Has experienced discrimination by Trust staff	**All**	**7.0**	**7.7**	**+0.7**
	CS1	*7.6*	*6.5*	*-1.1*
	CS2	7.1	7.4	+0.3
Survey Response Rate		**%**	**%**	**%**
	All	**41.0**	**49.8**	**+8.8**
	CS1	*44.2*	*55.2*	*+11.0*
	CS2	50.5	56.5	+6.0

APPENDIX XIV

NHS Staff Survey 2019

(Source: www.nhsstaffsurveys.com)

National NHS Staff Survey 2019

What is this survey and why are we asking you to complete it?

This is an independent survey of your experience of working in your organisation. The overall aim is to gather information that will help to improve the working lives of staff in the NHS and so help to provide better care for patients.

Your organisation will be able to use the results of the survey to improve local working conditions and practices and to increase involvement and engagement with staff. Other organisations, including NHS commissioners, the Care Quality Commission, the Department of Health, and NHS England, will make use of the results.

Please complete the survey for your current job, or the job you do most of the time. If you work across two or more employers in the NHS, please answer in relation to the organisation that pays your salary. Please read each question carefully, but give your immediate response by ticking the box which best matches your personal view.

Who will see my answers?

The survey is being conducted by Contractor Name and the NHS Staff Survey Coordination Centre on behalf of your organisation and NHS England.

Your answers will be treated in confidence. No one in your organisation will be able to identify individual responses. The bar code / number below is only used by Contractor Name to identify which staff should be sent a reminder and will not be available to staff in your organisation.

The survey findings will be analysed by Contractor Name and the NHS Staff Survey Coordination Centre and the results will be presented in a summary report in which no individual, or their responses, can be identified.

Please return this questionnaire, in the envelope provided, to:

Contractor Name
Address 1
Address 2
Address 3
Postcode

If you have any queries about this questionnaire please contact the [Insert] helpline on [Insert] or go to www.nhsstaffsurveys.com

YOUR JOB

1. Do you have face-to-face contact with patients / service users as part of your job?

1 ☐ Yes, frequently 2 ☐ Yes, occasionally 3 ☐ No

2. For each of the statements below, how often do you feel this way about your job?	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
a. I look forward to going to work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. I am enthusiastic about my job.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. Time passes quickly when I am working.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

3. To what extent do you agree or disagree with the following statements about your job?	**Strongly disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly agree**
a. I always know what my work responsibilities are.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. I am trusted to do my job.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. I am able to do my job to a standard I am personally pleased with.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

4. To what extent do you agree or disagree with the following statements about your work?	**Strongly disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly agree**
a. There are frequent opportunities for me to show initiative in my role.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. I am able to make suggestions to improve the work of my team / department.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. I am involved in deciding on changes introduced that affect my work area / team / department.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d. I am able to make improvements happen in my area of work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
e. I am able to meet all the conflicting demands on my time at work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
f. I have adequate materials, supplies and equipment to do my work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
g. There are enough staff at this organisation for me to do my job properly.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
h. The team I work in has a set of shared objectives.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
i. The team I work in often meets to discuss the team's effectiveness.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
j. I receive the respect I deserve from my colleagues at work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

5. How satisfied are you with each of the following aspects of your job?	**Very dissatisfied**	**Dissatisfied**	**Neither satis. nor dissatisfied**	**Satisfied**	**Very satisfied**
a. The recognition I get for good work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. The support I get from my immediate manager.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. The support I get from my work colleagues.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d. The amount of responsibility I am given.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
e. The opportunities I have to use my skills.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
f. The extent to which my organisation values my work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
g. My level of pay.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
h. The opportunities for flexible working patterns.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

6. How often do the following statements apply to your job?	Never	Rarely	Sometimes	Often	Always
a. I have unrealistic time pressures.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. I have a choice in deciding how to do my work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. Relationships at work are strained.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

7. Do the following statements apply to you and your job?	Not applicable to me	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a. I am satisfied with the quality of care I give to patients / service users.	☐ 9	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. I feel that my role makes a difference to patients / service users.	☐ 9	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. I am able to deliver the care I aspire to.	☐ 9	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

YOUR MANAGERS

8. To what extent do you agree or disagree with the following statements about your immediate manager?	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
My immediate manager (who may be referred to as your 'line manager')...					
a. ...encourages me at work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. ...can be counted on to help me with a difficult task at work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. ...gives me clear feedback on my work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d. ...asks for my opinion before making decisions that affect my work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
e. ...is supportive in a personal crisis.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
f. ...takes a positive interest in my health and well-being.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
g. ...values my work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

9. To what extent do you agree or disagree with the following statements about senior managers where you work?	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a. I know who the senior managers are here.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. Communication between senior management and staff is effective.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. Senior managers here try to involve staff in important decisions.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d. Senior managers act on staff feedback.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

[redacted] AND SAFETY AT WORK

10a. How many hours a week are you contracted to work?

1 ☐ Up to 29 hours 2 ☐ 30 or more hours

b. On average, how many *additional* PAID hours do you work per week for this organisation, over and above your contracted hours? *Please include paid overtime, bank shifts, and additional paid hours on-call.*

1 ☐ 0 hours 2 ☐ Up to 5 hours 3 ☐ 6-10 hours 4 ☐ 11 or more hours

c. On average, how many *additional* UNPAID hours do you work per week for this organisation, over and above your contracted hours? *Please include unpaid overtime and additional unpaid hours on-call.*

1 ☐ 0 hours 2 ☐ Up to 5 hours 3 ☐ 6-10 hours 4 ☐ 11 or more hours

11. Health & well-being

a. Does your organisation take positive action on health and well-being?

1 ☐ Yes, definitely 2 ☐ Yes, to some extent 3 ☐ No

	Yes	No
b. In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?	1 ☐	2 ☐
c. During the last 12 months have you felt unwell as a result of work related stress?	1 ☐	2 ☐
d. In the last three months have you ever come to work despite not feeling well enough to perform your duties?	1 ☐	2 ☐

If YES to d, please answer parts e to g below; if NO, go to Question 12

e. Have you felt pressure from **your manager** to come to work?	1 ☐	2 ☐
f. Have you felt pressure from **colleagues** to come to work?	1 ☐	2 ☐
g. Have you put **yourself** under pressure to come to work?	1 ☐	2 ☐

12. In the last 12 months how many times have you personally experienced physical violence at work from...?

a. Patients / service users, their relatives or other members of the public

1 ☐ Never 2 ☐ 1-2 3 ☐ 3-5 4 ☐ 6-10 5 ☐ More than 10

b. Managers

1 ☐ Never 2 ☐ 1-2 3 ☐ 3-5 4 ☐ 6-10 5 ☐ More than 10

c. Other colleagues

1 ☐ Never 2 ☐ 1-2 3 ☐ 3-5 4 ☐ 6-10 5 ☐ More than 10

d. The last time you experienced physical violence at work, did you or a colleague report it?

1 ☐ Yes, I reported it 2 ☐ Yes, a colleague reported it 3 ☐ No 4 ☐ Don't know 9 ☐ Not applicable

13. In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...?

a. Patients / service users, their relatives or other members of the public

1 ☐ Never 2 ☐ 1-2 3 ☐ 3-5 4 ☐ 6-10 5 ☐ More than 10

b. Managers

1 ☐ Never 2 ☐ 1-2 3 ☐ 3-5 4 ☐ 6-10 5 ☐ More than 10

c. Other colleagues

1 ☐ Never 2 ☐ 1-2 3 ☐ 3-5 4 ☐ 6-10 5 ☐ More than 10

d. The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?

1 ☐ Yes, I reported it 2 ☐ Yes, a colleague reported it 3 ☐ No 4 ☐ Don't know 9 ☐ Not applicable

14. Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?

1 ☐ Yes 2 ☐ No 9 ☐ Don't know

15. In the last 12 months have you personally experienced discrimination at work from any of the following?

a. Patients / service users, their relatives or other members of the public 1 ☐ Yes 2 ☐ No

b. Manager / team leader or other colleagues 1 ☐ Yes 2 ☐ No

If YES to either a or b above, please answer part c below; if NO, go to Question 16

c. On what grounds have you experienced discrimination? *Please tick all that apply*

1 ☐ Ethnic background 3 ☐ Religion 5 ☐ Disability 7 ☐ Other *(please specify)*

2 ☐ Gender 4 ☐ Sexual orientation 6 ☐ Age

16. In the last month have you seen any errors, near misses, or incidents that could have hurt...

a. Staff ☐ 1 Yes ☐ 2 No

b. Patients / service users ☐ 1 Yes ☐ 2 No

If YES to either a or b above, please answer part c below; if NO, go to Question 17

c. The **last** time you saw an error, near miss or incident that could have hurt **staff** or **patients / service users**, did you or a colleague report it?

☐ 1 Yes, I reported it ☐ 2 Yes, a colleague reported it ☐ 3 No ☐ 4 Don't know

17. To what extent do you agree or disagree with the following?	**Don't know**	**Strongly disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly agree**
a. My organisation treats staff who are involved in an error, near miss or incident fairly.	☐ 9	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. My organisation encourages us to report errors, near misses or incidents.	☐ 9	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	☐ 9	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d. We are given feedback about changes made in response to reported errors, near misses and incidents.	☐ 9	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

18. Raising concerns about unsafe clinical practice	**Yes**	**No**	**Don't know**
a. If you were concerned about unsafe clinical practice, would you know how to report it?	☐ 1	☐ 2	☐ 9

To what extent do you agree with the following statements about unsafe clinical practice?	**Strongly disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly agree**
b. I would feel secure raising concerns about unsafe clinical practice.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. I am confident that my organisation would address my concern.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

YOUR PERSONAL DEVELOPMENT

19a. In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?

☐ 1 Yes ☐ 2 No ☐ 3 Can't remember

If YES, please answer parts b to f below; if NO, go to Question 20

	Yes, definitely	**Yes, to some extent**	**No**
b. It helped me to improve how I do my job.	☐ 1	☐ 2	☐ 3
c. It helped me agree clear objectives for my work.	☐ 1	☐ 2	☐ 3
d. It left me feeling that my work is valued by my organisation.	☐ 1	☐ 2	☐ 3
e. The values of my organisation were discussed as part of the appraisal process.	☐ 1	☐ 2	☐ 3

f. Were any training, learning or development needs identified?

☐ 1 Yes ☐ 2 No

If YES, please answer part g below; if NO, go to Question 20

	Yes, definitely	**Yes, to some extent**	**No**
g. My manager supported me to receive this training, learning or development.	☐ 1	☐ 2	☐ 3

APPENDIX XV

Thematic Analysis Coding Structure

Code No.	Substantive Code	*Sub-Theme*	Theme	OVERARCHING THEME
1	Distributed leadership		Collective Leadership Model	RESPONSIBLE LEADERSHIP
2	Collective leadership			
3	Desirable leader behaviour	*Acting Responsibly*	Proactive Accountability	
4	Stability of leadership			
5	Doing the right thing			
6	Building staff relationships	*Actions*		
7	Being compassionate			
8	Demonstrating clear leadership			
9	Valuing staff			
10	Positive standout leadership behaviour			
11	Challenge from NEDs and Governors	*Responding to Challenge*		
12	Trust pressures			
13	Influencer	*Board Member* *Senior Leader* *Middle Manager*	Positive Distributed Influencing	
14	Role-modelled behaviour	*Role-Model*		
15	Organisational change		Strategic Organisational Development	
16	Organisational focus			
17	Organisational objectives			
18	Horizon scanning			
19	Optimising organisational structure			
20	Growing the reputation of the Trust			
21	Investing in new roles			
22	Being a system leader in the STP	*Taking Responsibility*	Whole System Involvement	
23	Taking action in the STP			
24	Building partnerships			
25	Developing external relationships			
26	Responding to the wider system			
27	Impact on Trust of whole system working	*Impact on Trust*		
28	Cultural influence by system partners			

29	Personal values aligned to NHS values	*Alignment*	Aligned Staff and Trust Values	VALUES-LED CULTURE
30	Personal values aligned to Trust values			
31	Patient centred	*For Patients*	Compassionate Caring	
32	Caring culture			
33	Showing compassion to patients			
34	Showing compassion to staff	*For Staff*		
35	Caring for staff			
36	Changing the culture	*Overcoming Obstacles*	Delivering Culture Change	
37	Barriers to change			
38	Negative staff behaviour			
39	Challenging unwanted behaviour	*Living a New Culture*		
40	Embedding change			
41	Openness and honesty			
42	Non-hierarchical leaders			
43	Role-modelling the new culture			
44	Living the Trust values	*Values Driven*		
45	Values-led organisation			
46	Just culture			
47	No blame			
48	Improvement focussed	*Patient-Centred*		
49	Patient experience awareness			
50	Proud of what they deliver	*Cultural Attitudes*		
51	Success is celebrated			
52	Proud to work at the Trust			
53	Positive atmosphere			
54	Desire to improve			

55	Communication style	*Building Staff Relationships*	Effective Communication	PEOPLE-FOCUSSED
56	Communication methods			
57	Improving communications			
58	Impact of communication on culture			
59	Trust investment in communication	*Investing in Communication*		
60	Digital exemplar			
61	Personal development		Staff Development	
62	Leadership development			
63	Professional development			
64	Talent management			
65	Giving staff feedback			
66	Recruiting the 'right breed of person'	*Values Matching*	Recruitment and Proactive Retention	
67	Having a strong moral compass			
68	Values-based interviews			
69	Low staff vacancy rate	*Attractive Place to Work*		
70	Staff stability			
71	Capitalising on 2nd CQC grading (G or O)			
72	Shared decision-making		Effective Teamwork	
73	Getting the best out of people			
74	Supportive team-working			
75	Safe staffing			
76	Definition of organisational resilience	*Perspectives on Organisational Resilience*	Resilience-Building Programmes	
77	Impact of CQC on organisational resilience			
78	Organisational resilience and whole system working			
79	Personal resilience related to organisational resilience			
80	Developing resilience of staff	*Personal Resilience*		
81	Emotional impact on staff of first CQC inspection (RI/I)			
82	Seeking staff feedback		Acting on Feedback	
83	Staff survey feedback			

84	Cautious approach to risk	*Attitude to Risk*	Robust Risk Management	RIGOROUS GOVERNANCE
85	Strong safety culture			
86	Risk management focus			
87	Attitude to regulation	*Impact of CQC Inspection*	Effective Response to Regulatory Feedback	
88	Impact of CQC 1st inspection (RI or I)			
89	Impact of CQC 2nd inspection (G or O)			
90	Impact of CQC on Trust strategic objectives			
91	Financial control	*Fiscal Responsibility*	Delivering Strategic Priorities	
92	Management of ED pressures	*Service Delivery*		
93	Getting the basics right			
94	Quality improvement			
95	Strong risk management	*Assurance of Systems and Processes*		
96	Strong governance			
97	Safety focussed			

98	Uncomplacent		Lack of Complacency	COMMITMENT TO LEARNING
99	Room for improvement			
100	Emotional impact of CQC 2nd inspection (G or O)			
101	Awareness of external perceptions			
102	Showing humility			
103	Seeking patient feedback	*Internal*	Acting on Feedback	
82	Seeking staff feedback			
83	Staff survey feedback			
104	Regulator feedback	*External*		
105	Whole system feedback			
106	Review of incidents	*Review Process*	Organisational Learning Imperative	
107	Datix reporting			
108	Root Cause Analysis			
109	Communicating the learning			
110	Learning from organisational memory			
111	Learning organisation	*Learning from Error*		
112	Learning from incidents			
113	Learning from complaints	*Learning from Feedback*		
114	CQC recommendations			
115	Sharing best practice	*Learning from Excellence*		
116	Reporting excellence			

Numbers (n) Identified through Data Analysis

Overarching Themes (Strategic Leadership Behaviour)	n = 5
Themes	n = 19
Sub-Themes	n = 34
Substantive Codes	n = 116

APPENDIX XVI

Example of NHS Staff Survey Internal Report to Trust Board March 2016: Case Study 1

(Source: BP 13)

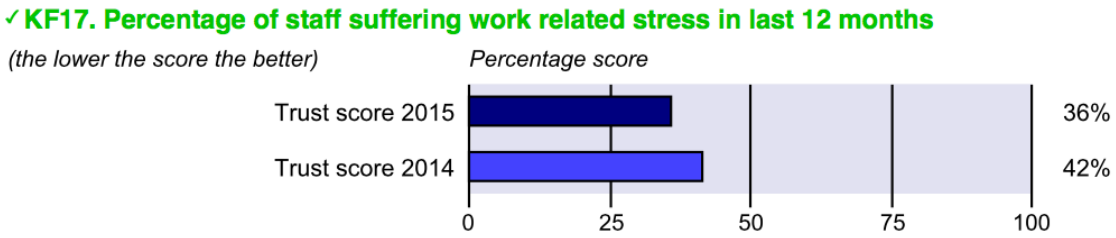
Your Organisation

The scores presented below are un-weighted question level scores for questions Q21a, Q21b, Q21c and Q21d. The percentages for Q21a – Q21d are created by combining the responses for those who "Agree" and "Strongly Agree" compared to the total number of staff that responded to the question.

		Your Trust in 2015	Average (median) for acute trusts	Your Trust in 2014
Q21a	"Care of patients / service users is my organisation's top priority"	77%	75%	70%
Q21b	"My organisation acts on concerns raised by patients / service users"	72%	73%	71%
Q21c	"I would recommend my organisation as a place to work"	61%	61%	56%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	77%	70%	70%

3.2 Largest Local Changes since the 2014 Survey

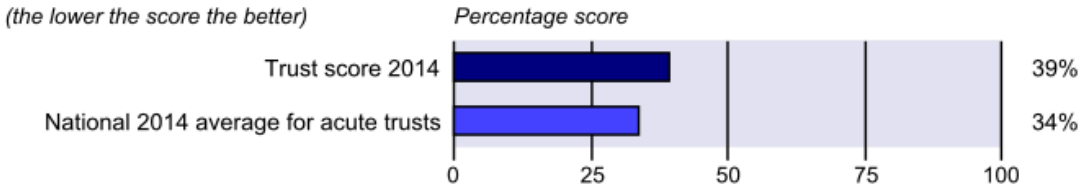
This page highlights the five Key Findings where staff experiences have improved at (Case Study 1 Trust) since the 2014 survey. (This is a positive local result.)



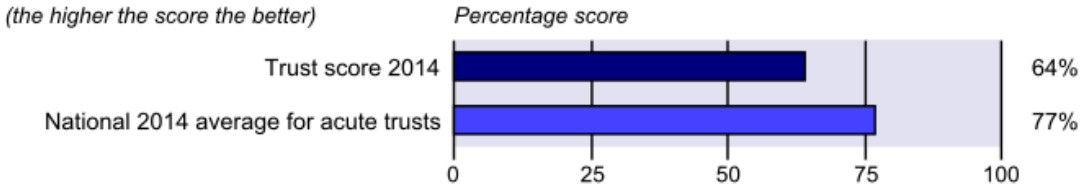
This page highlights the five Key Findings for which (Case Study 1 Trust) compares least favourably with other Acute Trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FIVE RANKING SCORES

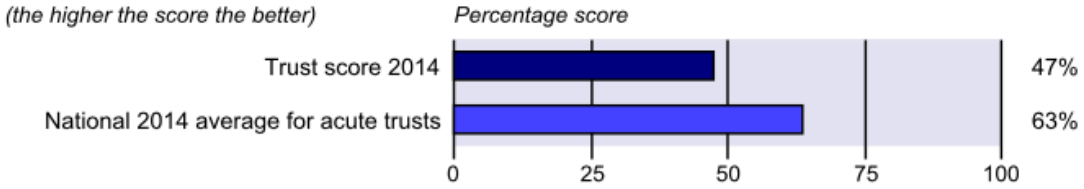
! KF12. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month



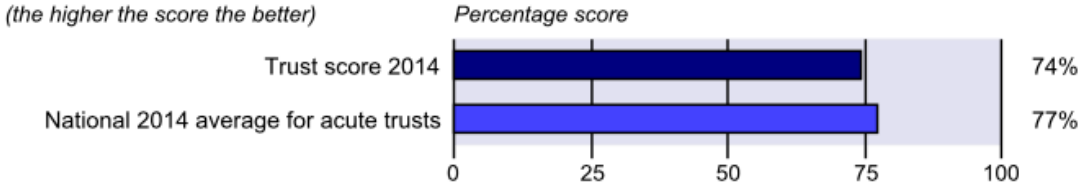
! KF10. Percentage of staff receiving health and safety training in last 12 months



! KF26. Percentage of staff having equality and diversity training in last 12 months



! KF1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver



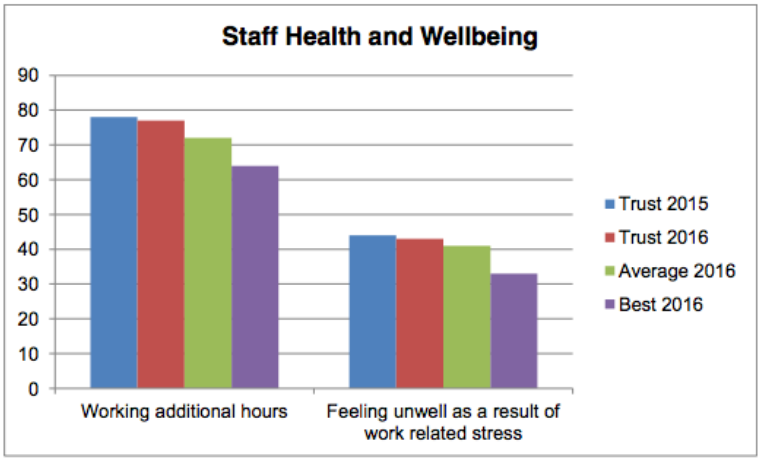
APPENDIX XVII

Example of NHS Staff Survey Internal Report to Trust Board March 2017: Case Study 2

(Source: BP 69)

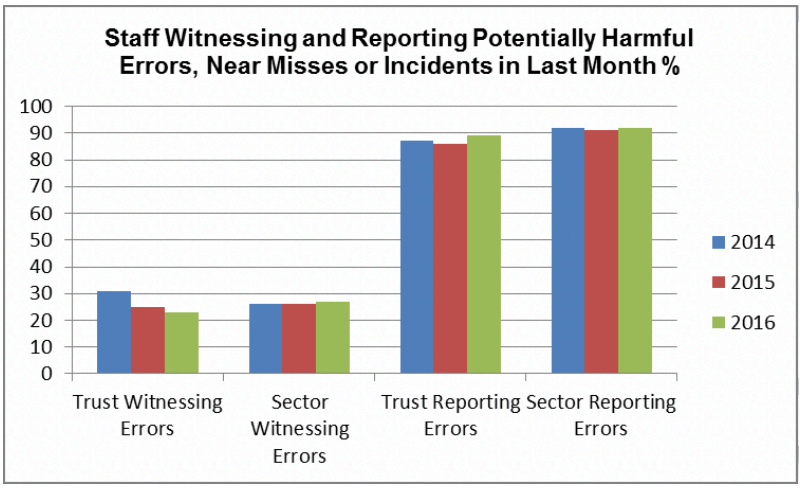
2. Staff health and wellbeing particularly staff working additional hours and work related stress felt by staff:

42% of staff responded that they had felt unwell due to work related stress in the last 12 months, a decrease of 3% since 2015 (45%). This is higher than the national average of 41%.



5. Staff reporting errors, near misses or incidents, and learning from that information

The percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month which may hurt staff has reduced to 16% in 2016 from 18% in 2015. The percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month which may hurt patients has reduced from 20% (2015) to 18% (2016). There are signs of a positive move towards improvement in reporting.



