The impact of organisational change for executive leaders in mental health services: Can leaders effectively govern to enhance quality and safety in organisations experiencing on-going organisational change?

Abstract

Purpose

This study examines the impact of organisational and structural change on the evolution of quality and safety in health organisations, specifically in mental health services.

Design/methodology/approach

Data was gathered through semi-structured interviews. Twenty-five executive management team members in both public and private mental health services were interviewed and data was analysed using Burnard's framework.

Findings

Three overarching themes emerged: 1) organisational characteristics, leadership and accountability; 2) sustaining collaboration and engagement with stakeholders; 3) challenges to and facilitators of quality and safety. Taken together, the findings speak to the disruptive and disorienting impact of on-going organisational change and restructuring on leaders' ability to focus on, and advance, the quality and safety agenda.

Research limitations/implications

Typical with qualitative research of this nature, the potentially limited generalisability of the findings must be acknowledged.

Practical implications

There is a need for strategies to implement change that are informed by evidence and theory and informed by decades of research on this topic, rather than introduced ad hoc. Change agents must pair effective change management and implementation science strategies to specific contexts, depending on what is being implemented and ensure appropriate evaluation of organisational change to bolster the evidence base around quality and safety and inform future decision-making.

Originality/value

The study explores an identified gap in the literature on the impact of on-going organisational re-structuring and transformation on the evolution of quality and safety in mental health services.

Keywords: Quality and Safety, leadership, change management, organisational re-structuring, implementation

Paper type: Research

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Introduction

Organisational change and restructuring in healthcare occur for many reasons: ideological (Kirkpatrick *et al.,* 2017); the need for enhanced service user empowerment (Anders and Cassidy, 2014); efforts to move away from a top down approach (Parlalis, 2011) and cultural change (Montgomery *et al*., 2010) among others. Evidently, while such change is often viewed positively, there can be negative consequences for stakeholders throughout the organisation. This may include executive managers exclusively focused on operational matters to the detriment of strategic attention (Boyal and Hewison, 2016), a perceived lack of support amongst front line managers (Kumah *et al.,* 2016), medical staff sickness absence (Grønstad, 2017) and in some cases, patients themselves through lack of access secondary to organisational restructuring (Sakellariou and Rotarou, 2017). McAuliffe (2014, p.310) in reviewing clinical governance progress among other changes in Irish healthcare suggests the need to ask, "what worked and why?". This qualitative study explores the implementation challenges in healthcare from the perspective of executive leaders and managers in a healthcare system that has experienced considerable upheaval and change in a relatively short period of time. The following question is posed – how have executives and executive leaders experienced and influenced the evolution of organisational change and restructuring in healthcare and what implications has this change had on the quality and safety of service delivery?

There is little knowledge of how local and national approaches to major quality transformations interface, which approaches are best, or how they impact on services and organisational effectiveness (Gauld *et al.,* 2017). Executive leaders exert an important influence on any quality and safety inspired change and their lived experience may be a key

enabler (Agarwal *et al.*, 2016; Jones *et al*., 2016; Pannick *et al*., 2016; Gutberg and Berta, 2017). Executive leaders themselves can also be affected – positively or negatively – by organisational change (Havaei *et al.,* 2013; Aslam *et al.,* 2016). In fact, what is clear is that the psychological impacts of change are significant (Dorling, 2017). Potentially serious implications include burnout due to a loss of job control (Day et al. 2017), fear (Senior et al. 2017) and cynicism due to successive work transitions (Dubois et al. 2014), but it is unclear as to whether major mental health disorders arise in and of themselves (Bamberger et al. 2012; Kelliher and Parry, 2015). Change models often note these psychological impacts, however, they can be reductive in outlining how supports for executive leaders might be realised (see for instance, the Irish guide to managing change in the health service (HSE, 2008) or the British National Health Service (NHS) Change Model (NHS, 2018)). In many respects, this might be considered surprising when one regards the unrelenting nature of change from NHS privatisation (Doyle and Bull, 2000), to European (Gelormino et al. 2011) and American (Waitzkin and Hellander, 2016) reforms. In the Irish context, mental health services are a prime example of the significant changes which can occur in a relatively short period of time in health systems. Details of these changes, as they unfolded in Irish mental health services can be found in Table 1.

