

Building Capabilities to Improve the Performance of Public Organizations: A Comparative Case Study of Different Turnaround Trajectories of UK's Public Hospitals

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Abstract

Over the past 20 years, governments in many countries around the world have sought to implement governance mechanisms to measure and assess the performance of public service organizations. Consequently, organizations considered as poorly performing are often subject to increased pressure to turn their performance around. Based on literature on organizational capabilities, this research sought to identify the capabilities whose development and use explain a public organization's ability to improve its performance and sustain good performance in the long run. This research applied longitudinal and comparative case studies method into two Hospitals Trusts represent two different turnaround trajectories: one case of a successful turnaround and one case of less-successful turnaround. The purpose was to examine how the development of a set of capabilities over time accounted for the differences in the performance outcome and trajectory of the two cases. The findings revealed the following capabilities as advantageous for good performance: collective leadership; action-oriented culture; effective clinical-managerial relationship; supportive external context; performance control capability; coordination capability of the key delivery process; sensing capability and learning capability. These findings add relevant insights to the existing literature and can be of practical value for public managers faced with challenge of turning the performance of their organizations around.

Keywords: Organizational capabilities, performance, recovery, public organizations, turnaround

1. Introduction

Governments' efforts to measure and improve the performance of public sector organizations have come into steep ascendancy over the past 25 years in many countries around the world, mostly influenced by New Public Management reforms (Butler & Ferlie, 2020). In Britain, during the first decade of the 2000s, for example, measuring the performance of public sector organizations has become almost an "obsession" in virtually all levels of governments. Public agencies, Hospitals, schools, universities, departments, and even whole Local Authorities had been the subject of scrutiny to assess their performance in the delivery of public services according to a predefined set of targets or other performance indicators. As a result, most of them were labelled according to the results of overall assessment as "poor", "good", "three stars" and so on, and the management team of poorly performing ones faced strong threat of being fired. This combination of "target" with a "threat" of sacking managers as a result of poor performance comprised what Bevan and Hood (2006) called a "target-and-terror" performance governance system. Although several changes regarding performance governance of public service organizations have changed since then (Vainieri et al. 2020), evaluating the performance of public services organizations remains an important aspect of public organizations' accountability systems of modern democracies in the world.

Organizations assessed as poorly performing public organizations are expected to be subject of actions, either self-initiated or triggered by external pressure, aimed at stopping the decline and turning their performance around. As a result, finding a way to achieve turnaround in "failing" public sector organizations has become one of the most striking challenges faced by public managers of poorly performing organizations. Hence, empirical studies on the determinants of performance improvement of failing organizations can then be of practical benefit

for public managers. Nonetheless, the management literature on this issue is still limited, despite some studies that emerged in the past 10 years (Rutherford, 2014; Favero & Rutherford, 2016; Rutherford & Favero, 2020; Alonso & Andrews, 2020).

Most empirical studies on organizational recovery have been drawn from private sector organizations (Hoffman, 1989; Pandit, 1996; Ketchen, 1998; McKiernan, 2006). These studies have focused on the association between “generic strategies” and turnaround. Many studies on turnaround of public services organizations have followed similar pattern. In particular, they measured the effect of strategies, such as repositioning, retrenchment, reorganization, or other specific turnaround strategies, on performance turnaround (Boyne, 2004, 2006; Boyne & Meier, 2009; Beerli, 2012; Rutherford, 2014; Favero & Rutherford, 2016; Reingewertz & Beerli, 2018; Rutherford & Favero, 2020; Alonso & Andrews, 2020).

This approach has some important limitations for public sector. This is not least because some “generic” strategies are simply not available for public organizations. For legal reasons, for instances, managers of a failing public Hospital or school in many countries around the world have not managerial discretion to decide either to add or close services they provide, leaving little, or no, room for repositioning or retrenchment-like strategies.

This article focusses on the organizational capabilities that need to be developed to bring about performance improvement of public services organizations. Based on the notion of organizational capabilities, as an organization’s intangible assets that “enable an organization to conceive, choose and implement strategies” (Barney, 1992. p. 44), this research seeks to identify the capabilities needed to improve the performance of a “failing” public organization, and how they can be built.

In doing so, this paper sheds light on the factors that explain recovery and renewal process of these organizations. It also seeks to develop a “theory for practice”, which provides advice to managers who face the challenge of recovering the performance of a public sector organization. In summary, this article seeks to provide answers to the following questions: What capabilities do “failing” public sector organizations need to improve their performance? Why are those capabilities so crucial in explaining performance improvement? How can these capabilities be built and applied?

The object of the empirical research was the public hospital trusts in England. These Hospitals have been subject of robust performance accountability and management system during the examined period (2000 to 2010). This accountability system enables us to identify and compare the evolution of the performance of similar organizations over a considerable period of time. This research adopted a qualitative, longitudinal and comparative case study method, consistent with processual analysis (Pettigrew, 1997) over two cases of organizations that went through distinct process of recovery and renewal: one case of a successful turnaround and one case of an organization that took longer to embark on a turnaround trajectory. This approach takes an ontological view of process as a sequence of event unfolding over time, within a context, that describes how things change (Van de Ven and Poole 2005). The purpose of processual analysis is thus to “account for and explain “the what, why and how of the links between context, processes and outcomes” (Pettigrew, 1997, p. 340). This approach enables us to highlight not only the key capabilities that are linked to the organizational recovery and renewal of the public organizations, but also how they were developed.

This article is structured in the following way. The next section provides a critical analysis of the main contributions and limitations of the theoretical and empirical studies on organizational recovery. After that, it is presented the research design and strategy for the empirical research, including the methods for data collection and analysis. Following the methodology section, the cross-case analysis of the two cases is presented. The key capabilities, as well as the processes by which they are developed, that explain the outcome and trajectory of the two cases will be analyzed and discussed in this section. The final section presents the conclusion, including the limitations of the research.

2. Literature Review

Organizational recovery has been defined as a process by which an organization improves its performance to a standard it used to have or would now possess if it had followed the standard achieved by the industry’s (or sector) leaders (Rumelt, 1995). In this research it is considered that a public service organization has “recovered” when it has improved its performance to a level considered as satisfactory or superior, after had been gone through a consistent period of unsatisfactory or poor performance.

Most empirical studies on organizational recovery primarily investigate the “content” of effective recovery strategies, often using regression analysis to assess the relationship between various strategy types and turnaround outcomes. From this body of research, three main types of recovery strategy have emerged. The first,

referred to as “retrenchment” (McKiernan, 2006) or “decline-stemming strategies” (Arogyaswamy, Barker & Yasai-Adekani, 1995), involves short-term actions intended to halt decline and stabilize the organization. The second type is “repositioning” (Boyne, 2004, 2006; Arogyaswamy, Barker & Yasai-Adekani, 1995), which includes actions aimed at market or product/service refocus, or significant changes in core activities or organizational technology. The third category, known as “reorganization” (Pandit, 1996), focuses on operational-level actions intended to improve the execution of existing strategies or support repositioning efforts (Boyne, 2006). In the public sector, another strategy, or a specific form of the “reorganization” known as “corporatization” - where local governments establish companies to provide public services (Andrews et al., 2020) - has been proposed as a viable recovery strategy for public service turnaround (Alonso & Andrews, 2020).

A characteristic of these studies is that most of the evidence is drawn from private sector organizations, which have more freedom to decide with strategy to take. While private sector organizations are relatively free to choose the market they want to serve or product they want to offer, for instance, public sector organizations are constitutionally required to provide a determined set of activities to a defined market. Boyne (2004, p. 100) illustrates this more clearly,

“...health authorities cannot diversify into the leisure and tourism market by providing hotels with fitness centres, even though this might contribute to the achievement of their mission. Similarly, social security benefit offices are not empowered to move into the banking market, although their technology skills in moving money might be suited to this form of diversification.”

The same reasoning applies to the case of the repertoire of internal actions (especially retrenchment) available to public organizations. Measures to reduce costs, such as firing employees, for instance, might not be possible in some countries due to legislation that imparts stability to public servants.

Notwithstanding the distinctive characteristics of the environment of public sector organizations, Boyne (2006, 2004) maintains that these three kinds of generic recovery strategies are also feasible in the case of public sector organizations, albeit with a more limited set of sub-strategies than in private sector. By reviewing eight cases of public sector turnaround published in the literature on public management, Boyne (2006) identified instances of recovery strategies that fit into each of these three kinds of strategies. Strategies of retrenchment were found in five of these eight cases, and included downsizing the organization (e.g. cut in Staff and equipment) and reduction in the supply of services. Four organization pursued strategies of repositioning, either by refocusing their priorities within the existing market or by extending the scope of its operation (e.g. by contracting in a manufacturing service that it used to contract out). Lastly, reorganization strategies were found in all cases examined, which included changes in management team, new performance management system and decentralization of power.

In a later work, (with Meier, 2009) Boyne applied regression analysis over a large-scale sample of 140 Texas schools to measure the association between variables related to the three categories of strategies and performance improvement. The results revealed that turnaround is significantly associated with both repositioning and reorganization. However, regarding retrenchment strategies, the results yielded a significant association between cutting-cost actions and recovery, but in an opposite direction. This result suggests that “in contrast to the evidence on private organizations, this form of retrenchment appears to be a route to further failure rather than rapid recovery” (Boyne & Meier, 2009).

However, while these studies have shed light on the generic strategies, they say little on “how” these recovery strategies are formulated and implemented. The process whereby strategies are formulated and implemented has been taken for granted. The static view provided by cross-sectional regression analysis overlooks the complex, dynamic and historical nature of the recovery process and, consequently, provides only a partial and possibly biased view of the process. As Abbott (2001, p. 183) points out, social reality happens in a sequence of actions located “within a constraining and enabling structure”.

Disappointingly, very few studies have focused on the historical development of the process of turnaround over time. Furthermore, very few (or even no) empirical comparative longitudinal case studies of a matched pairs of failing public sector organizations and those that have experienced turnaround have been conducted so far. Therefore, we still know very little about the dynamics of turnaround in organizations, in general, and in public organizations, in particular.

This study aims to address the gap by examining how organizational capabilities are developed and utilized to improve the performance of an underperforming public organization. It suggests that the concept of capability—defined as the organization’s intangible assets that “enable an organization to conceive, choose, and

implement strategies” (Barney, 1992)—can be beneficially applied to the framework of organizational recovery. From this perspective, a turnaround process can be understood as a series of actions where the organization cultivates and deploys the necessary capabilities for sustainable performance. The study’s objective is to identify the specific capabilities needed by a struggling public organization to enhance its performance and the ways in which these capabilities can be developed.

3. Methods

This research considers the longitudinal and comparative case study as the most appropriate approach for exploring the process by which organizations build a set of capabilities needed to recover and sustain good performance in the long run (Pettigrew, 1990). The population from which the sample of organizations was drawn is the public acute hospital trusts in England, during the first ten years of the 2000’s.