APPENDIX XVIII

Notation of Interview Transcription and Annotation of Reporting from Case Study Secondary Data Report Sources

Bold Participant emphasis

[…] Omission of text (verbal or written) within or between sentences of one response or paragraph

[C] Capital letter within square bracket at beginning of quotation signifies that the following text was originally placed within a sentence i.e. it did not start the sentence

… A pause by the participant

(words) Words in round brackets within a quotation are added by the researcher to contextualise the quotation. This may be used to reference a staff member referred to by the participant, replacing a proper name with a title to maintain anonymity

Case Study Interviews

Nodes

Name	Description
Attitude to regulation	Comments regarding how participant views the CQC process and regulation
Impact of CQC 1st inspection (RI or I)	Impact that CQC process has on the organisation's staff and resources; organisation's response to 1st inspection; Impact on Trust following grading of RI/I
Impact of CQC 2nd inspection (G or O)	Impact that CQC process has on the organisation's staff and resources; organisation's response to 2nd inspection; comments regarding impact of CQC grading on organisational reputation and recruitment.
Impact of CQC on Trust strategic objectives	The impact that a CQC grading has on the organisation's strategy; how objectives are affected by CQC
Background	Career history of participants
NHS	NHS career background / came to Trust with previous NHS experience
Non-NHS	Previous experience primarily outside of the NHS
Barriers to change	References to pressures within their Trust that are inhibitors of change; staff, finances, demand, etc.
Negative staff behaviour	References to staff resistance to change
Building staff relationships	Behaviour comments relating to building internal relationships

Name	Description
Being compassionate	References to staff acting with compassion; examples of behaviour that indicate compassion
Showing compassion to staff	Examples of leaders showing kindness, care, consideration and compassion to staff
Caring for staff	Descriptions that indicate a caring approach towards staff
Valuing staff	Comments that refer to staff expressing feelings of being valued by Trust leaders / managers
Challenge from Non-Executive Directors and Governors	References of challenges by NEDs or Governors, impact and response to them
Changing the culture	References to culture change; examples of old and new culture; attitudes and behaviours
Challenging unwanted behaviour	References to proactive management of old-style behaviours
Embedding change	Examples of behaviours in the Trust to embed culture change
Just culture	References to introducing a Just culture
No blame	References to old culture / moving to a non-blame mindset
Non-hierarchical leaders	References and examples of this style of leadership
Openness and honesty	References to a more open, honest and trusting culture
Role-modelling the new culture	Examples of how the new culture is lived / observed
Collective leadership	References to this style of leadership

Name	Description
Definition of organisational resilience	Participant's understanding of the concept of organisational resilience
Desirable leader behaviour	Examples of stated behaviour; references to what are desirable behaviours
Demonstrating clear leadership	References to proactive leader behaviour
Positive standout leadership behaviour	Examples of a positive leader behaviour observed by participant; response to a direct question
Role-modelled behaviour	References to leaders and colleagues who role model positive behaviours; participants stating their desire to be a good role model
Developing external relationships	Comments that relate to how relationships are being fostered externally with whole system partners, service users and the general community
Being a system leader in the STP	References to their position of leadership in the STP
Building partnerships	References to proactive building of relationships with partners
Responding to the wider system	References that acknowledge working in a whole system; ability or desire to address systems thinking; attitudes to system working; evidence of systems thinking
Taking action in the STP	References to being an active member of the STP; examples of involvement
Developing resilience of staff	References to individual resilience; how it is addressed in the Trust; references to staff well-being
Distributed leadership	References to working in a distributed leadership model

Name	Description
Doing the right thing	In Vivo references - 'right thing to do' and 'doing the right thing'; examples of behaviours that describe acting with this responsible leadership attribute
Emotional impact on staff of first CQC inspection	Emotional reactions of the staff to the first rating given to the organisation by the CQC (RI/I)
Financial control	References to keeping tight financial control; financial focus on keeping within budget
Getting the basics right	Comments on the importance and focus on 'getting the basics right'; In Vivo comments
Impact of CQC on organisational resilience	References to how participants perceive the impact of CQC process and outcomes on the Trust's organisational resilience
Impact on Trust of whole system working	References to the impact on the Trust of working in the whole system; examples
Cultural influence by system partners	References to the different cultures of system partner organisations and addressing conflicting interests
Influencer	Direct response to question regarding the influential people at the Trust; references to specific influential people
Board Member	Identification of a Board member being an influencer
Middle Manager	Identification of a middle manager being an influencer
Role Model	Identification or mention of specific role models; being influenced by someone whose behaviour they have role modelled
Senior Leader	Identification of a senior leader being an influencer

Name	Description
Learning organisation	References to being a learning organisation; examples of how the organisation learns; processes
Communicating the learning	Examples of how learning is shared throughout the organisation
CQC recommendations	References to addressing and acting on the recommendations by the CQC
Learning from complaints	References to how the Trust deals with and learns from complaints
Learning from incidents	References to incident examination, sharing and applying the learning
Datix reporting	References to the encouragement placed on staff to report incidents; volume of Datix reports
Root Cause Analysis	References to how they apply learning following Root Cause Analysis; identification of RCA as a process used by the Trust
Learning from organisational memory	References to staff stability; organisational memory contributing to learning
Review of incidents	Comments on the process taken to review incidents; references to the importance of reviews
Sharing best practice	References to the importance placed on sharing best practice; methods for sharing best practice
Reporting excellence	Methods developed within the Trust to report excellence and how they share the examples
Management of Emergency Department pressures	References to addressing the pressures of waits and volume of throughput in the ED; comments on the strategic priority to get ED issues resolved
Organisational change	References to processes and implementation of changes in the Trust; examples of recent change

Name	Description
Organisational focus	The priorities on which the organisation is focussed; where the organisation placed its focus after the first CQC inspection (RI / I)
Growing the reputation of the Trust	Examples of being proactive in spreading positive messages about the Trust's activities and achievements; references to the need to do more to grow a positive reputation following negative publicity
Horizon scanning	Who is responsible for horizon scanning in the Trust; comments on how it is encouraged and achieved
Investing in new roles	References to the need for and practice of employing staff in innovative roles e.g. clinical associates, innovations in mental health roles
Optimising organisational structure	Comments on changes to the organisational structure; impact of changes
Organisational objectives	The organisation's current objectives and priorities; description of how these are set
Organisational resilience and whole system working	References to how organisational resilience is related to the whole system, not solely the Trust; impact of the Trust's resilience on the whole system
Patient-centred	Descriptions that demonstrate a patient-centred approach e.g. responding to feedback; public engagement
Caring culture	Comments that indicate a caring culture within the Trust; references to addressing staff and patient concerns
Improvement focussed	Comments and examples of being focussed on delivering improvement
Patient experience awareness	References to patients' needs being considered; how they seek to understand the patients' experience
Seeking patient feedback	References to the patient feedback processes they have at the Trust

Name	Description
Showing compassion to patients	Comments referring to how patients are cared for with compassion; observations of participants regarding compassionate care
Personal resilience related to organisational resilience	Reference to the perceived inter-relationship between organisational and personal resilience
Positive atmosphere	References to how it feels working in the Trust
Desire to improve	Comments on staff attitude to their work, role and organisation
Proud of what they deliver	Comments on being proud of their work; change of feeling about pride over the past 5 years
Proud to work at the Trust	Comments on how they feel about working at the Trust
Success is celebrated	Examples of how they acknowledge achievement in the Trust; references to celebrating success
Quality improvement	References to quality; standards; quality improvement practice; keeping a focus on quality
Regulator feedback	References to sources of regulator feedback and acting on it; proactive engagement with regulators
Risk management focus	References to risk management; risk management behaviour; responses to question regarding the Trust / Board's attitude to risk
Cautious approach to risk	Trust's attitude to risk and why
Strong risk management	References to the attention to risk in the Trust being very strong

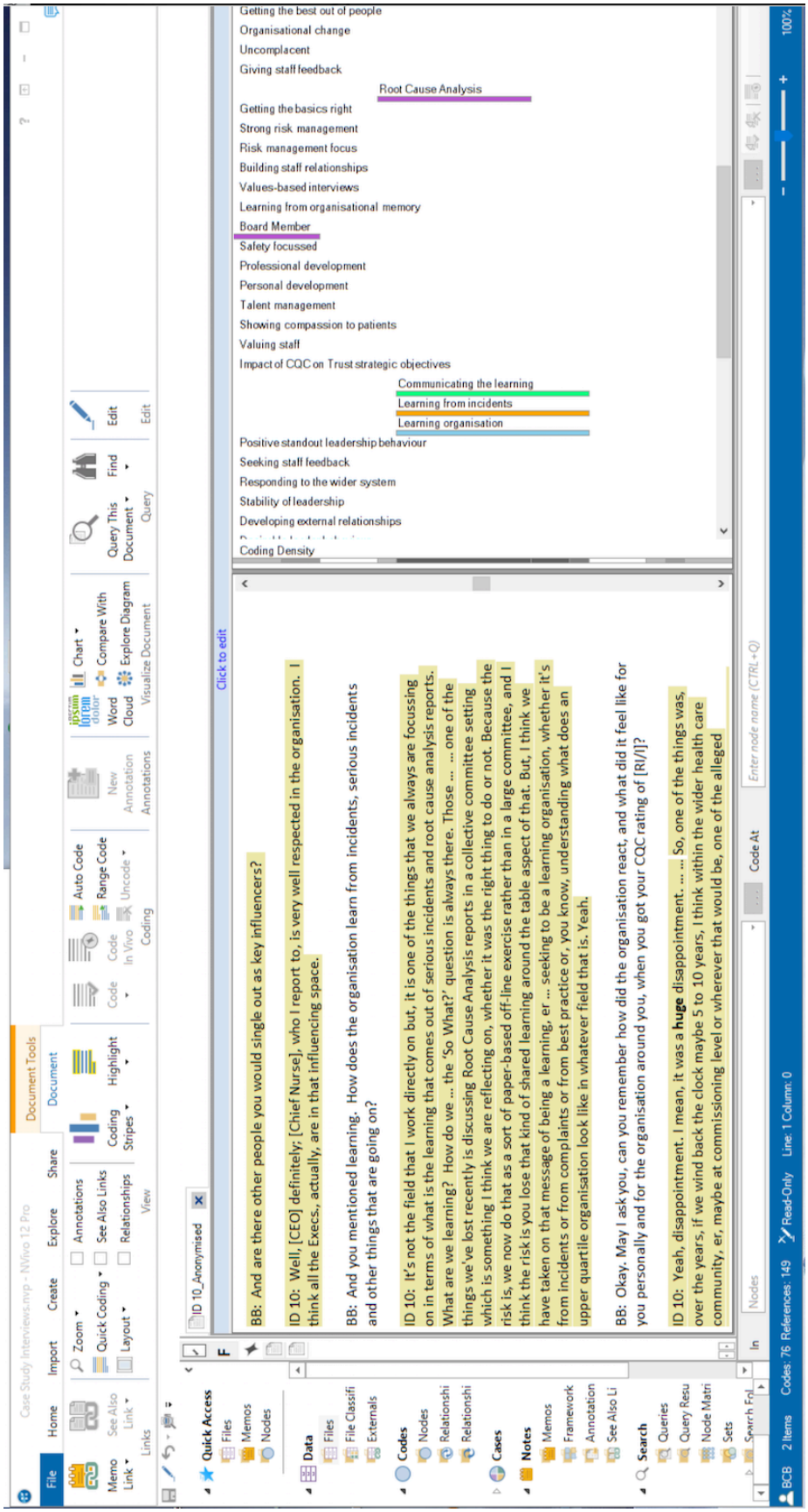
Name	Description
Stability of leadership	References to the low turnover rate of senior leaders and managers at the Trust; comments on stability contributing to organisational memory
Strong governance	References to being focussed on governance and governance issues
Strong safety culture	References to the Trust's attitude to safety; references to Trust having a strong safety culture
Safety focussed	Comments on patient safety; references to being safety focussed; examples of addressing safety issues
Supportive team-working	References to the development of better team working and improved team leadership
Getting the best out of people	References of being focussed on optimised staff engagement
Giving staff feedback	References to proactive feedback; examples – e.g. appraisals
Safe staffing	References to ensuring they have safe staffing levels; recruitment and retention focus to enable this
Seeking staff feedback	References to methods of getting staff feedback and acting on it; feedback processes
Staff survey feedback	References to the NHS staff survey and how the report is acted upon; increasing engagement of staff with it
Shared decision-making	Examples of involving staff in decision-making
Talent management	References to addressing talent management; examples of internal promotions; career development opportunities
Leadership development	References to developing leaders and managers; focus on being a well-led organisation; references to its importance

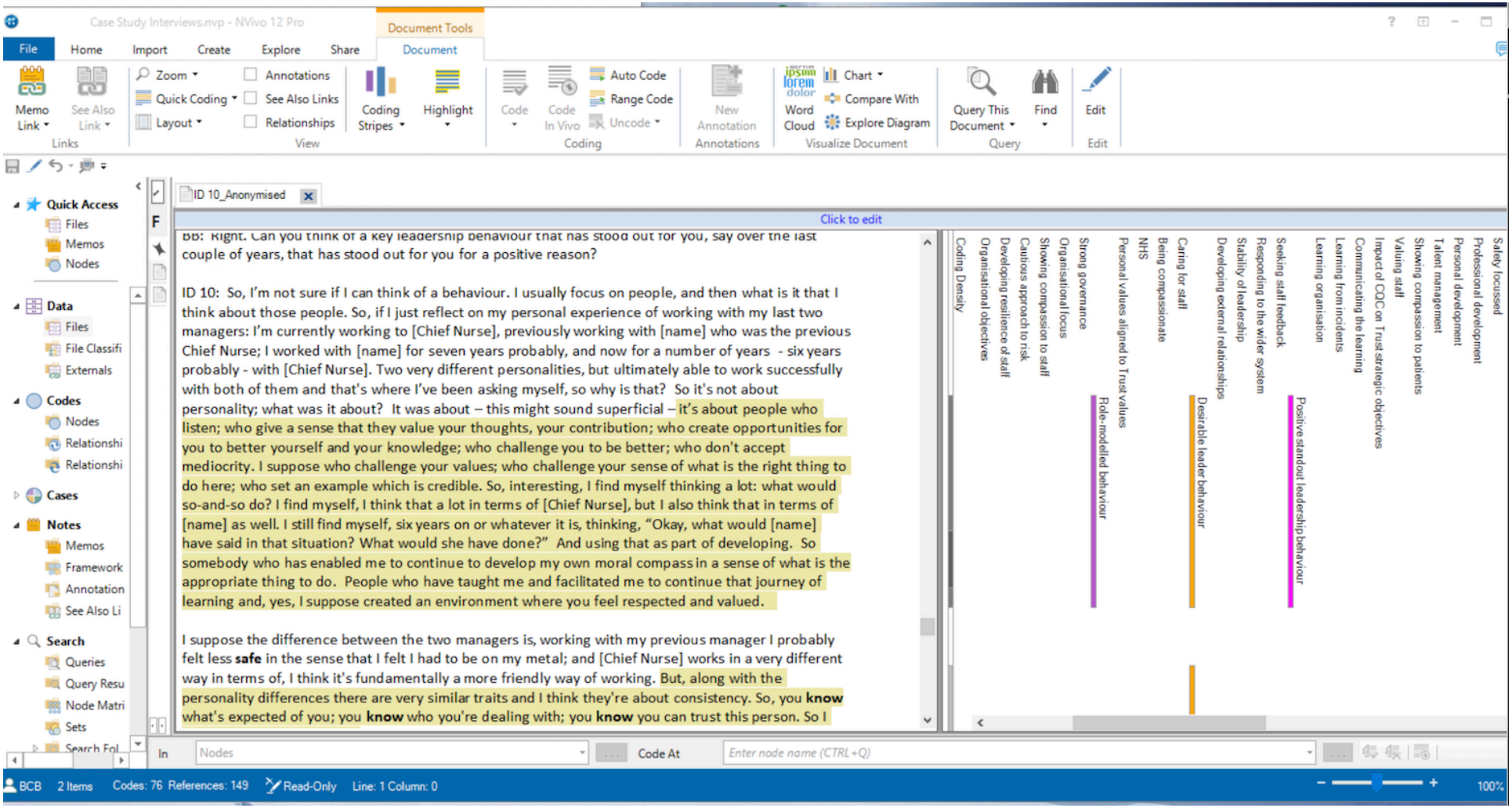
Name	Description
Low staff vacancy rate	Comments on their vacancy rates
Capitalising on 2nd CQC grading	References to benefitting from a positive CQC grade – e.g. staff recruitment; attracting funding for projects
Personal development	References to how participants have developed personally by working at the Trust
Professional development	References to the opportunities for professional development by working at the Trust
Staff stability	References to the low staff turnover rate; longevity of staff members at the Trust; comments referring to fostering staff stability
Trust investment in communication	References to how the Trust has prioritised and invested in new ways to communicate; examples
Communication methods	References to the different media used to communicate with staff e.g. video, blog
Communication style	References to the style of communication, particularly from CEO and Board members e.g. drop-ins, informal
Digital exemplar	References to the Trust becoming a digital exemplar
Impact of communication on culture	References to how the change in style and methods of communication has impacted the culture of the Trust
Improving communications	References to how communication style and methods have improved; innovation; impact of changes
Trust pressures	References to pressures affecting the Trust / NHS; identification of specific pressures e.g. ED volume
Uncomplacent	References alluding to lack of complacency; comments directly regarding a lack of complacency
Awareness of external perceptions	References regarding how other system partners perceive the Trust / their reputation

Name	Description
Emotional impact of CQC 2nd inspection (G or O)	Emotional reactions to improved CQC rating; references that a G/O grade is a starting point, not a reason to sit back and relax
Room for improvement	Acknowledgements that there is always improvement to be made
Showing humility	References to showing and the importance for humility; key message from CEO; examples of acting with humility
Values-led organisation	Comments relating to the Trust values being important; how they were developed and used
Having a strong moral compass	In Vivo references to having a 'strong moral compass'
Living the Trust values	Comments relating to the need for staff to behave according to the Trust values; embedding them into staff's actions and behaviour
Personal values aligned to NHS values	References to the participant's values being aligned with NHS values; inferences or comments regarding staff values to be aligned with NHS values
Personal values aligned to Trust values	References regarding the importance of staff values being aligned with Trust values
Recruiting the 'right breed of person'	Comments regarding proactively engaging specific type of staff; In Vivo references to 'right breed of person'
Values-based interviews	References to recruitment using a values-based approach
Whole system feedback	Whole system = NHS Trusts + other NHS providers + Social Care + GPs + other organisations / players. References to the feedback given by whole system partners; perceptions of whole system partners regarding Trust

APPENDIX XX

NVivo Coding Example: Case Study Interview

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BB: Right. Can you think of a key leadership behaviour that has stood out for you, say over the last couple of years, that has stood out for you for a positive reason?
ID 10: So, I'm not sure if I can think of a behaviour. I usually focus on people, and then what is it that I think about those people. So, if I just reflect on my personal experience of working with my last two managers: I'm currently working to [Chief Nurse], previously working with [name] who was the previous Chief Nurse; I worked with [name] for seven years probably, and now for a number of years - six years probably - with [Chief Nurse]. Two very different personalities, but ultimately able to work successfully with both of them and that's where I've been asking myself, so why is that? So it's not about personality; what was it about? It was about – this might sound superficial – it's about people who listen; who give a sense that they value your thoughts, your contribution; who create opportunities for you to better yourself and your knowledge; who challenge you to be better; who don't accept mediocrity. I suppose who challenge your values; who challenge your sense of what is the right thing to do here; who set an example which is credible. So, interesting, I find myself thinking a lot: what would so-and-so do? I find myself, I think that a lot in terms of [Chief Nurse], but I also think that in terms of [name] as well. I still find myself, six years on or whatever it is, thinking, "Okay, what would [name] have said in that situation? What would she have done?" And using that as part of developing. So somebody who has enabled me to continue to develop my own moral compass in a sense of what is the appropriate thing to do. People who have taught me and facilitated me to continue that journey of learning and, yes, I suppose created an environment where you feel respected and valued.
I suppose the difference between the two managers is, working with my previous manager I probably felt less **safe** in the sense that I felt I had to be on my metal; and [Chief Nurse] works in a very different way in terms of, I think it's fundamentally a more friendly way of working. But, along with the personality differences there are very similar traits and I think they're about consistency. So, you **know** what's expected of you; you **know** who you're dealing with; you **know** you can trust this person. So I
Coding Density
Organisational objectives
Developing resilience of staff
Cautious approach to risk
Showing compassion to staff
Organisational focus
Strong governance
Personal values aligned to Trust values
NHS
Being compassionate
Caring for staff
Developing external relationships
Stability of leadership
Responding to the wider system
Seeking staff feedback
Learning organisation
Learning from incidents
Communicating the learning
Impact of CQC on Trust strategic objectives
Valuing staff
Showing compassion to patients
Talent management
Personal development
Professional development
Safety focussed
Role-modelled behaviour
Desirable leader behaviour
Positive standout leadership behaviour
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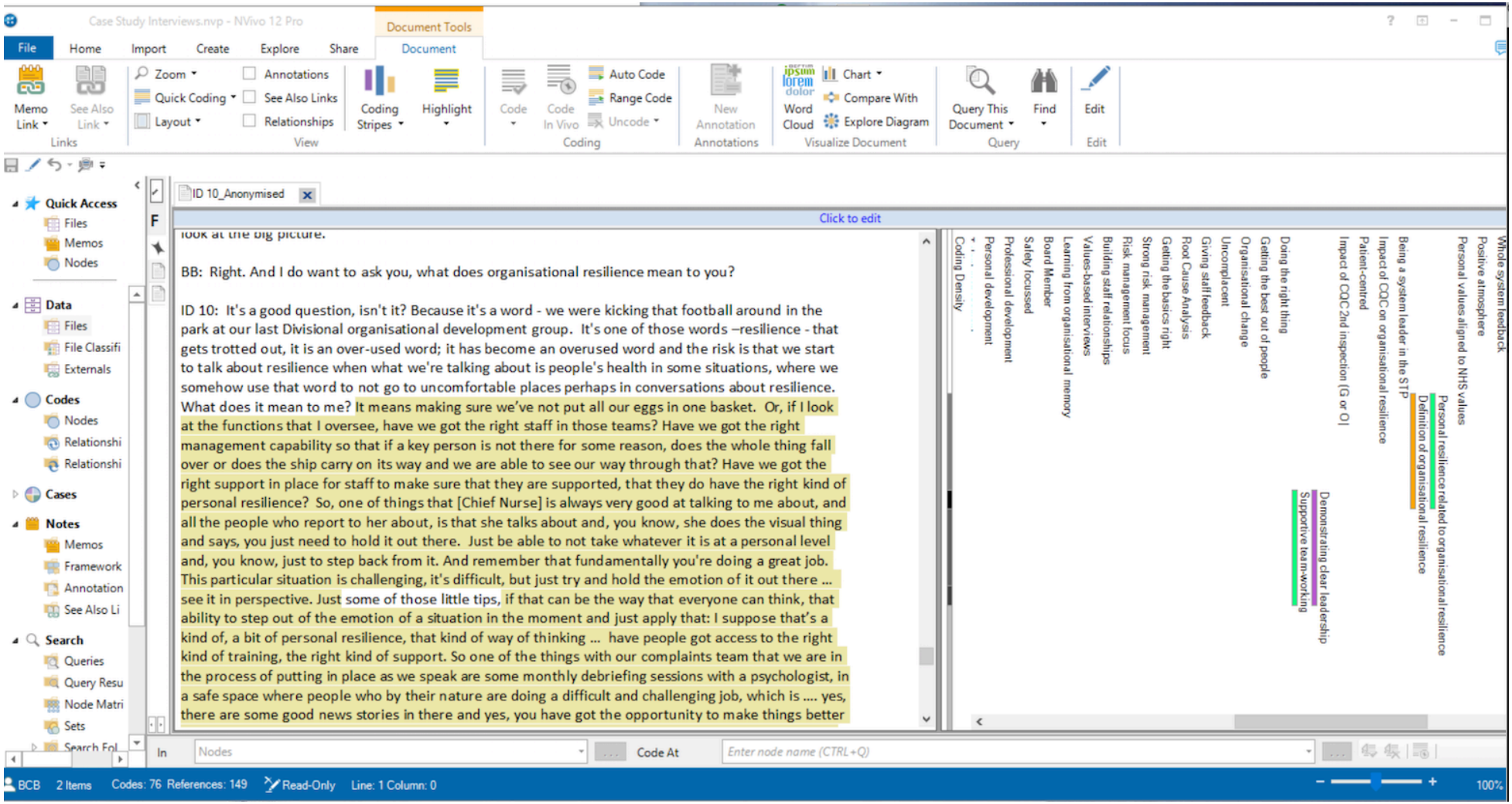
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BB: Right. And I do want to ask you, what does organisational resilience mean to you?
ID 10: It's a good question, isn't it? Because it's a word - we were kicking that football around in the park at our last Divisional organisational development group. It's one of those words –resilience - that gets trotted out, it is an over-used word; it has become an overused word and the risk is that we start to talk about resilience when what we're talking about is people's health in some situations, where we somehow use that word to not go to uncomfortable places perhaps in conversations about resilience. What does it mean to me? It means making sure we've not put all our eggs in one basket. Or, if I look at the functions that I oversee, have we got the right staff in those teams? Have we got the right management capability so that if a key person is not there for some reason, does the whole thing fall over or does the ship carry on its way and we are able to see our way through that? Have we got the right support in place for staff to make sure that they are supported, that they do have the right kind of personal resilience? So, one of things that [Chief Nurse] is always very good at talking to me about, and all the people who report to her about, is that she talks about and, you know, she does the visual thing and says, you just need to hold it out there. Just be able to not take whatever it is at a personal level and, you know, just to step back from it. And remember that fundamentally you're doing a great job. This particular situation is challenging, it's difficult, but just try and hold the emotion of it out there ... see it in perspective. Just some of those little tips, if that can be the way that everyone can think, that ability to step out of the emotion of a situation in the moment and just apply that: I suppose that's a kind of, a bit of personal resilience, that kind of way of thinking ... have people got access to the right kind of training, the right kind of support. So one of the things with our complaints team that we are in the process of putting in place as we speak are some monthly debriefing sessions with a psychologist, in a safe space where people who by their nature are doing a difficult and challenging job, which is .... yes, there are some good news stories in there and yes, you have got the opportunity to make things better
Coding Density
Personal development
Professional development
Safety focussed
Board Member
Learning from organisational memory
Values-based interviews
Building staff relationships
Risk management focus
Strong risk management
Getting the basics right
Root Cause Analysis
Giving staff feedback
Uncomplacent
Organisational change
Getting the best out of people
Doing the right thing
Impact of CQC 2nd inspection (G or O)
Patient-centred
Impact of CQC on organisational resilience
Being a system leader in the STP
Definition of organisational resilience
Personal resilience related to organisational resilience
Personal values aligned to NHS values
Positive atmosphere
Whole system feedback
Supportive team-working
Demonstrating clear leadership
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APPENDIX XXI

Full Interview Transcript – Case Study 1

Embargoed on grounds of confidentiality

APPENDIX XXII

Full Interview Transcript – Case Study 2

Embargoed on grounds of confidentiality

APPENDIX XXIII

Interview Quotations that Evidence Themes

Theme	Participant Quotation
Collective Leadership Model *(Code: Collective leadership)* *(Code: Distributed leadership)*	"In my time here we have gone through an evolution of being very medically-dominated, not very management-business savvy, through a continuum to being much more business savvy, much more collective leadership across the professions, less medical dominance" (ID36: CS1). "At the leadership level it's gone from being quite corporate and a bit distant with command and control, to being more authentic and present […] and I think a more modern approach of leadership […] one of devolved leadership" (ID27: CS2).
Proactive Accountability *(Code: Doing the right thing)* *(Code: Demonstrating clear leadership)*	"I think one of the key things for us going forward is about the role we play in the system leadership. We're a big player in it. We could easily sit back and not do that. It's not the right thing to do and I think morally and ethically it's the right thing to do, even if the business case is a bit thinner. We need to play our part in that and I think that signifies the way we lead the organisation, our ambition, no complacency, not battening down the hatches, but also that ability to think a bit more strategically about the next five years, not the next year" (ID2: CS1). "I think we do think of ourselves as stewards of the reputation of the NHS. So we're partly stewards of the reputation of **this** organisation and we're partly stewards of the reputation of this thing called the NHS, of which we are a sub-brand. […] And I think we are genuinely here trying to engage patients meaningfully in the nature of equality of services" (ID18: CS2).
Positive Distributed Influencing *(Code: Influencer)* *(Code: Role-modelled behaviour)*	"I think there are key influencers, but I don't think they are necessarily in any one role, and I think it's about being brave enough to empower the people who are the key influencers. […] It wasn't any one of us as an individual that changed the culture, but it was getting people who are really keen to improve that care, so they may have been a Band 5 nurse; they may have been a consultant anaesthetist; they may have been an 8A physio: but we looked at people who were engaged and wanted to change that process and they were our key influencers" (ID30: CS1). "I really love listening to (the CEO) and (the Chief Nurse) and others speak so that I can almost embody some of the things that they would say. So, I've learnt, in terms of cultural change, I've learned a lot from how they operate. So I will be more likely to stand alongside a carer by experience than I would have done before because (the CEO's) done it. I've always worked alongside family carers, always, always, but now I think: oh, actually, why would I open a conference and not have that? So some of that role modelling comes down, across the board" (ID31: CS2).