Given the number, pace, significance and apparent lack of evaluation of the impact of these changes period (as suggested by McDaid et al. 2009 and Culhane and Kearns, 2016) in a compressed 15-year it is important to understand the implications of this on-going structural and organisational re-structuring by asking stakeholders to share their experiences and reflections. Many of these changes are linked with concepts which would traditionally be viewed as components of clinical governance such as improving accountability, person and

public involvement and clinical effectiveness (McAuliffe, 2014). Previous research strongly suggests that such changes are likely to impact on leadership, quality of care and patient safety (Hayford, 2012; Burke *et al.,* 2016; de Jong *et al.,* 2016). Broadly, implementation science was the guiding framework underpinning this research. More specifically, Mazmanian and Sabatier (1983), Matland (1995), Peck and 6 (2006) and Hill and Hupe (2009) were instructive in informing the study. Additionally, operational and clinical governance literature as well as theoretical understandings of governance for quality and safety were central tenets underlying the research.

Heterogeneity of executive management teams and effects of centralisation

Singh (2009) demonstrated how different groups within a healthcare system view the world differently depending on their background and training. Consequently, understanding how these executives and executive leaders influence the evolution of transformative frameworks assumes greater importance. Given that mental health Executive Management Team members are drawn from both healthcare and non-healthcare orientated career pathways, this may allow for greater richness, eclecticism and heterogeneity compared to a study concerning a singular profession. There is value in exploring various interdisciplinary perspectives to gain a thorough and nuanced understanding of changes in structures and governance. For instance, Brennan and Flynn (2013) assert that there is a distinct lack of shared vision amongst the assorted healthcare professionals *vis-à-vis* quality and safety.

Exworthy and Frosini (2008) suggest that NHS executive managers have been accustomed to centralisation, inhibiting their ability to be dynamic in periods of devolved responsibility.

Centralisation can be positive (for example, as Eggink *et al.,* 2017 in the case of ovarian cancer in the NHS) but is not without challenges. Researchers have outlined the difficulty of balancing strategic and operational demands (Boyal and Hewison, 2015; Salmond and Echevarria, 2017), a gap between what is asked and corresponding resources to deliver (Byers, 2017) and the need to maintain patient referral pathways responsive to local need (Sakellariou and Rotarou, 2017). Therefore, as there is a paucity of research regarding this topic in the health sector (and particularly in the Irish mental health sector, as acknowledged by the national regulator (2014a; 2014b; 2014c)), it is necessary to pose these questions to those best placed to answer. Perla *et al.,* (2013) specifically identify that how people internalise, think about and engage with major healthcare changes is pivotal to their ultimate successful adoption or otherwise. In addition, given that Executive Management Teams typically are budget holders within each service, in the context of €917.8 million expenditure allocated to mental health services in 2018 (Health Service Executive, 2017), the relevance of understanding how they experience organisational change is apparent.

Given the identified gap in the literature in terms of understanding the impact of change in healthcare systems, particularly in Ireland, this study aims to explore the perspectives of executives in mental health services, where there has been multiple iterations and changes to service governance over the past 15 years. The study will explore executive leaders' views of the impacts of this change on leadership, organisational quality and safety.

Methods

Design

This qualitative study utilised a sequential research design (Saunders *et al.*, 2012) with semi-structured interviews as the primary data collection method. A questionnaire, the Organisational Progress in Clinical Governance (OPCG), was used as a precursor to the interviews to develop the interview schedule. The rationale for this was to connect data as described by Creswell *et al.,* (2011) and through this process create a more robust interview schedule than may otherwise be the case. Crucially, this approach was not chosen to provide confirmatory results as described by Harris and Brown (2010). Rather areas of concern and topicality were flagged through the OPCG, generating insights prior to the conduct of the interviews, a practice advocated by Boeren (2015). This survey instrument developed by Tim Freeman (2003) elicits the views of single respondents on a Likert scale. It is a 54-item schedule originally used by Freeman and Walshe (2004) to determine the degree of achievement and importance attached to components of governance. The schedule is also used in a survey examining the views of executive management team members in the NHS (Walshe et al. 2003) and this sequential approach has been used successfully in similar studies (for example, Quarmby *et al.,* 2011; Chesser-Smyth and Long, 2012). The results of the OPCG are presented in Table 2 and details of how it informed the interview schedule is included in Table 3.

