Organisational Failure and Turnaround Process in NHS Hospital trusts

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Abstract

Since 1997, public services improvement has been at the centre of the national policy agenda in the UK. The greater visibility of poor quality and performance has led to an increasing interest among policy makers, health care managers and clinicians in understanding the processes by which underperforming organisations can 'turnaround' their situation. The aim of this thesis is to contribute to a wider understanding of organisational failure and turnaround processes in the public sector, particularly health care organisations.

A conceptualisation was carried out concerning organisational failure and the turnaround process in the for-profit sector in relation to a range of theoretical frameworks and models. As a result, the 'stages' theory was selected as a conceptual framework with which to organise and interpret the findings of the empirical part of the study.

A comprehensive review was conducted to examine the findings of empirical studies regarding the processes of organisational failure and turnaround across a range of public services. The review showed insufficient empirical studies in this field in the health sector. The review concluded that a range of both external and internal factors contributed to organisational failure and various triggers were identified, which initiated the process of change. A range of turnaround interventions were identified including reorganisation, retrenchment and repositioning strategies.

A qualitative case study of a purposefully sampled hospital Trust, involving semi-structured interviews (57 interviewees from different organisations) and a review of background documents were carried out to explore the symptoms and causes of organisational failure, factors that triggered the process of change, and the perceived effectiveness of a variety of turnaround interventions. Symptoms of organisational performance failure were identified, including financial deficit, lack of good external relationships, inability to meet core targets, lack of clear management systems and low staff morale. These markers had not been taken seriously by the previous senior management team. Symptoms of failure reflected the presence of secondary and primary causes of failure. Poor managerial leadership, poor financial control and performance management, lack of an open culture, distraction by two large projects and the lack of clinician engagement were perceived as internal causes of failure and the high level of policy changes within the NHS as the key external cause. The level of

deprivation in the area was also thought to have had a negative impact on performance. The replacement of the Chief Executive Officer and executive members of the Board and the public reporting of poor performance and external investigation reports were perceived as the main triggers for change. The Trust's managers were able to develop and implement their action plan and turnaround performance without receiving direct intervention from external organisations. The interventions deployed within the Trust may be classified under three key categories: i) Reorganisation (replacement of the Chief Executive Officer and executive members of the board, internal restructuring and increased involvement of clinical staff in the management of the organisation, and an increased focus on performance management); ii) Retrenchment which aimed to stabilise the crisis situation using tight financial control and focus on main performance targets); iii) Repositioning strategies which aimed to sustain performance improvement by attempting to change organisational culture, better stakeholder management and external relationship and developing new vision. Several unintended consequences of turnaround interventions (e.g. distortions of clinical priorities and presence of stress and anxiety among staff) were identified.

The findings of this study make a significant contribution to our understanding of organisational failure and the turnaround processes and reinforce and expand those of recent studies in the public sector, particularly in health care.

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Author's Declaration

All the research presented in this thesis was initiated and carried out by the author between October 2003 and October 2006 under the supervision of Dr Russell Mannion, who commented on the design, conduct of the project, analysis of the data and interpretation of results. However, the author is responsible for the research presented in this thesis.

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List of Abbreviations

CEO	Chief Executive Officer
CHI	Commission for Healthcare Improvement
DoH	Department of Health
HRM	Human Resources Management
LEA	Local Education Authority
MA	Modernisation Agency
ODPM	Office of the Deputy of Prime Minister
OFSTED	Office For Standards in Education
PCT	Primary Care Trust
PDT	Performance Development Team
PFI	Private Finance Initiative
PPP	Public Private Partnerships
SATs	Standard Attainment Tests
SHA	Strategic Health Authority
SMT	Senior Management Team

Chapter 1: Introduction

The principal aim of this thesis is to identify and explore the key factors associated with organisational failure and turnaround in NHS hospital trusts. This chapter presents an introduction and brief background to the research, outlines the objectives of the study and details the structure and organisation of the thesis.

1.1 Introduction

Over the last two decades, increasing attention has been given to reforming the financing, organisation and delivery of public services, with a wide range of strategies deployed by national and local governments to this end (Pollitt and Bouckaert, 2000). These strategies can be divided into two broad approaches: those that focus on the *external* environment within which public sector organisations operate; and those that target changes *internal* to these organisations (Jas and Skelcher, 2005; Boyne, 2003a; Martin et al., 2001). Public sector reform has generated increasing interest in organisational performance measurement and management in the public sector, not least in the US and the UK (Propper and Wilson, 2003; Turner et al., 2005). For example, according to the American National Government, as cited in the Performance Results Act of 1993, all federal departments and agencies were given a mandate to develop a five year strategic performance plan for measuring the performance of each programmed activity against allocated agency budgets, using a range of quantifiable performance indicators and measures (Kravchuk and Shack, 1996). These performance measures differentiated between organisations on the basis of their performance, and considerable variations between US public organisations were identified following an appraisal process of federal, state and local government services (Ingraham et al., 2003). In the UK, although a range of performance indicators has been incorporated into the management of the public sector since 1979 (Propper and Wilson, 2003), the new Labour Government has placed a much greater emphasis than its predecessors on measuring and managing the performance of public services (Boyne, 2003a). This government, elected in 1997, has sought not only to improve the efficiency and quality of services delivered but also to reduce inequalities in service provision, across population sub groups and between geographical areas (Jas and Skelcher, 2003; Boyne, 2006).

In consequence, the performance of UK public sector organisations has increasingly been subject to external systems of checking, verification and audit, and a range of

performance metrics of varying obtrusiveness has developed (Walsh et al., 2004; Goddard et al., 1999; Propper and Wilson, 2003; Micheli and Kennerley, 2005). A variety of reasons motivates the use of performance measurement and assessment (Harris, 1998). Mannion and Goddard (2002) identify four:

- " ensuring the accountability of health organisations and professionals to a range of external stakeholders;
- facilitating efficient market mechanisms by providing consumers with information on the relative performance of health care providers, and thereby creating incentives for providers to improve quality and performance;
- securing central government control of semi-autonomous agencies within devolved health systems;
- promoting continuous performance improvement within provider organisations by identifying opportunities for improvement through comparison both within the organisation overtime and between similar organisations."

To date, a range of comparative performance rating and scoring systems have been applied to UK public organisations in service areas such as education, health, and transport, ranking their performance from poor to high (Boyne, 2003a). Organisations unable to achieve a minimum level of acceptable performance, are 'named and shamed' and labelled as 'poor' or 'failing'. One example is the national performance 'star rating' system in the National Health Service (NHS), operating between 2001 to 2005 to rank the performance of NHS organisations ranging from zero star (poor performance) to three stars (good performance). The ratings were based on organisational performance against a range of key national targets and information provided by the Commission for Health Improvement and other regulatory agencies. The comprehensive performance assessment (CPA) is another example of a performance measurement system in the UK public sector that classifies the local governments into five categories (poor, weak, fair, good and excellent). Such schemes bring poor performance into the public domain and contribute to political pressure to improve or 'turnaround' poor performers (Joyce, 2004; Andrews et al., 2006). As a result of the public release of comparative performance data, poorly performing organisations are identified and exposed. The greater visibility given to problems associated with poor performance has led to an increased interest in understanding how organisations can shift from low to high performance. This performance improvement process is commonly termed 'turnaround' (Mordaunt and Cornforth, 2004; Joyce, 2004).

In order to improve the performance of failing organisations, it is crucial to understand the causes of organisational failure and the factors that lead to successful turnaround. There is extensive literature on the nature of organisational failure and turnaround in the for-profit sector, but in the public sector and particularly in health care settings, such evidence is sparse (Edwards et al., 2003; Boyne, 2006; Jas and Skelcher, 2003). Meire and Bohte (2003) maintain that the causes of organisational failure in the public sector have been subject to insufficient academic attention, and policy makers and managers lack robust evidence to guide the implementation of successful strategies (Boyne, 2006). Against this background, the purpose of the present study is to contribute a deeper understanding of the process of organisational turnaround in NHS Trusts.

1.2 Aim and Objectives of the study

The aim of this study is to contribute to a wider understanding of organisational failure and turnaround processes in health care organisations through an investigation of the organisational process that led to a significant improvement in the performance of a zero starred acute hospital Trust.

The specific objectives of the study are to:

- explore the symptoms of failure and factors that have contributed to poor performance in the Trust;
- explore the factors (triggers) that have stimulated performance improvement in the Trust;
- identify the turnaround strategies used by the organisation in the processes of performance improvement in the Trust;
- identify any unintended and dysfunctional consequences of turnaround strategies in the Trust;
- identify factors that facilitated (or impeded) turnaround strategies and interventions in the Trust;
- explore the applicability of stage models, developed in the for-profit-sector, for understanding and predicting performance improvement in health services;
- draw out general lessons regarding the most appropriate strategies to prevent, diagnose and turnaround 'organisational failure' in NHS.

1.3 Outline of thesis

The thesis is organised around nine chapters, which closely align with the 'stage' theoretical framework set out by McKiernan (2002). The stage framework is discussed in detail in Chapter 2. The outline of the rest of the thesis is as follows:

- **Chapter 2 Organisational failure and turnaround process: definitions, concepts and models**

Chapter 2 discusses organisational failure and turnaround processes, from the perspective of a range of theoretical frameworks and conceptual models. The burden of the emphasis here is on the for-profit sector, from which most of the theories and empirical evidence are derived. Different definitions, symptoms, causes and the diagnosis of organisational failure are discussed using a range of theoretical perspectives. The concept of turnaround, turnaround 'stage' framework, turnaround interventions and their consequences are also discussed. In addition, where relevant, these concepts are examined within the context of public service delivery. The rationale for selecting McKiernan's stage model for conducting this empirical research is also set out. The concepts, models and theories, discussed in Chapter 2, are used later in the thesis in both Chapter 3, which provides conceptual background for conducting a comprehensive review of the public sector literature in this area, and in the chapters reporting and discussing the findings of the empirical phase of this study (Chapters 5, 6, 7 and 8) by providing a basis to interpret the empirical evidence.

- **Chapter 3 Organisational failure and turnaround in the public sector: a review of the evidence**

Chapter 3 presents the results of a comprehensive review of the literature on organisational failure and turnaround across a range of public services, with a particular focus on health care provision. The conceptual background detailed in Chapter 2 is used to organise, report and interpret the findings of the studies included in the review. A summary of the findings, key theoretical frameworks and key research methods related to the selected studies, and gaps in the existing empirical evidence, are reported. In particular, the symptoms and causes of organisational failure are presented, together with triggers for change, turnaround interventions and their consequences. The differences between the public and for-profit sectors in this regard are also examined.

- **Chapter 4 Research methodology**

Chapter 4 details the methods used in the empirical study: study design; sampling; data gathering; and analysis. A detailed explanation of the case study approach (the research strategy used in the study) and the 'Framework analysis' (used to analyze the qualitative data) are presented. The NHS 'star' performance rating system is outlined and star rating is used as a key indicator of organisational performance in the study. Validity, reliability and ethical issues (e.g. confidentiality and consent) are also outlined. The findings of this empirical study are presented in three sequential chapters which reflect the progressive nature of organisational failure and the turnaround processes within the 'stage' framework.

- **Chapter 5 Findings: organisational failure- symptoms and causes of failure**

Chapter 5 presents the findings regarding the symptoms of failure in the case study organisation and explores the factors that contributed to the failure of the Trust (both secondary and primary factors are addressed). In addition, the responses of staff to the announcement of the Trust's zero star rating are presented.

- **Chapter 6 Findings: triggers for change**

Chapter 6 presents the case study findings regarding the diagnosis of poor performance and the triggers for change in the Trust. The reactions of newly appointed managers to organisational failure are presented and the role of internal and external factors in initiating the process of change is explored at length.

- **Chapter 7 Findings: turnaround process- turnaround interventions and their consequences**

Evidence relating to the turnaround process in the Trust is presented in Chapter 7. The range of interventions and strategies deployed to improve the Trust's performance are explored and interpreted using the '3R' model (Boyne, 2004a). The impact of interventions and factors that facilitated or impeded the implementation of turnaround strategies are also discussed at length. The unintended and dysfunctional consequences of these interventions and their impact on staff, patients and delivery of services are also outlined.

- **Chapter 8 Discussion**

Chapter 8 draws together an overall summary of the evidence presented in previous chapters. These finding are compared and contrasted with the extant literature in the field and key similarities and differences are presented. It also examines the applicability of the 'stage theory', in the health sector and discusses whether the theory is well suited to understanding the process of change in the health sector.

- **Chapter 9 Conclusion, policy and research implications**

The final chapter sets out the overall conclusions of the study and discusses the policy and research implication of this research.

Chapter 2: Organisational failure and turnaround process: definitions, concepts and models

2.1 Introduction

There are major debates concerning the theoretical basis for understanding organisational failure. As most of the literature in this area is derived from the for-profit sector, particularly in the USA, the majority of definitions and theoretical models relate to this sector. The aim of this chapter is to define organisational failure and turnaround within the context of various theoretical frameworks and conceptual models. Although there is far less academic literature on public service organisations, the definition of these terms and their applicability to the public sector are also considered.

This chapter comprises the following sections. Section one outlines the concept of organisational failure and as this is closely related to performance, conceptualisation of performance and performance measurement are also discussed. Section two focuses on symptoms and causes of organisational failure and triggers for addressing failure. Section three discusses theoretical models, interventions and outcomes related to the turnaround process.

2.2 Definition of organisational failure

In the literature, there is no clear, consistent and objective definition of what represents 'organisational failure' and as a consequence, it is a subjective and contested term. Researchers and practitioners have described it variously as: decline; organisational mortality; organisational death; organisational exit; crisis; fiasco; and bankruptcy (Mellahi and Wilkinson, 2004).

Pandit (2000) defines failure as an 'existence-threatening decline' in the performance of a firm. Hambrick's (1985) definition is 'one in which business performance is persistently below some minimally acceptable level'. This definition shows that 'failure' is shaped by three elements: performance; the minimum acceptable level of performance; and performance which is 'persistently' below this acceptable level. These are now discussed in turn.

2.2.1 Organisational performance and performance measurement

Defining and measuring organisational performance is problematic, not least because for any organisation a wide range of performance criteria may apply (Palfery et al., 2004). Steer (1975) indicates that early empirical work in this area used a narrow measure of organisational success. However, organisational performance was later recognised as a multidimensional construct, and to capture its complexity a wide range of measures should be considered (Cameron, 1986; Boyne and Dahya, 2002).

Turnaround studies in the business sector have tended to define and measure performance in terms of financial criteria (e.g. profitability and rate of return on investment) (Hoffman, 1989; Boyne, 2004b). Decline and improvement in performance is usually judged against these criteria, although this approach may disregard important non-financial performance criteria that apply to the for-profit sector, such as corporate social responsibility, the welfare of staff and impact on the environment (Palfery et al., 2004) and stakeholders' opinions (Lohrke et al., 2004).

The performance of public organisations is even more complex and difficult to measure, (Jas and Skelcher, 2005; Boyne, 2004b) especially in a multi-agency and multi-layered organisation such as the NHS (Mannion et al., 2003). Rainey (1997) states that the multiple goals of public sector organisations are politically motivated and contested. Stakeholders continually judge the performance of an organisation from their own perspectives (Kimberley et al., 1983; Cameron, 1986). In any public organisation, there are a range of different internal and external stakeholders, such as consumers, providers, national government, regulators, and tax payers, each with a legitimate interest in organisational performance and each with a different viewpoint on what constitutes 'good' (or poor) performance (Appleby et al., 2002; Mannion et al., 2003; Boyne and Dahya, 2002). Even when stakeholders have the same criteria, they may weight them differently in importance (Boyne, 2004b), resulting in a variety of evaluations of the performance of an organisation (Mannion and Goddard, 2002). Conflict of interests and views among stakeholders is inevitable and, in many public sector services, it is difficult to establish a clearly agreed definition of performance (Shaw, 2003). Connolly et al. (1980) indicate that an organisation is likely to be viewed as a good performer if it can satisfy the demands of its key stakeholders.

The 'Competing Values Framework' (CVF) of organisational effectiveness developed by Quinn and Rohrbaug (1981, 1983) can be used to describe a political perspective on the performance of organisations. As illustrated in figure 2.1, two major dimensions (axes) generate four quadrants when they are intersected. The first dimension relates to the focus of the organisation, ranging from an internal emphasis on the well being and development of its staff to an external emphasis on organisational survival. It indicates where the location of power to define organisational performance: inside or outside the organisation (Boyne and Dahya 2001). The second dimension (axis) indicates the preference of the key stakeholders for structure, ranging from flexibility to control. Each of the four quadrants characterises a concept of organisational performance: open systems, rational goals, human relations, and internal processes.

The 'open system' model places prominence on flexibility and has an external focus, using performance criteria such as growth and resource acquisition and political support. The emphasis of the 'rational goal' is on control and the external position of power, using planning, goal setting and achievement and with productivity and efficiency as performance criteria. The 'human relations' model stresses the internal locus of power and flexibility, with an emphasis on cohesion, morale and development of human resources. It encourages participation and involvement of staff. The 'internal process' model accentuates control and the internal position of power, relating performance to stability and control, with information management and communication carrying most weight.

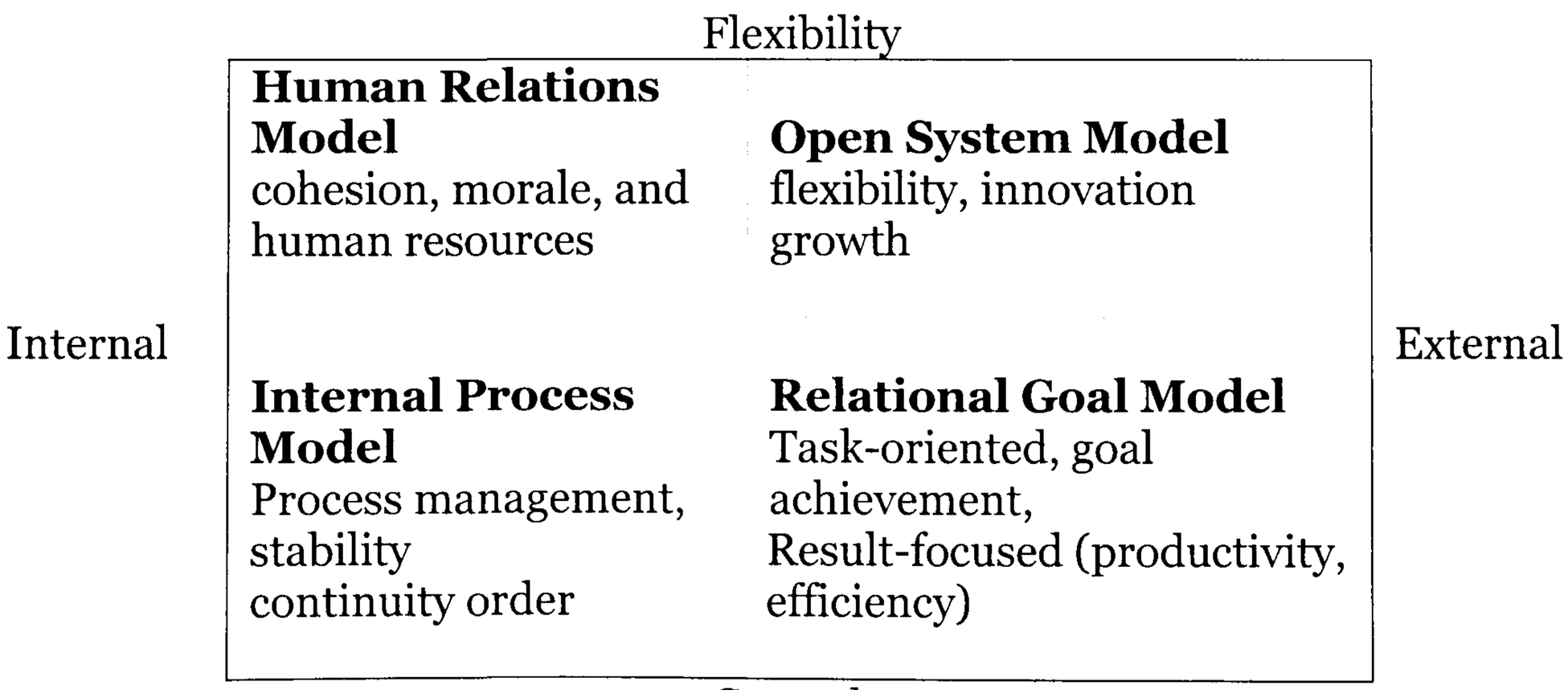


Figure 2.1 The Competing Values Framework of organisational effectiveness

adapted from Quinn and Rohrbaug (1983)

Although each of these dimensions is likely to be present in any organisation, certain political groups, with their preferred performance criteria, may predominate. For example, the current performance regime of the UK public sector reflects the 'rational goal model'. Public organisations in the UK (e.g. schools and hospitals) are currently under tight external regulation (a focus on control) from government agencies (powerful external stakeholders), in order to achieve explicit and quantifiable targets. The power to define performance measurement is clearly externally rather than internally located (Boyne and Dahya, 2001).

Mannion et al. (2003) discuss the particular difficulties and challenges in the measurement of organisational performance in the NHS, outlining the wide range of measures that can be used to assess health care performance depending on the purpose and particular audience in question (e.g. clinical outcomes, patient satisfaction, staff variables, productivity, equity etc). Assessing comparative performance across health care organisations is a difficult task, given the range of technical problems involved. For example, the data may be incomplete or inaccurate and the quality of available data may be poor (having a low level of validity and reliability). There are also difficulties in the risk adjustment of data. Smith (2005) stresses that mode of presentation, precision and timeliness of performance data can affect the value of the data for different end users. Discrepancies may also arise from 'hard' information contained in league tables (quantitative data) and 'soft' intelligence information (qualitative data) disseminated via informal professional networks (Goddard et al., 1999). These difficulties have led to serious problems in providing objective measures of health care performance and similar issues arise in the definition and measurement of performance in other public sector organisations, such as schools and local government services.

The inference from the above research is that a single measure of performance is unlikely to satisfy the needs of all end users. In the UK, the government applies composite indicators, which integrate a range of criteria, into a single measure in order to compare the performance of the organisations (e.g. star ratings in the NHS and Comprehensive Performance Assessment (CPA) for Local Government). Star ratings are discussed in detail in chapter 4.

2.2.2 Minimal acceptable level of performance

The acceptable level of performance is a key issue in Hambrick's definition of failure, though Harvey (2005a) argues that setting a point at which a poor performance situation becomes organisational decline is problematic, particularly when the organisation or external assessors use different sets of indicators to assess their performance. The business literature demonstrates that some managers achieve an acceptable level by setting lower performance thresholds in order to maintain or advance their personal reputation. In any objective analysis, it is important to consider who defines the level of acceptable performance in an organisation (Boyne, 2004b), this being even more problematic where the indicators and their underlying objectivity under criticism and public debate.

2.2.3 Definition of persistent poor performance

Nash (2002) argues that setting a specific period of time to identify persistently poor performance is a contested issue. Poor performance over a time period of between 2-4 years is commonly regarded in empirical research in the for-profit sector as 'persistently' poor performance (Lohrke and Bedeian, 1998). However, organisational decline may occur within a much shorter timescale as a result of unexpected or extraordinary events (Balgobin and Pandit, 2002). Most of the turnaround studies in the private sector use an annual performance assessment to evaluate an organisation performance. Boyne (2004b) maintains that the 'periodicity' of failure in the private sector is related to the nature of the services provided and the frequency of collecting, monitoring and publishing these data. He argues that, in the public sector, the time period over which persistent decline should be measured needs to be more flexible than in the private sector. For example, an annual performance assessment might be appropriate for a school, but in a hospital setting, a consistently high death rate over a short period of time (e.g. a month) requires more immediate consideration.

It is important to distinguish between a temporary decline in performance and a long-term failure. Miller (1994) states that even high performance firms can experience a short-term decline in attainment. Some commentators argue that such situations may be used as a learning opportunity to inform long-term success (Donaldson, 1999; McKiernan, 2002). However, organisations may see further decline if they do not respond to the performance problems through appropriate remedial and corrective action (Boyne, 2004b). A short-term decrease in the success of an organisation is not normally considered to be decline, but if the organisation

does not instigate strategic change, but continues to pursue its current strategy, 'organisational death' may occur, either through bankruptcy or takeover by other firms (Slatter, 1984).

2.2.4 Concept of failure in the public sector

As noted previously, studies conducted in the private sector tend to use financial criteria to measure performance and to track the decline of an organisation. In the public sector, difficulties with the definition and measurement of performance make defining failure more problematic (Walshe, 2004; Mordaunt and Otto, 2004). In the UK public sector, a combination of formulae and discretionary judgements are currently in use to define failure (Boyne, 2004b). Although different performance indicators are considered in the assessment of some public organisations (e.g. hospital star ratings), significant discretion from external assessors also plays an important role in the final judgement (Bache, 2003). Boyne (2004b) argues that on balance, it is judgment that carries more weight than standard formulae in the labelling of failing organisations in the UK public sector.

Pandit (2000) defined failure as an 'existence-threatening decline' in the performance of a firm. In the public sector, Pandit's definition is more difficult to apply, because 'existence –threatening' is not usually an issue for poor performers in the same way as in the private sector (Walshe, 2004). A public organisation such as a hospital or a school is unlikely to be dissolved completely (Kaufman, 1976), as it has a commitment to provide a range of services for the population and it is often politically insensitive to 'exit' the market (Jas and Skelcher, 2005). Consequently, the risk of closure or takeover is far less of an incentive to act than in the private sector (Boyne, 2004b). Meyer and Zucker (1989) in their typology classify poorly performing public organisations as "high persistence, low performance" organisations. They argue that in the public sector "social constraints impede the operation of economic or economic-like forces that would sustain high performing organisations and shut low performers." (Meyer and Zucker, 1989: 115), so these organisations continue to operate until positive changes are taken to address the poor performance (Jas and Skelcher, 2005). Nevertheless, public agencies do not always survive and poor performing public sector organisations may be merged with similar public organisations, be subject to privatisation or 'outsourcing', or split into smaller units (Boyne, 2004b).

According to the political perspective, public services failure arises when "key stakeholders are so dissatisfied that the continued existence of an organisation as a

separate entity is threatened" (Boyne, 2004a). When the performance of an organisation is not able to satisfy the expectations of its key stakeholders, legitimacy and support is likely to decline (Jas and Skelcher, 2005). Edwards et al. (2003) state 'in the NHS failure is possible through simply not moving forward sufficiently quickly'. However, there is obvious ambiguity in this definition and different stakeholders may have contrasting perspectives on failure and the speed of change. Jas and Skelcher (2005) argue that it is rare to see the total failure of a multi-functional organisation. Indeed, they cite examples of good performance within UK local authorities rated as poor performers. They also emphasise that in public organisations, the performance curve appears to be cyclical rather than linear, meaning that performance needs to be assessed in terms of the stage in the cycle an organisation finds itself. In brief, any assessment of organisational failure and turnaround needs to take into account a range of dimensions of the performance (e.g. efficiency, effectiveness, and equity) and the perception of their relative importance in order to judge whether or not a public organisation is in decline and in a turnaround situation (Boyne, 2004b).

2.3 Routes to failure

D'Aveni (1989) states that decline can occur suddenly or gradually. Although decline could be occasioned by a single event, some researchers consider the process as the product of a series of causal events. A range of models have been developed to explain decline. Weitzel and Jonsson's (1989) model separates decline into five sequential stages: blinded, inaction, faulty action, crisis, and dissolution. Table 2.1 details these stages and the corresponding organisational action that leads to them. Except for the dissolution stage, all are reversible if the organisation addresses the problem appropriately and within an acceptable time period.

Table2.1 Stages of organisational decline and corresponding organisational action

Stages	Organisational action
1. Blinded	Failure to anticipate or detect pressure toward entropy; decline begins
2. Inaction	Failure to decide on corrective action; decline becomes noticeable
3. Faulty Action	Faulty decisions; ineffective implementation of decisions
4. Crisis	Given faulty-action stage and unforgiving environment, last chance of reversal. Given forgiving environment, slow erosion
5. Dissolution	Given crisis stage and unforgiving environment, rapid demise. Given forgiving environment, slow erosion

Source: Weitzel, W. and E. Jonsonn (1989) 'Decline in Organisations: A Literature Integration and Extension' Administrative Science Quarterly 34, pp 97

McKiernan (2002) outlines a number of behavioural characteristics which commonly accompany organisational failure in the business sector. At first, the existence of a major problem may be rejected or concealed by managers (ignorance phase). When the problem continues and becomes evident to external and internal stakeholders, the senior managers try to relate the decline to other parties or external factors beyond their control in an attempt to transfer the blame (blaming others). Managers may even manipulate some of the information to give the impression of a better performance (information disguise) than is actually the case. Evidence shows that good managers become disillusioned and tend to leave when they perceive that there is no future for the organisation with the current weak managerial team, thereby worsening the situation for that particular organisation (managers tend to exit). Finally, the top management team, especially the CEO, may be replaced due to a loss of faith by external stakeholders in the present style of management.

Slatter (1984) delineates a model to understand crisis development. This is comprised of four stages: crisis denial; hidden crisis; organisational disintegration; and organisational collapse. He concludes that the consequence of the final stage is either failure or successful recovery depending on the action of the organisation, the latter usually being achieved by a new manager(s). It is important to find the main reason(s) behind the first stages of decline (occurring symptoms of decline) and this cannot be accomplished unless subtle scrutiny of organisational development takes place early enough in the process.

2.4 Definition of turnaround

Pandit (2000) defines organisational turnaround as "the actions taken to bring about recovery in performance in a failing organisation". He argues that the results of successful turnaround strategies vary. On a sliding scale, the lowest acceptable baseline for the organisation's stakeholders is 'survival' – the highest reflects 'sustainable' performance improvement.

In this process, organisations are often engaged in a range of short, medium and longer-term activities to develop their managerial and leadership capacity and capability, deal with operational problems immediately, reshape their structure and consider new strategies to assure their long term success (Harvey, 2005a). The

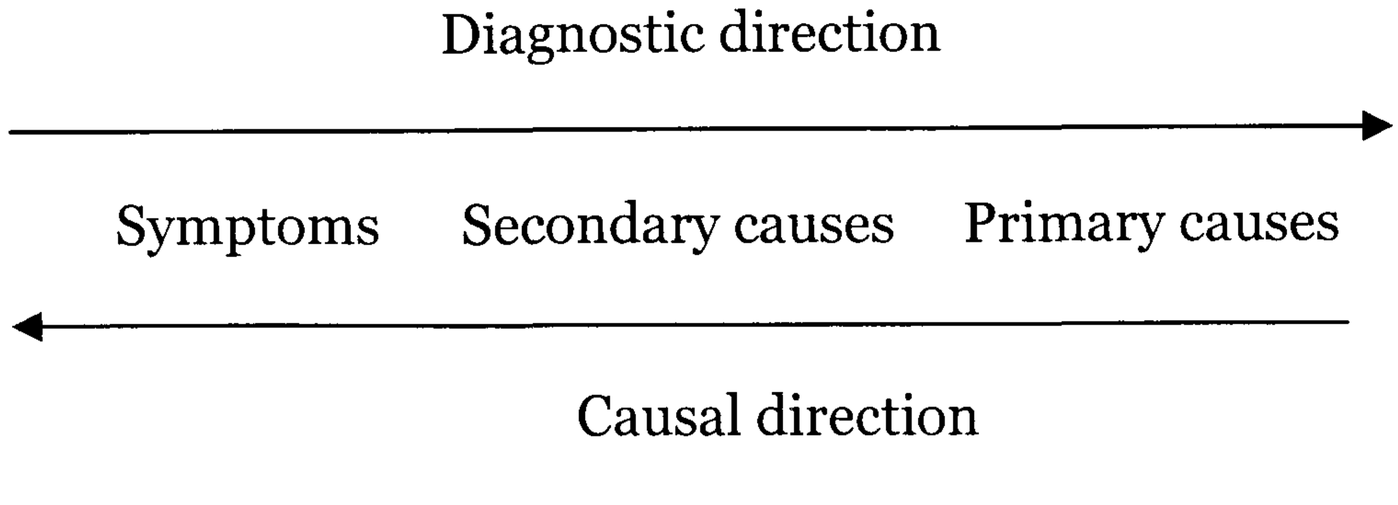
results of a successful recovery range from what the organisation's different stakeholders would consider merely acceptable economic performance to achieving sustainable, more highly competitive situations in the market (Balgobin and pandit, 2001). Temporary performance improvement in a poorly performing organisation is not referred to as 'turnaround' and an organisation is required to show continuous performance improvement.

The business literature reveals that the frequency of performance turnaround situation among firms is rising and surprisingly, the turnaround activities for organisations suffering considerable and/or chronic decline in performance result more in failure than recovery (Pandit, 2000). Poorly performing organisations in the UK public sector, which need turnaround activities, have also become more evident with the rise in external systems of checking, verification and audit.

2.5 Symptoms of organisational failure

Various symptoms and causes of organisational failure are identified in the literature (Mone et al., 1998; Hambrick and D'Aveni, 1988; D'Aveni, 1989; McKiernan, 2002). In McKiernan's framework (2002), he differentiates symptoms from causes of decline, whilst other researchers conflate these terms (Harvey et al., 2005a). Three separate, although inter-related, levels of organisational failure are categorised in McKiernan's model: 1) symptoms; 2) secondary causes; and 3) primary causes of failure. These are illustrated in figure 2.2.

Figure 2. 2 McKiernan's model of failure



McKiernan, (2002), developed from Neumair (1998)

McKiernan proposes that symptoms are the initial observable indicators of the presence of a problem in an organisation, and classifies these in to four categories:

- Physical (e.g. supply difficulties, lack of investment in new technologies, product failure)
- Managerial (e.g. managerial paralysis, lack of leadership, board conflict)
- Behavioural (e.g. ignoring problems, culture of cynicism and fatalism, lack of strategy, attitude)
- Financial symptoms (e.g. decreasing profit, increasing debts, declining in demand, high level of financial competition).

Mellahi and Wilkinson (2004) also identify a range of symptoms of failure in the for-profit sector through their broad literature review including: shrinking financial resources; negative profitability; shrinking market; exit from international markets; and severe market share erosion.

McKiernan (2002) argues that financial symptoms are more easily distinguished and measured than symptoms relating to 'human' and 'organisational' capital. Public domain and external stakeholders may have easier access to the former than the latter, which are likely to be found in internal reporting systems and may be disseminated by top managers with some discretion. However, financial problems and their severity can be consciously obscured through vague financial reporting (McKiernan, 2002). Slatter and Lovett (1999) refer to the difference between reported performance and actual performance of an organisation as the 'reality gap'. Early detection of the symptoms of failure may help organisations to recover. Adequate management consideration of these markers may result in identification of the causes of the problem and appropriate corrective action being taken during the early stages.

2.6 Causes of organisational failure

A running debate in the business literature has concerned the exact causes of organisational failure (Mellahi et al., 2002). McKiernan (2002) classifies the sources of the failure in the business sector into two broad groups: secondary and primary. Secondary causes are a combination of internal and external factors and decline can be related to multiple secondary causes. McKiernan (2002) suggests three further categories within the secondary causes, including financial (largely internal such as absence or inadequacy of cash flow forecast, costing systems, and budgetary control),

demand (largely but not entirely external), and managerial (internal such as poor management, especially at CEO level).

McKiernan (2002) relates all symptoms and secondary causes of failure to primary causes, pointing out dysfunction in terms of failure in organisational learning processes, as the primary cause of failure. He argues that the inability of the organisation to make proper use of available information to learn about themselves and their environment causes performance decline and failure. He cites a variety of reasons for problems with the learning process, including lack of experience (especially in young organisations), over confidence, complacency, and rigid thinking within the organisation. For example, in the case of 'rigid thinking', organisational members behave and act on the basis of a prevailing belief system (paradigm) and follow routines which have become embedded and entrenched over time. These comprise the central element of the culture of an organisation, so any changes or learning processes not compatible with the paradigm, may be disregarded. In consequence, organisations that are unwilling to challenge their dominant belief systems may not be able to adapt to environmental changes and these can ultimately cause the organisation to fail (Protopsaltis et al., 2003). Some organisations may diagnose problems but do not take corrective action sufficiently early perhaps , because of the presence of powerful routines that channel managerial responses. Typically, such organisations use existing rules and routines as comfort zones and resist change (McKiernan, 2002).

A review of the literature by Balgobin and Pandit (2001) reveals a clear agreement in the findings of cross-sectional studies for the causes of decline in the business sector. He highlights several inter-connected causes, of which three internal and three external are identified in all the studies. The three external causes are: *decline in demand; increase in competition;* and *increase in input costs* (e.g. salaries, raw materials, and number of personnel exceeding the organisation's resources).

The first internal cause of failure is poor management (e.g. an inadequate CEO; inadequate balance of skills and knowledge at the top level; management problems; poor quality of management; lack of participative boards; insufficient depth in middle management). A study conducted by Grinyer et al., (1990), identified poor management as the cause of failure in 45% of their sample of UK companies of different sizes, experiencing different levels of industrial decline but which, subsequently, presented a process of sharp and sustained recovery. The second cause

is inadequate financial control (e.g. a very conservative financial plan; high debt/equity ratio and improperly financed resources) (Slatter, 1984). The third cause is high cost structure (e.g. operating insufficiency, high overheads, and scale effects as three elements of high cost structure in 35%, 30% and 28% of Slatter's (1984) sample, respectively).

Bibeault (1982) found that 67 % of failure in his samples from the private sector was related to internal factors, 9% to external factors alone, and 33% to a combination of external and internal causes.

Mellahi and Wilkinson (2004) identified different perspectives through a comprehensive literature review on the causes of organisational failure: a Deterministic view including Industrial Organisation (IO) and Organisational Ecology (OE) on one hand and a Voluntaristic view comprising Organisational Studies (OS) and Organisational Psychology (OP) on the other.

Industrial Organisation refers to the economic theory of market competition and strategies used by firms. Organisational Ecology refers to a sociological tradition that studies the evolution of organisational populations. Both these perspectives emphasise the external environment as the cause of organisational failure (Mellahi and Wilkinson, 2004) and ignore internal factors, such as the threat of the rigidity effect and structural inertia (Witteloostuijn, 1998). Although these perspectives differ in some areas, both presume a deterministic role for the environment and argue that exogenous industrial and environmental restrictions constrain managers in their strategic choices. They argue that in many circumstances managers have little or no control over external factors that cause organisational failure (Mellahi and Wilkinson, 2004). On the other hand the Voluntaristic perspective sees internal factors as the main causes of failure (Cameron et al., 1988). Figure 2.3 maps four perspectives and their related concepts to organisational failure. Each discussed in detail below.

2.6.1 Industrial Organisation perspective (IO)

The Industrial Organisation perspective (IO) supposes that organisational failure is caused primarily by changes in the external environment, which are the result of a range of technological, economic, regulatory and demographic factors (Scott, 1992). A range of studies has highlighted the effect of the environmental factors on firms' performance (Robbins and Pearce, 1992; Melin, 1985; Zammuto and Cameron,

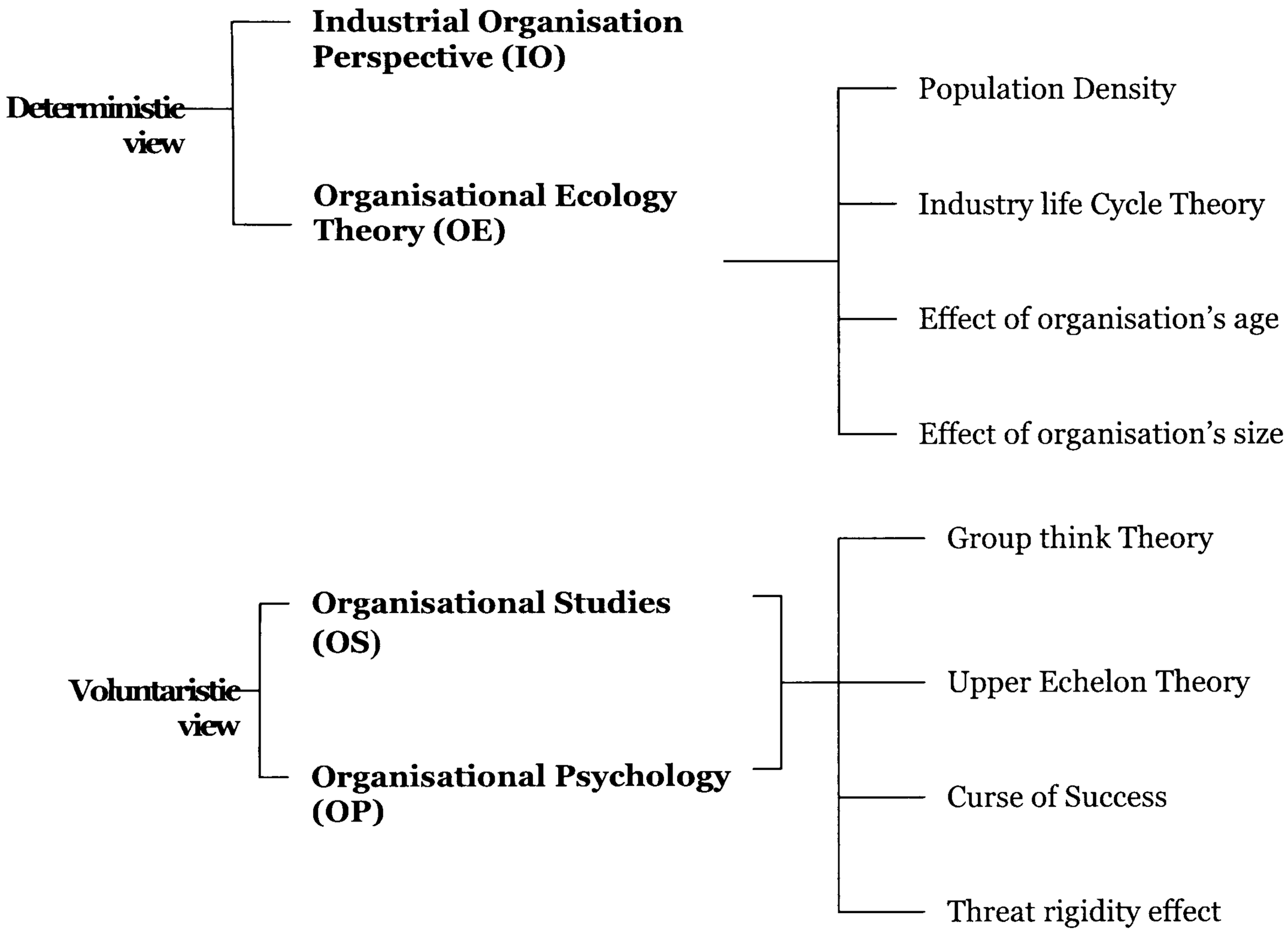
1985). Mellahi and Wilkinson (2004) illustrate some of the main causes of organisational decline according to the Industrial Organization (IO) literature, including 'turbulent demand structure' owing to 'brand shifting' by the main clients, changes in customer taste, declining demand.

Three different dimensions, which describe the industrial environment, are used to explain the relationship between an organisation and its environment: dynamism; munificence; and complexity. 'Dynamism' refers to an uncertain environment resulting from the extent of change and difficulty in predicting change. The term 'Munificence' refers to the extent of available resources. 'Complexity' illustrates the extent of heterogeneity and range of an organisation's functions, which reveal the extent of linkage, both internal and external (Dess and Beard, 1984). Mellahi and Wilkinson (2004) argue that dynamism and complexity have a positive correlation with the 'organisational death rate' and suggest that there is an adverse relationship between munificence and the 'organisational mortality' rate. However, Anderson and Tushman (2001) indicate that uncertainty (dynamism) is a considerably more serious problem than the other two.

2.6.2 Organisational Ecology theory (OE)

Organisational Ecology theory (OE) applies a natural selection model to organisational dynamics. It is based on a biological analogy, in which organisations scan the environment and compete and recognise situations, mechanisms and processes underlying emergence, growth, regulation and demise (Hannan and Freeman, 1989). OE emphasises the understanding of reciprocal relationships between populations and communities containing organisational ecosystems (Baum, 1996). It presumes that other institutions can affect the rate of success or failure of an organisation (Mellahi and Wilkinson, 2004). According to the OE perspective, organisational failure is related to four main factors: population density; industry life cycle (ILC); the organisation's age; and its size (Mellahi and Wilkinson, 2004). A brief explanation of these four factors is presented below.