The reason for choosing acute Hospital trusts in England as the site for research is threefold. Firstly, acute Hospitals are, together with schools and police departments, the most common kind of public service organizations in the U.K and many countries around the world. However, public Hospitals can be distinguished from the other public service organizations as they are often larger and have more complex professional bureaucracies (Mintzberg, 2023), as well as consuming a larger amount of financial resources. These make the study of the recovery and renewal of public Hospital trusts both academically interesting and economically relevant. Secondly, by choosing cases from the same sector (i.e. Health sector) and the same country (England) we can control some sectoral and cross-country environmental variations, thereby reducing “extraneous variation” across the studied organizations (Eisenhardt, 1989). Thirdly, all acute hospital trusts had been subjected to the same accountability systems that measure and rate the organizations’ overall performance in relation to the quality of services and use of resources (during the timeframe covered by this research (2001 - 2008) all acute Hospital trusts had been subject to the same annual evaluation process that rates them as weak, fair, good or excellent). This accountability system enables us to identify and compare the evolution of the organizations’ performance over a considerable period of time. The availability of time series data showing the evolution of performance indicators over time is the sine qua non of empirical study on the process of recovery in organizations

3.1 Timeframe of the Study

In order to obtain longitudinal data using retrospective interviews, interviewees are also asked to reflect upon specific events in the past. This, together with documentary analysis, helps to build issue-organized chronologies of events related to the transformation process of each organization studied. While there is no definitive and precise guidance to define the timeframe of analysis, this research covers the period of 2000 to 2007. The reason to choose 2000 as the start point is due to the fact that the overall performance rating systems (the “star rating”) was introduced around that year. Following the publication of the “star rating”, a series of measure are taken to bring about performance improvement in “failing” organizations. “Zero- and one-star” hospital trusts are required to submit to and agree a performance improvement with the SHA, which, in turn, has its improvement responsibility overseen by the Department of Health (Harvey et al., 2005). Key policies adopted by the latter have included “franchising” (change of management team) and external support through agencies specifically created to promote performance improvement in the “failing” organizations.

Thus, the publication of the first “star ratings” have been followed by measures that triggered the recovery process and thus constitute a suitable start point for the analysis. Fulop et al.,’s (2004) empirical studies of failure and turnaround in UK hospital trusts states that turnaround managers “plan their turnaround to run over a period of at least three years”. Hence, an elapsed time of 7 years, since the publication of the first ratings, is sufficient to demonstrate the development of capabilities needed to recover and sustain good performance in the long run.

3.2 Selection of the Case Study Organizations

Pettigrew (1990) argues that if we are interested in the links between organizational capabilities and performance it makes sense to choose polar types, which reflect extreme situations illustrating low and high performance. By following this advice, it was chosen to conduct the empirical study using two public service organizations which illustrate two different outcomes of the process of recovery. These situations are: one organization reflecting a case of a well-orchestrated successful turnaround attempt; and one case of a “failing” organization that went through several unsuccessful turnaround attempts and took longer to embark in a turnaround trajectory. A comparative analysis of these two cases should highlight the capabilities that are linked to the organizational recovery and those that organizations need to sustain good performance as a continuous process, thereby avoiding falling into decline again.

To track a consistent performance trajectory, the analysis considered a timeframe of 7 years. It was defined successful case of recovery and renewal as those in which the organizations' performance had been below the satisfactory level for at least two years followed by an upturn in performance, reaching a good performance level. This period is consistent with other studies on recovery and should enable the identification of "sustained" good performance, as opposed to a fleeting fluctuation in the organization's performance.

Following these criteria, by analyzing the time series of data showing the performance of acute Hospital Trusts since 2001, published by the then Commission of Healthcare Improvement, when the "star rating" system was firstly introduced, it was identified the following organizations as the sites for empirical work:

Table 1. Performance history of the Case study organizations

Hospital Trust	Performance ratings								
	2001	2002	2003	2004	2005	2006 (Q)	2006 (UR)	2007 (Q)	2007 (UR)
Hospital A ^a	Zero star	Zero star	Zero star	* *	*	good	fair	excellent	fair
Hospital B ^b	*	Zero star	Zero star	*	*	fair	weak	weak	weak

Notes. a = case of successful recovery; b = case of unsuccessful recovery attempt; Q = Quality of Services; UR = Use of Resources (UR).

Table 1 demonstrates that the two Hospital trusts followed two distinct performance trajectories since the introduction of the performance rating system in 2001. During the first three years both hospital trusts received a very poor score and thus can be considered as "failing" organizations according to this performance rating system. However, from 2004 the performance of the hospital trusts started to follow distinct trajectories. While there was a slight improvement in the overall score of Hospital B, from "zero star" in 2003 to "one star" in 2004 and 2005, its performance remained below a performance level considered as "good", returning to the lowest level of performance again in 2007 when it scored "weak" for both "use of resources" and "quality of services". By contrast, during the same period there was an upturn in the Hospital A's performance, from three consecutive "zero star" in the beginning of the period to "excellent", the highest level of achievement, in 2007 - the end of the period under analysis.

3.3 Data Collection

The research made use of retrospective interviewing as the method for gathering longitudinal data on the processes under analysis. Data was gathered by means of semi-structured interviews with key actor, conducted during 2008/09. The topics were explored by asking respondents questions regarding some features of the organizations during the "failing" period, including its processes, structure and managerial culture and attitude; the key source for change from both the external context; the key interventions and initiative to turn the performance around implemented over the timeframe of analysis.

The interviews were conducted with key people from each of the two selected organizations and from key stakeholders (see Figure 1). Pluralism in the selection of the interviewees was adopted in order to obtain different perspectives of the transformation process and avoid bias in favor of a single view of the "drama" (Pettigrew, 1990). Since the performance improvement attempts in the hospital trusts have a strong influence from the higher tiers of the National Health Services bureaucracy, data was collected from three levels: the hospital trust level, the strategic health authority level and the department of health level. In the trust level, it was interviewed about 20 people in each Hospital Trust. Interviewees in the hospital trust level were selected on the basis of their leadership in the organization and the change process under analysis, and their participation in and knowledge of the changes. Interviewees thus included the Chief Executive Officers, all executive director members of the board, top and middle level managers, and clinicians.

It was also interviewed an executive director member of the board of the Strategic Health Authority level, who was involved in the strategic direction and performance management of the concerned hospitals. The research also included one interview of a director of an external organization responsible for commissioning the services of the concerned hospital trusts (Primary Care Trust). In the Department of Health interviews was conducted with members of the team responsible for providing support to hospital trusts that failed to achieve the standards

and targets (Support Development Team). Hence, it was possible to obtain a comprehensive and holistic picture of the performance management process, as well as a balanced sample of around twenty informants for each hospital trust. This sample was enough to reach “theoretical saturation”, in the sense that additional interviews would not provide new data on the topics under analysis (Corbin & Strauss, 2015). In order to ensure precision in the analysis of the interview data, all interviews were tape recorded and transcribed.

3.4 Dealing with Challenges in Conducting Retrospective Interviews

The use of historical methods adds specific challenges to this kind of data collection. The main problems in gathering oral historical evidence are associated with the issues of reliability and validity (Dunkerley, 1988). The former refers to the reliability of the respondent’s account due to the vagaries of the respondent’s memory and bias introduced by distortion of emotions and motives (Ibid.). Validity refers to the extent to which the interviewee’s response is influenced by the interviewer. In order to circumvent the validity and reliability problem this research made use of a number of techniques that helped to overcome the bias introduced by the respondents’ memory lapse and distortion, and reduce the interviewer influence over interviewees. These included building the narrative from the account of diverse interviewees who have participation or knowledge of the process under analysis, rather than relying on only one informant (as described in the previous subsection). This helps to reduce the reliability problem because building a narrative from the perspective of diverse interviewees provides a more comprehensive account of the process, where one interviewee compensates for the possible memory lapse of the others, and reduces the possibility that the final account of the process, where one interviewee compensates for the possible memory lapse of the others, and reduces the possibility that the final account will be biased by the emotion or distortion of one interviewee.

Triangulation with other documental sources is also useful in reducing the reliability problem. The issue of validity was dealt with by making use of existing interviewing techniques that helped to reduce the influence of interviewer over the interviewees’ response. These included avoiding getting into a “real” conversation with the respondent in which the interviewer answers questions posed by the interviewee or manifests his/her opinion about the matter discussed (Fontana & Frey 1994), and avoiding leading “probing” questions (Easterby-Smith et al., 2021).

3.5 Procedures for Data Analysis

This part of the analysis process involves drawing meaning from the data. This will be done through cross-case analysis. Cross-case analysis allows the researcher to identify similarities and differences that account for the phenomena under analysis and enhances the chance of encountering novel findings that might not be anticipated (Eisenhardt, 1989). In this research, cross-case analysis was carried out in organizations that have gone through a recovery process and those that faced difficulties in turning their performance around. These comparisons allowed us to identify capabilities needed to recover the organizational performance and sustain good performance as a continuous process.

Consistent with processual analysis (Pettigrew, 1997), two groups of causal factors that explain the outcome of the efforts to turn the performance of the organization around was identified: process design features and context factors (Barzelay, 2007). The former is defined as “an array of elements that are crafted by the organization to make the operation” of the relevant process workable (Barzelay & Campbell, 2003). It is, therefore, the element of managerial intervention and action. The latter includes the characteristics of inner and outer context that influence the outcome of the component process under analysis (Pettigrew, 1987). Therefore, the empirical analysis of the two cases was geared towards answering the following question: how do the managerial intervention (process design feature) and the contextual factors explain the creation of the capabilities that accounted for the different performance outcomes of the two cases?

4. Results

This section presents the comparative case study analysis of two different trajectories of recovery and renewal of the two Hospital trusts in England. In both cases the initial condition was one of “failing”, according to the then established, “star rating” system. The Hospital A was the only acute Hospital trust in England to receive a “zero star” for three years in a row since the first publication of the ratings in 2001. Similarly, the Hospital B received “one star” in 2001, followed by two consecutive “zero star” scores in the ratings published in 2002 and 2003. In both cases the recovery and renewal attempts were triggered by changes in CEOs combined with external pressure.

There were striking differences in the trajectory and outcomes of the recovery and renewal process of the two cases. On the one hand, Hospital A went through a continuous upturn trajectory, locked into early attempts to

recover and renew. The outcome of the episode was the score of “Excellent” for “Quality of Service” received in the last Annual Health Check of the timeframe under analysis, along with a sustainable, positive financial situation. On the other hand, Hospital B went through three different stages representing different attempts to recover the organization, each triggered by change in CEOs. The first two attempts failed, but the third one eased the Hospital Trust into recovery trajectory. The outcome of the Hospital B trajectory was a financial balance, but with a “failing” score on the last result of the Annual Health Check. Therefore, the question arises as to what explains the differences in trajectory and outcome of the recovery and renewal attempts of the two cases.