Context of the research

Briefly, the Health Service Executive (HSE) is the Irish national health service. Many services are free at the point of contact, although a number of services incur co-payments or out-of-pocket expenses. The HSE is funded primarily through general taxation. Mental health services are provided through regional community healthcare organisations (CHOs) which

include access to inpatient services. The service can be accessed by all, although in some cases, depending on clinical need and geographical location, waitlists may represent a barrier to access. In the Republic of Ireland, there are seven independent service providers registered with the national regulator, the Mental Health Commission (MHC). The independent service providers are private mental healthcare organisations. Up to 50% of the Irish population have private health insurance and may be able to access these. The independent service providers are regulated by the Mental Health Commission but their exposure to the organisational changes listed in Table 1 are of a lesser gradation when compared with the national public health service. Many of the independent service providers, although large organisations in their own right, are generally based on a single campus with more direct reporting structures. These differences underpin the reasons for purposefully selecting participants from both sets of organisations as this may facilitate a greater heterogeneity in the data.

Sampling

Purposeful sampling (Denscombe, 2010) was adopted given the relatively small pool of public mental health services and independent service providers. Sampling aimed to recruit participants who had experienced organisational change and restructuring and sought to represent a mix of professional backgrounds, length of qualification and experience and a balanced gender spread. Inclusion and exclusion criteria can be seen in Table 4 while number of invitations by organisation type and response rate is shown in Table 5.

Of note, the response rate for national organisations was lower (56.5%) than recruitment of participants from independent service providers (70.5%). In total 25 participants (13 male, 12 female) from five mental health services were interviewed as part of this study.

Participants were executive management team members. A list of the grades of personnel included in an executive management team is given in the inclusion criteria in Table 4.

Data collection

Prior to data collection, ethical approval was obtained from the relevant institutional ethics committees of the participant organisations. Participants facilitated interviews at their place of work or in some cases, at a different location. Interviews ranged in length from 50 to 105 minutes.

Qualitative analysis

The stages and process involved in data analysis were adapted from Newell and Burnard (2011). This approach builds on the concept of thematic content analysis, first expounded by Burnard (1991, 1994), the maintenance of field notes and the use of thick description are recommended, both utilized in this study. Qualitative interviews were audio-recorded and demographic information was collected. All interviews were transcribed from electronic audio files were then imported into NVivo. A record of memos was kept after each interview. Immersion was achieved by reading and re-reading the transcripts and memos, noting general themes. Following this a process of open coding was undertaken, inductive in nature. The first author coded the data and codes and themes were checked and discussed with other authors before being finalised. This aided the creation of categories. Data reduction was undertaken allocating data into broader themes to clarify meaning and role within overall framework. This process was followed by the creation, validation and synthesising of analytical memos. The process through which Newell and Burnard's (2011) framework was applied and used in conjunction with NVivo is expounded upon in Table 6.

Sample characteristics

A survey of the demographic profile of participants was undertaken to aid a deeper analysis of the data (see Table 7). Inclusion and exclusion criteria are listed in Table 4. The response rate by organisation type is included in Table 5.

Findings

Three major themes emerged from the data as follows: organisational characteristics, leadership and accountability; sustaining collaboration and engagement with stakeholders; challenges to and facilitators of quality and safety. Participants clearly articulated their experience of change and transformation as executive leaders and executives working within the health service. They also discussed enablers and inhibitors to change from their perspective. However, participants focused primarily on the challenges experienced and therefore, these are explored in greatest detail in the results section.

Organisational characteristics and recruitment processes

Organisational size was a characteristic deemed important by participants. The public health services, providing a range of interventions across the State, was felt to be unwieldly as exemplified in the following extract from Participant 23. This view may be considered alongside the experience of Participant 19, who articulates that a leaner, more transparent structure exists within the independent hospital sector.