Strategic Organisational Development *(Code: Organisational focus)* *(Code: Optimising organisational structure)*	"We have got a lot to do with Outpatients. We're trying to get nurses with extended roles, that can do things to help the junior doctors, and carrying some staff with us who aren't used to that, and managing that change. […] The focus is on getting the people who do the job to come up with the ideas about how we can make it better and different" (ID19: CS1). "I think what I've seen is us become a much slicker, intelligent organisation, a much more streamlined organisation. […] We used to have four […] for Adult Services: there is now one, with a good structure of deputies underneath. Certainly the clinical leadership, I think there's still work to be done there, but there has been a journey around the professional leads and getting clinical leadership onto the equation, working that through with managers" (ID25: CS2).
Whole System Involvement *(Code: Taking action in the STP)* *(Code: Responding to the wider system)*	"I think there's this system-Trust link that we're also on that journey, so that we all see what's going on within the Trust. And I am very firm that unless we play in the system effectively, we won't change things in the Trust. […] We are the lead for talent and leadership for the STP" (ID1: CS1). "We are just talking to the Commissioners at the moment about taking delegated commissioning for (county). […] What we want to do is bring our clinicians together and say we've done with the new models of care with NHS England, where we are taking on commissioning secure and forensic, and CAMHS inpatient services, to take delegated commissioning and be like a health maintenance organisation in the States. […] So I think that would be a really fundamental change to the organisation and will require a cultural change as well, because it's about ownership of the whole system. There won't be anybody to blame the system for why something's not right. If we've got the resources, we would be able to sort it out" (ID4: CS2).
Alignment (Staff and Trust Values) *(Code: Personal values aligned to Trust values)* *(Code: Personal values aligned to NHS values)*	"An example about where our values are as an organisation […] this is my expectations. This is what the standard we expect. […] I do all the interviews for consultants in the Trust. […] I've made it very clear here the type of people that we should be employing to consultant posts should be technically very good […] but they should also have the right moral compass and if they haven't got that then I don't want them here. This isn't the place for them to work" (ID2: CS1). "I think there is something about local people, the NHS as our community and something about: I live and work in an area that I want to own as my pride, so that it's a bit about some of my values, about why (CS2)" (ID25: CS2).

Compassionate Caring *(Code: Caring for staff)* *(Code: Caring culture)*	"During the winter period we've decided that actually, having two [peer staff members] is definitely safer, it's more manageable. But even when […], I make sure that on Saturday morning, I do find a bit of a struggle, so I always say to the Sisters or Charge Nurses: You'll get to all of your areas before I'll get to every area. So if you walk into an area and you think 'Oh God, I'm really concerned that the skill mix is quite weak, or the staffing isn't very safe,' you must bleep me straight away and I'll prioritise coming to you. But I **will** visit every single area, so I don't want you to routinely be asking about the staffing, because that's what I'm going to do" (ID28: CS1). "What I found in the NHS and I think with (CS2) has been an organisation where I've really noticed humanity on a massive level. And I think, looking at the way that people are looking after people, they're **trying** to look after people, they're **trying** to do the right thing, that it has become a family of people who are: how can we get this right against extraordinary circumstances, those pressures from the outside?" (ID15: CS2).
Delivering Culture Change *(Code: Success is celebrated)* *(Code: Openness and honesty)*	"The other thing I would say here, which is quite important actually, is a real strength of celebrating success. So, whilst we might have been (RI/I), we really made a big focus to celebrate the things that we were doing really well, rather than that natural thing just to reflect on all the things that are not going well" (ID20: CS1). "In our patch, and the bit that I've had more influence over immediately here in this area is, we've done quite a lot on psychological safety and there's a lady who worked for the Department of Health who has written quite a lot on it, (name), and I've really been interested in it. So I've read quite a bit of her stuff. She came here about a year ago and I went to that session and I found that really, really fascinating, because this whole thing of having a culture where people can be open about the challenges that we're working with; being open and honest if we could have done things differently or better; being okay to talk about that and not to hide things or feel that you're going to be blamed if things go wrong; that there's just more of an openness and transparency for people to feel safe to have those difficult conversations" (ID16: CS2).
Effective Communication *(Code: Communication style)*	"[I]nformation is very accessible. It's done by direct reporting and reporting back. So I go to Operational Leads meetings, the Quality and Governance meetings and the (directorate) Board meetings. So those meetings keep you in touch with what's going on and then the rest of my team get information back through me, but also through newsletters and messages from the Chief Exec and that sort of thing. One of my nurses wrote to the Chief Exec the other day to tell him/her how helpful someone on the IT desk was for her and he/she responded to that. I was a bit surprised but … people like (the CEO). He/she's approachable. He/she came and met with the team and we did a 'Show and Tell' for him/her. He/she seemed really impressed and that face to face contact - although it was a big deal at the time because people had to make time for it, I think it was a useful thing to do" (ID38: CS2).

(Code: Improving communications)	"There's been a real effort around **communications**. And we have got the Chief Exec briefing: he/she has open staff meetings, and it's literally an open invite via connecting all of the e-mails. Anyone can just go and listen to his/her briefings: that's only been in the last few years" (ID33: CS1).
Staff Development *(Code: Talent management)* *(Code: Leadership development)*	"I got a post here (in 1999) as a Senior {…}, which would be equivalent to a Band 6 now. And then I worked here as a […] on […]. So, very clinically based initially, worked my way up to a Band 7, took a Band 7 in probably about 2006, and applied for this post when my predecessor took retirement in 2011. I actually leapfrogged a couple of my colleagues, they'd been here a substantial amount of time, so who knows who I was upsetting or not upsetting at the time! So, yes, I took the post in 2011. […] I've been here coming up nine years now, in my current role as […]" (ID21: CS1). "Well I went on a leadership course that the Trust did, that was fantastic I have to say. That came at the right time. It came before this role came up. I was a Band 7 then so I was managing the […] here. That was a really good opportunity and it was fantastic, that course. It was really eye-opening and I use a lot of stuff that I learnt on that course. Now I will do going forwards, so that was good" (ID7: CS2).
Recruitment and Proactive Retention *(Code: Capitalising on 2nd CQC grading (G or O)* *(Code: Staff stability)*	"Yes, we did (capitalise on our success) - immediately. We put it on everything, which we did do the first time around but it took a while. So it is on our letter, we talk about it on our new qualifier letter, with having it there. It's a very external - it's the best of external consultancy, free consultancy you ever get. It's an external kite mark, whatever you think about them - and it's not the whole picture by any means, but it is an important part of that picture" (ID6: CS1). "So we're really reliant on really good teams and people not wanting to leave their team because it's well led, because they're supported, because they've got say … so they become our retainers. […] It's definitely true, the hypothesis is right: if we can get a really good leadership team in there and we can get people with a reasonable case load, they'll stay regardless of whether they've got to drive 45 minutes. And if they can't have those things, then they don't" (ID14: CS2).
Effective Teamwork *(Code: Supportive team-working)*	"I think leadership is about breaking down the barriers that stop you doing stuff. Good leadership. So if they have a problem, they don't know how to do something, I might try to give them some training or find them some training and communication is key. If you're all talking together, then when somebody is flagging a bit you ask them: Do you need any help? Could you do this differently?" (ID3: CS2).

(Code: Getting the best out of people)	"So, people would expect, if we for example have to do a particular thing every shift: if it doesn't happen, people would expect either the matron or the sister to come back to them and go: Oh, I notice this didn't happen on that shift, can you tell me about that? And it might be a simple: Hands up, do you know what? I completely forgot about that! In which case it'll be: OK, how can we make it so you don't forget it? Shall we add it to your check list? Shall we put up a notice here? What is it that's going to help you to remember it? Should we make it a team responsibility? It's never: Oh, you're a numpty! Don't be daft! Don't do it again! It's like: OK, Why did you forget? What was it? What can we do to help that not happen again? And I think that's the difference: that it isn't about whose mistake was it? It's about OK, this didn't happen. Why not? What can we do to change and improve that, and help you in the future to get it right?" (ID37: CS1).
Resilience-Building Programmes *(Code: Definition of organisational resilience)* *(Code: Developing resilience of staff)*	"Well, I think a resilient organisation is one that can fundamentally focus on its core purpose of really delivering safe, good care everyday. And that means an understanding of the risks to being able to do that and an openness about what can and can't be addressed and how we do have to do something to work around those risks. So I think for me the resilience comes from the individual resilience of the individuals who work in it" (ID 35: CS1). "We talk about it (resilience) a lot. Everyday people are talking about it. I think we (Clinical Leads) do too, as well: we ask about how are you feeling? Are you OK? I think in the Trust we're good at resilience. It comes down to you just looking after each other on a day-to-day basis and I think that helps with people's individual resilience. And I think as an organisation […] people's well-being, and it's really important. It's a real priority" (ID11: CS2).
Acting on Feedback *(Code: Staff survey feedback)* *(Code: Seeking staff feedback)*	"I think the feedback loop is there. The staff survey helps: reacting to the staff survey, being clear on your outcomes from that, what we need to work on, what we do really well. That feedback is equally as important. And I think in Divisions certainly, something we do really well is feeding back when people do well, and reflecting and debriefing on all those things that are going well, or things that have not gone so well" (ID21: CS1). "There's lots of opportunities (for staff engagement) and what I'm always mindful of as a leader is that, we'll get a lot of people's attention and a lot of people's engagement and involvement. What we need to consistently keep reminding ourselves to do is to think about the people who we **don't** hear through those forums.[…] It's really important to keep thinking about that because we need to make sure we remain diverse in those ideas" (ID23: CS2).
Robust Risk Management *(Code: Cautious approach to risk)*	"I think sometimes we can stumble a bit just because we frighten ourselves a bit. This positive risk taking in an organisation like this sometimes means things go wrong. So I think sometimes we get a bit caught in the: let's try it first in one little area and see if it works" (ID34: CS2).

(Code: Risk management focus)	"One of the other things that was impressed on me when I first came to the Trust (in October 2017) was the importance of the management of risk. And the importance of the risk register and keeping that up to date and on top of those things so the Trust is sighted and has the right actions in place to mitigate those risks: that was considered very important" (ID39: CS1).
Effective Response to Regulatory Feedback *(Code: Attitude to regulation)* *(Code: Impact of CQC 1st inspection (RI or I))*	"So one of the obvious things there is taking the recommendations very seriously. So, one of the things that always surprises me is when I find in another organisation where they will deliver the regulatory aspects of what they've been told to do, but will perhaps note the recommendations but will not follow through on those in terms of the Should Do things. The ideas, in a sense, that come forward from the CQC. So we would treat, and we **do** treat, the recommendations from the CQC on an equal footing to the Must Do things. We know that a regulator has come into our organisation, has identified that we have fallen short in these areas, we could do better" (ID10: CS1). "So there was a very specific action around closing one service in (geographical location): that took place. That was a residential rehab. service and was one of the things that the organisation was marked down on. And then, just more generally, a proactive series of quality improvements that the organisation took. So the organisation put in place, helped with CQC governance process, around actually following through on your Must Dos and your Should Dos, etc., etc." (ID8: CS2).
Delivering Strategic Priorities *(Code: Strong governance)* *(Code: Quality improvement)*	"I think governance here is extreme. I've never worked in any organisation where every risk is carefully recorded, is monitored, reviewed. Action plans. We function through a risk management mechanism: that is core to how we are managed and governed. I think that suits quality very well because, at the end of the day, you're looking at the outcomes of quality, particularly of patient care. And, if you make a mistake, you know, you dive into that detail and you rectify things and you don't judge" (ID1: CS1). "When it comes to improvement we're in a good place, where we've got lots of people initiating project work and looking at their own areas. What is most important to people is what they cite on improving first. And so they're doing a lot of that work, and we've got around about 115 and 120 improvement projects at lots of different varying degrees of development, and that's a healthy place. And we've also got the work streams and people leading work streams through the clinical strategy project management office, global digital exemplars, which are all now citing these Quality Improvement projects that people are working on" (ID32: CS2).
Lack of Complacency *(Code: Room for improvement)*	"I also think that when we got the (G/O) rating, I think there had been significant improvements. But it's slightly difficult to benchmark yourself because there is that subjectivity to it. And obviously there's still things that need improving. There are obviously pockets of totally outstanding stuff but, I think for me, there's maybe not quite the consistency of them" (ID14: CS2).

(Code: Uncomplacent)	"What we're doing, it's not about maintaining - it's about improving. So there are things in that report that I wasn't happy with. So we only got Good for Caring, and I was really disappointed with that. We didn't get any areas of improvement identified, absolutely nothing. It was just all highlighted as good practice and stuff, but we actually still only got the Good and we actually challenged that but they said: well, you know Good is Good. But no, Good is not good enough!" (ID 9: CS1).
Organisational Learning Imperative *(Code: Datix reporting)* *(Code: Learning from incidents)*	"So, we have 'Message of the Month' across the whole Trust, and that's learning from either clinical incidents or DATIXs, so if there's a theme emerging. And it's a really simple but effective way of everybody learning. So it goes out to everyone via e-mail, on a poster, and it's a really simple message. And in the department, we have 'Message of the Week', because there's a lot to learn every week. […] We have a big patient safety team now, both in divisions and Trust-wide, so there's been a lot of investment in that and Root Cause Analyses are taken very seriously. There's a lot of training around that and the findings are taken seriously. The process of DATIXing, the reporting of clinical incidents, that's taken very seriously" (ID29: CS1). "I spent all morning on Monday sat down with (colleagues names), going: If we look at this as a case study, what's the learning that we can take? So we took that case step-by-step, from throughout the whole process and what's the learning that we can take from each part and will now put that into action. So I think the organisation in the main is actually really good at learning from incidents. And one thing I think (the CEO) pushes very hard, but he/she's pushing at an open door here, is viewing every incident as an opportunity. That's really key" (ID12: CS2).

REFERENCES

Acar, W. and Winfrey, F.L. (1994) 'The resilient organization: sustaining organizational renewal and performance', *Journal of Strategic Change*, 3, pp. 165-173.

Ahmed, E., Kilika, J. and Gakenia, C. (2022) 'Progressive convergent definition and conceptualization of organizational resilience: a model development', *International Journal of Organizational Leadership*, 10, pp. 385-400.

Akhtar, M., Casha, J.N., Ronder, J., Sakel, M., Wight, C. and Manley, K. (2016) 'Leading the health service into the future: transforming the NHS through transforming ourselves', *International Practice Development Journal,* 6(2), pp. 1-21.

Alaszewski, A. (2002) 'The impact of the Bristol Royal Infirmary disaster and inquiry on public services in the UK', *Journal of Interprofessional Care,* 16(4), pp. 371-378.

Alderwick, H. and Raleigh, V. (2017) 'Yet more performance ratings for the NHS', *BMJ,* 358:j3836 [online] doi: 10.1136/bmj.j3836 (Accessed: 1 September 2020).

Alderwick, H., Dunn, P., McKenna, H., Walsh, N. and Ham, C. (2016) *Sustainability and transformation plans in the NHS: how are they being developed in practice?* London: The King's Fund.

Alderwick, H., Dunn, P., Gardner, T., Mays, N. and Dixon, J. (2021) 'Will a new structure in England help recovery from the pandemic?', *BMJ*, 372:n248 [online]. doi: 10.1136/bmj.n248 (Accessed: 7 May 2021).

Alimo-Metcalfe, B. (1999) 'Leadership in the NHS: what are the competencies and qualities needed and how can they be developed?', in Mark, A.L. and Dopson, S. (eds.) *Organisational behaviour in health care: the research agenda.* Palgrave Macmillan, pp. 135-152.

Alimo-Metcalfe, B. (2013) 'A critical review of leadership', in Leonard, H.S., Lewis, R., Freedman, A.M. and Passmore, J. (eds.) *The Wiley-Blackwell handbook of the psychology of leadership*. John Wiley & Sons, Ltd., pp. 16-47.

Alimo-Metcalfe, B. and Alban-Metcalfe, J. (2005) 'Leadership: time for a new direction?', *Leadership*, 1(1), pp. 51-71.

Allen, P., Keen, J., Wright, J., Dempster, P., Townsend, J., Hutchings, A., Street, A. and Verzulli, R. (2012) 'Investigating the governance of autonomous public hospitals in England: multi-site case study of NHS foundation trusts', *Journal of Health Services Research & Policy*, 17(2), pp. 94-100. doi: 10.1258/jhsrp.2011.011046 (Accessed: 12 May 2019).

Allen, P., Osipovič, D., Shepherd, E., Coleman, A., Perkins, N., Garnett, E. and Williams, L. (2017) 'Commissioning through competition and cooperation in the English NHS under the Health and Social Care Act 2012: evidence from a qualitative study of four clinical commissioning groups', *BMJ Open*, 7:e011745 [online]. doi: 10.1136/bmjopen-2016-011745 (Accessed: 10 April 2021).

Alvarez-Rosete, A. and Mays, N. (2014) 'Understanding NHS policy making in England: the formulation of the NHS Plan, 2000', *British Journal of Politics & International Relations.,* 16(4), pp. 624-644.

Amanatidou, E., Butter, M., Carabias, V., Könnölä, T., Leis, M., Saritas, O., Schaper-Rinkel, P. and van Rij, V. (2012) 'On concepts and methods in horizon scanning: lessons from initiating policy dialogues on emerging issues', *Science and Public Policy,* 39, pp. 208-221.

Anandaciva, S. (2020) *Financial debts and loans in the NHS* [online]. The King's Fund. Available at: kingsfund.org.uk/publications/financial-debts-and-loans-nhs (Accessed: 2 December 2020).

Anderson, J.E., Ross, A.J., Back, J., Duncan, M., Snell, P., Walsh, K. and Jaye, P. (2016) 'Implementing resilience engineering for healthcare quality improvement using the CARE model: a feasibility study protocol', *Pilot and Feasibility Studies*, 2(61), pp. 1-9. doi: 10/1186/s40814-016-0103-x (Accessed: 24 May 2021).

Anderson, M., Pitchforth, E., Asaria, M., Brayne, C., Casadei, B. *et al*. (2021) 'LSE-Lancet Commission on the future of the NHS: re-laying the foundations for an equitable and efficient health and care service after COVID-19', *The Lancet*, 397, pp.1915-1978. doi: 10.1016/s0140-6736(21)00232-4 (Accessed: 24 May 2021).

Andersson, T., Cäker, M., Tengblad, S. and Wickelgren, M. (2019) 'Building traits for organizational resilience through balancing organizational structures', *Scandinavian Journal of Management*, 35, pp.36-45.

Andrews, S. and Thorne, F. (2015) 'What do people need to be resilient in the current NHS?', *Clinical Psychology Forum*, 276, pp. 12-15.

Annarelli, A. and Nonino, F. (2016) 'Strategic and operational management of organizational resilience: current state of research and future directions', *Omega*, 62, pp. 1-18.

Appleby, J., Galea, A. and Murray, R. (2014) *'The NHS productivity challenge': experience from the front line.* London: The King's Fund.

Argote, L. and Miron-Spektor, E. (2011) 'Organizational learning: from experience to knowledge', *Organization Science*, 22(5), pp. 1123-1137.

Argyris, C. (1976) 'Leadership, learning and changing the status quo', *Organizational Dynamics*, 4(3), pp. 29-43.

Argyris, C. (1999) *On organizational learning*. 2nd edn. Blackwell Publishers Ltd.

Arksey, H. and Knight, P.T. (1999) *Interviewing for social scientists.* London: Sage Publications Ltd.

Armstrong, D., Gosling, A., Weinman, J. and Marteau, T. (1997) 'The place of inter-rater reliability in qualitative research: an empirical study', *Sociology,* 31(3), pp. 597-606.

Atewologun, D., Cornish, T. and Tresh, F. (2018) *Unconscious bias training: an assessment of the evidence for effectiveness*. Equality and Human Rights Commission.

Atkins, P.W.B. and Parker, S.K. (2012) 'Understanding individual compassion in organizations: the role of appraisals and psychological flexibility', *Academy of Management Review*, 37(4), pp. 524-546.

Atkinson, P.E. (2012) 'Creating culture change', *Operations Management*, 5, pp. 32-37 [online]. Available at: http://www.philipatkinson.com/uploads/7/1/5/0/7150143/creatingculturechange-philipatkinson.pdf (Accessed: 24 June 2021).

Aurini, J.D., Heath, M. and Howells, S. (2016) *The how to of qualitative research.* London: Sage Publications Ltd.

Azungah, T. (2018) 'Qualitative research: deductive and inductive approaches to data analysis', *Qualitative Research Journal,* 18(4), pp. 383-400. doi: 10.1108/QRJ-D-18-00035 (Accessed: 24 June 2021).

Bailey, S. and Burhouse, A. (2019) 'From super-hero to super-connector, changing the leadership culture in the NHS', *Future Healthcare Journal,* 6(2), pp. 106-109.

Ball, H.C. (1996) 'Management of bullying and bullying in management', *Accident and Emergency Nursing,* 4(3), pp. 114-118.

Balmer, J.M.T. and Burghausen, M. (2015) 'Introducing organisational heritage: linking corporate heritage, organisational identity and organisational memory', *Journal of Brand Management*, 22(5), pp. 385-411.

Bamford, D. and Daniel, S. (2005) 'A case study of change management effectiveness within the NHS', *Journal of Change Management,* 5(4), pp. 391-406.

Barasa, E., Mbau, R. and Gilson, L. (2018) 'What is resilience and how can it be nurtured? A systematic review of empirical literature on organisational resilience', *International Journal of Health Policy and Management,* 7(6), pp. 491-503.

Barbour, R. (2008) *Introducing qualitative research: a student's guide to the craft of doing qualitative research.* London: Sage Publications Ltd.

Bartlett, C.A. and Goshall, S. (1995) 'Rebuilding behavioral context: turn process reengineering into people rejuventation', *MIT Sloan Management Review*, 37(1), pp. 11-23.

Bartsch, S.M., Ferguson, M.C., McKinnell, J.A., O'Shea, K.J., Wedlock, P.T., Siegmund, S.S. and Lee, B.Y. (2020) 'The potential health care costs and resource use associated with COVID-19 in the United States: a simulation estimate of the direct medical costs and health care resource use associated with COVID-19 infections in the United States', *Health Affairs*, 39(6), pp. 1-7. doi: 10.1377/hlthaff. 2020.00426 (Accessed: 3 December 2020).

Bazeley, P. and Jackson, K. (2013) *Qualitative data analysis with NVivo.* London: Sage Publications Ltd.

Beaussier, A.L., Demeritt, D., Griffiths, A. and Rothstein, H. (2016) 'Accounting for failure: risk-based regulation and the problems of ensuring healthcare quality in the NHS', *Health, Risk & Society,* 18(3/4), pp. 205-224.

Beckerman, A. and Fontana, L. (2001) 'The transition from AFDC to PRWORA in Florida; perceptions of the role of Case Manager in welfare reform', *Journal of Sociology and Social Welfare,* 28(3), pp. 29-48.

Beirne, M. (2017) 'The reforming appeal of distributed leadership', *British Journal of Healthcare Management,* 23(6), pp. 262-270.

Bell, S, (2019) 'Organisational resilience: a matter of organisational life and death', *Continuity and Resilience Review*, 1(1), pp. 5-16.

Bell, C., Chan, M. and Ne, P. (2014) 'The impact of participative and directive leadership on organisational culture: an organisational development perspective', *Mediterranean Journal of Social Sciences*, 5(23), pp. 1970-1985.

Benson, L.A., Boyd, A. and Walshe, K. (2006) 'Learning from regulatory interventions in healthcare', *Clinical Governance: An International Journal,* 11(3), pp. 213-224.

Berg, B.L. and Lune, H. (2012) *Qualitative research methods for the social sciences.* 8th edn. Pearson.

Berg, S.H., Akerjordet, K., Ekstedt, M. and Aase, K. (2018) 'Methodological strategies in resilient health care studies: an integrative review', *Safety Science*, 110, pp. 300-312.

Bergström, J., van Winsen, R. and Henriqson, E. (2015) 'On the rationale of resilience in the domain of safety: a literature review', *Reliability Engineering and System Safety,* 141, pp. 131-141.

Berwick, D. (2013) *A promise to learn - a commitment to act: improving the safety of patients in England.* London: Williams Lea.

Best, C. (2020) 'Is there a place for servant leadership in nursing?', *Practice Nursing,* 31(3), pp. 128-132.

Bettis, R.A., Helfat, C.E. and Shaver, J.M. (2016) 'The necessity, logic, and forms of replication', *Strategic Management Journal,* 37, pp. 2193-2203.

Bevan, G. (2006) 'Setting targets for healthcare performance: lessons from a case study of the English NHS', *National Institute Economic Review*, 197, pp. 67-79.

Bevan, G. (2008) 'Changing paradigms of governance and regulation of quality of healthcare in England', *Health, Risk & Society,* 10(1), pp. 85-101.

Bhaidkar, A. and Goswami, A. (2016) 'Doctor-manager relationship, a changing paradigm', *Aweshkar Research Journal*, 21(2), pp. 67-75.

Bhamra, R., Dani, S. and Burnard, K. (2011) 'Resilience: the concept, a literature review and future directions', *International Journal of Production Research,* 49(18), pp. 5375-5393.