The way that was chosen to address this question followed two major stages. Firstly, it was presented an overview of the recovery and renewal macro-processes, and their respective component sub-processes. Secondly, it is explained the causal factors (process design feature and context factors) that accounted for the outcome of the efforts to overcome the requirements/challenges involved in the operations of each of the process requirements. The key component processes of the recovery and renewal process were drawn from the cases studies and are depicted in the framework presented in Figure 2. The component processes are laid out in a hierarchical form, i.e. decomposed into lower order sub-steps, each of the latter being in turn a “parent” of the next lower level.

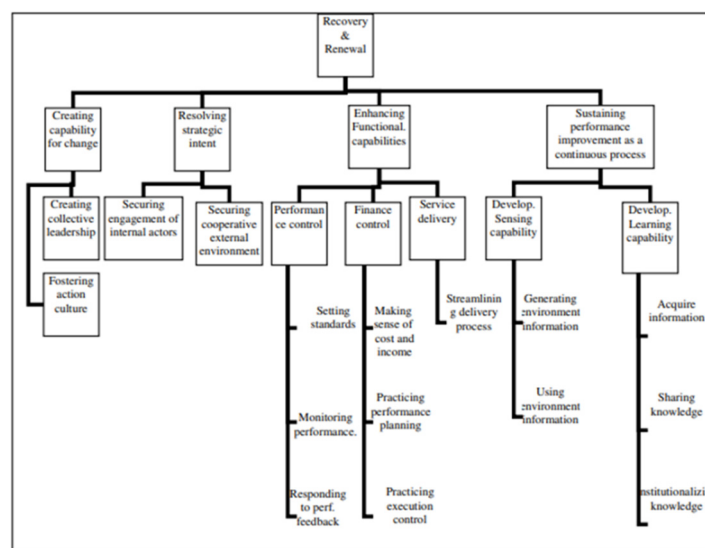


Figure 2. Decomposing recovery and renewal process. Source: Developed by the authors

The purpose of decomposing the recovery and renewal process into its hierarchical component steps is to reduce the complexity of the analysis of the causal factors that explain recovery and renewal. Herbert Simon, in his seminal book *The Sciences of the Artificial* (1996), highlights the fact that decomposability is a property of most complex social systems. He goes on to argue that “the fact then that many complex systems have a nearly decomposable, hierarchic structure is a major facilitating factor enabling us to understand, describe and even “see” such systems and their parts” (p. 207). Indeed, it is easier, and perhaps more accurate, to reason about the causal factors that explain the outcome of the specific steps of a complex process, taken separately, than of the process as a whole. In the case of the organizations presented in this article, for instance, one could ask how a given characteristic of the context of the organization contributed to satisfy (or precluded the satisfaction of) the challenges involved in implementing any of the four major processes.

Having dissected the recovery and renewal process into its component processes, it is now time to explain the second stage of the analysis of the cases, which is to identify the causal factors that explain the outcome of the key processes. This section then proceeds by detailing how the combination of “process design features” that were crafted by the managers and “context factors” of the two cases contributed (or not) to satisfy each of the challenges involved in implementing the four above-mentioned processes and their sub-processes.

4.1 Creating Capability for Reacting and Changing

Studies on organizational renewal and change have highlighted the importance of creating a management team committed to renewal and change (Baden-Fuller & Stopford, 1996; Pettigrew, Ferlie & McKee, 1992; Pettigrew & Whipp, 1992; Grinyer, Mayes & McKiernan, 1988). Recovery and renewal of the performance of a “failing”

organization is rarely achieved by a one-shot fixing-up of a single great issue that is seen to be dysfunctional. It rather involves changes in the different aspects, parts and levels of the organization (Baden-Fuller & Stopford, 1996). Thus, it is difficult for such multi-faceted changes to be brought about by acts of a single, "heroic" leader. Empirical studies on management of change led by Pettigrew in both public and private organizations (Pettigrew & Whipp, 1992; and Pettigrew, Ferlie & McKee, 1992), demonstrated that leading changes requires a "collective leadership" if the changes are to have effective, long-term results. This collective leadership, they maintain, involves the formation of a managerial cadre made up of managers and key lead professionals at both executive and operational level who are convinced of, and committed to, the need for change.

Building capability for change thus concerns creating and sustaining teams of managers, at both executive and more operational level, committed to changes and ready to act in response to adverse performance feedback. This helps to build the momentum for change which is necessary to overcome the forces for continuity (Leavy & McKiernan, 2009). The operation of this function was found to be a crucial difference between the Hospital A and Hospital B cases.

In the Hospital A, this functional requirement was largely satisfied by two major undertakings, namely: creating a collective leadership by making key people available in critical posts across the hospital Trust, at both executive and operational level; and fostering of an action-oriented attitude among managers within the hospital Trust. The formation of the collective leadership started at the top management level, with the arrival of the new CEO 4 in 2004 (see Figure 3) and the subsequent appointments of the Chief Operating Officer (COO) and the Medical Director.

The COO post, as opposed to the traditional post of Director of Operations, was deliberately created to have, at the top management level, an executive with a clear mandate and authority to bring about change in the organization. The appointment of the hospital Trust's first COO was also a key step in the introduction of change agenda in the Hospital Trust. He was described as an active leader with a demonstrated "bias towards action". Being a medical graduate with a high-level management education and experience, he was able to understand the concerns and communicate easily with both clinicians and managers. The leadership at the top management level was reinforced with the appointment of a medical director committed full-time to the executive position and with a demonstrated leadership capacity.

At a more operational level, this functional requirement was satisfied by the selection and appointment of the "head of divisions", under the general principle that those selected should necessarily be clinicians with demonstrated leadership capacity and commitment to the managerial agenda. The COO described the selection of clinicians to lead the recently created clinical divisions as an opportunity to choose the "best levers" for each division.

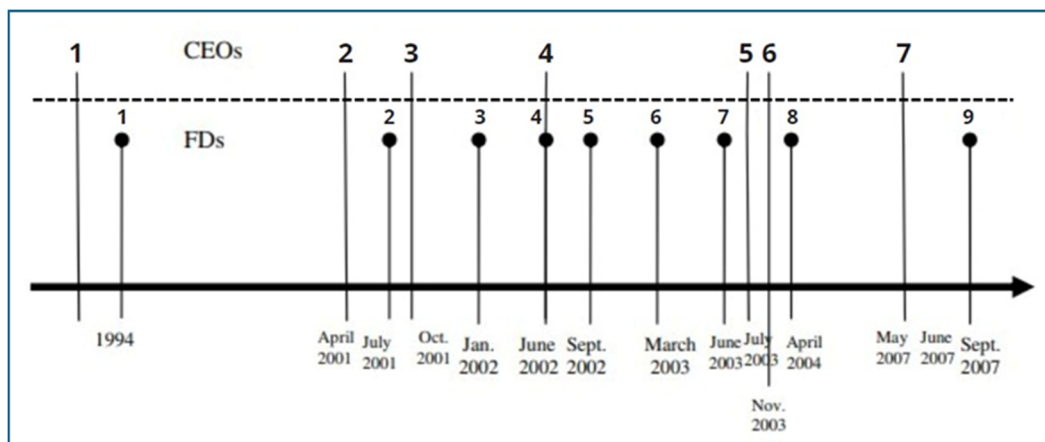
The other process design feature that contributed to creating the capability for change was the action-oriented culture. An action-oriented culture is important to prevent a culture of collective denial and the narrative of silence problem that could lead to organizational failure (Hendy & Tucker, 2021). In Hospital A this action-oriented culture was fostered by the COO. He systematically disseminated the notion across the management team that "a variance explained is not a variance managed". The purpose was to foster a culture in the organization by which managers would be prompted to act upon adverse performance data, as opposed to expending energy and time finding excuses or blaming external agents for poor performance. As the COO recalled, "I switched the emphasis of the performance reviews meeting from 80 % on explanation and 20 % on action to 20 % on explanation and 80 % on action".

As important as the dissemination of the message about the need to focus on "action" to foster an action-oriented culture was also the "sense of urgency" on the key targets deliberately heightened by the COO. This sense of urgency was generated by means of regular checking during review meetings of what was done from a previous week to the next. The review meetings always ended with a list of actions and short-term targets which would be assessed in the following week's meetings. A sense of urgency is thus part of the "productive management of anxiety", which has the effect to increase the impetus for change in the organization (Leavy & McKiernan, 2009). These process design features, combined with the selection of clinical leaders who were more likely to "act" on than to "explain" poor performance, helped to create within the Hospital A a collective leadership committed to change.

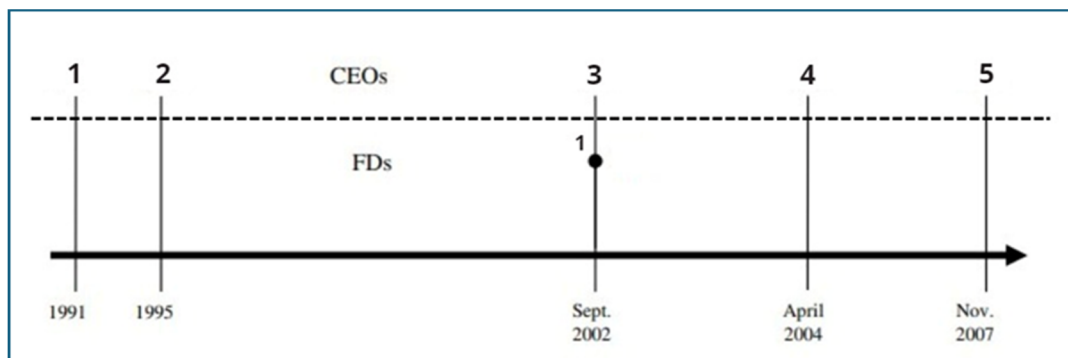
Two contextual factors contributed to the creation of a collective leadership committed to change, namely a balanced external pressure and relative management stability. The CEO 4 of Hospital A entered office when the central government had already given up a policy of "franchising" the Hospital Trust. He thus could enjoy a less intrusive external context. Furthermore, during the whole period of analysis there was a relative stability and

continuity of the management team. Paradoxically, the substantial degree of stability was crucial for him to be able to create a strong executive team committed to the changes.