> I think in terms of again going back to structures, we tend to get some pieces of information and the HSE tend to have conflicting bits of information communicated. Generally, you find that somebody is doing this piece of

> work down the country yet nobody knows about it up here and it is impacting on service development. You find out about it through another way rather than an official channel. (Participant 23, Female, Health Service Executive)

> We benefit from our size insofar as we are a big organisation all doing the same thing largely. Although, I don't think we have the same layers of structure between, excuse the phrase, between the cleaner and the CEO, you know it is transparent. Whereas I suppose for a lot of people working in sort of more separate, bigger organisations overall, say somewhere like the HSE, it's bigger but it's in lots of different pockets so there isn't that sense of one main campus and building and perhaps it is harder to see between one layer and another. (Participant 19, Male, Independent Service Provider)

It was felt that centralised recruitment processes, a feature of the national health organisation, delayed and/or prevented the recruitment and selection of staff for specific posts. This included recruitment at executive levels within organisations and was viewed as a constraining factor associated with large organisations.

> They (*the national health service*) have a national recruitment system which I don't agree with because I like to select staff that are going to work in the service and that will contribute to the service. Instead of that we are operating a pooling system where you go for an interview and you could land here but wanted forensic. I never see the person until they come in. (Participant 21, Female, Health Service Executive)

Leadership and accountability

Participants identified several facilitators which assisted organisational re-structuring and the implementation of quality and safety initiatives. Buy-in from executive leaders was an integral facilitator of promoting and successfully implementing change related to quality and safety improvement.

> The fact that there's a level of leadership required and a level of commitment to re-structuring right from the top and if you don't have that, you won't have good quality and safety. (Participant 8, Male, Independent Service Provider)

Executive leaders also detailed how they played an active role in championing key organisational causes which directly impacted performance. One example of this was the organisational imperative of improved care-planning and the significant impact that visible executive leader's support can have on awareness and perceived importance of a quality and safety initiative.

> One of our imperatives is around care planning and I ask people at the coal face, how are we doing around care planning? So then people think, oh the boss is coming around asking about that. It's everywhere and all these people are coming around and asking about care-planning so this organisation must care about it. (Participant 9, Female, Independent Service Provider)

Evidently then, executive leaders perceive themselves as having some positive impacts. However, restructuring is often to achieve clearer delineation of roles and responsibilities, but conversely, through the manner in which change is implemented, leadership roles and functions may be further obfuscated and confused, and in fact delay improvements. This was evident in the results through legacy issues, rebranding and restructuring and the impact this

had on leadership, accountability and in turn, on implementation of the quality and safety agenda. As an example, in January 2018, the community healthcare organisations were renamed, less than four years after their initial launch. Significant energy and time is invested in these transformations and changes by executive leaders, time which could be better spent focusing on a quality and safety agenda. This can adversely impact upon corporate identity and executives' sense of place in an organisation (Balmer, 2017), undermining understanding of who is accountable for actions (Genovese *et al.,* 2017) and potentially de-stabilizing established organisational culture (Belias and Koustelios, 2014).

> Since 2005, since the inception of the HSE and I'm not being critical of the HSE, but there was a structure that was there before that had 11 health boards or 8 health boards and the ERHA [*Eastern Regional Health Authority*]. They weren't without their problems but there was a focal point per se as in the chief executive officer in each health board, there was a management team and clarity around decision making. In my role, at that time, I was very clear who I reported to and who I needed to go to, to get decisions either supported or if I wanted to bring around any service change. Everything then went centralised into the HSE. Decision making was pulled to the centre and it became diffuse. Who was responsible? (Participant 4, Male, Health Service Executive)

When these positive and negative impacts are contrasted, it is apparent that executive leaders can and do play an important role in the advancement of a quality and safety agenda. However, insufficient attention is paid to how learning from

change management and implementation science theory is applied in practice when service re-organisation and transformation occurs.

Collaboration to enhance quality and safety

There was sense that establishing external collaborations signposted the way forward in terms of growing organisational capacity and expertise. This was particularly apparent in the public service where inter-organisational links were already evident and were actively enhancing the organisation's ability to implement evidence-based practice around quality and safety issues.

> But if you had some of these links in genuine partnership [*with the universities and private sector education*] and looking at the quality agenda in terms of what's being done, link that to research and developments and all of that. This is something we have embarked upon more formally in the last 2-3 years and it's showing results (Participant 15, Male, Health Service Executive).