Figure 2.3 Perspectives on the causes of organisation failure and their related concepts



Source: Mellahi and Wilkinson (2004)

2.6.2.1 *Population density*

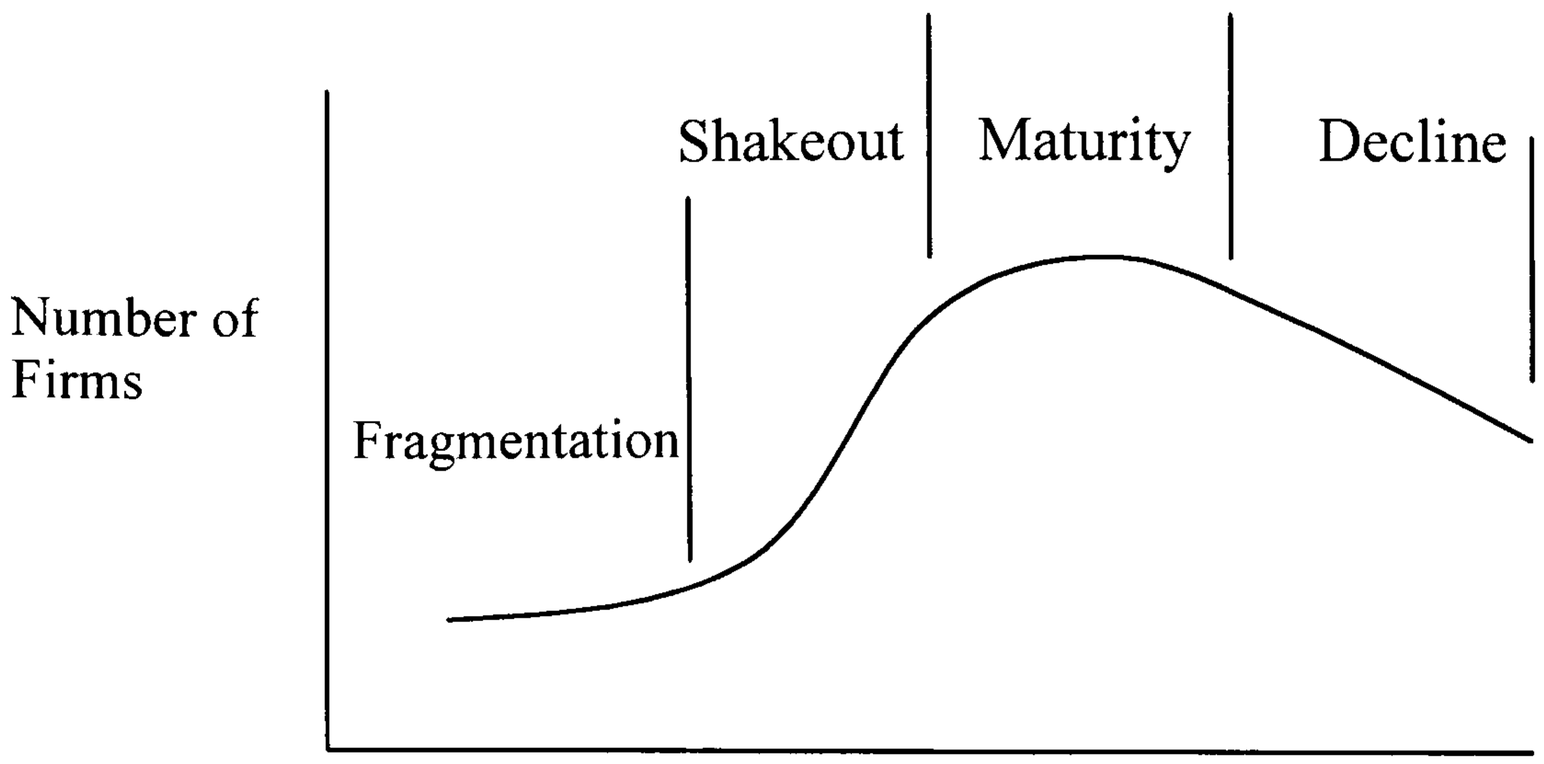
The total number of organisations within the relevant population in the market (population density) can indicate the expected failure rate. In the private sector, the relationship between population density and the probability of failure has been found to be U-shaped (Hannan and Freeman, 1988a). There are two key mechanisms with two opposing effects- legitimation (the recognition of the group of organisations) and competition (justification of the effect of population density on the failure rate). Organisational death begins at a high level and drops when legitimacy rises, then rises when the competition rate increases. An escalation in the number of organisations within a population results in raising the legitimacy of the population and consequently causes greater absorption of resources by those organisations. This decreases the failure rate. Before reaching legitimacy, the number of organisations is fairly small. They cannot attract resources, so a high rate of failure may result. But, when the number of organisations increases in a way that boosts competition for resources, the failure rate will rise because of the increasingly competitive environment (Hannan and Freeman, 1989 - cited in Mellahi and Wilkinson, 2004).

Dobrev et al. (2001) state that the location of an organisation in the market can affect the failure rate once the population density rises. In this situation, organisations in the centre of the niche market are more likely to fail than those on the periphery.

2.6.2.2 *Industry Life Cycle (ILC) theory*

ILC theory explains that businesses move through a predictable sequence of developmental phases (Klepper, 1997). Several variants on the number and definition of the life cycle stages can be found in the literature. Figure 2.3 depicts one of the examples shown in the curve of the Industry Life Cycle (ILC) stages. Industry Life Cycle (ILC) theory presumes that all organisations move irreversibly towards the equilibrium of death through different stages (Boulding, 1950). In consequence, organisational failure is considered a natural and objective event, the outcome of factors such as saturation of demand, running out of supplies, and introduction of new technology (Mellahi and Wilkinson, 2004).

Figure 2.4 Industry Life Cycle (ILC), Mellahi and Wilkinson (2004)



2.6.2.3 The effect of organisation's age

Mellahi and Wilkinson (2004) show that the expected probability of failure among young organisations is higher than among similar, but more established and more mature organisations. They apply 'liability of newness' theory and 'adolescence' theory to explain this phenomenon. Henderson (1999) states that rates of decline ultimately decrease as the age of an organisation increases. The high rate of failure in younger organisations is caused mainly by inadequate or lack of formal organisational structure, unstable relationships with customers and a lack of attention to the necessary costs involved in learning new tasks and processes. Also, insufficient investment in creating new roles, the conflict such roles present and the lack of organisational stability contribute to a higher risk of failure in younger organisations (Mellahi and Wilkinson, 2004). Aldrich and Auster (1986) outline some key constraints that affect new organisations, such as government regulations, tax laws, increasing capital, and competition for labour.

2.6.2.4 Effect of organisation's size

Empirical findings support the view that mortality rates decrease with increased size (Ranger-Moore, 1997). According to the liability of smallness theory, small firms are more susceptible to failure than larger ones because of inadequate resources, problems in competition for premium labour supplies, and higher administration costs (Aldrich and Auster, 1986). Furthermore, Baum (1996) illustrates that small firms do not have adequate legitimacy with external stakeholders. In contrast, larger organisations have access to more resources, are able to recruit more highly skilled

staff (Aldrich and Auster, 1986) and possess greater political authority (Ranger-Moore, 1997). However, some researchers argue that larger size may increase organisational inertia, including inadequate responses to environmental changes, resulting in a higher risk of failure (Ranger-Moore, 1997).

2.6.3 Criticism of the deterministic view

In general, OE perspectives place more emphasis on the role of industry/population than on the firm's internal strategies and relate the performance of organisations to the environments within which they exist. Environmental factors are viewed as the main cause of both the birth and demise of organisations. However, this perspective cannot explain why, in the same environment, some organisations fail while others succeed. In addition, some studies have found that organisational strategies have a more significant role than environment as the main determinants of performance (e.g. Harrigan, 1980; Meyer, 1982). They maintain that IO/OE perspectives alone cannot justify the failure of an organisation, except in cases affected by very extreme external factors. Therefore, internal factors should be taken into account when attempting to explain the failure process (Mellahi and Wilkinson, 2004).

2.6.4 Organisation Studies and Organisational Psychology

The Organisation Studies (OS) and Organisational Psychology (OP) perspectives view failure and success as a result of internal rather than external and environmental factors (Cameron et al., 1988). They focus on the role of managers as the key decision makers in a firm and assess their ability to react to external factors (Mellahi et al., 2002), rejecting the IO/OE perspective that assumes managers are powerless in determining organisational performance.

Mone et al. (1998) emphasise that managers' perceptions of the external environment influence the way in which organisations are managed. Mellahi and Wilkinson (2004) conclude that managers' personal characteristics and erroneous perceptions may cause organisational failure. However, they argue that organisational decline cannot be explained by any grand theory in the OS/OP literature and outline middle range theories including: Groupthink theory; Upper echelon theory; Curse of success; and Threat rigidity effect. Each of these internal causes of failure is discussed in turn below.

2.6.4.1 Group think theory

Janis (1972, P. 286) developed the 'Groupthink' theory, defining it as "a mode of thinking that people engage in when they are deeply involved in a cohesive in-group, when the members' strivings for unanimity override their motivation to realistically appraise alternative courses of action". He states that such consensus- seeking in a group may result in sub-optimal decision-making. Groupthink practice is likely to be exhibited under the following conditions: the presence of a highly cohesive group (members with similar backgrounds); existence of an isolated external group with contrary views; presence of a directive leader who discloses his or her desires; and absence of a clear decision making process in the group (Janis, 1972). Janis (1972) reports that, according to group thinking, people in the group assume that they comprise a harmonic group and that the decisions they make are moral and ethical. They view themselves as invulnerable and are overconfident regarding the success of the decisions they have made. Information is not processed accurately and external information is disregarded by such teams, where self-censorship is practiced. Performance decline and the consequent organisational decline are likely results of this kind of thinking and decision making process (Peterson et al., 1998).

2.6.4.2 Upper Echelon Theory

'Upper Echelon' theory (Hambrick and Mason, 1984) relates organisational outcomes - strategic choice and organisational performance - to the characteristics of their managers. The composition of the top management team and managerial succession are considered to be two important factors contributing to organisational failure (Mellahi and Wilkinson, 2004).

The response of the senior management teams to their firms' decline is influenced by different factors: homogeneity of the senior management team (Pitcher and Smith, 2001; Ferrier et al., 2002; Ferrier and Lyon, 2004); tenure (Mone et al., 1998; Miller, 1991); and the functional background of senior managers, especially the CEO (Zimmerman, 1989). In terms of tenure, the literature highlights the difference in reaction to the causes of failure in a crisis situation (e.g. external threat) on the part of new management and long-tenured managers. New managers tend to relate failure to internal factors (Mone et al., 1998), while long-serving managers typically blame external factors, deeming them transitory and beyond their control. Managers with longer tenure tend to ignore internal factors and are highly committed to the

existing routines. They are also apt to rely only on a limited source of information, fail to investigate warnings and challenges facing them, and do not respond to environmental changes (Wiersma and Bantel, 1993; Mellahi and Wilkinson, 2004). In Miller's (1991) view, such senior managers may become 'stale in the saddle', leaving their organisation to face severe problems which result in failure. The evidence shows that heterogeneous groups (members with different backgrounds) react better than homogenous groups in uncertain and turbulent environments. However, some researchers argue that in a crisis situation, where timely decisions are important, a homogenous group can make decisions more quickly (Mellahi and Wilkinson, 2004). Ferrier and Lyon (2004) notes that less homogeneity among senior management teams results in the reduction of the range of strategic actions carried out by failing organisations.

Mellahi and Wilkinson (2004) state that different effects of succession on organisational failure are identified in the literature. When the composition of the firm's top management is changed, it is referred to as the executive succession. The appointment of new executive can affect strategic decision-making processes (Wiersma, 1992). Some studies show a higher probability of failure through the succession process, especially when it occurs in small organisations (Alexander and Lee, 1996) or in their early stages (Carrol, 1984). Insufficient experience in working with succession is the cause of this failure (Mellahi and Wilkinson, 2004). However, the positive effect of succession on the performance and survival of organisations has been addressed, especially in turbulent environments (Virany et al., 1992). In addition, Helmich (1974) argues that outsider successors are more successful than those internal to the firm.

2.6.4.3 Curse of success (fallacy of success)

Starbuck and Hedberg (1977) have coined the phrase 'success breeds failure' to explain a specific type of organisational failure among successful firms. Miller (1994) argues that a firm's history in terms of its previous success may breed overconfidence and arrogance among its managers. A dominant idea might be established among the leaders of an organisation as a result of its previous success (Jas and Skelcher, 2004), which indicates how the organisation should be run and what is important to the organisation (Weiss, 1995). At some level this dominant idea and way of working may prove successful, but it may also result in neglecting further search into performance improvement, with the organisation maintaining the operating

functions related to the dominant idea associated with success in the past (Jas and Skelcher, 2004). As a consequence, the firm may reduce its focus on quality and product development, fail to deal with negative customer feedback, reduce its attention to any short-term falls in sales, and fail to monitor product innovation, persisting with previous successful routines (Whetten, 1987). Such organisations are more likely to show resistance to change (Miller, 1994) and may become vulnerable (Whetten, 1988). The failure of Marks and Spencer over the past decade is an example of the 'curse of successes', with no focus on the changes taking place in the external environment (e.g. new technology, higher level of competition, and new ways of retailing). Management of Marks and Spencer disregarded information which was in conflict with their dominant paradigmatic beliefs (Mellahi et al., 2002).

2.6.4.4 Threat rigidity effect

Some types of organisational failure have been explained by the threat-rigidity effect model developed by Staw et al. (1981). This model assumes that in the face of a threat or crisis, individuals, groups and organisations tend to act rigidly by avoiding changes and trying to maintain the status quo. Organisations and managers restrict information flow and persist in applying previous internally-established assumptions and expectations. These may not result in the strategic actions and adaptations required to solve the problem (Staw et al., 1981; Millikien and Lant, 1991). Furthermore, managers centralise authority, exercise stricter control over the organisation and restrict new actions. D'Aunno and Sutton (1992) report less participative decision-making, and more commitment to existing procedures, as consequences of the threat rigidity effect among senior managers faced with a decline in funding sources. In addition, poor information systems may not allow sufficient consideration of information on the part of management, which is likely to result in poor performance (Wilson et al., 1999). Peterson and Behfar (2003) argue that some managers blame others for failure as a reaction to performance problems. They add that reduction of group consistency (reaction at intergroup level) and task conflict and relationship conflict (reaction at intragroup level) are exhibited in a crisis.

As managers do not always make an adequate response to external threats (environmental changes) and crises, or even ignore problems altogether (McKiernan, 2002), the situation can worsen and result in failure. Organisational psychology perspectives argue that the response of managers in such situations could be related to factors that are beyond their awareness. Indeed, they believe that organisational

failure is often linked to hidden, sub-conscious feelings on the part of management (Mellahi and Wilkinson, 2004).

2.6.5 Criticism of the Voluntaristic view

Some researchers criticise the voluntaristic view on organisational failure. The main weakness of the OS/OP perspectives is the lack of a 'grand theory' to explain organisational failure. Literature shows a high level of confidence in a series of middle range theories (Groupthink, Upper echelon, Curse of success, Threat rigidity effect). In addition, the outcome of middle range theories has shown fragmented and unconnected results, as discussed previously. Furthermore, this perspective relies highly on internal factors and overlooks the context within which organisations work. Most of the studies that have investigated the effect of internal factors on failure have been conducted in the USA, so their findings may be heavily context-dependent, and caution should be used when generalising to other countries (Mellahi and Wilkinson, 2004).

In conclusion, it is important to note that only in some extreme conditions, organisational failure can be caused by external or internal factors independently. For example, environmental or economic catastrophes as external causes, or severe managerial misconduct as an internal cause can result in organisational failure. In other cases, both internal and external factors contribute jointly to the process of decline (Pajunen, 2005). For instance, the result of the succession process in failure is dependent on both the nature of the succession (e.g. internal successor vs. external successor) and the context within which succession occurs, as well as ecological specifications such as the age, size, density and life cycle stage of the organisation (Mellahi and Wilkinson, 2004).

According to the literature, Jas and Skelcher (2004) have developed a typology by combining two factors: source of failure (internal and external) and the capability level of the organisation to deal with the decline and initiate turnaround (high or low). This is illustrated in table 2.2.

Table 2.2 Typology of performance decline

		Ability of organisation to initiate turnaround	
		High	Low
Source of decline	External	e.g. changing user preferences, failure by service supplier where alternatives available	e.g. authoritative reallocation of resource base, disasters
	Internal	e.g. ineffective management systems, poor consumer information	e.g. political instability, corruption

Source: Jas and Skelcher (2004)

Jas and Skelcher (2004) divide external sources of failure in two types. The first consists of factors that undermine the organisation's functioning and the organisation is unlikely to avoid failure and initiate turnaround when confronted with such issues. Disasters (natural or man-made) or reallocation of resources by a party with a higher level of authority, are examples of the first type. In contrast, when organisations face the second type of external factors (e.g. shifts in customer preferences, redesign of service delivery mechanism, development of new technology by competitors or failure by service suppliers where options exist) they are more likely to manage or even prevent failure.

In this model, internal causes are categorised into two groups. They can affect the capability of the organisation to deal with them effectively. Some causes are mainly technical in nature (e.g. poor management systems or poor consumer information) and organisations probably address them through relevant interventions. However, some factors are more complex and difficult to resolve. Political insecurity, corruption and problems related to managerial culture are examples of this second group. The existence of complex internal political or managerial problems, make it more difficult to initiate turnaround strategies (Jas and Skelcher, 2004).

McKiernan (2002) argues that symptoms, primary and secondary causes of decline cannot be isolated and are inter-related and interactive in such a away that they can potentially combine to exacerbate the situation. Except in very extreme situations, such as disasters, failure is usually caused by a combination of different factors. However, in the literature, top management teams are commonly identified as the main cause of failure and as a result the most common form of intervention to turnaround poor performers is their replacement, especially CEOs. It is assumed that management is unlikely to be the sole cause of decline and managers may be symptoms of failure as much as causes (Walshe et al., 2004).

2.7 Prediction and diagnosis of failure

The failure of an organisation may be prevented if a detection system is set up to identify early signs and symptoms of performance decline. McKiernan (2002) suggests that early detection is likely to be the result of the presence of a good scanning system for alerting the organisation to changes in the environment, an effective management information system and a recognised management control framework, such as a balanced scorecard. It is difficult to predict decline when relying too heavily on quantitative measurement of performance because other sources of data, such as soft data (non-quantitative measurement), that may highlight gaps in the organisation's performance are not given sufficient and/or timely consideration. Walshe et al. (2004) indicate that in some studies failure has been predicted by using a wide variety of sources of data, particularly in the short or medium term (up to two years). They suggest that the benefit of using a wide source of data (both hard and soft data), is to identify 'at risk' organisations in an attempt to avert future failure and decline.

McKiernan (2002) emphasises that in order to recognise the main secondary causes of failure, an excellent diagnostic procedure is requested. He suggests a diagnostic policy should: avoid hurried decisions; adopt multiple perspectives; search for broad initial information; consider ambiguous symptoms; create multiple hypotheses; generate diagnostic algorithms for reduction; and consider the type I error (rejection of a hypothesis when it is true) and type II error (acceptance of a hypothesis when it is false). This diagnostic procedure needs to be adapted to the particular situation of each organisation (e.g. organisational culture) and recognize prevailing externalities if it is to work effectively. This system is likely to provide direction and guidance for the organisation to recognise secondary causes of decline appropriately and at the right time. McKiernan (2002) adds that even overconfidence in professional consultants is likely to be moderated by such a diagnostic framework.

When performance levels are far below the acceptable level, a triggering process is required. Triggers act as activators for both a diagnosis process and a call for action (McKiernan, 2002). Inertia and active resistance to change are exhibited by the majority of organisations (Crow and Hartman, 2003). As a consequence, a significant jolt or trigger to act must take place, otherwise the organisation faces a high risk of failure (McKiernan, 2002).

Both internal and external stakeholders can delay the diagnosis of failure. Indeed, they may fail to recognise, disregard or conceal problem until incidents or a crisis trigger interventions (Walsh et al., 2004). Meyer and Zucker (1989) argue that before failure is identified some organisations may experience intermittent cycles of decline and partial improvement or slow escalating decline.

Triggers can be internal (e.g. recognition of the problem by senior managers) or external (e.g. high pressure for change from external stakeholders) (McKiernan, 2002). Walshe et al. (2004) argue that formal diagnosis of organisational failure is often not totally unexpected for most stakeholders, especially internal ones. They argue that for these stakeholders, only public acknowledgement of problems that were already evident, gave impetus for changes to be made.

Some commentators argue that performance decline has to be severe to trigger radical change. In this situation, the problem is rarely ignored or disguised by those within the organisation (Balgobin and Pandit ,2001; Weitzel and Jonnson, 1989). In their case studies, Grinyer et al. (1990) found different types of triggers. They revealed that introducing a new chief executive (in 55% cases) and recognition of major problems by managers (in 35% of cases) were the most important triggers in the for-profit sector. The other sources of triggering were intervention from external bodies, a change of ownership or the threat of such a change, and perception by management of new opportunities. In most cases, multiple rather than single triggers have been recognised, especially in the case of severe problems or crises. Some researchers, including Schendel et al. (1976) and Bibeault (1982) find management change to be the most important trigger for action. Walshe et al. (2004) identify extreme events or accidents which result in performance failure, as playing a role as a trigger for action because they are so obvious and may expose wider organisational failure.

Grinyer et al. (1990) emphasise that the mere presence of triggers may not necessarily induce remedial responses. Jas and Skelcher (2004) outline the changes which are necessary to recover an organisation, particularly a permanently failing organisation, on the basis of the 'stress-inertia' theory of strategic renewal. Inertia in the organisational context is defined by Huff et al. (1992, p 56) as 'the level of commitment to current strategy, reflecting individual support for a given way of operating, institutional mechanism used to implement strategy, monetary

investments and social expectations'. They note that inertia is characterised by a predilection to maintain the status quo and resist strategic renewal, especially when the current strategies have worked successfully in the past (fallacy of success). Katz and Kahn (1978) in Crow and Hartman (2003) highlight sources of resistances to change, including structural inertia, limited focus of change, group inertia, threat to expertise, threat to established power relationships, threat to established resource allocation, economic factors (e.g. reduction in an individual's income), and the fear of uncertainty which emerges after change. On the other hand, organisational stress uncovers ways in which the current strategy is not satisfactory. The lack of fit between demands and opportunities confronted by an organisation and the capacity of current strategies to react to those situations, can build up organisational stress (Huff et al., 1992).

According to the stress-inertia theory, organisations are conceived essentially as inertial and a significant strategic change happens only when the level of stress becomes greater than the inertia and its resulting resistance (Barker et al., 2001). Therefore, strategic changes might happen through decreasing resistance stemming from inertia or increasing stress levels deriving from dissatisfaction with the status quo. Stress can increase as a result of different factors, such as dynamism of the environment (environmental changes), performance decline, executive replacement, and changes in rules and policies (Huff et al., 1992).

Accumulation of stress in the organisation necessitates the strategic renewal process. However, Barker et al. (2001) theorise that performance decline is not sufficiently stressful to initiate change, and other factors such as external intervention or internal power repositioning (e.g. change in senior management) are also required. This assumption can potentially justify the necessity of external interventions to initiate change in poorly performing organisations which are unable to develop turnaround processes internally.

2.8 Stages theories of failure and turnaround

Despite an increasing interest in the academic and practitioner literature, to date, no coherent theory of organisational turnaround has been developed (Lohrke et al., 2004; Pajnuen, 2005). The focus of studies has typically been on the examination of the turnaround strategies (e.g. Hall, 1980; Goodman, 1982; Altman, 1983; Hoffman,

1989; Hambrick and Schecter, 1983; Barker and Duhaime, 1997), causes of failure (e.g. D'Aveni, 1989; Mone et al., 1998; Hambrick and D'aveni, 1988), and the composition of boards and turnaround managers' characteristics (e.g. Barker et al., 2001; Daily and Dalton, 1994). Most empirical evaluations overlook the investigation of turnaround as a whole process (Pajunen, 2005: Shook, 1998). Chowdhurry (2002) highlights the fact that separation between empirical findings (mostly on the basis of correlational studies in the private sector) and research explaining the causal structure of events, from the beginning of the organisation's decline to its eventual recovery or death, has resulted in a lack of coherent theory in organisational turnaround. However, the 'stage' approach is exceptional because it purports to explain the process of decline and/or turnaround as occurring in sequential stages (Pajunen, 2005) that may result in the survival and performance improvement or failure of an organisation (Chowdhurry, 2002). It structures the process in terms of sequential phases.

A variety of stage theories or conceptual models can be found in the literature, each of which applies slightly different definitions and distinctions. The focus of some stage theories is on the turnaround process itself and these divide the process into different stages (e.g. Arogyaswamy et al., 1995; Bibeault, 1982). According to the former, two different stages of response to decline can be by the organisation, including a 'decline-stemming stage' which aims to overturn dysfunctional consequences of decline (erosion of external stakeholders, loss of efficiency and deterioration of internal climate and decision process) and stabilise the situation, and the 'recovery stage', which comprises activities that result in the growth of the organisation in terms of competition in the market and achieve long-term success. The decline stemming stage goes beyond the activities that only emphasise reduction in cost and assets, considering garnering stakeholder support and stabilising the internal climate and decision processes of the firm. These two stages are comparable to 'operational' and 'strategic' activities (Hofer, 1980) or 'efficiency' and 'entrepreneurial' functions (Hambrick and Schecter (1983), which are discussed in the next section (turnaround interventions). Bibeault (1982) characterises the turnaround process comprising five stages including: management change; evaluation; emergency (stop the progress of the firm's financial haemorrhaging); stabilisation (improve core operation); and return to normal growth. A combination of the emergency and stabilisation phases forms the firm's retrenchment stage. The return-to-growth phase is identical to the recovery stage.

In another class of stage models (e.g. Balgobin and Pandit, 2001; McKiernan, 2002; Chowdhurry, 2002), the turnaround phase forms only one part of the process and the decline and crisis phase, as well as triggers for change that precede the turnaround phase, are also included (Pajunen, 2005). In fact, these stage approaches link the process of failure and turnaround and pursues the level of improvement in the organisation. These models place emphasis on the incidents that explain how conditions change over time. Balgobin and Pandit (2001) develop a model explaining the failure and turnaround process in five overlapping but distinct stages consisting of decline and crisis, triggers for change (stimulation of the activity required for change to happen), recovery strategy formulation, retrenchment and stabilisation (cost cutting and asset reduction), and return to growth (profitable growth).

In a similar model developed by McKiernan (2002), the process is divided into six stages: failure phase (poor performance due to the internal and external factors); triggering actions (the very stimulation of the activity required for change to happen in terms of both problem diagnostic process and call for actions); diagnosing activities (identification of the main secondary causal factors); retrenchment (stabilising the situation and providing positive cash flow through cost cutting and asset reduction, tighter control, autocratic management and rationalisation); recovery (activities to achieve further performance improvement after stabilisation through efficiency and/or entrepreneurial strategies); and renewal (return to a level of performance similar or even better than that prior to decline). The interventions are discussed in detail in the next section.

Chowdhury (2002) defines a model consisting of four different stages: decline (including role of internal and external factors in occurring decline and also shows the source of interventions that trigger actions in this stage such as replacement of the incumbent CEO); response initiation (starting corrective operational and/or strategic actions); transition (the time period needed before the results of the turnaround strategies shows and includes implementation of strategies and complex interaction of strategy, culture, structure, technology and human variables); and outcome (failure or success). Ghowdhurry (2002) states that "the stages are not disparate, rather, they are sequentially linked and mutually reinforcing." In this model, four core concepts including performance, strategy, implementation and performance are allocated to these four stages (decline, response initiation, transition, and outcome) respectively (Chowdhurry, 2002).

The 'decline phase' in Chowdhury's model is similar to the first two stages of McKiernan's model ('failure phase' and 'triggering actions') and Balgobin and Pandit's model ('decline and crisis' and 'triggering for change'). Response initiation is comparable with the 'recovery strategy formulation' in the model of Balgobin and Pandit and is also analogous with 'diagnostic activities' in McKiernan's model. Transition is analogous with 'retrenchment' in Balgobin and Pandit's model and with the two last stages of McKiernan's model (retrenchment and recovery). The last stage of Chowdhury's model (outcome- success) is in accordance with the 'return to growth' and 'renewal' stages of Balgobin and Pandit's model and McKiernan's model respectively.

Boyne (2004b) has developed, through an extensive review of the business literature, a model containing seven separate stages: the onset of decline; corrective action to avert a turnaround situation; the turnaround situation; the search for new strategies; selection of a new strategy; implementation of the new strategy; and outcomes of turnaround strategy. No model of the turnaround process has yet been developed in the public sector (Boyne, 2004b).

Although the stage models assume all turnaround processes will be successful, in the real world that may not be the outcome of turnaround strategies (ineffective turnaround), as they may end in bankruptcy and organisational failure (McKiernan, 2002). Pandit (2000) points out that the number of organisations in the private sector subject to ineffective turnaround is increasing.

These stage theories provide a useful framework to investigate the whole process but it should be recognised that in real world contexts they do perform interdependently rather than in a sequential, logical and linear fashion (Arogyaswamy et al., 1995). This means organisations may experience movement between stages, miss out a stage, become trapped in a stage for a long period or apply several stages concurrently (McKiernan, 2002).

The McKiernan stage model (2002), consist of six stages, has been selected as the theoretical framework to organise, report and interpret the findings of this empirical case study. The framework provides the opportunity to link organisational decline and turnaround processes as together as occurring in sequential and differentiates between symptoms and causes of failure (secondary and primary), allowing the

researcher to discover diagnostic and causal relationship relationships between these (see section 2.5). Triggers of change, turnaround interventions used by the organisation, and the outcome of the turnaround strategies are also considered using this framework. As this framework has been in limited use in the health sector (two studies, one of which remains unpublished), the findings of this case study can be compared with those studies. The applicability of the model is also investigated within the health sector.

2.9 Turnaround interventions

According to the stage approach, when the decline is diagnosed a series of strategies (interventions) should be selected and implemented to turnaround the performance of the organisation. Turnaround strategies have been examined by different researchers (e.g. Robbins and Pearce, 1992; Hoffman, 1989; Hambrick and Schecter, 1983; Barker and Duhaime, 1997; Pearce and Robins, 1993). For example, Hofer (1980) dichotomizes the response of the organisation to the strategic response (e.g. by changing marketing processes or entrance to the new business) or operational responses (e.g. using cost reduction). In the former approach, organisations reverse the problem through implementing strategic changes but in the latter by increasing efficiency and exerting more control. Hambrick and Schecter (1983) have referred to these as 'entrepreneurial' strategies and 'efficiency' strategies respectively.

There is no single, generally accepted description for turnaround strategies within the private sector literature (Boyne, 2004a). Some experts classify intervention into major generic strategies. For example, Walshe et al. (2004) distinguish between three: Replacement, Retrenchment, and Renewal and similarly Boyne (2004a) categorises these as the '3Rs', including Reorganisation, Retrenchment and Repositioning. In spite of the different titles, similar areas of activity are addressed by each, including:

1) Reorganisation (Replacement) refers to change in the management of the organisation. Boyne (2004a) refers to reorganisation as any change in the internal management of an organisation (e.g. changes in planning, styles of human resources management, performance management, and the extent of decentralisation) but he emphasises that the most prevalent type of the reorganisation is the replacement of the chief executive and/or the entire or part of the senior management team.

2) Retrenchment refers to employing short-term actions to stabilise the organisation and controlling short-term problems (e.g. cost cutting and asset reduction).
3) Repositioning or renewal refers to initiating new strategies to assure long-term success.

All three strategies may be adopted by an organisation simultaneously rather than sequentially (Harvey et al., 2005a). To choose appropriate and timely turnaround strategies, organisations need to consider the causes of the decline (external vs internal) (Pearce and Robins, 1993; Arogyswamy et al., 1995; James, 2002; Slatter and Lovett, 1999; Schendel and Paton, 1976; Hofer, 1980) and the severity of the decline (e.g. severe vs not severe) (Hofer, 1980; Pearce and Robins, 1993). Turnaround strategies that do not focus on the causes and severity of the turnaround situation may not achieve appropriate results or may accomplish only short-term successes rather than long-term growth. For example, if the failure is related to the poor quality of leadership or ineffective operational management, replacing this management may result in improving performance but it may not be effective in the case of long term unresolved strategic issues (Edward et al., 2003). Initiating new strategies (repositioning) has frequently been applied when the problems are related to external factors (Pearce and Robins, 1993). Hofer (1980) suggests that in less severe crises, small changes such as cost cutting may be enough to engender recovery but when the organisation faces severe crisis, other dramatic interventions, such as market reorientation, should be used. There is no rigorous evidence on the effectiveness of turnaround strategies in the public sector which reveals the necessity of further research in this area. Boyne (2004b) and Fox (2003) highlight the need for the speedy and timely development and implementation of strategies in the turnaround situation for public organisations. Boyne (2004b) suggests that highly visible and politically prominent public organisations may experience huge pressure to provide a recovery plan quickly. In contrast, less prominent organisations are less visible and probably under less pressure, which means that they are likely to have more time to analyse the situation and benefit from more consultation when implementing a recovery plan and implementing turnaround strategies.

2.9.1 Replacement (Reorganisation)

One of the most common types of turnaround strategies discussed in the literature, is the replacement of key members of the management team with either internal or external people (Walshe et al., 2004; Jas and Skelcher, 2005). Top management

team replacement is considered an essential prerequisite for a successful turnaround by some commentators (Barker et al., 2001; Mueller and Barker, 1997). In most cases, only the chief executive officer is at high risk of removal. However, it can often entail one or two other senior managers or, in special cases, all members of the top management team (Walshe et al., 2004). The new CEO or senior managers may also act in the process of diagnosis of failure and act as a trigger factor (an agent for initiating change) (McKiernan, 2002). Some researchers state that the most significant trigger for change is to effect change in the top management team (Schendel and Paton, 1976; Bibeault, 1982; Slatter, 1984). Boyne (2006) also categorise changes in the planning system, the extent of decentralisation and style of human resources management as reorganisation strategies.

The upper echelon theory (Hambrick and Mason, 1984), discussed earlier, is employed by some researchers to justify the significant impact of senior managers (especially CEO) on the development of strategic plans and consequently organisational performance. In addition, according to stress-inertia theory, management replacement may increase the level of stress to such an extent that organisational change is essential (Huff et al., 1992).

In a turnaround situation, long-serving managers may be highly committed to the existing strategies that resulted in the decline, and reject any change of these in response to the identification of problems (Barker and Patterson, 1996). In the crisis situation they may demonstrate the threat rigidity effect, mentioned earlier, which limits them in dealing with the crisis properly (Barker et al., 2001). Slatter (1984) also argues "the existing management is rarely capable of taking the drastic action needed to effect a turnaround". Hoffman (1989) highlights substantive reasons for changing the top managers, including managers' incapability to identify or deal with the decline, the need for different expertise and information to tackle the crisis, and removal of untrustworthy staff. In this situation, the presence of new leaders seems necessary to unfreeze current attitudes and provide new insights into the situation. New leaders may also collect information on the cause of the failure using different analytical methods, consult with internal and external people, change the power structure within the organisation, and provide new strategic direction (Hoffman, 1989; Barker and Mone, 1998; Barker et al., 2001).

Removal of long-serving managers and replacing them with new staff also has a symbolic function. It can relay a clear message about the gravity the organisation is

placing on the recovery programme and strategic changes that, in turn, may prompt the staff, and particularly external stakeholders, to allocate the required time and resources to reverse decline (Boyne and Meier, 2005).

Boyne (2004b) has reviewed the impact of reorganisation or replacement strategies on turnaround processes in nine studies that compared successful and unsuccessful turnarounds in the for-profit sector. He found that in six, replacement intervention resulted in performance improvement (O'Neil, 1986a; Muller and Barker, 1997; Pearce and Robbins, 1994; Thietart, 1988; Stopford and Baden Fuller, 1990; Harker and Sharma, 1999). There was no difference in the outcome in two of the studies (Sudarsanam and Lai, 2001; Bruton et al., 2003) and there was a negative effect on the turnaround in one study conducted by Barr et al., (1992). As the number of cases investigated in the latter study was too small (only two cases), its result needs to be interpreted with caution.

There are debates over the effectiveness of a new Chief Executive Officer (CEO) either from inside the organisation (insider) or outside (outsider) due to a lack of robust research evidence (Boyne and Meier, 2005). The probability of replacing incumbent managers by outsiders is much higher when the causes of decline are believed to be internal, and in the case of failure caused by external factors, internal people are likely to replace top managers (Bibeault, 1982). O'Neil (1986a) found that in successful turnarounds, new top managers are more likely to come from outside rather than inside the organisation. In contrast, in other studies, internal senior managers were found to be leading the turnaround process (e.g. Zimmerman, 1989). As shown above, appropriate and speedy action is crucial in a turnaround situation (Arogyaswamy et al., 1995). Although outsiders can apply radical changes, especially in non-failing organisations (Wiersma, 1992), they may be unable to formulate and implement new strategies quickly and effectively because of a lack of detailed knowledge of the organisation. On the other hand, insiders may have more in depth knowledge about organisational problems and about the capability and political context of the organisation, making them better able to develop rapid responses to the problems and achieve recovery. However, some commentators argue that insiders may have closer working relationships, which may have a deleterious impact on the development and implementation of the new strategies (Boyne and Meier, 2005).

2.9.2 Retrenchment

Retrenchment denotes a series of largely short-term activities applied by management to stabilise an organisation in order to secure its survival (Bibeault, 1982; Finkin, 1985; Dumaine, 1990; Grinyer and McKiernan, 1990) and tackles the immediate problems responsible for initiating the crisis (Robins ad Pearce, 1992). Some commentators suggest that retrenchment strategies are the first options in the turnaround process (Bibleaut, 1982; Sloma, 1985; Pearce et al., 1987; McKiernan, 2002), which consider financial losses, and provide positive cash flow and can be viewed as 'efficiency' interventions (Hambrick and Schecter, 1983). The resources released from a retrenchment strategy can also be employed for investment in more productive areas (Boyne, 2004b).

Retrenchment comprises cost cutting (e.g. changing prices, exit from markets, elimination of unprofitable products and reducing the scale of the operation, staff numbers and overheads) and assets reduction (e.g. selling land and equipments) (Hambrick and Schecter, 1983; Bibeault, 1982). For example, Mellahi et al. (2002) highlight the retrenchment strategies used by Marks and Spencer following a rapid drop in profits, in order to stabilise the organisation including the exit from overseas markets, closing retail outlets, and selling assets.

Furthermore, retrenchment may involve the focus of senior managers on the internal operation of an organisation (Arogyaswamy et al., 1995) to improve operational management (e.g. reshaping work process, waiting time reduction or increasing throughput) (Robins ad Pearce, 1992). McKiernan (2002) also emphasises closer control, autocratic management and rationalisation as retrenchment strategy.

Retrenchment is likely to lead the organisation towards recovery, in the event that performance problems are related to high cost and low efficiency. However, it is unlikely to produce better results when the organisation faces other problems (Boyne and Meiere, 2005). Robins and Pearce (1992) argue that organisations are likely to choose retrenchment strategies when failure originates from internal factors. Some commentators suggest that cost reduction should be the initial retrenchment response, particularly in cases of less severe decline and, if that does not solve the problem, then aggressive asset reduction should supplement it (Hofer, 1980; Robins and Pearce,1992). As discussed above, retrenchment can result in the revival of organisations in less severe crises (Hofer, 1980), but more entrepreneurial and

strategic reorientations (repositioning) should be adopted when organisations face severe problems (Robins and Pearce, 1992; Hambrick and Schecter, 1983).

In a review, Boyne (2004b) explored the impact of retrenchment strategies on the reversal of performance in the for-profit sector, including studies that compared successful and unsuccessful turnaround processes among firms. Of 18 studies reviewed, 12 showed a strong association between retrenchment strategies (asset reduction and/or cost cutting) and performance improvement. (Hambrick and Schecter, 1983; Chowdhury and Lang, 1996; Barr et al., 1992; Bruton and Wan, 1994; Bruton et al., 2003; Dawley et al., 2002; Pearce and Robbins, 1994; Robbins and Pearce, 1992; Stopford and Baden-Fuller, 1990; and Thietart, 1988).

In six studies, no significant association was found (Barker and Mone, 1994; Chowdhury and Lang, 1994; Evans and Green, 2000; Sudarsanam and Lai, 2001; Pant, 1991). Interestingly, no significant negative relationship was noted in the studies. Boyne identifies discrepancies between the results of studies on the basis of the views of Arogyrawasmy et al. (1995), who argue that some researchers consider retrenchment an isolated and sufficient strategy, but others treat it as the first and necessary stage of a turnaround intervention.

In general, the burden of the empirical evidence supports retrenchment as an effective turnaround strategy (Pajunen, 2005; Boyne, 2004a). Some researchers, however, have questioned the effectiveness of retrenchment in the turnaround process (e.g. Barker and Mone, 1994). These commentators question whether an organisation needs to go through retrenchment as this may not have a significant effect. Some commentators support retrenchment as a crucial and established stage, but argue that too much focus on cost and asset reduction may lower staff morale or may even encourage resistance by increasing organisational inertia and increase turnover of the most talented employees (McKiernan, 2002; Greenhalgh, 1983; Hardy, 1987; Sutton et al., 1986). A successful retrenchment strategy should be followed by a long-term strategy to assure future growth of the organisation (Grinyer et al., 1988; McKiernan, 2002).

2.9.3 Renewal (Repositioning)

Repositioning (renewal) strategies are activities, utilised to reorient the direction of an organisation and its vision, with the aim of assuring long-term successful survival

(Walshe et al., 2004; Boyne, 2004a). Hofer (1980) refers to such interventions as strategic responses and Hambrick and Schecter (1983) term them 'entrepreneurial' strategy. 'Repositioning' includes a range of long-term activities, such as changing the mission and direction of an organisation, entrance to a new market, introducing new products, and searching for new sources of profit. Slatter and Lovett (1999) argue that change in the leadership style and culture of an organisation can be classified as repositioning or renewal. Unlike the retrenchment phase, in which an autocratic leadership style is more likely to be applicable, in the repositioning stage it may be better to have a more democratic form of leadership (McKiernan, 200).

McKiernan (2002) argues that established operating patterns, beliefs, and rules (OBR) are unlikely to promote entrepreneurial strategies because old OBRs tend to be rigid and maintain the status quo. If organisations are not able (as a key part of the organisational culture) to challenge the belief systems that inform their work, even temporary interventions such as cost cutting and reorganisation, are unlikely to guarantee long-term success. Thus McKiernan highlights the important role of new OBRs in developing and implementing entrepreneurial intervention. In addition he suggests that in severe cases, organisations are not likely to be able to develop entrepreneurial changes because of lack of financial resources.

Boyne (2004b) has reviewed the impact of repositioning strategies on performance improvement among private sector organisations. Seven out of eleven studies in the review demonstrated a positive effect of repositioning on firm performance (Pearce and Robbins, 1994; Barker et al., 1998; Thietart, 1988; Stopford and Baden Fuller, 1990; Barr et al., 1992; Hambrick and Schecter, 1983; Harker and Sharma, 1999; Evans and Green, 2000). Two of the studies found no difference (Sudarsanam and Lai, 2001; Pant, 1991) and two revealed a negative impact (O'Neil, 1986a; Schendell and Paton, 1976). The latter had either a small sample size (O'Neil, 1986a) or used a narrow measurement of repositioning (new capital investment) (Schendell and Paton, 1976). The overall evidence seems to be in favour of the positive effects of repositioning strategies.

2.10 Outcome of turnaround strategies

In general, the burden of the evidence in private sector organisations suggests that three different strategies (retrenchment, repositioning and reorganisation) have a

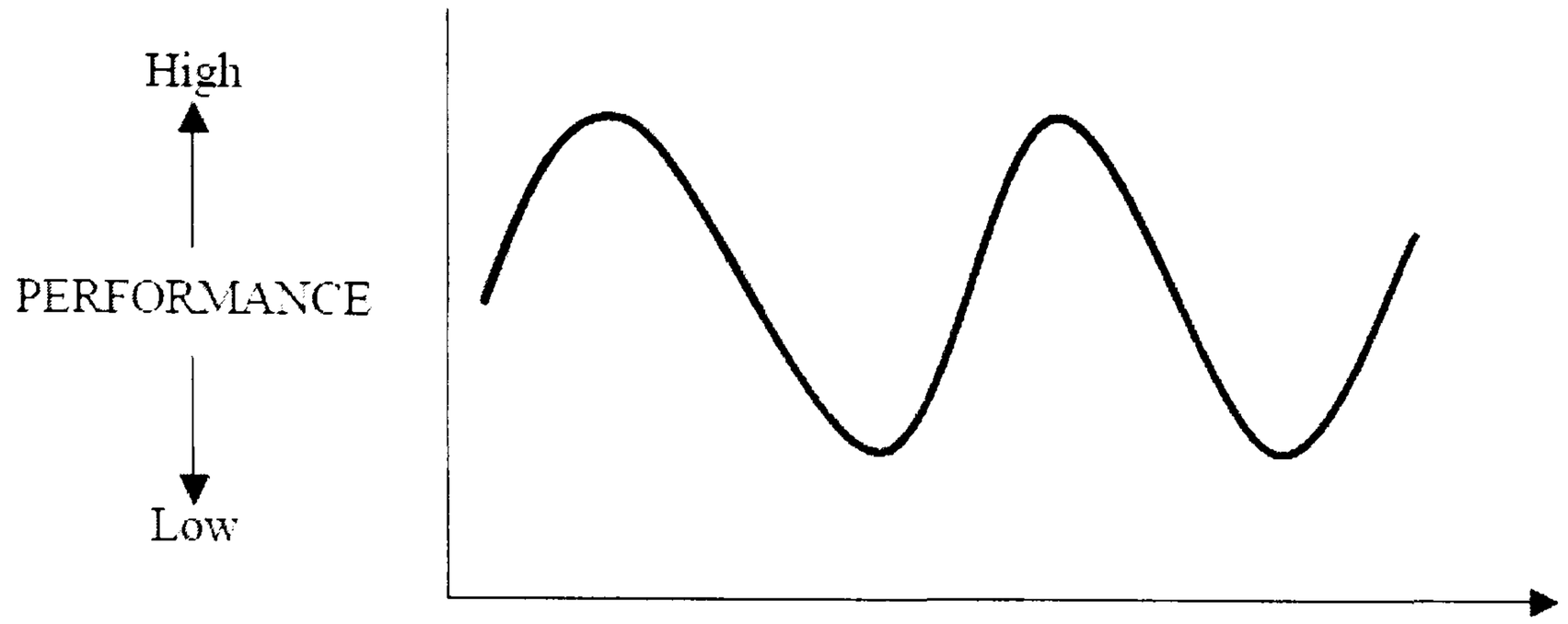
positive impact on the turnaround of financial decline (Boyne et al., 2004). However, the extent of their positive impact on performance varies according to both the external and internal circumstances of an organisation (McKiernan, 2002). As each organisation has special characteristics and exists in a unique context, a generic turnaround solution is likely to be ineffective. Therefore, tailor-made interventions are suggested in order to consider those special organisational characteristics (Pandit, 2000).

Turnaround strategies can result in both successful and unsuccessful turnarounds. Some organisations that are able to initiate the turnaround process and improve their performance are termed 'self regulating' organisations. Unsuccessful turnarounds produce two different outcomes, one is organisational 'death' and the other is the persistence of poor performance (a 'permanently failing' situation) [Meyer and Zucker, 1989]. Organisational death may have resulted from the formulation of inappropriate strategies or improper implementation of a good strategy. As discussed earlier, organisations in the public sector may not be allowed to disappear completely. Persistence of poor performance is the second possible outcome of an unsuccessful turnaround and here error correction processes may have little effect as the organisation becomes locked in a cycle of poor performance.

2.11 Permanently failing organisation and turnaround process

Jas and Skelcher (2005a; 2005b) argue that a typical performance trajectory in the public services organisations is cyclical rather than linear over the medium to long-term (figure 2.5). The figure shows that the performance of an organisation may be higher or lower than an acceptable level of performance (Dichotomous variable) over time. If the organisational performance is persistently below the minimal acceptable level of performance organisational failure is deemed to have occurred.