Biernacki, P. and Waldorf, D. (1981) 'Snowball sampling: problems and techniques of chain referral sampling', *Sociological Methods & Research,* 10(2), pp. 141-163. Available at: http://ftp.columbia.edu/itc/hs/pubhealth/p8462/misc/biernacki_lect4.pdf (Accessed 2 June 2021).

Birch, M., Miller, T., Mauthner, M. and Jessop, J. (2002) 'Introduction', in Mauthner, M., Birch, M., Jessop, J. and Miller, T. (eds.) *Ethics in qualitative research.* London: Sage Publications Ltd.

Blaikie, N. (2009) *Designing social research.* Polity Press.

Bleiker, J., Knapp, K., Hopkins, S. and Johnston, G. (2016) 'Compassionate care in radiography recruitment, education and training: a post-Francis Report review of the current literature and patient perspectives', *Radiography*, 22, pp. 257-262.

Bleiker, J., Knapp, K., Morgan-Trimmer, S. and Hopkins, S. (2020) 'What medical imaging professionals talk about when they talk about compassion', *Journal of Medical Imaging and Radiation Sciences,* 51, pp. S44-S52. doi: 10.1016/j-jmir.2020.08.09 (Accessed: 13 May 2021).

Bloor, K. (ed.) (1998) *Radicalism and reality in the National Health Service: fifty years and more*. Centre for Health Economics, University of York.

Bohigas, L., Brooks, T., Donahue, T., Donaldson, B., Heidemann, E., Shaw, C. and Smith, D. (1998) 'A comparative analysis of surveyors from six hospital accreditation programmes and a consideration of the related management issues', *International Journal for Quality in Health Care,* 10(1), pp. 7-13.

Boin, A. and van Eeten, M.J.G. (2013) 'The resilient organization', *Public Management Review,* 15(3), pp. 429-445.

Bonanno, G.A. (2004) 'Loss, trauma and human resilience: have we underestimated the human capacity to thrive after extremely aversive events?', *American Psychologist,* 59(1), pp. 20-28.

Bond, K. and Brimblecombe, N. (2003) 'Violent incidents and staff views', *Mental Health Nursing,* 23(6), pp. 10-12, 17.

Boorman, S. (2010) 'Health and well-being of the NHS workforce', *Journal of Public Mental Health*, 9(1), pp. 4-7.

Bouaziz, F. and Hachicha, Z.S. (2018) 'Strategic human resource management practices and organizational rsilience', *Journal of Management Development*, 37(7), pp.537-551.

Bowns, I.R., Rotherham, G. and Paisley, S. (1999) 'Factors associated with success in the implementation of information management and technology in the NHS', *Health Informatics Journal*, 5, pp. 136-145.

Box, T.M. and Byus, K. (2007) 'Ryanair (2005): successful low cost leadership', *Journal of the International Academy for Case Studies*, 13(3), pp. 65-70.

Boyatzis, R.E. (1998) *Transforming qualitative information: thematic analysis and code development.* Thousand Oaks, CA: Sage Publications, Inc.

Boyd, A., Addicott, R., Robertson, R., Ross, S. and Walshe, K. (2017) 'Are inspector's assessments reliable? Ratings of NHS acute hospital trust services in England', *Journal of Health Services Research & Policy,* 22(1), pp.28-36.

Boyd, A., Moralee, S. and Ferguson, J. (2020) *CQC's impact on the quality of care: an assessment of CQC's contribution and suggestions for improvement.* Alliance Manchester Business School. Available at: https://www.research.manchester.ac.uk/portal/files/178442417/20200408_CQC_impact_on_quality_of_care_Main_report.pdf (Accessed: 20 October 2020).

Braes, B. and Brooks, D. (2010) 'Organisational resilience: a propositional study to understand and identify the essential concepts', *3rd Australian Security and Intelligence Conference*, 2010, 14-22. doi: 10.4225/75/579ec432099ca (Accessed: 20 October 2021).

Braithwaite, J. and Travaglia, J.F. (2008) 'An overview of clinical governance policies, practices and initiatives', *Australian Health Review,* 32(1), pp. 10-22.

Braithwaite, J., Wears, R.L. and Hollnagel, E. (2015) 'Resilient health care: turning patient safety on its head', *International Journal for Quality in Health Care*, 27(5), pp. 418-420.

Brandt, M.J., Ijzerman, H., Dijksterhuis, A., Farach, F.J. *et al.* (2014) 'The replication recipe: what makes for a convincing replication?', *Journal of Experimental Social Psychology,* 50, pp. 217-224.

Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology', *Qualitative Research in Psychology,* 3(2), pp. 77-101.

Braun, V. and Clarke, V. (2013) *Successful qualitative research: a practical guide for beginners.* London: Sage Publications Ltd.

Brennan, N.M. and Flynn, M.A. (2013) 'Differentiating clinical governance, clinical management and clinical practice', *Clinical Governance: An International Journal*, 18(2), pp. 114-131.

Brewer, J. and Hunter, A. (1989) *Multimethod research: a synthesis of styles*. Thousand Oaks, CA: Sage Publications, Inc.

Brewerton, P.M. and Millward, L.J. (2001) *Organizational research methods.* Thousand Oaks, CA: Sage Publications, Inc.

Bridges, J., May, C., Fuller, A., Griffiths, P., Wigley, W., Gould, L., Barker, H. and Libberton, P. (2017) 'Optimising impact and sustainability: a qualitative process evaluation of a complex intervention targeted at compassionate care', *BMJ Quality & Safety,* 26(12), pp. 970-977.

Brinberg, D. and McGrath, J.E. (1985) *Validity and the research process.* Thousand Oaks, CA: Sage Publications, Inc.

Brinkmann, S. (2018) 'The interview', in Denzin, N.K. and Lincoln, Y.S. (eds.) *The Sage handbook of qualitative research.* 5th edn. Thousand Oaks, CA: Sage Publications, Inc., pp. 576-599.

British Medical Association (2018) *Bullying and harassment: how to address it and create a supportive and inclusive culture* [online]. BMA. Available at: bma-bullying-and-harassment-policy-report-oct-2019.pdf (Accessed: 15 April 2021).

Brown, A. (1992) 'Organizational culture: the key to effective leadership and organizational development', *Leadership & Organization Development Journal,* 13(2), pp. 3-6. Available at: https://www.emerald.com/insight/content/doi/10.1108/01437739210009545/full/html (Accessed: 18 May 2021).

Brown, T. (2003) 'Towards an understanding of local protest: hospital closure and community resistance', *Social & Cultural Geography*, 4(4), pp. 489-506.

Brunetto, Y., Dick, T., Xerri, M. and Cully, A. (2020) 'Building capacity in the healthcare sector: a strengths-based approach for increasing employees' well-being and organisational resilience', *Journal of Management & Organization*, 26, pp. 309-323.

Bryce, C., Ring, P., Ashby, S. and Wardman, J.K. (2020) 'Resilience in the face of uncertainty: early lessons from the COVID-19 pandemic', *Journal of Risk Research*, 23(7-8), pp. 880-887.

Bryman, A. (2012) *Social research methods.* 4th edn. Oxford University Press.

Buchanan, D.A. (2012) 'Case studies in organizational research', in Symon, G. and Cassell, C. (eds.) *Qualitative organizational research*: *core methods and current challenges.* London: Sage Publications Ltd., pp. 351-370.

Buetow, S. (2010) 'Thematic analysis and its reconceptualization as 'saliency analysis'', *Journal of Health Services Research & Policy,* 15(2), pp. 123-125.

Bui, H., Chau, V.S., Degl'Innocenti, M., Leone, L. and Vicentini, F. (2019) 'The resilient organisation: a meta-analysis of the effect of communication on team diversity and team performance', *Applied Psychology,* 68(4), pp. 621-657.

Burman, R., Cairns, R., Canestrini, S., Elias, R., Metaxa, V., Owen, G., Polat, H., Keene, A.R. and Sutherland, E. (2020) 'Making ordinary decisions in extraordinary times', *BMJ,* 370:m.3268 [online]. doi: 10.1136/bmj.m3268 (Accessed: 26 August 2020).

Burnard, K. and Bhamra, R. (2011) 'Organisational resilience: development of a conceptual framework for organisational responses', *International Journal of Production Research,* 49(18), pp. 5581-5599.

Bush, T. and Glover, D. (2012) 'Distributed leadership in action: leading high-performing leadership teams in English schools', *School Leadership and Management*, 32(1), pp. 21-36. doi: 10.1080/13632434.2011.642354 (Accessed: 30 June 2021).

Bustinza, O.F., Vendrell-Herrero, F., Perez-Arostegui, M. and Parry, G. (2016) 'Technological capabilities, resilience capabilities and organizational effectiveness', *The International Journal of Human Resource Management,* 30(8), pp. 1370-1392.

Byrne, D. and Ragin, C. (2009) *The Sage handbook of case methods*. Thousand Oaks, CA: Sage Publications, Inc.

Cahill, L. and McGaugh, J.L. (1998) 'Mechanisms of emotional arousal and lasting declarative memory', *Trends in Neurosciences,* 21(7), pp. 294-299.

Caley, M. and Sidhu, K. (2011) 'Estimating the future healthcare costs of an aging population in the UK: expansion of morbidity and the need for preventative care', *Journal of Public Health,* 33(1), pp. 117-122.

Cameron, K. (2010) 'Five keys to flourishing in trying times', *Leader to Leader*, 55, pp. 45-51.

Cameron, K. (2011) 'Responsible leadership as virtuous leadership', *Journal of Business Ethics,* 98(1), pp. 25-35.

Care Quality Commisssion (2010) *The state of health care and adult social care in England: key themes and quality of services in 2009.* The Stationery Office Limited. Available at: https://webarchive.nationalarchives.gov.uk/20110504133347/http://www.cqc.org.uk/_db/_documents/CQC_Complete_2009_18.pdf (Accessed: 16 October 2020).

Care Quality Commission (2013a) *CQC launches consultation on the future of inspection and regulation.* Newcastle-upon-Tyne: Care Quality Commission. Available at: https://www.cqc.org.uk/news/releases/cqc-launches-consultation-future-inspection-regulation (Accessed: 16 October 2020).

Care Quality Commission (2013b) *Raising standards, putting people first: our strategy for 2013 to 2016.* Newcastle-upon-Tyne: Care Quality Commission. Available at: www.cqc.org.uk/sites/ default/ les/documents/20130503_cqc_strategy_2013_ nal_cm_tagged.pdf (Accessed: 16 October 2020).

Care Quality Commission (2015) *The state of health care and adult social care in England 2014/15*, Newcastle-upon-Tyne: Care Quality Commission. Available at: https://webarchive.nationalarchives.gov.uk/20160407164639/http://www.cqc.org.uk/content/state-care-201415 (Accessed: 16 October 2020).

Care Quality Commission (2016a) *Shaping the future: CQC's strategy for 2016 to 2021*. Newcastle-upon-Tyne: Care Quality Commission. Available at: https://www.cqc.org.uk/sites/default/files/20160523_ strategy_16-21_strategy_final_web_01.pdf (Accessed: 16 October 2020).

Care Quality Commission (2016b) *Shaping the future: CQC's strategy for 2016 to 2021: what our strategy means for the health and adult social care services we regulate*. Newcastle-upon-Tyne: Care Quality Commission. Available at: https://www.cqc.org.uk/about-us/our-strategy-plans/our- strategy- 2016-2021 **(**Accessed: 16 October 2020).

Care Quality Commission (2017a) *State of care in NHS acute hospitals: 2014 to 2016*. Newcastle-upon-Tyne: Care Quality Commission. Available at: https://www.cqc.org.uk/sites/default/files/20170302b_stateof hospitals_web.pdf (Accessed: 16 October 2020).

Care Quality Commission (2017b) *The state of care in mental health services 2014 to 2017*. Newcastle-upon-Tyne: Care Quality Commission. Available at: https://www.cqc.org.uk/sites/default/files/ 20170720_stateofmh_report.pdf (Accessed: 16 October 2020).

Care Quality Commission (2017c) *Driving improvement: case studies from eight NHS trusts.* Newcastle-upon-Tyne: Care Quality Commission. Available at: https://www.cqc.org.uk/sites/default/files/ 20170614_drivingimprovement.pdf (Accessed: 2 March 2018).

Care Quality Commission (2018a) *The state of health care and adult social care in England 2017/218*. Newcastle-upon-Tyne: Care Quality Commission. Available at: https://webarchive.nationalarchives.gov.uk/20190112070317/https://www.cqc.org.uk/publications/major-report/state-care (Accessed: 16 October 2020).

Care Quality Commission (2018b) *Beyond barriers: how older people move between health and social care in England*. Newcastle-upon-Tyne: Care Quality Commission. Available at: https://www.cqc.org.uk/sites/default/files/20180702_beyond_barriers. pdf (Accessed: 16 October 2020).

Care Quality Commission (2018c) *Annual report and accounts 2017/18.* Newcastle-upon-Tyne: Care Quality Commission. Available at: https://www.cqc.org.uk/sites/default/files/ 20180711_Annualreport 201718.pdf (Accessed: 16 October 2020).

Care Quality Commission (2018d) *Driving improvement: case studies from seven mental health trusts.* Newcastle-upon-Tyne: Care Quality Commission. Available at: https://www.cqc.org.uk/sites/default/files/20180320_drivingimprovementmh_report.pdf (Accessed: 2 March 2018).

Care Quality Commission (2019a) *The state of health care and adult social care in England 2018/19*. Newcastle-upon-Tyne: Care Quality Commission. Available at: https://webarchive.nationalarchives.gov.uk/20200302143247/https://www.cqc.org.uk/ publications/major-report/state-care (Accessed: 16 October 2020).

Care Quality Commission (2019b) *Annual report and accounts 2018/19.* Newcastle-upon-Tyne: Care Quality Commission. Available at: https://www.cqc.org.uk/sites/default/files/ 20190812_Annualreport 201819.pdf (Accessed: 16 October 2020).

Care Quality Commission (2020) *The state of health care and adult social care in England 2019/20*. Newcastle-upon-Tyne: Care Quality Commission. Available at: https://www.cqc.org.uk/sites/default/files/20201016_stateofcare1920_fullreport.pdf (Accessed: 16 October 2020).

Carlo, G., Christ, C., Laible, D. and Gulseven, Z. (2016) 'An evolving and developing field of study: prosocial morality from a biological, cultural and developmental perspective', in Shackelford, T.K. and Hansen, R.D. (eds.) *The evolution of morality*. Switzerland: Springer International Publishing, pp. 53-78.

Carmeli, A. and Schaubroeck, J. (2008) 'Organisational crisis-preparedness: the importance of learning from failures', *Long Range Planning*, 41, pp. 177-196.

Carroll, J.S. and Edmondson, A.C. (2002) 'Leading organisational learning in health care', *Quality and Safety in Health Care*, 11, pp. 51-56.

Carson, C.M. (2005) 'A historical view of Douglas McGregor's theory Y', *Management Decision*, 43(3), pp. 450-460.

Carthey, J., de Leval, M.R. and Reason, J.T. (2001) 'Institutional resilience in healthcare systems', *Quality in Health Care*, 10, pp. 29-32.

Cassell, C. and Symon, G. (2011) 'Assessing 'good' qualitative research in the work psychology field: a narrative analysis', *Journal of Occupational and Organizational Psychology*, 84, pp. 633-650.

Castro, A.C. (2018) *Evaluating the effect of external inspections of the Care Quality Commission of acute NHS hospitals in England*. PhD Thesis, University of York. Available at: https://etheses.whiterose.ac.uk/21399/7/Thesis%20Ana%20Castro%20v2.pdf (Accessed: 2 December 2020).

Castro-Avila, A., Bloor, K. and Thompson, C. (2019) 'The effect of external inspections on safety in acute hospitals in the National Health Service in England: a controlled interrupted time-series analysis', *Journal of Health Services Research & Policy,* 24(3), pp. 182-190.

Catchpole, K.R., Giddings, A.E.B., Wilkinson, M., Hirst, G., Dale, T. and de Leval, M.R. (2007) 'Improving patient safety by identifying latent failures in successful operations', *Surgery*, 142(1), pp. 102-110.

Cereste, M., Doherty, N.F. and Travers, C.J. (2003) 'An investigation into the level and impact of merger activity amongst hospitals in the UK's National Health Service', *Journal of Health Organization and Management*, 17(1), pp. 6-24.

Chada, B.V. (2018) 'Resilience in the NHS: a necessary leadership attribute', *British Journal of Healthcare Management,* 24(9), pp. 437-439.

Chambers, N., Harvey, G. and Mannion, R. (2017) 'Who should serve on health care boards? What should they do and how should they behave? A fresh look at the literature and the evidence', *Cogent Business and Management,* 4: 1357348 [online]. Available at: https://doi.org/10.1080/23311975.2017.1357348 (Accessed: 2 June 2021).

Charlesworth, A. and Johnson, P. (eds.) (2018) *Securing the future: funding health and social care to the 2030s.* The Institute for Fiscal Studies. Available at: https://ifs.org.uk/uploads/R143_Chapter4.pdf (Accessed: 13 May 2021).

Cheese, P. (2016) 'Managing risk and building resilient organisations in a riskier world', *Journal of Effectiveness: People and Performance,* 3(3), pp. 323-331.

Chen, R., Xie, Y. and Liu, Y. (2021) 'Defining, conceptualizing and measuring organizational resilience: a multiple case study', *Sustainability*, 13(5), 2517 (online). Available at: https://doi.org/10.3390/su13052517 (Accessed: 16 October, 2021).

Cho, I., Kim, J.K., Park, H. and Cho, N-H. (2013) 'The relationship between organisational culture and service quality through organisational learning framework', *Total Quality Management & Business Excellence*, 24(7-8), pp. 753-768.

Chowdhury, D. (2020) 'The effects of the COVID-19 pandemic in the UK- at a local, national and international level perspective from the emergency department', *Advanced Journal of Emergency Medicine,* 4(2s), pp. 59-62. doi: 10.22114/ajem.v0i0.398 (Accessed: 15 March 2021).

Chu, L-C. (2014) 'Mediating toxic emotions in the workplace — the impact of abusive supervision', *Journal of Nursing Management*, 22, pp. 953-963. doi: 10.1111/jonm.12071 (Accessed: 4 July 2021).

Clark, C.M. and Harrison, C. (2018) 'Leadership: the complexities and state of the field', *European Business Review*, 30(5), pp. 514-528.

Coffey, A. and Atkinson, P. (1996) *Making sense of qualitative data: complementary research strategies.* Thousand Oaks, CA: Sage Publications, Inc.

Cole, C., Chase, S., Couch, O. and Clark, M. (2011) 'Research methodologies and professional practice: considerations and practicalities', *The Electronic Journal of Business Research Methods*, 9(2), pp. 141-151 [online]. Available at: https://academic-publishing.org/index.php/ejbrm/article/view/1276/1239 (Accessed: 18 February 2021).

Cole-King, A. and Gilbert, P. (2014) 'Compassionate care: the theory and the reality', in Shea, S., Wynyard, R. and Lionis, C. (eds.) *Building compassionate healthcare: challenges in policy and practice.* Routledge, pp. 68-84.

Collins, J. (2001) *Good to great*. Random House Business Books.

Collins, M. (2006) 'Taking a lead on stress: rank and relationship awareness in the NHS', *Journal of Nursing Management*, 14, pp. 310-317.

Collinson, G. (2006) 'What makes an effective healthcare leader? Results of the best leadership practices research in healthcare in the UK', *Practice Development in Health Care,* 5(2), pp. 81-91.

Comfort, L.K., Boin, A. and Demchak (eds.) (2010) *Designing resilience - preparing for extreme events.* University of Pittsburgh Press.

Conz, E. and Magnani, G. (2020) 'A dynamic perspective on the resilience of firms: a systematic literature review and a framework for future research', *European Management Journal,* 38(3), pp. 400-412.

Cooke, F.L., Wang, J. and Bartram, T. (2019) 'Can a supportive workplace impact employee resilience in a high pressure performance environment? An investigation of the Chinese banking industry', *Applied Psychology,* 68(4), pp. 695-718.

Costanza, D.P., Blacksmith, N., Coats, M.R., Severt, J.B. and DeCostanza, A.H. (2016) 'The effect of adaptive organizational culture on long-term survival', *Journal of Business and Psychology,* 31(3), pp. 361-381.

Cotta, D. and Salvador, F. (2020) 'Exploring the antecedents of organizational resilience practices - a transactive memory systems approach', *International Journal of Operations & Production Management*, 40(9), pp. 1531-1559.

Coutu, D.L. (2002) 'How resilience works', *Harvard Business Review,* 80(5), pp. 46-56.

Creswell, J.W. (2013) *Qualitative inquiry and research design: choosing among five approaches.* 3rd edn. Thousand Oaks, CA: Sage Publications, Inc.

Creswell, J.W. (2014) *Research design.* 4th edn. Thousand Oaks, CA: Sage Publications, Inc.

Crichton, M.T., Ramsay, C.G. and Kelly, T. (2009) 'Enhancing organizational resilience through emergency planning: learnings from cross-sectoral lessons', *Journal of Contingencies and Crisis Management,* 17(1), pp. 24-37.

Crilly, D., Schneider, S.C. and Zollo, M. (2008) 'Psychological antecedents to socially responsible behavior', *European Management Review*, 5, pp. 175-190.

Cruickshank, N. (2020) 'He who defends everything, defends nothing: proactivity in organizational resilience', *Transnational Corporations Review*, 12(2), pp. 94-105.

Currie, G. and Suhomlinova, O. (2006) 'The impact of institutional forces upon knowledge sharing in the UK NHS: the triumph of professional power and the inconsistency of policy', *Public Administration,* 84(1), pp. 1-30.

Dahms, T. (2009) 'Resilience and risk management', *The Australian Journal of Emergency Management,* 26(2), pp. 21-26.

Dall, T.M., Gallo, P.D., Chakrabarti, R., West, T., Semilla, A.P. and Storm, M.V. (2013) 'An aging population and growing disease burden will require a large and specialized health care workforce by 2025', *Health Affairs,* 32(11), pp. 2013-2020.

Damschroder, L.J., Aron, D.C., Keith, R.E., Kirsh, S.R., Alexander, J.A. and Lowery, J.C. (2009) 'Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science', *Implementation Science,* 4(1), pp. 1-15.

Darling, J.R. and Beebe, S.A. (2007) 'Effective entrepreneurial communication in organization development: achieving excellence based on leadership strategies and values', *Organization Development Journal*, 25(1), pp. 76-93.

Dartey-Baah, K. (2015) 'Resilient leadership: a transformational-transactional leadership mix', *Journal of Global Responsibility*, 6(1), pp. 99-112.

Dartey-Baah, K., Amponsah-Tawiah, K. and Sekyere-Abankwa, V. (2011) 'Leadership and organisational culture: relevance in public sector organisations in Ghana', *Business and Management Review*, 1(4), pp. 59-65.

Darzi, A. (2008) *High quality care for all: NHS next stage review final report.* London: The Stationery Office.

Dasan, S., Gohil, P., Cornelius, V. and Taylor, C. (2015) 'Prevalence, causes and consequences of compassion satisfaction and compassion fatigue in emergency care: a mixed-methods study of UK NHS consultants', *Emergency Medicine Journal,* 32(8), pp. 588-594.

Davies, A.C.L. (2013) 'This time it's for real: the Health and Social Care Act 2012', *The Modern Law Review*, 76(3), pp. 564-588. doi: 10.1111/1468-2230.12024 (Accessed: 16 May 2021).

Davies, H.T.O. and Mannion, R. (2013) 'Will prescriptions for cultural change improve the NHS?', *BMJ*, 346:f11305 [online]. doi: 10.1136/bmj.f11305 (Accessed: 20 March 2021).

Davis, T. and Higgins, J. (2013) 'A blockbuster failure: how an outdated business model destroyed a giant', *Bankruptcy Case Studies*, Chapter 11 [online]. Available at: https:// trace.tennessee.edu/utk_studlawbankruptcy/11 (Accessed: 7 June 2021).

Dawson, J. (2018) *Links between NHS staff experience and patient satisfaction: analysis of surveys from 2014 and 2015*. University of Sheffield. Available at: https://www.england. nhs.uk/wp-content/uploads/2018/06/01-018-edc03-staff-inpatient-survey-report.pdf (Accessed: 15 January 2021).

de Oliveira Teixeira, E. and Werther, W.B. (2013) 'Resilience: continuous renewal of competitive advantages', *Business Horizons,* 56(3), pp. 333-342.

de Vaus, D. (2001) *Research design in social research.* London: Sage Publications Ltd.

de Zulueta, P.C. (2016) 'Developing compassionate leadership in health care: an integrative review', *Journal of Healthcare Leadership*, 8, pp. 1-10. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5741000/pdf/jhl-8-001.pdf (Accessed: 16 April 2021).

DeJoy, D.M. (2005) 'Behavior change versus culture change: divergent approaches to managing workplace safety', *Safety Science*, 43, pp. 105-129. doi: 10.1016/j.ssci.2005.02. 001 (Accessed: 24 June 2021).

Deloitte (2021) *Deloitte insights: 2021 global health care outlook* [online]. Available at: https://documents.deloitte.com/insights/Globalhealthcareoutlook (Accessed: 7 May 2021).

Denscombe, M. (2017) *The good research guide: for small-scale social research projects*. 6th edn. Open University Press.

Denzin, N.K. and Lincoln, Y.S. (eds.) (2018) *The Sage handbook of qualitative research.* 5th edn. Thousand Oaks, CA: Sage Publications, Inc.

Department of Health (1997) *The new NHS: modern, dependable.* London: The Stationery Office. Available at: assets.publishing.service.gov.uk/government/uploads/system/upload s/attachment_data/file/266003/newnhs.pdf (Accessed: 2 October 2020).

Department of Health (1998) *A first class service: quality in the new NHS.* London: The Stationery Office. Available at: webarchive.nationalarchives.gov.uk/20110322225724/ http:www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGui dance/DH_4006902 (Accessed: 2 October 2020).

Department of Health (2000) *The NHS plan: a plan for investment, a plan for reform*. London: HMSO. Available at: https://webarchive.nationalarchives.gov.uk/20110506041304/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002960 (Accessed: 2 October 2020).