By contrast, in Hospital B this challenge (creating capability for change) was not successful during the first two stages of the turnaround attempts, notably during the two CEOs' term of office (CEO 3 and CEO 4, see Figure 3 below). During the CEO 3's period, the managerial turmoil caused by investigations of the "waiting-lists" and questionable accountancy practices, and abuse of private practice by doctors, prevented him from assembling a strong management team committed to change. Quite the contrary; during his period, he witnessed a rapid turnover of most of the key executive directors. During CEO 4's term there was the first attempt at galvanizing the management team, notably with the establishment of what was called the "do or die" meetings, which injected a sense of urgency among some key senior managers. Nevertheless, this process design feature was not on its own sufficient to create a collective leadership across the organization. During his period, the Hospital Trust was hit by the intense pressure from the central government to franchise the Hospital Trust. The external pressure had the effect of engendering a sense of impermanence among the management team. Due to the clashes with the national policy he, with most of the executive team, left the Hospital Trust.



(a)



(b)

Figure 3. (a) Changes in CEOs and Financial Directors in Hospital B; (b) Changes in CEO and Financial Director in Hospital A. The numbers represent the appointment of a new CEO; e.g. CEO 4 of hospital A was appointed in April 2004. Source: Developed by the authors

It was not until CEO 6's arrival, in November 2003, that the Hospital Trust could enjoy a period of relative managerial stability and absence of highly intrusive policies from central government. He started assembling what turned out to be a much more stable and stronger executive team. Like the CEO 4 of Hospital A, he also arrived at Hospital B after the decline of the franchising policy and could also enjoy a less intrusive external pressure, following an orchestrated process of change in leadership in the region implemented by the CEO of the Strategic Health Authority. However, unlike the CEO 4 of Hospital A, CEO 6 could not count on a change in the

organization's structure as an opportunity to select the "best levers" for key operational positions. The organizational structure had recently been changed by his predecessor and for him another change in a short period of time could be traumatic. Hence, apart from the selection of key people within the executive level and the finance department, few other changes were implemented in the other functions at a more operational level, especially among lead clinicians. The formation of a "collective leadership" during CEO 6's period was thus more selective than it was the case for Hospital A.

The effectiveness in performing the function of creating capabilities for change was a crucial difference between the Hospital A and Hospital B cases. This supports the argument that creating a capability for changing is a crucial step in the renewal and recovery process (Baden-Fuller & Stopford, 1996). This function involved creating a "collective leadership", characterized by the existence of key people committed to and leading change at different levels and parts of the organization (Pettigrew & Whipp, 1992; Pettigrew, Ferlie & McKee, 1992). The inductive analysis revealed that such functional requirements can be effectively satisfied by such management practices as conscious team-building (using a formal selection process to put key "levers" in the key positions); increasing the "capacity for action" by heightening a "sense of urgency" and setting expectation among managers that an action-oriented attitude should prevail when faced with adverse performance feedback (more emphasis on "action", as opposed to "justification").

It also demonstrated that the outcome of an attempt to galvanize the management team is more effective within a context of managerial stability. The differences in managerial stability between the Hospital B and Hospital A cases are clearly evidenced in the Figure 3.

4.2 Resolving Strategic Intent

4.2.1 Securing Internal Engagement

Securing engagement of internal actors is advantageous for accomplishing the recovery and renewal a "failing" organization. This is mainly because recovering and renewing an organization involves changing some established values, processes, behaviors, priorities and/or structure of the organization. These changes often alter the power relations within the organization, resulting in an opposition or resistance of the groups affected by the changes. Meyer and Zucker (1989) argue that the failure of an organization to implement the changes deemed necessary to recover and renew the organization is due to a "stalemate" between those actors who want to change the organization and those who need the organization in its current template. Hardy's (1990) research in both public and private organizations found that failure to implement retrenchment strategies can be attributed, among other causes, to an orchestrated opposition campaign conducted by powerful interest group. Similarly, Jas and Skelcher's (2005) research shown that divergence in interest between key actors was an important factor that explained failure of local authorities in England to turn their performance around.

In professional organizations, as it is the case of the two organizations under analysis, the need to secure engagement from key internal actors, qua professionals, gains especial relevance. This is because in this kind of organization, professionals (such as doctors) have considerable influence and power in relation to the production or delivery of services (Mintzberg, 2023). Empirical studies on failure and recovery of Hospital trusts in England have shown that the lack of engagement of clinicians with the managerial agenda was a determinant factor of failure (Protopsaltis et al., 2002; Fulop et al., 2004).

In Hospital A, the challenge of securing the engagement of powerful clinicians was largely satisfied by a conjunction of process design features and context factors. One process design feature was the communication pattern between the key executives, notably the COO and the medical director, and key clinicians. The COO gave a strong emphasis to the importance of establishing an open communicating channel with key clinicians. He was constantly communicating with key clinicians, in both informal and formal events, such as the "doctor's away day". This open, continuous communication pattern was important to secure engagement for two main reasons. On the one hand, it served as an opportunity for the COO to identify, face and offset the argument of "negative" leaders. On the other hand, it germinated an overall sensation among clinicians that their concerns had been listened to and were given proper attention by executive managers in the organization.

A second feature was to have influential clinicians who were committed to the change agenda in key leadership position within the Hospital Trust. The executives most involved with the operations of the Hospital Trust, therefore who interact with professionals on a daily basis, had at the same time a clinical educational background and a demonstrated leadership capacity. These positions were the Chief Operation Office, the Medical Director and the Head of Divisions. The COO was a medical graduate with strong managerial knowledge and experience. The Medical Director was selected because of his demonstrated leadership capacity. Similarly, the head of divisions went through a normal selection process, in which being a clinician was a necessary condition, but not

sufficient. It was also required that they had a demonstrated leadership capacity and a commitment to the managerial agenda.

Having the linking, managerial positions filled by clinicians committed to the managerial agenda had the effect of legitimizing the managerial actions among the clinician's community. Professionals display more propensities to engage into managerial actions if they perceive them as legitimate (Suchman, 1995; Zott & Huy, 2007). Clinicians are more likely to perceive an organizational directive as legitimate if it is proposed by a reputable clinician, rather than from a non-clinical manager. The reason for this is twofold: firstly, clinicians in managerial position are more capable of providing plausible arguments and explanation for the desired changes.

Secondly, the clinician community assumes that a clinician in a managerial position, as opposed to a non-clinician manager, is more capable of understanding challenges and embed their medical profession values into the decision-making. These two reasons are consistent with what Suchman (1995) called legitimacy based on "comprehensiveness" and "taken-for-grantedness". Pettigrew, Ferlie and McKee (1992) found that implementing change in a public Hospital was easier where managers had a hybrid background.

A third process design feature to bring about clinicians' engagement into the managerial agenda was to involve the clinicians into the Hospital Trust's main decisional forums. The involvement of clinicians into the decision making was increased by means of the creation of two decisional boards, namely the Trust Executive Group (TEG) and the Divisional Boards. The TEG was composed of the six executive directors, the CEO and the five Head of Divisions. The way the membership of the Trust Executive Board was composed afforded a stronger decision power to clinicians than non-clinical executives. Two out of the six executive directors were clinicians (the medical director and the director of nursing) and all head of divisions were clinicians. Hence, the majority of the Trust Executive Group were clinicians. Similarly, though at a more operational level, the Divisional Boards pulled together the managers and the lead clinicians of all clinical specialties, to make decision regarding the operational and strategic issues of each division.

The involvement of clinicians into the decision-making process, at both executive and more operational level has the effect of stimulating an effective managerial-clinical relationship (Shortell et al., 1990). An effective managerial-clinician relationship, in its turn, has shown to be instrumental in bringing about strategic change in an organization. Pettigrew, Ferlie and McKee's (1992) research on the NHS organizations found that the quality of the managerial-clinical relations was an important determinant of a favorable context for change.

A fourth process design feature was the educational program organized by the Hospital Trust and an university to give management and leadership training to all managers, head of divisions and lead clinicians. Such an educational program had the intrinsic effect of not only providing management knowledge to managers and clinicians, but also helped to create a common language between them. Clinicians, in general, do not receive management education as part of their educational curriculum. Thus, the provision of management education to lead clinicians reduces the cognitive barrier, enabling them to "think across the patch".

In Hospital B the engagement of clinicians with managerial agenda followed different patterns. During CEO 4's period, an important process design feature that contributed to engaging clinicians into the managerial agenda was the establishment of the Boards to lead the two recently created divisions. The Boards put together lead clinicians and top managers to discuss and make decision about the key operational issues.

However, the long, intense period of managerial instability, a contextual factor, made the clinicians' engagement more volatile and difficult to sustain in Hospital B than was the case in Hospital A.

CEO 6's period was marked by the implementation of retrenchment strategy, considering the enormous accumulated financial deficit and the need to bring about financial recovery. Securing financial balance was potentially difficult because it required an immense sacrifice from the part of clinicians. The challenge of engaging key clinicians into the "saving" agenda was exacerbated by the effect of the aforementioned instability of the management team. Nevertheless, the Hospital Trust was able to secure the level of clinician's engagement necessary to meet the huge saving targets imposed by managers. Several process design features and a context factor played a role.

The first process design feature was an intense and open communication between, on the one hand, the financial director and the CEO and, on the other hand, the lead clinicians. Both the CEO and the Finance Director were described as having established an open and trusting communication with clinicians. A second, and related, process design feature was the "attribution of threat". CEO 6 furnished his argument to justify the need for savings with the recurrent idea, which floated in the external environment, that reducing the scope of Hospital B was a plausible solution for its financial problems. Thus, he sent the message across that if clinicians did not

engage in the managerial agenda, Hospital B ran the risk of ceasing to exist in its current form. In doing so, he activated a social mechanism known in the sociology literature as “Attribution of threat” (McAdam, Tarrow & Tilly, 2001). This social mechanism has the effect of bringing about engagement because, when activated, actors believe that important values (e.g. the Hospital B in its current form) will not hold in the future, unless they engage with the proposed changes. A third process design feature was education. Similar to the case of the Hospital A, a leadership development program was also implemented to provide management training to lead clinicians and managers.

The effect of the process design features was enhanced by a context factor, namely: an existing belief among some stakeholders that Hospital B, in its existing form, was over dimensioned in relation to the characteristics of its external environment. According to this view, any sustainable solution to Hospital B would necessarily have to consider the reduction of the scope of the Hospital Trust in terms of the different type of specialized services provided. CEO 6 could then use this generalized perception to justify the need for clinicians to engage in the cost-cutting policy.

4.2.2 Securing Cooperative External Environment

Securing a cooperative external environment is effectively performed when the organization creates an externally supported, shared interpretation on how the organization should change. In Hospital A, this requirement was satisfied by the CEO 4’s emphasis on establishing closer relationship with key external stakeholders. Key initiatives in this direction were the frequent meetings with CEOs of external stakeholders and local organizations, and the executive-team-to-executive-team meetings with other Hospitals trusts. Another process feature was the creation of the position of Chief Operating Office. By delegating as far as possible the daily operational agenda to someone with authority to bring about change in the Hospital Trust, he could play a more external role, without being continuously dragged into minor operational issues. The availability of a Chairman with a strong link with the business community also helped the organization to secure a cooperative external environment.