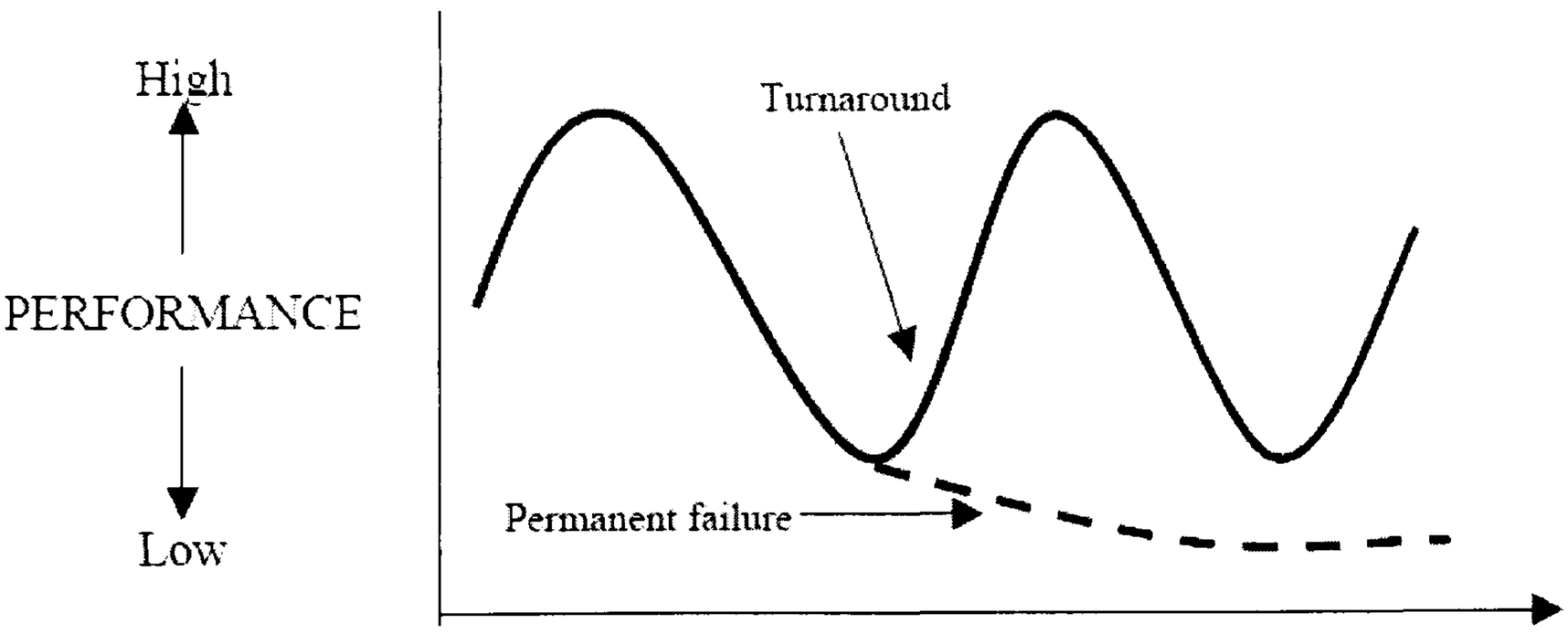
Figure 2.5 A typical performance trajectory



Source: Jas and Skelcher (2005b)

As shown in figure 2.5, organisations can actually improve after a period of poor performance. However, other organisations, which do not react to low performance and which are not able to recover themselves, continue to act consciously or unconsciously at the poor performance level and are termed as 'permanent failure' organisations (Meyer and Zucker, 1989). Figure 2.6 illustrates two situations including 'permanent failure' and 'turnaround'.

Figure 2.6 Permanent failure and turnaround



Source: Jas and Skelcher (2005b)

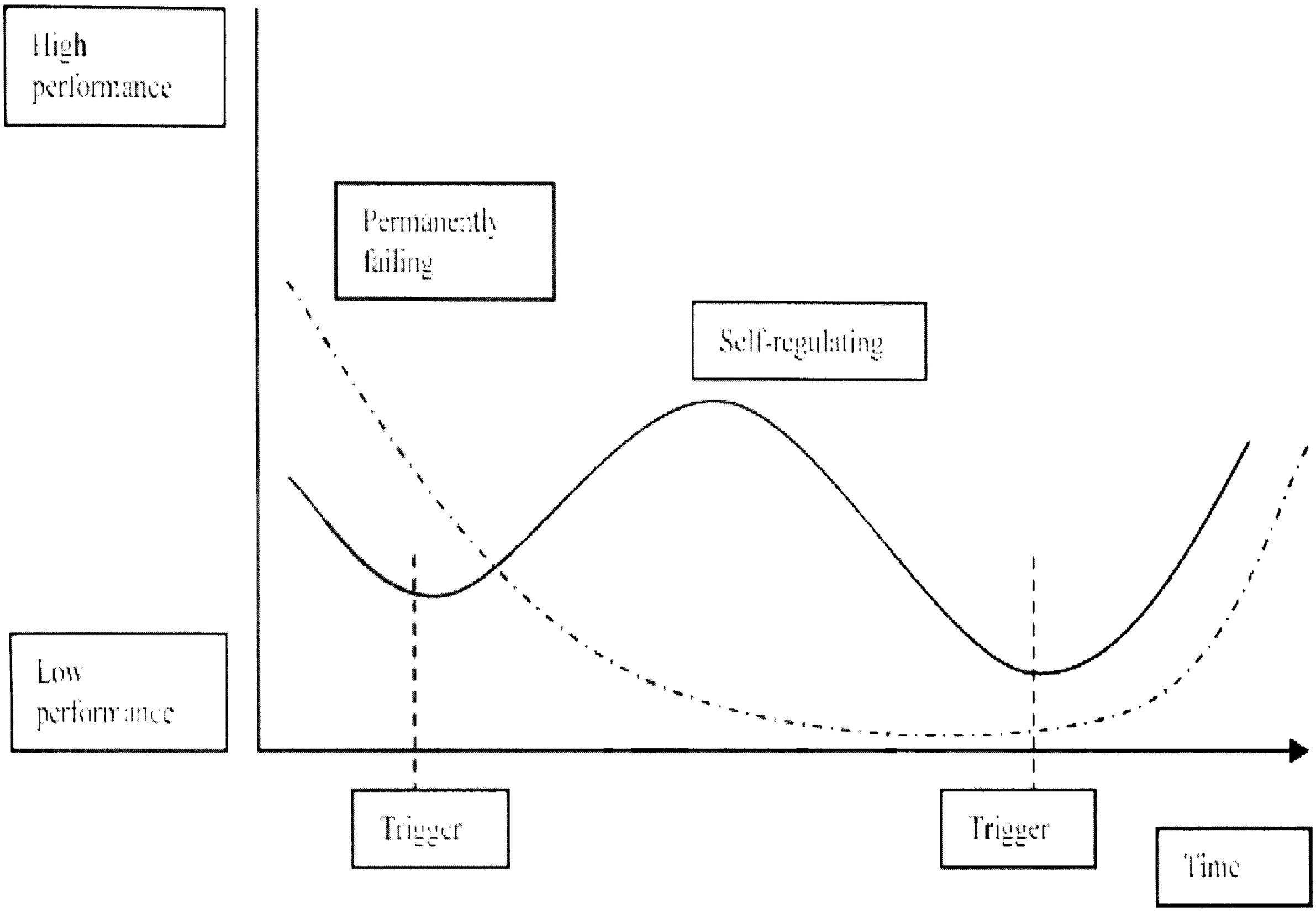
Meyer and Zucker (1989) use the rational actor theory to explain situations where there is permanent organisational failure. They suggest that the presence of diverse motivations, interests and power among three groups of organisational stakeholders

including owners, managers and dependant actors (non managers staff, consumers, and community who receive the organisation's services) can explain permanent failure situations especially in the for-profit sector.

Furthermore, they argue that when organisations perform at a high level, a congruent interest among the three main stakeholder groups is seen. However, once performance declines, these groups display divergent interests as the owners seek turnaround changes in order to return to profitability status. The managers have dual interests, seeking turnaround changes to make profit for the organisation, on the other hand, and they disagree with changes due to their concern about their employment situation as a consequence of the change process. As the changes may affect employment prospects and the situation of employers and community (dependant actors), they demonstrate resistance to change. The value of the existence of the organisation for dependant actors is greater than their valuation of its performance. Consequently, organisations may experience sustained poor performance because the possibility of change is blocked. Inability of an organisation to align diverse interests presents a collective action problem that may contribute to a permanent failure situation. For example, the leaders of an organisation may accept the risk of selecting and implementing new strategies to improve performance, however, the workforce may be less willing to take such risks and prefer to keep the status quo, which means that they prefer organisational persistence rather than organisational performance (Jas and Skelcher, 2005a).

Meyer and Zucker (1989) argue that the low performance level for such organisations becomes accepted as an unavoidable norm. However, it is assumed that a rescue action is still possible if the collective action problems originated from diverse interest, mentioned before, are considered. A combination of external and internal factors may act as triggers for actions in self-regulating organisations (Jas and Skelcher, 2005b). Whereas, in permanently failing organisations only external triggers can initiate changes (Turner and Whiteman, 2005). Figure 2.7 illustrates the performance profiles for self-regulating and failing organisations.

Figure 2.7 Illustrative performance profiles for self-regulating and failing organisations



Source: Jas & Skelcher (2004)

Jas and Skelcher (2004) indicate that although failure in the alignment of diverse interests within an organisation is likely to result in an unsuccessful turnaround process, diverse interests cannot always explain failure in self-initiated turnaround in poor performing organisations. Other factors, they state, seem to inhibit self-initiating turnaround and lead to organisations continuing to act under conditions of poor performance. These factors include a lack of cognizance of problems, incapability of leadership (political and managerial) in initiating change and establishing turnaround-oriented programmes, and a lack of capacity within the organisations to implement changes.

Jas and Skelcher (2004) compare the characteristics of permanently failing organisations with other failing organisations, that are able to initiate their own turnaround process (self-regulating organisations), as illustrated in table 2.3.

Table 2.3 Characteristics of self-regulating and permanently failing organisations

Class of organisation	Self-regulating	Permanently failing
Key feature	capable of self-motivated turnaround	not capable of self-motivated turnaround
Fallacy of success	Moderate	High
Motivational investment in the status quo	Moderate	High
Internal source of sufficient authority to initiate change	High	Low
Threat rigidity effect 1. Restriction of information	Low	High
Threat rigidity effect 2. Constriction of information	aims to maintain unity through process of change	aims to protect existing leadership by resisting change

Source: Jas and Skelcher (2004)

In addition, Jas and Skelcher (2004) indicate that to act as a self-regulating organisation, political stability and internal political and managerial leadership are very important factors which emphasise the necessity for change and motivate people within the organisations to take steps in that direction. However, they argue that the 'fallacy of success' and motivational investments in the 'status quo' are two factors that impede leadership capacity and capability to turnaround the organisation. They also assume that organisations that do not experience performance decline have low levels of 'fallacy of success' and motivational investment in the 'status quo' which shows their high potential for adaptation. However, self-regulating and permanently failing organisations have moderate and high levels of these factors respectively. Self-regulating organisations also display high levels of internal sources of sufficient authority to initiate change vs low levels for permanently failing organisations. As noted by Meyer and Zucker (1989), decision makers in permanently failing organisations tend to rely on familiar and routine behaviour during organisational failure, which may not be effective when crises occur.

As a consequence, permanently failing organisations require an authoritative external mediator(s) to intervene and initiate the turnaround process (Turner and Whiteman, 2005). Jas and Skelcher (2004) use principal-agent analysis to show the effect of different types of interventions, depending on the relationship between the principal (intervening body) and the agent (organisation which requires

intervention). Principal–agent theory, defines the relationship between two parties (principal and agent), which exists when an individual or organisation (the principal) delegates a task, provides services or generates output to an individual, group or organisation (the agent) and in return the agent receives reward. Such delegation may be problematic in two situations: first, when the interests and objectives of principal and agent are different, which causes that agent to behave in ways that are not aligned with the principal's wishes and second, when the agent has an informational advantage over the principal (information asymmetry), which means the principal has insufficient information about the performance of the agent. The latter can provide an opportunity for the agent to mislead the principal about his or her performance and/or shirk his or her agreed duties (Mannion et al., 2004). To mitigate these problems, Smith et al. (2003) (cited in Mannion et al., 2004) recommend three broad strategies: first, development of a better information system which enhance the control of the principal over the agent; second, the implementation of cultural change strategies to better align the interests of the agent to the interests of the principal; and third, the use of appropriate incentive structures to encourage the agent to perform as the principal desires. Briefly, the main concern of principal-agent theory is how to get an agent to perform in the best interests of the principal.

Jas and Skelcher (2004) present three alternative types of interventions: *episodic*, *relational/mutual*, and *mandated*. The characteristics of these interventions are presented in table 2.4.

Table 2.4 Approaches to external turnaround of permanently failing organisations (a principal-agent analysis)

Type of approach	Principal	Agent	Financial costs	Incidence of political risks
Episodic (intermittent inspections)	Hands-off Focused on outcome	Discretion to react	Low	Agent
Relational/mutual (self-managed turnaround)	Agreement between all parties Monitoring	Obligation to comply with agreement	Moderate	Shared
Mandated (take-over)	Power differential Information symmetry	Duty to comply	High	Principal

Source: Jas and Skelcher (2004)

In the *episodic* approach, the principal allows the agent to develop and implement required strategies to improve performance. However, the principal carries out intermittent inspections which lead to a series of suggestions for change. After the inspection, organisations may produce a new action plan or correct their current action plan. In the period between the audit programmes, there is a low level of interaction between principal and agent. The principal's main focus is the outcome, rather than process of performance improvement through a hands-off approach. On the other hand, the agent reacts to the principal's assessment with a high level of discretion (Jas and Skelcher, 2004).

In the *mandated* approach, the principal deals with the problems and takes action directly to improve performance. Very little alternative is left for the agent, and only his complicity is required. In this approach, the principal faces problems in performance monitoring, because of information asymmetry, which provides the opportunity for the agent to share the existence of selected information in order to present a more positive picture of the organisation and its performance. This approach causes a high level of incidence of political risk to the principal and has the highest level of financial cost of all three approaches.

The *relational/mutual* approach rests on the basis of agreement between two parties to deal with problems and improve performance, so an action plan is developed and implemented by the agent under the supervision of the principal. The agent has enough authority to choose strategies to turnaround the situation. In addition, a monitoring process is agreed between parties. This approach is in accordance with the current UK government policy to turnaround failing local authority organisations. The incidence of political risks is shared between the two parties and the financial cost is moderate (Jas and Skelcher, 2004).

In terms of financial cost, the episodic approach has the lowest level of cost compared with the mandated approach, which has the highest, because in the former, organisations use their staff to implement changes. In the mandated approach, a number of external consultancy and staff resources are needed to implement the action plan, which is costly. The cost of the relational approach is moderate. The risks are political, and the highest level of political risks to the principal is in the mandated approach because the principal plays a direct role in order to turnaround the organisation, the turnaround process may not be successful and, then, the principal will be questioned. However, the highest level of risk to the

agent is seen in the episodic approach and the principal may experience the lowest level of risk in this approach. Jas and Skelcher (2004) argue that in the hands-off approach (episodic), governments may also experience political risks in another way, as they might be accused of having done nothing to solve the problem.

Harvey et al., (2005a) note that all three types of intervention have been used in the NHS. For example, intermittent inspections by the Health Care Commission and Monitor (for Foundation Trusts), accompanied by their suggestions for action, are examples of the episodic approach. In the case of serious problems, according to their inspection reports, the Department of Health may apply closer investigation and stricter monitoring (using special measures). A good example of the relational approach is the function of the Performance Development Team (PDT) [as a part of the Modernisation Agency] in the turning around of failing organisations in the NHS. The Performance Development Team helps the organisation to develop and implement an action plan. One of the examples of the mandated approach is the 'Franchising' process in the NHS. Through franchising, the Government brings in new management with a positive record of success to take over the poor-performance organisation in order to affect improvement. Willmott (1999) and Turner et al., (2004) also address the mandated approach in the education field and local government, respectively, in the UK. However, it seems that UK government prefers to encourage a voluntary relationship between poor-performance organisations and a relevant external agency, rather than applying a mandated approach in the first instance. Harvey et al. (2005a) indicate that the relational approach could be the most favourable approach to the NHS with a reasonable level of risk and cost.

2.12 Summary

This chapter has defined organisational failure and turnaround processes in poorly performing organisations, particularly in the for-profit sector in which most of the literature is rooted, and explains related models from different theoretical and conceptual perspectives. It demonstrates that the concepts of performance and failure are contested and complex, particularly in the public sector, not least because of the political nature and difficulties in measuring the performance of public organisations. It has also shown the importance of turnaround processes in reversing decline and improving organisational performance.

The Chapter presented a range of symptoms (markers) of organisational failure which are visible at an early stage. If organisations are able to identify these markers and carry out proper and timely action, then decline may be avoided. The secondary and primary causes of organisational failure were also explored, using a range of theoretical frameworks and models. Both internal and external causes of failure were outlined. Failure to learn throughout an organisation was identified as the primary cause of decline.

Diagnosis and factors that are able to initiate the process of change (triggers) were reviewed. It was revealed that the triggers for 'self regulating' and 'permanently failing' organisations are often different. The latter tend to be subject to external triggers to initiate remedial action.

This chapter has shown that a lack of coherent theory currently exists to define organisational turnaround. The 'stage' model was considered as a framework in which the process of organisational failure and/or turnaround is structured in terms of sequential phases. A range of 'stage' models developed in the for-profit sector were compared and contrasted. Three generic turnaround interventions – replacement (reorganisation), retrenchment and return to growth (repositioning) were discussed. The role of external agents and their interactions with poorly performing organisations, as the trigger for change and facilitator or promoter of turnaround interventions, was explained in detail using the lens of principal-agent theory. The outcomes of turnaround strategies were considered and it was shown that turnaround strategies may not always deliver the desired organisational outcomes and 'organisational death' (exit of the organisation from the market) or 'permanent failing' organisations (organisations which continue working at a poor level of performance over a long period of time) result following an unsuccessful turnaround.

The next chapter (Chapter 3) presents a comprehensive review of the literature on organisational failure and turnaround processes in the public sector, with an emphasis on the heath care services.

Chapter 3: Organisational failure and turnaround in public services: a review of the evidence

3.1 Introduction

In Chapter 2, the theories of organisational failure and turnaround were discussed in relation to a range of conceptual frameworks and models. The aim of this chapter is to review the findings of empirical studies concerning the processes of organisational failure and turnaround across a range of public services, with particular focus on health care provision. In the first part of the chapter, the methods used in the review are explained in detail. Then the findings of the studies included are presented using the 'stages' framework as an organising framework for discussion. In alignment with McKiernan's model (2002), the symptoms, secondary (internal and external) and primary causes of failure are presented as separate sections and then triggers for change, (both internal and external) are demonstrated. Turnaround strategies used in the included studies are explained using the '3Rs' model (Reorganisation, Retrenchment, Repositioning) (Boyne, 2004a) [see section 2.9]. Because of the important role of CEOs and the wider senior management team during turnaround, the leadership styles of managers enacting turnaround strategies are also considered. External organisations commonly play a central role in all stages of turnaround and these are presented in detail in a separate section. The impact of intended and unintended consequences of turnaround strategies on organisational performance is also discussed. Finally, the key similarities and differences between public and private sectors in organisational failure and the turnaround process are also presented.

3.2 Background

As outlined in the previous chapter, existing theoretical frameworks and empirical evidence of organisational failure and turnaround are, in the main, derived from studies in the private sector, particularly in the USA (Ketchen, 1998). The first studies were conducted in the mid-1970s (Cameron et al., 1988) and have grown in number to date (Barker et al., 2001; Bruton et al., 2003, Ketchen, 1998). Borins (1998) argues that early

interest in the subject was on the part of practitioners rather than researchers, and focused on practical rather than theoretical concerns.

Several commentators have highlighted the paucity of robust empirical evidence and theoretical frameworks to explore turnaround in public sector organisations (Walshe et al., 2004; Boyne, 2003a; Jas and Skelcher, 2004). However, interest in this subject has grown a pace over recent years. Boyne (2003a) argues that strategies deployed by managers to turnaround poorly performing public organisations have not been chosen on the basis of robust evidence and well constructed theory, adding that the quality and quantity of research on organisational performance in the public sector, are limited and in need of development. Borins (2001) suggests that efforts should be made to explore the determinants of organisational success and failure in the public sector to facilitate practitioners' and managers' strategies to turnaround their organisation's performance.

There is no comprehensive review (especially in the health sector) of the empirical evidence in this area. The aim of the present review is to provide a summary of the research conducted on organisational failure and turnaround process across the public sector, and to identify the key themes, findings and areas of debate.

3.3 Objectives of the review

The specific focus of the review is as follows:

- to produce a summary of the key theoretical frameworks and models used in the studies;
- to identify the signs and symptoms of organisational failure;
- to identify the likely causes of organisational failure;
- to determine the factors that are likely to 'trigger' turnaround processes;
- to identify the range and effectiveness of interventions and strategies employed during the turnaround processes;
- to identify interventions and strategies employed to sustain continual improvements in organisational performance.

3.4 Methods of the review

The scope of the review is to identify studies relating to organisational failure or turnaround process in public services.

3.4.1 Inclusion criteria

The following selection criteria were used to select the 'included' studies:

- Setting: only studies undertaken in the public sector were included;
- Publication type: only empirical studies were included and abstracted;
- Language: only studies in English were considered, because of translation difficulties and costs;
- Study period: Only papers published since 1970;
- Study design: All types of study design and research methods were included.

3.4.2 Search strategy

A broad search strategy was used to ensure that the maximum number of eligible studies were captured. One of the initial strategies used was a search of the library catalogues and internet using internet search engines, for example Google Scholar. This method has been termed 'systematic browsing' by Greenhalgh et al. (2004), as it provides an opportunity to locate rich sources of information at very early stage of the review process. It also helped when identifying the key index terms used to structure the search strategy. The broad approach included electronic databases, reference scanning, hand searching of key journals, and contacting academic experts and practitioners.

3.4.2.1 Electronic databases

Several key databases were searched including HMIC (Health Management Information Consortium via Ovid - a combination of the Department of Health, King's Fund and HELMIS); Medline (Via Ovid); SSCI (Social Sciences Citation Index); ASSIA (Applied Social Science Index and Abstracts); Business Source Premier (one of the main bibliographic sources used for identifying organisational science; public administration;

and management literature). The SIEGLE (System for Information on Grey Literature in Europe) and the ASLIB Index to theses (http://www.theses.com) were searched for theses and dissertations produced in the UK and Ireland.

Searches were undertaken using a range of *'failure'* and *'turnaround'* synonyms which were linked to *'organisation'* synonyms. The keywords used were: *'failure'*, *'decline'*, *'mortality'*, *'crisis'*, *'death'*, *'exit'*, *'turnaround'*, *'recovery'*, *'success'*, *'retrenchment'*, *'rejuvenation' and 'renewal'*. For each database an appropriate search strategy was used and two librarians from the NHS Centre for Reviews and Dissemination (CRD) were consulted in order to focus the search strategy. A key difficulty with the medical/health databases used was the use of similar phrases in clinical papers such as *'failure'*, *'mortality'*, and *'death'*.

As organisational failure and turnaround processes are diverse and multifaceted topics, it is difficult to strike an optimal balance between sensitivity (avoiding the non-retrieval of relevant items) and specificity (precision in retrieving only what is relevant) when a search strategy is devised. Hence, a substantial amount of time was required for searching for all relevant studies. Although both MESH terms and free text terms were used to enhance the sensitivity of the search, dispersed subjects are unlikely to be well represented in bibliographic databases in terms of the indexing system, so it was necessary to increase the free text searching. Sheaf et al. (2003) state that the loss of specificity in retrieval could be a result of this strategy. Some additional methods of exploration employed when electronic databases were searched in order to capture additional sources, such as using the authors' names of relevant papers as a search term. The first search was conducted during November 2004 and refined and updated in August 2006. The search strategy is detailed fully in Appendix 3.1.

To eliminate duplication, results from the different databases were placed into a reference manager package and reference lists from the systematic reviews were crosschecked. To avoid duplication, studies included in both were not abstracted.

3.4.2.2 Reference scanning

Reference lists of all relevant articles were scanned. This most commonly took the form of following up references in papers that were candidates for inclusion. Some publications unavailable in electronic form were also included. Though costly in terms of time, this method has the advantage that other articles in a specific issue, for example, may have some bearing on the search, especially where the journal has produced a special issue covering a particular topic.

3.4.2.3 Hand searching of key journals

Following consultation with experts (Boyne, G; Skelcher, C; Gray, J; Walshe, K), relevant journals from 1990 selected from a range of disciplinary areas including public administration (Public Management Review; Public Money and Management), health policy (Journal of Health Services Research & Policy; Health Policy; Health Affairs) and management (Health Care Management Review; Strategic Management Journal) were hand searched.

3.4.2.4 Contacting experts and relevant organisations

Experts and relevant health care research and funding organisations (e.g. NHS Service Delivery and Organisation Research & Development Programme NHS SDO) in this field were identified worldwide, either through their published work, or identified by other researchers, and were contacted via e-mail to obtain their empirical and theoretical papers (including unpublished and research in progress).

3.4.3 Quality assessment

There is no objective method of appraising the quality of non-experimental studies (CRD, 2001). Following consultation with an expert in this area, an *a priori* decision was taken not to specify a minimum cut off point to assess the quality of studies, owing to the presence of heterogeneity and the variability in the quality of research. Egger and Smith (1998- cited in McDonald, 2003) argue that considerable debate has arisen about what kinds of studies form 'good enough' evidence. Where necessary, the quality of

studies are discussed in the presentation of study findings. Most of the included studies were qualitative and various checklists for quality assessment was considered (Blaxter, 1996; Popay et al., 1998; Mays and Pope, 2000; Mays et al., 2001). There are many similarities among these and Mays and Pope's checklist (2000) was adopted, as it covers several important criteria (See Appendix 3.3). To assess the quality of the quantitative studies, a checklist developed by Boynton and Greenhalgh (2004) was used (See Appendix 3.4)

3.4.4 Data extraction

A data extraction form was designed (Appendix 3.2) to distil details concerning the aims of the study, setting, study design, participants, method of data collection and analysis, reported findings, and implications for research and policy.

3.4.5 Method of analysis

It was felt inappropriate to use the meta-analysis technique (CRD, 2001) to aggregate the data, owing to the absence of homogenous quantitative evidence and the wide variety of study design. The literature on organisational failure and turnaround processes is mainly discursive and the studies rarely include objective measurable outcomes commonly used in quantitative research. In such cases, a narrative approach is used to synthesise the results of the studies (Pawson, 2000a; Mays et al., 2005). The stage theoretical framework was used to summarise and interpret the study findings.

3.4.6 Results

Once duplicates were removed, the search identified 9156 papers. During the initial stage, 8671 papers were excluded on examination of the title and abstract. In the next stage, the complete texts of the remaining papers (485) were assessed against the inclusion criteria and a further 470 studies were excluded. Finally, 15 studies (13 primary studies and 2 reviews) were included. One of the included studies (Turner and Whiteman, 2005) reports the results of a three year longitudinal multiple case study. A range of policy reports (Skelcher et al., 2004; Hughes et al., 2004; Jas, 2004;

Whiteman, 2004) and articles (Turner et al., 2004; Jas and Skelcher, 2005a) were published about this study. However, as the last article (Turner and Whiteman, 2005) covered all the results of the study, it was the only one included and abstracted but key issues covered in the policy reports and articles were used for further discussion. Table 3.1 presents a brief summary of the included studies. A more detailed summary is presented in Appendix 3. 5. It is important to note that many papers about organisational failure and turnaround were largely anecdotal and published in non-academic journals. Some of the material studied was either deemed theoretically and/or practically weak or, more commonly, covered areas irrelevant to the study. These categories include editorial pieces, or articles by consultants that appear designed to capture the interest - or even custom - of readers. Two included reviews were not related to the health sector, so their primary studies were not abstracted and only the findings were used to inform the results of this review. The first (Boyne, 2006) covered the turnaround strategies used in the US public services and included seven separate studies (Contino and Lorusso, 1982; Rainey and Rainey, 1986; Holzer, 1988; Decker and Paulson, 1988; Stephens, 1988; Poister, 1988; Moore, 1995). The second (Gray, 2000) reviewed organisational failure and turnaround strategies in UK state schools.

3.5 Overview of the included studies

3.5.1 Setting of the studies

Studies have been conducted across a wide range of organisational settings including: health services (Protopsaltis et al., 2002; Fulop et al., 2004; Harvey et al., 2005a); local government (Turner and Whiteman, 2005; Andrews et al., 2006; Eitel, 2004; Joyce, 2004); schools (Harris et al., 2003; Harris and Chapman, 2002; Wilmott, 1999; Meier and Bohte, 2003; Boyne and Meier, 2005; Gray, 2000); and a combination of public services (Paton and Mordaunt, 2004; Boyne, 2006) (See table 3.1).

3.5.2 Aims of the included studies

The aims of the studies were multiple and diverse. Two focused only on the symptoms, causes and patterns of failure, and the impact of contextual factors in contributing to failure (Andrews et al., 2006, Meier and Bohte, 2003). Andrews et al. (2006) examined

Table 3.1 Summary of studies

Authors	Unit of analysis	Sample characteristics	Time period	Data Sources	Methodology
Protop-saltis et al. (2002)	acute trusts	9 NHS hospitals (4 zero star hospitals and 5 hospitals at different stages of turnaround)	2001-2002	interviews with managers and staff of hospitals at different levels; interviews with external stakeholders and relevant organizations; 2 focus groups with senior managers; a workshop with contributions from academics and practitioners	qualitative multiple case studies
Fulop et al. 2004	acute trusts	9 NHS hospitals which had replaced their senior manager(s) (5 hospitals at different stages of turnaround and 4 zero star trusts or the trusts that were at risk of becoming zero star hospital)	2002-2004	semi-structured face to face interview with 106 internal and external stakeholders over two years, data from a sample of local media reports from the web, national patient survey programme, and the performance rating data	qualitative multiple case studies
Harvey et al. 2005	range of NHS organ-isations	A range of zero star NHS trusts that were subject to help from the PDT (5 organisation from 2003 rating	2003-2004	Data collected through interviews and review of documents. 52 interviews – 38 interviewees from the 2003 cohort of zero-star trusts (people from trust's senior mangers, PDT staff working with the trust and related SHA) and 14 interviewees from the 2002 cohort of zero-star trusts (senior managers of trusts and their related SHA)	qualitative multiple case studies
Turner and Whiteman 2005	local govt auth-orities	15 English poorly performing local government authorities	2002-2004	interviews with key stakeholders (internal and external to the organisation including managers, staff, politicians and external advisors) and key actors in relevant national agencies; reviewing documentary evidence and CPA reports provided theory approach by the Audit Commission; quantitative survey (staff attitude survey)	case study method within the grounded theory

Authors	Unit of analysis	Sample characteristics	Time period	Data Sources	Methodology
Andrews et al., 2006	local govt authorities	120 English local authorities	2001-2003	Data collected using an electronic questionnaire survey sent via e-mail to 386 authorities for 4184 officers and politicians working in English local authorities at corporate and eservice level (education, social support, benefit and leisure, environment, housing and libraries) and a range of secondary data sources. Data analysis was conducted for only 120 local authorities with 1257 informants	questionnaire based survey
Eitel, 2004	regional office of a national agency	A Regional governmental office in a major metropolitan city	1976-2001	review of a range of archival and documentary sources (internal and external) and also tracking the changes by the researcher as he had worked as both internal and external consultant to the organisation	qualitative single case study
Joyce, 2004	council	An English council (London borough of Newham)	1996-1999	interview with the former chief executive of a Newham council which experienced a successful turnaround	qualitative single case study
Harris et al., 2003	school	8 English schools (2 primary and 6 secondary) in former coalfield areas	1998-2002	semi-structured interviews with participants (head teachers, senior and middle managers, teachers, non-teaching staff and group of pupils), review of inspection data and contextual data (socioeconomic data)	qualitative multiple in-depth case studies

Authors	Unit of analysis	Sample characteristics	Time period	Data Sources	Methodology
Wilmott, 1999	school	English school	1996-1998	data collected using participant observations almost immediately after the inspection by Local Education Authority advisers, and interviews with staff about their experiences of the LEA inspection	qualitative single case study
Meier and Bohte, 2003	school	1000 public school districts in Texas	1995-1998	secondary data available to measure effect of four independent variables (task diversity/goal conflicts, available resources, bureaucracy and incentives) on the dependent variables as indicators of organisational micro-failure (absenteeism, retention [classes failure], and dropout)	quantitative survey
Boyne and Meier, 2005	school districts	150 Texas school districts performing in the lowest quartile on the primary assessment criterion in 1995	1995-2002	data on organisational strategies (retrenchment, reorganisation, repositioning) and good luck or context (munificence – change in financial resources - and hostility - socio economic characteristics of school children through proportion of minority and low income students) derived partly from secondary sources and partly from surveys of school super-intendents in Texas in 2000 & 2002 (mailed survey with three follow ups. Evaluation of failure and turnaround based on Texas assessment of academic skills (TAAS), assessing student function (retrospectively) 1995-2002. Size of school and tenure of superintendents were control variable	retrospective questionnaire based survey
Paton and Mordaunt 2004	local authority, health care trust, school	three different organisations (a local authority, a health care trust, a school in deprived area)		Interview with individual who led the turnaround in the local authority, chief executive of the health care trust, an academic who was also as a member of the governing body for a period of time for the school. Review of documents and internal data for the health care trust	qualitative multiple case studies

the impact of both misfortune (adverse circumstances faced by some organisations beyond their control) and the mismanagement of organisations. Meier and Bohte (2003) examined under-performance in some school districts. They explored the contribution of four independent variables (task diversity, available resources, bureaucracy and incentives) to failure, defined as micro failure (pattern of suboptimal performance for a period of time) measured by three indicators (absenteeism, class failure and dropout).

Five studies focused only on the turnaround strategies and factors that affected their impact (Harvey et al., 2005a; Joyce, 2004; Harris et al., 2003; Boyne and Meier, 2005; and Boyne, 2006). Specifically, Harvey et al. (2005a) focused on the role of an external intervention agent (the Performance Development Team) in promoting and facilitating turnaround of poorly performing (zero star rated) organisations. Joyce (2004) placed exclusive emphasis on the role of the new CEO in the turnaround process of a poorly performing English council. Harris et al. (2003) explored the strategies used for raising and sustaining attainment in English schools, in a former coalfield area, over 5 years. Boyne and Meier (2005) tested a new model of turnaround that evaluated the impact of both a range of 'turnaround strategies' (reorganisation, retrenchment and repositioning) selected by managers and 'good luck' - the change in external circumstances (beyond managerial control) on the success of turnaround processes in 150 Texas school districts. Boyne (2006) reviewed seven studies in order to assess the impact of turnaround strategies (reorganisation, retrenchment, and repositioning) on the reversal of performance of poorly performing public service organisations.

The remaining eight studies explored both organisational failure and turnaround processes (Protopsaltis et al., 2002; Fulop et al., 2004; Turner and Whiteman, 2005; Eitel, 2004; Harris and Chapman, 2002; Wilmott, 1999). Both Protopsaltis et al. (2002) and Fulop et al. (2004) sought to explore the symptoms, causes of failure, triggers for change and turnaround strategies used in their case studies (nine low performing NHS acute Trusts) and to investigate the impact of turnaround strategies on the performance of organisations and key stakeholders. Turner and Whiteman (2005) examined the causes of failure and turnaround process in 15 English local authorities that were categorised as poor performers over a three year period. One study explored the reasons

why improvement strategies failed to turnaround a US regional government office, which had been assessed as underperforming for the previous 25 years (Eitel, 2004). Harris and Chapman (2002) looked at leadership processes and approaches in ten schools facing challenging circumstances, that demonstrated gradual performance improvement. Wilmott (1999) investigated the ways in which a Local Education Authority (LEA) advisory team (as the external turnaround agent) had responded to the needs of a 'failing' school, identified by the OFSTED auditors, and how the school mediated LEA interventions.

3.5.3 Time of publication

There has been a growing interest in this topic since the late 1990s. Eight studies were published before 1999 and seven of these (from the USA) were included in the review conducted by Boyne (2006). Twelve studies were published after 2002 (see table 3.1) and a number of high quality studies were published after 2005. All quantitative studies were published after 2005, so that at the time of starting this research, the size and quality of the available literature was far less than at present. In addition, one of the key studies, conducted in the health sector (Fulop et al., 2004) is still unpublished.

3.5.4 Terminology used in the included studies

Most of the studies used the terms 'failure' and 'decline' to identify serious performance problems. None used similar terms to those that have been used in the for-profit sector (e.g. organisational mortality, organisational death, and organisational exit) to represent failing situations. All three studies conducted in the health sector used the star rating system to define failure and improvement in the star rating classification. Similarly, the Comprehensive Performance Assessment (CPA) was used to define performance attainment in the local government sector (Turner and Whiteman, 2005; Andrews et al., 2006; Boyne and Meier, 2005). Turnaround, recovery, success and retrenchment were used interchangeably to present performance improvement following a period of poor performance. The terms rejuvenation and renewal were sometimes used in the included studies.

3.5.5 Research methods used in the included studies

The most commonly used research method was the qualitative case study (employing interviews, document analysis and observations to gather data). Three studies used a single case study, and multiple case studies were used in seven studies. In two, the data was collected by interviewing a senior manager only in order to explore the objectives of the study. Three studies used quantitative survey methods. All the studies, conducted in the health sector used qualitative multiple case studies; (these studies are detailed in table 3.1).

3.5.6 Theoretical frameworks used in the included studies

Several studies had no explicit theoretical framework to explain organisational failure and/or turnaround (Andrews et al., 2006; Eitel, 2004; Joyce, 2004; Harris et al., 2003; Harris and Chapman, 2002; Meier and Bohte, 2003). However, some studies did use different stage theoretical framework, including Argyowasmy's two stage model (Paton and Mordaunt, 2004) and McKiernan's six stage model (Protopsaltis et al., 2002; Fulop et al., 2004). A 'realistic' evaluation methodology (Pawson and Tilley, 1998) was adopted, by Turner and Whiteman (2005), which sought to identify the Context for poor performance (causes), Mechanisms for recovery, and Outcome of the recovery interventions on local authority performance (CMOs model). Two studies used the "3Rs" strategy (Retrenchment, Repositioning and Restructuring) [see section 2.9] to explain the impact of interventions in turning around poor performance (Boyne and Meier, 2005; Boyne, 2006).

The remainder of the chapter considers the symptoms of organisational failure, its primary and secondary causes, triggers for change, and strategies used to turnaround poor performance. In addition, the impact of these interventions on organisational performance and on staff, the role of external organisations in triggering change and the turnaround process are also explored.

3.6 Symptoms of failure

As noted in section 2.5, the symptoms or markers of failure are the initial observable indicators of the presence of a problem in an organisation. If organisations are able to detect these, decline may be prevented. In accordance with McKiernan's (2002) classification, different categories of symptoms of failure are identified in some of the studies included in this review: **financial** (financial deficit, poor financial control); **physical** (inability to hit core targets, management turnover, a high level of staff turnover, recruitment problems, poor public and press image, poor working relations with external stakeholders, and major incidents - such as avoidable deaths in hospitals); **behavioural** (ignoring problems, placing the blame for problems on others, low staff morale, loss of reputation, absence of pride in the organisation, low levels of expectation, and poor behaviour in school classes); **managerial** (stagnating management, mistrust on the part of employees, internal conflict, lack of teamwork, centralised decision making behind close doors). Table 3.2 summarises the symptoms of failure reported in each included study.

Inability to meet key performance targets is a common symptom in all studies, regardless of sector. Examples are the failure to achieve waiting list targets in the health sector and the inability to provide an acceptable level of education as set by OFSTED in schools. Poor working relationships with external stakeholders, a high level of staff turnover, recruitment problems, and a poor public image were the symptoms that presented in all three settings (health, school and local government sectors). Paton and Mordaunt (2004) reported a physical sign of failure during the period of the NHS 'internal market'. They found a poor performing health care trust suffered from significant clinical weakness and inadequate competition reflected in a substantial net export of patients to surrounding hospitals, which put the Trust in an uncertain situation, with the possibility that its management might be taken over by external organisation.

Financial symptoms were addressed in two studies in the health sector, (Protopsaltis et al., 2002; Fulop et al., 2004) as obvious indicators of failure, though in the school setting it was not reported as an evident symptom. Only Paton and Mordaunt (2004)

and Gray(2000) reported lack of financial balance in poorly performing schools in deprived areas. Among managerial symptoms, employee mistrust, internal conflict and lack of teamwork were the most prevalent markers across three settings (health, school and local government sectors). Low staff morale was a common symptom (behavioural) reported in all three contexts. Unsatisfactory teaching quality, poor behaviour in classes and low levels of expectation were the specific symptoms identified in the school setting.

Fulop et al. (2004), in a study covering nine poorly performing English NHS acute trusts, classified indicators of decline, as perceived by stakeholders, into multiple 'clusters' rather than 'singular' events. Two main 'clusters' were identified. Cluster type 1 represented "the organisation as an insular 'fortress' exhibiting poor media image, poor external relationships, low staff morale, high turnover and recruitment problems". This cluster was common to zero star rated trusts, and in particular was perceived by incoming managers as a key symptom of failure. Cluster type 2 represented "the organisation that is unable to implement core targets (breaches of core access and waiting list targets, poor A & E performance) and exhibits financial problems (breaches of core financial, external financial pressures and inability to adjust to new funding systems". It was reported that all samples of trusts were represented in this cluster, though 'at risk' samples that had not been rated as zero star (reduced performance, but not absolute failure) exhibited it more commonly.

Included studies showed good managers leaving organisations, which is a classic marker of failure, and a high level of management turnover ensued (Fulop et al., 2004; Protopsaltis et al., 2002; Eitel, 2004; Turner and Whiteman, 2005; Gray, 2000). The posts tended not to be (or could not be) filled, or inexperienced managers were brought in. Consequently, the organisation lost its managerial capacity and capability (valued at a premium during the crisis phase) exacerbating the situation and likely to be the cause of further decline in performance (Fulop et al., 2004).

Table 3.2 Symptoms of decline

	Protop-saltis 2003	Fulop 2004	Turner & Whiteman 2005	Andrew 2006	Eitel 2004	Harris 2003	Harris & Chapman 2002	Wilmot 1999	Meier & Bohte 2003	Paton & Mordaunt 2003	Gray 2000
Physical											
inability to hit core targets	•	•	•	•	•	•	•	•	•	•	•
high level of staff turnover and/or recruitment problems	•	•			•					• school	•
poor public/press image	•	•			•					• local authority	•
poor working relations with media	•	•								• local authority	
poor working relations with external stakeholders	•	•	•		•		•				•
management turnover	•	•	•		•						•
inadequate competition (export of the clients to other providers)										• health care trust	
major incidents (deaths in hospital)		•								•	
unsatisfactory teaching quality						•	•	•		•	•
Financial											
poor financial control	•	•			•					• school	•
financial holes or unexplained deficit	•	•									

	Protop-saltis 2003	Fulop 2004	Turner & Whiteman 2005	Andrew 2006	Eitel 2004	Harris 2003	Harris & Chapman 2002	Wilmot 1999	Meier & Bohte 2003	Paton & Mordaunt 2003	Gray 2000
Managerial											
Stagnating management	•	•	•								•
Employee distrust/ internal conflict		•	•		•		•	•		• local authority	•
No visible mangers in organisation		•									
Lack of teamwork		•	•		•			•		• school	•
Centralised decisions made behind close doors		•									
Behavioural											
Low staff morale	•	•	•		•			•		• health care trust/ school	•
Ignoring problem	•	•	•								•
Blames for problems placed on others		•									
Loss of reputation/ no pride in organisation		•			•						
Low level of expectation						•	•				
Poor behaviour in classes						•	•			•	•

Turner and Whiteman (2005) report that in six of their cases, the need for turnaround interventions had been denied by managers over a long period (behavioural marker). Fulop et al. (2004) and Eitel (2004) found that managers tended to blame others for performance problems and did not consider themselves as a cause or contributor to the failure (behavioural marker).

Some studies defined certain causes of failure as symptoms. Fulop et al. (2004) viewed distraction by a major development plan (e.g. a merger or implementation of a Private Finance Initiative (PFI) scheme) as symptoms of failure rather than secondary causes. Certain researchers do not differentiate between symptoms and secondary causes of failure, despite McKiernan's view to the contrary (Harvey et al., 2005a).

3.7 Secondary causes of failure

As outlined in section 2.6, a range of internal and/or external factors combine to cause organisational failure in the for-profit sector. The current review similarly found that both internal and external factors contribute to organisational failure in public services. For example Andrews et al. (2006) reported that both mismanagement (an internal factor) and misfortune (an external factor in which untoward circumstances are faced by some public organisations and are beyond the control of the organisation) had an impact on the performance of public organisations. They reported that around 55% of the variation in the relative success and failure of 120 UK local authorities was collectively explained by misfortune and mismanagement variables.

McKiernan (2002) classifies secondary causes of failure in the for-profit sector in terms of following: (1) financial (largely internal); (2) demand (external environment); and (3) managerial (internal) causes. This current review identified five different internal secondary causes of failure within public sector, including: (1) managerial; (2) financial; (3) organisational; (4) cultural; and (5) political. Table 3.3 summarises the internal and external secondary causes of failure reported by each of the studies. The following section considers internal and external secondary causes of failure in more detail.