Department of Health (2012) *Report on the effect of the NHS constitution*. London: Department of Health. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/212840/Effect-of-the-NHS-Constitution.pdf (Accessed: 25 January 2021).

Department of Health (2015) *Report on the effect of the NHS constitution*. London: Department of Health. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/440171/2904073_Report_on_the_NHS_Accessible_v0.1.pdf (Accessed: 25 January 2021).

Department of Health and Social Care (2021a) *Handbook to the NHS constitution for England.* London: Department of Health and Social Care. Available at:https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england/the-handbook-to-the-nhs-constitution-for-england#contents (Accessed: 25 January 2021).

Department of Health and Social Care (2021b) *Integration and Innovation: working together to improve health and social care for all.* London: Department of Health and Social Care. Available at: https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version#contents (Accessed: 25 January 2021).

Dewar, S. and Boddington, P. (2004) 'Returning to the Alder Hey report and its reporting: addressing confusions and improving inquiries', *Journal of Medical Ethics,* 30(5), pp. 463-469.

Dhumad, S., Wijeratne, A. and Treasaden, I. (2007) 'Violence against psychiatrists by patients: survey in a London mental health trust', *Psychiatric Bulletin*, 31, pp. 371-374. doi: 10/1192/pb-bp.106.012815 (Accessed: 10 June 2021).

Diefenbach, T. (2009) 'Are case studies more than sophisticated storytelling?: Methodological problems of qualitative empirical research mainly based on semi-structured interviews', *Quality & Quantity*, 43(6), pp. 875-894. doi: 10.1007/s11135-008-9164-0 (Accessed: 27 October 2020).

Digby, A. (1998) 'Continuity or change in 1948? The significance of the NHS', in Bloor, K. (ed.) *Radicalism and reality in the National Health Service: 50 years and more.* Centre for Health Economics, pp. 4-17.

Dionne, S.D., Yammarino, F.J., Atwater, L.E. and Spangler, W.D. (2004) 'Transformational leadership and team performance', *Journal of Organizational Change Management*, 17(2), pp. 177-193.

Dixon-Woods, M., McNicol, S. and Martin, G. (2012) 'Ten challenges in improving quality in healthcare: lessons from the Health Foundation's programme evaluations and relevant literature', *BMJ Quality & Safety,* 21(10), pp. 876-884.

Dixon-Woods, M., Baker, R., Charles, K., Dawson, J., Jerzembek, G., Martin, G., McCarthy, I., McKee, L., Minion, J., Ozieranski, P., Willars, J., Wilkie, P. and West, M. (2014) 'Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study', *BMJ Quality & Safety,* 23(2), pp. 106-115.

Doh, J.P. and Quigley, N.R. (2014) 'Responsible leadership and stakeholder management: influence pathways and organizational outcomes', *Academy of Management*, 28(3), pp. 255-274.

Donald, W.E. (2017) *Students' perceptions of graduate employability: a sequential explanatory approach.* PhD Thesis, University of Southampton. Available at: https://eprints.soton.ac.uk/415935/ (Accessed: 14 June 2020).

Donald, B.L. and Southern, R.M. (1978) 'Quality care: commonplace or chimera', *Journal of Medical Ethics,* 4(4), pp. 186-194.

Drennan, L.T. and McConnell, A. (2007) *Risk and crisis management in the public sector*. Routledge.

Dromey, J. (2014) *Meeting the challenge: successful employee engagement in the NHS*. London: IPA.

Dubois, A. and Gadde, L-E. (2002) 'Systematic combining: an abductive approach to case research', *Journal of Business Research,* 55(7), pp. 553-560.

Duchek, S. (2020) 'Organizational resilience: a capability-based conceptualization', *Business Research*, 13, pp. 215-246.

Dunn, P., McKenna, H. and Murray, R. (2016) *Deficits in the NHS 2016*. London: The King's Fund.

Dutton, J.E., Workman, K.M. and Hardin, A.E. (2014) 'Compassion at work', *The Annual Review of Organizational Psychology and Organizational Behavior*, 1, pp. 277-304. doi: 10.1146/annurev-orgpsych-031413-091221 (Accessed: 15 April 2021).

Dworkin, S.L. (2012) 'Sample size policy for qualitative studies using in-depth interviews', *Archives of Sexual Behavior,* 41(6), pp. 1319-1320.

Dyer, C. (2013) 'Second children's cardiac surgery unit set for closure takes its case to High Court', *BMJ,* 346:1957 [online]. doi:10.1136/bmj.f957 (Accessed: 3 June 2021).

Easterby-Smith, M., Golden-Biddle, K. and Locke, K. (2008) 'Working with pluralism: determining quality in qualitative research', *Organisational Research Methods*, 11(3), pp.419-429. doi: 10.1177/1094428108315858 (Accessed: 2 June 2021).

Edwards, N. (2005) 'Doctors and managers: building a new relationship', *Clinical Medicine*, 5(6), pp. 577-579.

Edwards, N. (2016) 'Burdensome regulation of the NHS', *BMJ,* 353:i3414 [online]. doi: 10.1136/bmj.i3414 (Accessed: 15 September 2020)

Edwards, J.D. and Kleiner, B.H. (1988) 'Transforming organisational values and culture effectively', *Leadership & Organization Development Journal*, 9(1), pp. 13-16.

Edwards, R. and Holland, J. (2013) *What is qualitative interviewing?* Bloomsbury Academic.

Eisenberger, R., Armeli, S., Rexwinkel, B., Lynch, P.D. and Rhoades, L. (2001) 'Reciprocation of Perceived Organizational Support', *Journal of Applied Psychology*, 86(1), pp. 42-51.

Ekici, D. and Beder, A. (2014) 'The effects of workplace bullying on physicians and nurses', *Australian Journal of Advanced Nursing,* 31(4), pp. 24-33.

Elias, S. (2008) 'Fifty years of influence in the workplace: the evolution of the French and Raven power taxonomy', *Journal of Management History,* 14(3), pp. 267-283.

Eliot, J.L. (2020) 'Resilient leadership: the impact of a servant leader on the resilience of their followers', *Advances in Developing Human Resources*, 22(4), pp. 404-418.

Elkind, A. (1998) 'Using metaphor to read the organisation of the NHS', *Social Science of Medicine,* 47(11), pp. 1715-1727.

Ellwood, S. and Garcia-Lacalle, J. (2016) 'Examining audit committees in the corporate governance of public bodies', *Public Management Review,* 18(8), pp. 1138-1162.

Emmel, N. (2013) *Sampling and choosing cases in qualitative research: a realist approach.* London: Sage Publications Ltd.

Endacott, R., Sheaff, R., Jones, R. and Woodward, V. (2013) 'Clinical focus and public accountability in English NHS trust board meetings', *Journal of Health Services Research Policy*, 18(1), pp. 13-20. doi: 10.1258/jhsrp.2012.0011154 (Accessed: 2 June, 2021).

Espiner, S., Orchiston, C. and Higham, J. (2017) 'Resilience and sustainability: a complementary relationship? Towards a practical conceptual model for the sustainability-resilience nexus in tourism', *Journal of Sustainable Tourism*, 25(10), pp. 1385-1400. doi: 1 0.1080/09669582.2017.1281929 (Accessed: 3 June 2021).

Evenseth, L.L., Sydnes, M. and Gausdal, A.H. (2022) 'Building organizational resilience through organizational learning: a systematic review', *Frontiers in Communication*, 7:837386 (online). doi: 10.3389/fcomm.2022.837386 (Accessed: 2 May 2022).

Exworthy, M., Mannion, R. and Powell, M. (2016) *Dismantling the NHS?: Evaluating the impact of health reforms.* Policy Press.

Fenn, P. and Egan, T. (2012) 'Risk management in the NHS: governance, finance and clinical risk', *Clinical Medicine*, 12(1), pp. 25-28.

Ferlie, E. and Pettigrew, A. (1996) 'Managing through networks: some issues and implications for the NHS', *British Journal of Management,* 7(s1), pp. S81-S99.

Fiksel, J. (2003) 'Designing resilient, sustainable systems', *Environmental Science and Technology,* 37(23), pp. 5330-5339.

Firth-Cozens, J. and Mowbray, D. (2001) 'Leadership and the quality of care', *BMJ Quality & Safety,* 10(suppl 2), pp. ii3-ii7.

Fisher, E. and Dorning, H. (2016) *Winter pressures: what's going on behind the scenes.* The Health Foundation and Nuffield Trust. Available at: https://www.nuffieldtrust.org.uk/files/2018-10/1540144602_qualitywatch-winter-pressures.pdf (Accessed: 15 March 2021).

Fletcher, L., Robinson, D., Truss, C., Alfes, K., Holmes, J., Madden, A., Buzzeo, J. and Currie, G. (2014) *Measuring employee engagement and Interpreting survey results*. Institute for Employment Studies.

Flick, U. (2018) 'Triangulation', in Denzin, N.K. and Lincoln, Y.S. (eds.) *The Sage handbook of qualitative research.* 5th edn. Thousand Oaks, CA: Sage Publications, Inc., pp. 444-461.

Flodgren, G., Gonçalves-Bradley, D.C. and Pomey, M.P. (2016) *External inspection of compliance with standards for improved healthcare outcomes (review).* Cochrane Library.

Flyvbjerg, B. (2006) 'Five misunderstandings about case-study research', *Qualitative Inquiry,* 12(2), pp. 219-245.

Forgeard, M.J.C., Jayawickreme, E., Kern, M.L. and Seligman, M.E.P. (2011) 'Doing the right thing: measuring wellbeing for public policy', *International Journal of Wellbeing*, 1(1), pp. 79-106.

Forrest-Lawrence, P. (2019) 'Case study research', in Liamputtong, P. (ed.) *Handbook of research methods in health social sciences: an introduction.* Singapore: Springer. Available at: https://doi.org/10.1007/978-981-10-5251-4_67 (Accessed: 16 December 2020).

Fotaki, M. (2015) 'Why and how is compassion necessary to provide good quality healthcare?', *International Journal of Health Policy and Management*, 4(4), pp. 199-201.

Frame, J., Watson, J. and Thomson, K. (2008) 'Deploying a culture change programme management approach in support of information and communication technology developments in Greater Glasgow NHS Board', *Health Informatics Journal,* 14(2), pp. 125-139.

Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust public inquiry: Executive Summary.* London: The Stationery Office.

Franco, M. and Almeida, J. (2011) 'Organisational learning and leadership styles in healthcare organisations: an exploratory case study', *Leadership and Organization Development Journal*, 32(8), pp. 782-806.

Frankel, A.S., Leonard, M.W. and Denham, C.R. (2006) 'Fair and just culture, team behavior, and leadership engagement: the tools to achieve high reliability', *Health Services Research,* 41(4 Part II), pp. 1690-1709.

Freeman, R.E. and Auster, E.R. (2011) 'Values, authenticity and responsible leadership', *Journal of Business Ethics*, 98, pp. 15-23.

Freeman, R.E., Wicks, A.C. and Parmar, B. (2004) 'Stakeholder theory and "the corporate objective revisited"', *Organization Science,* 15(3), pp. 364-369.

Freeman, T. and Walshe, K. (2004) 'Achieving progress through clinical governance? A national study of health care managers' perceptions in the NHS in England', *BMJ Quality & Safety,* 13(5), pp. 335-343.

Fulop, N.J. and Ramsay, A.I.G. (2019) 'How organisations contribute to improving the quality of healthcare', *BMJ,* 365:l1773 [online]. Available at: https://www.bmj.com/content/bmj/365/bmj.l1773.full.pdf (Accessed: 20 October 2020).

Fulop, N.J., Capelas Barbosa, E., Hill, M., Ledger, J., Ng, P.L., Sherlaw-Johnson, C., *et al.* (2020) *Rapid evaluation of the special measures for quality and challenged provider regimes: a mixed-methods study*. Southampton: NIHR Health Services Research Topic Report. Available at: https://www.nuffieldtrust.org.uk/files/2020-09/rset-smq-final-report-reformat-16-sept-2020.pdf (Accessed: 23 May 2021).

Gainsbury, S. (2017) *The bottom line: understanding the NHS deficit and why it won't go away.* London: Nuffield Trust.

Gaynor, M., Laudicella, M. and Propper, C. (2012) 'Can governments do it better? Merger mania and hospital outcomes in the English NHS', *Journal of Health Economics,* 31, pp. 528-543.

George, A.L. and Bennett, A. (2005) *Case studies and theory development in the social sciences.* MIT Press.

Gerada, C., Chatfield, C., Rimmer, A. and Godlee, F. (2018) 'Making doctors better: personal resilience was never enough — systems must change', *BMJ,* 363:k4147 [online]. Available at: https://www.bmj.com/content/363/bmj.k4147 (Accessed: 28 November 2020).

Gerring, J. (2004) 'What is a case study and what is it good for?', *The American Political Science Review,* 98(2), pp. 341-354.

Gershon, R.A. (2013) 'Innovation failure: a case study of analysis of Eastman Kodak and Blockbuster Inc.', in Albarran, A.B. (ed.) *Media management and economics research in a transmedia environment.* Routledge, pp. 46-68.

Gibson, C.A. and Tarrant, M. (2010) 'A 'conceptual models' approach to organisational resilience', *The Australian Journal of Emergency Management*, 25(2), pp. 6-12.

Gilbert, P. (2007) 'Evolved minds and compassion in the therapeutic relationship', in Gilbert, P. and Leahy, R.L. (eds.) *The therapeutic relationship in the cognitive behavioural psychotherapies.* Routledge, pp. 106-142.

Gilbert, P. (ed.) (2017) *Compassion: concepts, research and applications*. Routledge.

Gilburt, H., Rose, D. and Slade, M. (2008) 'The importance of relationships in mental health care: a qualitative study of service users' experiences of psychiatric hospital admission in the UK', *BMC Health Services Research*, 8(92) [online]. doi: 10.1186/1472-6963-8-92 (Accessed: 12 June 2021).

Gillham, B. (2005) *Research Interviewing: the range of techniques.* Open University Press.

Gilmartin, M.J. and D'Aunno, T.A. (2007) 'Leadership research in healthcare: a review and roadmap', *The Academy of Management Annals*, 1(1), pp. 387-438. Available at: https://journals.aom.org/doi/epub/10.5465/078559813 (Accessed: 14 April 2021).

Gilson, L., Ellokor, S., Lehmann, U. and Brady, L. (2020) 'Organizational change and everyday health system resilience: lessons from Cape Town, South Africa', *Social Science & Medicine*, 266, 113407 (online). Available at: https://doi.org/10.1016/j.socscimed.2020.113407 (Accessed: 16 October 2021).

Gioia, D.A., Corley, K.G. and Hamilton, A.L. (2012) 'Seeking qualitative rigor in inductive research: notes on the Gioia methodology', *Organizational Research Methods*, 16(1), pp. 15-31.

Glasper, A. (2016) 'Moving from a blame culture to a learning culture in the NHS', *British Journal of Nursing,* 25(7), pp. 410-411.

Glendinning, C. (2003) 'Breaking down barriers: integrating health and care services for older people in England', *Health Policy*, 65, pp. 139-151.

Goddard, A.F. (2016) 'Lessons to be learned from the UK junior doctors' strike', *Journal of American Medical Association,* 316(14), pp. 1445-1446.

Goetz, J.L., Keltner, D. and Simon-Thomas, E. (2010) 'Compassion: an evolutionary analysis and empirical review', *Psychological Bulletin*, 136(3), pp. 351-374.

Gomes, J.F.S., Marques, T. and Cabral, C. (2022) 'Responsible leadership, organizational commitment and work engagement: the mediator role of organizational identification', *Nonprofit Management and Leadership*, pp. 1-20. doi: 10.1002/nml.21502.

Gomm, R., Hammersley, M. and Foster, P. (eds.) (2000) *Case study method*. London: Sage Publications Ltd.

Gorard, S. (2013) *Research design: creating robust approaches for the social sciences.* London: Sage Publications Ltd.

Gorli, M., Kaneklin, C. and Scaratti, G. (2012) 'A multi-method approach for looking inside healthcare practices', *Qualitative Research in Organizations and Management: An International Journal,* 7(3), pp. 290-307.

Gover, L. and Duxbury, L. (2018) 'Inside the onion: understanding what enhances and inhibits organizational resilince', *The Journal of Applied Behavioral Science*, 54(4), pp.477-501.

Gracey, A. (2019) 'Building an organisational resilience maturity framework', *Journal of Business Continuity & Emergency Planning,* 13(4), pp. 313-327.

Gray, R. and Sanders, C. (2020) 'A reflection on the impact of COVID-19 on primary care in the United Kingdom', *Journal of Interprofessional Care,* 34(5), pp. 672-678. doi: 10.1080/13561820.2020.1823948.

Griffin, J. (2009) 'Monitoring pressure damage using Datix risk reporting system', *Wounds UK*, 5(4), pp. 36-42.

Griffin, S. (2020) 'Covid-19: wating times in England reach record highs', *BMJ*, 370:m3557 [online]. Available at: http://dx.doi.org/10.1136/bmj.m3557 (Accessed: 7 July 2021).

Griffiths, R. (1983) *Griffiths Report on NHS*. London: DHSS.

Gronn, P. (2002) 'Distributed leadership as a unit of analysis', *The Leadership Quarterly*, 13, pp. 423-451.

Gryna, D. (1992) 'Celebrating success', *Managing Service Quality: An International Journal*, 2(6), pp. 329-333. Available at: https://doi.org/10.1108/09604529210029605 (Accessed: 29 May 2021).

Guest, D.E. (2017) 'Human resource management and employee well-being: towards a new anaytic framework', *Human Resource Management Journal*, 27(1), pp. 22-38.

Hailey, J. and James, R. (2002) 'Learning leaders: the key to learning organisations', *Development in Practice,* 12(3,4), pp. 398-408.

Hallett, R.E. (2013) 'Dangers of member checking', in Midgley, W., Danaher, P.A. and Baguley, M. (eds.) *The role of participants in education research*, Routledge, pp. 29-39.

Halliman, R.W. (2014) 'Understanding leadership: let's put the horse before the cart', *American Journal of Management,* 14(4), pp. 68-74.

Ham, C. (2003) 'Improving the performance of health services: the role of clinical leadership', *The Lancet,* 361, pp. 1978-1980.

Ham, C., Alderwick, H., Dunn, P. and McKenna, H. (2017) *Delivering sustainability and transformation plans: from ambitious proposals to credible plans*, London: The King's Fund.

Hamann, S. (2001) 'Cognitive and neural mechanisms of emotional memory', *TRENDS in Cognitive Sciences*, 5(9), pp. 394-400.

Hamel, G. and Välikangas, L. (2003) 'The quest for resilience', *Harvard Business Review,* 81(9), pp. 52-63.

Hammersley, M. and Gomm, R. (2000) 'Introduction', in Gomm, R., Hammersley, M. and Foster, P. (eds.) (2000) *Case study method*. Sage Publications Ltd, pp. 1-16.

Han, Z., Wang, Q. and Yan, X. (2019) 'How responsible leadership motivates employees to engage in organizational citizenship behavior for the environment: a double-mediation model', *Sustainability*, 11(3): 605, pp. 1-13. doi: 10.3390/su11030605.

Hanson, R. (2018) *Resilient.* Penguin Random House, UK.

Haque, A. (2021) 'The COVID-19 pandemic and the role of responsible leadership in health care: thinking beyond employee well-being and organisational sustainability', *Leadership in Health Services*, 34(1), pp. 52-68.

Haque, A., Fernando, M. and Caputi, P. (2021) 'Responsible leadership and employee outcomes: a systematic literature review, integration and propositions', *Asia-Pacific Journal of Business Administration*, 13(3), pp. 383-408.

Harlock, J., Williams, I., Robert, G., Hall, K., Mannion, R. and Brearley, S. (2017) 'Doing more with less in health care: findings from a multi-method study of decommissioning in the English National Health Service', *Journal of Social Policy,* 47(3), pp. 543-564.

Harris, A. (2008) 'Distributed leadership: according to the evidence', *Journal of Educational Administration,* 46(2), pp. 172-188. doi: 10.1108/09578230810863253 (Accessed: 30 June 2021).

Harrison, S. (1982) 'Consensus decision-making in the National Health Service: a review', *Journal of Management Studies,* 19(4), pp. 377-394.

Harrison, S. (1994) *National Health Service management in the 1980s.* Avebury.

Harrison, S. and Lim, J.N.W. (2003) 'The frontier of control: doctors and managers in the NHS 1966 to 1997', *Clinical Governance,* 8(1), pp. 13-18.

Harrison, S. and Wood, B. (1999) 'Designing health service organization in the UK, 1968 to 1998: from blueprint to bright idea and 'manipulated emergence'', *Public Administration,* 77(4), pp. 751-768.

Hart, D. and Baruch, Y. (2022) 'The dynamics of diplomatic careers: the shift from traditional to contemporary careers', *Human Resource Management*, 61, pp. 259-276.

Hatton, T., Brown, C., Kipp, R., Seville, E., Brouggy, P. and Loveday, M. (2018) 'Developing a model and instrument to measure the resilience of critical infrastructure sector organisations', *International Journal of Critical Infrastructures,* 14(1), pp. 59-79.

Hay, I. (2006) 'Transformational leadership: characterisitics and criticisms', *E-Journal of Organizational Learning and Leadership,* 5(2). Available at: http://www.weleadinlearning.org/ejournal.htm (Accessed: 30 June 2021).

Haynes, K. (2012) 'Reflexivity in qualitative research', in Symon, G. and Cassell, C. (eds.) *Qualitative organisational research: core methods and current challenges.* London: Sage Publications Ltd., pp. 72-89.

Health Foundation (2010) *Evidence scan: complex adaptive systems.* The Health Foundation.

Heavin, C. (2017) 'Health information systems - opportunities and challenges in a global health ecosystem', *Journal of the Midwest Association for Information Systems*, 2, pp. 1-7. Available at: http://aisel.aisnet.org/jmwais/vol2017/iss2/1 (Accessed: 7 May 2021).

Heckmann, I., Comes, T. and Nickel, S. (2015) 'A critical review on supply chain risk–definition, measure and modelling', *Omega*, 52, pp. 119-132.

Hendry, J. (2019) 'Promoting compassionate care in radiography — what might suit pedagogy? A discussion paper', *Radiography,* 25, pp. 269-273. doi: 10.1016/j.radi.2019.01.005 (Accessed: 17 April 2021).

Hennink, M., Hutter, I. and Bailey, A. (2011) *Qualitative research methods.* London: Sage Publications Ltd.

Henry, P. (2015) 'Rigor in qualitative research: promoting quality in social science research', *Research Journal of Recent Sciences*, 4(IVC-2015), pp. 25-28.

Hex, N., Bartlett, C., Wright, D., Taylor, M. and Varley, D.J.D.M. (2012) 'Estimating the current and future costs of Type 1 and Type 2 diabetes in the UK, including direct health costs and indirect societal and productivity costs', *Diabetic Medicine,* 29(7), pp. 855-862.

Hillmann, J. (2021) 'Disciplines of organizational resilience: contributions, critiques, and future research avenues', *Review of Managerial Science*, 15, pp. 879-938.

Hills, M. and Allen, N. (2018) 'Organisational resilience at the University of Northampton: growing immunity to a full spectrum of threats', *Journal of Business Continuity & Emergency Planning*, 12(2), pp. 173-179.

Hinshelwood, R.D. and Skogstad, W. (eds.) (2000) *Observing organisations: anxiety, defence and culture in health care.* Routledge.

Ho, J.C. and Chen, H. (2018) 'Managing the disruptive and sustaining the disrupted: the case of Kodak and Fujifilm in the face of digital disruption', *Review of Policy Research,* 35(3), pp. 352-371. doi: 10.1111/ropr.12278 (Accessed: 7 June 2021).

Holling, C.S. (1973) 'Resilience and stability of ecological systems', *Annual Review of Ecological Systems,* 4, pp. 1-23. Available at: https://www.annualreviews.org/doi/pdf/10.1146/annurev.es.04.110173.000245 (Accessed: 22 May 2021).

Hollnagel, E. (2013) 'Prologue: the scope of resilience engineering', in Hollnagel, E., Braithwaite, J. and Wears, R.L. (eds.) *Resilient health care*. Ashgate Publishing Ltd.pp. xxix -xxxix.

Hollnagel, E., Wears, R.L. and Braithwaite, J. (2015) 'From Safety-I to Safety-II: a White Paper', *Resilient Health Care Net,* University of Southern Denmark, University of Florida, USA and Macquarie University, Australia. Available at: https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.708.2789&rep=rep1&type=pdf (Accessed: 1 April 2020).

Holmberg, R., Larsson, M. and Bäckström, M. (2016) 'Developing leadership skills and resilience in turbulent times', *Journal of Management Development,* 35(2), pp. 154-169.

Holmes, D. (2013) 'Mid Staffordshire scandal highlights NHS cultural crisis', *The Lancet,* 381(9866), pp. 521-522.

Hopkin, P. (2014) 'Achieving enhanced organisational resilience by improved management of risk: summary of research into the principles of resilience and the practices of resilient organisations', *Journal of Business Continuity & Emergency Planning,* 8(3), pp. 252-262.

Horne, J.F. and Orr, J.E. (1997) 'Assessing behaviors that create resilient organizations', *Employment Relations Today,* 24(4), pp. 29-39.

Horton, R. (2016) 'Offline: the 500-year old cause of the doctors' strike', *The Lancet,* 387(10031), pp. 1982.

Hovlid, E., Braut,G., Hannisdal, E., Walshe, K., Bukve,O., Flottorp, S., Stensland, P. and Frich, J. (2020) 'Mediators of change in healthcare organisations subject to external assessment: a systematic review with narrative synthesis', *BMJ Open,* 10:eo038850 [online]. doi: 10.10.1136/bmjopen-2020-038850 (Accessed: 11 May 2021).

Howell, A-M., Burns, E.M., Bouras, G., Donaldson, L.J., Athanasiou, T. and Darzi, A. (2015) 'Can patient safety incident reports be used to compare hospital safety? Results from a quantitative analysis of the English national reporting and learning system data', *PloS one,* 10(12), p. e0144107 [online]. Available at: https://journals.plos.org/plosone/ article?id=1 0.1371/journal.pone.0144107 (Accessed: 29 March 2021).