In Hospital B, the challenge of securing a cooperative relationship with key external stakeholders was less successfully performed during the two main rounds of recovery attempts, notably the CEO 4’s and CEO 6’s terms. A process design feature and a context factor played a role in explaining the failure to secure a cooperative relationship with key external stakeholders during CEO 4’s term. A process design feature was the confrontational style adopted in his relationship with the commissioners (Primary Care Trusts). During his period, he went into a row with the commissioners over the financing of the Hospital B’s deficit. This contention over the “ownership” of the Hospital B’s deficit prevented him from building a more effective relationship with the external stakeholders. As an interviewee recalled: “So, relationships within the health community became very poor during his time and the PCT’s were not really speaking to us, nor was the Health Authority.”

A contextual factor was the management instability. The rapid turnover over his and his predecessors’ periods made it difficult for the external stakeholders to establish a more effective relationship with the management team of the Hospital B. Earlier report released by Commission of Healthcare Improvement had already indicated the difficulty faced by external stakeholders to establish a working relationship due to the frequent turnover of managers.

In CEO 6’s term, the quality of relationship with key external stakeholders was also not very effective. Similarly in CEO 4’s period, the main source of tension came from the commissioners and the Strategic Health Authority. Both CEOs tried to involve the health economy in sorting out Hospital B’s problem. Though CEO 6 adopted a much less confrontational style, he did not manage to secure a supportive environment with commissioners. Regarding the Strategic Health Authority, after the death of its CEO, CEO 6 lost the support he enjoyed during the first months of this term. His relationship with the SHA CEO’s successor was described as appalling.

The unsupportive external environment was thus a context factor that explains the Hospital Trust’s difficulty to obtain resources that could have helped it to resolve its economic situation. Consequently, the Hospital Trust had to go through an enormous saving sacrifice, which had an impact on the achievement of the other targets.

4.3 Building Up Functional Capabilities

4.3.1 Performance Control

The managers’ ability to control the performance of the organization was obviously critical to the recovery and renewal. The link between performance control and performance resides in the potential of the former to regulate crucial activities in the organization and ‘by implication, output’ (Mills, 1983). Such a regulation seeks to engage actors in corrective actions, as a specific response to a past experience of success or failure (Greve, 2003). This

kind of control is often called in the literature “cybernetic” (Antony, 1964) or “diagnostic” control (Simons 1995). The importance of performance control in bringing about performance improvement has been well documented in most empirical studies on both the failure and recovery of public and private organizations (e.g. Jas & Skelcher, 2005; Grynier, Mayes & McKiernan, 1988; Andrews, Boyne & Enicott, 2006; Wilson, Hickson & Miller, 1999). Moore (1995) found out that the emphasis on setting targets and performance accountability is relevant to recovery because it sends an implicit message across that performance matters and gives employees a focus on where concentrates their energy and efforts. As he puts it: “the attention of the organizations shifts from worries and speculations about new bosses to the specific tasks that the new bosses have handed out” (p. 279)

A useful way to operationalize the performance control capability is by referring to the processes by which it is put into use. In the specific literature on performance control, such cybernetic or diagnostic control is often described as involving the following processes: setting standards and/or targets regarding critical performance variables; monitoring performance; and responding to performance feedback (Green & Welsh, 1988; Simons, 1995). The effectiveness with which the organization operates each of these processes has shown to be crucial for explaining the different outcome characteristics of the Hospital A and Hospital B.

In both Hospital A and Hospital B the identification and setting of key performance targets was largely facilitated by a context factor, namely the well-established performance assessment framework set up by the central government to evaluate the performance of the acute Hospital Trusts. The key targets and performance indicators created by the central government provided a clear notion of the performance standard that needed to be achieved by the Hospital Trusts in England. Once the rules and criteria for assessing the performance of the Hospitals had been defined, the tasks left to the Hospitals were: to fully understand how their performance will be assessed; to monitor the performance of the organization against the key performance variables; and to respond to performance feedback.

In the Hospital A there was a strong focus on understanding how its performance would come to be measured and assessed. The monitoring of the performance against the key performance targets was effectively operated through two process design features: the creation of an information system (the “target tracker”), which emulated the Healthcare Commission’s performance assessment framework; and more frequent, systematic review meetings with all concerned actors. The target tracker provided colored information on how well the Hospital Trust was performing against the key targets and performance indicators. Such process design features enabled the Hospital Trust to have the right information available for the right people at the right time and in a simple and understandable format. With the information from the “target tracker”, COO’s team made sure that all relevant people received the information, both during the weekly review meetings and by pinning it on the doors of the key managers.

Responding to performance feedback was successfully accomplished by an increased performance accountability introduced by the CEO 4 and the COO. It was a strict requirement that all review meetings ended up with a list of corrective actions alongside the name of the persons responsible for implementing them. In the following meeting, all of them were called to account for their designated action. These frequent review meetings, the act of pinning the performance report on the door of the managers’ office and of naming the managers responsible for corrective actions and of calling them to account for their designed action sent a clear message across that performance matters and helped the Hospital Trust to keep on track regarding the performance targets.

In the Hospital B the performance control capability in the early 2000’s had been influenced by the absence of systematic practices to perform the performance control function of the Hospital Trust. It was not until the arrival of CEO 4 that the performance control capability started to be built. The three functions that needed to be effectively performed if the organization is to successfully control its performance were operated by the establishment of the frequent performance meetings (the “do or die” meetings in the surgical division). Participants of these meetings were charged to identify and produce information regarding key performance variables, and propose actions to respond to adverse performance feedback. The effect of the actions on the performance against the critical performance variables was then checked in the following week’s meeting and, in the case of an unsatisfactory result, new actions were then proposed until a satisfactory level of performance was reached.

However, such an arrangement was dismantled with the departure of CEO 4. During CEO 6’ term the operation of the performance control function was reestablished, though less intense and frequent meetings. During this period there were some attempts to define and elaborate the performance information system through the creation of the “balance scorecard”.

The requirement of responding to performance feedback was operated through the performance review meetings,

which occurred in three instances: the monthly board meetings; the quarterly performance management meetings, and less formal meetings with divisional managers, headed by the Director of Operations, on a more “exceptional” basis. However, due to the strong financial pressure, the priority of corrective action was attached to achieving financial balance and most of the managers’ energy and attention was placed on this purpose.

4.3.2 Financial Control

Improving the financial control capability is a cornerstone in the recovery and renewal process, particularly when an organization’s financial situation is taken into account during the evaluation of its performance. Without a sound financial control capability, an organization will be unable to pinpoint the activities and process in which it is losing money, thereby preventing it from implementing more effective corrective action to improve its financial results (Slatter, 1984). Indeed, a poor financial control capability has been considered as one of most common characteristics of declining organizations (Slatter, 1984; Grinyer, Mayes & McKiernan 1988; McKiernan, 2006). Similarly, studies on the recovery of organizations have pointed to the ability to perform the function of finance control as a crucial element of the recovery process (Slatter, 1984; Grinyer, Mayes & McKiernan, 1988; Grinyer & McKiernan, 1990; Poister & Larson, 1988; Stopford & Baden-Fuller, 1990; Bibault, 1999; Balgobin & Pandit, 2001). Fredenberger, Lipp and Watson (1997) indicated that timely financial information is directly or indirectly used to improve the cash flow when companies are in financial crisis. In NHS organizations, Protopsalitis et al. (2002) empirical study of recovery of Hospital Trusts found that performance improvement was associated with a better understanding of the organizations’ financial situation and the use of more realistic and sound budgeting practices.

To have a finance control capability means that an organization has an ability to successfully perform the following component functions: making sense of cost and income; practicing finance planning; and practicing execution control. A capacity to effectively perform these component functions is a crucial requirement to turn the performance of a “failing” organization around. This capability was present in both Hospital A and Hospital B, though starting to be developed at different point in time. Both Trusts managed to recover their financial situation after a period of considerable financial deficit. The successful operation of these component functions in both Hospital A and Hospital B can be traced to a set of similar process design features and contextual factors.

The requirement of “making sense of cost and income” was largely satisfied by two process features: the bottom-up budgeting exercise and the service coding exercise. The bottom-up budgeting exercise carried out in the Hospital B during CEO 6’s term started to paint a more realistic picture of the cost of the budgetary units. This exercise provided the information that served as the basis for the formulation of a more realistic budget for approximately 400 cost centres. The service coding exercise refers to the registering of all services episodes carried out in the Hospital Trust and served as a unit of measurement for income generation. By improving the coding of the services episodes delivered by the Hospital Trust, it was possible to have a more accurate and precise picture of the potential income generation of the organization units. The coding exercise enabled the Hospital Trust to make sense of the potential income of the services delivered by the Hospital Trust.

The effect of the coding exercise on making sense of the income position and potential of the Hospital Trust was enhanced by a contextual factor: the introduction of the “payment by results” policy of the central government.

The second component function, practicing financial planning, was successfully performed by such a device as realistic budgeting, with saving targets as part of it. Having made sense of the cost and income potential of units it was possible to establish a realistic aspiration for achievement over time. Hence, in both Hospital A and Hospital B, the budget was grounded on a more accurate informational basis, making it possible to set clear and realistic expectations for each unit.

Executing financial control, the third component function, is a crucial element of the financial control capability. Having a robust budget system will produce little effect if managers in the organization are not able to perceive and act upon the need to undertake corrective action during the execution and delivery process. In the instances under analysis, the performance of this function was highly sensitive to process design features, such as an effective accounting system that enabled managers to monitor finance execution and detect deviance.

Two other related process design features were a regular and interactive control of the budget execution; and making budget holders accountable for their performance.

4.3.3 Service Delivery Capability

Streamlining service delivery processes is obviously instrumental to gaining productivity in a Hospital setting. Such an increase in productivity has a direct effect on key performance variable, notably those impacted by waiting time and waiting lists. Streamlining service delivery entails coordinating the dependencies of resources

and tasks along the path of service delivery in order to perform faster and better. Davenport and Short (1998) highlight that it is a characteristic of a production or service delivery process to have intermediate customers and to cross organizational boundaries between organizational sub-units. These characteristics suggest that the effectiveness of the whole delivery process is contingent on the quality with which an organization manages the dependencies among the individual tasks and resources across the delivery path (Crowston, 1997). Despite these characteristics, studies have shown that many “processes result from a series of ad hoc decisions made by functional units, with little attention to effectiveness across the entire process” (Davenport & Short, 1997, p. 48). Streamlining the delivery process thus involves coordinating and optimizing the relationship of activities, tasks and resources involved in the entire process. The coordination and optimization of the relationship between activities and tasks that add value to a service delivery or a production process is considered as a central element of a firm’s competitive advantage (Porter, 1985).