Table 3.3 Causes of decline

	Protop-saltis 2002	Fulop 2004	Turner & White-man 2005	Andrew 2006	Eitel 2004	Harris 2003	Harris & Chapman 2002	Wilmot 1999	Meier & Bohte 2003	Paton & Mordaunt 2003	Gray 2000
Setting	*health sector*	*health sector*	*local govern-ment*	*local govern-ment*	*regional govern-ment office*	*school*	*school*	*school*	*school*	*local govern-ment, school, health sector*	*schools*
Internal factors											
poor managerial leadership	•	•	•	•	•			•		• local govern-ment	•
poor operational/financial management	•	•	•							• local govern-ment	•
poor performance management	•	•	•	•				•			
cultural issues	•	•	•		•	•	•	•			•
unaware of need to turnaround (lack of cognizance of poor performance)			•								•
inadequacy of staff engagement	• clinicians	• clinicians	•		•			•			•

	Protop-saltis 2002	Fulop 2004	Turner & White-man 2005	Andrew 2006	Eitel 2004	Harris 2003	Harris & Chapman 2002	Wilmot 1999	Meier & Bohte 2003	Paton & Mordaunt 2003	Gray 2000
distraction by major projects (eyes off ball)	•	•									
silo management	•		•		•						
insularity (insufficient relationship with other stakeholders at local and/or central level)	•	•	•	Not signi-ficant	•	•	•	•			•
lack of strategies	•	•	•							• school	•
poor political leadership			•	•							
stagnant political environment			•								
volatile political environment)			•								
change to unitary status			•								
poor political-managerial relationship			30%								
poor corporate structure (departmentalism)	•		•		•						

	Protop-saltis 2002	Fulop 2004	Turner & White-man 2005	Andrew 2006	Eitel 2004	Harris 2003	Harris & Chapman 2002	Wilmot 1999	Meier & Bohte 2003	Paton & Mordaunt 2003	Gray 2000
inertia related to the previous success		•	•								
Inattention to the warning external message	•	•	•		•						
lack or inappropriate response to changing external environment (organisational introspection)		•	•		•						•
poor internal relationship			•	no statistical signif-icance	•		•	•		• local govern-ment	•
mismanaged priorities	•	•	•	no statistical signif-icance						• school	
lacked management/ political will for turnaround			•								•
instability within the organisation		•									

	Protop-saltis 2002	Fulop 2004	Turner & White-man 2005	Andrew 2006	Eitel 2004	Harris 2003	Harris & Chapman 2002	Wilmot 1999	Meier & Bohte 2003	Paton & Mordaunt 2003	Gray 2000
organisational myopia		•									
organisational trauma		•									
lack of system process and policies	•	•	•								•
lack of attention to new governmental strategies					•						
lack of corporate vision					•					• school	
lack of capability to turnaround					•					• school	•
insufficient professional confidence and capability					•	•	•				•

	Protop-saltis 2002	Fulop 2004	Turner & White-man 2005	Andrew 2006	Eitel 2004	Harris 2003	Harris & Chapman 2002	Wilmot 1999	Meier & Bohte 2003	Paton & Mordaunt 2003	Gray 2000
External factors											
policy change	●	●	●								
increased competition		●									
diverse services needs			●	●							
high level of poverty and deprivation			●	●				●	●		●
social class diversity				Not significant					●		●
financial resources directly available to organisation				Not significant							

3.7.1 Internal secondary causes

Included studies identified five different categories of internal secondary causes of failure: managerial; financial; political; organisational; and cultural factors.

3.7.1.1 Managerial factors

A range of managerial related factors were identified, including poor managerial leadership, poor operational performance, lack of performance management arrangements, a lack of managerial skills and capacity, lack of data management systems, 'silo' management, lack of corporate vision and strategies, insufficient staff engagement (lack of clinical staff involvement in the health sector), lack of relationship with external stakeholders, inattention to external warning signals, distraction by a major development plan (e.g. merging of organisations or development of a new organisational site), mismanaged priorities, lack of system process and policies, lack of managerial capability to turnaround, loss of credibility on the part of management among staff and remote managers (where the management team were located off the main site) [see Table 3.3].

Lack of managerial leadership was one of the most common factors reported in all three sectors. Protopsaltis et al. (2002) found that Chief Executive Officers (CEOs) of poorly performing NHS acute trusts were a key contributor to the problem. Lack of leadership, unwillingness to make decisions, reluctance to distribute power (delegation), working in isolation from managers in other organisations, and the inability to challenge internal vested interests were found to be key managerial problems. Lack of leadership by the Trust board was also a factor in some cases. For example, non-executive members of the board were unable to raise problems and effectively challenge executive members. In one case the board of the Trust had focused entirely on financial problems; attaining access targets, such as waiting lists was not viewed as a key priority.

Andrews et al. (2006) examined the impact of mismanagement and misfortune on the success or failure of 120 UK upper tier local authorities measured by the Comprehensive Performance Assessment (CPA) scores using a questionnaire based survey. They used seven criteria to measure mismanagement including: (1) performance management

(management information system at corporate and service level); (2) having clear priorities; (3) internal partnership (joint working and cross cutting working); (4) links with users (the importance of understanding users' needs, the importance of users' demands and the involvement of external stakeholders in strategy making); (5) external partnerships; (6) managerial leadership; and (7) political leadership. There were significant associations between three out of seven mismanagement variables (performance management ($T= 2.602$, $p<0.05$), managerial leadership ($T= 3.527$, $p<0.01$) and political leadership ($T= 2.881$, $p<0.01$)) and the performance of local authorities. It was shown that English local authorities were more likely to fail if they had poor performance management systems and poor political and managerial leadership as their internal characteristics. This suggests that a lack of leadership rather than weak organisational structure and process is more likely to lead to organisational failure. The clarity of priorities, internal relationships, links with users and external relationships did not show a statistically significant impact on the performance of local authorities. However, only the development of a relationship with the private sector was considered as the external relationship in this study and relationships with other public and governmental organisations were not included. This suggests that the impact of the working relationship with other external stakeholders should be the focus of future research regarding organisational failure. It was noted that the study measured joint working and cross cutting working in order to evaluate internal relationships, though these two factors are only one form of internal relationship and did not present significant correlation with failure. The other elements of internal relationship, which may show a relationship to failure, were not included in this study. Turner and Whiteman (2005) also highlighted poor political and managerial leadership as causes of failure in some of the local authorities in their study.

Different kinds of poor operational management in under-performing NHS acute trusts were identified as causes of failure, such as lack of financial understanding and management, inadequate and unclear plans for managing clinical (e.g. waiting list, A& E and patient discharge) and non-clinical tasks, and inability or unwillingness to address key targets. Furthermore, some CEOs and/or senior managers were reluctant to invest in improving their management structure (Protopsaltis et al., 2002).

In studies conducted in all three sectors, poor working relationships between managers and other stakeholders at local and/or central level were reported as an important cause of failure. Senior managers of such organisations were distracted by major development plans, resulting in them taking their 'eyes off the ball'. Fulop et al. (2004) and Protopsaltis et al. (2002) reported that a major development plan (e.g. a merger or PFI scheme) caused senior mangers' attention to become distracted in several poorly performing NHS trusts.

3.7.1.2 Financial factors

A series of financial problems were reported in included studies, particularly in the health sector (Fulop et al., 2004; Protopsaltis et al., 2002), as internal causes of failure. Fulop et al. (2004) identified poor financial control and financial instability, a high cost structure (drugs and agency staff), overspends in key clinical directorates and the duplicating of services across two or more hospital sites of a trust as examples of financial problems in their sample (nine poorly performing NHS acute trusts). Protopsaltis et al. (2002) reported that in certain cases, previous managers had hidden the existence of financial problems and that they were revealed when investigated by new managers.

3.7.1.3 Political factors

Political factors were reported as an important internal cause of failure in some studies conducted within the local government setting (Turner and Whiteman, 2005; Andrews et al., 2006). Turner and Whiteman (2005) reported several relatively common political factors among their cases, including poor political leadership characterised by a lack of vision, stagnant political environment or volatile political environment (frequent changes in control, such as different parties in power following two elections, poor inter-party relations and internal political dispute). Parochial politicians, lacking strategic vision and the ability to make complex decisions, were also perceived as political factors in two cases. Andrews et al. (2006) also found a statistically significant ($T=2.881$, $P< 0.01$) relationship between political leadership and the performance of 120 selected UK local authorities. It was argued that poor leadership or unsteady

('volatile') leadership, is unlikely to be able to respond to performance problems appropriately and the ability to improve may not be fully embedded within the organisation owing to constant change (Turner and Whiteman, 2005).

Joyce (2004) also placed emphasis on the importance of both managerial and political leadership as important factors in preventing continuing failure. The importance of political leadership was rated more highly than managerial leadership because of the power of politicians, who can approve or reject decisions made by managers (Andrews et al., 2006). They also argued that good political and managerial leaders were unlikely to be attracted by poorly performing organisations, creating a vicious circle, where poor leadership resulted in poor performance.

3.7.1.4 Organisational factors

A number of organisational factors contributing to the failure of organisations were reported in some included studies. These factors were: poor corporate structure (departmentalism) [Protopsaltis et al., 2002; Turner and Whiteman, 2005; Eitel, 2004]; tense employee relationships and internal conflicts (Fulop et al., 2004; Turner and Whiteman, 2005; Wilmott, 1999; Eitel, 2004; Harris and Chapman, 2002); insufficient professional confidence and capability (Harris and Chapman, 2002; Harris et al., 2003); loss of a CEO following a major disaster such as a significant patient safety accident (Fulop et al., 2004); poor relationships and/or conflict between political and managerial leadership (fear amongst managers driven by political intimidation); and complex relationships between members, managers, union and community organisations (Turner and Whiteman, 2005).

As an example of the role of organisational factors, Eitel (2004) reported that a US regional office, which had performed poorly for years, worked as a 'siloed' organisation with a poor corporate structure, within which each department functioned separately and had its own decision making pathways, with counterparts in the national office. It was a highly bureaucratic organisation and significant mistrust between managers and staff was evident, encouraging staff resistance to some key decisions made by senior managers.

3.7.1.5 Cultural factors

As culture is a contested term, it is necessary to discuss organisational culture and explain its impact on organisational processes and outcomes before stating the role of cultural factors as a secondary cause of poor performance identified in the included studies.

Culture as a concept comes originally from the academic study of social anthropology in the early twentieth century. Organisational culture is a multidimensional concept that developed independently in several disciplines ranging from social anthropology to organisational psychology. There are many approaches to culture and even more definitions. Various definitions portray different ontological, epistemological, and methodological assumptions (Smircich, 1983; Ashkanasy et al., 2000). Definitions of organisational culture range from a very short description given by Bower (1966): "It's the way we do things around here" to more complex definitions. Atkinson (1990) defines organisational culture as: "reflecting the underlying assumptions about the way work is performed; what is acceptable and not acceptable; and what behaviour and actions are encouraged and discouraged". Schein (1985, p19) defines organisational culture as: "A pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems". According the Schein, organisational culture is the learned result of group experiences, and it is to a large extent unconscious. Schein (1992) contends that underlying assumptions grow out of values, until they become taken for granted and drop out of awareness. Schein (1992) views organisational culture as a three mutually reinforcing layers, which are artifacts (tangible signs), espoused values and basic assumption from surface to core.

During the past two decades, research in organisational culture has shown two competing perspectives, each based on very different ontological assumptions: culture as a critical variable (e.g. the functionalist view) vs. culture as a root metaphor (interpretivist view) (Smirich, 1983). In the former, culture is defines as a variable that an organisation has and aaccording to this approach leaders develop the culture and an organisation's value system Here the managers are viewed as manipulators and cultural

change agents to achieve corporate objectives (Peters and Waterman, 1982). In a strong and corporate culture all workers must, according to this approach, adopt the manager's values as their own underlying assumptions and act according to them. Here, Unitary (strong) culture is pursued as the theory of cultural cohesion and conflicts or differing opinions are considered harmful and every effort is made to eradicate them (Alvesson & Berg 1992; Parker, 2000). This view is seen in those models, which try to distinguish different 'types' of organisational culture. The latter perspective views culture as a metaphor. Here culture defines the whole character and experience of organisational life or what an organization is. Here organisations are viewed as a culture existing in and generated through the social interactions of their participants. The emphasis in this approach is to understand how organizations are socially accomplished and reproduced rather than what organization can achieve (Mannion et al, 2005). Therefore, this approach considers cultural cohesion in terms of co-existing sub cultures rather than a unitary culture. Interpretivists explore the active creation of meaning and the ways in which meanings are associated in organization (Schultz and Hatch, 1996).

Johnson and Scholes (2002), state that culture can act as a filter through which members of the organisation relate to their world both internally and externally. This can be helpful in two ways: first as a shorthand way to understand complex situations and second as a basis for organisational success and competitive advantage because the culture itself is difficult to imitate. Kotter (1995) cites the inability to anchor change initiatives in the organisation's culture as one of the primary reasons that change efforts are not sustained. Regardless of the size, industry, or age of the organisation, culture affects many aspects of organisational performance (Fisher & Alford, 2000). Therefore, it is important to take into account the concept of organisational culture when attempting to develop and manage organisation-wide change initiatives. Cultural transformation is a central component of the NHS plan (DoH, 2000, 2002) in the UK alongside structural change to deliver desired improvement in quality and performance. In the healthcare context, organisational culture has been associated with several organisational factors that contribute to quality, such as quality of nursing care, job satisfaction, and patient safety.

Several cultural issues were identified as secondary causes of poor performance in the studies. These included: the lack of a performance culture (Turner and Whiteman,

2005); low levels of expectation, especially in the education sector (Harris et al., 2003; Harris and Chapman, 2002; Gray, 2000); the presence of a blame culture (Fulop et al., 2004; Eitel, 2004); a risk averse culture (Eitel, 2006); resistance to changing the inappropriate behaviour of some doctors within trusts (Protopsaltis et al., 2002) and resistance to turnaround owing to the lack of management/political will (Turner and Whiteman, 2005). Protopsaltis et al. (2004) reported that some of their cases (poorly performing NHS trusts) had a reputation for a 'poor culture' and their values, beliefs and rules were inappropriate or even toxic.

3.7.2 External secondary causes of failure

Changes in the external environment were a contributing factor to organisational failure reported in several studies. Policy change was reported as an important external secondary cause in several studies [Protopsaltis et al. (2002), Fulop et al. (2004) in the health sector, Turner and Whiteman (2005) in local government. Fulop et al. (2004) reported a series of structural changes and reforms that were experienced by the trusts during 1999-2001, such as the introduction of the Performance Assessment Framework. The changes resulted in a re-definition of roles and responsibilities that caused major unintended and dysfunctional consequences in an increasing number of hospital trusts. This was an indication that the speed of change required by the government was too rapid, with management teams finding it difficult to both transform their roles and satisfy the new expectations of partner organisations. Fulop et al. (2004) also maintained that increased competition, following imposed structural changes and reforms, played an important role in the drift into failure. Some of the services provided by trusts were transferred to Primary Care Trusts (PCTs) and Mental Health Trusts, which resulted in more competition between these organisations.

Some studies identified the impact of contextual factors on organisational failure in school settings (Wilmott, 1999; Harris et al., 2003; Gray, 2000; Meier and Bohte, 2003) and local government (Andrews et al., 2006; Turner and Whiteman, 2005). No studies in the health sector made an exclusive investigation of the impact of contextual factors on the failure or turnaround of organisations. Andrews et al. (2006) examined the impact of misfortune (untoward circumstances faced by some public organisations,

beyond the control of organisations) on the success or failure of 120 UK upper tier local authorities measured by CPA scores. They used five criteria to measure misfortune, including the size of the local authorities measured by the population of the areas which were served, two dimensions of diversity of service needs including ethnic diversity (using a calculated index) and social class, the prosperity of local residents by using two proxies for the capacity of local citizens to co-produce services including the percentage of single parent households and the percentage change in the population between 1991 to 2001. The results showed that among misfortune variables the diverse service needs (supported by higher ethnic diversity ($T= -3.779$, $p<0.01$)), poverty (supported by the higher number of lone-parents household ($T= -3.267$, $p<0.01$) and population change ($T= 6.522$, $p<0.01$)) contributed to the organisational failure. This meant that organisations with ethnically diverse populations or higher levels of poverty (more lone-parent households or a declining population) were more likely to be classified as performing poorly. The size of the local authority and financial resources, directly available to the local authority, had no statistically significant relationship with performance.

Turner and Whiteman (2005) also showed that the local population's need for various services was a factor that increased the possibility of failure. It concluded that a high level of poverty and deprivation had a negative effect on the performance of local government. Gray (2000) also indicated that most of the schools on 'Special Measures' were located in areas with high levels of social deprivation. This was viewed as their most obvious contextual characteristic, as measured by the percentage of pupils entitled to receive free school meals. Gray (2000) added that poorly performing schools had historical difficulties, such as 'changes in the composition of their catchments areas, problems with their local communities, difficulties in managing falling pupil numbers, budget restraints and the threat of closure'. Harris et al. (2003) reported that all selected schools in former coalfield areas perceived that environmental disadvantage (deprivation and poverty), faced by the pupils, inevitably had a deleterious effect on their performance. Although social class diversity was reported as a factor that increased the possibility of failure in both schools and local government (Paton and Mordaunt, 2004; Gray, 1999), Andrews et al. (2006) did not find a significant statistical effect between social class and failure in UK local government.

Wilmott (1999) examined the ways in which a Local Education Authority (LEA) advisory team (as external turnaround agent) had responded to the needs of a 'failing' school (as identified by OFSTED auditors). The catchments area of the case study (a poorly performing school) had mainly local authority housing and high levels of economic and social deprivation. In Wilmot's study (1999), the evaluation of school effectiveness by the OFSTED advisors was based only on measurable outcomes. However, the author discussed the fact that the socioeconomic background of the pupils (level of deprivation) could affect their achievements but that it was not considered by the advisors.

Meier and Bohte (2005) examined the impact of four independent variables (task diversity and goal conflicts, adequate resources, the level of bureaucracy, and the level of incentives) upon the likelihood of micro-failure (the pattern of suboptimal performance over a period of time) measured by three key indicators (absenteeism, classes failure, and dropout) in 1000 public school districts in Texas. The emphasis of the study was not on macro-failure (the total collapse and demise of the organisation) as micro-failure is likely to occur more frequently than macro-failure in public services. The authors suggested that the public organisation's micro-failure, in the long run, might be associated with the macro-failure of governance. It was hypothesised that greater task diversity and goal conflict, inadequate resources, increased bureaucracy, and the failure of incentives in the public sector would all result in more micro-failures. Detailed information about the measurements of these four criteria is presented in the data extraction form (See Appendix 3.4).

The regression analysis showed that of the four hypotheses, only task diversity/goal conflicts was correlated positively with micro-failure measurements (absenteeism, retention and dropout) [11 out of 15 measures]. The measurement of resources gave rise to mixed findings. Class size, as a measure of resources, is always significant in the direction that was hypothesised, which means that larger social classes are likely to be at risk of micro-failure. Resources committed to classroom instruction, however, do not show correlation with absenteeism and retentions and positively is correlated with dropout rate. The relationship between instructional expenditure per pupil and micro-

failure was weak, showed variations in the cost of educational input and did not offer reliable evidence of the relationship between resources and failure. The incentive measures also presented a mixed relationship. In two cases, surplus funds are correlated with fewer organisational failures. Teacher turnover as a measure of incentive (adequate salaries) did not have an impact on micro-failure. There was no general association between increased bureaucracy and greater organisational failures.

3.8 Primary causes of failure

As outlined in section 2.6, according to the for-profit literature, both symptoms and secondary causes of decline were related to the primary causes of failure. McKiernan (2002) argued that dysfunction of organisations in terms of their organisational learning processes was a main cause of organisational failure (McKiernan, 2002).

Several studies explored the primary causes of failure (Fulop et al., 2004; Eitel, 2004; Turner and Whiteman, 2005). Fulop et al. (2004) explicitly reported organisational introspection or 'eyes off the ball', organisational myopia, organisational trauma, and organisational arrogance were four important factors that had a negative impact on organisational learning processes, causing performance decline and failure among their nine case study NHS acute trusts. Table 3.4 presents definitions of factors that contributed to organisational learning problems.

Table 3.4 Primary causes of failure

Defects in the organisational learning process identified among the nine case study trusts
Organisational introspection: Learning from the past is used for future behaviour. Management becomes a closed system unable to deal with external challenges.
Organisational arrogance: Arrogance is embedded in the core of the organisation. Changes in external environment are ignored. The organisation continues on set course oblivious to need for adaptation to remain successful. The seeds of failure are built into the organisations belief in its own success.
Organisational trauma: High profile negative media coverage, clinical investigations, lead to removal of CEO followed by period of interim leadership leaves the organisation traumatized and spiralling towards failure.
Organisational myopia: The decline into failure happens because of myopia among management who have poor ability to scan the environment. Long service executives are shut into past successful recipes. The organisation is conservative and risk/change averse. This behaviour is exacerbated when the organisation is spiralling down into failure.

Source: Fulop et al. (2004)

Organisational introspection occurred as a consequence of senior management being distracted by a range of factors, such that they were unable to deal with external challenges. These factors were: (1) the redevelopment of hospital sites; (2) clinical investigations; or (3) negative media interests.

Organisational arrogance arose in those trusts that enjoyed a high profile because of a reputation for clinical excellence or a well-regarded clinical specialty. This necessitated a struggle by the management when dealing with the clinical reforms as set out in the NHS plan, and as a consequence, the management team neglected the overall performance of the organisation, while they focused on achieving clinical service change.

Organisational trauma describes a situation in which a traumatic event (e.g. replacement of a CEO following a serious problem at a hospital and covered by the national media) happens when senior managers are already faced with problematic

internal relationships. The difficult situation of such a traumatised trust is exacerbated when the trust has no CEO in post for a period of time, or has an interim manger. The resulting leadership hiatus makes the trust highly vulnerable to failure.

Organisational myopia depicts circumstances in which senior management teams are unable or unwilling to modernise and develop a new system of working. For example, a 'bunker mentality' is often exhibited by a myopic corporate team in a trust and development of the essential corporate learning strategies required to avoid failure is prevented (Fulop et al., 2004). Turner and Whiteman (2005) also indicated that resistance to external pressure (e.g. failure to implement modernisation and change) was an important issue in declining performance in local government.

Turner and Whiteman (2005) reported that inertia related to previous success (organisational arrogance) and lack of appropriate response to a changing external environment (organisational introspection) were causes of failure among their cases (poorly performing local government authorities).

Some studies highlighted lack of organisational learning in poorly performing organisations as a main cause of failure (Eitel, 2004). Eitel argued that a regional governmental office was categorised as a permanently failing organisation. According to the cognition approach to failure (Anheire and Moulton, 1999), the organisation did not learn from its mistakes and used only 'single loop' learning (Stead and Smallman,1999). Single loop learning refers to the process of detection and correction of errors in relation to the difference between expected and obtained outcomes within an organisation, without questioning the current organisational policies, goals, values and assumptions (Argyris and Schon, 1987). Eitel (2004) reported that both the organisation and its staff suffered from a lack of 'double loop' learning when confronting organisational failure. Double loop learning occurs when an organisation detects and corrects its errors and also questions and amends its strategic goals, policies and values to avoid the recurrence of such errors (Argyris and Schon, 1987).
Findings of the above studies support evidence from the for-profit sector literature, which shows that the lack of an organisational learning capacity, is a key primary cause of organisational failure.

The foregoing sections considered all symptoms, internal and external secondary and primary causes of failure explored in the included studies. In the following sections, factors initiating the processes of change (triggers), and strategies used by organisations to turnaround poor performance are discussed.

3.9 Triggers for change

As outlined in section 2.7, literature in the for-profit sector shows that when the actual or perceived performance of an organisation falls far below an acceptable level, a significant internal and/or external jolt or trigger for action is required, otherwise the organisation faces a high risk of failure. According to stress-inertia theory (discussed in detail in section 2.7), strategic changes occur within an organisation when the level of stress becomes greater than the level of inertia. This can occur by decreasing the inertia level or increasing the stress level. Triggering factors can increase the level of stress and stimulate change processes.

Some of the studies in the current review explored triggers for change in various public services, including health care (Protopsaltis et al., 2002; Fulop et al., 2004), local government (Turner and Whiteman, 2005; Eitel, 2004), schools (Gray, 2000; Wilmott, 1999) and mixed settings (Paton and Mordaunt, 2004). Table 3.5 details the triggers reported by each study.

As with the for-profit sector, both internal and external factors were recognised as triggers for change. Replacement of senior manager(s), change of politician(s), contact of internal managers with central government agencies concerning the poor performance of the organisation, opposition at different levels of the hierarchy, conflict among different groups within the organisation striving to maintain their autonomy, and reaction to the announcement of poor performance were internal triggers. New policies and programmes originated by central government that aimed to improve the performance of the organisation, external inspection or intervention and the concern of external stakeholders (e.g. consumers of services) served as external triggers.

Table 3.5 Triggers for change

Studies / Triggers	Protopsaltis 2002	Fulop 2004	Turner and Whiteman 2005	Eitel 2004	Paton and Mordaunt 2004	Joyce 2004	Gray 2000
Setting	health sector	health sector	local government	regional government office	local government/ school/ health care trust	local government	schools
Replacement of senior manager(s)	•	•	•	•	• school	•	•
Politician(s) change			•				
External inspection or intervention	•	•	•	• national office	• school (external mentor)		•
Reaction to announcement of poor performance	•	•	•				•
Contact of internal managers with central government agencies		•					
Concern of external stakeholders		•	•	•			•

Replacement of senior manager(s) was the most common trigger found in all the above studies. This aligns closely with the findings from the for-profit sector. For example, Turner and Whiteman (2005) and Paton and Mordaunt (2004) showed that the departure, or the replacement of the CEO or council leader in selected poorly performing UK local government services, was an important trigger. Turner and Whiteman (2005) also reported that a change in politicians at the local level triggered change in some of their cases.

Fulop et al. (2004) showed that, in some poorly performing NHS trusts, internal managers contacted central government agencies and raised serious concerns about the poor performance of their organisation. For example, chairmen sometimes contacted the Department of Health (DoH) or Regional Office (RO) to voice their concerns about the functioning of the existing management team and its lack of attention to the wider changes in the local health economy. This resulted in a change of management team. In two other cases, the newly appointed CEO and senior mangers called in the Commission for Health Improvement (CHI) to conduct a diagnostic investigation. The subsequent CHI report acted as a significant stimulus for the first trust by enabling the newly appointed CEO to gain support for remedial interventions. The existing CEO of the second trust was replaced by an interim management team imposed by the Regional Office following publication of the CHI report (Fulop et al., 2004).

External inspection or intervention was an external trigger that played an important role in initiating change. Fulop et al. (2004) reported that for some of the poor performing NHS trusts, the call for action arose from external stakeholders, such as the Regional Office, Strategic Health Authority and user groups. Jas (2004) similarly noted that the need for change and specific action was perceived when the external inspectors' reports in UK local government setting emerged. Likewise, Eitel (2004) indicated that in his case study (a regional government agency), the national office's report had a role in seeking change, although the outcome of the changes deployed by the organisation was not positive. Wilmott (1999) identified the role of the Office for Standards in Education (OFSTED) audit report in the initiation and development of an action plan in a poorly performing school. In the UK, those schools ranked by OFSTED auditors as poorly performing or 'failing' are subject to help from Local Education Authorities

(LEA) and the OFSTED report was regarded as an impetus for change (Office for Standards in Education Report, 1996). Paton and Mordaunt (2004) showed the role of the Local Education Authorities (LEA) in triggering change by appointing an experienced mentor (the head teacher of another school) to aid a poorly performing school to provide a suitable action plan for improvement.

Revealing performance decline within the organisation and the announcement of poor performance ('naming and shaming') were also important triggers for organisations to initiate a series of strategies to address their performance problems. For instance, the public reporting of Comprehensive Performance Assessment (CPA) scores – a system that ranks the performance of UK local governments - was a trigger for change. Seven out of 10 authorities stated that the CPA process had influenced turnaround. However, two authorities believed that the CPA had no effect on turnaround (these organisations lacked an 'achievement' culture) and one case defined the role of the CPA as a delaying factor for turnaround (Turner and Whiteman, 2005). The latter's claims were consistent with Barker et al's (2001) study findings, who argued that performance decline was an insufficient factor to initiate change and that other factors, such as external intervention or internal power repositioning (e.g. change of senior management) were also required for change to occur.

The concerns of different external stakeholders were also an important trigger. Fulop et al., (2004) reported that the external community of user groups raised concerns about the performance of organisations using local and/or national media. This action triggered change in some organisations. Strong lobbying by local and national media highlighted the poor performance of four NHS trusts. Jas and Skelcher (2004; 2005b) indicated that 'naming and shaming' may have also resulted in enforcing pressure from citizens or service-users on poorly performing UK local governments. Gray (2000) highlights the concern of parents of pupils in schools with poor standards of teaching and the low level of pupils' achievement was considered to be a trigger. In some studies (e.g. Paton and Mordaunt, 2004) the need for change was accepted by senior staff but there was insufficient agreement on the precise nature of the change.

3.10 Turnaround strategies used in included studies

As outlined in section 2.9, a range of turnaround strategies used in the for-profit sector are assessed in the literature. Although there is no dominant classification of turnaround strategies in the for-profit literature (Boyne, 2004a), three generic strategies, including Reorganisation (Replacement), Retrenchment, and Repositioning (Renewal), can be distinguished in the for-profit sector literature (Boyne, 2004a; Walshe, 2004) [see section 2-9 for a detailed description of these concepts]. Different studies have used these conceptual categories (or similar labels) in order to examine the impact of different approaches to reversing organisational decline. However, it should be borne in mind that some variables and labels do not fit neatly into any of these three conceptual categories. Therefore, some slightly different patterns of evidence might arise because of different subjective judgments (Boyne, 2006). Table 3.6 details all the turnaround interventions used in each included study and Table 3.7 presents the same strategies, categorised by the '3Rs' framework (Boyne, 2004b).

3.10.1 Reorganisation (replacement) strategies

As outlined in section 2.9, reorganisation strategies include changes in the internal management of an organisation, and the most common reorganisation strategy in the for-profit sector literature is the replacement of the CEO and/or senior management (Boyne, 2006). This current review also shows that the most common intervention used in the public services to stimulate turnaround is the replacement of senior manager(s).

Protopsaltis et al. (2002) reported that the replacement of senior managers occurred in all five turnaround cases (NHS acute trusts). In all, the CEO was replaced, and in two, the chair of the trust was also replaced. In three cases, most or all of the trust board had been replaced.

Turner and Whiteman (2005) argued that the replacement of management was a common intervention used by the local authorities, reflecting the perception that poor leadership influenced failure. Although success is not guaranteed by the replacement of senior managers, an increase in managerial commitment may be facilitated by the appointment of the 'right people at the right time'. The extent of political leadership in

Table 3.6 Turnaround interventions

intervention \ study	Protop-saltis 2002	Fulop 2004	Harvey 2005	Turner & White-man 2005	Eitel 2004	Joyce 2004	Harris 2003	Harris & Chapman 2002	Boyne & Meier 2005	Wil-mott 1999	Paton & Mordaunt 2004	Boyne 2006	Gray 2000
replacement of CEO	•	•		•	•	•	•		•	•	• LG/ HCT/ school	•	•
replacement of sr. management team	•	•		•					•		• LG/HCT	•	•
internal restructuring	•	•		•					•			•	
focus on performance management	•	•		•		•	•	•				•	•
focus on main performance targets	•	•		•			•	•	•	•			•
improving operational performance	•	•		•		•	•	•	•		• LG	•	•
financial analysis and control (retrenchment)	•	•			• staff				•		• staff school/ HCT	•	
focus on human resources and organisational development	•	•		•		•	•	•	•		• LG/ school		•

study / intervention	Protop-saltis 2002	Fulop 2004	Harvey 2005	Turner & White-man 2005	Eitel 2004	Joyce 2004	Harris 2003	Harris & Chapman 2002	Boyne & Meier 2005	Wil-mott 1999	Paton & Mordaunt 2004	Boyne 2006	Gray 2000
participative leadership	•	•				•	•	•				•	
attempts to change organisational culture	•	•		•		•	•	•			• LG		•
develop relations with external stakeholders	•	•		•		•	•	•	•		• HCT	•	•
developing strategic vision	•	•				•		•				•	•
additional resources and external support	•	•	•	•			•	•		•			•
use of external consultants and peer mentors	•		•	•			•	•		•	• school		•
use of interim management		•		•						•	• school		
staff and clients involvement in design & running of services	•	•		•		•	•	•			• LG	•	•
refocusing of organisation's effort (repositioning)					•				• seeking private funding		• HCT	•	

study / intervention	Protop-saltis 2002	Fulop 2004	Harvey 2005	Turner & White-man 2005	Eitel 2004	Joyce 2004	Harris 2003	Harris & Chapman 2002	Boyne & Meier 2005	Wil-mott 1999	Paton & Mordaunt 2004	Boyne 2006	Gray 2000
improvement of internal working relationship							●	●		● not succ-essful			●
improving physical appearance as symbolic action								●			● HCT		
focus on client needs											● LG		
improving system process (data management)		●		●		●	●	●					●
creation/renewal of staff commitment to the organisation													●

LG: Local Government, HCT: Health Care Trust

Table 3.7 '3Rs' turnaround strategies

Author	Reorganisation (Replacement)	Retrenchment and stabilisation	Repositioning (Renewal)
Protopsaltis 2002	Change of the CEO in all 5 Trusts; new executive management team (3 trusts); Management Change following merging (one trust); Focus on human resources management; focus on performance management; internal restructuring; improving operational performance; more staff participation and communication; more strategic planning	Focus on financial analysis and control (reduction in expenditure); focus on main performance targets	Attempt to change organisational culture; better stakeholder management and external relationship;
Fulop 2004	Change of the CEO and/or senior management team in all 9 selected NHS trusts; internal restructuring; Focus on human resources management; focus on performance management; improving operational performance; more strategic planning; development of system process and policies	Focus on financial analysis and control (e.g. control of expenditure on agency staff and drugs); focus on main performance targets	Attempt to change organisational culture; better stakeholder management and external relationship; implement organisational learning programmes, creating clinical network
Turner and Whiteman 2005	New CEO (5 LAs); New senior management Team (6 LAs) (interim managers in some cases); new council leaders (political leaders) (5 LAs); introducing new corporate management working, more staff participation	Focus on main performance targets and tasks	Attempt to change organisational culture; better stakeholder management and external relationship
Eitel 2004	Change of director; change of senior management team	Reduction in staffing level	Refocusing of organisation's effort

Author	Reorganisation (Replacement)	Retrenchment and stabilisation	Repositioning (Renewal)
Joyce 2004	Change of CEO, focus on performance management, improving operational performance; focus on human resources management and organisational development; more staff participation and participative leadership; improving system process (better data management); more strategic planning		Attempt to change organisational culture (more visible managers); better stakeholder management and external relationship; developing new vision
Harris 2003	Change of head teachers; focus on performance tracking; improving operational performance; focus on human resources management and professional development; developing better internal working relationship; focus on teaching and learning; more staff participation and empowerment, focus on teaching and quality		Attempt to change organisational culture by setting high expectation culture; better stakeholder management and external relationship; attempt to provide learning environment to insure sustaining performance improvement; developing distributed leadership (teachers as leaders)
Harris and Chapman 2002	developing better internal working relationship; focus on human resources management and professional development; focus on teaching and learning; focus on teaching and learning; Creating an information-rich environment to encourage change	improving the physical appearance of the schools (e.g. painting of walls) as a symbolic action to show that school is starting changing (e.g. painting of walls); focus on main performance targets	Attempt to change organisational culture by setting high expectation culture; developing new vision; better stakeholder management and external relationship and developing external network; developing distributed leadership (teachers as leaders)
Wilmott 1999	Change of head teacher (early retirement); try to develop internal working relationship among staff and reduce confrontation;	focus on main performance targets (SATs result)	

Author	Reorganisation (Replacement)	Retrenchment and stabilisation	Repositioning (Renewal)
Boyne and Meier 2005	Replacement of superintendent (insider or outsider); changes in staff allocated to teaching (core staff), and change in teacher experience as the marker of quality of core staff	Lowering cost/increasing efficiency by superintendents; focus on the exam results (TAAS), focus on internal management.	Focus on seeking change; seeking private funding; initiation of contact and interaction with external stakeholders
Paton and Mordaunt 2004	Local Authority setting: Change of the CEO; change of the senior management team; more staff participation and communication; focus on human resources management; focus on client needs; Health Care Trust: Change of the CEO; change of the senior management team; more clinician involvement; School: change of the head teacher; internal restructuring and change in staffing;	Health Care Trust: Cutting or removing staff to reduce cost; removing g the suspended clinician; initiative with a definite symbolic dimension (e.g. building car parks) School: improving financial management and more financial control	Health Care Trust: Attempt for cultural change; focus on the external marketing (Playing the NHS system) and reputation building; introducing clinical networking with the surrounding hospitals;
Gray 2000	Changes in leadership at senior level (head teacher and /or senior manger(s); focus on human resources management and professional development;		
Boyne 2006	Change of director or CEO; change of senior management team; focus on performance management; more staff participation, internal restructuring; more strategic planning; decentralisation	Cut in expenditure on overtime, reduction in overstocking of materials, reduction of staffing level, reduction in housing staff	In-sourcing of manufacturer or replacement parts; change in balance of activities; better stakeholder management; change in mission

such changes, and the qualities of new manager(s) can influence the effectiveness of the new senior manager(s). In some cases, interim managers were appointed to provide temporary leadership capacity. Turner and Whiteman (2005) found several local authorities did not change their CEO or senior management team within the first year following a low CPA score. In the later CPA score, these organisation were seen to have the slowest progress in turning around poor performance.

Fulop et al. (2004) found that although the CEO and/or senior manager(s) in their case studies had been replaced, four were unable to turnaround their performance. The implication was that the replacement of a CEO was a necessary but not sufficient factor in turning around poor performance. Fulop et al. (2004) explored several factors to explain differences between their cases, which are discussed in another section.

In Boyne and Meier's (2005) study in a school setting, internal reorganisation had a significant positive effect on performance improvement. The reorganisation was assessed using the following measures: new superintendent from inside the organisation (insider); new superintendent from outside of the organisation (outsider); changes in staff allocated to teaching (core staff); and change in teacher experience as the marker of quality of core staff. Recovery from failure situation was more likely to occur when schools districts replaced their superintendents with insiders, but the appointment of an outsider did not result in a significantly different outcome from persevering with the superintendent who had led the district to failure. It was shown that increases in the proportion of core staff (teachers) and the recruitment of more experienced teachers resulted in a significantly better prospect of turnaround of a failing situation. Thus, Boyne and Meier (2005) showed that turnaround was associated not only with top management change but also with an effective human resource strategy that focused on core staff.

Eitel (2004) reported that the replacement of managers was used to turnaround the situation of a poorly performing regional government organisation. However, this did not result in performance improvement because inappropriate leaders (poor leadership) had been appointed. The appointed managers were often close to retirement (insufficient motivation). Their focus was on local politics rather than national

directives and their decisions were reached independently from those of the national office (representing poor corporate citizenship), which resulted in weak support from the national office. These managers suffered from a lack of corporate vision, poor external relationships, insufficient communication and staff involvement in the decision making process, and lack of involvement with the national office. These factors caused long-term failure, and as a consequence, the regional office was targeted for closure by the national office.

In a school setting, Gray (2000) reported that in a study conducted by Stark (1998) during the period 1993-96, over half the case study schools had changed their head teachers within a term or two prior to (25%) or following (75%) the school's failure.

Other reorganisation strategies were used in the included studies, such as focusing on: performance management; human resources strategies; internal reorganisation; and strategic planning. For example, most of the studies emphasised the important role of robust performance management to aid recovery of the organisation. Both Harris and Chapman (2002) and Harris et al. (2002) reported that all schools applied a performance tracking system using a better data management system to monitor pupils' performance and progress.

Fulop et al. (2004) reported that different turnaround strategies were planned to be run over a period of three years in three different time periods (first six months, between 7 to 12 months, and 12 to 36 months). Managers used various turnaround strategies to influence a range of organisational issues, including management structure, finance, human resources, organisational culture, external relationships, systems and protocol, strategic vision and operational performance. The reorganisation strategies used within the first six months were: strategic issues (focus on consultation on strategy); managerial issues (reorganisation of management structure to improve clinical engagement, a reduction in the number of clinical directorates, creation and appointment of new posts for key directorates; Human Resources Management issues (communication strategies to gain staff commitment to national targets); systems process and policies issues (data management); operational performance (prioritising of operational performance targets).

In the second time frame (between 7 to 12 months), the focus of reorganisation strategies changed and included: Management issues (re-organisation of middle management and leadership programme); Human Resources Management issues (developing staff training and staff reward system); systems process and policies issues (modernise procedures). Table 3.6 and 3.7 detail the range of reorganisation strategies used in each study.

3.10.1.1 Leadership styles

Different leadership behaviour was reported in studies during the turnaround process. In health care, Fulop et al. (2004) reported that a range of different leadership styles from participative, facilitative and risk-taking to more mechanistic approaches based on hierarchical principles had been deployed by new managers to turnaround poor performance.

In the school setting, head teachers showed a broad range of leadership styles from directive leadership to participative, people oriented, and dispersed leadership during the turnaround process related circumstances. However, greater emphasis was placed on the people-oriented leadership approach (setting a clear vision in terms of personal and professional values, morale, honesty, fairness and equality, promoting respect for individuals, and the overall development of staff) and transformation and empowering staff (Harris et al., 2003; Harris and Chapman, 2002; Gray, 2000). Harris and Chapman (2002) argued that whilst directive leadership was likely to be required during the initial phase of turnaround, more democratic and delegated forms of leadership (staff engagement and ownership, staff empowerment, promoting collaboration and investing in quality of relationship and raising commitment within the school) was required as a school responded positively to change. It was reported that a more autocratic leadership style (e.g. focus on policy implementation and consistent standards of teaching) was used by head teachers during the pre-inspection phase (e.g. OFSTED inspection) but they displayed more supportive styles of leadership during the inspection phase (Harris and Chapman, 2002).

Joyce (2004) examined the behaviour of a new chief executive during the successful turnaround of a poorly performing English council. The council moved from 31st to third out of 33 London boroughs over a three year period (1996 – 1999), as assessed by a composite set of performance indicators used by the Audit Commission. Joyce (2004) reported that an effective turnaround leader should also be a good manager. The CEO presented both leadership characteristics (e.g. work through a strategic vision, communication and empowerment) and management capability (e.g. paying attention to operational details, having the ability to take staff into uncomfortable areas, investing time in planning and control). The CEO was more visible than the previous incumbent and learnt how the organisation was performing by visiting and listening to staff and on the basis of soft intelligence, a new vision was formulated. Support from local politicians and external stakeholders were viewed as an important factor to support senior management team decisions. Strategy development, performance management and focusing on human resources and organisational development were the three major tactics employed by the CEO. In addition, through reasoned argument, the CEO actively challenged resistance on the part of certain managers to the new vision. The CEO presented a significant level of energy and resilience in the development of performance management. Considerable emotional energy was seen to be necessary when dealing with resistance to change. Therefore, a clear contrast between management and leadership was defined in the literature and the ideal CEO was viewed as a mixture of Kotter's manager and leader. [Kotter (1990) differentiates between leadership and management and suggests that leaders set a direction and develop a vision for the future, while managers are more concerned with planning and implementing strategies. Kotter maintains that managers typically promote stability while leaders encourage change]. So Joyce (2004) concluded that effective turnaround leaders need to know detailed information with regard to its performance. Leaders should deal with resistance and conflict resulting from the presence of disagreement amongst stakeholders. It should be borne in mind that the data was collected only via interviewing a new CEO, so does not necessary present a rounded view of what happened within the organisation.

Included studies indicated that a varied range of leadership styles were exercised by senior managers during the process of turnaround, relevant to each stage of the

turnaround cycle. None of the studies prescribed a single leadership style as being appropriate during the whole course of the turnaround processes.

3.10.2 Retrenchment strategies

As outlined in section 9.2.2, retrenchment strategies included a range of short-term activities used by organisations to secure their survival and were aimed at tackling the immediate problems responsible for initiating the crisis. The most common interventions used in the for-profit sector were cost cutting and asset reduction to increase cash flow. In addition, core performance targets were commonly homed in upon. Some of the included studies in the current review also reported retrenchment interventions in the public sector. Table 3.6 and 3.7 detail the range of retrenchment strategies identified in the included studies.

A focus on core performance targets and tasks was a retrenchment strategy used in various public sector services including health care (Fulop et al., 2004; Protopsaltis et al., 2002), local government (Turner and Whiteman, 2005) and schools (Wilmott, 1999; Boyne and Meier, 2005). Both studies, conducted in the health sector, placed emphasis on achieving the main performance targets measured by the NHS star rating system.

Cost reduction was a 'classic' retrenchment strategy through financial control (e.g. reduction in staffing levels, cuts in expenditure, reduction in stock) [Fulop et al., 2004; Protopsaltis et al., 2002; Eitel, 2004; Paton and Mordaunt; 2004; Boyne, 2006; Boyne and Meier, 2005]. In Boyne and Meier's (2005) study, retrenchment was assessed using a questionnaire completed by school superintendents who were the most powerful stakeholders in planning and implementing strategies through: the level of priority given to reducing costs/increasing efficiency by superintendents, the extent of focus on exam results (TAAS) as a core business, and calculating the percentage of superintendents' time on internal management. There was no statistically significant relationship between two of the three retrenchment variables (focus on core business and time spent on internal management) and performance change. More emphasis on reducing costs and increasing efficiency was extremely unlikely to produce improved results. This finding contrasts with the effect of retrenchment on performance

improvement in the for-profit sector and seems likely to result in further failure, rather than to initiate recovery.

As discussed in Chapter 2, some factors such as the degree of performance problems and the extent of environmental munificence (availability of resources), may affect the selection and impact of managerial strategies in the for-profit sector. It was found that cost cutting may improve performance where the level of decline is moderate and the organisation is in an environment of low munificence. In contrast, in a serious decline situation, or in an environment of high munificence, a radical repositioning strategy is required. Compared with results in the private sector, Boyne and Meyer's findings (2005) did not show a significant relationship between the effects of managerial strategies, performance problems and environmental munificence.

Eitel (2004) noted that downsizing (reduction in staffing) was used as a turnaround strategy (retrenchment) in a poorly performing US governmental regional office. It was not successful in the first two rounds of turnaround because of local political pressure and the resistance of unions, which sought to retain staff and preserve their working terms and conditions. The reduction of staffing levels suffered from the lack of a clear plan and it was not apparent which staff were to leave the organisation. Some key staff soon left and were not replaced, and management treated this attrition as its downsizing strategy. However, this resulted in the loss of several high quality staff, with the consequence that the remaining staffs were required to work harder and take on new duties, and these factors led to even more staff leaving. In 1994, when the government proposed closing two regional offices because of financial problems, this organisation was one of the candidates for closure. Finally, duties of the local organisation were given to other offices and a merger was eventually forced.

In the school setting, the included studies did not place exclusive emphasis on the role of cost cutting as the main retrenchment strategy. It would appear that compared with the for-profit sector, the use of retrenchment strategies, particularly cost reduction, is less frequent in the public sector – at least for organisations in a school setting. Neither was asset reduction identified as a way to balance financial problems.

3.10.3 Repositioning strategies

As discussed in section 2.9.3, repositioning (renewal) strategies refer to activities that attempt to reorient the corporate vision and strategy of an organisation in order to assure its long-term survival. Interventions such as changes in the strategic mission of an organisation, entry into new markets, changes to the organisational culture, pioneering new products, improving stakeholder management, development of new external relationships, and searching for additional sources of profits, are the types of long-term repositioning strategies commonly found in the for-profit sector literature. The current review also found a range of repositioning strategies in public services.