A view prevailed that improving metrics and supporting organisations' ability to measure clinical outcomes would lead to improvements in the quality of services. Fourteen participants expressed the opinion that organisations do not necessarily measure the right things, however, and that often performance and safety indicators are imposed on organisations, rather than being collaboratively developed to ensure relevance. In fact, key performance indicators currently in use were considered mostly irrelevant to mental health settings. This points to a disconnect between performance measurement as is, and how performance should be measured to enable a learning culture that is focused on continuous quality and safety

improvement. This might also be viewed as further evidence that people at local level had little or no input into and struggle to see the relevance of the metrics developed – suggesting that performance measurement is failing to drive quality and safety improvement as intended.

> The performance outcomes are probably not fully defined and not fully applicable to mental health settings. There's so much emphasis on financial management, so much emphasis on throughputs, numbers of attendances, bed occupancy days and so forth (Participant 22, Female, Health Service Executive)

Regulation was considered a positive influence and a key driver of change by a majority of participants. There were several reasons for this positive interpretation including a sense that services received an external validation in instances where organisations were doing well. Additionally, high standards of care could be better maintained, clarified and benchmarked against others. This provided an external motivator for staff and allowed executives to pinpoint reasons why certain services developments were mandatory and not just desirable. This view was encapsulated in the following extract.

> So the regulator can definitely set the agenda in terms of driving change, particularly around inspection or registration time. If they're looking at particular areas you then tend to focus on what the regulator is saying and what we need to address and in that vein, they would certainly be huge influencing factors (Participant 26, Male, Independent Service Provider)

An issue raised by four participants related to internal collaboration in executive management teams. It was suggested that executive management teams can be inherently patriarchal and skewed towards financial and budgetary discussion as opposed to quality of care issues. This was viewed as a particular challenge for those professionals emanating from exclusively clinical backgrounds.

> The whole other piece is when you look at finance but also that corporate piece, there is a different language when you look at clinical language. It's very, very different. I think some training in that whole piece in language across the board so that you are hitting the ground running when you go into something rather than being constantly on the back foot and reliant on other people giving you the heads up on things. That flies in the face of I think governance where there needs to be open communication. (Participant 18, Female, Independent Service Provider)

Discussion

This study examined how executive leaders experienced the history of rapid and significant organisational changes and restructuring in mental healthcare settings and the implications this change had on staff and on the quality and safety of service delivery. Several issues emerged concerning recruitment processes, change management, change fatigue, and anxieties about organisational restructuring within large health services, which was perceived as multi-layered.

Theme 1: Organisational characteristics, leadership and accountability

Organisational characteristics and practices came to the fore at several junctures. It was felt that recruitment processes being centralised prevented the recruitment and selection of staff for specific posts. Recruitment of healthcare professionals and increasingly mental health professionals has become a significant challenge in Ireland and internationally (Seo and Spetz, 2013). This included recruitment at executive levels within organisations and was viewed as a factor which constrained an organisations ability to effectively manage local staffing needs. It is striking that having invested a significant financial outlay in the establishment of a national recruitment service over the last decade, in April 2018, it was recommended that consideration be given to a more localised method of recruitment in the Irish mental health service (Government of Ireland, 2018).

Embedding a culture of continuous quality improvement in the context of change management and resistance to change was viewed as another significant factor of relevance in the domain of staff and staff management. In fact, ineffective change management was described by 14 participants. It was evident that there was a sense of change fatigue within large health organisations due to ongoing policy redirection and organisational restructuring. This raises the question as to whether there is sufficient understanding of the critical and core activities that support effective change within the health service. There appears little recognition of the effect that the establishment of new services and reconfiguration of existing structures has on those working within these structures. Certainly, the intentions underpinning these changes may be aimed at delivering improved outcomes for service users. However, from the perspective of executive management team members, these changes may involve new work locations, organisational names and structures, teams, roles, work practices or procedures. They often involve the merging of services, teams and professional groupings.

Mergers, by their very nature, imply the coming together of different cultures, that is, different ways of doing things, different values and underlying assumptions (Bernerth *et al.,* 2011; McMillan and Perron, 2013). Culture is not receptive to change in the way structures and processes are.