Huff, A.S. (2009) *Designing research for publication.* Thousand Oaks, CA: Sage Publications, Inc.

Humphries, R. (2015) 'Integrated health and social care in England — progress and prospects', *Health Policy,* 119, pp. 856-859.

Hunter, M. (2001) 'Alder Hey report condemns doctors, management, and coroner', *British Medical Journal,* 322(7281), p. 255.

Hutchinson, M. and Jackson, D. (2015) 'The construction and legitimation of workplace bullying in the public sector: insight into power dynamics and organisational failures in health and social care', *Nursing Inquiry*, 22(1), pp. 13-26.

Hyett, N., Kenny, A. and Dickson-Swift, V. (2014) 'Methodology or method? A critical review of qualitative case study reports', *International Journal of Qualitative Studies on Health and Well-being,* 9(1), pp. 1-12.

Iacobucci, G. (2020a) 'Rogue breast surgeon Ian Paterson: what has the inquiry told us?', *BMJ,* 368:m560 [online]. doi: 10.1136/bmj.m560 (Accessed: 15 October 2020).

Iacobucci, G. (2020b) 'Government's "new deal" does not erase years of underinvestment in NHS buildings, say leaders', *BMJ,* 370:m2646 [online]. doi: 10.1136/bmj.m2646 (Accessed: 13 May 2021).

Iflaifel, M., Lim, R.H., Ryan, K. and Crowley, C. (2020) 'Resilient health care: a systematic review of conceptualisations, study methods and factors that develop resilience', *BMC Health Services Research,* 20:324, pp. 1-21. Available at: https://doi.org/10.1186/s12913-020-05208-3 (Accessed: 16 October 2021).

Illing, J.C.C.M., Carter, M., Thompson, N.J., Crampton, P.E.S., Morrow, G.M., Howse, J.H., Cooke, A. and Burford, B.C. (2013) *Evidence synthesis on the occurrence, causes, consequences, prevention and management of bullying and harassing behaviours to inform decision-making in the NHS.* Project Report. London: HMSO.

Ishak, A.W. and Williams, E.A. (2018) 'A dynamic model of organizational resilience: adaptive and anchored approaches', *Corporate Communications: An International Journal,* 23(2), pp. 180-196.

Israel, M. (2015) *Research ethics and integrity for social scientists.* 2nd edn. London: Sage Publications Ltd.

Iszatt-White, M. and Saunders, C. (2014) *Leadership*. 2nd edn. Oxford University Press.

Iwami, M., Ahmad, R., Castro-Sanchez, E., Birgand, G., Johnson, A.P. and Holmes, A. (2017) 'Capacity of English NHS hospitals to monitor quality in infection prevention and control using a new European framework: a multilevel qualitative analysis', *BMJ Open,* 7:e012520 [online]. doi: 10.1136/bmjopen-2016-012520 (Accessed: 3 July 2018).

Jackson, D., Firtko, A. and Edenborough, M. (2007) 'Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: a literature review', *Journal of Advanced Nursing,* 60(1), pp. 1-9.

Jacobs, R., Mannion, R., Davies, H.T.O., Harrison, S., Konteh, F. and Walshe, K. (2013) 'The relationship between organizational culture and performance in acute hospitals', *Social Science & Medicine,* 76, pp. 115-125.

James, G. (2020) *Report of the Independent Inquiry into the issues raised by Paterson*. London: DHSC. Available at: https://assets.publishing. service.gov.uk/government/up loads/system/ uploads/attachment_data/file/863211/issues-raised-by-paterson-independent-inquiry-report-web-accessible.pdf (Accessed: 24 September 2020).

Jang, Y. and Huber, D.E. (2008) 'Context retrieval and context change in free recall: recalling from long-term memory drives list isolation', *Journal of Experimental Psychology: Learning, Memory and Cognition,* 34(1), pp. 112-127.

Janjua, A. (2014) *Leadership vacancies in the NHS: what can be done about them?* London: The King's Fund.

Javadi, M. and Zarea, K. (2016) 'Understanding thematic analysis and its pitfall', *Journal of Client Care,* 1(1), pp. 34-40.

Jeffs, L., Tregunno, D., MacMillan, K. and Espin, S. (2009) 'Building clinical and organizational resilience to reconcile safety threats, tensions and trade-offs', *Healthcare Quarterly*, 12, pp. 75-79.

Johnson, B. (2014) 'Ethical issues in shadowing research', *Qualitative Research in Organizations and Management: An International Journal,* 9(1), pp. 21-40.

Johnson, P., Buehring, A., Cassell, C. and Symon, G. (2006) 'Evaluating qualitative management research: towards a contingent criteriology', International Journal of Management Reviews, 8(3), pp. 131-156. doi: 10.1111/j.1468-2370.2006.00124.x (Accessed: 3 June 2021).

Jonas, S., McCay, L. and Keogh, B. (2011) 'The importance of clinical leadership', in Swanwick, T. and McKimm, J. (eds.) *ABC of Clinical Leadership.* Wiley-Blackwell, pp. 1-3 [online]. Available at: https://scele.ui.ac.id/berkas_kolaborasi/konten/MKK_2014genap/ ABC.pdf#page=11 (Accessed: 25 June 2021).

Jones, L. (2015) 'What does a hospital mean?', *Journal of Health Services Research & Social Policy*, 20(4), pp. 254-256. doi: 10.1177/1355819615585893 (Accessed: 3 June 2021).

Jones, R.D. (2010) 'Do NHS cost pressures follow long-term patterns?', *British Journal of Healthcare Management,* 16(4), pp. 192-194.

Jones, B. and Woodhead, T. (2015) *Building the foundations for improvement: how five trusts built quality improvement capability at scale within their organisations.* The Health Foundation. Available at: https://www.health.org.uk/publications/building-the-foundations-for-improvement (Accessed: 14 May 2021).

Jønsson, T., Unterrainer, C., Jeppesen, H.J. and Jain, A.K. (2016) 'Measuring distributed leadership agency in a hospital context', *Journal of Health Organization and Management*, 30(6), pp. 908-926.

Jordan, P.J., Werner, A. and Venter, D. (2015) 'Achieving excellence in private intensive care units: the effect of transformational leadership and organisational culture on organisational change outcomes', *SA Journal of Human Resource Management/SA Tydskrif vir Menslikehulpbronbestuur*, 13(1), pp. 1-10. Available at: https://sajhrm.co.za/index.php/sajhrm/article/view/707/973 (Accessed: 15 April 2021).

Kanov, J., Powley, E.H. and Walshe, N.D. (2017) 'Is it OK to care? How compassion falters and is courageously accomplished in the midst of uncertainty', *Human Relations*, 70(6), pp. 751-777.

Kantabutra, S. and Ketprapakorn, N. (2021) 'Toward and organizational theory of resilience: an interim struggle', *Sustainability*, 13, 23, 13137 (online). doi: 10.3390/su132313137 (Accessed: 2 May 2022).

Kantur, D. and İşeri-Say, A. (2012) 'Organizational resilience: a conceptual integrative framework', *Journal of Management & Organization,* 18(6), pp. 762-773.

Keaver, L., Xu, B., Jaccard, A. and Webber, L. (2018) 'Morbid obesity in the UK: a modelling projection study to 2035', *Scandinavian Journal of Public Health,* 48(4), pp. 422-427.

Kennedy, I. (2001) *Learning from Bristol: public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995*. London: HMSO.

Keogh, B. (2013) *Review into the quality of care and treatment provided by 14 hospital trusts in England: an overview report.* Available at: www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf (Accessed: 15 September 2020).

Keogh-Brown, M.R., Jensen, H.T., Edmunds, W.J. and Smith, R.D. (2020) 'The impact of COVID-19, associated behaviours and policies on the UK economy: a computable general equilibrium model', *SSM - Population Health*, 12,100651 [online]. Available at: https://doi.org/10.1016/jssmph.2020.100651 (Accessed: 10 May 2021).

Khan, Z.A., Nawaz, A., Khan, I. and Khan, D.I. (2016) 'Leadership theories and styles: a literature review', *Journal of Resources Development and Management,* 16(1), pp. 1-7.

Kimmel, A.J. (1988) *Ethics and values in applied social research.* Thousand Oaks, CA: Sage Publications, Inc.

King, A.S. (1990) 'Evolution of leadership theory', *Vikalpa,* 15(2), pp. 43-54. Available at: https://journals.sagepub.com/doi/pdf/10.1177/0256090919900205 (Accessed: 12 May 2021).

King, N. and Horrocks, C. (2010) *Interviews in qualitative research.* London: Sage Publications Ltd.

King, D.D., Newman, A. and Luthans, F. (2016) 'Not if, but when we need resilience in the workplace', *Journal of Organizational Behavior*, 37(5), pp. 782-788.

King's Fund (2011) *The future of leadership and management in the NHS: no more heroes.* London: The King's Fund.

Kirkup, B. (2015) *The report of the Morecambe Bay investigation.* London: The Stationery Office.

Kirkup, B. (2019) 'NHS Improvement's just culture guide: good intentions failed by flawed design', *Journal of the Royal Society of Medicine,* 112(12), pp. 495-497.

Kitto, S.C., Chesters, J. and Grbich, C. (2008) 'Quality in qualitative research: criteria for authors and assessors in the submission and assessment of qualitative research articles for the Medical Journal of Australia', *Medical Journal of Australia*, 188(4), pp. 243-246.

Kline, R. (2019) 'Leadership in the NHS', *British Medical Journal,* 3(4), pp. 129-132.

Kline, R. and Lewis, D. (2019) 'The price of fear: estimating the financial cost of bullying and harassment to the NHS in England', *Public Money & Management,* 39(3), pp. 166-174.

Koeva, S. and Rohova, M. (2020) 'Health system resilience: concept development', *Journal of IMAB*, 26(3), pp. 3251-3258.

Könnölä, T., Salo, A., Cagnin, C., Carabias, V. and Vilkkumaa, E. (2012) 'Facing the future: scanning, synthesizing and sense-making in horizon scanning', *Science and Public Policy*, 39(2), pp. 222-231.

Koronis, E. and Ponis, S. (2018) 'Better than before: the resilient organization in crisis mode', *Journal of Business Strategy*, 39(1), pp. 32-42.

Kort, E.D. (2008) 'What, after all, is leadership? 'Leadership' and plural action', *The Leadership Quarterly*, 19, pp. 409-425.

Kossek, E.E. and Perrigino, M.B. (2016) 'Resilience: a review using a grounded integrated occupational approach', *The Academy of Management Annals,* 10(1), pp. 1-69.

Kumar, R.D.C. (2013) 'Leadership in healthcare', *Anaesthesia and Intensive Care Medicine*, 14(1), pp. 39-41.

Kuntz, J.R.C., Näswall, K. and Malinen, S. (2016) 'Resilient employees in resilient organizations: flourishing beyond adversity', *Industrial and Organizational Psychology,* 9(2), pp. 456-462.

Kvale, S. (2007) *Doing interviews.* London: Sage Publications Ltd.

LaBar, K.S. and Cabeza, R. (2006) 'Cognitive Neuroscience of emotional memory', *Nature Reviews Neuroscience*, 7(1), pp. 54-64.

Labrague, L.J., Lorica, J., Nwafor, C.E. and Cummings, G.G. (2021) 'Predictors of toxic leadership behaviour among nurse managers: a cross-sectional study', *Journal of Nursing Management,* 29, pp. 165-176. doi: 10.1111/jonm.13130.

Lafond, S., Charlesworth, A. and Roberts, A. (2016) *A perfect storm: an impossible climate for NHS providers' finances?* The Health Foundation.

Laing, A.W. and Shiroyama, C. (1995) 'Managing capacity and demand in a resource constrained environment: lessons for the NHS?', *Journal of Management in Medicine,* 9(5), pp. 51-67.

Lalonde, C. (2011) 'Managing crises through organisational development: a conceptual framework', *Disasters,* 35(2), pp. 443-464. Available at: https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1467-7717.2010.01223.x (Accessed: 26 January 2021).

Lancet (1946) 'N.H.S. Bill in Parliament', *The Lancet,* 247(6397), pp. 509.

Lancet (2020) 'Building a resilient NHS, for COVID-19 and beyond', *The Lancet* 396(10256), pp. 935.

Lawton, R. and Parker, D. (1999) 'Procedures and the professional: the case of the British NHS', *Social Science & Medicine*, 48, pp. 353-361.

Learmonth, M. (2017) 'Making history critical: recasting a history of the "management"of the British National Health Service', *Journal of Health Organization and Management,* 31(5), pp. 542-555.

Leatherman, S. and Sutherland, K. (2004) *A quest for quality in the NHS: a mid-term evaluation of the ten year quality agenda*. London: Nuffield Trust and The Stationery Office.

Lee, B. (2012) 'Using documents in organisational research' in Symon, G. and Cassell, C. (eds.) *Qualitative organisational research: core methods and current challenges.* London: Sage Publications Ltd., pp. 389-407.

Lee, R., Baeza, J.I. and Fulop, N.J. (2018) 'The use of patient feedback by hospital boards of directors: a qualitative study of two NHS hospitals in England', *BMJ Quality & Safety,* 27, pp. 103-109. doi: 10.1136/bmjqs-2016-006312 (Accessed: 16 June 2021).

Lehman, R. (2006) 'Doctors must debate hospital closures', *BMJ*, 333:661 [online]. doi: 10.1136/bmj.333.7569.661 (Accessed: 3 June 2021).

Leistikow, I. and Bal, R.A. (2020) 'Resilience and regulation, an odd couple? Consequences of Safety-II on governmental regulation of healthcare quality', *BMJ Quality and Safety*, 29, pp. 869-872. doi: 10.1136/bmjqs-2019-010610 (Accessed: 21 May 2021).

Lengnick-Hall, C.A., Beck, T.E. and Lengnick-Hall, M.L. (2011) 'Developing a capacity for organizational resilience through strategic human resource management', *Human Resource Management Review,* 21(3), pp. 243-255.

Levey, J. and Levey, M. (2019) 'Mindful leadership for personal and organisational resilience', *Clinical Radiology*, 74(10), pp. 739-745. Available at: https://doi.org/10.1016/j.crad.2019.06.026 (Accessed: 3 December 2020).

Levit, K., Smith, C., Cowan, C., Lazenby, H., Sensenig, A. and Catlin, A. (2003) 'Trends in US health care spending, 2001', *Health Affairs,* 22(1), pp. 154-164.

Lewins, A. and Silver, C. (2007) *Using software in qualitative research: a step-by-step guide.* London: Sage Publications Ltd.

Lewis, D. and Kline, R. (2019) 'Tackling bullying and harassment in the NHS: the critical roles played by managers', *British Journal of Healthcare Management,* 25(1), pp. 7-10.

Lichtman, M. (2014) *Qualitative research for the social sciences.* Thousand Oaks, CA: Sage Publications, Inc.

Lilleyman, J. (2005) 'A blame-free culture in the NHS: quixotic notion or achievable ambition?', *Perfusion,* 20(4), pp. 233-233.

Limnios, E.A.M., Mazzarol, T., Ghadouani, A. and Schilizzi, S.G.M. (2014) 'The resilience architecture framework: four organizational archetypes', *European Management Journal*, 32, pp.104-116.

Linnenluecke, M.K. (2017) 'Resilience in business and management research: a review of influential publications and a research agenda', *International Journal of Management Reviews,* 19(1), pp. 4-30.

Linstead, S., Fulop, L. and Lilley, S. (2004) *Management and organization: a critical text.* Basingstoke: Palgrave Macmillan.

Lok, P. and Crawford, J. (2004) 'The effect of organisational culture and leadership style on job satisfaction and organisational commitment: a cross-national comparison', *Journal of Management Development*, 23(4), pp. 321-338.

London, M. (1993) 'Relationships between career motivation, empowerment and support for career development', *Journal of Organizational Behavior*, 27, pp. 387-393.

López-Castro, L.F. and Solano-Charris, E.L. (2021) 'Integrating resilience and sustainability criteria in the supply chain network design. A systematic literature review', *Sustainability*, 13(19), p. 10925. Available at: https://doi.org/10.3390/su131910925 (Accessed: 3 November 2021).

Lostao, L., Regidor, E., Geyer, S. and Aïach, P. (2007) 'Patient cost sharing and social inequalities in access to health care in three western European countries', *Social Science & Medicine,* 65(2), pp. 367-376.

Louisot, J.P. (2015) 'Risk and/or resilience management', *Risk, Governance & Control: Financial Markets and Institutions,* 5(2), pp. 84-91.

Lowe, G. (2012) 'How employee engagement matters for hospital performance', *Healthcare Quarterly,* 15(2), pp. 29-39.

Lown, B.A., Rosen, J. and Marttila, J. (2011) 'An agenda for improving compassionate care: a survey shows about half of patients say such care is missing', *Health Affairs,* 30(9), pp. 1772-1778.

Lowndes, V. (2014) 'How are things done around here? Uncovering institutional rules and their gendered effects', *Politics and Gender*, 10(4), pp. 685-691.

Lucas, H.C. and Goh, J.M. (2009) 'Disruptive technology: how Kodak missed the digital photography revolution', *Journal of Strategic Information Systems*, 18, pp. 46-55.

Luo, D. and Shi, K. (2011) 'Research on connotation and implication of organizational resilience - a comparison perspective', *IEEE International Conference on Management and Service Science:* IEEE, 2011, 1-4.

Luthans, F. (2002) 'The need for and meaning of positive organizational behavior', *Journal of Organizational Behavior*, 23, pp. 695-706.

Luthans, F., Avolio, B.J., Avey, J.B. and Norman, S.M. (2007) 'Positive psychological capital: measurement and relationship with performance and satisfaction', *Personnel Psychology*, 60, pp. 541-572.

Luthans, F., Vogelgesang, G.R. and Lester, P.B. (2006) 'Developing the psychological capital of resiliency', *Human Resource Development Review,* 5(1), pp. 25-44.

Lyng, H.B., Macrae, C., Guise, V., Haraldseid-Driftland, C., Fagerdal, B., Schibevaag, L. and Wiig, S. (2022) Capacities for resilience in healthcare; a qualitative study across different healthcare contexts', *BMC Health Services Research*, 22:474 (online). doi: 10.1186/s1291 3-022-07887-6 (Accessed: 2 May 2022).

Lynham, S.A. and Chermack, T.J. (2006) 'Responsible leadership for performance: a theoretical model and hypotheses', *Journal of Leadership and Organizational Studies,* 12(4), pp. 73-88.

Ma, Z., Xiao, L. and Yin, J. (2018) 'Toward a dynamic model of organizational resilience', *Nankai Business Review International*, 9(3), pp. 246-263.

Maak, T. and Pless, N.M. (2006) 'Responsible leadership in a stakeholder society — a relational perspective', *Journal of Business Ethics,* 66(1), pp. 99-115.

Macdonald, N., Clements, C., Sobti, A., Rossiter, D., Unnithan, A. and Bosanquet, N. (2020) Tackling the elective case backlog generated by Covid-19: the scale of the problem and solutions', *Journal of Public Health*, 42(4), pp. 712-716.

Macpherson, G. (1998) '1948: a turbulent gestation for the NHS: some things don't change', *British Medical Journal,* 316(7124), pp. 6.

Maier, S.F. and Seligman, M.E.P. (1976) 'Learned helplessness: theory and evidence', *Journal of Experiential Psychology: General*, 105(1), pp. 3-46.

Mallak, L.A. (1998a) 'Measuring resilience in health care provider organizations', *Health Manpower Management,* 24(4), pp. 148-152.

Mallak, L. (1998b) 'Putting organisational resilience to work', *Industrial Management*, 8(13), pp. 1-9.

Manley, K., Martin, A., Jackson, C. and Wright, T. (2016) 'Using systems thinking to identify workforce enablers for a whole systems approach to urgent and emergency care delivery: a multiple case study', *BMC Health Services Research,* 16(1), pp. 1-10.

Mannion, R. (2014) 'Enabling compassionate healthcare: perils, prospects and perspectives', *International Journal of Health Policy and Management,* 2(3), pp.115-117.

Mannion, R. and Goddard, M. (2001) 'Impact of published clinical outcomes data: case study in NHS hospital trusts', *British Medical Journal,* 323(7307), pp. 260-263.

Mannion, R., Blenkinsopp, J., Powell, M., McHale, J., Millar, R., Snowden, N. and Davies, H. (2018) 'Understanding the knowledge gaps in whistleblowing and speaking up in health care: narrative reviews of the research literature and formal inquiries, a legal analysis and stakeholder interviews', *Health Services and Delivery Research,* 6(30). doi: 10.3310/hsdr0 6300 (Accessed: 6 July 2021).

Mannion, R., Davies, H., Freeman, T., Millar, R., Jacobs, R. and Kasteridis, P. (2015) 'Overseeing oversight: governance of quality and safety by hospital boards in the English NHS', *Journal of Health Services Research and Policy,* 20(Suppl.1), pp. 9-16.

Markos, S. and Sridevi, M.S. (2010) 'Employee engagement: the key to improving performance', *International Journal of Business and Management*, 5(12), pp. 89-96.

Marnoch, G. (2008) 'Performance stories: a comparison of the annual reports presented by the U.S. department of veterans affairs and the English National Health Service', *Public Performance & Management Review,* 31(4), pp. 570-603.

Marques, T., Reis, N. and Gomes, J.F.S. (2018) 'Responsible leadership research: a bibliometric review', *Brazilian Administration Review*, 5(1), pp. 1-25.

Marsden, J., Bazzard, D., Breeze,K., De'Ath, A. and Thwaites, A. (2020) *Rapid literature review on effective regulation: implications for the Care Quality Commission*. Newcastle upon Tyne: Care Quality Commission.

Mascaro, J.S. and Raison, C.L. (2017) 'The body of compassion', in Gilbert, P. (ed.) *Compassion: concepts, research and applications.* Routledge, pp. 89-104.

Mason, J. (2018) *Qualitative researching.* 3rd edn. London: Sage Publications Ltd.

Mason, M. (2010) 'Sample size and saturation in PhD studies using qualitative interviews', *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, 11(3), Art. 8.

Masood, S.A., Dani, S.S., Burns, N.D. and Backhouse, C.J. (2006) 'Transformational leadership and organizational culture: the situational strength perspective', *Proceedings of the Institution of Mechanical Engineers, Part B: Journal of Engineering Manufacture*, 220(6), pp. 941-949. Available at: https://journals.sagepub.com/doi/pdf/10.1243/09544054JEM499 (Accessed: 18 May 2021).

Masten, A.S. (2001) 'Ordinary magic: resilience processes in development', *American Psychologist*, 56(3), pp. 227-238.

Matheson, C., Robertson, H.D., Elliott, A.M., Iverson, L. and Murchie, P. (2016) 'Resilience of primary healthcare professionals working in challenging environments: a focus group study', British Journal of General Practitioners, 66(648), pp. e507-e515 [online]. Available at: https://bjgp.org/content/bjgp/66/648/e507.full.pdf (Accessed: 6 July 2018).

Mayor, S. (2000) 'English NHS to set up new reporting system for errors', *British Medical Journal,* 320, pp. 1689.

McAndrew, S., Chambers, M., Nolan, F., Thomas, B. and Watts, P. (2014) 'Measuring the evidence: reviewing the literature of the measurement of therapeutic engagement in acute mental health inpatient wards', *International Journal of Mental Health Nursing*, 23, pp. 212-220.

McDonald, S. (2005) 'Studying actions in context: a qualitative shadowing method for organizational research', *Qualitative Research,* 5(4), pp. 455-473.

McGivern, G. and Fischer, M.D. (2012) 'Reactivity and reactions to regulatory transparency in medicine, psychotherapy and counselling', *Social Science and Medicine,* 74, pp. 289-296.

McKee, L., Charles, K., Dixon-Woods, M., Willars, J. and Martin, G. (2013) '‘New’ and distributed leadership in quality and safety in health care, or ‘old’and hierarchical? An interview study with strategic stakeholders', *Journal of Health Services Research & Policy*, 18(Suppl.2), pp. 11-19.

McKibbin, W.J. and Fernando, R. (2020) *The global macroeconomic impacts of COVID-19: seven scenarios: analysis working paper 19/2020.* The Australian National University: Centre for Applied Macroenomics. Available at: https://www.researchgate.net/profile/RoshenFernando/publication/342685818_Global_Macroeconomic_Scenarios_of_the_COVID-19_Pandemic/links/5f07da4f45851550509a169f/Global-Macroeconomic-Scenarios-of-the-COVID-19-Pandemic.pdf (Accessed: 3 December 2020).

McLachlan, G. (1976) 'Monitoring health services', *International Journal of Epidemiology,* 5(1), pp. 83-86.

McManus, S., Seville, E., Vargo, J. and Brunsdon, D. (2008) 'Facilitated process for improving organizational resilience', *Natural Hazards Review*, 9(2), pp. 81-90.

McQueen, R.A. and Knussen, C. (2002) *Research methods for social science: an introduction.* Pearson Education.

Mehta, S. and Maheshwari, G.C. (2013) 'Consequence of toxic leadership on employee job satisfaction and organizational commitment', *The Journal - Contemporary Management Research*, 8(2), pp. 1-23.

Men, L.R. and Jiang, H. (2016) 'Cultivating quality employee-organizational relationships: the interplay between organizational leadership, culture and communication', *International Journal of Strategic Communication,* 10(5), pp. 462-479.

Mengis, J. and Nicolini, D. (2010) 'Root cause analysis in clinical adverse events', *Nursing Management*, 16(9), pp. 16-20.

Meyer, A.D (1982) 'Adapting to environmental jolts', *Administrative Science Quarterly*, 27(4), pp. 515-537.

Miles, M.B., Huberman, A.M. and Saldaña, J. (2014) *Qualitative data analysis: a methods sourcebook.* 3rd edn. Thousand Oaks, CA: Sage Publications, Inc.

Millar, R., Mannion, R., Freeman, T. and Davies, H.T.O. (2013) 'Hospital board oversight of quality and patient safety: a narrative review and synthesis of recent empirical research', *The Milbank Quarterly,* 91(4), pp. 738-770.