In the case of NHS organizations, delivering Accident and Emergency service, for instance, involves tasks of different organizational units/specialties, generating potential areas of bottleneck along the patient flow with reflection on the Hospital Trust productivity and waiting times (National Audit Office, 2004). Indeed, the inadequacy in managing the key delivery processes, such as waiting lists, discharge procedures and Accident and Emergency, has been cited as key causes of “failing” organizations inability to turn its performance around (Protopsaltis et al., 2002).

In the Hospital A, this challenge, streamlining delivery process, was satisfied by such devices as inclusive meetings with representative of all units involved in a particular delivery process. In these meetings participants were charged to reflect on the entire path in order to identify and propose actions to overcome bottlenecks.

From 2007 onwards, the Hospital Trust started to adopt more elaborated techniques to improve the delivery process. The key initiative was the introduction of “lean thinking”. Lean thinking is a management approach that was initially developed in the manufacturing sector, notably the Toyota production system, and which had spread into the service sector.

By the end of the interview process, five pilot projects had been introduced. Early data on the impact of the projects had shown to be promising. Such a prospect increased CEO 5’s conviction of the potential of lean thinking in improving the productivity and efficiency of the delivery process.

The effect of these process design features in streamlining the delivery process was enhanced by a context factor, namely the grouping of the organizational units involved in the delivery of a core process into the same division. The CEO 4 collapsed the traditional clinical directorate structure and created five divisions that reflected the core delivery processes of the Hospital Trust. Such a new arrangement helped to pull together all specialties and tasks involved the patient “care pathway”, thereby enhancing the management of the dependencies of tasks and resources among different units/specialties along the delivery process. This evidence is consistent with the research carried out by McNulty and Ferlie (2004) on the implementation of process redesign and reengineering in public Hospitals in UK. The authors attributed the cause of failure to implement process redesign and reengineering to the fact that it was introduced within established clinical directorate structure and did not succeed in crosscutting the units’ boundaries. Hence, they concluded that “process management and process redesign are therefore framed and constrained by an organizational form that reinforces values of clinical specialization and promotes vertical reporting rather than horizontal working” (p. 1403).

In the Hospital B, the first attempt to improve the organizational performance via streamlining the delivery process was made during CEO 4’s term. His approach to improving the performance against the key targets strongly relied on the use of process redesign technique. As in the case of Hospital A, the organizational structure was changed in order to group together all specialties and tasks involved in the core delivery process into the same division, rather than into separated clinical directorates. During this period there was substantial improvement in the performance of the Hospital Trust against the key delivery targets. During the same period, there was also an increase in the financial deficit of the organization. It was thus difficult to separate the effect of the process redesign from the effect of a simple increase on the Hospital Trust’s capacity. Anyway, such an arrangement, however, lasted less than a year, and was dismantled after CEO 4’s dismissal.

The use of a process-oriented improvement approach gained traction later on, with the Hospital B’s “2010 Change Program”, launched in 2007. This program is strongly focused on the use of process design as a way to improve efficiency and productivity. A consultancy company specialized in process engineering was contracted to design and implement the changes. Twelve projects were identified and have been implemented during the current year. Some of them were set up to have a direct impact on the key performance targets. By the end of the data collection, the Hospital Trust was undergoing an assessment to measure the impact of the intervention. This

activity has yielded positive evidence, which made executive directors optimistic about the impact of the intervention onto the Hospital Trust's performance.

4.4. Sustaining Performance Improvement

4.4.1. Maintaining 'Good' Managerial and Organizational Practices

Stabilizing good managerial and organizational practices entails creating the conditions to sustain the organizational and managerial characteristics that led to performance improvement. Research on sustained organizational recovery has found that maintaining the organizational and managerial features that helped to recover its performance contributes to sustained improvement (McKiernan, 2006; Grinyer, Mayes & McKiernan, 1989). Features like sound performance and financial control systems, an effective managerial-clinical relationship, which had been developed to recover the performance of the organization, are also instrumental in sustaining the good performance in the long run. However, the managerial and organizational practices that account for these features are vulnerable to collapse, especially when leadership changes. Stabilizing the practice is thus necessary to provide a "secure footing" (Barzelay & Thompson, 2005) for maintaining the good features in the long run.

One of the keys to ensuring the continuation of these characteristics was careful succession management after the changes in leadership. When the CEO 4 of Hospital A left the Trust, after leading a considerable transformation in the organization, the Hospital Trust's then Chief Operating Officer, succeeded him as the new CEO (CEO 5). Because he had played an active role in the transformation process, such a change was viewed as a way to ensure continuity of the "good" managerial and organizational practices that drove the performance improvement of the Hospital Trust.

4.4.2 Developing Sensing Capability

Maintaining the good features that led to successful recovery is an important condition for long term success, but it is not sufficient. It is also important that the organization is able to adapt to a changing environmental circumstance (McKiernan, 2006). This capacity to adapt to a changing environment has been strongly dependent on the organization's ability to sense the environment in order to identify needs and opportunities for change (Teece, Pisano & Shuen 1997; Teece, 2007). The failure to detect and respond to a changing environment, also known as "organizational blindness", has been cited as one of the major causes of performance decline (McKiernan, 2006; Weitzel & Johnson, 1989).

The link between the use of systematic environmental scanning activities and performance has been examined in several empirical studies (Thomas, Clark & Gioia, 1993; Daft, Sormune & Parks, 1988). Systematic scanning of the environment helps the organization to identify new market opportunities and threats (Teece, 2007; Day, 1994); to implement strategic change (Pettigrew & Whipp, 1992); to increase the sense of controllability of issues and, consequently, the willingness to act (Thomas et al., 1993); and, especially in the case of the public sector, to be attentive to demands and needs of key stakeholders (Bryson & George, 2024).

In the Hospital A, three process design features contributed to the development of the Hospital Trust's ability to sense the environment: the systematic use of scenarios; the creation of community and business advisory groups; and the increased use of benchmarking. From 2004 the Hospital Trust started to use scenario to serve as an informational basis for the formulation of their business planning. The practice of thinking about possible futures had become an integral part of the Hospital Trust's day to day work.

Parallel to the use of scenarios, the sensing capability of the Hospital Trust was also enhanced by the creation of the stakeholder and business advisory groups. These groups were composed of community people and the business sector with the purpose of advising the Hospital Trust's board on strategic issues by bringing fresh information from the external environment. These groups provided the Hospital Trust with valuable information regarding community demands and business trends.

Lastly, an important process design feature was the increased use of benchmarking in the organization. Benchmarking has been regarded as an effective practice for sensing the environment (Camp, 1989). Teece, Pisano and Shuen (1997, p. 521) suggest that "narcissistic organizations are likely to be impaired".

The increased use and scope of benchmarking practices in Hospital A gained traction after the CEO 4's arrival and was a crucial part of the behavioral change they sought to bring about in the Hospital Trust. In terms of chronology, such evolution was described as follows:

"2000/2003 benchmarking locally...[that was] benchmarking against Hospital X, and [from 2004] the CEO 4 got us to benchmark against other teaching trusts, and the CEO 5 is now saying to us benchmark against

the world’s best.”(Note 1)

4.4.3 Building Up Learning Capability

Organizational learning has been considered as the key factor for long-term performance. The organization’s ability to learn in order to adapt to a changing environment “plays a central role in distinguishing failing from surviving companies and lies beneath organizational performance” (McKiernan, 2006). This capability informs the organization’s ability to constantly improve the organization’s existing product, services or processes, in order to perform quickly and better. Such an ability to develop and adapt operating routines has often been referred to as “dynamic capability” (Teece, Pisano & Shuen, 1997; Zollo & Winter, 2002, Nelson & Winter, 1982). Zollo and Winter (2002) propose that the development of dynamic capability is underlined by the co-evolution of three learning mechanisms: experience accumulation; knowledge articulation; and knowledge codification processes.

Experience accumulation is effectively performed when the organization has implemented and perfected routines to perform some productive tasks in a novel way. Routines are considered an organization’s “knowledge depository” (Nelson & Winter, 1982), where the outcome of trial and error learning in the operation of particular tasks is accumulated (Gavetti & Levinthal, 2000). Knowledge articulation is performed effectively when groups in the organization “figure out what works and what doesn’t in the execution of a certain organizational task” (Zollo & Winter, 2002). Knowledge codification is effectively performed when ‘understanding of the performance implications of internal routines’ (Ibid, p. 342) is translated into ‘explicit’ knowledge (Nonaka & Takeuchi, 1990).

From 2007, the Hospital A started to deliberately invest in the development of knowledge processing routines. One of the keys to accumulating knowledge was the use of pilot projects to perform new operating routines and managerial approaches. Instances of this are the creation of the pilot project to introduce the “lean thinking” in some operating routines. Articulating knowledge about the new operating and managerial processes was facilitated by the creation of an innovation group and an innovation board, which served as a discussion forum and communication vehicle between the innovation team and the operational and managerial staff. The innovation board met monthly to assess the pilot projects. The requirement of codifying knowledge was effectively operated by the systematic production of manuals and training modules, underlain by a careful assessment and understanding of what worked and why it did so. Lastly, another process design feature that had a positive effect across all the three knowledge processing routines was the investment on training on knowledge management and transfer techniques.

4.5 Summary

The analysis of the Hospital A and Hospital B revealed that, depending on the context, some managerial interventions have considerable potential to satisfy the above-mentioned requirement to recover “failing” organizations and sustain good performance in the long run. The results of the analysis are represented in Table 2.

The first two columns represent a component function of the recovery process that needed to be successfully performed if the organization is to turn its performance around and sustain good performance in the long run. The other columns show the process design features and context factors that contributed to the outcome of the specific row’s component function.