The following repositioning strategies were used in the included studies: attempts to change organisational culture; refocusing of the organisation's activities; better stakeholder management and improvement of external relationships; implementing a constructive organisational learning environment; creating clinical networks with other hospitals; developing a new vision and change in mission; seeking private funding, focusing on external marketing (only one example); and a shift towards in-sourcing of manufacturing of replacement parts. Tables 3.6 and 3.7 detail the repositioning strategies used in each included study.

Repositioning strategies were assessed in Boyne and Meier's (2005) study. Here repositioning was assessed using a survey completed by school superintendents using measurement of a range of variables: the extent to which the superintendent resolves to implement change; seeking private funding, and contact and interaction with external stakeholders. Two of the three repositioning variables were positively related to the extent of turnaround; the superintendents who sought change and initiated interactions with a wide range of stakeholders were more likely to lead their school districts towards performance improvements. The third element of repositioning, the emphasis on acquiring private funding, had no significant impact on recovery and performance improvement. Taken together, the results for retrenchment and repositioning suggest that 'financial' turnaround strategies (cost cutting and seeking revenue) were not effective in school districts.

Protopsaltis et al. (2002) reported that several hospital trusts had attempted to change their organisational culture by creating a 'can do' philosophy through a range of organisational changes including promoting transparency in decision making, clearer goal setting and setting intended performance targets. The trusts had also tried to develop better relations with external stakeholders.

Fulop et al. (2004) reported that different turnaround strategies were planned to be run over a period of three years in three different time periods (first six months, between 7 to 12 months, and 12 to 36 months). They presented a range of repositioning strategies including the development of external relationships (better relationships with the media and better working relationships with external stakeholders, engagement of service users and the development of clinical networks); attempts to change the culture (increasing the visibility of the top team and use of 'quick wins' over the first six months) and more focus on completion of a new building/PFI scheme to demonstrate management ability and commitment to a time scale between 7 to 12 months. The implementation of organisational learning processes, improving clinical networks and encouraging ownership of a strategic vision throughout the organisation were the focus of repositioning strategies during the third phase of turnaround (being carried out in a period between 12 and 36 months).

Both Harris et al. (2003) and Harris and Chapman (2002) highlighted the positive impact of some repositioning strategies in successful turnaround in a school setting. They showed that a 'high expectation' culture was nurtured by the management team through using a range of activities, including award ceremonies and celebratory events. They also found that attempts to nurture and improve external relationships (e.g. better engagement with the community and increasing involvement of parents in school life) were strategies deployed by the schools.

In one study (Paton and Mordaunt, 2004), the managers of a poorly performing healthcare trust focused on external marketing and reputation building as repositioning strategies. They emphasised a series of activities which expanded their clinical partnership with the hospitals that had proposed taking over the Trust when it was

performing poorly. They used this strategy when the 'internal market' policy existed within the NHS context and were successful in providing a larger clinical network and broadening their area of service provision. However, because of the nature of the public sector, entrance to new markets or introduction of a new product is less likely to occur than in the for-profit sector.

3.11 Role of external organisations in turning around poor performance

Some included studies considered the role of external agents in turning around poorly performing public service organisations. These strategies can be divided into those forced upon them by the government and those initiated by the organisations themselves. In the health sector, Harvey et al. (2005a) explored the role of the Performance Development Team (PDT) (previously a part of the Modernisation Agency) as an external agent in promoting and facilitating turnaround in zero star rated NHS organisations. During their one year contract, the PDT was responsible for engaging with the Trust through PDT client managers to develop an agreed work plan with each trust and help staff to implement the plan.

Harvey et al. (2005a) present their findings under four broad themes:

a) Nature and content of PDT interventions:

The main aim of the PDT was to help trusts to obtain sustained improvement in performance through changes to their organisational culture and the development of whole-system working. The PDT's role was consistent with the 'relational approach' rather than 'episodic' or 'mandated' approaches (Jas and Skelcher, 2004) [see section 2.11], and it focused on the main causes of failure (secondary and primary) rather than merely concentrating on its symptoms. However, this aim contrasted with the aims of some trusts and their external stakeholders, particularly the SHA, who sought quick performance improvements (through hitting essential targets) and achieving one or more stars in the next round of ratings. There were questions as to whether the one year contract between the PDT and the failing organisation could ensure sustained performance improvement in the long term.

b) Impact of PDT intervention:

The focus of PDT activity was on retrenchment and renewal, as the PDT did not have the authority to replace key managers (replacement). Although the initial purpose of the PDT was to apply flexible and responsive interventions, depending on the needs and contingencies of each organisation (tailor-made approach), the strategies they used were not in necessarily in accordance with the organisational needs, and as a result some organisations declared that this approach limited the range and breadth of available interventions. In general, organisations studied were positive about the impact of the PDT, stating that the PDT provided the required skills and experiences to assist change, as well as confirmation for initiating change within the trusts from an external agent. Furthermore, the trusts indicated that the PDT assisted them in developing networks with other external organisations and also gave constructive criticism, helping the trusts to concentrate their efforts across the organisation. Most of the PDTs (86%) delivered their agreed plan on time and there was an improvement in star rating in most of (80%) of the zero star organisations studied. However, attribution of such improvements to the activity of the PDT, which is only one among several factors, is problematic. Some organisations reported that they (especially new managers) could improve performance without help from the PDT and, in some cases, it was argued that the PDT impeded positive change within the organisation and was seen as an interfering factor in processes of change.

c) Facilitating factors in achieving successful turnaround supported by an external agent (the PDT):

Harvey et al. (2005a) explored specific factors that enhanced the effectiveness of PDT interventions, such as the role of the client manager of the PDT. This effectiveness was influenced by individual's level of maturity, background and experience; the organisation's willingness to accept the PDT's help, the clarity of the role and the quality of the relationship between the PDT, the trust and other related organisations such as the Strategic Health Authority (SHA), the type of approach adopted by the PDT and its flexibility, and the establishment and management of realistic expectations.

d) Impeding factors in progressing the turnaround process:

The progress of turnaround strategies was hindered by insufficient resources (especially financial resources), inadequacy of PDT skills and experience in certain areas (e.g. financial expertise), a poor relationship between trusts and external organisations such as the SHA, a shortage of time for the PDT to work with the trusts. It was also the trusts' perception that the huge amount of pressure and stress on a zero-star organisation to improve its performance served to inhibit positive change.

Harvey et al., (2005a) argued that PDT resources were used by poor performers that were both willing and able to achieve recovery (self initiating organisations), limiting the amount of PDT help for organisations that were unable and/or unwilling to initiate turnaround themselves (permanently failing organisations). Therefore, they emphasized the importance of discriminating between these in advance of planning external support, noting that, as PDT interventions included both retrenchment and renewal (repositioning) strategies, the members of the PDT should have relevant expertise in these areas. They argued that a one year period is not long enough, especially in terms of renewal (repositioning) interventions, for those organisations that have more serious problems and are less prepared for change. They felt that additional time should be spent on negotiation and initial engagement before implementing specific turnaround interventions.

Similarly to Harvey et al. (2005a), Turner and Whiteman (2005) reported that the government preferred to use a 'relational' approach or engagement (motivation and support of the organisations to turnaround with the main responsibility for the process of change owned by the individual authority) as a first choice, rather than direct intervention using its legal power (mandated approach) to turnaround poorly performing local authorities. The 'relational approach' might bolster co-operation and coalition building between government supporting agencies and poorly performing organisations, reducing the level of resistance by authorities to the involvement of the Office of the Deputy Prime Minister (ODPM). There were three particularly important mechanisms used by the government to help poorly performing local authorities, including the use of Lead Officials, Government Monitoring Board and Political Mentors. It should be borne in mind that almost all of the selected organisations

received government funding as a source of extra support during the turnaround process (Turner and Whiteman, 2005).

The Lead Officials worked with both local authorities on the one hand, and officials in central government and other national agencies on the other. Their role was to assist local government to understand the nature of performance problems, develop their action plan and help the organisation to recognize the external sources of support. Another important role was to make a preliminary judgment about whether the local authority was capable of implementing its action plan and to give advice to central government as to which kind of approach ['engagement' ('relational') or 'intervention' ('mandated')] should be used. Co-ordination with the Monitoring Board, which was responsible for monitoring the implementation of the plan, was another responsibility of the Lead Officials. Five out of fifteen local authorities showed good progress. The ODPM reduced engagement or even disengaged, with the five successful organisations, but continued engagement with other local authorities according to their CPA scores or suggestions by Lead Officials or the Monitoring Board. Three organisations that did not improve their CPA scores were categorised as 'permanently failing organisations' and direct intervention was used in one case by a government minister because the local authority was reluctant to cooperate with the engagement process.

The responsibility of this board was 'to provide the government with a means of assessing, guiding, and challenging a council in relation to its turnaround of poor performance, and in agreeing recommendations to ministers, the Audit Commission, individual inspectorates and others.'

An important strategy used to change political views and behaviours within local government was the introduction of political mentoring where there was perceived weak political management and poor member-officer relations (Whiteman, 2004). Political mentors are experienced councillors, from outside authorities, who assist their equivalents in implementing turnaround processes. They support group leaders, council executives and councillors by providing an overview and scrutiny of the turnaround process. According to the context, mentoring varied from organisation to organisation. For example, the role of mentors was to provide advice on how political capital could be

best gained from service improvement. In another example, council leaders reluctant to change were advised by their mentors to adhere to the turnaround agenda. A direct cause and effect relationship between the function of the mentors and actual outcome in terms of service improvement cannot be demonstrated, but it was indicated that a new commitment amongst members towards improving their councils was achieved as a result of the role of political mentors (Turner and Whiteman, 2005). The level of experience and skills of Lead Officials and political mentors was perceived to be an important factor in assisting organisations to address resistance to change and to develop a commitment to recovery. Nevertheless, resistance to the function of the external political mentors was reported owing to the mentees' own political culture. The mentors also played a crucial role in identifying and accessing both internal and external capacity. Sometimes political mentors entered areas that the Lead Officials regarded as being within their own remit. Thus, the issue of delimiting the boundaries for the work of political mentors and Lead Officials was important (Whiteman, 2004).

Eitel (2004) highlighted the important role of a US national office in seeking to transform (trigger of changes) a poorly performing regional office by the appointment of a new management team.

Harris et al. (2003) reported that additional resources and support, through external interventions or projects, were received by poorly performing schools. The schools received support for professional development through mentoring, coaching, and peer review (half of the schools set up a new peer review system). Harris and Chapman (2002) also emphasised that these schools received external support from OFSTED or LEA advisors, which helped them develop external networks to facilitate the generation of ideas, professional development and dissemination of good practice.

Wilmott (1999) investigated the role of the Local Education Authority advisory team in dealing with a school identified as a poor performer following an OFSTED visit in 1996. It was reported that the school managers developed an action plan under the supervision of the LEA advisory team and that the implementation of the action plan, which was evaluated by three LEA advisors, was found to be unsatisfactory. Lack of communication, constructive discussion and feedback between advisors and staff

caused disbelief and anger among staff, who reported that the assessment lacked depth. It was also stated that the advisors had focused only on measurable outcomes and lesson planning and paid little attention to the reality of the socioeconomic background of the pupils which affected their achievements. One of the limitations of the study was the lack of interviews with the three LEA advisors. Neither did the study present the relationship between school managers and LEA advisors during the implementation of the action plan. Wilmott (1999) concluded that environmental constraints, such as the level of local deprivation, should be taken into account when the outcome of a turnaround process is considered. After the LEA advisors' inspection, the head teacher decided to take early retirement and one of the senior members of staff was appointed as temporary head. The new head teacher used the following strategies: (1) reorganisation of staff meetings to reduce the high level of confrontation between the staff, (however, this did not produce a positive outcome); and (2) focusing on SATs (Standard Attainment Tests) as most the important target.

3.12 Impact of turnaround strategies

The impact of turnaround strategies on the organisational performance (outcome of turnaround interventions) and on the staff are considered in the included studies, which are presented below:

3.12.1 Organisational performance

The included studies demonstrate that some organisations experienced successful turnaround and improvement in their performance, at least in the short term, but that the performance of many organisations remained as poor, if not worse than before the implementation of turnaround strategies. For example, Fulop et al. (2004) found that five trusts out of nine showed consistent improvement in their performance assessed by the 'star rating' system over the study period, which meant that the new managers of these organisation were able to transform their 'failing' organisations into 'self regulating' organisations. However, the performance of four remained the same or declined. Two out the four cases could be classified as 'permanently failing'

organisations. Similarly, Turner and Whiteman (2005) reported that six organisations showed good progress, as measured by the CPA scores, but three did not improve their scores. Turner and Whiteman (2005) reported several common characteristic among those local authorities that successfully turned around their performance in a short time. All possessed cognition, capability and capacity. Cognition is the term used to define to the level of awareness and understanding of the organisation's key players regarding the performance trajectory. Capability refers to the politico-managerial leadership coalition which is able to construct and institutionalise a change-oriented narrative. The extent to which political and managerial technologies (e.g. performance management arrangements, human resources systems, consultation with the public and consumers of services) exist in the organisation, and are in line with the goals set by the political and managerial leadership, are referred to as capacity. These organisations presented a forward-looking, turnaround-oriented plan initiated by a (new) dynamic leadership at both managerial and political levels.

The presence of certain problems, caused by the lack of one or more of these characteristics, had been identified amongst those local authorities that were unable to turnaround their performance. Also, different local authority backgrounds, political histories and socio-economic contexts had an impact on the level of effectiveness of similar strategies. These local contingencies and problems reveal that a flexible and tailor-made approach is required to deal with the problems of each organisation because of the differences in the level of cognizance, capacity, capability and the contextual background of the organisation.

Similarly, Fulop et al. (2004) found that although the CEO and/or senior manager(s) in their case studies had changed, four were unable to improve their performance. This implies that the replacement of the CEO is a necessary, but not sufficient step its own. Various constraints on turnaround and the level of access to required resources for the turnaround, can explain differences between successful and unsuccessful organisations. Some factors constrained the turnaround interventions, including cultural diversity (competing sub-cultures among different clinical professionals and also between clinical and non-clinical staff), complexity (the multi- layered nature of hospitals), lack of leadership, and external influences (impact of government policy and pressure from

public image). Resentment and resistance from the clinical body and middle management were the result of cultural diversity and complexity. The success of the managers in turnaround was also contingent upon their having certain core skills (establishing a clear agenda for change, developing a strategic vision and the ability to communicate this, the ability to grasp the detail required to deliver core targets) and access to financial, temporal (time and stability), and external (support from SHA/ PCT/ MA) resources. The impeding factors that were very found by Harvey et al. (2005a) were similar to those explored by Fulop et al. (2004).

Gray (2000) placed emphasis on the notion that an adequate period of time should be given to managers to turnaround poor performance and stressed that evaluating performance over a short time period may not capture their improvement properly. He argued that the average time reported for the primary and secondary schools to improve performance was 20-22 months and 27 months respectively. Protopsaltis et al. (2002) and Fulop et al. (2004) also emphasized that sufficient time be given to organisations to improve their performance.

Eitel (2004) reported an unsuccessful turnaround process based around downsizing (reduction of staffing level) in a US governmental regional office owing to local political pressure and the resistance of unions, which sought to protect staff positions and working conditions. The policy of staff reduction suffered from the lack of a clear plan, and it was not apparent which people should leave the organisation. In addition, staff resisted change (internal factors) over a long period of time and because of sustained poor performance a culture of failure developed, with the organisation finally being taken over by another.

3.12.2 Staff

Some of the included studies showed that concerns were expressed, by staff and managers, about working under the high level of pressure placed upon them by the turnaround interventions introduced by senior managers. As a consequence, low staff morale and a variety of change resistance strategies were reported relating to the replacement of some staff and greater expectations of the workforce. Furthermore,

changes in job descriptions and increased stress among staff were further factors contributing to low staff morale and resistance to change (Protopsaltis et al., 2002; Fulop et al., 2002, Eitel, 2004; Turner and Whiteman, 2005). High workloads were perceived by staff, particularly when the reduction in staffing was used as a strategy to lower costs (Protopsaltis et al., 2002; Fulop et al., 2002, Eitel, 2004).

Some studies reported that several staff referred to work overload as 'recovery fatigue', as it impacted on their energy and morale. Senior managers reported that they had to manage the turnaround process over and above their day to day responsibilities and that they were also required to invest a large proportion of their time, energy and effort in responding to the demands of inspectors and external agencies. So once the engagement process eased, as a result of improvements in performance, many managers felt a high degree of relief (Turner and Whiteman, 2005). Both Protopsaltis et al. (2002) and Fulop et al. (2004) reported conflicts between new incoming managers and clinicians because of the type and level of changes introduced by managers in reorganising clinical practice and procedures. Middle managers felt frustration, as they were continuously being asked to meet targets without the time to stand back and plan to improve the processes.

3.12.3 Role of contextual factors in turning around performance

Some of the included studies, especially those in school settings, found that contextual issues may be important factors in the success of turnaround strategies (Boyne and Meier, 2005; Wilmott, 1999; Gray, 200; Harris et al., 2003).

Boyne and Meier (2005) hypothesized that both good luck (favoured changes in the external circumstances beyond managerial control) as well as good management influenced the possibility of successful turnaround in the public sector. The indicators for evaluating the organisational environment were munificence (change in financial resources) and environmental hostility (the socio-economic characteristics of school children, which make it easier or more difficult to teach them). The latter was measured by the proportion of minority (black and Hispanic) and low income students in selected cases. Here, good luck is perceived as the availability of financial resources and a lower

proportion of minority and low income students. Several variables were used as controls comprising the size of the schools measured by the number of pupils enrolled in 1995, tenure measured by the number of years that superintendents have spent in the current school district, and finally the extent of the severity of failure. The statistical evidence showed turnaround to be associated with good luck as well as good management. The greatest level of the performance improvement was found in districts with worst baseline and non-linear relationship between superintendents' experiences and performance improvement was shown. It was concluded that the size of school had a negative correlation but was only significant at .01 level and an increase in munificence and decrease in hostility were likely to lead to better performance.

In Boyne and Meier's study (2005) although luck (changes in the external environment) was included in the analysis of turnaround in Texas school districts, the data only covered munificence and hostility as aspects of luck, but data on change in the complexity of the conditions, confronted by school superintendents, was not considered. Secondly, the focus of the analysis was on the technical but not the institutional environment of turnaround (e.g. changes in external stakeholders' support and shifts in judgments regarding the legitimacy of different response to failure). The authors emphasised that future studies of turnaround should seek to extend the analysis of good luck by including these variables.

Also, Boyne and Meier (2005) tested whether or not the impact of managerial strategies was contingent on the severity of performance problems and the extent of environmental munificence. Earlier work shows that when the organisation is facing only moderate performance decline, the cost cutting may be beneficial, however, in a severe decline situation, a radical repositioning strategy is necessary (Hambrick and Schechter, 1983; Robbins and Pearce, 1992). Likewise, retrenchment is required in an environment of low munificence, whereas in a situation when munificence is high a strategy of repositioning is more feasible (Thietart, 1988). The validity of these arguments was tested through interaction terms that captured the combined effects of managerial strategies, performance problems and environmental munificence. No additional variables produced a significant effect on the explanatory power of the turnaround model developed by Boyne and Meier (2005).

Furthermore, the measures of all three generic turnaround strategies were included in the same statistical model, but previous research has typically tested only one or two strategies in relation to performance decline. For example, some researchers only examined retrenchment (Chowdhury and Lang, 1994; Morrow et al., 2004; O'Neill, 1986), and in a number of studies the reorganisation was not taken into account in the turnaround models (Bruton and Wan, 1994; Evans and Green, 2000, Hambrick and Schechter, 1983; Robbins and Pearce, 1992).

Moreover, Gray (2000) stated that schools in areas with an absence of extreme social deprivation, were more likely to recover by themselves and also to have a relatively short history of poor performance, which is another positive contributor in performance improvement. Harris et al. (2003) found that additional resources and support through external interventions or projects, and changes in the social mix of the pupil population were positive external factors influencing the outcome of turnaround interventions.

In Wilmot's study (1999), it was concluded that environmental constraints, such as the level of deprivation, should be taken into account when the outcome of the turnaround process was considered. Turner and Whiteman (2005) also reported that different local authority backgrounds, political histories and socio-economic contexts had a significant impact on the level of effectiveness of turnaround strategies.

3.12.4 Unintended and dysfunctional consequences of turnaround interventions

Several of the included studies noted that turnaround interventions might induce a range of unintended and dysfunctional consequences for organisations and their staff (Turner and Whiteman, 2005; Fulop et al., 2004).

Turner and Whiteman (2005) argued that achieving a better CPA score became the most important priority for some local authorities. Two negative consequences were identified: first, the local authorities were unwilling to criticise the government (Compliance); and second, local authorities focused on meeting centrally set targets

(heavily oriented to the CPA score possibly incompatible with the requirements of their local communities). In addition, organisations might be distracted from the focus on sustainable performance improvement. The tension between external criteria-based assessment and internal culture, and the process of performance management, were highlighted here. It was shown that some organisations were willing to perform activities that were likely to result in positive responses from inspectors or auditors. Some leading participants attributed quick improvement to dealing with the inspection and audit processes rather than turnaround strategies. They indicated an improvement in the level of cognition, capability and capacity in dealing with audit processes. Further investigation is needed to explore whether the improvement is attributable to the turnaround strategies or to gaining more capabilities and capacities to deal with central targets and audit processes (Turner and Whiteman, 2005). They also reported that the organisations needed to consider financial costs due to changes in both management and organisational restructuring and that two local authorities reported changes in their current budget priorities during turnaround.

3.13 Discussion

This is the first comprehensive review to consider both organisational failure and the turnaround processes in the public sector. It has distilled the available evidence, within the public sector, and compared it with the existing literature derived from the for-profit sector. Using the findings of this review, several propositions are developed, which informed the design of the empirical fieldwork in this thesis. The review has highlighted key issues with regard to the theoretical framework and methods used in the studies and has summarised the results of the included studies on the symptoms and causes of failure, triggers for change, and turnaround interventions. These are each discussed in turn below.

3.13.1 Symptoms of failure

As in the for-profit sector, four different types of markers of failure (financial, physical, behavioural and managerial) were also found in the public sector. The most common

markers of failure in the public sector were an inability to hit core targets, poor working relationships with external stakeholders, high management turnover, employee distrust/internal conflict and low staff morale. In the health sector, poor financial balance, the high level of staff turnover and/or recruitment problems and poor public/media image were evident markers of failure. Financial issues were not a crucial marker in the school sector, although there were some examples indicating the inability of schools to achieve a financial balance. Only two studies (Fulop et al., 2004; Eitel, 2004) identified a link between markers, secondary causes of failure and primary causes of failure (dysfunction in organisational learning).

3.13.2 Secondary and primary causes of failure

Findings of this review show that internal and/or external secondary factors, similar to those in the for-profit sector, contribute to the organisational failure process in the public sector. Five different secondary internal causes were found, including managerial, financial, organisational, cultural and political factors. It should be borne in mind that, except in very special circumstances (e.g. the occurrence of a disaster) that a single factor can lead to a failure, whereas in other situations, several different factors contribute to a decline in performance.

The most common internal secondary causes of failure were poor managerial leadership; poor operational management; poor performance management (not evident in school settings); cultural problems; insularity (poor relationships with other stakeholders), poor internal relationships, lack of staff engagement and inattention to external warnings. Poor political leadership was an important cause of failure found in local government settings. As a result of the political context of the public sector, particularly in local government, political issues (e.g. poor political leadership and poor political-managerial relationships) were key contributing factors to organisational failure, although this was not a cause of failure in the for-profit sector.

There are some differences between the symptoms and causes of failure between the two sectors, owing to the nature of the services provided and the context of provision. For example, decline in demand was not found to be a contributory issue that in

performance decline in the public sector, though it was an important cause of failure in the for-profit sector (see section 2.6 for more details). On the other hand, Walshe et al. (2004) argued that the inabilities of a public sector organisation to meet customer demand and create satisfaction for its stakeholders were indeed issues that can contribute to failure.

Policy change, diverse service needs and a poor socioeconomic situation (high level of poverty and deprivation) were the most important external factors contributing to performance decline and failure within public services. In the health sector, policy change was perceived as the most evident external contributor to organisational failure, but the impact of contextual factors (e.g. socioeconomic factors) has not been considered in the health sector.

3.13.3 Triggers for change

This review identified that both internal and external factors have made a contribution in initiating processes of change (triggers) within the public sector. Replacement of senior management was the most common internal trigger in all the included studies, and reports provided by external agents and concerns expressed by external stakeholders were the most common external triggers. Reaction of organisations to the announcement of poor performance was also an important trigger. The findings of this review were comparable with literature from the for-profit sector, though the role of external agents in diagnosing and triggering change was more common and of greater importance in the public sector than the for-profit sector. Harvey et al. (2005a) identified the valuable role of the PDT as an external agent in diagnosing problems of NHS organisations and serving as agents of change. It is vital to note that, in all included studies, multiple factors rather than a single factor played a crucial role in the initiation of the process of change.

3.13.4 Turnaround interventions

To organise and report the interventions used in the included studies in this review, the '3Rs' strategy (Boyne, 2004a), derived from the literature in the for-profit sector was

used. This review showed that three generic turnaround strategies (Reorganisation, Retrenchment and Repositioning) used in the for-profit sector, have been also used in the public sector, though the feasibility, frequency and extent of use of these strategies have not been similar across the two sectors. Reorganisation strategies were the most common form of intervention used in the public sector. Although retrenchment strategies have been used in the public sector, particularly in health care trusts facing financial difficulties, their effectiveness is not proven. In the school setting, it was the least used strategy. The use of repositioning strategies to change the activities of the organisation or to expand its services by entering into new markets is often impossible for public service organisations, as the objective providing services is mandatory due to the statutory obligations. Although, in some of the cases, this review showed that the responsibility for service provision of an organisation was transferred to other organisations (e.g. Eitel, 2004). The evidence in this area within the public sector is still limited and existing studies are not comprehensive, so it is difficult to reach a firm conclusion on the effectiveness of these strategies.

However, the limited evidence base may provide important information for policy makers and managers charged with turning around poorly performing organisations.

3.13.5 Limitations of this review

As outlined in section 3.4.2.1, a broad search strategy, following consultation with two librarians from the NHS Centre for Reviews and Dissemination (CRD), was used to ensure that the maximum number of eligible studies was included. However, owing to the diversity of the topic (organisational failure and turnaround processes) and the presence of under-developed search strategies for non-experimental studies, it is possible that some studies were missed. To minimise this problem, some additional exploratory pathways were employed, e.g. searching using the authors' names of relevant papers as a search term.

Because of the nature of student research, all the processes of this review (inclusion of studies, data extraction and data synthesis) were carried out by one reviewer, which will not necessarily ensure an unbiased approach. To reduce the probability of bias, the 485

papers examined against the inclusion criteria were double checked. In addition, the doctoral supervisor checked the data extraction for the included studies.

3.13.6 Limitations of included studies

As mentioned in section 3.5.5, the principal research method used to study organisational failure and turnaround was the qualitative case study design, although the number of quantitative studies has increased since 2005. In some case studies (Joyce, 2004; Paton and Mordaunt, 2004), data were collected by interviewing only one informant, and so may not provide a rounded view of the issue under question, and the potential for bias should be considered. In addition, some studies used a retrospective approach (e.g. Paton and Mordaunt, 2004; Protopsaltis et al., 2002; Joyce, 2004), making recall bias (selective recall) a cause for concern. It should, however, be noted that Paton and Mordaunt (2004) tried to use document analysis to support interviews in two out of four of their cases.

3.13.7 Gaps in the literature

This review highlights difficulties regarding the methodology of review of non-experimental studies: searching (particularly electronic databases); quality assessment; and data synthesis. With all of these issues, it seems that more methodological development is required.

The gap in linkage between symptoms, secondary and primary causes of failure in the public sector is also apparent from this review. So far it is not clear how the identification of the symptoms of failure can result in the diagnosis of secondary and ultimately primary causes of failure. Similarly it is unclear how diagnosis of symptoms and causes of failure can result in the selection and implementation of appropriate turnaround strategies.

This review also shows that the existing relevant literature lacks robust longitudinal studies, which track over time how organisations sustain their hard won improvements in performance.

In relation to the effectiveness of the turnaround strategies, there remain gaps in the literature. There is currently insufficient evidence about which turnaround strategy of the three broad generic types (Reorganisation, retrenchment and repositioning) is the most appropriate to use, and in what contexts and circumstances the different strategies would achieve the best outcomes. Moreover, how these turnaround interventions can be combined in different contexts is an important issue that is not explored fully in the public sector literature.

This review also revealed a gap in the literature with regard to the role of external organisations in dealing with poorly performing organisations, as relates to the initiation of the turnaround process, and support both during the process and while the organisation improves and attempts to sustain its improvement. The type of strategies used by external organisations and the duration of these interventions with regard to the type of poorly performing organisation (self initiating and permanently poor performing) are insufficiently covered by empirical studies, although three different kinds of relationship between external supporting organisations and poorly performing organisations have been defined by Jas and Skelcher using principal-agent theory (see section 2.11 and table 2.4). There is not sufficient empirical evidence to differentiate between 'permanently failing' and 'self initiating' organisations, which may help policy makers to focus their support more on 'permanently failing' organisations.

It is clear from the review, that several research studies in this area are not underpinned by sound theoretical frameworks. For example, most of the studies conducted in a school setting had not used or reported a theoretical framework or conceptual model.

Moreover, the gap in the literature about the impact of contextual factors on organisational failure and the probability of success or failure of turnaround interventions within the public sector was highlighted.

3.13.8 The relevance of this review to the empirical part of the thesis

The findings of the review revealed a serious gap in the existing literature concerning organisational failure and the turnaround process within health care organisations.

Particularly during the first search (November 2004), only one published report was found relating to the health sector (Protopsaltis et al., 2002). As this study only investigated change performance, in terms of star ratings, over one year, it was not possible to measure sustainable performance improvement as an outcome of the turnaround process over a longer period of time. As a consequence, the findings of the review confirm the need for further research in this area in health care. A unique case study (an acute hospitals NHS Trust) was selected (this is explained in detail in chapter 4) that allowed the researcher to investigate how the poorly performing Trust was able to make significant improvement in its performance during a very limited period of time (one year) and to sustain this improvement in performance for two successive years.

The results of the review were also used to develop a number of propositions which guided the empirical phase of the study. These are outlined below, and the findings of this empirical study are linked specifically to addressing these propositions. Yin (1994) maintains that the data collected in any study should relate to the initial propositions (if there are any). He states that "data analysis consists of examining, categorizing, tabulating, or otherwise recombining the evidence to address the initial propositions of a study" (Yin, 1994).

3.13.9 Proposition for the study

The following propositions are derived from the overall study objectives and the findings of the literature review. These were used to inform research design, data gathering, analysis and interpretation.

1) A range of markers and symptoms of failure of the Trust, under study, will be shown to be similar to those identified in the literature review.
2) A range of secondary external and internal factors contribute to organisational failure.
3) The primary causes of failure are the main source of organisational decline.
4) A range of internal and external factors trigger the process of change.

5) Organisations, able to 'self' turnaround, do not necessarily require a large degree of external support (particularly in terms of the presence of an in-house performance support team).
6) Although a range of turnaround interventions are used within the Trust, reorganisation strategies will be the most important ones deployed.
7) In the process of replacement strategy, the appointment of an appropriate managerial team, with sufficient skills and capabilities, is an important factor in initiating turnaround interventions.
8) A range of unintended consequences and barriers related to implementing turnaround interventions, within the Trust, will be apparent.
9) The 'stage' model theory, developed in the for-profit sector, is applicable in the public sector, particularly the health sector.
10) The Trust's managers will use more mechanistic (directive) style of leadership during the first phase of the turnaround process

In the Chapter 4, the research method used in this empirical study will be presented and issues regarding study design, sampling methods used, the process of data collection and data analysis will be explained. All ethical issues are also discussed.

Chapter 4: Research methodology

4.1 Introduction

As outlined previously, the aims of this study are threefold: i) to better understand organisational failure and turnaround processes in health care settings, ii) to place the findings of the empirical study in the context of the wider literature on organisational failure and turnaround, and iii) to draw lessons from both the literature review and empirical phase of study for the development of health policy and the focus of future research. The choice of research design and methods has been informed by the literature review.

The purpose of this chapter is to outline and justify the methods used in the empirical phase of the study. The focus is on exploring the overall study design, sampling strategies used, and methods of data gathering, analysis and interpretation.

4.2 Methodology

Methodology refers to the ways in which knowledge is attained about the social world (Bowling, 2002). Silverman (2004: p19) defines 'methodology' as 'a general approach to studying research topics'. Two main methodological traditions are discussed in the theoretical literature: *Nomothetic* and *Ideographic* approaches. Those holding objective ontological assumptions and positivist epistemological assumptions seek knowledge through nomothetic methodologies. Nomothetic approaches rely on scientific methodology, and *a-priori* hypothesis testing. They use quantitative tests including surveys, personality tests, and standardised research tools to investigate the empirical world. Nomothetic analysis attempts to formulate general laws that explain regularities and patterning in social phenomena. Alternatively, researchers with subjective ontological assumptions and interpretive (anti-positivist) epistemological assumptions adopt ideographic approaches to investigate and understand the social world. Ideographic approaches place greater emphasis on "getting inside" a subject and exploring their detailed background and life history, using a range of qualitative methods including interviews, observation and the use of diaries. Ideographic analysis focuses on what is unique about a person, a time period, or a locale (Burrell and Morgan, 1979).

In nomothetic methodological approach, the researcher begins by identifying a set of variables for analysis and subjects these to quantitative and statistical analysis (Silverman, 2004). Qualitative approaches incorporate a different set of research methods. Holloway (2005) outlines the key characteristics of qualitative enquiry as follows:

- An emphasis on obtaining and analysing textual data;
- A focus on extensive interaction with the people being studied, which provides an opportunity for the research to be open and unstructured;
- Based on field work (e.g. participant observation, and unstructured and semi-structured interview);
- An emphasis on a flexible plan of inquiry. Qualitative researchers do not rely heavily on a pre-defined protocols or hold a rigid approach to sampling, data collection and analysis.

Qualitative research using case study methods provides the opportunity for researchers to observe complex phenomena and understand the dynamics of behaviour in organisations (Lee, 1999). Organisational failure and turnaround are complex and dynamic phenomena to study and to gain an in-depth understanding of the processes at work it was decided that a qualitative case-study design would be the best approach as it would allow a rich description of the organisational processes and mechanisms leading to performance decline and renewal. The following sections detail the research design, the selection of the study case and the methods of data gathering and analysis.

4.3 Research design

Yin (2003) argues that the selection of an appropriate research strategy in the social sciences depends on three key factors: *i)* the type of research question; *ii)* the extent of researcher control over events; and *iii)* the level of focus on contemporary rather than historical events. He classifies research strategies into five broad categories: experiments; surveys; case studies; history; and archival analysis. Following Yin's framework, Table 4.1 shows the most appropriate fit for a research strategy depending on these factors.

Table 4.1 Selection of search strategy

Strategy	Form of research question	Control over behavioural events	Focus on contemporary events
Experiment	how, why, who, what, where	Yes	yes
Survey	how many, how much	No	yes
Case study	how, why	No	yes/no
History	how, why	No	no
Archival analysis	Who, what, where, how many, how much	No	yes

Source: Yin (2003)

In Table 4.1 a range of basic categorisation schemes for the types of research questions are identified including: "who"; "what"; "where"; "how"; and "why". There are two types of 'what' questions: the first is exploratory, and is used to justify a rationale for conducting an exploratory study aimed at generating hypotheses and propositions for further research. All five research strategies for this type of question can be used. The second type of "what" question actually means "how many" or "how much". This type is used mostly in survey or archival type work. "Who" and "where" questions are the same as the second type of "what" question, indicating that they are likely to be used in survey and archival research. Such questions are used by those wanting to present incidence or prevalence of an occurrence or when the aim is to predict a specific outcome.

In contrast, "how" and "why" questions are used in studies with explanatory objectives. Case study, history and experiment are three strategies that are more likely to use these types of research questions.

When a "how" and/or "why" question is key, the degree of researcher's control over behavioural events may differentiate among history, case study and experiment. In experimental research, the researcher is able to manipulate behavioural events. However, when there is no control over events, both histories and case studies are the preferred strategies. The focus on contemporary events makes a distinction between case studies and history strategies, as history is not able to examine contemporary events.

4.3.1 Case study design

The aims of the research considered alongside the methodological issues discussed above, make it clear that the case study method is the most appropriate strategy for use here. Yin (2003) defines the case study as 'an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident, and which relies on multiple sources of evidence'. Stake (1988: 258) defines a case study as 'the study of a bounded system, emphasizing the unity and wholeness of that system, but confining the attention to those aspects that are relevant to the research problem at the time'. In case study research, the researcher attempts to comprehend the case in depth in a natural setting and take account of its complexity and context. In addition, understanding the wholeness and unity of the case (through a holistic focus) is a key characteristic (Punch, 2005). Miles and Hubermann (1994) maintain that a case may be an individual, a role, a small group, an organisation, a community, or even a nation.

Yin (2003) notes the applicability of case study methods in the following situations:

- to explain complex causal links in real-life interventions;
- to demonstrate the real-life context in which the intervention has happened;
- to describe the intervention itself;
- to explore the conditions within which the intervention is scrutinised has no evident set of outcomes.

4.3.1.1 Types of case study design

Eisenhardt (1989) suggests that case study methods can be used to develop a theory, test a theory, or provide a rich description. According to Yin (2003), case studies can be explanatory, descriptive, or exploratory. In explanatory studies the aim is to explore causal relationships, whereas the aim of an exploratory case study is to guide the development of relevant research questions and hypotheses. A descriptive case study begins with a descriptive theory (Tellis, 1997c). Stake (1995) classifies case studies into three categories: i) *Intrinsic* (the researcher has an interest in the case); ii) *Instrumental* (the aim is to give insight into an event or to refine a theory); and iii) *Collective* (an instrumental study is extended to cover several cases/groups of cases to gain more insight into the phenomenon and condition). Tellis (1997c) notes that intrinsic case studies are single case studies, in which the focus is within the case. In collective case studies, the focus is both within and across cases.

Case studies can be either single or multiple-case in design (Yin, 2003). Yin (2003) holds that they can be holistic (single unit of analysis) or embedded (multiple unit of analysis in the same case, where subunit(s) are examined in a single case). Yin identifies four different types of case studies as detailed in Table 4.2:

Table 4.2 Types of case studies

	Single case design	Multiple case design
Holistic (single unit of analysis)	Type I	Type III
Embedded (multiple unit of analysis)	Type II	Type IV

Source: Yin (2003)

Type I: A single case study approach, which has only one unit of analysis and the overall nature of an organisation or a programme is examined in a single case study.
Type II: A single case study where multiple units of analysis are incorporated. Although only a single case is selected, the analysis includes different subunit(s).
Type III: A multiple case study approach, involving only one unit of analysis in each case.
Type IV: A multiple case study approach in which more than one unit of analysis is incorporated in each case.

Yin (2003) argues that researchers may use a single case study to confirm or dispute a theory, or scrutinise a unique or extreme case. He also suggests that a single case study is used when the possibility exists for the researcher to investigate a case which has not previously been accessible. Flyvbjerg (2004) notes that when a researcher is seeking the maximum amount of information on a phenomenon, the selection of an atypical or extreme (unusual) case often uncovers more valuable information than an average or typical case. He argues that studying such cases provides an opportunity to understand and achieve deeper insights into organisational processes and mechanisms, and maintains that studying a critical case is valuable owing to its strategic importance in relation to the general problem. If researchers study cases with maximum variations, they may obtain insights into the various significant circumstances of case process and outcome. A case with specific characteristics in relation to a single dimension (e.g. in terms of size, budget, form of organisation) could be an example of such a situation.

4.3.1.2 Advantages of the case study approach

The comparative advantages of case studies have been discussed in the literature. A case study allows the researcher to obtain a holistic overview which takes into account the local context and any contingent factors (Stake, 1995; Yin, 2003). Tellis (1997a, 1997b) argues that case study approaches provide the opportunity to use both qualitative and quantitative methods to collect data on organisational processes and outcomes. Three principles of qualitative research, relating to 'description', 'understanding' and 'explaining', are included as part of case study analysis (Tellis, 1997a; Pettigrew 1990). Exploratory case studies may result in the development of new hypotheses, which need to be tested, and may also help in establishing more specific research questions (Stake, 1995; MacNealy, 1997; Yin, 2003).

4.3.1.3 Limitation of the case study approach

The above notwithstanding, case study research has a number of limitations and it has been subject to a wide ranging critique, particularly by positivist social scientists.

One area of concern is the issue of generalisation (Yin, 2003). It can be argued that the results of a case study cannot be generalised, as the sample does not necessarily represent the total population in a statistical sense. In answer to the question "How can you generalise from a single case?", Yin (2003, 10) states:

> *'The short answer is that case studies, like experiments, are generalisable to theoretical propositions and not to populations or universe. In this sense, the case study like the experiment does not represent a "sample" and the investigator's goal is to expand and generalise theories (analytical generalisation) and not to enumerate frequencies (statistical generalisation)'.*

Indeed Yin (2003) argues that the generalisation of case study results, (either single or multiple designs), is made with regard to theory development rather than statistical generalisation. Tellis (1997a) contends that this interpretation, in which sample cases are taken from a larger universe of cases, is inappropriate. He maintains that terminology such as a "small sample" is incorrect, as though a single case study was a single respondent. Punch (2005) maintains that in two types of situations, generalisation is not an issue. The first is when the case is very important, interesting, or unique in some respects that in itself makes it worthy of study. This situation is similar to Stake's (1995) intrinsic case study. This type of case study does not propose to generalise but rather to comprehend the case in its complexity and wholeness. The

second situation concerns 'negative cases'. Study of such atypical cases provides the opportunity to learn why they are different and may contribute toward a better understanding of typical cases. This is similar to Stake's (1995) second type of case study (instrumental case study).

Another potential problem in case study research is researcher bias, where the researcher may influence the process of data collection (e.g. biased data collection, which seeks to collect only evidence that strengthens the initial assumptions and hypotheses), data analysis and interpretation of results (Yin, 2003).

In response to those questioning whether a single case is as robust as a multiple case design, Ragin (1992: 225) states that even single case studies 'are multiple in most research efforts because ideas and evidence may be linked in many different ways'.

To conduct case studies, researchers should consider the time and resources required for the research because a case study is expensive, time consuming and presentation of results may require preparation of a lengthy document (Yin, 2003; MacNealy, 1997).

4.3.1.4 Why was a case study design selected for this study?

A case study design was selected for the following reasons:

The case study is appropriate when an empirical study proposes to investigate a contemporary phenomenon within a real-life context (Yin, 2003; Tellis, 1997a). Indeed, Yin (2003) differentiates a 'case study' from a 'history', as the focus of a case study is on contemporary events. However, some academics (e.g. Bryman, 1984; Stake, 1995) do not specify a focus on contemporary events as being a necessary characteristic of a case study. Similar methods, such as reviewing archival data, are used by both historical and case study researchers, but case studies may also use direct observations and systematic interviews. Hence, in the present study research participants were asked to recall their attitudes and perceptions regarding both preceding and current events relating to their explanation of decline and turnaround in the organisation. It is evident that in the present study the events being examined are contemporary, although retrospective information is used where appropriate. Consequently, the case study method seems to be an appropriate design for this study.

Table (4.2) shows that when a research question takes the form of a 'how' or 'why' question, the case study is an appropriate method. As the aim of this empirical study is to understand 'how' and 'why' a large acute NHS trust failed and then successfully turned around its performance, it would appear that the case study method is suitable (Yin, 2003)

When the boundaries between a phenomenon and its context are not clearly defined, the case study is a suitable research method (Yin, 2003). As the processes of organisational failure and turnaround are context-related and no evident boundary exists between the processes and context, again the case study is an appropriate method.

When the researcher is unable to manipulate behaviours and has no control over the events (in contrast with experimental studies), the strength and suitability of the case study make it a substantial and an appropriate method, resulting in the provision of 'thick description' and a deep level of understanding of the phenomenon under examination (Merriam, 1988; Yin, 2003; Burns, 1990). In the current study, the researcher was not able to have control over events and the case study approach seems suitable for forming a deeper understanding of the factors leading to organisational failure and turnaround in the organisation.

Using the categories defined by Yin (2003), a holistic single case study design (Type I) was selected for this study in order to elicit deeper insights into organisational failure and turnaround processes in English acute trusts. The study uses a single case study organisation as the unit of analysis. It is necessary to mention several practical issues considered when the researcher proposed tackling the case (acute Trust): accessibility of the case; costs of the project; time required for data collection; management of large and complex data sets; and the number of participants within the case. More justification on the selection of the case is provided in the next section.

4.4 Sampling strategies

In the present study, a two stage sampling strategy was used. The first stage concerned the selection of the organisation using a purposive sampling method. In the second stage, internal and external participants were selected in order to provide relevant information from different professional and managerial groups and at different levels of the organisational hierarchy.

4.4.1 Selection of the case

One of the most important issues in the case study method is the selection of the case(s) to be examined (Eisenhardt, 1989). In the case study approach, cases are often selected on the basis of theoretical sampling (Glaser and Straus, 1967) or purposive sampling (Lincoln and Guba, 1985), rather than conventional or statistical sampling. Statistical sampling is applied for experiment hypothesis-testing studies within which samples are randomly selected from the population. The goal of statistical sampling is to provide accurate statistical proof on the distributions of sample variables within the population (Eisenhardt, 1989). Lincoln and Guba (1985: P. 202) state when referring to the differences between purposive sampling and statistical sampling: 'It [Purposive sampling] is based on informational, not statistical considerations. Its purpose is to maximise information, not to facilitate generalisation. Its procedures are strikingly different, too, and depend on particular ebb and flow of information as the study is carried out rather than *a priori* consideration. Finally, the criterion used to determine when to cease sampling is informational redundancy, not a statistical confidence level'. Eisenhardt (1989) suggests that the purpose of the selection of case(s) is to replicate previous cases or to expand or test evolving theory. He maintains that although random selection of cases is possible, it is neither necessary nor even preferable.

Purposive selection of cases with extreme situations among a limited number of cases that could be investigated is recommended by Pettigrew (1988) and Flyvbjerg (2004). Purposive sampling results in increasing of the scope and range of data and a higher probability of revealing multiple realities (Lincoln and Guba, 1985). Tellis (1997c) emphasises that, in the process of purposive selection of cases, concentrating on one or two issues which are crucial in understanding the system being scrutinised is necessary.