Miska, C. and Mendenhall, M.E. (2018) 'Responsible leadership: a mapping of extant research and future directions', *Journal of Business Ethics,* 148(1), pp. 117-134.

Miska, C., Hilbe, C. and Mayer, S. (2014) 'Reconciling different views on responsible leadership: a rationality-based approach', *Journal of Business Ethics,* 125(2), pp. 349-360.

Mitchell, T. and Harris, K. (2012) *Resilience: a risk management approach*. London: Overseas Development Institute.

Mitsakis, F.V. (2020) 'Human resource development (HRD) resilience: a new 'success element' of organizational resilience?', *Human Resource Development International*, 23(3), pp. 321-328.

Mjøset, L. (2009) 'The contextualist approach to social science methodology', in Byrne, D. and Ragin, C.C. (eds.) *The Sage handbook of case-based methods*, London: Sage Publications Ltd., pp. 39-68.

Mmobuosi, I.B. (1988) 'Problems of creativity and organisational change: the experiences of some chief executives', *Leadership & Organization Development Journal*, 9(1), pp. 23-31.

Moberly, T. (2017) 'Advertisements for medical vacancies increase by 8% in a year', *BMJ,* 358:j3610 [online]. doi: https://doi.org/10.1136/bmj.j3610 (Accessed: 27 June 2021).

Monitor (2014) *The NHS foundation trust code of governance*. Monitor. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/327068/CodeofGovernanceJuly2014.pdf (Accessed: 2 March 2021).

Moon, G. and Brown, T. (2001) 'Closing Barts: community and resistance in contemporary UK hospital policy', *Environment and Planning D: Society and Space*, 19, pp. 43-59. doi: 10.1068/d35j (Accessed: 3 June 2021)

Moore, M.D. (2020) 'Historicising “containment and delay”: COVID-19, the NHS and high-risk patients', *Wellcome Open Research,* 5(130) [online]. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7348669/pdf/wellcomeopenres-5-17506.pdf (Accessed: 24 September 2020).

Morales, S.N., Martinez, L.R., Gómez, J.A.H., López, R.R. and Torres-Argüelles, V. (2019) 'Predictors of organizational resilience by factorial analysis', *International Journal of Engineering Business Management*, 11, pp. 1-13.

Morgan, D.L. (2014) 'Pragmatism as a paradigm for social research', *Qualitative Inquiry,* 20(8), pp. 1045-1053. doi: 10.1177/1077800413513733 (Accessed: 4 June 2021).

Morris, J.A., Super, J., Huntley, D., Ashdown, T., Harland, W. and Anakwe, R. (2020) 'Waiting lists for symptomatic joint arthritis are not benign: prioritizing patients for surgery in the setting of COVID-19', *Bone & Joint Open,* 1(8), pp. 508-511. doi: 10.1302/2633-1462.18.BJO-2020-0112.RI (Accessed: 7 July 2021).

Morse, J. (2018) 'Reframing rigor in qualitative inquiry', in Denzin, N.K. and Lincoln, Y.S. (eds.) *The Sage handbook of qualitative research.* 5th edn. Thousand Oaks, CA: Sage Publications, Inc., pp. 796-817.

Moss Kantor, R. (1979) 'Power failure in management circuits', *Harvard Business Review*, 57(4), pp. 65-75.

Mousa, M., Abdelgaffar, H.A., Chaouali, W. and Aboramadan, M. (2020) 'Organizational learning, organizational resilience and the mediating role of multi-stakeholder networks - a study of Egyptian academics', *Journal of Workplace Learning*, 32(3), pp. 161-181.

Mullins, L.J. (1999) *Management and organisational behaviour.* 5th edn. Prentice Hall.

National Quality Board (2011) *Quality governance in the NHS — a guide for provider boards.* National Quality Board. Available at: https://www.sth.nhs.uk/clientfiles/File/Enclosure%20O3%20-%20NQB%20%20Quality%20Governance%20in%20the%20NHS%20-%20Guide%20for%20Provider%20Boards.pdf (Accessed: 20 March 2021).

Nemeth, C.P. and Herrera, I. (2015) 'Building change: resilience engineering after ten years', *Reliability Engineering and System Safety,* 141, pp. 1-4.

Nestler, S., Blank, H. and Egloff, B. (2010) 'Hindsight ≠ hindsight: experimentally induced dissociations between hindsight components', *Journal of Experimental Psychology: Learning, Memory and Cognition,* 36(6), pp.1399-1413.

Newdick, C. (2014) 'From Hippocrates to commodities — three models of NHS governance: NHS governance, regulation, Mid Staffordshire inquiry, health care as a commodity', *Medical Law Review,* 22(2), pp. 162-179.

Newdick, C. and Danbury, C. (2015) 'Culture, compassion and clinical neglect: probity in the NHS after Mid Staffordshire', *Journal of Medical Ethics,* 41(12), pp. 956.

NHS England and NHS Improvement (2018) *Refreshing NHS plans for 2018/19* [online]. Available at: https://www.england.nhs.uk/wp-content/uploads/2018/02/planning-guidance-18-19.pdf (Accessed: 16 October 2020).

NHS England, Care Quality Commission, Health Education England, Monitor, Public Health England, Trust Development Authority (2014) *Five Year Forward View.* Available at: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf (Accessed: 2 June 2020).

NHS Staff Survey (2015) [online]. Available at: https://www.nhsstaffsurveys.com/Page/1062/Past-Results/Staff-Survey-2015-Detailed-spreadsheets/ (Accessed: 12 November 2020).

NHS Staff Survey (2016) [online]. Available at: https://www.nhsstaffsurveys.com/Page/1019/Past-Results/Staff-Survey-2016-Detailed-Spreadsheets/ (Accessed: 12 November 2020).

NHS Staff Survey (2017) [online]. Available at: https://www.nhsstaffsurveys.com/Page/1100/Past-Results/Staff-Survey-2017-Detailed-Spreadsheets/ (Accessed: 12 November 2020).

NHS Staff Survey (2018) [online]. Available at: https://www.nhsstaffsurveys.com/Page/1101/Past-Results/Staff-Survey-2018-Detailed-Spreadsheets/ (Accessed: 12 November 2020).

NHS Staff Survey (2019) [online]. Available at: https://www.nhsstaffsurveyresults.com/homepage/benchmark-directorate-reports-2019/ (Accessed: 12 November 2020).

NHS Staff Survey (2020) [online]. Available at: https://www.nhsstaffsurveyresults.com/wp-content/uploads/2020/01/P3255_ST19_National-briefing_FINAL_V2.pdf (Accessed: 12 November 2020).

Nica, E. (2015) 'Moral leadership in health care organizations', *American Journal of Medical Research*, 2(2), pp. 118-123.

Nicol, E.D., Mohanna, K. and Cowpe, J. (2014) 'Perspectives on clinical leadership: a qualitative study exploring the views of senior healthcare leaders in the UK', *Journal of the Royal Society of Medicine,* 107(7), pp. 277-286. doi: 10.1177/0141076814527274 (Accessed: 25 June 2021).

Nixon, R.A. (2019) *Unconscious bias in employee management: evolving with emotional intelligence development.* University of Wisconsin: Stout.

Northouse, P.G. (2016) *Leadership: theory and practice*. 7th edn. Thousand Oaks, CA: Sage Publications, Inc.

Nuffield Trust (2018) *NHS Reforms Timeline* [online]. Available at: http://nhstimeline.nuffieldtrust.org.uk/ (Accessed: 2 June 2020).

Nutley, S.M. and Davies, H.T.O. (2001) 'Developing organizational learning in the NHS', *Medical Education*, 35, pp. 35-42.

O'Hara, J.K., Canfield, C. and Aase, K. (2019) 'Patient and family perspectives in resilient healthcare studies: a question of morality or logic?', *Safety Science,* 120, pp. 99-106.

O'Reilly, M. and Parker, N. (2013) ''Unsatisfactory saturation': a critical exploration of the notion of saturated sample sizes in qualitative research', *Qualitative Research,* 13(2), pp. 190-197.

O'Reilly, D. and Reed, M. (2010) ''Leaderism': an evolution of managerialism in UK public service reform', *Public Administration*, 88(4), pp.960-978. Available at: https://onlinelibrary-wiley-com. ezproxye.bham.ac.uk/doi/epdf/10.1111/j.1467-9299.2010.01864.x (Accessed: 19 June 2018).

Oikonomou, E., Carthey, J., Macrae, C. and Vincent, C. (2019) 'Patient safety regulation in the NHS: mapping the regulatory landscape of healthcare', *BMJ Open,* 9:e028663 [online]. doi:10.1136/bmjopen-2018-028663 (Accessed: 6 November 2020).

Oliver, D. (2015) 'Why shouldn't hospitals challenge inspections?', *BMJ,* 351:h5320 [online]. doi: 10.1136/bmj.h5320 (Accessed: 29 June 2021).

Oliver, D. (2020) 'Do the NHS workforce plans really add up?', *BMJ,* 370:m3203 [online]. Available at: http://dx.doi.org/10.1136/bmj.m3203 (Accessed: 27 June 2021).

Ollier-Malaterre, A. (2010) 'Contributions of work-life and resilience initiatives to the individual/organization relationship', *Human Relations*, 63(1), pp. 41-62.

Onn, L.P. (2015) 'What lies ahead for Malaysian healthcare?', *ISEAS Yusof Ishak Institute,* Economics Working Paper (2015-4), pp. 1-35.

Ortiz-de-Mandojana, N. and Bansal, P. (2016) 'The long-term benefits of organizational resilience through sustainable business practices', *Strategic Management Journal,* 37(8), pp. 1615-1631.

Oussedik, S., Macintyre,S., Gray, J., McMeekin, P., Clement, N.D. and Deehan, D.J. (2021) 'Elective orthopaedic cancellations due to the COVID-19 pandemic: where are we now, and where are we heading?', *Bone & Joint Open*, 2(2), pp. 103-110. doi: 10.1302/2633-1462.22.BJO- 2020-0161.R1 (Accessed: 7 July 2021).

Øyri, S.F. and Wiig, S. (2019) 'Regulation and resilience at the macro-level healthcare system — a literature review', *Proceedings of the 29th European Safety and Reliability Conference,* pp. 1373-1380. Available at: https://www.researchgate.net/profile/Siri-Wiig/publication/338770166 (Accessed: 29 April 2021).

Parker, D. (2009) 'Managing risk in healthcare: understanding your safety culture using the Manchester Patient Safety Framework (MaPSaF)', *Journal of Nursing Management*, 17, pp. 218-222.

Parker, V.A., Wubbenhorst, W.H., Young, G.J., Desai, K.R. and Charns, M.P. (1999) 'Implementing quality improvement in hospitals: the role of leadership and culture', *American Journal of Medical Quality*, 14(1), pp. 64-69.

Parsons, D. (2010) 'Organisational resilience', *The Australian Journal of Emergency Management*, 25(2), pp. 18-20.

Patel, P., Thomas, C. and Quilter-Pinner, H. (2020) *State of health and care: the NHS long term plan after COVID-19.* Institute for Public Policy Research.

Pathiraja, F. and Outram, C. (2011) 'Making the case for shadowing', *BMJ*, 342:di52 [online]. doi: https://doi.org/10.1136/bmj.d152 (Accessed: 2 June 2021).

Patterson, F., Prescott-Clements, L., Zibarras, L., Edwards, H., Kerrin, M. and Cousans, F. (2016) 'Recruiting for values in healthcare: a preliminary review of the evidence', *Advances in Health Sciences Education,* 21(4), pp. 859-881.

Patterson, K., Grenny, J., McMillan, R. and Switzler, A. (2002) *Crucial conversations: tools for talking when stakes are high.* McGraw-Hill.

Patton, M.Q. (2014) *Qualitative research & evaluation methods.* 4th edn. Thousand Oaks, CA: Sage Publications, Inc.

Patzer, M., Voegtlin, C. and Scherer, A.G. (2018) 'The normative justification of integrative stakeholder engagement: a Habermasian view on responsible leadership', *Business Ethics Quarterly,* 28(3), pp. 325-354.

Pearson, C.M. and Clair, J.A. (1998) 'Reframing crisis management', *Academy of Management Review,* 23(1), pp. 59-76.

Peck, E. and Dickinson, H. (2009) 'Partnership working and organisational culture', in Glasby, J. and Dickinson, H. (eds.) *International perspectives on health and social care: partnership working in action.* Blackwell Publishing Ltd., pp. 10-26.

Peckham, S. (2014) 'Accountability in the UK healthcare system: an overview. Obligation de rendre compte dans le système de santé du Royaume-Uni: un aperçu. (French)', *Healthcare Policy,* Special Issue (10), pp. 154-162.

Pelletier, K.L. (2010) 'Leader toxicity: an empirical investigation of toxic behavior and rhetoric', *Leadership,* 6(4), pp. 373-389. doi: 10.1177/1742715010379308 (Accessed: 5 July 2021).

Peräkylä, A. and Ruusuvuori, J. (2018) 'Analyzing talk and text', in Denzin, N.K. and Lincoln, Y.S. (eds.) *The Sage handbook of qualitative research.* 5th edn. Thousand Oaks, CA: Sage Publications, Inc. pp. 669-691.

Perruci, G. and McManus, R.M. (2013) 'The state of leadership studies', *Journal of Leadership Studies,* 6(3), pp. 49-54.

Petchey, R. (1986) 'The Griffiths reorganisation of the National Health Service: Fowlerism by stealth', *Critical Social Policy,* 6, pp. 87-101.

Petruzzi, J. and Loyear, R. (2016) 'Improving organisational resilience through enterprise security risk management', *Journal of Business Continuity & Emergency Planning*, 10(1), pp.44-56.

Pincock, S. (2004) 'Poor communication lies at heart of NHS complaints, says Ombudsman', *British Medical Journal,* 328(7430), pp. 10.

Pinder, R.J., Greaves, F.E., Aylin, P.P., Jarman, B. and Bottle, A. (2013) 'Staff perceptions of quality of care: an observational study of the NHS Staff Survey in hospitals in England', *BMJ Quality & Safety,* 22(7), pp. 563-570.

Pitt, C. (1990) 'Organisational audit: a national approach to setting and monitoring organisational standards', *International Journal of Health Care Quality Assurance*, 3(3), pp. 13-16. doi: 10.1108/09526869010141675 (Accessed: 7 May 2021).

Pless, N.M. (2007) 'Understanding responsible leadership: role identity and motivational drivers', *Journal of Business Ethics,* 74, pp. 437-456. doi: 10.1007/s10551-007-9518-x (Accessed: 3 March 2021).

Pless, N.M. and Maak, T. (2011) 'Responsible leadership: pathways to the future', *Journal of Business Ethics,* 98, pp. 3-13.

Pless, N.M., Maak, T. and Waldman, D.A. (2012) 'Different approaches toward doing the right thing: mapping the responsibility orientations of leaders', *Academy of Management Perspectives*, 26(4), pp. 51-65.

Pojasek, R.B. (2013) 'Organizations and their contexts: where risk management meets sustainability performance', *Environmental Quality Management,* 22(3), pp. 81-93.

Poksinska, B.B., Fialkowska-Filipek, M. and Engström, J. (2017) 'Does Lean healthcare improve patient satisfaction? A mixed-method investigation into primary care', *BMJ Quality & Safety,* 26(2), pp. 95-103.

Pollitt, C. (1996) 'Antistatist reforms and new administrative directions: public administration in the United Kingdom', *Public Administration Review*, 56(1), pp. 81-88.

Pollitt, C., Harrison, S., Hunter, D.J. and Marnoch, G. (1991) 'General management in the NHS: the initial impact 1983-88', *Public Administration,* 69(1), pp. 61-83.

Ponomarov, S.Y. and Holcomb, M.C. (2009) 'Understanding the concept of supply chain resilience', *The International Journal of Logistics Management*, 20(1), pp.124-143.

Pope, R. (2019) 'Organizational silence in the NHS: 'hear no, see no, speak no'', *Journal of Change Management,* 19(1), pp. 45-66.

Porter-O'Grady, T. and Malloch, K. (2007) *Quantum leadership: a resource for health care innovation.* 2nd edn. Sudbury, Massachusetts: Jones and Bartlett Publishers.

Powell, M., Dawson, J., Topakas, A., Durose, J. and Fewtrell, C. (2014) *Staff satisfaction and organisational performance: evidence from a longitudinal secondary analysis of the NHS staff survey and outcome data*. National Institute for Health Research. doi: 10. 3310/hsdr02500 (Accessed: 19 November 2020).

Pratt, P. (2015) 'How one trust made its way out of special measures', *Nursing Management,* 22(8), pp. 22-25.

Price, T., Tredinnick-Rowe, J., Walshe, K., Tazzyman, A., Ferguson, J., Boyd, A., Archer, J. and Bryce, M. (2020) 'Reviving clinical governance? A qualitative study of the impact of professional regulatory reform on clinical governance in healthcare organisations in England', *Health Policy*, 24(4), pp. 134-142.

Priest, N., Esmail, A., Kline, R., Rao, M., Coghill, Y. and Williams, D.R. (2015) 'Promoting equality for ethnic minority NHS staff—what works?', *BMJ,* 351:h3297 [online]. Available at: https://www.bmj.com/content/351/bmj.h3297.short (Accessed 12 January 2021).

Propper, C., Stoye, G. and Zaranko, B. (2020) 'The wider impacts of the coronavirus pandemic on the NHS', *Fiscal Studies,* 41(2), pp. 345-356.

Punukollu, B. (2009) 'Shadowing the chief executive officer', *BMJ,* 338:b890 [online]. Available at: bmj.com.content/338/bmj/b890 (Accessed: 2 June 2021).

Purohit, K. (2020) 'The National Health Service's 'special measures': Cambridge - a case study', *Health Services Management Research*, 0(0), pp. 1-5. doi: 10.1177/0951484820 931061 (Accessed: 30 April 2021).

Quirk, H., Crank, H., Carter, A., Leahy, H. and Copeland, R.J. (2018) 'Barriers and facilitators to implementing workplace health and wellbeing services in the NHS from the perspective of senior leaders and wellbeing practitioners: a qualitative study', *BMC Public Health*, 18(1362), pp. 1-14. Available at: https://doi.org/10.1186/s12889-018-6283-y (Accessed: 22 May 2021).

Rahi, K. (2019) 'Indicators to assess organizational resilience - a review of empirical literature', *International Journal of Disaster Resilience in the Built Environment*, 10(2/3), pp.85-98.

Raleigh, V.S., Hussey, D., Seccombe, I. and Qi, R. (2009) 'Do associations between staff and inpatient feedback have the potential for improving patient experience? An analysis of surveys in NHS acute trusts in England', *BMJ Quality & Safety* 18(5), pp. 347-354.

Ramsay, A., Fulop, N., Fresko, A. and Rubenstein, S. (2013) *The healthy board 2013: principles for good governance.* NHS Leadership Academy. Available at: https://www.leadershipacademy.nhs.uk/wp-content/uploads/2013/06/NHSLeadership-HealthyNHSBoard-2013.pdf (Accessed: 24 March 2021).

Randall, D., O'Brien, J., Rouncefield, M. and Hughes, J.A. (1996) Organisational memory and CSCW: supporting the 'Mavis Phenomenon'. *Proceedings Sixth Australian Conference on Computer-Human Interaction, IEEE.* Available at: https://ieeexplore.ieee.org/abstract/ document/559984 (Accessed: 7 June 2021).

Randle, J. (2003) 'Bullying in the nursing profession', *Journal of Advanced Nursing,* 43(4), pp. 395-401.

Randle, J. (2011) 'Workplace bullying in the NHS', *Journal of Perioperative Practice,* 21(11), pp. 391-394.

Ravalier, J.M., McVicar, A. and Boichat, C. (2020) 'Work stress in NHS employees: a mixed-methods study', *International Journal of Environmental Research and Public Health,* 17(18), pp. 6464-6477. Available at: https://www.mdpi.com/1660-4601/17/18/6464/htm (Accessed: 25 January 2021).

Razzaghian, M. and Shah, A. (2011) 'Prevalence, antecedents, and effects of workplace bullying: a review', *African Journal of Business Management*, 5(35), pp. 13419-13427. doi: 10.5897/AJBMX11.021 (Accessed: 6 July 2021).

Redfern, M., Keeling, J. and Powell, E. (2001) *The Royal Liverpool Children's Inquiry Report*. London: Stationery Offfice.

Reinmoeller, P. and van Baardwijk, N. (2005) 'The link between diversity and resilience', *MIT Sloan Management Review*, 46(4), pp. 61-66.

Reisberg, D. and Heuer, F. (1992) 'Remembering the details of emotional events', in Winograd, E. and Neisser, U. (eds.) *Affect and accuracy in recall: studies of "flashbulb" memories.* Cambridge University Press, pp. 162–190. Available at: https://doi.org/10.1017/CBO9780511664069.009 (Accessed: 6 May 2022).

Rendel, S., Crawley, H. and Ballard, T. (2015) 'CQC inspections: unintended consequences of being placed in special measures', *British Journal of General Practice*, October, e640. [online]. doi: 10.3399/bjgp15X686809 (Accessed: 23 May 2021).

Rhodes, P., Nocon, A., Booth, M., Chowdrey, M.Y., Fabian, A., Lambert, N., Mohammed, F. and Walgrove, T. (2002) 'A service users' research advisory group from the perspectives of both service users and researchers', *Health and Social Care in the Community*, 10(5), pp. 402-409.

Ribeiro, J.P. and Barbosa-Povoa, A. (2018) 'Supply chain resilience: definitions and quantitative modelling approaches - a literature review', *Computers & Industrial Engineering*, 115, pp. 109-122.

Richardson, S. and McMullan, R. (2007) 'Research ethics in the UK: what can sociology learn from health?', *Sociology,* 41(6), pp. 1115-1132. doi: 10.1177/0038038507082318 (Accessed: 2 June 2021).

Ritchie, J., Mellows, H., Chalmers, I. and Bash, J. (2000) *The report of the inquiry into quality and practice within the National Health Service arising from the actions of Rodney Ledward.* London: Department of Health.

Robbins, B. and Davidbizar, R. (2020) 'Transformational leadership in health care today', *The Health Care Manager*, 39(3), pp. 117-121. doi: 10.1097/HCM.0000000000000296 (Accessed: 30 June 2021).

Robertson, I.T., Cooper, C.L., Sarkar, M. and Curran, T. (2015) 'Resilience training in the workplace from 2003 to 2014: a systematic review', *Journal of Occupational and Organizational Psychology*, 88(3), pp. 533-562.

Robertson, R., Wenzel, L., Thompson, J. and Charles, A. (2017) *Understanding NHS financial pressures: how are they affecting patient care?* London: The King's Fund.

Robson, R. (2013) 'Resilient health care', in Hollnagel, E., Braithwaite, J. and Wears, R.L. (eds.) *Resilient health care*. Ashgate Publishing Ltd., pp. 191-203.

Robson, C. and McCartan, K. (2016) *Real world research.* 4th edn. West Sussex, U.K.: Wiley.

Rodríguez-Sánchez, A.M. and Perea, M.V. (2015) 'The secret of organisation success: a revision on organisational and team resilience', *International Journal of Emergency Services,* 4(1), pp. 27-36.

Rodriguez-Santana, I.R., Aragón, M.J., Rice, N. and Mason, A.R. (2020) 'Trends in drivers of healthcare expenditure in the English NHS: a retrospective analysis', *Health Economics Review*, 10(20), pp.1-11. Available at: https://doi.org/10.1186/s13561-020-00278-9 (Accessed: 20 May 2021).

Roese, N.J. and Vohs, K.D. (2012) 'Hindsight bias', *Perspectives on Psychological Science*, 7(5), pp. 411-426.

Rost, J. and Smith, A. (1992) 'Leadership: a post-industrial approach', *European Management Journal*, 10(2), pp. 193-201.

Rubin, H.J. and Rubin, I.S. (2012) *Qualitative interviewing: the art of hearing data.* 3rd edn. Thousand Oaks, CA: Sage Publications, Inc.

Ruiz, M., Bottle, A. and Aylin, P. (2013) 'A retrospective study of the impact of the doctors' strike in England on 21 June 2012', *Journal of the Royal Society of Medicine,* 106(9), pp. 362-369.

Ruiz-Martin, C., López-Paredes, A. and Wainer, G. (2018) 'What we know and do not know about organizational resilience', *International Journal of Production Management and Engineering,* 6(1), pp. 11-28.

Rundall, T.G., Kaiser, H.J., Davies, H.T.O. and Hodges, C.L. (2004) 'Doctor-manager relationships in the United States and the United Kingdom', *Journal of Healthcare Management*, 49(4), pp. 251-268.

Russ, T.L. (2013) 'The relationship between Theory X/Y: assumptions and communication apprehension', *Leadership and Organization Development Journal,* 43(3), pp. 238-249.

Rutter, M. (1985) 'Resilience in the face of adversity: protective factors and resistance to psychiatric disorder', *British Journal of Psychiatry*, 147, pp. 598-611.

Saldaña, J. (2016) *The coding manual for qualitative researchers.* 3rd edn. London: Sage Publications Ltd.

Salter, B. (2007) 'Governing UK medical performance: A struggle for policy dominance', *Health Policy,* 82(3), pp. 263-275.

Sanderson, M., Allen, P. and Osipovic, D. (2017) 'The regulation of competition in the National Health Service (NHS): what difference has the Health and Social Care Act 2012 made?', *Health Economics, Policy and Law*, 12, pp. 1-19. doi: 10.1017/S17441331160001 16 (Accessed: 8 May 2021).

Saunders, M.N.K. (2012) 'Choosing research participants', in Symon, G. and Cassell, C. (eds.) *Qualitative organisational research: core methods and current challenges.* London: Sage Publications Ltd., pp. 35-52.

Saunders, M.N.K. and Townsend, K. (2016) 'Reporting and justifying the number of interview participants in organization and workplace research', *British Journal of Management,* 27(4), pp. 836-852.