Theme 2: *Sustaining collaboration and engagement with stakeholders*

Key stakeholders can be external but may also be internal. To sustain change over the long-term, the cultural and the human aspects of change must be addressed (Whelan, 2015). This includes confronting deeply embedded traditions and practices through an inclusive, partnership process. Some participants felt that while progress was being made locally, within the national health service there was an information vacuum, which prevented services from learning from one another, and that this acted as an impediment to cultural change, best practice and standardisation. A sense of change fatigue was not helped by what Greenhalgh et al. (2004) document as factors affecting the re-organisation of a service. That is, some participants felt that governance had fuzzy boundaries, a perceived complexity from a frontline staff perspective and a certain lack of support available centrally to implement key components. Given this, it is worth accentuating the need for strategies to implement change being informed by evidence and theory after decades of research on this topic, rather than introduced ad hoc. There is a pressing need to pair effective change management and implementation science strategies to specific contexts and depending on what is being implemented. Consideration of how frameworks such as the Consolidated Framework for Implementation Research (Damschroder *et al.,* 2009) can promote the implementation of health services research findings in practice is merited. For instance, this may mean that major policy interventions are more routinely adapted for implementation in specific

organisational settings. Adaptation would require subtlety so as to ensure fidelity to the original vision, and consideration of which aspects should be considered 'core' intervention components and which 'peripheral' aspects may be more amenable to adaptation. A further domain might be the people and human relations dimension. That is to say people are not passive agents but that their agency can be neglected, leading to behaviours akin to Lipsky's Street Level Bureaucrat (Lipsky, 1980).

Many change efforts go askew when leaders miscalculate the effect of change on the individual and on themselves and pay scant attention to the learning from past change efforts (Burnes, 2004; Frahm and Brown, 2007; Young 2009). The personal transition or journey experienced typically involves numerous phases. People require help to distinguish these transition stages as a standard part of any major structural or personal change, and to prepare for and appreciate their reactions to change as they happen along the journey. This means providing opportunities for people to express their expectations and fears, and to address these responsively. Leaders themselves will also require sustenance and this should be strategically arranged at an early stage (Northouse, 2012). Ambiguity and unpredictability are unescapable during a major change process. Sometimes change is deliberate and planned, and sometimes it unfolds in an apparently spontaneous and organic way. Large scale organisational change often impacts on people's sense of identity and connection (Smith 2011; Hussein-Sarayreh *et al.,* 2013). There may be a sense of waiting around for the change to happen, while at the same time individuals may experience uncertainty as the wider change unfolds. This can create high levels of anxiety for people and, as a result, people may resist the change.

Theme 3: Challenges to and facilitators of quality and safety

Anxieties about impending organisational restructuring were referred to, in fact, by a total of 18 participants. Concerns were raised in relation to the multi-layered, complex nature of the national health service and the panoply of personnel one is required to navigate compared with the independent sector. From the perspective of a large health organisation, a lack of clarity around decision making, even a lack of clarity around which personnel have responsibility for this decision making, revealed a stark picture of uncertain role clarity and accountability. A further participant viewed the NHS model of Trust Status as preferable, and it is interesting to observe that the Irish national health organisation is pursuing this model in parts of the state [HSE, 2017]). Given the recent announcement, however, of a public consultation on the merits of geographic alignment of hospital groups and community healthcare organisations (Department of Health, 2018), the possible effects and implications on accountability, leadership and decision-making on quality and safety are quite unclear. What is known is that such uncertainty can adversely affect accountability due to role confusion (Brennan and Flynn, 2013), create a disconnect between policy makers and those charged with implementation (Pyone *et al.,* 2017) as well as creating a loss of buy-in amongst some executive executives (Rai, 2016).