Purposive sampling has been used for this study, and the importance and relevance of the selected case study organisation to the research questions can be used to justify its selection. For ethical considerations, the organisation and staff remain anonymous. In selecting the case, first the change in the performance of all English NHS acute trusts according to the 'star rating system' was considered between 2001 and 2004. As the case under study was selected on the basis of performance assessment by the star rating system, this system (as a composite measure of performance) is outlined below.

4.4.1.1 The Star Rating system

Since the introduction of the NHS Plan in 2000 (Department of Health, 2000), NHS organisations have been subject to increased external performance measurement and management. A system for measuring the performance of NHS organisations was introduced by the Department of Health in 2001. This management system was a composite measure of performance (Davies et al., 2003), which categorised NHS organisations from zero to three stars according to their performance level (star rating system) (Department of Health, 2002). The star rating system is the first attempt at publicising the quality of the provider's performance in the English NHS (Shekelle, 2005). This policy is predicated on the premise that the publication of these comparative data can encourage organisations to respond and improve their performance, especially those dimensions of performance that are measured (Mannion et al., 2005; Davies and Lampell, 1998). The following table details the four-point scale (zero to three stars) used in the star rating system (Department of Health, 2001).

Table 4.3 Star rating system

3 star	Trusts with the highest levels of performance
2 star	Trusts that are performing well overall, but have not quite reached the same consistently high standards
1 star	Trusts where there is some cause for concern regarding particular key targets or extremely poor performance on the balanced scorecard
zero star	Trusts that have shown the poorest levels of performance against key targets or in CHI clinical governance reviews

Source : www.healthcarecommission.org.uk

In September 2001, the first star ratings for acute hospital trusts were published. In 2002, the second assessment covered all acute hospitals, specialist hospitals and ambulance services. In July 2003, an independent organisation - the Commission for Health Improvement (CHI) - took on the responsibility for publishing a table of the annual performance star rating and more recently a new organisation – the Healthcare Commission – took on the role in 2004 when CHI was abolished (www.healthcare commission.org.uk; Mannion et al., 2005). Over time, additional and more sophisticated indicators were included in the star rating system. The focus of the ratings in 2000/1 was 'not primarily a commentary on the quality of clinical care ', but an evaluation of the overall 'experience of NHS patients' (Department of Health, 2001). Other approaches have been used to assess the performance of NHS organisations, along with the star rating system, including national and local audits,

clinical governance reviews and performance monitoring by strategic health authorities (Mannion et al., 2005).

One of the aims of the star rating system is to incentivise improvement in performance in a way which enables good performers to be rewarded and poor performers to receive external support. The Trust can then take any necessary action with regard to their overall assessment as well as the scores placed on their individual performance indicators (Department of Health, 2002). The Department of Heath has awarded three stars to trusts by allocating additional capital payment of up to £1 million, along with different managerial freedoms, in order to support further service development and improvement (Department of Health, 2002). Each of the three star trusts also became eligible to apply for 'Foundation Trust' status and taken out of the NHS performance management hierarchy, with new powers to borrow from private markets for capital investment.

The Department of Health stated that zero star trusts will 'have to develop immediate plans to improve performance. If this does not happen, the management of the hospital will be put out to franchise' (Department of Health, 2002, P.9). Franchising refers to the replacement of the Chief Executive and perhaps other members of the senior management team (Snelling, 2003). Such organisations are required to submit their plans to the relevant Strategic Health Authority (SHA), which applies a performance management system to the organisation's performance. In turn, the performance management and improvement responsibilities of the SHA are overseen by the Recovery and Support Unit at the Department of Health. The star rating system has focused the attention of NHS managers on meeting strategic priorities and key national targets (Mannion et al., 2005).

Five key areas (Table 4.4) have been used to assess the performance of NHS acute trusts. The trust star rating is produced by combining the scores derived from each key area through a complex six-step algorithm process (Mannion et al., 2005). Ten 'key indicators', which mostly relate to waiting times, are the key determinants of an organisation's rating. In addition to these key indicators, the performance of the organisation is viewed through a composite measure of performance on the basis of a series of subsidiary indicators, merged in the form of a 'balance scorecard'. Only a small component of the calculation is comprised by measures of clinical quality (Health Care Commission, 2004). These five key areas and their scoring systems are summarised in Table 4.4.

Table 4.4 Key areas, criteria and scoring for the star rating system

Performance areas	Criteria	Scoring system
Key governments targets	Mostly relate to access and waiting list targets	Each targets scored as 'achieved', 'under achieved', or 'significantly underachieved'
Performance indicators with a clinical focus	included indicators relating to mortality rates, re-admission rates and rates of successful discharge to home following hip fracture and stroke	Judges as 'significantly above average', 'above average', 'average', 'below average', significantly below average'.
Performance indicators with a patient focus	Included indicators relating to waiting times for inpatient treatment, outpatient appointments, casualty and cancer treatment, delayed discharge, cancelled operations and patient experience of care (from survey)	Five points awarded to highest level and one to lowest. Indicator scores combined (unweighted) to produce overall score for clinical care. Scores presented with confidence intervals
Performance indicators with a capacity and capability focus	Includes indicators relating to data quality, staff opinion (from survey), junior doctor hours and sickness absence rates	As above. Scores banded in percentiles
CHI reviews	Largely qualitative assessment of clinical Governance systems across seven components: risk management; clinical audit; research and education; patient involvement; information management; staff involvement; education training and development	Judged as zero star if significant weakness found by CHI review in five or more of the seven areas. Judged as three star if significant strength in all areas and no significant weakness in any area

CHI, Commission for health improvement

Source: Mannion et al. (2005)

It is important to note that few differences existed in the set of indicators used between 2001 and 2005. However, in 2004 acute trusts were not assessed in relation to their clinical governance reviews.

4.4.1.2 Justification for using star rating system in the sampling process

Numerous commentators have questioned the validity and accuracy of star ratings as a measurement of health care performance (Snelling, 2003; Gulland, 2002). Jas and Skelcher (2005, p 197) acknowledge that, from a methodological perspective, the development of a composite indicator to measure overall performance, through combining multiple measures of organisational performance, is a complex undertaking and not beyond criticism. However, they argue that there is clear evidence that some public organisations display lower levels of performance than others. The Comprehensive Performance Assessment (CPA) is given as an example by them and relates it to the English local government. Although CPA has been criticised by some councils, academics and policy commentators, local councils have generally accepted its scores (Jas and Skelcher, 2005b).

Davies et al. (2003) suggest that despite the fact that the star rating system has been criticised, it has important political, managerial, financial and reputational implications which trusts cannot ignore. In health care this means that zero-star rated organisations are required to take very seriously challenges that they face to improve their performance. Whilst the accuracy of star rating is questioned, the public, trusts and the wider NHS community perceive a zero star rating as a general indication of 'failure' (Harvey et al., 2005a). On the other hand, a three-star rated organisation is viewed as 'successful' and a high achiever. Smith (2005) argues that the real impact of performance data has occurred for the first time in England through the introduction of the star rating system and highlights improvements in the waiting lists in the English NHS. Similarly, Hauck and Street (2007) identify major improvements in the performance of the English NHS when compared with the service in Wales, where the star rating has not been implemented. Nonetheless, Smith (2005) adds that intense debate is required as to whether the overall impact has been positive or negative. In addition to beneficial changes, a number of unintended and adverse-side effects of the star rating system have also been identified (Mannion et al., 2005; Smith, 2005).

4.4.1.3 Why was this Trust selected for this study?

The Trust was selected as a case of successful turnaround, as it fulfilled the criteria below.

- The performance of the Trust declined in terms of star rating for two successive years.

- The Trust subsequently obtained three stars in the following year. It was a unique case among acute Trusts because the organisation had improved its performance dramatically moving directly from zero or one to three stars.
- There was acknowledgment by the Trust's senior managers and external stakeholders (e.g. Strategic Health Authorities) that the Trust had faced serious problems, especially in terms of access indicators, and an evident turnaround in performance had occurred.
- The Trust allowed access to the researcher for the collection of primary and secondary data.

To gain access to the organisation, a letter of invitation was sent to the Chief Executive of the Trust and the Research and Development unit (R & D) of the Trust for the final decision. All the required documents were submitted to the R & D unit (proposal and University of York support letter). Permission was granted for the researcher to access the Trust following local ethics approval (LREC).

4.4.2 How were the participants selected for this study?

A decision was made to select different participants using a purposive sample of staff from different organisations (external and internal to the Trust), departments (clinical and non clinical), organisational positions (senior, middle and junior levels), and professional groups (clinical consultants, matrons, nurses) in order to provide a rounded view of the performance decline and turnaround processes. Different factors, such as the complexity of the phenomenon under study, the size of the Trust and the plan to interview people from diverse groups and organisations, played an important role in deciding how many staff to interview. It was envisaged that about 50 people needed to be interviewed to obtain a rounded view of organisational dynamics and events. However, the plan was to keep sampling until no new ideas emerged. The sampling was flexible and the interviewees were selected according to both their degree of knowledge and understanding of the context and phenomenon under study and appearance of new ideas from ongoing data collection and analysis.

Therefore, it was proposed to select participants who had prior knowledge of the failure and/or were involved in the turnaround process. When selecting participants within the Trust, an attempt was made to select staff who had continued to work in the organisation since the early stages of the failure and people who had started to work there since the failure occurred, although, new managers were included even when they were not in post at the initial stages of performance decline. It should be

noted that most of the views and information were obtained from staff, in particular at senior manager level, who were not in post at the time of the failure, so there is a greater possibility of interviewing those individuals who may have been more inclined to criticise previous managers. To avoid such an imbalance in information, those individuals that were working at the time of failure were also contacted. Inevitably, the views of the managers in the Trust are likely to be partial and one-sided (Patton and Mordaunt , 2004). In order to corroborate information provided by internal staff and minimise the potential for bias, it was suggested that data should be also gathered from outsiders (Mellahi and Wilkinson, 2004) and cross-checked with relevant documents.

The internal participants were identified using the organisational chart for the Trust. The external participants were selected on the basis of their organisational position and the extent of their involvement with the Trust during the time of the failure and turnaround process. Participants from the following external organisations were interviewed: local Strategic Health Authority (SHA); local Primary Care Trusts (PCT); the Performance Development Team of the Modernisation Agency; and patient representatives.

To invite staff to participate in the study, an invitation letter and a participant information sheet (See Appendix 4.2) were sent by email or mail. The participant information sheet comprised of: an introduction of the research project and the researcher; the possible benefits of the research; the amount of time that participants would be required to spend on the project; confidentiality and ethical procedures; emphasis on voluntary participation; the right to withdraw at any stage of the study; and the audio-taping process. Staff were given three weeks to respond. A total of 57 people agreed to be interviewed. During interviews some interviewees introduced potential participants who would shed new light on rich information to incorporate into the data being collected.

Eleven out of fifty seven people were external to the organisation. The participants from the trust were from both clinical and non-clinical groups. The Trust's interviewees were from the following groups: executive and non executive members of the board; senior non-clinical managers; clinicians with managerial position; middle clinical and non-clinical managers; clinical directors; junior managers; consultants without managerial responsibility; matrons; and nurses (senior and junior). Eight people did not agree to participate in the study because of high workloads or that they had no interest in the study. This group mostly comprised clinical consultants (both

clinical directors and consultants without managerial positions) but also included several junior nurses. Table 4.5 shows the number and organisational positions of the interviewees who participated in this study and also details of staff who refused to participate or did not reply to the invitation letter. Table 4.6 provides further details of each interviewee, listing their background characteristics (gender, job position, duration of working in the NHS and in the Trust).

Table 4.5 Interview sample of the case study

Organisation	Role and/ or position		No. of staff inter-viewed	No. refused interview or did not reply
Trust	Senior managers	Directors	6	2
		Non-directors	9	
	Non executive members		2	3
	Middle managers		8	1
	Clinicians with managerial position		4	10
	Clinicians and nurse consultants		3	1
	Matrons (nursing background)		5	
	Nursing staff	Ward manager	2	2
		Staff nurse	4	5
	Others (junior manager, clerical staff, and staff representative)		3	1
***SHA**	Senior managers		2	1
	Clinical staff with managerial post		2	
Primary Care Trust	Senior managers		2	
**** PDT**	Members of PDT		2	
Patient representative			3	
Total			57	26

***Strategic Health Authority**
****Performance Development Team - Modernisation Agency**

Table 4.6 Characteristics of interviewees in the case study

Characteristics / Interviewees	Gender	Role or position	Work in the NHS (years)	Work in Trust or relevant organisation (years)
1	F	Senior manager- director	18	3
2	M	Clinician with managerial position	27	15
3	M	Middle manager	9	3
4	F	Senior manager- Director	20	3
5	M	Senior manager (Non director)	17	14 (3 years in sr. position)
6	M	Non executive	-	8
7	M	Senior manager (Non director)		2
8	F	PCT- Senior manager	-	3
9	F	Senior manager (Non director)	20	5
10	M	Senior manager (Non director)	24	21 (2 years in sr. position)
11	M	Senior manager- director	18	18 (5 years in sr. position)
12	F	Non executive	5	5
13	F	SHA- Clinical staff with managerial post	30	3
14	F	Senior manager (Non director)	19	14
15	F	Middle manager	27	18 (3 years as middle-mgr)
16	F	Senior manager- director	20	3
17	F	Middle manager	25	11
18	M	Senior manager (Non director)	10	3
19	M	Senior manager (Non director)	-	3
20	F	Junior manager	5	5
21	M	SHA- Senior manager	34	3
22	M	SHA- Senior manager	5	2
23	F	Middle manager	10	2
24	M	Middle manager	11	2
25	F	Senior manager (Non director)	30	18 (3 years in sr position)
26	M	MA- member of the PDT	-	-

Character-istics / Inter-Viewees	Gender	Role or position	Work in the NHS (years)	Work in Trust or relevant organisation (years)
27	F	Senior manager (Non director)	21	2
28	F	Middle manager	12	2
29	M	Matron (nursing)	23	8
30	F	Ward manager (nursing)	21	21 (6 years as ward mgr)
31	F	Matron (nursing)	22	2
32	M	Clinician	35	16
33	F	Nurse consultant	14	7
34	F	Matron (nursing)	16	3
35	F	Staff nurse	5	5
36	F	Staff nurse	33	32 (12 years as sister)
37	M	MA- member of the PDT team	15	3
38	M	Clinician with managerial position	-	4
39	M	Middle manager	16	7
40	M	Staff representative	33	23 (15 years staff rep.)
41	F	Patient rep.	-	2
42	M	Clinician with managerial position	21	12 (4 years mgr position)
43	F	Matron (nursing)	39	28
44	F	Matron (nursing)	22	22 (3 years as matron)
45	M	PCT- Senior manager	-	5
46	M	Senior manager- director	13	2
47	M	SHA- Clinical staff with managerial post	38	2
48	M	Senior manager- director	8	2
49	M	Middle manager	-	2
50	M	Patient representative	-	1
51	F	Patient representative	-	1
52	F	Staff nurse	9	4
53	M	Clinicians with managerial position	15	8
54	M	Clinician	16	7
55	F	Staff nurse	8	3
56	F	Clerical staff	10	4
57	F	Ward manager (nursing)	18	10 (3 years ward mgr

The researcher was aware that clinicians (particularly clinicians with managerial positions) working in the NHS are very busy due to their high workload and that they may not be willing or interested in taking part in the study. For these reasons, all the divisional and clinical directors were sent an invitation letter via e-mail or internal mail. Six out of fourteen (42%), agreed to be interviewed in their offices. However, on the day of the scheduled interview, two were not able to take part due to unexpected circumstances (clinical matters) having arisen at short notice. There were eight clinical directors, who chose not to participate in the study: four of whom did not reply and four refused to participate. However, four consultants interviewed in the study gave both supportive and critical perspectives with regards to organisational failure processes and turnaround strategies selected by the new managers. Therefore, it does not seem that they only gave a one-sided opinion on the processes under study. In addition, one of the interviewees from outside of the Trust was a consultant who had worked as a divisional director for a few years in the Trust, having had experience of working with both the previous and the current management team.

4.5 Data collection

Yin (2003) considers data collection in the case study approach as a design issue, which can determine the reliability and validity of the study. Tellis (1997c) argues that data collection in case studies should not be isolated from other aspects of the research process and refers to the case study as a triangulated research strategy. Yin (2003) also states that the accumulation of converging evidence and triangulation of data over a given issue, is the aim of data collection.

4.5.1 Triangulation strategies

Triangulation is a strategy which can be used to corroborate the validity of research findings. Different types of triangulation have been identified by Denzin (1984) including:

i) *Data sources triangulation:* This refers to the collection of data from various relevant groups and stakeholders who have a vested interest in the phenomenon under study. Therefore, convergent results from all or most of the groups/stakeholders are more likely to offer a better understanding of the situation.

ii) *Investigator triangulation*: This includes using several researchers (usually a research team with same discipline) to study the same phenomenon using the same method (e.g. observation or interviews).

iii) *Theory triangulation:* This refers to the strategy used when different investigators with different perspectives (multidisciplinary research team) interpret the same data/results.

iv) Methodological triangulation: This involves utilisation of various methodologies (multiple qualitative and/or quantitative methods) to examine a particular phenomenon. Yin (2003) emphasizes that utilisation of many sources of information will result in more robust evidence. In terms of methodological triangulation, Yin (2003) suggests using different sources of evidence and classifies these sources into six groups: documentation; archival records; interviews; direct observation, participative observation; and physical artefacts. Not all sources of evidence are relevant or essential for every case study. The strengths and weaknesses of these sources are detailed in Table 4.7. There are two different groups of data, primary and secondary. Whether primary or secondary, the data can be internal or external. Primary data refers to the data that are mainly gathered for the ongoing research. Secondary data are gathered not for the purpose of ongoing research because they are already documented. When the data are derived from within the organisation, under scrutiny or external to the organisation, they are referred to as internal and external data respectively in the study.

Table 4.7 Sources of evidence and their strengths and weaknesses

Source of Evidence	Strengths	Weaknesses
Document-ation	• stable - repeated review • unobtrusive - exist prior to case study • exact - names etc. • broad coverage - extended time span	• retrievability - difficult • biased selectivity • reporting bias - reflects author bias • access - may be blocked
Archival Records	• same as above • precise and quantitative	• same as above • privacy might inhibit access
Interviews	• targeted - focuses on case study topic • insightful - provides perceived causal inferences	• bias due to poor questions • response bias • incomplete recollection • reflexivity - interviewee expresses what interviewer wants to hear
Direct Observation	• reality - covers events in real time • contextual - covers event context	• time-consuming • selectivity - might miss facts • reflexivity - observer's presence might cause change • cost - observers need time
Participant Observation	• same as above • insightful into interpersonal behaviour	• same as above • bias due to investigator's actions
Physical Artefacts	• insightful into cultural features • insightful into technical operations	• selectivity • availability

Source: Yin (2003), Page 80

4.5.2 Which kinds of triangulation strategies and sources of data were used in this study?

In this study, both data source triangulation and methodological triangulation were used. Because the research was conducted by one PhD student, investigator triangulation and theoretical triangulation were not possible. As explained above, the study proposed to gather data from all relevant internal and external people in the Trust in order to produce a rounded view on the processes being studied (data sources triangulation). Any controversy about data derived from different sources should be addressed and should undergo further analysis, scrutiny and investigation (Lacey and Luff, 2001). In this research, a number of follow up interviews and a review of additional data was undertaken to clarify ambiguities and mismatches between official documents and interview responses. Therefore, the principal data collection for the study was semi-structured interviews and a review of relevant documents and reports (internal and external). Table 4.8 details the data sources used in the study.

Table 4.8 Sources of data

	Primary sources	Secondary sources
Internal sources	▪ interviews with managers at different levels (senior, middle, and junior)	▪ documents (e.g. annual reports, trust board minutes, performance outcomes)
External sources	▪ interviews with managers of other organisations (PCT, SHA, MA, consultants and patient representatives) ▪ interviews with researchers with an interest in the public health sector	▪ documents (e.g. inspection reports, government reports, press release, journal articles, and websites

i) Interviewing:

Tellis (1997c) notes that one of the most important sources of information in a case study is the interview. In the present study, face to face interviews were undertaken by the researcher with the individuals in the sample population. An interview topic guide was developed on the basis of the theoretical framework forming the basis of the of the study (stage theory) and findings from the literature review and the views of experts in the field. The interview topic guide was tested in a pilot interview with three participants (one senior manager and two middle managers). The results of the pilot were then used to construct additional sub-questions that allowed the researcher to obtain more focused information (See Appendix 4.3 for the interview topic guide).

Semi-structured interviews were then conducted with the remaining participants, who were recruited and interviewed between May and November 2005. Most interviews took between 45 to 60 minutes to complete and were conducted at the workplace of the interviewees, in a quiet area. Once a participant agreed to take part in the project, an informed consent form was signed by both participant and researcher (see Appendix 4.4). At the start of the interview, the researcher introduced himself and gave a brief explanation of the research project and its objectives. The first questions related to background characteristics of the respondents including their qualifications and employment history. The questions focused on the history of the Trust's performance and presence of performance problems, factors that were likely to have contributed to the performance decline, factors initiating the process of change, the process of development and implementation of an action plan to turnaround the situation, the intended and unintended consequences of turnaround interventions, and finally, factors that had facilitated or impeded the turnaround process. The researcher tried to ask fairly general question and provide ample opportunity for the interviewees to articulate fully their views, perceptions and ideas. The interviewer also

tried to avoid the use of 'leading' questions. Once all the questions were asked, each respondent was given the opportunity to add anything that he or she thought would be of value to the study.

An interview summary sheet was completed shortly after each interview. Within 24 hours, each tape was listened to twice by the researcher and important information was noted briefly in the 'interview summary sheet' prior to the completed transcription. Miles and Hubermann (1994) emphasize the importance of such a sheet, as it helps the researcher to retain the initial impressions and compare them later with the transcript. The summary sheet also played a valuable role in the data collection process, as it highlighted key information and resulted in the posing of more pertinent questions. Subsequently, interviews were audio-taped, transcribed verbatim, and converted into text. A total of several-hundred pages constituted the interview text and taken together comprised the raw 'data' for the study. Some follow-up interviews with respondents (face to face, telephone interviews or by e-mail) were undertaken with the aim of clarifying any ambiguities or issues requiring fuller explanation and confirmation about key events or issues raised in previous interviews.

ii) Review of documents:

The role of reviewing documents is to corroborate the information gathered at the interview stage (Yin, 2003; Tellis, 1997c). Mellahi et al. (2002) note that, as the interviews generally reveal people's insights rather than presenting deeper realities relating to the incident, the stress is on the confirmatory role of the reviewing documentation. In this empirical study, both internal documents (e.g. Trust annual report, annual clinical governance reports; internal audit reports; documents related to patient complaints; minutes of board meetings) and external documents (e.g. CHAI reports, audit reports, Clinical Governance reports, SHA reports; media text) were reviewed in order to examine the awareness of the crisis, reactions and interventions in response to identified problems. All information collected from different sources was cross-checked to increase the validity of the study.

4.5.3 Search for disconfirmatory evidence:

Popper (1959 in Easterby-Smith et al., 1991) suggests that researchers should always take into account both confirmatory evidence as well as disconfirmatory evidence and to resist the temptation to consider only data that confirms to whatever position or stance they take. Other scholars recommend that deviant cases (evidence), those which may not fit with the findings should also be looked for and examined in

qualitative research ((Dey, 1999; Glaser & Strauss, 1967; Glaser, 1978; Mays & Pope, 1995; Strauss & Corbin, 1998). Easterby-Smith et al. (1991) claim that if researchers search carefully for disconfirmatory evidence, they may develop more useful theory and findings.

In this study, the researcher tried to avoid the 'confirmation trap' by not neglecting to search for disconfirmatory evidence. For example, a significant number of interviewees criticised the previous management team as a key contributor to the Trust's failure. The researcher was aware that most of the views and information were obtained from staff, in particular at senior manager level, who were not in post at the time of the failure, so there is a greater possibility of interviewing those individuals who may have been more inclined to criticise previous managers. To avoid such an imbalance in information, those individuals that were working at the time of the failure were also contacted and interviewed (particularly staff who were working closely with the previous senior management team). In addition other sources of data (e.g. SHA report) were used to make clearer the role of the previous management team with regards to organisational decline. During the data collection process, the researcher tried to explore any disconfirmatory evidence and explore the reasons for such discrepancies and identify any alternative explanations. Any significant differences in perceptions of senior, middle and junior managers and between managers and clinicians were investigated and the researcher attempted to clarify any differences. Inevitably, the views of the managers in the Trust are likely to be partial and one-sided (Patton and Mordaunt, 2004). In order to corroborate information provided by internal staff and minimise the potential for bias, it was decided that data should be also gathered from outsiders (Mellahi and Wilkinson, 2004) and cross-checked with relevant documents. Participants from the following external organisations were interviewed: local Strategic Health Authority (SHA); local Primary Care Trusts (PCT); the Performance Development Team of the Modernisation Agency; and patient representatives.

4.6 Data Analysis

Data analysis consists of "examining, categorizing, tabulating, or otherwise recombining the evidence to address the initial propositions of a study" (Yin, 2003). The qualitative data were analysed using the 'framework analysis' approach with the

assistance of the Atlas-Ti (version 5) as a computerised qualitative data analysis package.

4.6.1 Framework analysis

The interview transcripts were analysed using the 'framework' analysis approach (Ritchie and Spencer, 1994). Pope and Mays (2000) state that thematic framework analysis provides the opportunity to include both *a priori* theoretical (deductive approach) and empirical (inductive approach) issues into the analysis process. In addition, the framework allows for structuring the process of data analysis, rendering it more objective. Lacey and Luff (2001: p 9) state that:

> *"The framework approach was explicitly developed in the context of applied policy research. Applied research aims to meet specific information needs and provide outcomes or recommendations, often within a short timescale. Framework analysis shares many of the common features of much qualitative analysis, and of what is often called 'thematic analysis'. The benefit of 'framework' analysis is that it provides systematic and visible stages to the analysis process, so that funders and others can be clear about the stages by which the results have been obtained from the data. Also, although the general approach in 'framework' analysis is inductive, this form of analysis allows for the inclusion of a priori as well as emergent concepts, for example in coding".*

In the 'framework' approach, when themes emerging from the data are similar to the issues in which the researcher is interested, the data have confirmed the importance of these issues identified by the researcher and can be investigated further (Lacey and Luff, 2001). Framework analysis has been used successfully by health services researchers (e.g. Todd, 2003; Griffiths et al., 2001).

Framework analysis consists of five complementary stages (Ritchie and Spencer, 1994). Although there is essentially a sequential process, researchers can move between stages during the process of analysis in order to apply his or her conceptual ability for clarification of meanings and links between data. In addition, data analysis can be carried out while data collection is ongoing. Box 4.1 displays the different stages of the Framework Analysis (Lacey and Luff, 2001).

Key stages of Framework Approach

- Familiarisation
- Identifying a thematic framework
- Indexing
- Charting
- Mapping and Interpretation

Adapted from Lacey and Luff (2001)

Data analysis process in this study:

i) Familiarisation:

At this stage, I read and re-read the transcripts three times and where necessary listened again to the tapes to obtain an overall view. During the process, memos were made and important issues and repeated themes were noted before starting the formal analysis using Atlas-Ti. The participants were contacted via e-mail or telephone whenever it was necessary to ask for further clarification of points raised in the interview.

ii) *Identifying the thematic framework:*

In this stage, the preliminary coding framework (categories) was developed both from *a priori* issues based on the earlier literature review (deductive approach; see Pope et al. (2000) and categories during the familiarisation stage (inductive approach; see Pope et al., 2000). The 'stage' theory (Mckiernan's model) was used to develop the thematic framework and different parts of the 'stage' theory in the framework were deliberately included. Discussions regarding the preliminary framework were conducted over several meetings between the researcher and supervisor.

iii) *Indexing:*

During this stage (usually referred to as coding in other qualitative analysis) the developed thematic framework was applied to the whole data set using both numerical and textual codes to identify relevant pieces of data with the different themes. Some pieces of data corresponded to more than one theme and were indexed by multiple themes. In addition, if the developed thematic

framework was not able to index a piece of data, new categories were developed, thus expanding the thematic framework. The first step for indexing was to export transcriptions in Rich Text Format (RTF) into Atlas-Ti version 5.

During the process of indexing (assigning codes to the data) within Atlas-Ti, memoing was adopted as a strategy to capture deeper and more coherent thoughts on the case. Memos are defined by Strauss and Corbin (1990: 198) as 'the written forms of our abstract thinking about the data'. The importance of memos is described by Charmz (1999) as a 'pivotal intermediate step between coding and writing' which provides an opportunity for researchers to stop and think about the data and move beyond its descriptive codes to considering how codes can become categories for analysis, and alerting the researcher to gaps in the data and points where comparison can be made. Memos include operational notes about data collection, but also theoretical memos, which are an essential step in the development of analytical ideas. Theoretical memos include initial ideas about data, emerging hypotheses about relationships between codes and the properties of codes, and detailed notes later in the analysis on how the axial and selective coding is developing. Crucially, memos keep the researcher writing, which is an essential element in the analysis itself (Green and Thorogood, 2004). Lacey and Luff (2001) suggest that researchers need to keep a record of their thoughts and theories as they carry out analysis, often called journal or memo keeping. They add that researchers need to keep any flow charts, diagrams, tables and other visual sources in the journal to support the analysis.

iv) *Charting:*

During this stage, headings from the thematic framework were used to develop a chart form so the whole data set could be read more easily. Two different types of charts (thematic and case charts) can be used, either thematic for each themes across all participants (cases) or by case for each participant across all themes. These are illustrated below:

Table 4.9 Charting

Case chart

	Theme 1	Theme 2	Theme 3
Case			

Thematic chart

	Case 1	Case 2	Case 3
Theme			

In the study, the researcher used the case chart and words or quotations were included in each chart from the transcripts that had already been transferred into Atlas-ti. The paragraph reference (developed in the Atlas-Ti software) for each part of the passage was placed in the chart by the researcher to facilitate retrieval of the data relevant to the theme. Table 4.9 presents an example of a case chart developed and compiled for this study. When the chart was completed for all participants, it provided the opportunity to compare the views of one interviewee about different themes (by looking across the rows in the thematic chart), and to contrast the views of different interviewees about one theme (by looking across columns in the thematic chart).

v) *Mapping and interpretation:*

Once all the data was charted according theme, the researcher searched to find the main characteristic of the data. The chart was used to compare and contrast data extracted between interviewees at different managerial levels, with different professional backgrounds, and between individuals from inside and outside the Trust. The relationship between themes was searched. Ritchie and Spence (1994: 186) argue that during this stage the aim of the researcher should be to define concepts, map the range and nature of phenomena, develop typologies, find associations, provide explanations and develop strategies. The original research objectives and also emerging themes were the main guides and influential factors for the researcher at this stage of the analysis (Pope and Mays, 2000). Ritchie and Spencer (1994) state that: 'this part of the analytical process is the most difficult to describe'.

Each interviewee was allocated a number, which could subsequently be quoted. In addition, Atlas-Ti generated the paragraph numbers of the transcriptions. When reporting the results, at the end of each quotation

(written in italics) a bracket is entered with two numbers separated by a colon. The first number represents the interviewee code and the second is the number of the paragraph (generated by Atlas-Ti) from which the quotation comes, for example, (1:12) shows that the quotation has been stated by interviewee number 1 and the quotation is in paragraph 12.

Yin (2003) emphasizes that a general analytical strategy should be presented for each investigation, to clarify the data used and for what reason they will be analysed. Three analytic techniques are recommended by Yin: *pattern-matching*, *explanation-building*, and *time-series analysis*. Tellis (1997c) argues that in general the analysis will rely on either theoretical propositions or the development of a descriptive framework around which the case study is organized (in the absence of theoretical propositions). In addition, the original objective of the case study may help to identify some causal links that could be analyzed.

Pattern-matching is an important analytical strategy and compares the pattern of results derived from an empirical study with a predicted one (Trochim, 1989). Congruence between actual patterns with those predicted, which are often derived from previous qualitative and quantitative studies, can enhance the internal reliability of the study (Yin, 2003). In this study, pattern-matching was used. However, as Tellis (1997c) notes, the discretion of the researcher is necessary when interpreting the data.

Explanation-building as a form of pattern-matching is a method of analysing the data on the basis of building an explanation of the case. It is very useful in explanatory case studies, though it has been used for exploratory studies as well as part of a hypothesis-generating process. Explanation-building is an iterative process that begins with a theoretical statement, refines it, revises the proposition, and repeats this process from the beginning (Tellis, 1997c).

Time-series analysis refers to a technique that analyzes changes and trends in a variable over time. The results of this technique are used to support the findings derived from other methods (Tellis, 1997c).

4.6.2 Computer Assisted Qualitative Data Analysis Software (CAQDAS)

Different dedicated software packages are available to facilitate the management, processing and analysis of qualitative data (Green and Thorogood, 2004). ETHNOGRAPH, ATLAS-Ti, NUDIST, QSR and NVivo are some examples of Computer Assisted Qualitative Data Analysis Software (CAQDAS). Silverman (2005) notes that using CAQDAS results in managing and retrieving a large volume of data more quickly, thus providing an opportunity for the researcher to explore several analytic questions. It also facilitates a more consistent and transparent coding scheme for members of a research team, particularly in large or multi-centre studies, and it improves the rigor of analysis. However, it must be stressed that none of the software packages is able to do the analysis and the researcher is still responsible for developing a coding scheme, interpreting all data and formulating conclusions.

The researcher had access to Atlas-ti via the University of York's computer system. Atlas-Ti is a conceptual network builder which allows researchers to perform qualitative analysis of large bodies of textual, graphical, audio and video data. It is a flexible software package that facilitates management, extraction, comparison, exploration and reconstruction of meaningful pieces of data in a creative, adaptable, yet systematic, way (http://www.atlasti.de). It provides the opportunity for coding, developing memos, search and retrieval, data linking, and creating conceptual diagrams that illustrate linkage between emerging ideas. The researcher participated in two different Atlas-Ti training workshops to achieve the required skills prior to working with Atlas-Ti in the project.

4.7 Validity and reliability of methods

The reliability and validity of qualitative studies have long been of concern in the social science literature (Merriam, 1988; Yin, 2003). Studies should be well constructed to maximise validity (construct validity, internal validity, and external validity) and reliability. However, some commentators (e.g. Lincoln and Guba, 1985) use a different terminology to define reliability and validity issues in qualitative studies. Lincoln and Guba (1985) present four criteria of 'trustworthiness' to verify the accuracy and appropriateness of the data interpretation. These include i) *credibility* (the 'truth value' or the level of credibility of the results for the participants), ii) *transferability* (the extent to which the results can be transferred and applied to other populations and interviews), iii) *dependability* (the extent to which the results would be repeated if the study was to be replicated) and iv) *confirmability* (the extent to which the results are derived from the participants and not due to bias or

misinterpretation by the researcher). Instead of using the terms construct validity, internal validity, external validity and reliability, Lincoln and Guba (1985) use confirmability, credibility, transferability and dependability respectively, as definitions of the same concepts. In this study, criteria suggested by Yin (2003) are used to address validity (construct validity, internal validity, external validity) and reliability issues.

Construct validity is 'corroboration that the instrument is measuring the underlying concept it purports to measure" (Bowling, 2002). Internal validity (particularly important in explanatory or causal studies) is 'the approximate truth about inferences regarding cause-effect or causal relationships' (Tellis, 1997c). External validity refers to generalisability of study results beyond the immediate case or cases (Tellis, 1997c). Reliability demonstrates issues of stability, precision, accuracy of measurement and results. To address reliability, researchers need to determine whether or not the research is consistent, traceable and reproducible. For a study to be reliable, other researchers must be able to obtain the same conclusions when they apply the same methods and data.

Yin (2003) addresses these quality issues in the case study approach and recommends specific strategies in order to enhance the validity and reliability of case studies. These are outlined in table 4.10.

Table 4.10 Validity and reliability issues in case study approach

	Techniques used to meet the criteria	**Phase of study**
Construct Validity	Data triangulation	Data Collection
	Maintaining a chain of evidence	Data collection/ordering
	Have key informants review draft case study report	Composition
	Seminar presentation	Analysis/Composition
Internal Validity	Explanation building	Design/Analysis
	Peer Debriefing	Analysis/debriefing
	Pre publishing	Composition
	Pattern matching	Data analysis
External Validity	Relate to extant literature	Design/Analysis
Reliability	Case study protocol	Data collection
	Establish a case study database	All phases
	Keep a research diary	All phases

Source: Yin (2003)

Tellis (1997a) outlines serious concerns about construct validity in case study research. Following Yin (2003), three strategies for enhancement of construct validity have been used in this study, which consist of applying multiple sources of evidence (triangulation), developing a chain of evidence, and reviewing the findings of the study by key participants. The emergent themes were sent via e-mail to the key participants, both within and outside the trust, when seeking verification and providing additional comments. Tellis (1997a) and Lacey and Luff (2001) emphasize that feedback to respondents, and taking account of their comments, increases the accuracy of both data recording (by giving respondents' quotations) and analytical interpretation. In addition, they stress that it may reduce the concerns that the researcher has sole power over interpretation. Lacey and Luff (2001) note that new data are also generated from respondents' feedback. It is necessary to note that, in the process of applying for ethics approval, seeking feedback from participants was explicitly acknowledged.

In order to maximise internal validity and following the work of Yin (2003), pattern-matching was used in the analysis. The pattern-matching technique links pieces of information from the same case to the propositions developed earlier. The propositions for the study were presented in Chapter 3.

As discussed above, in the case study approach the aim of data analysis is analytical generalisation rather than statistical generalisation. Following Yin's method (2003), to perform analytical generalisation, the results of this study have been compared with existing theories (stage theories), which served as a template, in order to generate possible theoretical relationships. Detailed information about how the comparison was made is provided in Chapter 8.

Different techniques can be used to assure the reliability of the case study. As with Yin's example (2003), a study protocol was developed prior to the data collection process. This was approved by the research advisory group and obtained ethics and Research Governance approval. Yin (2003) places emphasis on the important role of protocols in safeguarding the reliability of case study research. To increase reliability, efforts were made to ensure the process was transparent and auditable. In addition, a research diary was used.

4.8 Reflexivity in research process

Conducting qualitative research exposes the personal influence of the researcher far more than quantitative methods, as the researcher is central to data collection, analysis and interpretation. Within the qualitative research paradigm, a high degree of 'reflexivity' on the part of the researcher is required throughout the research process. Researchers need to take in to account the way that their own background and social position, *a priori* knowledge and assumptions affect all aspects of research: development and design, data collection, analysis and interpretation (Jaye, 2002). Mays and Pope (2000) relate the concept of 'reflexivity' to sensitivity to the way in which the researcher and research process have both formed the data. Through personal accounting, the researchers become aware of how their own position (e.g. gender, race, class, and power within the research process) and how these factors necessarily shape all stages of data collection and analysis (Hertz, 1997).

Academically and professionally, I have a medical background (clinical pathology). I worked as head of a clinical laboratory for eight years with 22 staff members who were under my supervision. This provided a good opportunity to deal directly with staff and also to develop my managerial and leadership skills (e.g. how to outline a clear vision, strategic planning, and communication). Following this, I was appointed as a hospital manager where I had to deal with a range of staff ranging from high ranking consultant specialists to junior doctors and nurses. This provided an opportunity to become familiar with a hospital environment, the interaction between different groups of staff especially doctor- managers relations and issues related to patients and the delivery of a high quality services. I was also a member of an audit group that was responsible for assessing and evaluating other provincial hospitals across the country. This experience, as well, gave me a broader perspective with regards to the audit process and how to assess hospital procedures and practices. During my time in audit I became interested in organisational performance and how it could be improved within a hospital setting.

So, I entered this research with a broad background in hospital management, having studied relevant evidence about the NHS in Britain. During the participant recruitment and data collection period, my clinical background also helped me to be accepted more readily by the clinical staff and I felt that they disclosed issues related to the performance of the Trust and the Trust's management team more willingly and openly because I could understand the technical issues involved and I could empathise with their situation.

I attended two qualitative research method workshops and gained relevant knowledge in the conduct of qualitative research before to starting my fieldwork in 2004. During my PhD study, I gained a post graduate diploma relating to "leading change and innovation". I used a qualitative approach, using semi-structured interviews and document analysis when writing empirical reports for the diploma. This provided an insight into the benefits of using a qualitative approach and I gained valuable experiences, which equipped me with the necessary skills to conduct my field work during the course of my study. A change, that I have identified since carrying out my PhD research, is that I have developed a stronger interest in qualitative methods and I have found that I now prefer to carry out research that "gives voice" to participants.

During the earlier stages of this project, I first reviewed all available literature on organisational performance, organisational failure and the turnaround process. I also became aware of the strengths and weaknesses of the performance star-rating within the NHS which facilitated better understanding of the pitfalls of attempting to measure performance in such a complex organisation as the NHS.

Being an overseas student, I have no allegiance to any group of managers or service providers in the UK. Therefore, I had and still do not have any personal vested interest in the findings. A researcher's journal was kept to reflect thoughts, feelings or ideas arising from interaction with the research participants. This was used when interpreting the data and writing up the findings. In addition, questions and problems regarding the conduct of the research project were recorded and discussed with my supervisor, academic advisors and experts in the field.

4.9 Ethical considerations

According to national regulations, all research within the NHS must obtain Ethics and Research Governance approval before the research can be conducted. As this study was a doctoral research project, the ethics committee of the Department of Health Sciences of the University of York also approved the study before submitting documentation to the relevant Local Research Ethics Committee (LREC).

The main identified ethical issues that might arise within this study were as follows:

- risks to the confidentiality and privacy of the participants or persons they refer to;

- risks of any possible prejudice to the participants (interviewees), their employing organisations, or persons or other local organisations mentioned by interviewees, as a result of inadvertent release of information that could be identified with, or might be prejudicial to, those people or organisations;
- risks to data security.

In order to avoid ethical problems during the course of the study, the following steps were taken:

- Confidentiality issues: The name of each organisation was kept anonymous. In all output from the project, interviewees, persons they reported in the course of the interviews, their employing organisations and other local organisations, are anonymised;
- Prejudice issue: The protection of confidentiality effectively prevented any risk of prejudice to individuals or organisations;
- Security: All digital data were kept on password protected computers during the course of the project. Thereafter, it was stored on CD ROM and made subject to access controls by the Department of Health Sciences, University of York. All paper data were in locked filing cabinets in the researcher's personal office. Only the researcher and his supervisor had access to these cabinets. After completion of the analysis the physical data was packed and sealed in cardboard boxes and transferred to the storeroom of the Department of Health Sciences of the University of York. Access to these data is possible only with the permission of the researcher.

The research proposal and relevant documents (e.g. completed ethics forms, participant information sheet and consent form) were considered by LREC (in order to keep the name of Trust anonymous, the LREC has not been identified) and LREC approved the study after a minor amendment in the participant information sheet (REC reference number: 05/Q1401/11). Following Ethics Committee approval, the required documents were sent to the Trust to obtain Research Governance approval. Finally, after Research Governance approval was granted, the Trust's Research & Development (R & D) Directorate, gave permission to conduct the study. An honorary contract was issued to the researcher for a period of six months by the Human Resources office that provided access to the site of research. The Ethics and Research Governance approval letters are shown in the Appendices 4.5 and 4.6 respectively.

4.10 Limitations of the study

As outlined in section 4.3.1.3, case study research is subject to a number of limitations and the following should be borne in mind. The nature of research conducted by a single student, in which all the processes of data collection and analysis have been carried out by a single researcher, the likelihood of subjectivity in the findings is increased (Mays and Pope, 1995). With regard to issues of validity and reliability (Section 4.7), different strategies were used to minimise the likelihood of bias. The findings of this study were presented at two seminars and advisory meetings and the feedback received was used in reconsidering the analysis process. The verbatim quotations from interviewees were also presented in order to support the validity of the findings and show the link between interpretation and original data. However, the possibility of bias cannot be ruled out. The other limitations of the case study approach, mentioned in this chapter in section 4.3.1.3 should also be borne in mind in regard to this study.

4.11 Summary

This Chapter has presented methods employed in the empirical phase of the study. A qualitative single case study design was used to examine the process of organisational failure and turnaround in an acute NHS hospital Trust. A purposive sampling strategy was chosen as the means of selecting the case and participants for the study. In selecting the case for the study, the NHS 'star' rating system as a composite measure of performance, was used to define organisational failure and performance improvement (notwithstanding serious criticism of the 'star' rating's accuracy in assessment of organisational performance). On this basis, a single acute NHS hospital Trust was selected as a unique case in the English NHS, as once the senior management team was replaced, it had demonstrated a significant performance improvement following two successive years of poor performance.

The main methods of data collection for the study were interviews and a review of relevant internal documents (e.g. the Trust annual reports, board meeting minutes, internal reports) and external reports (e.g. the CHI report, the SHA report, the Audit Commission report). Fifty-seven participants (both internal and external to the Trust) at different organisational positions (senior, middle and junior levels) and from different professional and managerial groups were interviewed to provide a rounded view of the processes under study. To select participants from within the Trust, the Trust's organisational chart was used in the first instance, and interviewees were

asked to introduce staff who had relevant information about the Trust' performance decline and/or the turnaround process. Eleven out of the fifty-seven interviewees were external to the Trust (from the SHA, the PCT, the MA and patient representatives). Eight people refused to participate in the study. Interviews were audio-taped, after obtaining interviewees' consent, transcribed verbatim, and converted into text. All ethical and governance reservations were considered in conducting this study. Both the ethical and research governance committees' approval were obtained before starting the study.

The 'framework analysis' approach was used to analyse the data obtained from interviews, which provided an opportunity to use both inductive and deductive approaches in the qualitative data analysis process. The 'framework' analysis approach has been designed for use in the analysis of data for policy-focused projects. Atlas-ti, computer software created for qualitative data analysis, was used. To maximise the validity and reliability of the findings, different strategies, as suggested by Yin (2003), were employed. Data triangulation, key informants' reviews, the developing chain of evidence, and seminar presentations were all used to enhance construct validity. To increase the level of internal validity, the pattern matching technique was used. A research protocol and development of a case study database were strategies used to improve the reliability of the findings.

The next three chapters (Chapters 5, 6 and 7) present the findings of the empirical study, in the same sequential order as set out in the in the 'stage' theoretical framework. Chapter 5 focuses on the Trust's decline and identifies the symptoms, causes and related issues reported by the interviewees. The focus of Chapter 6 is on the factors that initiated change process (triggers) within the organisation. Chapter 7 discusses the development and implementation of the performance action plan implemented by the Trust.