Table 2. Explaining recovery and renewal

Component function of the recovery and renewal process	Sub-components	Key process design features	Key context factor
Creating capability for change	Creating collective leadership	Appointment of a COO and Medical Director committed to change; Use of selection process to select the best “levers” to head divisions; Leadership development program.	Management stability/continuity; Balanced pressure
	Fostering capacity for action	Dissemination of the notion that “a	

Resolving strategic intent	culture	variance explained is not a variance managed”; Setting expectation that action should prevail in relation to “justification”; Introduction of a “sense of urgency”.	
	Securing internal engagement	Open communication between COO and key clinicians; the role of influential medical director committed to management; Divisional boards, involving leading clinicians into managerial decisions and planning; “Strategic” clinicians in leadership position - clinician with demonstrated leadership and commitment to managerial agenda as criteria to select the head of divisions; attribution of threat; management education.	Organizational climate of openness and truthfulness. Management stability (relatively continuity)
Enhancing operational and managerial process	Securing cooperative relationship with key external stakeholders	Networking externally; executive team-to-executive team peer meetings with Hospital “x” to set up common agenda; one-to-one meeting with CEOs from key stakeholders, including PCT to “sell’ what the Hospital was doing.	The number of commissioners; CEO established informal network and reputation; Management team stability
	Setting performance standards	Fully understanding of how the performance will be assessed and the variables that had a bearing on the performance; Frequent monitoring on specific indicators; Introduction of the “target tracker”; Frequent meetings which bring and discuss data on performance and make sure that people could do something about the data; Reports of the performance units against the targets, highlighting in red, amber, green on all the key targets and which were pinned on the door of all the key managers’ room across the trust.	Existing performance indicators set up by central government, against which performance will be assessed; Management stability; Availability of key people leading change; Supportive organizational culture - effective managers-clinicians relationship.
	Performance control	Making sense of performance data	
	Responding to performance feedback	Reviewing meetings to identify performance deviance, set corrective actions and allocate responsibility; Calling people to account for their corrective actions in next performance review meeting; Increased performance accountability - call managers to account for performance	
Financial control	Making sense of cost and income. Practicing	Bottom-up budget setting; Enhancing coding process. Setting realist budget and saving	Pressure for balancing the budgets; “paying by performance”

Sustaining good performance	Service delivery	financial planning	plans as part of it.	governmental policy/ Management stability/ availability of key people leading change/ effective managers-clinicians relationship.
		Practicing budget execution control	Emphasis on frequent and detailed monitoring of the budget execution; detecting deviance and taking timely action;	
	Stabilizing practices	Streamlining processes related to key services delivery	Inclusive meetings with all participants in the delivery process; Application of lean thinking.	Organizational structure that facilitated coordination of tasks along the pathway of service delivery.
		Generating environmental information	Managing succession (appointment from inside, COO took over CEO position in Hospital A; Ensuring continuity of good practices/features; Systemic use of scenario; increased use of benchmarking; integrated business plan; creation of the Community Advisory Group, Creation of Business Advisory Group.	Level of environmental pressure; Management stability
	Building up learning capability	Using environmental information	Robust business planning; Robust business case, underpinning decision making; Use of “pilot projects” to test new management innovation;	
		Accumulating experience	Experimentation, learning-by-doing; Benchmarking best practices in Hospital across the world.	
		Articulating knowledge	Creation of the Innovation Group and the Innovation Board	
		Codifying knowledge	Use of KM&T Techniques; Training sessions;	

5. Conclusion

This paper provides a detailed account of the causal factors from each case study that explained the successful performance of each element of the recovery and renewal process. Consistent with “processual analysis”, this research explained the success (or failure) of the organization in satisfying key challenges of the recovery and renewal process by referring to features of the process and context.

It can be concluded from this analysis that organizational recovery and renewal is highly sensitive to managerial interventions that: create collective leadership; foster an action-oriented culture; secure clinician engagement; foster a supportive external environment; strengthen functional capabilities, especially performance control, financial control and service delivery (coordination); build up the organization’s sensing and learning capabilities; and ensure maintenance of good managerial features over the time.

Like most research, this article has also its limitations, which, on the other hand, open up challenges and suggest avenues for future research. The analysis was drawn on the basis of only two cases of acute Hospital trusts: one case of successful turnaround and one case of a less-successful turnaround. Consequently, questions might be raised as to the extent to which the research’s findings can be applicable to other contexts or other kinds of public service organizations, such as schools, police departments, local authorities and so on. Considering that the findings are supported by literature on organizational failure, recovery and renewal in both public and private organizations, some “generalizability” may be claimed. However, peculiar characteristics of these kinds of

organizations and context, notably in terms of regulatory and performance accountability arrangements, demand that further research into other kinds of public service organizations be conducted before the external validity of the findings to other contexts can be claimed.

The intention of this paper was to provide a holistic view of the process, which encompasses most of the challenges managers in similar situation have to face. Such a holistic framework helps to “identify the relevant variables and the questions which the users must answer in order to develop conclusions tailored to a particular industry and company” (Porter, 1991, p. 98). The research then zoomed in on the components of the recovery process to provide detailed information of how process design features and context factors contributed to meet the challenges involved in the process. Therefore, the findings can advisedly be used by managers as “precedent” in the process of designing (Barzelay et al., 2022) interventions aimed at the recovery and renewal of a failing organization.

Another potential limitation has to do with the time passed since the research was conducted (2008/2009). However, this research obtained data that allowed the elaboration and comparison of two rich longitudinal case studies, encompassing a timeframe of almost 10 years of two organizations that went through opposite turnaround trajectories. This research strategy is rare in the literature on this topic and the rich data it generates should not be underrated based merely on the time it was gathered. Thus, the research findings have value and add relevant insights to the existing literature, as well as can be of practical value for managers faced with challenge of turn the performance of their organizations around.

Finally, the recovery and renewal of organizations is a complex and multi-faceted phenomenon. This article sought to shed light on this complex phenomenon, particularly by identifying several challenges of the recovery and renewal process and how they could be satisfied by the development of some key capabilities. The findings are a valuable contribution to the field and practice of management of organizations, in general, and public service organizations in particular. Nevertheless, and despite some progress in the literature over the past ten years, more research needs to be done in the field of the performance improvement of public service organizations.

Ethics approval

This research received ethical Approval from the NHS National Research Ethics, and from the Local Research Ethics Committee of each of the case study organizations.

Consent to participation

Participants signed a “consent form” where they formally agreed to participate in the research.

Informed consent

Obtained.

Ethics approval

The Publication Ethics Committee of the Canadian Center of Science and Education.

The journal and publisher adhere to the Core Practices established by the Committee on Publication Ethics (COPE).

Provenance and peer review

Not commissioned; externally double-blind peer reviewed.

Data availability statement

The data that support the findings of this study are not available due to ethical restrictions.

Data sharing statement

No additional data are available.

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References

- Alonso, J. M., & Andrews, R. (2020). Government-created nonprofit organizations and public service turnaround: Evidence from a synthetic control approach. *Journal of Public Administration Research and Theory*, 31(2), 346-362. <https://doi.org/10.1093/jopart/muaa035>
- Andrews, R., Boyne, G. A., & Enticott, G. (2006). Performance failure in the public sector: Misfortune or mismanagement? *Public Management Review*, 8(2), 273-296. <https://doi.org/10.1080/14719030600587612>
- Andrews, R., Ferry, L., Skelcher, C., & Wegorowski, P. (2020). Corporatization in the public sector: Explaining the growth of local government companies. *Public Administration Review*, 80(3), 482-493. <https://doi.org/10.1111/puar.13052>
- Arogyaswamy, K., Barker, V., & Yasai-Ardekani, M. (1995). Firm turnarounds: An integrative two-stage model. *Journal of Management Studies*, 32, 493-525. <https://doi.org/10.1111/j.1467-6486.1995.tb00786.x>
- Baden-Fuller, C. & Stopford, J. M. (1994). *Rejuvenating the mature business: The competitive challenge*. Harvard Business Press.
- Balgobin, R., & Pandit, N. (2001). Stages in the turnaround process: The case of IBM UK. *European Management Journal*, 19(3), 301-316. [https://doi.org/10.1016/S0263-2373\(01\)00027-5](https://doi.org/10.1016/S0263-2373(01)00027-5)
- Barney, J. (1992). Integrating organizational behavior and strategy formulation research: A resource-based analysis. In P. Shrivastava, A. Huff, & J. Dutton (Eds.), *Advances in Strategic Management* (Vol. 2). Greenwich, CN: JAI Press.
- Barzelay, M. (2007). Learning from second-hand experience: Methodology for extrapolation-oriented case research. *Governance*, 20(3), 521-543. <https://doi.org/10.1111/j.1468-0491.2007.00369.x>
- Barzelay, M., & Campbell, C. (2003). *Preparing for the future: Strategic planning in the U.S. Air Force*. Washington, DC: Brookings Institution Press.
- Barzelay, M., & Thompson, F. (2005). *Efficiency counts: Developing the capacity to manage costs at Air Force Materiel Command* (Financial Management Series). IBM Center for the Business of the Government. Retrieved July 22, 2024, from <https://www.businessofgovernment.org/sites/default/files/Efficiency%20Counts.pdf>
- Barzelay, M., Andrenacci, L., Seabra, S., & Yan, Y. (2022). Good trouble in the academy: inventing design-focused case studies about public management as an archetype of policy design research. In B. G. Peters & G. Fontaine (Eds.), *Research Handbook of Policy Design* (pp. 212-229). Cheltenham, UK: Edward Elgar Publishing. <https://doi.org/10.4337/9781839106606.00021>
- Beeri, I. (2012). Turnaround management strategies in public systems: The impact on group-level organizational citizenship behavior. *International Review of Administrative Sciences*, 78(1), 158-179. <https://doi.org/10.1177/0020852311430284>
- Bevan, G., & Hood, C. (2006). What's measured is what matters: Targets and gaming in the English public health care system. *Public Administration*, 84(3), 517-538. <https://doi.org/10.1111/j.1467-9299.2006.00600.x>
- Bibeault, D. (1999). *Corporate turnaround: How managers turn losers into winners*. Washington, DC: Beard Books.
- Boyne, G. (2004). A '3Rs' strategy for public service turnaround: Retrenchment, repositioning and renewal. *Public Money & Management*, 24(2), 97-103. <https://doi.org/10.1111/j.1467-9302.2004.00401.x>
- Boyne, G. (2006). Strategies for public service turnaround: Lessons from the private sector? *Administration & Society*, 38(3), 365-388. <https://doi.org/10.1177/0095399705286004>
- Boyne, G., & Meier, K. (2009). Environmental change, human resources and organizational turnaround. *Journal of Management Studies*, 46(5), 835-863. <https://doi.org/10.1111/j.1467-6486.2008.00813.x>
- Bryson, J., & George, B. (2024). *Strategic planning for public and nonprofit organizations: A guide to strengthening and sustaining organizational achievement* (6th ed.). Hoboken, NJ: John Wiley.
- Butler, M. J., & Ferlie, E. (2020). Developing absorptive capacity theory for public service organizations: Emerging UK empirical evidence. *British Journal of Management*, 31(2), 344-364. <https://doi.org/10.1111/1467-8551.12342>
- Camp, R. (1989). *Benchmarking: The search for industry best practices that lead to superior performance*. Milwaukee, WI: Quality Press.