Boyle (2005) clearly states that sophisticated monitoring and evaluation processes are a key attribute of a well developed governance system. Over recent decades, it has been increasingly apparent that greater focus on outcomes, effectiveness and efficiency is required rather than to foster continued reliance on inputs, processes and outputs (Ferris *et al.,* 1992; National Economic and Social Forum, 1997; Organisation for Economic Co-operation and Development (OECD), 2008). Also, there is a need for performance measurement in health services to be meaningful and useful for organisational learning at local and regional levels. An argument arising from this study is that there is insufficient evidence of evaluation of

existing models of service provision at the present, prior to being jettisoned and replaced by the new. As previously delineated, in the context of €917.8 million in expenditure being allocated to mental health services in 2018 (HSE, 2017), such evaluation assumes a critical importance. In an era defined by uncertain resources, building evaluation capacity is paramount (Prashanth, 2014) and transcending the current tendency for ex-post evaluation is central to this (Parry *et al.,* 2018).

A key challenge identified in this study refers to the multi-layered nature of the public health organisation when compared with the independent sector. While the purpose was not exclusively to compare and contrast publicly funded services with the independent service provider sector, this is a notable area for discussion. How the multi-layered and complex decision making structures of large organisations affect governance has been cited by both by participants and in the literature. Greenhalgh et al. (2009) explore the role of culture, duplication and fragmentation in the evolution of governance. Several participants in the study have indicated that the national health organisation model can lead to fragmentation, and that innovation, while at times flourishing locally, can founder nationally. In separate studies, Greenhalgh et al. (2004) and Robbins et al. (2008) discuss how size and functional differentiation influence the evolution of processes within organisations, and how this can be exacerbated in the absence of clearly delineated decentralised decision making systems. Some participants in the study describe the national health organisation as a behemoth in which the distance from an 'idea to a cheque' is considerable. Executive management team members did not perceive themselves as passive recipients of directives from above as described by Macfarlane (2011, p.924), however, a sense prevailed that a complex nested

system of power brokers and decision makers was at times inaccessible when compared with the less hierarchical independent service providers.

Structural instability and the deleterious impact of leading transformation as discussed by Hertting et al. (2004) was also apparent. Participants described the advent of the national health service, in 2005, leading to decision making being centralised and becoming diffuse. It was felt that there was a lack of clarity around who actually made decisions, and this persists to the present. It is apparent that there are indeed important differences with respect to how governance has evolved in the national health service compared to independent provider services; it is likely, based on both the literature and participant responses, that clearer decision-making structures and points of accountability are in some part responsible for this.

Limitations

The limitations of this study may include the possible lack of transferability to other settings, although the study involves interviewing area and executive management team members across three national and two independent service provider organisations. Another limitation, typical with research of this nature and reflecting the experience of Wallace et al. (2004) is the elicitation of "single respondents' views on complex issues of organisational performance". In summary, while new and significant information is added by this study, there may be limited generalisability to other health settings and in particular jurisdictions outside Ireland.

Conclusion

That recruitment and retention of staff within mental health services remains a challenge. This is particularly complicated by national recruitment systems currently in place which are

not always responsive to local need. The fact that mergers can impact on people's sense of identity and connection to an organisation has received scant attention. This study reveals that change fatigue is a real phenomenon amongst executive leaders who have experienced rapid and significant systems change over a relatively brief period. Furthermore, the lack of a joined-up information communication technology structure at the frontline level has greatly impeded opportunities for accurate recording of clinical effectiveness within services to include basic key performance, safety and quality indicators and robust clinical audit. Despite the considerable merits of the national health service, it can be multi-layered and may create barriers to innovation within individual mental health services due to an overly complicated system of external decision-making structures when compared to the independent service provider or private sector. Role clarity within executive teams and clear lines of accountability remain essential to good governance. There is also a need for training in corporate governance for those executive leaders emanating from clinical backgrounds and an enhanced understanding of the important role of implementation science, change management and subsequent evaluation play in structural re-organisation.

Other practical implications stemming from this study suggest that planning for robust organisational evaluation should take place prior to embarking on new whole or part systems change. Closer attention to metrics and outcome measurement may inform such evaluation. This should be underpinned by a fit for purpose information technology system. Training should be provided on a transdisciplinary basis to foster greater interprofessional understanding, internal collaboration and esprit de corp. More encompassing supports for those personnel leading change are to be welcomed. Future research might focus more

specifically on those factors which enhance policy implementation in mental health services. It would also be useful to gain the perspective of a wider array of stakeholders beyond executive management teams, such as service users, family members and supporters of those attending the mental health services.

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