Chapter 5: Findings - organisational failure - symptoms and causes of failure

5.1 Introduction

The aim of this chapter is to present the findings of the empirical study in relation to the causes and symptoms of organisational failure in the case study. The stages theory, discussed in section 2.9, is used as a conceptual framework to organise and report the findings. Symptoms, secondary and primary causes of failure, and the response of managers and staff when the organisation was zero star rated are also explored. Themes related to the diagnosis of performance problems and the triggers of change and turnaround processes, are presented in Chapter 6 and 7.

5.2 Study context

5.2.1 History of the organisation

The organisation under study is located in a large metropolitan city. It incorporates a teaching hospital and a community ambulatory care centre, which was previously an acute hospital. The Trust's annual budget is around £200 million. It employs about 4,200 staff and services around 1,000 beds. Over the past decade, the organisation has undergone a substantial restructuring and reconfiguration of its services.

Until 1994, the local Health Authority was responsible for running three hospitals. When the Conservative government introduced NHS Trusts as part of the 1991 internal market reforms, the Health Authority was split into two Trusts. The first (the organisation under study) comprises two hospitals under the auspices of one management team, hereafter referred to as hospitals A and B. Hospital A was a district general hospital providing several tertiary specialities and hospital B was as a teaching hospital with a good clinical reputation. Another Trust ran the third hospital. Our focus here is on the first Trust which is now one of the largest NHS Trusts in the English NHS.

In 1994, an expert review of the services was conducted by members of the Local Health Authority and staff from a local university. In 1995, the local Health Commission [the joint management organisation of local Health Authority and Family Health Services Authority (FHSA)] published a consultation document on the

rationalisation and reconfiguration of services. Various options were put forward for discussion and a vigorous debate ensued about the best way to organise local secondary care. Public consultation resulted in the following decisions:

1) a merger of both hospitals with all acute in-patient services moving to hospital A;
2) the provision of primary care facilities for minor injuries;
3) development of an Education & Research Centre in the acute hospital;
4) provision of outpatient/day care services in hospital B (Vening, 2002).

The Board of the Trust aimed to make the new hospital one of the top 10 most efficient Trusts in the country. The Private Finance Initiative (PFI) was used as a source of funding for the reconfiguration of services in the region. This was a fairly new strategy in England at the time, and the Trust was one of the first to use the PFI to fund large scale service changes.

Until 1991, the main source of funding for major capital investment in the NHS was through tax or government borrowing. However, in 1992 another option, the Private Finance Initiative (PFI), was introduced by the Conservative Government to pay for capital works in the public sector, particularly in the health and education sectors. Edwards et al. (2004) state:

> *'The introduction of partnership working, known as the Private Finance Initiative (PFI), was heralded with much enthusiasm by the then Conservative Government in the early 1990s and was later adopted with similar enthusiasm as a cornerstone of the incoming Labour Government's policy for improving infrastructure and public services. The Labour Government re-branded the policy Public Private Partnerships (PPP), widened it to include several different forms of which the PFI is but one, and has, confusingly, used the terms PPP and PFI interchangeably. Under the PFI, the public sector procures a capital asset and non-core services from the private sector on a long-term contract, typically at least 30 years, in return for an annual payment.'*

In the case of hospitals, private sector consortiums are responsible for designing, building, financing and running the organisation. According to the terms of the contract, over a pre-determined period (generally 25 to 35 years), an annual fee to cover both the capital cost, including the cost of borrowing, and maintenance of the hospital and any non-clinical services is paid by the NHS (Pollock et al., 2002).

For the organisation under study, initially it was planned that the project would create debts of less than £40 million and if this was exceeded, it would need the approval of Ministers. Originally, the cost was estimated at £39½ million but had risen to £110 million by the time it had been built. In 1995, it was decided that all services should

move from hospital B to hospital A and that a new acute block should be built with PFI finance. At the time, there were debates about which hospital should be the main site for the PFI project. There was more space in hospital A's area and although there were problems with the state of its concrete, the building itself was satisfactory, so it was decided that hospital A would be used as the main site.

Hospital B, a teaching hospital, and hospital A had about 900 and 600 beds, respectively. Hospital A was approved and an additional beds (400 beds) were provided on the site, reducing the total number of beds across the two hospitals by 500. Those planning the reconfiguration of services believed that money could be saved and the Trust was keen to assure the local Health Authority that the merger would result in a substantial reduction in overhead costs. In addition, the Local Health Authority and previous Trust's senior management team considered the shift away from closing hospital B would inevitably mean that many patients would prefer not to travel to hospital A but choose a different hospital, located closer to the centre of town. They estimated that the total workload of the merged hospital (on the new site) would be 20% less than the total workload of the hospitals prior to the merger. However, neither of these suppositions was well founded. No savings were made and the hospital was left with a substantial deficit. This caused severe difficulties in relation to the PFI scheme, because the Trust had contracted with the PFI partner for activity which was 20% less than the total workload, but found that clinical activity remained the same or greater in some area, as patients continued to use hospital A. Indeed, the PFI scheme was sanctioned before a national bed review took place. A national bed review for subsequent PFIs was carried out later, preventing the reduction of beds for subsequent PFIs by as much as the Trust did.

There was a gradual transferral of services from hospital B to hospital A. The process began in January 2000 and in 2001, a major rationalisation was implemented and all the beds were closed on hospital B's site. As there were still ongoing debate about the transfer of services from hospital B to hospital A, it was decided in September 2001, that hospital B should become a new community ambulatory care centre. The SHA gave a sector of hospital B's services to the newly created local PCT, without any prior notice to the Trust. This caused a lot of a dissatisfaction in the Trust and managers wanted to know why the SHA had not consulted them before making this important decision. There did not appear to be a close working relationship between the Trust and the SHA at that time.

5.2.2 Characteristics of the population served by the Trust

It is important to consider the social, economic and clinical characteristics of the population served by the Trust, in order to understand its activity and performance. According to the revised English indices of deprivation (Office of the Deputy Prime Minister, 2004), the local area was rated as one of the 50 most deprived districts in the UK. A large population of very poor people lived in the area who presented a high level of healthcare need.

As stated by one of the interviewees:

> *"Patients who are coming in here are much sicker than we've ever seen before and there aren't that group of patients who are self caring and really could be at home." (1:35)*

Some interviewees stressed that patient characteristics should be taken into account when the performance of local services was considered.

5.2.3 Performance of the Trust: star rating

The Trust was rated as 'two star' in the 2000/2001 National Perforamnce Rating and was subsequently rated as performing poorly for two successive years (2001/2002 and 2002/2003). The Trust lost its stars because of the difficulties in reaching the desired financial targets, A & E targets and the presence of irregularities in the presentation of its waiting list data. Following the replacement of the senior management team, the Trust was rated as a high performing Trust, over two successive years (2003/2004 and 2004/2005). Several members of the previous senior management team had left the Trust, as a result of promotion, and some had been replaced with the arrival of the incoming CEO.

5.3 Findings

The following section presents the key themes derived from the analysis of the transcripts and a review of internal and external documentation. Quotations are provided to support the discussion, where they help with interpretation.

5.3.1 Markers and symptoms of failure

As outlined in Chapter 2 (section 2.5), McKiernan (2002) provides a framework which differentiates symptoms from causes (secondary and primary causes) of failure, although these concepts have a close correlation. He argues that there are several initial observable markers and symptoms that indicate the presence of problems in an organisation. Nevertheless, in real world contexts, it may be difficult to separate symptoms from secondary causes of failure.

McKiernan (2002) identifies four different types of symptom in the for-profit sector literature: financial; physical; managerial; and behavioural. The symptoms of failure identified in the case study are detailed below, on the basis of the McKiernan's classification.

i) *Financial symptoms:*

One of the most prominent markers of failure cited by different interviewees and referred to in internal and external documents was the existence of a large financial deficit within the organisation. The Trust had not met its financial targets set by central government (a key determinant of the star rating system). Most of the interviewees suggested that there was a long-standing historical deficit and that staff had been aware of this for some time. In addition, (see also section 5. 2.1), the predicted efficiencies and cost savings following the reconfiguration of services from hospital B to hospital A, did not come to fruition. Financial difficulties were exacerbated, causing additional financial pressure on the Trust to the extent of approximately £7 million.

> *"We had massive financial problems, we were at the time in the order of seven million so that was quite a cynic that we were faced with so the whole lot sort of came crashing in." (1:4)*

ii) *Physical symptoms:*

Inability to hit core targets:

The Trust was not able to achieve its main operational targets (access targets were key in the star rating), in particular A & E targets. The long waiting time for emergency patients and for surgery, were some of the examples, perceived by the interviewees, which demonstrated the poor performance of the Trust.

Poor public and press image:

The Trust received adverse publicity and had a poor reputation locally owing to the

waiting list irregularities and the low star rating score. This was a symptom referred to by several interviewees. This issue of reputation, which had attracted national media attention, created a lot of adverse publicity for the organisation.

> *"There was a massive enquiry at that time, which was very widely published in the press and as those things do, they caused some damage within the organisation." (4:19)*

Poor working relations with external stakeholders:

Another symptom of organisational failure, highlighted by some interviewees and which could also be seen as a cause of the failure, was the poor relationship between the Trust and relevant external organisations, in particular the Strategic Heath Authority (SHA). One of interviewees, a senior manager from an external organisation, believed that it should be considered a serious weakness if an organisation is not willing to develop relationships with its external stakeholders. This characteristic was clearly evident in the Trust. Another senior manager from an external organisation, stressed that it was difficult to get information from the Trust. In addition, several external reports (e.g. documents produced by the SHA) also demonstrated poor performance in this regard.

> *"So when the new Chief Executive and team arrived, the culture of the organisation changed markedly. It became much more positive, much more friendly externally; before it was never particularly a friendly organisation and the new Chief Executive, particularly, adopted a position of establishing partnerships that never play as external, which he saw as necessary for the organisation's strategic future, which the previous Chief Executive did not." (21:104)*

Managers leaving their posts:

Several managers at different levels in the organisational hierarchy (both clinical and non-clinical) had left the Trust and this was perceived as another symptom of failure. In some cases, it was attributed to the autocratic leadership style of the Chief Executive Officer (CEO). More detail is presented relating to the leadership style of the CEO in the following sections.

iii) Managerial symptoms:

Employee distrust and internal conflict:

Some interviewees reported internal conflicts between departments and problems with unions as indicators of low performance and for this reason, several doctors were seen to be unwilling to bring their patients to the hospital.

> *"We had a lot of internal conflicts, there was no staff development, there were a lot of problems with the unions. So we had to resolve all of that and again it doesn't take much of a genius to look back and think but if that kind of thing is happening, then actually utilisation and efficiency has got to be bad and if you look back on it historically, it was terrible." (25:156)*

Another marker of failure, highlighted by internal staff, was the sense of fear among the managers and in particular middle managers, when they needed to meet and report to senior management – especially the CEO.

Centralised decision making behind close doors:

Middle managers highlighted the fact that most important decisions were made by a few members of the senior management team and the middle managers themselves were not involved in this process.

> *"Whereas, in the past decisions were made behind closed doors and you had to work with the consequences". (40:53)*

iv) Behavioural symptoms:

Ignoring and hiding problems:

Waiting list irregularities reflected failure, and were perceived by the interviewees to be the result of poor leadership. Indeed, it was reported that the actual waiting list had been hidden by the previous management team, in an attempt to report that patient waiting lists were shorter than they actually were.

Blame for problems placed on others:

It was reported that the senior managers tried to blame other staff when something went wrong instead of accepting responsibility themselves. In the case of data misrepresentation one interviewee stated:

> *"So, there was the investigation and as a result [*name of a director*] came back from leave [...] and basically tried to accuse me of doing everything [*data misrepresentation*] that he had done basically." (5:35)*

Low staff morale:

Another marker of failure, perceived by most of the interviewees, was the low level of morale among staff. They reported that, although the quality of clinical services was generally perceived as good, the hospital was rated as performing poorly causing low staff morale throughout the Trust.

> *"I think people felt very demoralised because they knew how hard they'd worked and how they'd tried and they were very conscious of the good things that we did here." (20:31)*

Other reasons were given for low staff morale. Some respondents perceived that the actions of the senior management team, especially in asking for data to be misrepresented, exacerbated low morale, particularly among junior staff who were involved against their will in the process of providing incorrect waiting list data. Staff reported that, although they disagreed, there was little they could do in the circumstances.

> *"We felt helpless, you can't turn to your manager and your manager can't turn to people at the top or they get dismissed, in terms of the shouting that was going on. What can you do? There was no sort of [...], people mentioned whistle blowing policies but there really was not one at the time." (10:17)*

> *"So, it was, you know, very low morale but, as I said, I'd say it had come from the top really and that was where the problem was." (5:56)*

Some interviewees pointed out that the introduction of a new, inadequate IT system (new computer-based Patient Administration System - PAS), which was not as effective as the previous one, demoralised staff working in administration. The merging of the hospitals lowered morale, because some staff, especially on the nursing side, were not appropriately graded in their new roles. These factors had caused some tension between staff and their managers.

> *"It's not easy when morale has been quite poor and at some point it's caused quite a lot friction not just with the Boards but with the different departments." (29:37)*

In addition, the CHI review highlighted low staff morale. It found that staff felt unsupported because of the many changes in the senior management team and also the scale and pace of change in the organisation. The review also reported that staff felt certain professional groups (e.g. nurses) were more likely to be blamed than others (e.g. doctors) following adverse events, demoralising staff in those groups that were blamed unfairly.

Although most interviewees reported that staff morale was low, some had a positive view of the working environment in the hospital. In their view, the hospital was still a place where the staff were happy to work, and that generally clinicians and staff liked their jobs. Records on staff retention supports this. Although the consultants were

frustrated by the star rating targets, one interviewee felt that the consultants' morale was good as they moved from an old hospital to a new one with better facilities.

> *"From my point of view, the hospital has always been a very pleasant hospital to work in and as somebody who works in the organisation, I must say I have not seen a great deal of difference between what we were doing before to what we're doing now." (38:15)*

5.3.2 Concerns relating to performance

The concerns relating to the clinical and non-clinical performance of the Trust are given in order to reveal the opinions of staff, both internal and external to the organisation. The level of awareness of the Trust's declining performance of staff, both internal and external to the Trust, is also presented.

5.3.2.1 Quality of care and clinical services

There was a general consensus among interviewees (both clinical and non-clinical) and those external to the Trust that the organisation was performing well in terms of delivering high quality clinical services. According to the Dr Foster data (a dataset provided by an independent commercial provider and comparing services and standards in NHS and private hospitals throughout the UK), the hospital was rated as a high performing Trust with a range of good clinical outcomes. To produce this dataset, both Hospital Episode Statistics (HES) and Nationwide Clearing Service Data (NWCS) are used. It is important to appreciate that the Dr Foster data places more weight on clinical indicators than the star rating system. An interviewee reported that clinical staff never viewed the Trust as a failing organisation in relation to the clinical services it delivered, but that the failure was due to poor management. Some interviewees, in particular nursing staff, emphasized that nursing care had not changed, although the Trust had gone from zero to 3 stars. The patient representatives also supported the view that the quality of care was high.

> *"The Trust has always had a very strong clinical reputation, particularly in terms of outcomes and if you look at Dr Foster and things like that, we'd always been a very strong clinical Trust." (23:7)*

> *"I say, from a ward perception it was not seen as a big failure because the things that we were failing on were not the clinical side of it and as I said, the feedback we get from patients is always so positive." (44:19)*

5.3.2.2 Internal awareness of poor performance

Some interviewees did not have a clear understanding of the Trust's performance as a whole, but only had information about the relative performance of their divisions or departments. It is an interesting to note that at the time, very little attempt was made by senior managers to inform staff about the importance of meeting targets and the global performance of the Trust. Generally, junior staff were unaware of what was actually going on in their Trust, in terms of global performance, and some of them reported that it did not really interest them.

> *"I don't have any global vision of the Trust's performance. I really only know the vision of the division's performance. That might be a management weakness of our organisation." (2:26)*

> *"I think as a ward manager, I probably was not very aware of it* [Trust's performance] *at all. As Matron, as I've become more open with the management team, I'm very much aware of it but I think if you're working on the wards you're quite insular really and you're just in your own ward and you're not interested in the Trust's performance." (57:7)*

There was some internal awareness of performance issues:

i) Awareness of waiting list irregularities:

The Trust had lost a star in the rating assessment because of the manipulation of waiting list data. There was serious concern over waiting list irregularities among the staff charged with producing this data. Three interviewees highlighted the fact that senior level managers were aware of the waiting list irregularities. According to an external document (the SHA investigation report), several key managers had stated that although the adjustment of the data had been introduced before the previous CEO was in post, the CEO became aware of it and then asked for the adjustments to be continued. Sometimes the staff had even been asked to make further adjustments to the data in order to show the Trust in a better light and senior managers had tried to keep such matters undisclosed.

> *" We often got a situation where top management would see the data and maybe it was unacceptable to them and it was a case of come back when it's such and such a figure or when it's more acceptable for them. So we would always declare the truth or the official set of figures but it was not acceptable to them. So we got into a situation where everyone was taking numbers off the list until it reached an acceptable level for them to sign off, by as I say, keeping two sets of figures." (10:17)*

> *"I explained to what was going on* [about data misrepresentation], *believing that he didn't know what was going on. As I said, eventually I found out he did know [...] and he said well let's see this planned activity out to the end of the financial year where hopefully everything will then be sorted out." (5:17)*

In the SHA report, one of the senior managers who had left the Trust argued that he informed the CEO and Deputy CEO about the waiting list irregularities immediately he became aware of them, but he was not able to give the information to external organisations. He added that:

> *'He (a senior manager) had no further avenue and the pervading management culture was not conducive to an ethos of raising concerns externally.'*

In the report provided by the local SHA, the previous CEO said that she was not aware of the adjustments made to waiting lists until the year 2000. She then accepted that, under pressure, she had made a serious error for which she should be accountable. She also admitted that the Board of the Trust should have been told about the long-standing adjustments to waiting list numbers as soon as she was made aware of them. She concurred that sometimes loopholes in interpretation were exploited and the Trust did not always follow best practice. However, she emphatically denied that the Trust had made a deliberate attempt to mislead .

It was evident that misrepresentation of data had become embedded in the management culture of the Trust. Staff who provided waiting lists, reported that when they were asked for information by senior managers they often had to think which figures were being requested, it was whether the manipulated data for external use or actual data for internal use. Staff reported real concerns for patients who were removed from the "active waiting" list and transferred to the "planned admissions" list. [The active waiting list comprised people who were available for treatment if hospital capacity allowed and these patients were included in the waiting list report. However, the planned admissions list included patients who had a scheduled treatment plan (e.g. periodical treatment plan), and therefore were not waiting for treatment. The waiting list data did not include the latter group of patients.] Staff had reported the problem to their line managers by writing formal letters on at least two occasions. It was the staff's perception that this misreporting could not have continued indefinitely as it would have eventually been revealed through external investigation and scrutiny.

ii) Awareness of financial difficulties:

With regard to the Trust's financial status, staff were generally more aware of financial difficulties, although one interviewee argued that the level of awareness was likely to be insufficient to focus the attention of staff trying to work within the budget allocated to them by the Trust. The Trust's financial deficit was considered to be of major concern given the huge financial burden in relation to the PFI building and rationalisation process.

> *"So, I think it's probably fair to say that we all had to take a gulp and think, my god, how do we actually deal with these issues and actually I think the issues almost came one after the other, so you were still reeling from the we've got a massive financial problem to this misreporting of the waiting list data." (4:17)*

iii) Awareness of insufficient capacity:

There were real concerns raised by the senior and middle managers, about the lack of capacity (beds), as the Trust lost about 500 beds after the rationalisation process. In addition, an inappropriate flow of patients throughout the hospital caused further problems and impacted deleteriously directly on A & E, waiting list targets and operation cancellation rates.

Some of the interviewees (both internal and external to the Trust) stressed that the Trust had not dealt with all the problems, or still had issues to address at that time. A source of concern for the Trust was the inability to hit key access targets, particularly A & E targets set by the government. The previous management team was said to aware of the problems in A & E and difficulties with the discharge process, but did not or could not resolve these issues. A clinical consultant stated that the hospital was a 'busy clinical area' but was seen as probably one of the 'less dynamic' and 'go-getting' hospitals in the region.

On the other hand, some interviewees (e.g. a staff representative) argued that the hospital had never under-performed, and that it had always performing reasonably well. With regard to the resources available to the hospital, they did not report significant major performance problems, and said that receiving a zero star rating came as a shock to them. One interviewee believed that the Trust was the same as other Trusts that were struggling to reach targets but that the management team had caused the waiting list problems.

> *"I think that on the whole, like the rest of the hospitals, we're performing as well as anyone else but we put a spoke in our wheel." (15:7)*

5.3.2.3 External awareness of poor performance

To some extent, a number of external organisations were aware of deficiencies in the performance of the Trust, both before and after the organisation received a zero star rating. The concerns of different external organisations were pointed out by some of the interviewees at different levels of the managerial hierarchy. Several external stakeholders claimed that their view of the organisation's performance was not particularly positive, as the Trust had not tried to nurture a constructive relationship with them and they considered the Trust to be insular. One of the external interviewees reported that 'the mentality of the Trust' was to state that everything was fine because they did not want the external organisation to come into the Trust and investigate their procedures'. He believed that organisations with larger problems were less likely to ask for help in their areas of weakness. The interviewees added that the financial deficit was a source of concern for the external organisations, in particular the SHA, which was responsible for managing the performance of the local health economy.

> *"There was a huge external concern particularly from the Strategic Health Authority. Yes, we had auditors in we had the modernization here, we had from the Prime Minister's office, so yes there were huge concerns about our performance." (1:6)*

The CHI report revealed several areas of under performance and made comments on the Trust's performance. Different interviewees supported the use of the CHI report as a lead for the Trust improvement plan. It was evident that the CHI was aware of problems in the performance of the Trust.

Although the Trust had been audited by the National Audit Office for 2000/01, through the mandatory "light touch" review of data quality, the waiting list irregularities and the manipulation of the data had not been detected. Three interviewees reported that it seemed that the National Audit Office had not examined and investigated the accuracy of waiting list data in enough detail in the course of its 'light touch' review. The Audit Office gave no satisfactory response as to why they had not unearthed this problem, a question asked by some new members of the Board of the Trust. The new management team was also concerned about the accuracy of the data, but felt that they could ascertain the truth quite quickly. This demonstrates the importance of the quality of external inspection and the need for in-depth auditing. However, the Audit Office did stipulate a number of recommendations that the Trust needed to carry out including:

> *'Strengthen the formal documentation and procedures; ensure correct outpatient referral dates are used in all cases; ensure accuracy and timeliness of suspensions is improved in some cases; and demonstrate accountability to the Trust Board.' (Report for Strategic Health Authority, 2003).*

In the Audit Commission's opinion, there was no problem with the performance of the Trust in terms of waiting lists in the 2000/01 report. Regarding the inappropriate adjustments to waiting lists of nine NHS Trusts, forty seven Trusts were randomly selected for a 'spot check' review of in-patient and out-patient waiting lists and the Trustunder study was one of those selected. The external auditors revealed the waiting list irregularities following a report given by internal staff. There were two sets of reports, internal and external. External reports showed fewer patients waiting than had been reported internally. It was surprising that at the time, only external reports were given to the Board of the Trust and its operational management team. The briefing report produced by the District Audit revealed that the misreporting of waiting list information had started before the year 2000, although the Auditors had not investigated figures prior to that year.

Following the new CEO's report to the SHA on waiting list irregularities (discovered by the National Audit Commission), an independent external investigation was launched by the SHA. This investigation indicated that the adjustment process began during the period 1996/97. At that time, the Regional Office and the Trust agreed a waiting list profile, which was monitored on a monthly basis. If there was an excess of 5% in the figures, the Trust would be required to provide an exception report, but still the waiting list irregularities did not become evident to the Regional office. The SHA report showed that the Trust aimed to adjust the figures within the range of a 5% profile, and claimed that recording waiting list irregularities had become entrenched as a standard practice within the Trust. Some e-mails presented in the SHA report clearly showed that senior managers had intentionally manipulated data.

One of the interviewees argued that the PCT must take some responsibility for what went on in the Trust, as it had not performed its monitoring and commissioning role properly. It was concluded that the failure was in the local health economy rather than an individual organisation.

5.3.3 Secondary causes of failure

A range of internal and external factors, perceived by the interviewees, that had contributed to the Trust's performance decline and failure were identified in this

study. The internal causes of failure can be classified into four key categories including: i) managerial; ii) financial; iii) organisational; and iv) cultural.

5.3.3.1 Managerial factors

i) Leadership issues

Leadership style:

In order to understand the contribution that the Trust's managers made to the failure of the Trust, it is important to have an appreciation of the situation at the time the previous CEO took up her post. She was appointed following a period of about seven months when the Trust had been run by an acting CEO. Also, the CEO who was in post prior to this was given another position in the region as a consequence of a report written by the Chair and non-executives showing his inability to achieve a financial balance.

At that time, the chair of the Trust was a rather strong character who was frequently in contention with the CEO. When the CEO left the Trust, for a six month period the organisation was run by an acting CEO with only two executive members of the Board. Two executive positions remained unoccupied. These were the circumstances in which the post was advertised and the CEO was appointed. At that time, the Trust suffered a financial imbalance and was making plans to merge two hospitals and build a new one under the PFI scheme. The CEO was assigned to balance the books and to prioritise the processes involved despite having little experience of healthcare management and coming from the private sector.

Most of the interviewees attributed the Trust's performance problems to the actions of the CEO and other senior managers, and to their leadership styles. The previous management team and particularly the CEO were perceived as autocratic. It seems that the hierarchical culture of the organisation established by the CEO and executive team meant that whatever the senior management team decided (even in the case of manipulation of data), others had to follow. Participants pointed out that the previous senior management team lacked effective leadership and that no attempt was made to encourage participative leadership or to empower middle managers. The CHI report confirmed this, demonstrating that the staff felt that the support from the top was inadequate.

> *"The other thing that seems to have been true at that time was that the old management ethos was top heavy, a bit dictatorial, emphasis on discipline and people having to do what they were told." (7:18)*

With regard to the personality of the previous CEO (as explained below), one interviewee maintained that she was the right person to carry out the necessary changes during the period of rationalisation. In addition, the CEO in post before her had a very facilitative style, but he was always undermined by the Chair. Poor financial management and inability to balance the books was evident at the time, so removing the Chair and appointing a stronger leader (the previous CEO) helped in running the organisation more effectively. Nevertheless, the previous CEO was not perceived as an appropriate person for the job. The interviewee felt that a leader who paid more attention to staff development and empowerment and showed concern for people ('people' leadership style) was needed for next stage following rationalisation. Two junior nursing staff did not perceive any significant differences between the leadership style of the previous and current senior management team, or at least that would affect them at ward level.

> *"To be perfectly honest no difference to how it [leadership style] is now. I can't see any difference at a ward level [...] how any changes within that structure or the management team, [...], for the management style and structure, it doesn't impact on me." (30:23)*

The following characteristics and behaviour, as reported by the interviewees, were evident in the leadership style of the CEO and previous senior management team.

Centralised decision making:

The view was expressed that the process of decision making was very centralised in the Trust and power was limited to a few senior managers. No input was sought from the rest of managerial team and middle management could only implement the decisions that had been made at the top, often without knowing the reasoning behind them.

> *"In the past you only learnt about the decision making, you did not get involved in the decision making process, you were given a fait accompli, this is that somebody else has decided and we had to sort out the problems that that generated." (40:47)*

Bullying behaviour:

Although the executive team was a fairly close knit group, the interviewees perceived

that the CEO, with her strong personality, dominated the senior management team. There was almost complete agreement among the respondents, both internal and external, that a bullying culture was being promoted by the CEO, with divisional managers under enormous pressure and feeling uncomfortable because of the way that they had been treated by the CEO and senior management team. As a consequence of her leadership style, several managers left the organisation, although some reported that they were not directly involved with the CEO, but had heard rumours and gossip about her. The perception was that the senior managers tended to bully others (e.g. in the case of waiting list irregularities) and would not brook disagreement concerning decisions made at the top, especially any challenges to the CEO. Her behaviour made it clear that staff were not at liberty to challenge her decisions. Those who did were disciplined (e.g. using secondment of staff). In certain examples given in interviews, it was stated that the CEO banged on the table, demanding that certain things be done.

> *"Our previous CEO that left was a bully and everybody lived and walked in fear of her and that was the atmosphere in the Trust really." (25:15)*

> *"Whereas against how things are now, it was just a case of being shouted at from the top saying 'go and deliver this'." (5:218)*

> *"I think during the reign of the previous CEO [name], it was an odd time. I think people would say there was bullying going on, [...] people were fearful, frightened of the CEO, she was quite an aggressive individual." (10:45)*

> *"I think previously the culture was very much command control and a lot of people were quite scared of saying actually, you know, we're not doing things, you say we're doing one thing and we're actually doing the opposite. There's still quite a lot of that that we need to overcome." (23:35)*

On the other hand, three respondents perceived the CEO as a very bright and talented person and one noted that she was focused on enhancing the quality of care in the organisation. Two of the interviewees did not view the CEO and her deputy deliberately dishonest. The CEO was not described as a sensitive person, but was perceived by middle management and certain Board members as an individual who did not like debate, preferring short and focused reporting to any form of discussion.

Some interviewees believed that the previous management team had concentrated only on their own advancement in the NHS, rather than seeking appropriate response to the external performance management system. They held that the CEO was pursuing a better position and indeed, that she was focusing her efforts on a possible merger and to opening a PFI project to promote herself when applying for her next

job. The Deputy CEO appeared to be exhibiting similar behaviour before obtaining a position as the CEO in another trust.

> *"They* [senior management team] *seemed to be denying us* [staff] *that access for the sake of rewards for the individuals concerned that we knew they were on performance related pay and if the PFI went ahead they would get rewarded and they would get promoted and we would see it at the expense of our members who'd transferred over to the private finance." (40:33)*

Lack of flow of information within the organisation:

The senior managers were viewed as secretive and unwilling to share information with staff. Some middle managers said that, at the time, they did not know why they were asked to perform certain tasks.

> *"The shroud of secrecy that the Trust used to run under has disappeared because it was like running the secret service, you never, ever, ever got to find out why you were doing something." (25:79)*

A staff representative stated that it was management's prerogative to withhold certain information, such as that relating to PFI, or irregularities in waiting list figures (seen as the worst example).

> *"So, some of the contributing factors might be that the messages were not relayed down, you know, management obviously knew what was going on but I don't think it actually got to ward level and by the time it did get to ward level it was done in a very abrupt way [...]. Yeah, so perhaps leadership because certainly the leadership we've got now has definitely changed." (42:55)*

The SHA report noted that the practices at the Trust did not fit with the Code of Conduct and Code of Accountability, published in April 1994. There were three key elements, including 'Accountability, Probity, and Openness'. A member of the Board also stressed that the CEO did not demonstrate the transparency expected as one of the main responsibilities of her position.

> *"I don't think there is any way in which it was acceptable what they did. you know this is at the heart of some responsibilities. As public servants you know the probity issue, transparency, you know, you do not circulate and generate misinformation." (12:33)*

Insufficient delegation of power:

There was little delegation of power and responsibility to encourage leadership and

empowerment at lower level. A complaint of some middle managers was that they did not feel that they had sufficient authority to challenge both clinicians (divisional managers in clinical divisions) and their superior managers and to questions their decisions.

> *"When I came into the post I inherited two divisions that previously had been managed separately whose managers had left, most of whom had not survived 9 months, so there was not a culture because there was not any leadership and I think that's management leadership. There was clinical leadership and clinical management leadership within those settings, so clinicians were very used to people coming up to them and saying, hello, I'm your new manager and then not seeing them again." (23:126)*

It was reported that the CEO had not developed a constructive and good working relationship with key internal staff, principally doctors, and with external stakeholders who would be the likely sources of help for the organisation. The senior management team, and particularly the CEO, did not provide adequate leadership owing to her unwillingness to give sufficient time to establishing good relationships with key staff. These irregularities were considered to be symptoms of poor leadership:

> *"The key stakeholders internally were not properly engaged, principally the doctors and to a less extent external stakeholders like this organisation and the PCT, were not properly engaged by the Trust. I think the waiting list irregularities were symptomatic of poor leadership in the organisation." (21:104)*

Invisibility of senior management team:

Most interviewees emphasised that the executive team was practically 'invisible' and often unapproachable. Some complained that the CEO and executive team did not visit front line staff on clinical wards. Two interviewees reported that, although staff had been given the opportunity to meet the CEO in her office to discuss their issues, as one hour per week viewed as very formal and did not see them as a substitute for CEO visiting staff in their places of work.

> *"You know you did not see the Board out on the wards." (15:19)*

Lack of ownership of the performance problems for senior managers:

The Senior Management Team's (SMT) lack of ownership of problems was reported by both internal and external staff. A member of the Performance Development Team stated that this matter was evident with regard to meeting the four hour A & E target

because some senior managers and clinical directors did not recognize this as their problem, with no clear line of accountability apparent.

> *"In the early diagnostic work, I thought that there was not strong ownership of some aspects of what needed to be done by some of the senior members of the executive team, I think they wanted it to happen but I did not think there was strong ownership of getting the job done." (26:15)*

Role of Non-executive:

Two members of the Board argued that the non-executive members of the Board failed to challenge the executive members effectively. Although they said that they had supported the executives during the rationalisation process, they still felt that the non executives had not asked them sufficiently challenging questions to clarify matters. The relationship between the non-executives and executive teams was perceived as poor by one interviewee, and it was even thought that the CEO was not interested in the engagement of non-executives. In addition, the CEO and certain other executives failed to provide appropriate and accurate information for the Board. The most prominent example was inaccurate information on waiting list data, which caused the Board of the Trust, particularly the non-executives, difficulties in carrying out their senior leadership roles.

> *"We were not getting the right information and I find this quite difficult I suppose and uncomfortable. I [Non-exec] always felt that we were told what they believed. The minimum, sort of, they could get away with divulging, if you will. And I suppose my part in that you know, I take responsibility for saying, well maybe I did not know the right questions to ask at that stage in my development." (12:61)*

> *"There was a Trust Board, not the Trust Board but a sort of exec directors team which would meet. So it was a fairly small group of people who would meet on a regular basis to go through all the issues about service." (47:11)*

Lack of managerial capacity and capability:

Some interviewees believed that the scale of the changes (the rationalisation process and the PFI scheme) managed by the previous executive team did not leave enough time for the executive team to focus on performance difficulties in the organisation (insufficient time to focus on performance targets). In their view, the previous team could have managed to meet targets and overcome performance issues if they had had sufficient time.

> *"To be fair to the previous team, there was so much change being managed, this might sound like an excuse but my perception was that there was so much change to be managed, that had the previous team having made the change had the opportunity to think, okay what are we missing now, what do we need to develop? And so on, that if they'd had a bit more time it would have gotten into those things as well. But some of our problems were happening just after the change and the waiting list problem was discovered shortly after the rationalisation." (11:103)*

According to the SHA report, the previous CEO gave high workload as her main defence against waiting list irregularities. The SHA report quotes the following reasons given by the previous CEO for this high workload:

> *'introduction of new PFI facilities management scheme, involving transferring a major teaching hospital, shutting an accident and emergency department, re-routing patient flows, the need to save £30m recurrently per annum, the problems associated with transferring large numbers of staff to private sector provider of non-clinical services at the new hospital, the workload involved in totally redesigning operational policies, staffing patterns and work practices.' (The SHA report, 2003).*

Considering the extent of the changes she was dealing with, some interviewees (in particular those external to the organisation), argued that the CEO lacked insight and self awareness, qualities essential for effective leadership when dealing with a failing situation. It was stressed that the CEO paid no attention to the management capacity and capability necessary to effect such changes. At the time, two executive members of the Board left the organisation and for a lengthy period it was managed by the CEO and two members of the executive. Both internal and external senior managers, maintained that there was not enough management capacity at the senior level to run the organisation, co-ordinate the changes and manage their impact on the organisation. The perception was that the management lacked basic managerial skills.

> *"If you're a CEO of an organisation and you are struggling because of the size of the agenda, then you need to recognise that and you need to do something about it. CEOs with insight and self awareness will do that, CEO who don't do that will struggle and fail and you can't be a leader without insight and self awareness [...] I think it was leadership and basic general management that was the problem." (21:108)*

> *"I think there was an issue about capacity and capability with the previous executive team. [...] there were a number of the issues it was trying to deal with and manage at the same time and perhaps it was not as clear then about what it was seeking to do or how it was going to go about it." (45:13)*

In terms of inadequate leadership capability, one interviewee gave an example which indicated the lack of leadership over the Information Technology (IT) used in the organisation:

> *"Previously informatics (IT) was managed under the Director of Finance and it seemed okay as a management structure but the Directors of Finance have often got IT underneath them and are not IT experts and therefore struggled to provide leadership." (11:115)*

Lack of ability to provide bed capacity:

There was a perceived weakness in developing sufficient capacity in the organisation, which related in part to the underestimation of the required beds for the Trust. Indeed, the number of beds required by the organisation had never been accurately calculated. An interviewee reported that the whole health capacity planning process had been under question 'from the first day'. One interviewee argued that the particular problems of the Trust in terms of capacity related to medical long stay patients and shortage of surgical beds and that this could be a result of poor leadership and lack of vision regarding future needs. Even when the problem was revealed, the management team did not know how it should be resolved.

> *"Everybody was acutely aware that we did not have the bed configuration right, so it was things like, we know we're failing but why are we failing, we can't get our patients in." (25:57)*

> *"Part of the problems that the Trust face are to do with the sheer number of people that have wanted to come here and the lack of beds." (5:82)*

Two interviewees reported on the Trust's inability to provide the level of capacity that was needed, particularly in some clinical areas, owing to the high flow of patients through medical beds. They felt this to be related to the difficulties encountered in the process of patient discharge. Poor bed utilisation and management was another factor that they indicated was a contributing factor to the reduction of capacity. One interviewee explained that inconsistency on the part of clinicians on ward rounds and in the discharge of patients, on only one or two days per week, had a negative impact on the flow of patients. An external consultant saw the medical assessment unit in the A & E as dysfunctional. These issues had a direct effect on the performance of the A & E department, which was another reason that the hospital lost one of its stars. Some interviewees related a lack of appropriate flow of patients and discharge to inadequate coordination and collaboration with other organisations, such as social support services, which were not able to facilitate the process of discharging patients.

"In truth the vast majority of individuals occupying acute medical beds have straight forward medical problems and the reasons why there are not discharged in a timely fashion is not owing to their illness, it's owing to the processes and system inefficiencies." (26:78)

"Getting focused on the discharge rate per day from the ward was actually quite helpful and it certainly produced a sort of step change in their medical bed utilisation and certainly helped flows around their A&E access because that was one where they were most vulnerable." (26:57)

Insufficient attention to performance targets:

An important issue highlighted in the interviews, was that the CEO did not focus on national performance targets. It was reported that staff often had no idea what the targets were or why they were important. Also, response to the targets was very slow on the part of the senior management team.

"They [Trust's executive team] *literally did not care what was happening outside of [Name of the Trust], I think their whole focus was just about maintaining the hospital and as I say, I don't think they paid any attention to national standards." (8:17)*

"I think the current exec team are more focused on the targets and the achievement of the targets where some of the last exec team perhaps were not as focused on that" (9:17)

"I didn't get any feeling at all of anxieties about performance or finance. There was a lot of stress about moves [merging two hospitals] but no anxieties about performance or finance." (18:365)

It was reported that the CEO was not interested in knowing the details of the Trust's performance and the 'truth' about what was happening. This led the Trust to experience the problems outlined above. Respondents did not consider the monthly performance report as an adequate vehicle for assessing detail and thus being able to manage the Trust. One interviewee (a non executive member) said that despite the fact that they were focused on the targets, clearly they were not meeting them. However, two interviewees maintained that the CEO did not deliberately ignore targets. One noted that the CEO was very sensitive to the need for timely and honest responses to complaints and if something was not right, the CEO investigated it thoroughly.

Finally, two interviewees raised the issue that misrepresentation of waiting list data might be a reflection of what was going on higher up the chain of command, which had been questioned on occasion but not taken as a part of the terms of reference.

"My understanding is that the execs here were so driven by the people above them that they believed that because they could not square this circle, because they could not deliver, they basically resorted to manipulating the information." (12:31)

ii) Distraction

There was general agreement amongst respondents that a huge amount of the previous senior management team's time was absorbed in the completion of large projects. The top senior managers needed to merge into one site, two hospitals that had already been under a single management structure but were physically separate. An extensive PFI project, building an Education & Research Centre and developing a big central clinical laboratory, was also to be completed at that time. It was perceived that these projects and the relocation of services distracted the top management team from the day-to-day management of organisation. Indeed, the senior management team had taken their 'eyes off the ball' concerning certain key access targets. However, as outlined previously, some interviewees highlighted a lack of leadership as an excuse for the previous management regime's considerable contribution to Trust's failings. It is important to note that some interviewees thought that the merging of two hospitals was a major distraction, but others looked more favourably upon the PFI project than the merger.

"I think that the previous CEO and other exec members would say well at the time yes they were disproportionately distracted by what was happening around the PFI. Virtually new ground really and a huge project, huge initiative and fraught with a lot of difficulties not least you know, the closure of inpatient services at [name of hospital] what that meant for the local community. How that was managed." (12:27)

"That was a huge project to bring the two organisations together and moving to a new building, I just think it's a distraction from the things that were nationally being measured. I think it's difficult to run an organisation from two very distinct sites but I don't think that's the reason why things went wrong, I think the reason why it probably went wrong or one of the things is that the time when we were no stars we were concentrating on making the PFI come together." (28:175)

PFI project:

The Trust's PFI project was one of the first PFI builds in the UK. At that time, the PFI was quite new to the health services, so insufficient expertise and experience was brought to bear on writing the contract between the Trust and private sector. Neither was guidance from the centre as good as it was later. It was unclear how the partnership would work, nor and it what PFI meant. An interviewee termed it "the morass of complexity of the PFI".

"I think the PFI area is a problem because we can't control it, managers can't manage it, you have a third party doing your work and they're in it for profit, they're looking at what the agreement says, they're experts in handling contracts and agreements. Whereas the people on the NHS side don't necessarily have these skills and the staff who implemented PFI, a lot of people who were involved at a high level have all gone, they've been replaced by other staff who are not familiar with what the content of the contract was, so we're not quite sure what services we can expect from the PFI partners and if you want anything else which is out with that contract, the Trust has to pay early and sometimes you can't even get it done. But there are restrictions that you can't bring outside contractors in for certain things because the PFI won the rights to provide that service." (40:135)

Merging the two hospitals:

The merging of the two hospitals was not completed in a single action but was a sequential process, between 2000 and 2001. The process influenced the working practices in the Trust. In addition, star rating as an external performance measurement had been introduced and the management team was required to meet its targets. It was likely that these factors would have an impact on the performance of the Trust. It was reported that it was difficult to manage two hospitals on two sites, particularly in clinical terms where provision of services on two sites had created problems in meeting targets and providing quality services.

Although respondents were in general agreement that the process of merging the two hospitals went well in terms of clinical issues, some serious problems were reported in other areas. A level of resistance was noted, with some staff not wanting to relocate. Neither were they entirely happy with some of the decisions such as restructuring and re-staffing the departments and units, made by the Board of the Trust at the time. Many staff who had worked in hospital B for years were required to move to the new location, engendering problems in terms of operational, cultural and interrelationship issues. As the number of beds was reduced following the merger, one of the main problems was insufficient capacity and how the Trust could accommodate the burden of high workload on the staff. Some lost high status positions and took on lower organisational roles, especially on the nursing side, and for this reason and the stressful nature of new levels of workload, certain E grade nurses in the medical wards left the Trust within a year. However, the D grade nurses were accepted easily new situation and remained at the new hospital. Hospital A was not as academic and did not have as good an external reputation as hospital B, where the staff had an intense pride in their hospital. Those who moved to the new organisation, felt that a better atmosphere existed in the old hospital. Because of the presence of two completely

different cultures within the new organisation, a high level of anxiety and extensive conflict between staff members was reported, requiring a large percentage of management time to affect new working arrangements. One interviewee reported that although the relationship between staff did improve, during the first year the staff from the two different hospitals were aware of detachment between the two different staff teams.

High levels of stress were perceived by the management team and in particular middle managers were trying to deliver changes and also consider the performance targets introduced at that time.

> *"Well people have been through a very traumatic time, moving from a very small close knit hospital to a big site which is much more, so they were apathetic and anxious and there were a lot of unsettling times." (43:31)*

Some interviewees described the successful transfer of services and the carrying out of the PFI scheme as the result of the intense concentration placed on them. Indeed, they argued that completion of these huge projects needed such aggressive management, it could not have been reached without such a high level of focus.

Some felt that the NHS needed to put in a specialist team, familiar with the processes involved in making the necessary changes when hospitals were undergoing closure, because handling a merger and also running the hospitals on a day-to-day basis may provide a level of stress in the organisation sufficient to cause it to fail.

iii) External relationships

Many interviewees at senior management level (both internal and external), viewed the relationship between the Trust and other external stakeholders in the local health economy as poor. The Trust was seen as inward looking and insular. Some interviewees associated this behaviour with the presence of the old hierarchy in the organisation, saide to be obstructive and difficult to deal with, an issue they felt contributed to the failure of the Trust. As outlined above, the Trust was undergoing a huge process of change and, in such circumstances, might benefit from the establishing constructive relationships with organisations such as the SHA and the PCT. However, the interviewees highlighted that, in general, the Trust kept some organisations (particularly the SHA) at arm's length, thus depriving itself of external sources of help.

"I think they were very insular and I think they literally did not care what was happening outside of [name of Trust]." (8:17)

"Our previous chief exec was very clear that kept Strategic Health Authority at arm's length. You can keep somebody at arms length but if you've got a problem I'd like to know who's going to help you sort it out." (1:43)

Working relationship with the local PCT:

It was reported by saff that there was not a close working relationship with the PCT at that time, but changes have since occurred and much better relationships exist now. For example, there were no regular meetings between the Trust and the PCT,the main commissioner. In mitigation, some staff maintained that the PCT was then a very young organisation, also struggling to develop and establish its own organisational structure and culture. Both organisations had learned about the commissioning relationship which was being developed and was evolving, so the PCT might not have been very helpful to the Trust during that process.