Saunders, M.N.K. and Townsend, K. (2018) 'Choosing participants', in Cassell, C., Cunliffe, A. and Grandy, G. (eds.) *Sage handbook of qualitative business and management research methods.* London: Sage Publications Ltd., pp. 480-494.

Saunders, M., Lewis, P. and Thornhill, A. (2016) *Research methods for business students.* 7th edn. Pearson.

Sausman, C. (2001) 'New roles and responsibilities of NHS chief executives in relation to quality and clinical governance', *Quality in Health Care,* 10 (Suppl. II), pp. ii13-ii20.

Sawalha, I.H.S. (2015) 'Managing adversity: understanding some dimensions of organisational resilience', *Management Research Review*, 38(4), pp.346-366.

Scally, G. and Donaldson, L.J. (1998) 'The NHS's 50 anniversary. Clinical governance and the drive for quality improvement in the new NHS in England', *British Medical Journal,* 317(7150), pp. 61-65.

Scarborough, P., Bhatnagar, P., Wickramasinghe, K.K., Allender, S., Foster, C. and Rayner, M. (2011) 'The economic burden of ill health due to diet, physical inactivity, smoking, alcohol and obesity in the UK: an update to 2006–07 NHS costs', *Journal of Public Health,* 33(4), pp. 527-535.

Schein, E.H. (2004) *Organizational culture and leadership.* 3rd edn. Jossey-Bass.

Schofield, J.W. (2000) 'Increasing the generalizability of qualitative research', in Gomm,R., Hammersley, M. and Foster, P. (eds.) *Case study method.* London: Sage Publications Ltd., pp. 69-97.

Schostak, J. (2006) *Interviewing and representation in qualitative research.* Open University Press.

Schraeder, M., Tears, R.S. and Jordan, M.H. (2005) 'Organizational culture in public sector organizations', *Leadership & Organization Development Journal,* 6, pp. 492-502.

Schultz, W.L. (2006) 'The cultural contradictions of managing change: using horizon scanning in an evidence-based policy context', *Foresight*, 8(4), pp. 3-12.

Schwandt, T.A. (2001) *Dictionary of qualitative inquiry.* 2nd edn. Thousand Oaks, CA: Sage Publications, Inc.

Schwandt, T.A. and Gates, E.F. (2018) 'Case study methodology', in Denzin, N.K. and Lincoln, Y.S. (eds.) *The Sage handbook of qualitative research.* 5th edn. Thousand Oaks, CA: Sage Publications, Inc., pp. 341-358.

Scobie, S. (2018) *Snowed under: understanding the effects of winter on the NHS.* Nuffield Trust. Available at: https://www.nuffieldtrust.org.uk/files/2018-12/1544789063_effects-of-winter-on-the-nhs-web.pdf (Accessed: 15 March 2021).

Seale, C. (1999) 'Quality in qualitative research', *Qualitative Inquiry,* 5(4), pp. 465-478.

Seawright, J. and Gerring, J. (2008) 'Case selection techniques in case study research: a menu of qualitative and quantitative options', *Political Research Quarterly,* 61(2), pp. 294-308.

Senge, P.M. (2006) *The fifth discipline: the art & practice of the learning organisation.* 2nd edn. Random House Business Books.

Sergeant, J. and Laws-Chapman, C. (2012) 'Creating a positive workplace culture', *Nursing Management*, 18(9), pp. 14-19.

Shaw, R., Drever, F., Hughes, H., Osborn, S. and Williams, S. (2005) 'Adverse events and near miss reporting in the NHS', *BMJ Quality and Safety in Health Care,* 14(4), pp. 279-283.

Shea, S., Wynyard, R. and Lionis, C. (eds.) (2014) *Building compassionate healthcare: challenges in policy and practice.* Routledge.

Sheaff, R., Endacott, R., Jones, R. and Woodward, V. (2015) 'Interaction between non-executive and executive directors in English National Health Service trust boards: an observational study', *BMC Health Services Research*, 15(470) [online]. doi: 10.1186/s 12913-015-1127-2 (Accessed: 2 June 2021).

Sheard, S. (2011) 'A creature of its time: the critical history of the creation of the British NHS', *Michael Quarterly,* 11(8), pp. 428-441.

Sheffi, Y. and Rice, J.B. (2007) 'A supply chain view of the resilient enterprise', *MIT Sloan Management Review*, 47(1), pp. 41-49.

Sheu, S-J., Wei, I-L., Chen, C-H., Yu, S. and Tang, F-I. (2009) 'Using snowball sampling methods with nurses to understand medication administration errors', *Journal of Clinical Nursing,* 18, pp. 559-569.

Shipton, H., Armstrong, C., West, M. and Dawson, J. (2008) 'The impact of leadership and quality climate on hospital performance', *International Journal for Quality in Health Care,* 20(6), pp. 439-445.

Siegel, D.S. (2009) 'Green management matters only if it yields more green: an economic/strategic perspective', *Academy of Management,* 23(3), pp. 5-16.

Silverman, D. (2013) *Doing qualitative research.* 4th edn. London: Sage Publications Ltd.

Simsekier, M.C.E., Card, A.J., Ruggeri, K., Ward, J.R. and Clarkson, P.J. (2015) 'A comparison of the methods used to support risk identification for patient safety in one UK NHS foundation trust', *Clinical Risk*, 21(2-3), pp. 37-46.

Smithson, R., Richardson, E., Roberts, J., Walshe, K., Wenzel, L., Robertson, R., Boyd, A., Allen, T. and Proudlove, N. (2018) *Impact of the Care Quality Commission on provider performance: room for improvement?* London: The King's Fund.

Sobhani, F.A., Haque, A. and Rahman, S. (2021) 'Socially responsible HRM, employee attitude and bank reputation: the rise of CSR in Bangladesh', *Sustainability*, 13(5): 2753, pp. 1-17. Available at: https://doi.org/10.3390/su13052753 (Accessed: 20 May 2022).

Som, C. (2009) 'Sensemaking of clinical governance at different levels in NHS hospital trusts', *Clinical Governance: An International Journal,* 14(2), pp. 98-112.

Somers, S. (2009) 'Measuring resilience potential: an adaptive strategy for organizational crisis planning', *Journal of Contingencies and Crisis Management,* 17(1), pp. 12-23.

Spector, P.E., Zhou, Z.E. and Che, X.X. (2014) 'Nurse exposure to physical and nonphysical violence, bullying, and sexual harassment: a quantitative review', *International Journal of Nursing Studies,* 51(1), pp. 72-84.

Speculand, R. and Chaudhary, R. (2008) 'Living organisational values: the bridges value inculcation model', *Business Strategy Series*, 9(6), pp. 324-329. doi: 10.1108/17515630810923630 (Accessed: 30 June 2021).

Spencelayh, E. and Dixon, J. (2014) *Lessons from the decision to block the proposed merger of hospitals in Bournemouth and Poole*. The Health Foundation. Available at: http://health.org.uk/publications/mergers-in-the-nhs (Accessed: 20 May 2021).

Spencer, L. and Ritchie, J. (2012) 'In pursuit of quality', in Harper, D. and Thompson, A.R. (eds.) *Qualitative research methods in mental health and psychotherapy: a guide for students and practitioners*. John Wiley and Sons, Ltd., pp. 227-242.

Spencer, L., Ritchie, J., Lewis, J. and Dillon, L. (2003) *Quality in qualitative evaluation: a framework for assessing research evidence.* UK: Government Chief Social Researcher's Office.

Sprinks, J. (2012) 'Eradicating NHS blame culture will improve safety, nurses argue', *Nursing Standard,* 26(35), p. 10.

Stahl, G.K. and Sully de Luque, M. (2014) 'Antecedents of responsible leader behavior: A research synthesis, conceptual framework, and agenda for future research', *The Academy of Management Perspectives,* 28(3), pp. 235-254.

Stake, R.E. (1995) *The art of case study research.* Thousand Oaks, CA: Sage Publications, Inc.

Stake, R.E. (2006) *Multiple case study analysis.* The Guilford Press.

Stewart, J. and Walshe, K. (1992) 'Change in the management of public services', *Public Administration,* 70(4), pp. 499-518.

Storey, J. and Holti, R. (2013) *Towards a new model of leadership for the NHS*. NHS Leadership Academy. Available at: http://oro.open.ac.uk/37996/1/Towards-a-New-Model-of-Leadership-2013%20online.pdf (Accessed: 17 May 2021).

Street, A.D. (2016) 'The financial crisis in the National Health Service: insufficient funding will derail transformation plans', *Radical Statistics*, August, pp. 37-53.

Studer, Q., Hagins, M. and Cochrane, B.S. (2014) 'The power of engagement: creating the culture that gets your staff aligned and invested', *Healthcare Management Forum*, 27, pp. 579 - 587.

Suleiman, N. and Othman, Z. (2021) 'Forensic accounting investigation of public sector corruption in Nigeria: the Gioia methodology', *The Qualitative Report*, 26(3), pp. 1021-1032. Available at: https://doi.org/10.46743/2160-3715/2021.3907 (Accessed: 24 June 2021).

Sull, A., Harland, N. and Moore, A. (2015) 'Resilience of health-care workers in the UK: a cross-sectional survey', *Journal of Occupational Medicine and Toxicology*, 10(20) [online]. doi: 10.1186/s12995-015-0061-x (Accessed: 20 April 2021).

Suryaningtyas, D., Sudiro, A., Troena, E.A. and Irawanto, D.W. (2019) 'Organizational resilience and organizational performance: examining the mediating roles of resilience leadership and organizational culture', *Academy of Strategic Management Journal*, 18(2), pp. 1-7.

Sutherland, K. and Leatherman, S. (2006) *Regulation and quality improvement: a review of the evidence.* The Health Foundation.

Sutherland, W.J. and Woodroof, H.J. (2009) 'The need for environmental horizon scanning', *Trends in Ecology and Evolution*, 24(10), pp. 523-527.

Swanwick, T. and McKimm, J. (2011) 'What is clinical leadership … and why is it important?' *The Clinical Teacher*, 8, pp. 22-26.

Symon, G. and Cassell, C. (eds.) (2012) *Qualitative organisational research: core methods and current challenges.* London: Sage Publications Ltd.

Taylor, S.J. and Bogdan, R. (1998) *Introduction to qualitative research methods: a guidebook and resource.* 3rd edn. John Wiley & Sons.

Tennyson, W.W. and Strom, S.M. (1986) 'Beyond professional standards: developing responsibleness', *Journal of Counseling and Development,* 64, pp. 298-302.

Teo, W.L., Lee, M. and Lim, W-S. (2017) 'The relational activation of resilience model: how leadership activates resilience in an organizational crisis', *Journal of Contingencies and Crisis Management,* 25, pp. 136-147.

Teoh, K.R.H., Hassard, J. and Cox, T. (2020) 'Individual and organizational psychosocial predictors of hospital doctors' work-related well-being: a multilevel and moderation perspective', *Health Care Management Review,* 45(2), pp. 162-172.

Thomas, C. (2020) *Resilient health and care: learning the lessons of COVID-19 in the English NHS.* London: Institute for Public Policy Research.

Thomas, G. (2011) *How to do your case study.* London: Sage Publications Ltd.

Thomas, M. (2015) 'Ryanair: success before love', *Strategic Direction*, 31(8), pp. 1-3. doi: 10.1108/SD-02-2015-0034 (Accessed: 7 June 2015).

Tiernan, A., Drennan, L., Nalau, J., Onyango, E., Morrissey, L. and Mackey, B. (2019) 'A review of themes in disaster resilience literature and international practice since 2012', *Policy, Design and Practice,* 2(1), pp. 53-74. doi: 10.1080/25741292.2018.1507240

Timm, A. (2014) ''It would not be tolerated in any other profession except medicine': survey reporting on undergraduates' exposure to bullying and harassment in their first placement year', *BMJ Open,* 4:e005140 [online]. doi: 10.1136/bmjopen-2014- 005140 (Accessed: 26 November 2020).

Timmins, N. (2007) 'Hospital closures: the great taboo', *BMJ,* 335:535 [online]. doi: 10.1136/bmj.39335.652488.DB (Accessed: 3 June 2021).

Timmins, N. (2018) *Amending the 2012 Act: can it be done?* [online]. The King's Fund. Available at: https://www.kingsfund.org.uk/publications/amending-2012-act-can-it-be-done (Accessed: 8 May 2021).

Tomlinson, J. (2015) 'Using clinical supervision to improve the quality and safety of patient care: a response to Berwick and Francis', *BMC Medical Education,* 15(103), pp. 1-8. doi: 10.1186/s12909-015-0324-3 (Accessed: 31 March 2021).

Tonkin, A. and Whitaker, J. (2021) 'Play and playfulness for health and wellbeing: a panacea for mitigating the impact of coronavirus (COVID-19)', *Social Sciences and Humanities Open,* 4(1), pp. 100142. Available at: https://doi.org/10.1016/j.ssaho.2021.100142 (Accessed: 27 April 2021).

Topakas, A., Admasachew, L. and Dawson, J. (2010) *Staff engagement in the NHS —a multilevel analysis.* Aston Business School, Aston University.

Tourish, D. and Hargie, O.D.W. (1998) 'Communication between managers and staff in the NHS: trends and prospects', *British Journal of Management*, 9, pp. 53-71.

Towse, A. and Danzon, P. (1999) 'Medical negligence and the NHS: an economic analysis', *Health Economics*, 8, pp. 93-101.

Tracy, S.J. (2010) 'Qualitative quality: eight "big tent" criteria for excellent qualitative research', *Qualitative Inquiry,* 16(10), pp. 837-851. doi: 10.1177/1077800410383121 (Accessed: 2 June 2021).

Travaglia, J.F., Debono, D., Spigelman, A.D. and Braithwaite, J. (2011) 'Clinical governance: a review of key concepts in the literature', *Clinical Governance: An International Journal,* 16(1), pp. 62-77.

Tugade, M.M. and Frederickson, B.L. (2004) 'Resilient individuals use positive emotions to bounce back from negative emotional experiences', *Journal of Personality and Social Psychology,* 86(2), pp. 320-333.

Useem, M. (2005) 'Leadership: making responsible decisions', in Doh, J.P. and Stumpf, S.A. (eds.) *Handbook on responsible leadership and governance in global business*. Cheltenham, UK: Edward Elgar Publishing Limited, pp. 71-86.

Välikangas, L. (2010) *The resilient organization: how adaptive cultures thrive even when strategy fails.* McGraw Hill Professional.

Van Bogaert, P., Clarke, S., Willems, R. and Mondelaers, M. (2012) 'Staff engagement as a target for managing work environments in psychiatric hospitals: implications for workforce stability and quality of care', *Journal of Clinical Nursing*, 22, pp. 1717-1728.

Van Nieuwerburgh, C. (2020) *An Introduction to coaching skills: a practical guide.* 3rd edn. London: Sage Publications Ltd.

Veronesi, G. and Keasey, K. (2010) 'NHS boards: knowing the 'what' but not the 'how' ', *Public Money & Management*, 30(6), pp. 360-370. doi: 10.1080/09540962.2010.525005 (Accessed: 2 June 2021).

Voegtlin, C., Frisch, C., Walther, A. and Schwab, P. (2019) 'Theoretical development and empirical examination of a three-roles model of responsible leadership', *Journal of Business Ethics*, 167, pp. 411-431. Available at: https://doi.org/10.1007/s10551-019-04155-2 (Accessed: 25 February 2021).

Vogus, T.J. and Sutcliffe, K.M. (2007) 'Organizational resilience: towards a theory and research agenda', *IEEE International Conference on Systems, Man and Cybernetics*: IEEE, 2007, 3418-3422.

Vrtička, P., Favre, P. and Singer, T. (2017) 'Compassion and the brain', in Gilbert, P. (ed.) *Compassion: concepts, research and applications.* Routledge, pp. 135-150.

Wahyuni, D. (2012) 'The research design maze: understanding paradigms, cases, methods and methodologies', *Journal of Applied Management Accounting Research,* 10(1), pp. 69-80.

Wake, M. and Green, W. (2019) 'Relationship between employee engagement scores and service quality ratings: analysis of the National Health Service staff survey across 97 acute NHS Trusts in England and concurrent Care Quality Commission outcomes (2012-2016)', *BMJ Open*, 9:e026472 [online]. doi: 10.1136/bmjopen-2018-026472 (Accessed: 14 January 2021).

Waldman, D.A. and Galvin, B.M. (2008) 'Alternative perspectives of responsible leadership', *Organizational Dynamics,* 37(4), pp. 327-341.

Walker, H.J. (2011) *The cost of caring among healthcare professionals: the development of compassion fatigue and preventative measures and interventions for burnout.* DClinPsych Thesis, University of Hull. Available at: https://hydra.hull.ac.uk/assets/hull:5117a/content (Accessed: 30 June 2021).

Walker, B., Holling, C.S., Carpenter, S.R. and Kinzig, A. (2004) 'Resilience, adaptability and transformability in social-ecological systems', *Ecology and Society*, 9(2): 5 (online). Available at: http://www.ecologyandsociety.org/vol9/iss2/art5 (Accessed: 1 May 2018).

Walsh, K., Burns, C. and Antony, J. (2010) 'Electronic adverse incident reporting in hospitals', *Leadership in Health Services*, 23(4), pp. 292-303.

Walshe, K. (1999) 'Improvement through inspection? The development of the new Commission for Health Improvement in England and Wales', *Quality and Safety in Health Care,* 8(3), pp. 191-196.

Walshe, K. (2002) 'The rise of regulation in the NHS', *British Medical Journal,* 324(7343), pp. 967-970.

Walshe, K. (2017) 'Sustainability and transformation plans for the NHS in England: radical or wishful thinking?', *BMJ,* 356:j1043 [online]. doi: 10.1136/bmj.j1043 (Accessed: 1 September 2020).

Walshe, K. and Chambers, N. (2017) 'Clinical governance and the role of NHS boards: learning lessons from the case of Ian Paterson', *BMJ,* 357:j2138 [online]. doi: 10.1136/bmj.j2138 (Accessed: 15 October 2020).

Walshe, K. and Higgins, J. (2002) 'The use and impact of inquiries in the NHS', *British Medical Journal,* 325(7369), pp. 895-900.

Walshe, K. and Shortell, S.M. (2004) 'When things go wrong: how health care organizations deal with major failures', *Health Affairs,* 23(3), pp. 103-111.

Walshe, K. and Smith, J. (2016) *Healthcare management.* 3rd edn. UK: McGraw-Hill Education.

Walshe, K., Addicott, R., Boyd, A., Robertson,R. and Ross, S. (2014) *Evaluating the Care Quality Commission's acute hospital regulatory model: final report* [online]. Manchester Business School and The King's Fund. Available at: https://www.cqc.org.uk/sites/default/files/CM071406%20item%206%20Acute%20regulatory%20model%20evaluation%20report.pdf (Accessed: 31 August 2020).

Walton, M. (2007) 'Leadership toxicity - an inevitable affliction of organisations?', *Organisations & People,* 14(1), pp. 19-27.

Walumbe, J., Swinglehurst, D. and Shaw, S. (2016) 'Any qualified provider: a qualitative case study of one community NHS Trust's response', *BMJ Open,* 6:e009789 [online]. doi: 10.1136/bmjopen-2015-009789 (Accessed: 7 June 2021).

Wang, G. and Hackett, R.D. (2016) 'Conceptualization and measurement of virtuous leadership: doing well by doing good', *Journal of Business Ethics*, 132(2), pp. 321-345.

Ward, E., Gillies, J., Armstrong, D., Grant, L., Elder, A., Burton, J., Ryan, C. and Quinn, C. (2018) 'Cultivating compassionate care: why does it matter and what can we do to promote it?', *Journal of the Royal College of Physicians of Edinburgh*, 48(1), pp. 71 -77.

Waring, J.J. (2005) 'Beyond blame: cultural barriers to medical incident reporting', *Social Science & Medicine,* 60(9), pp. 1927-1935.

Waterman, R.H. and Peters, T.J. (2004) *In search of excellence: lessons from America's best-run companies.* 2nd edn. Profile Books Ltd.

Weick, K.E. and Roberts, K. (1993) 'Collective mind in organizations: heedful interrelating on flight decks', *Administrtive Science Quarterly*, 38(3), pp. 357-381.

Weick, K.E. and Sutcliffe, K.M. (2015) *Managing the unexpected: sustained performance in a complex world.* 3rd edn. John Wiley & Sons.

Werner, E.E. and Smith, R.S. (2001) *Journeys from childhood to midlife: risk, resilience and recovery*. Cornell University Press.

West, M.A. (2013) 'Creating a culture of high-quality care in health services', *Global Economics and Management Review*, 18(20), pp. 40-44.

West, M.A. (2015) 'Ad hoc leadership approaches are unacceptable in the NHS', *The Health Service Journal,* 125(6466), pp. 16-17.

West M.A. (2020) 'Compassionate and collective leadership for cultures of high-quality care', in Montgomery A., van der Doef M., Panagopoulou E. and Leiter M.P. (eds.) *Connecting healthcare worker well-being, patient safety and organisational change: aligning perspectives on health, safety and well-being* [online]. Springer, pp. 207-226. Available at: https://doi.org/10.1007/978-3-030-60998-6_13 (Accessed: 13 April 2021).

West, M.A. and Chowla, R. (2017) 'Compassionate leadership for compassionate health care', in Gilbert, P. (ed.) *Compassion: concepts, research and applications.* Routledge, pp. 237-257.

West, M.A. and Dawson, J. (2012) *Employee engagement and NHS performance.* London: The King's Fund.

West, M.A. and Lyubovnikova, J. (2013) 'Illusions of team working in health care', *Journal of Health Organization and Management*, 27(1), pp. 134-142.

West, M., Eckert, R., Steward, K. and Pasmore, B. (2014) *Developing collective leadership for health care.* London: The King's Fund.

White, S.M. (2006) 'Confidentiality, 'no blame culture' and whistleblowing, non-physician practice and accountability', *Best Practice & Research Clinical Anaesthesiology*, 20(4), pp. 525-543.

Whitmore, J. (2017) *Coaching for performance: the principles and practice of coaching and leadership.* 5th edn. Nicholas Brealey Publishing.

Wied, M., Oehmen, J. and Welo, T. (2020) 'Conceptualizing resilience in engineering systems: an analysis of the literature', *Systems Engineering,* 23(3), pp. 3-13.

Wiig, S., Aase, K., Billett, S., Canfield, C., Røise, O., Njå, O., Guise, V., Haraldseid-Driftland, C., Ree, E., Anderson, J.E. and Macrae, C. (2020) 'Defining the boundaries and operational concepts of resilience in the resilience in healthcare research program', *BMC Health Services Research,* 20(330), pp. 1-9. Available at: https://doi.org/10.1186/s12913-020-05224-3 (Accessed: 24 May 2021).

Wiles, R. (2013) *What are qualitative research ethics?* Bloomsbury.

Willan, J., King, A.J., Jeffery, K. and Bienz, N. (2020) 'Challenges for NHS hospitals during COVID-19 epidemic', *BMJ*, 368:m1117 [online]. Available at: https://www.bmj.com/content/368/bmj.m1117.full (Accessed: 24 May 2021).

Willcocks, S.G. and Wibberley, G. (2015) 'Exploring a shared leadership perspective for NHS doctors', *Leadership in Health Services*, 28(4), pp. 345-355.

Wilson, S. (2013) 'Resilience, persistence and unshakeable optimism', *British Journal of Healthcare Management*, 19(9), pp. 449-451.

Winnard, J., Adcroft, A., Lee, J. and Skipp, D. (2014) 'Surviving or flourishing? Integrating business resilience and sustainability', *Journal of Strategy and Management*, 7(3), pp. 303-315.

Wise, J. (2001) 'UK government and doctors agree to end "blame culture" ', *British Medical Journal,* 323(7303), pp. 9.

Wise, J. (2018) 'Survey of UK doctors highlights blame culture within the NHS', *BMJ,* 362:k4001 [online]. Available at: https://doi.org/10.1136/bmj.k4001 (Accessed: 31 March 2021).

Wise, J. (2021) 'Covid-19: second vaccine doses expedited in areas of England where new variant is high', *BMJ*, 373:n1266 [online]. Available at: http://dx.doi.org/10.1136/bmj.n.1266 (Accessed: 24 May 2021).

Witmer, H. and Mellinger, M.S. (2016) 'Organizational resilience: nonprofit organizations' response to change', *Work*, 54, pp. 255-265.

Woods, D.D. (2015) 'Four concepts for resilience and the implications for the future of resilience engineering', *Reliability Engineering and System Safety*, 141, pp. 5-9.

Woods, D.D. and Hollnagel, E. (2006) 'Prologue: resilience engineering concepts', in Hollnagel, E., Woods, D.D. and Leveson, N. (eds.) *Resilience engineering: concepts and precepts*. Ashgate Publishing Ltd., pp. 1-8.

Woolf, S.H. and Henshall, C. (2000) 'Health technology assessment in the United Kingdom', *International Journal of Technology Assessment in Health Care,* 16(2), pp. 591-625.

Wright, T.A. and Cropanzano, R. (2004) 'The role of psychological well-being in job performance: a fresh look at an age-old quest', *Organizational Dynamics,* 33(4), pp. 338-351.

Yammarino, F.J. and Dubinsky, A.J. (1994) 'Transformational leadership theory: using levels of analysis to determine boundary conditions', *Personnel Psychology*, 47, pp. 787-811.

Yano, H. (2020) 'The National Health Service (NHS) response to the COVID-19 pandemic: a colorectal surgeon’s experience in the UK', *Global Health & Medicine,* 2(2), pp. 138-139.

Yin, R.K. (2014) *Case study research: design and methods.* 5th edn. Thousand Oaks, CA: Sage Publications, Inc.

Yukl, G. (2012) 'Effective leadership behavior: what we know and what questions need more attention', *Academy of Management Perspectives,* 26(4), pp. 66-85. Available at: https://journals.aom.org/doi/10.5465/amp.2012.0088 (Accessed: 3 June 2018).

Yukl, G. (2013) *Leadership in Organizations*. 8th edn. Pearson Education Ltd.

Zinn, J.O. (2008) 'Heading into the unknown: everyday strategies for managing risk and uncertainty', *Health, Risk & Society*, 10(5), pp. 439 - 450.