- Corbin, J., & Strauss, A. (2015). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (4th ed.). Thousand Oaks, CA: Sage.
- Crowston, K. (1997). A coordination theory approach to organizational process design. *Organization Science*, 8(2), 157-175. <https://doi.org/10.1287/orsc.8.2.157>
- Daft, R. L., Sormunen, J., & Parks, D. (1988). Chief executives scanning, environmental characteristics, and company performance: An empirical study. *Strategic Management Journal*, 9, 123-139. <https://doi.org/10.1002/smj.4250090204>
- Davenport, T. H., & Short, J. E. (1990). The new industrial engineering: Information technology and business process redesign. *IEEE Engineering Management Review*, 26(3), 46-60.
- Day, G. (1994). Continuous learning about markets. *California Management Review*, 36(4), 9-30. <https://doi.org/10.2307/41165764>
- Easterby-Smith, M., Jaspersen, L., Thorpe, R., & Valizade, D. (2021). *Management and business research*. Sage Publications.
- Eisenhardt, K. (1989). Building theories from case study research. *Academy of Management Review*, 14(4), 532-550. <https://doi.org/10.5465/amr.1989.4308385>
- Favero, N., & Rutherford, A. (2016). For better or worse: Organizational turnaround in New York City schools. *Public Management Review*, 18(3), 1-19. <https://doi.org/10.1080/14719037.2014.999819>
- Fontana, A., & Frey, J. (1994). Interviewing: The art of science. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. xx-xx). Sage Publications.
- Fredenberger, W. B., Lipp, A., & Watson, H. J. (1997). Information requirements of turnaround managers at the beginning of engagements. *Journal of Management Information Systems*, 13(4), 167-192. <https://doi.org/10.1080/07421222.1997.11518147>
- Gavetti, G., & Levinthal, D. (2000). Looking forward and looking backward: Cognitive and experiential search. *Administrative Science Quarterly*, 45(1), 113-137. <https://doi.org/10.2307/266698>
- Green, S., & Welsh, A. (1988). Cybernetics and dependence: Reframing the control concept. *Academy of Management Review*, 13(2), 187-301. <https://doi.org/10.5465/amr.1988.430689>
- Greve, H. (2003). *Organizational learning from performance feedback: A behavioural perspective on innovation and change*. Cambridge University Press.
- Grinyer, P., & McKiernan, P. (1990). Generating major change in stagnating companies. *Strategic Management Journal*, 11, 131-146. <http://www.jstor.org/stable/2486674>
- Grinyer, P., Mayes, D., & McKiernan, P. (1988). *Sharpbenders: The secrets of unleashing corporate potential*. Basil Blackwell.
- Hardy, C. (1990). Strategies for retrenchment and turnaround: The politics of survival. *New York: Walter de Gruyter*.
- Hendy, J., & Tucker, D. A. (2021). Public sector organizational failure: A study of collective denial in the UK National Health Service. *Journal of Business Ethics*, 172, 691-706. <https://doi.org/10.1007/s10551-020-04517-1>
- Hoffman, C. (1989). Strategies for corporate turnarounds: What do we know about them? *Journal of General Management*, 14(3), 47-66. <https://doi.org/10.1177/030630708901400304>
- Jas, P., & Skelcher, C. (2005). Performance decline and turnaround in public organizations: A theoretical and empirical analysis. *British Journal of Management*, 16(3), 195-210. <https://doi.org/10.1111/j.1467-8551.2005.00458.x>
- Ketchen, D. (Ed.). (1998). *Turnaround research: Past accomplishments and future challenges*. JAI Press.
- McAdam, D., Tarrow, S., & Tilly, C. (2001). *Dynamics of contention*. Cambridge University Press. <https://doi.org/10.1017/CBO9780511805431>
- McKiernan, P. (2006) Turnarounds. In A. Campbell, and D. Faulkner (Eds.), *The Oxford Handbook of Strategy: A Strategy Overview and Competitive Strategy* (pp. 759-810). Oxford University Press. <https://doi.org/10.1093/oxfordhb/9780199275212.003.0026>
- McNulty, T., & Ferlie, E. (2004). Process transformation: Limitations to radical organizational change within

- public service organizations. *Organization Studies*, 25(8), 1389-1412. <https://doi.org/10.1177/0170840604046349>
- Meyer, M., & Zucker, L. (1989). *Permanently failing organizations*. Sage.
- Mills, P. (1983). Self-management: Its control and relationship to other organizational properties. *Academy of Management Review*, 8, 445-453. <https://doi.org/10.5465/amr.1983.4284594>
- Mintzberg, H. (2023). *Understanding organizations... Finally!: Structuring in sevens*. Berrett-Koehler Publishers.
- Moore, M. H. (1995). *Creating public value: Strategic management in government*. Harvard University Press.
- National Audit Office. (2004). *Improving emergency care in England*. The Stationary Office. Retrieved July 22, 2024, from <https://www.nao.org.uk/wp-content/uploads/2004/10/03041075.pdf>
- Nelson, R. R., & Winter, S. G. (1982). *An evolutionary theory of economic change*. Harvard University Press.
- Nonaka, I., & Takeuchi, H. (1990). A theory of the firm's knowledge-creation dynamics. In D. Chandler, P. Hagstrom, & O. Solvell (Eds.), *The dynamic firm* (pp. 214-241). Oxford University Press.
- Pandit, N. (1996). A meta-analysis of the corporate turnaround literature (Working Paper No. 326). Manchester Business School.
- Pettigrew, A. (1987). Context and action in the transformation of the firm. *Journal of Management Studies*, 24, 649-670. <https://doi.org/10.1111/j.1467-6486.1987.tb00467.x>
- Pettigrew, A. (1990). Longitudinal field research on change: Theory and practice. *Organization Science*, 1(3), 267-292. <https://doi.org/10.1287/orsc.1.3.267>
- Pettigrew, A. M. (1997). What is processual analysis? *Scandinavian Journal of Management*, 13(4), 337-348. [https://doi.org/10.1016/S0956-5221\(97\)00020-1](https://doi.org/10.1016/S0956-5221(97)00020-1)
- Pettigrew, A., Ferlie, E., & McKee, L. (1992). Shaping strategic change-The case of the NHS in the 1980s. *Public Money & Management*, 12(3), 27-31. <https://doi.org/10.1080/09540969209387719>
- Pettigrew, A., Whipp, R. (1992). Managing Change and Corporate Performance. In K Cool, D. J. Neven and I. Walter (eds.), *European Industrial Restructuring in the 1990s*. Palgrave Macmillan, London. https://doi.org/10.1007/978-1-349-12582-1_9
- Poister, T. H., & Larson, T. D. (1988). The revitalization of PennDOT. *Public Productivity Review*, 11(3), 85-103. <https://doi.org/10.2307/3380268>
- Porter, M. E. (1985). *Competitive advantage*. New York, NY: Free Press.
- Porter, M. E. (1991). Towards a dynamic theory of strategy. *Strategic Management Journal*, 12, 95-117. <https://doi.org/10.1002/smj.4250121008>
- Protopsaltis, G., Fulop, N., Meara, R., & Edwards, N. (2002). *Turning around failing hospitals*. London, UK: The NHS Confederation.
- Reingewertz, Y., & Beerli, I. (2018). How effective is central enforcement? Evidence from convened committees in failing local authorities. *Environment and Planning C: Politics and Space*, 36(2), 357-380. <https://doi.org/10.1177/2399654417713494>
- Rumelt, R. P. (1995). Inertia and transformation. In C. A. Montgomery (Ed.), *Resource-based and evolutionary theories of the firm: Towards a synthesis* (pp. 101-132). Boston, MA: Springer. https://doi.org/10.1007/978-1-4615-2201-0_5
- Rutherford, A. (2014). Organizational turnaround and educational performance: The impact of performance-based monitoring analysis systems. *The American Review of Public Administration*, 44(4), 440-458. <https://doi.org/10.1177/0275074012470022>
- Rutherford, A., & Favero, N. (2020). Organizational turnaround: Moving beyond one-size-fits-all solutions. *International Public Management Journal*, 23(3), 315-335. <https://doi.org/10.1080/10967494.2019.1580645>
- Shortell, S., Morrison, E., & Friedman, B. (1990). *Strategic choices for America's hospitals*. San Francisco, CA: Jossey Bass.
- Simon, H. A. (1996). *The science of the artificial*. Cambridge, MA: The MIT Press.

- Simons, R. (1995). *Levers of control: How managers use innovative control systems to drive strategic renewal*. Boston, MA: Harvard Business School Press.
- Slatter, S. (1984). *Corporate recovery*. Harmondsworth, UK: Penguin.
- Stopford, J. M., & Baden-Fuller, C. (1990). Corporate rejuvenation. *Journal of Management Studies*, 27(4), 399-415. <https://doi.org/10.1111/j.1467-6486.1990.tb00254.x>
- Suchman, M. C. (1995). Managing legitimacy: Strategic and institutional approaches. *Academy of Management Review*, 20(3), 571-610. <https://doi.org/10.5465/amr.1995.9508080331>
- Teece, D. (2007). Explicating dynamic capabilities: The nature and micro-foundations of (sustainable) enterprise performance. *Strategic Management Journal*, 28, 1319-1350. <https://doi.org/10.1002/smj.640>
- Teece, D., Pisano, G., & Shuen, A. (1997). Dynamic capabilities and strategic management. *Strategic Management Journal*, 18(7), 509-533. [https://doi.org/10.1002/\(SICI\)1097-0266\(199708\)18:7<509::AID-SMJ882>3.0.CO;2-Z](https://doi.org/10.1002/(SICI)1097-0266(199708)18:7<509::AID-SMJ882>3.0.CO;2-Z)
- Thomas, J., Clark, S., & Gioia, D. (1993). Strategic sense making and organizational performance: Linkages among scanning, interpretation, action, and outcomes. *Academy of Management Journal*, 36(2), 239-270. <https://doi.org/10.5465/256522>
- Vainieri, M., Noto, G., Ferre, F., & Rosella, L. C. (2020). A performance management system in healthcare for all seasons? *International Journal of Environmental Research and Public Health*, 17(15), 5590. <https://doi.org/10.3390/ijerph17155590>
- Van de Ven, A. H., & Poole, S. M. (2005). Alternative approaches for studying organizational change. *Organization Studies*, 26(9), 1377-1404. <https://doi.org/10.1177/0170840605056907>
- Weitzel, W., & Jonsson, E. (1989). Decline in organizations: A literature integration and extension. *Administrative Science Quarterly*, 34(1), 91-109. <https://doi.org/10.2307/2392987>
- Wilson, D., Hickson, D. J., & Miller, S. J. (1999). Decision overreach as a reason for failure: How organizations can overbalance. In H. Anheier (Ed.), *When things go wrong: Organizational failures and breakdowns* (pp. 35-49). London, UK: Sage. <https://doi.org/10.4135/9781452231457.n3>
- Zollo, M., & Winter, S. G. (2002). Deliberate learning and the evolution of dynamic capabilities. *Organization Science*, 13(3), 339-351. <https://doi.org/10.1287/orsc.13.3.339.2780>
- Zott, C., & Huy, Q. N. (2007). How entrepreneurs use symbolic management to acquire resources. *Administrative Science Quarterly*, 52(1), 70-105. <https://doi.org/10.2189/asqu.52.1.70>

Note

Note 1. Interview with an executive director of Hospital A.

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