Working relationship with the local SHA:

The working relationship between the Trust and the SHA was not a close one, according to staff. Some interviewees had noted tensions between the SHA and the Trust during that time and that it was a 'distant' relationship. Although the performance management system was becoming more important and the role of the Health Authority, and thereafter the SHA as a performance management agent, became prominent, the relationship was not constructive. One interviewee external to the Trust put forward the idea that an organisation should be under suspicion if its managers wanted to keep themselves at a distance from other organisations, and that such organisations should be closely monitored.

"The Strategic Health Authority [...] was never given the opportunity or allowed near the Trust and about that there was a barrier around this Trust." (16:19)

"Before there was always a distant relationship [between the Trust and the SHA]*, they were not particularly close and afterwards because of the incident* [waiting list irregularities] *they had to become closer but that was because we had to sort out the problem. So it was distant, they never saw themselves as corporate players in the area [local health economy]...." (21:37)*

Some saw this type of relationship, especially between the CEOs, as a factor that had an impact on how the Trust was assessed and supported by the CEOs of external organisations. One interviewee cited the following example of the relationship between the Trust and the SHA:

*"I don't know but my take was well how was this Strategic Health Authority supporting the work that the team here were doing at the Trust so for example the Board, this Board got to know about the transfer of [*name of the hospital*] to the PCT, through a document that went on a website. We did not even know about that and given that they were and still are the staff of the acute Trust I just thought that was extremely unhelpful really quite shoddy and so it made me think well what sort of support are the exec team having higher up the chain when they're clearly dealing with some ground breaking work and some difficult issues." (12:29)*

iv) Lack of performance management system

Most interviewees on the managerial side, insisted that there was no clear and effective performance management system within the Trust, and no appropriate, accurate and timely reporting of both financial and clinical matters. The appropriate attention to detail needed to diagnose and predict performance problems was not available. There was no performance management culture in the Trust and no serious attempt was made to rectify this. Lack of an effective internal performance management system was seen as contributing to the performance problems, as the Trust was not able to track fluctuations in the performance of individual units such as A & E, which allowed performance targets to drift. One interviewee also said that staff did not get any feedback on how they were doing- that "they were going in blind". It was felt that the previous management team did not quite understand how to develop a performance framework that changed clinical behaviour in a way that would support performance improvement and the attainment of key performance targets.

> *"It was really around performance management I guess that had let us down." (14:66)*
>
> *"A huge amount of time wastage but there was no performance monitoring in 2002 that we were aware of, so there was nothing for us to actually and say this was really, really bad, we've got to improve it and we've got to stop wasting time." (25:156)*
>
> *"Well, the waiting list irregularities in my view would have been a reflection of the management culture of the Trust and the poor internal performance management controls."*

v) Strategic issues

According to external reports, in particular the CHI report, and the view of some interviewees, the Trust lacked strategies for clinical governance, performance

management, external relationships, human resources, nursing, and corporate strategies. Indeed it was described as a "strategy free zone organisation" by an interviewee. Indeed, there were no clear plans on how to respond in an appropriate and timely manner to changes in the health economy. This lack would seem to be a result ofpoor leadership, as one of the major tasks of effective leadership is the development of organisational strategies, as affirmed by the CEO of an external organisation. He added that strategy development was omitted by the previous management regime. A further participant argued that some of the policies and strategies that the Trust had formulated on paper, were not being implemented in practice.

> *"It's one of the criticisms from all the external agencies and from our report that we [the Trust] had no organisational strategy. We were really criticized for being in the organisation with no strategy of any sort." (1:27)*

> *"We were missing a whole bunch of strategies. I mean, I suppose we were missing a whole organisation of strategies. At the time CHI came [...] we had no strategy." [11:83]*

One interviewee reported that in some areas, poor performance, was related to the lack of a clear strategy. For example, the lack of a plan for emergency care resulted in poor performance in A & E. He also thought that the relationship between managers and clinicians was reasonably good, but was rather 'cosy' rather than challenging. Management had no clear policy as to what they wanted clinicians to achieve, or specific behaviour they wanted to see changed.

5.3.3.2 Financial factors

Poor financial control and management and the presence of a high cost structure were financial factors (as secondary causes of failure) interviewees saw as contributing to the Trust's decline in performance.

Poor financial control and management:

Lack of effective financial control was highlighted by the respondents, especially those at senior management level. The planned reduction of 20% in workload of the merged hospitals did not occur, nor was the Trust able to balance its annual financial budget in 2002. Complete funding was not provided to cover the merger of the two hospitals,

new development and early PFI bills. This weakness caused an approximate £7 million deficit during the amalgamation of services and along with historical financial deficits caused serious difficulties for the Trust and resulted in CHI removing one star from their rating. One respondent indicated that there had been a lack of good financial discipline over the whole of a financial year. Poor communication between the finance department and operational general managers reportedly resulted in the finance department's inability obtain the financial balance required. One interviewee maintained that, from a financial perspective, the organisation had placed too much emphasis on the correctness of financial details, rather than the overall picture.

Although people in the organisation might have knowledge of their allocated budgets, it was argued that there were no reliable control mechanisms for ensuring these were adhered to. There was also a tendency to commit to expenditure with no consideration for recovering costs. Indeed, it was thought that the whole organisation was unaware of the extent of the problem and might not be able to control its finances during a period of extensive change. There was an attitude across the organisation that overspend was allowed and staff need not own the Trust's financial problems. One of the interviewees said:

> *"There was an acceptance that it was alright to be overspent here, we'll be okay because we'll be overspent, not to worry about it and also there was no real measure until we got our new finance director, of how big the problem was." (16:31)*

There were also problems concerning contracts with the PCTs where the Trust's level of delivery to the PCT was far in excess of what it had been contracted to undertake. Also, the Trust lacked rigour in following up and negotiating with PCTs when it could not continue to deliver this level of activity within funding provided.

High cost structure:

Three directors considered the high cost structure as an important factor in the Trust's financial problems. One interviewee gave excessive hours of work for junior doctors as an example:

> *"Junior doctors' hours were totally out of control and we just looked at the money side of it, [...] so basically every junior doctor was earning double what they should have been earning and there was no plan really in place to do anything about it." (4:81)*

Another example of the high cost structure and lack of financial control reported by two senior managers, was overspending on staffing costs, such as the high fees

charged by the bank agency for nursing, administrative and clerical staff. They felt there was no attempt to reduce the staffing costs through a revision in the skill mix in the organisation, particularly on the wards.

As outlined earlier, the lack of experience in drafting the PFI contract with the private sector also created increased financial pressures and it was difficult for the Trust to constrain the costs of the PFI project, with several interviewees indicating that the PFI created a higher cost structure for the Trust. One of the managers reported that, if they were going to do it again, they would probably do it differently. Interviewees felt that there was no tight control on the internal process, and neither was there any proper internal control on the performance of the PFI partner.

> *"Nobody quite understood what PFI meant, how the partnership was worked because they'd got rid of everything that we knew, like our portering system, our own domestic system, catering went out, everything went out of house and it had a huge impact really." (25:31)*

5.3.3.3 Cultural factors

A general idea was prevalent among the respondents that cultural issues contributed to the failure of the organisation. Most of the participants believed that the organisation had a very different organisational culture at the time they were performing poorly.

A Culture of fear and blaming:

As stated in relation to the leaders' behaviour, a culture of fear was prominent in the organisation and the divisional managers were under pressure to deliver the services by transferring stress down to their teams in order to 'get the job done'. Inter-departmental teamwork was not seen to be working effectively, and in such a climate of fear, if staff found a problem they did not necessarily alert senior management because they were frightened of the consequences. It was reported that managers felt stressed and uncomfortable in meetings with the CEO. Most respondents, both on the clinical and managerial staff, felt that there was not an open culture in the Trust. It was stated that previous executives were trying to lay the blame for the problem on others, with the most prominent example being concealment of waiting list data. A senior manager accused a member of middle management of misrepresenting the data. Indeed, the previous managers consistently blamed other people for their mistakes and did not accept any responsibility for failing to complete the task

properly.

> *"I think it was a culture of fear really and being scared to admit there was a problem." (16:43)*

> *"And [now] it is more of a working together kind of thing rather than in order to go and do something panic setting in and people not being able to deliver. Go back and there's further pressure and shouting and knowing that somebody has not delivered as opposed to having done so." (5:224)*

> *"There was quite a climate of fear really that if you found something that you did not necessarily alert senior management because you were scared and that's still quite a big factor really. There was lack of assurance within the Trust" (23:23)*

> *"[Now it is] solution focused rather that blaming and the shaming which I think was how, maybe, you could have characterised the culture in the past." (12:45)*

A Culture of denial and hiding the problems:

Denial of the problems rather than effecting remedial action on the part of senior management was reported by several interviewees. There was a culture stemming from the top of the hierarchy to conceal mistakes and damaging information, particularly waiting list data. As a result, people tried to misrepresent data to make it appear that targets were being met, when in fact the Trust could not deliver these targets. Staff, especially on the managerial side, were not comfortable when reporting something that did not go according to plan.

> *"One lie leads to another lie I think [...] someone thought it could be moved on and never be found out but in fact the problem just got bigger and bigger." (16:43)*

However, two of the interviewees did not agree that information was being hidden and the data falsified and they even believed that there were no serious complaints from the patients about the consequences of misrepresentation of the data.

A no learning culture:

The CHI report indicated a lack of effort in creating an active learning environment in which staff could speak openly about mistakes without fear of reprisal. The CHI report referred to creating a 'just culture'. No clear system of individual accountability was in place when the problems occurred, and in general, within the organisational culture, there was no systematic attempt to encourage staff to learn from their mistakes. Although the CHI report emphasized that there was a good reporting

system in the Trust, some interviewees pointed out the inadequacy of the learning environment, saying many staff were not keen to report mistakes owing to the aforementioned climate of fear.

> *"I think there was a bit of a blame culture, therefore people were not part of a learning organisation to make the change or did not feel the power to make the change." (22:89)*

Disconnection between the senior management team and staff:

Some interviewees expressed the feeling that there was an evident 'detachment' between the senior management team and the rest of the organisation. Two interviewees referred to an 'us and them' culture that had caused a lack of trust, and expressed the view that the executive members of the Board, and particularly the CEO, were not visible.

> *"If I was to be honest, I think it was very much 'us and them'. You know you did not see the Board out on the wards." (15:19)*

> *"At that time it did seem to be I suppose the directors and to say, in the particular CEO there was a definite gap between them and the rest of the staff." (5:56)*

Conflict between staff following the merger of two hospitals:

A mixture of two different organisational cultures, after merging the two hospitals was another issue that had a negative impact on the Trust. It was stated that there was in-house fighting because one hospital's staff thought they were better than the other (as detailed above), and such cultural issues created a lot of anxiety, which impacted negatively on the performance of the organisation as a whole. One interviewee likened the situation to the Berlin wall.

> *"The first year was absolutely awful. The geography of the hospital such as where we are now is the old site of the hospital and in half a mile there is the new site and you might as well have put up the Berlin Wall across the corridor because the twain shall never meet. It took a lot of work to break down the barriers." (25:51)*

Interviewees maintained that two different kinds of service were provided in the Trust (tertiary care and the general services provided by all district hospitals), which one respondent said was like having two hospitals under one roof with different cultures. With respect to the provision of tertiary care, the Trust had a good national and international reputation and its consultants felt that they were separated from the rest of the hospital and clinically dominant over the general services.

*"There was also quite an interesting kind of culture, it was almost like two hospitals under one roof here. There were the tertiary aspects of their business with the [*name of centre*] and [*name of centre*] and then there were the core services of their DGH function." (26:13)*

5.3.3.4 Organisational factors

Lack of a robust information systems:

The lack of a robust information system to enable staff to monitor performance was highlighted by the middle and new senior managers. The Trust had implemented a new information system that was not viewed as effective. In addition, the project manager, who had led discussions on the contracts with the suppliers for the new Information Technology system (IT system), and the director of IT, left the Trust. This left the Trust facing a serious lack of IT expertise. The previous management team did not consider it important to have an IT director to coordinate the IT system, so the Trust was not able to give a proper report of information for three to six months. One interviewee said:

"Basically, at that time we'd have thought that it was an achievement if we could have reported what we had previously reported up until March 2002 but because of the new system. I suppose the reports and the way the system was used, etc, it meant that we had actually gone a step backwards by getting this new IT system, not only reporting wise but also operationally. I guess for example people in outpatients and people like that. It was taking them half an hour to do something that would have taken 5 minutes." (5:82)

There was inadequate consultation or understanding of the IT contract implications and this caused several operational problems, such as difficulties in providing comprehensive patient information. Staff were exhausted and some of them left the organisation as it was so ineffective. Lack of adequate resources also resulted in insufficient investment in the IT system, which resulted in a poor performance measurement system.

Lack of a communication systems:

Formal channels of communication were lacking. According to the CHI review, the lines of communication both upward and downward in the Trust were not working well. No formal information system on performance was in place.

> *"From the doctor clinician standpoint we did not have enough communication opportunity for people." (11:135)*

One interviewee highlighted the fact that the flow of information throughout the organisation and the way it was represented internally and to external partners been both inadequate and inappropriate.

> *"I think no wonder they've got problems because on the information that they have or the way that they use it or represent it it's not telling you anything and there's not enough detail going to the Board etc it's sort of filtered." (37:156)*

Lack of a corporate accountability systems:

The issue accountability was problematic. Several interviewees explained that the organisation was run without clear lines of accountability and the CHAI report highlighted lack of clear processes for key risk issues such as clinical governance. One interviewee raised the fact that clinicians did not have a strong input into the corporate agenda. Although there was a relatively good relationship between managers and clinicians in some areas and they were seen as having a high level of commitment, they did not appear to be very committed to the performance improvement agenda.

Methods of working:

Some interviewees had a negative view of the method of working in the Trust, especially on the managerial side under the previous management team. Not enough people could make routine decisions because of the number of changes. This occupied much of the managers' time, leaving too few people to carry out all the operational work in the divisions. Confrontation between various departments was pointed out by some interviewees.

External secondary causes of failure:

Two interviewees, one a middle manager and as the other a matron, did not see the zero star situation solely as the fault of senior management. They perceived that the previous management regime did not focus on targets because there were not so many at that time and that the 'target culture' was not as important as it later became. If

they were operating in the existing environment, they thought that the previous team might have behaved in much the same way as the current team.

> *"I think the current exec team are more focused on the target and the achievement of the targets where some of the last exec team perhaps were not as focused on that. But I'm just trying to think whether there was a real difference or whether just the environment in which they all worked is different. Just, I don't know if the previous exec had been here now with the importance of focus on targets as there is externally would the culture have been the same? I suspect it probably would actually." (9:17)*

Primary causes of failure:

Organisational introspection and organisational arrogance were perceived as two important factors having a negative impacton the organisational learning process, as a primary cause of failure.

Organisational arrogance:

A degree of arrogance within the hierarchy in the old, poorly performing Trust was reported, with interviewees feeling that senior management could not be challenged. They were perceived as believing they could ignore nationally set targets and had no need to change. They saw themselves as a teaching hospital with nationally and internationally renowned departments whose decisions would not be contested. This arrogant stance led to them failing to respond appropriately to the changes in the external environment, or doing what was expected of them. For example, it was widely accepted the Trust could overspend with impunity. Indeed, some respondents saw the lack of a culture of change to be a result of this attitude. According to the McKiernan model (2002), this kind of behaviour is classified as a primary cause of failure, putting the organisation in a situation that blocks the learning process.

A respondent stated:

> *"There was an arrogance here that we're a University Trust that we're very good about quality of care. It doesn't really matter what we do on target." (16:15)*

According to the McKiernan model (2002), this kind of behaviour is classified as a primary cause of failure, placing the organisation in a situation that blocks the learning process.

Organisational introspection:

Organisational introspection (explained in section 3.8) occurred when the managers of the Trust, distracted by the reconfiguration of the hospital site, were unable to deal with external challenges. (The distraction issue was explained in previous section.)

5.3.4 Response of the staff to the results of star rating

Most of the interviewees felt that the star rating was an unfair assessment of their performance, which did not represent a 'rounded' or 'balanced scorecard' for their organisation. They saw themselves as hard working, and mistakes on the managerial side caused the hospital to lose one its stars.

> *"I think to be fair, the standards that we were measured against, as far as I'm concerned are not quite the standards you should be measured by."(40:91)*

The receipt of a zero-star rating was, in the staff's judgment, a very bad experience. They had not expected such a rating, because Dr Foster's data had shown quite good results. The staff believed the patients were happy being treated by the Trust.

> *"I think that people although particularly the second time we'd got zero stars that the staff actually found it quite frustrating because at the same time there were other reports coming out, like the Dr Foster and I think there was another report that came out that actually rated the Trust quite highly."(34:15)*

> *"I think there was a degree of a sense of hopelessness amongst some of the junior members that were, you know,* [saying] *we're working as hard as we can and nothing can change and we can't make this better and that's a familiar scenario as you probably know in any acute trust that feels as though it's under pressure and not delivering on its performance framework." (26:19)*

Several staff reported that it was difficult to work for a zero-star organisation. They felt that the zero-star rating was inappropriate for the Trust and certainly did not reflect what they did on a day-to-day basis.

> *"I think you feel quite disappointed really because it doesn't really reflect what you might be doing as a department and the fact that the Trust is judged on that as a level of performance."(33:19)*

> *"I think a lot of people did say I don't want to work in a no stars Trust. We are better than that. We deserve better than that. So I think there was a*

sort of feeling of we are better than that. No way is the hospital down the road a 3 stars rust and we are not." (9:108))

"The people in the front line believed that they delivered good quality of care to patients and they were very demoralised and very upset about the fact that we were a zero star but it certainly did not feel like a zero star Trust." (18:60)

Several interviewees compared their performance with another Trust in a neighbouring area, which was given three stars, and did not feel its performance was better than their own. Several interviewees said they were shocked, particularly when the hospital was rated as poor performer for a second year. One of the interviewees argued that the previous management team were telling them that every thing was fine, and the receipt of a zero-star rating came as a bit of shock.

"I think it probably impinged a little bit on us and thinking because one of the hospitals down the road got a three star rating and, you know, I think a lot of people said, 'well if we do a much better job than them why have they got three and we've got one? So, I suppose it had a negative impact on people how they felt a little bit in the morale sense."(32:23)

"I think it was for individuals quite personally it was devastating. I think people felt quite let down, you know, [...], there'll always be excellence for which the star ratings aren't an appropriate measure." (22:85)

The new senior management team were expecting a zero star rating in the second year because it was already too late to do anything, since the hospital had lost its stars in the first quarter of the year. One of the interviewees from outside the Trust, pinpointed that senior management accepted the reasons for as the zero starrating and did not think it unfair. Some of the senior managers expressed great disappointment and they were sad to have to tell the staff that, although they had worked very hard and clinical outcomes were good, the Trust was still rated as a poor performer.

However, one of the new members of the Board did not see it as a totally bad outcome, explaining that the situation gave the executive team some real 'fighting spirit' with which to face the problems and advise the staff of their predictions for the coming year. It was felt that the organisation was not going backwards and that it would be unacceptable to be a poor performer in the following year, so the Trust focused on changing in order to gain stars.

"So I think we all had a bit of steely determination and I think we all felt, [...] really felt that we were going to push for this organisation to make sure that we improved in the public perception." (4:71)

On the other hand, some staff, especially among clinicians and at the junior nursing level, were not concerned by the results of the rating, believing that they provided as high a quality of service as possible. They believed that the senior managers were very interested to the results of the star rating. A few interviewees, particularly nurses, maintained that the star rating had not affected them.

> *"I think a lot of our doctors were very disappointed, they probably felt very disillusioned with the management at the time, you know, about what was going on, why were we zero star because they felt that they were delivering good care and patients liked this Trust as well." (14:62)*

> *"I don't think that the people at clinical level really relate to stars from the sense of stars. It doesn't really matter to those of us who are giving the bedside patient care, it doesn't matter to the patient really who's receiving the care how many stars we've got, what they care about is that their needs are being met at that level and that's what most nurses care about as well." (17:33)*

Star rating system and performance targets

Various issues were raised regarding the use of the star rating system to measure performance. An important issue pointed out by the respondents, was that clinical priorities differed from those considered in the star rating system. They maintained that the criteria selected for the star rating system would not necessarily those involved in the effective running of a hospital. More than half of the respondents perceived a conflict between the quality of service and attainment of national targets. They held that targets excused people from paying attention to things that were measured by the star rating, which encompassed only part of the whole picture of performance related issues. It was argued that this system was a poor, crude measurement of performance which did not cover clinical issues and some interviewees stated that the effort and money put into measuring performance did not represent value for money in terms of the improvements received by the patients. Some clinicians did not have a good perception of the targets and claimed that they were not motivated by them. Most of the nurses did not hold a positive view of the national targets. It was perceived that the targets, in particular A & E targets, put a high level of pressure on the system. As there was inadequate capacity owing to the high bed occupancy rate, hitting the A & E targets was one of the most important concerns for the Trust, and a conflict between the quality of the care and hitting the 4 hours A & E target was mentioned by most of the interviewees.

" It's difficult to have any real belief in an assessment process that is really just looking at target achievement and of course as targets become more focused and more specific, coming from our current Government, then the target achievement by the Trust has become all encompassing and all powerful. Indeed, there seems to be little regard to other services or other issues where targets don't apply." (42:18)

"I have a worry about the star ratings it is an attempt to assess an organisational activity and I think is politically driven rather than clinically driven." (38:31)

"That was always a criticism from the clinicians to say that, you know, we've never seen these targets before. They're just given to us and we are meant to achieve them." (5:178)

The clinical staff denied having been doing anything particularly different, although the external perception of the Trust had changed radically once the Trust received three stars. One interviewee noted that perception on the part of clinicians made the situation more difficult for managers when they needed to exert their influence in order to achieve targets. However, certain interviewees did not support this view, stating that the clinicians in the Trust were already engaged in the process of achieving targets.

Two interviewees criticised the star rating system, because it compared all acute Trusts, irrespective of the different factors such as size, teaching status, socio-economic status of the population served by the Trust and that can potentially affect its performance. All Trusts were measured by the same scale, without considering variations in terms of local factors and contingencies.

An important issue raised by some respondents, was that during the previous management period the extent of emphasis on performance targets was less than when the new management team arrived, because the star rating system was evolving. In addition, the performance management system at that time was not dealt with as systematically as it has been since.

"There was money that was provided by the government and if you get money from the government to achieve targets then you go out and spend it as a manager because you need to achieve your targets because that's what you're told to do. It doesn't quite seem right as far as consultants are concerned." (47:15)

It was reported by some interviewees that the population of the area did not pay serious attention to the results of the star rating and saw the hospital as a good place for treatment.

> *"I think the reality was that the general public who actually come here and use the services, I don't think a zero star rating would have meant anything to them greatly. It was the wider perception because I think as the general public come through the door, they were still getting good treatment." (4:73)*

Some interviewees referred to the level of pressure staff were undergoing owing to the national performance targets. One interviewee even maintained that some targets, such as the 4 hours A & E target, acted as a hindrance.

> *"It's obviously worked and it's successful because we have gone from 0 to 3 stars in a year but, you know, that's happened. What I'm saying though for somebody on the shop floor for those of us in clinical practice, I'm not sure how relevant that is to us and what difference it's made to us, apart from this constant pressure to achieve to meet targets or be on budget or whatever. I don't think it's been an enjoyable process the shall we say for the staff that are working at the coalface to achieve those targets." (17:174)*

An interesting point raised by an interviewee, was that staff at the lower levels did not feel a sense of ownership of the targets. Even, some staff reported that they did not know much about the performance targets and the only way that they perceived that the targets existed was the time when a target was breached and a directorate manager came to the ward to sort it out. Although, they emphasised that since last couple of years they know more about the targets.

On the other hand, although respondents criticised the targets, they also supported some of their positive effects, with one interviewee believing that the incentives introduced by the star rating did benefit organisations but that the process was very costly. The system was referred to as a 'new model' approach, for those who had been working in the NHS, which pushed the organisations to conform and raise their performance. The star rating was seen to be a strong trigger that caused a high level of focus on the development of a performance management regime and alignment of reporting systems. Indeed, the star rating programme made central government targets the highest priority for management and for manipulating resources to reach these targets and improve performance. Certain managers argued for the need for targets in order to facilitate changes and take the organisation forward.

> *"But it's (targets) also pushed through improvement. I can see why they're also designed that way." (12:136)*

> *"So, I think targets are a complete nonsense, however you have to acknowledge they have improved efficiency, that people don't wait in casualty as long as they used to. So they've had a good effect but I think*

that the quality of care is not as good as it used to be because of the targets." (32:107)

5.4 Summary

A range of symptoms of organisational decline was identified in the study including *financial*, *behavioural*, *organisational* and *managerial*. Both internal and external factors that had contributed to performance decline and failure were also reported. Internal factors were classified in four categories: i) *manageria;*, ii) *financia;*, iii) *cultural;* and iv) *organisational*. Change in the external environment (e.g. new policies) was also perceived as an external secondary cause of failure. A contextual factor (poor socioeconomic situation of the population served by the Trust) was also perceived as a factor that had contributed to performance decline. Two factors perceived as the primary cause of failure were organisational arrogance and organisational introspection. Clinical staff could not accept two successive zero star ratings, because they believed that it did not reflect the high level of quality of care that the Trust provided for its patients.

In the next chapter the findings of the empirical study regarding the factors (both internal and external) that had initiated the processes of change within the organisations (triggers) are discussed.

Chapter 6: Empirical evidence on the triggers for change

6.1 Introduction

The previous chapter explored a rich source of qualitative evidence on the symptoms and causes of organisational failure in the Trust. The aim of this chapter is to present empirical evidence regarding the recognition of failure and triggers for change (both external and internal drivers) within the organisation. The stage theory, set out in section 2.9, is used as a conceptual framework within which the case study evidence is organised, reported and interpreted.

6.2 Acceptance of failure

The literature on turnaround processes in the private sector demonstrates that diagnoses and triggers for change (as outlined in part 2.8), can be attenuated or impeded by various stakeholders. Both internal and external stakeholders can fail to recognise that a problem exists, or may even conceal it in order to make the situation appear in a better light. Stakeholders also face different incentives and constraints in relation to their ability and willingness to accept and report failure. One of the key themes emerging from this study, was the positive effect of the new management team in rescuing the Trust and their ready acceptance that changes were required to remedy and turnaround the situation.

In the case study, several problems (e.g. waiting list irregularities) had been concealed by previous management. The new team did not attempted to hide the existence of failure, but apologised publicly for the Trust's poor performance. One member of the board argued that it was not possible to choose to deny the problem, as there was clear evidence that there were serious failings within the organisation.

> *"I think some of issues were inexcusable, really, in the public interest and also from the point of view of staff. Their organisation that they care a lot about was dragged through the press in a not very nice and pleasant way." (4:21)*

Staff explained that, when the Trust recognised and accepted failure, all external stakeholders assessing the organisation were viewed in a more positive manner by the senior management team and there had been no confrontation between them. One interviewee from the Performance Development Team (PDT) noted that the response of the senior management team was to affirm that receiving a zero star was fair, as they knew why they were performing poorly as an organisation, and were focusing on strategies for improvement rather than looking for excuses. Indeed, there was a general consensus amongst interviewees that the new management team wanted to learn from past failure and focus attention on improving internal management processes and performance reporting arrangements.

> *"So we set up a process about doing that both internally and externally which was about, yes the organisation has some failures, yes the organisation have learnt from what those failures are, this is what we have got to do to improve." (4:23)*

> *"Yeah, they recognised and they acknowledged, there was no denial so they did stand up and say, 'we've got a problem here, we need to address it'." (45:49)*

The new management team had obviously identified the existence of problems and accepted responsibility more readily than the team previously in place. The new managers had been brought in from outside the organisation, so owed no allegiance to the previous management regime. Most had arrived at the organisation armed with some information about the performance problems of the Trust, although they had been unaware that waiting list data had been misrepresented.

6.3 Triggers for change

In section 2.8, it was noted that, in situations where performance levels are far below those considered acceptable, a triggering process is required to initiate change and recovery. This stage has been highlighted in the literature as a key phase in the turnaround process (Balgobin and Pandit, 2001), and both internal and/or external factors can trigger positive change (McKiernana, 2002; Grinyer et al., 1990). In stage theory, the decline phase is followed by triggers for change (Balgobin and Pandit, 2001; Mckiernan, 2002). In Chowdhury's stage model (2002), this phase is referred to as 'response initiation'. The following section

presents evidence from the study concerning the initial diagnosis of failure within the Trust and internal organisational responses to the situation.

6.3.1 Diagnosis process

As outlined in previous sections, the Trust was awarded a lower star rating because it failed to meet central key performance targets: financial targets; 4 hour A & E targets; and the misrepresentation of waiting list data. When the new CEO was appointed, the Trust had been awarded one star and problems relating to finance and the A & E waiting list were evident to the new CEO. However, the waiting list misrepresentation had not been made public at the time and, when it was revealed, the result was the Commission for Health Improvement removed yet another star.

Identification of the misrepresentation of data occurred through the confluence of both internal and external factors. The Trust had been randomly selected for a 'spot check' by the National Audit Office to determine the accuracy of its waiting list data. In the previous year, the 'light touch' inspection by the Audit Commission Office had found no irregularities in this area. Although it was publicized that the Audit Commission had discovered the Trust's misrepresentation, the internal staff, who were aware of the existence of irregularities, played a key role in the speedy diagnosis of the problem and reported the irregularities to the new CEO two days before the Audit Commission commenced its investigative work. It was reported that they wanted to be open about the misrepresentation, as they had also informed the previous senior management team about the irregularities, but had been instructed by the senior management team not to make changes until the end of that financial year. The new CEO and his Deputy notified the Audit Commission of the likelihood that there was a problem, causing the Audit Commission to investigate the waiting list data in more depth. The staff in charge of collecting, processing and reporting the waiting list data presumed that the irregularities would be discovered by the Audit Commission group, although one of the interviewees reported that a senior auditor had said that they would not have been able to find the problem without inside information volunteered by the Trust. In addition, one of the new managers reported that she had become suspicious when she had found discrepancies in the waiting lists. A middle manager maintained that during the CHAI inspection, the Trust expressed

concerns about the identification of waiting list irregularities in 2002, although the CHAI investigation did not concentrate on waiting list information, and the quality of audit data was outside its remit.

> *"The staff didn't know the detail of how the audit process had happened because basically how it was said at the time was that the auditors had found this. And they didn't find it. From day one that's how it was put in the newspapers etc. And the auditors, one senior auditor actually said to me that they wouldn't have been able to find it, which kind of surprised me." (5:114)*

The outcome of the Audit Commission enquiry was the publication of a comprehensive report, including 95 recommendations for the Trust's performance improvement. The new CEO identified the problem to the SHA, after the Audit Commission revealed the existence of misrepresentation, and requested further investigation. The SHA sent an expert team who provided a detailed account of waiting list irregularities within the Trust. In the staff's perception, both internal and external factors had contributed towards diagnosing the existence of the problem.

6.3.2 Role of external factors in triggering change

6.3.2.1 Investigation by external organisations

There was a general view among those interviewed that several external factors had played an important role in stimulating remedial action within the Trust. Indeed, it was reported that the external report simplified the job of the new management team by identifying the key problems to address. Both internal and external interviewees saw the external inspection process as one of the most crucial factors in triggering changes, even though the investigative process was highly stressful for the staff, especially those who were directly involved. One interviewee likened the situation to a "review city". A number of investigation teams, each with a different focus across the organisation, reported that three external reports (the Audit Commission report, the SHA report, and CHAI report), had significantly influenced the response of the Trust. Some interviewees reported that the external investigation helped the Trust to look at things differently and fixed the attention of the new management team on the key performance issues which needed to be addressed.

"It was very much external people had come and had looked at the organisation. The original action plans were very much top down. This is what we've got to do, and I think it was born from the fact that we'd had external reviews." (9:92)

"The external review had shown weaknesses in our system therefore there wasn't a choice about it, we had to improve it. So I think that was as much as was needed at the time." (9:68)

It was noted that the CHAI report presented several recommendations for improving performance, although it conceded that the Trust had made positive attempts in some areas. The Trust, and in particular its governance Committee, dealt with each issue seriously, which resulted in the development of a plan with emphasis on meeting the desired outcomes. Most of the interviewees confirmed the positive effect of the CHAI report as guidance on performance improvement, though one did not view the CHAI report as a major driver of change in the organisation.

"I think it [CHAI report] was a wake up call for the organisation and then there were rapid strives made around clinical governance around the CHAI action plan." (12:77)

"The help to the Trust, I think certainly since the last CHAI report, a lot better guidance has come out of the centre in terms of supporting the executive team." (6:93)

"People were glad when CHAI came in, although there was quite a lot of hard work, but I think the people were glad. It gave people an opportunity to say, 'look we are more than just a hospital which has got a problem with a waiting list'." (9:80)

The Strategic Health Authority (SHA) report focused on the quality of waiting list data and was perceived by the majority of the interviewees as a major driver for change. Some interviewees felt that the strong influence of the SHA exerted pressure on the Trust to quickly turnaround its poor performance and meet the Department of Health targets. In accordance with the role of the SHA as a performance management agent, the poorly performing Trusts in the area and especially the Trust under study, were asked to develop an action plan for improving their performance. This control strategy is discussed below.

"We always felt that the Strategic Health Authority very much wanted to see [name of the Trust] its performance." (4:99)

"There was quite a lot of close scrutiny from the Chief Executive and the Performance Director at the SHA." (16:46)

The role of the Audit Commission in triggering change and facilitating the development of the action plan, was highlighted by several interviewees. The Audit Commission's plan contained 95 points. The Trust management team focused their attention on these recommendations and it was stated that this plan played a key role in developing factors such as data quality arrangements.

> *"I think really in terms of organisation, we didn't have policies and procedures in place, so they [The Audit Commission] came up with a number of recommendations around getting a policy together, making sure that responsibilities are highlighted." (10:61)*

Although the Trust had to accept a review of its performance undertaken by several external organisations, a senior manager maintained that most of the executives were very willing to 'open the doors' and let the external agencies scrutinise their working practices as they wanted prevent the situation recurring.

On the other hand, certain interviewees believed that each external organisation investigating the Trust had provided its own action plan and that managers had been swamped by their number and scope. Although the Trust's managers agreed that these investigations had a positive influence in triggering change, they felt that providing documentation and attending numerous meetings, had been very time consuming. Some were of the opinion that more time could have been spent addressing performance problems rather than dealing with information requests from external organisations.

> *"So, the Audit Commission came and did some work for us and they established that there were about 30 odd committees meeting on a very regular basis and when we looked at the number of man hours that that involved, there was quite a lot of time that was being involved and we didn't say it wasn't of value but we felt it could be put too much better use." (27:32)*

Although the Performance Development Team (PDT) of the Modernisation Agency had been involved in the performance improvement process, respondents did not consider them a trigger for change. This might have been the result of the sequence of investigations undertaken by different organisations, as the PDT came into the Trust after the performance improvement plan had already been developed. Because of the function of the

PDT, outlined in Chapter 3, they did not play an important part in either the diagnosis or triggering of activities in the Trust.

6.3.2.2 Public announcement of the Trust's performance

The public announcement of the low star rating, coupled with a negative media campaign, was also cited by staff as an external factor that had helped to trigger change. Some pointed out that to the Trust's wish to avoid losing their reputation had played an important role in starting the turnaround process. They also felt that the organisation did not have any choice but to turnaround the situation, having reached "rock bottom". Moreover, publicising the waiting list irregularities had had a direct effect on the star rating, and was perceived as a strong driver for change.

> *"No star rating provided some benefits for the Trust as well, you know, they were able to use that as a lever to instigate other change which might have been more difficult if they'd been a comfier three star organisation and people can legitimately say, well do we need to change?" (45:105)*

> *"In my view the most, the turning point [trigger] in all of this was the loss of all our stars. We'd gone from a 2 star to a 1 star to a 0 star trust in a very short period of time. For me that was the turning point. Obviously there was nowhere else you could go. You were right at rock bottom. That was really significant for the organisation I thought [...] because it was a shameful time. But that forced our attention on meeting, on absolutely meeting the key targets that were set for us. So, we started to change our game which was interesting, we started to play the game that people were expecting us to play." (39:34)*

> *"I think the biggest factors are your own desire to avoid adverse publicity and shame and the external scrutiny that you come under as an organisation both from the SHA, your primary care organisations but crucially the Department of Health." (38:63)*

One interviewee reported that receipt of a zero star rating had facilitated the process of change and served to reduce internal resistance, as staff became aware of the severity of the problem. Several staff (e.g. in the operating theatres and A & E Department), reported as initially seeing no necessity for change, began to accept that it was inevitable. This finding appears to support the stress-inertia theory put forward by Hoffman (1992).

"As a no star, it's obviously helpful because you can use that as an argument to apply the change." (45:105)

6.3.3 Role of internal factors in triggering change

A factor referred to by most interviewees as an internal trigger for change, was the introduction of the new management team. The new CEO his deputy were two key, proactive individuals in setting the turnaround in motion. However, it was emphasised by some interviewees that both the external factors (mentioned above), and the substitution of key managers as an internal factor, contributed to triggering remedial action. The new CEO was also reportedly asked by the SHA to remedy the situation over a period of six months, otherwise his organisation would come under threat of being franchised, which was a strategy used to replace the senior managers at that time, where they not successful in turning around performance.

"We got a complete new executive team, I suppose that was the trigger." (25:77)

According to Walshe et al. (2004), internal staff are frequently aware of problems that exist in an organisation, so diagnosis of failure is not totally unexpected. In this case study, several internal staff were clearly aware of the waiting list problems and when, on the entrance of new management, they got the opportunity to report the problem, it also became evident to others. However, as this outcome occurred parallel with an external audit, staff were generally of the opinion that the external auditors were responsible for identifying the problem. The findings of this study confirm the crucial role of internal staff in recognising failure and if they were able to speak freely about the problem within the organisation, further decline may had been prevented.

The valuable role of a thorough external assessment, with the capacity for diagnosing problems and proposing solutions is demonstrated clearly in this case study. As was discussed above, if the auditors are no thorough in their dealings with data, as in the 'light touch' programme, they may not be able to discover the problem. Inexperienced auditors may be another reason that the outcome of the audit process was less effective than required.

6.4 Discussion

According to the stress-inertia theory (Huff et al., 1992) discussed in section 2.7, strategic change may occur by decreasing the resistance stemming from inertia or by increasing the stress levels originating from dissatisfaction with the status quo. Thus, change may arise when the levels of stress exceed the levels of resistance and inertia to change (Barker et al., 2001). Several internal and external factors were identified as contributing to heightening stress in the case study. The key internal factor was the replacement of senior management and the key external factors were investigations by outsiders agencies, receipt of a zero star rating, hostile local media coverage and support provided by the government to help turnaround failing organisations.

The findings of the present study on triggering change align closely with the theory developed by Barker et al. (2001), derived from their empirical findings. The present study confirms that, although receipt of a zero star rating was an important factor in turning around the Trust, both the establishment of a new senior management team and external investigations and interventions were also required to affect the performance of the organisation.

The findings of this present study reinforce those of recent research conducted in the NHS (Protopsaltis et al., 2002; Fulop et al., 2004) in relating to triggers for change. Although the role of external stakeholders, such as the SHA, was evident in facilitating change, the role of the external community of user groups, which Fulop et al. (2004) found to be an important trigger for change, was not evident in this study.

Similarly, Mannion et al (2005) found that the star rating and a critical CHAI report, identifying serious problems not previously addressed by senior management, acted as triggers. However, opposition between managers at different levels relative to making important decisions, and conflict among different groups within the organisation, attempting to maintain their autonomy, were found by Jas and Skelcher (2004), to be important internal triggers for change. These factors seem that had not played important role in initiating change in this case study.

The next chapter presents the development and implementation of the performance action plan implemented by the Trust.

Chapter 7: Study findings –implementing turnaround strategies in the Trust

7.1 Introduction

Diagnosis of performance failure and subsequent triggers for change were explored in the previous chapter. The aim of this chapter is to present the findings of the study in relation to the specific turnaround strategies used within the Trust and their impact on organisational functioning and performance. The stages theory, outlined in section 2.9, is used as a conceptual framework against which to report and interpret the evidence gathered in the study.

7.2 Turnaround strategies

Within the stage approach (McKiernan's model), when organisational decline is diagnosed a limited range of turnaround interventions are likely to be used to remedy failure. McKiernan (2002) classifies these strategies as (i) retrenchment and (ii) recovery. As outlined earlier (part 2.10) three major turnaround strategies are identified in the for-profit sector literature including i) reorganisation (replacement), ii) retrenchment, and iii) repositioning (renewal). Against this framework, the following section explores the range and effectiveness of the different interventions to improve performance used within the Trust.

7.2.1 Reorganisation strategies

As outlined in section 2.9, reorganisation strategies include changes within the internal management of an organisation. The most common reorganisation strategy in the for-profit sector literature is the replacement of the CEO and/or other members of the senior management team. A range of reorganisation interventions were used in the Trust.

7.2.1.1 Replacement of senior managers

The replacement of the CEO and/or other senior managers, is one of the most frequently used turnaround interventions identified in the literature in both private and public sectors. In the case under study, the CEO, Chair and most of the senior

management team (the Deputy CEO and Director of Operations, Director of Finance, Director of HR, and Director of Nursing) were replaced by staff recruited from outside the organisation (external succession). All these changes happened over a period of five months, between August and December 2002. The previous CEO and the Deputy CEO left the organisation to take up more senior positions within the NHS, although subsequently they were suspended from their current posts and held responsible for what had happened in their previous positions. The Director of Finance had previously retired, as the new CEO was not willing to work with him and the Chair of the Trust was replaced on the advice of the SHA. Two executive positions remained unoccupied for a relatively lengthy period. The Medical Director was the only member of the executive team who retained his position. Interviewees at all levels of the Trust identified a range of characteristics and behaviour of the new senior management team that they believed had been beneficial to the improvement processes.

A cohesive Board with highly experienced executive members:

Some interviewees emphasized that the new CEO recruited staff with considerable senior management team experience. Both internal and external interviewees reported that the new executive team was composed of appropriate personnel, who had sufficient experience to form a cohesive team with good working relationships and had played a key role in facilitating a successful turnaround in performance. Two had experience of working in organisations that had faced a similar crisis. They felt this experience helped them to recognise and understand the Trust's situation and to select the right strategies. One key senior manager in particular was perceived as having a strong operational background. Closer working relationships between the Finance Department and the Directorate of Operations and between the Medical Director and the Director of Human Resources were reported by both senior and middle managers as examples of improvements at board level. Interviewees described the new team as dynamic and highly focused, with a positive attitude towards achieving organisational change. One of the clinical staff expressed the view that the new management team communicated problems very clear. Some middle managers believed that changing the executive team was the biggest factor in helping the Trust to improve and one even insisted that the organisation would not have achieved its turnaround in performance without such a change in the senior management team. Interviewees from outside of the organisation (e.g. the SHA) also viewed the senior management team, particularly the Trust's CEO, as highly experienced and effective.

"That the Chief Executive did very well was actually because those he recruited as executives very well in terms of personality mix and we actually do get on well together, so there's no real in-fighting within the team, it's quite cohesive and I think that's actually helped support the organisation." (4:31)

"The difference when the new people [senior executives] *came along was that they had a high profile and I'm sure it wasn't like this in 2002" (18:273)*

"I think the thing that helped was a really close relationship in the Board in terms of the executive members of the Board because we all get on well together and know what each others problems are and I think, you know, I'd say the finance director and the director of operations have been at logger heads because they are potentially conflicting interests there, I don't think we would have got anywhere, so, the fact that we actually work together on problems rather than, you know - so I would say that it's a big help." (46:68)

One interviewee stated that the new senior management team brought fresh ideas, was not linked to the problems of the past and had a positive and constructive approach to solving the Trust's problems.

"It was helpful that it was a new management team, executive team in any case, so they were able to say, well distance themselves from the past in that sense. So that helped them position themselves to make a fresh start and introduce new management methodologies for addressing the issues." (45:49)

Visible and honest senior managers:

There was consensus among interviewees that the new management team was much more visible, approachable, credible, honest and supportive than the previous team. Its members were open to discussion and debate about problems as well as being keen to communicate with clinicians and middle managers. On the other hand, only one interviewee, a nursing staff member at ward level, reported that the previous executive team were also visible. Two managers currently working with the new management team, and with experience of working with their predecessors, did not view the previous executive members of the Board as being dishonest and unapproachable.

"I think this Board on the whole are more visible within the Trust." (15:19)

"But being close to this team I find them all approachable and I find them all honest and truthful with me." (39:24)

Focus on performance targets:

It was reported by most of the interviewees that the new management team, particularly the CEO and Deputy CEO, were very performance oriented and focused on the task of meeting central government performance targets. It was reported that it was not acceptable for them to hear that the targets were not being achieved. Divisional and directorate managers perceived clearly that if they sought to introduce new developments, they should first meet their performance targets. This message quickly filtered down to the lower levels of the organisation. The focus on targets by the Trust's senior management team was supported by the SHA, as achieving these targets was also the main objective of the SHA as the local performance management agent.

> *"I think management focus upon, it's very goal orientated, very much focused on achievement and performance where I think that leadership is not as succinct as that and it's about how we do manage and how we do lead the people to get to that point where you might have common goals decided that are focused but at a higher level is more upon specifics." (29:23)*

> *"I think the new management team made it very clear what their top priorities were. They clarified it for everybody that hitting the targets and achieving financial balance were the main goals. That's what we're here to do and that's what we're going to do and they made sure that those were the priorities." (39:63)*

> *"The exe team were very clear that this is what we expect of you and, you know, there's no point coming knocking wanting something else if you're not delivering on that. So that became a clear message really." (23:115)*

Focus on performance information and data by the senior management team:

Most interviewees, particularly middle managers, believed that members of the senior management team(and in particular the Deputy CEO) were highly experienced in understanding and analysing performance. One senior manager emphasised that, without adequate focus on performance data the new management team had not been able to meet central government targets. On the other hand, an executive member of the Board argued that senior board level staff should not be involved in that degree of detail, but should be focusing more on strategic issues.

> *"I [an executive director] think any NHS organisation now needs quite directional top team just because it is so variable and so changing and I think what I've realised in the past few years, you know, an executive team needs to know every detail and if you don't know every detail you get yourself into a lot of problems really and I think that's not just from*

culture and disorganisation, I think it's a culture of the department at the moment." (16:171)

Leadership style:

The leadership style of the newly appointed senior management team, particularly the CEO and Deputy CEO, and especially in early stages of the turnaround process (in the first year following appointment of the new management team) was a directive, 'top down' transactional leadership approach with strong performance management architecture and tight internal control. The main focus was on the achievement of centrally set performance targets and the role of the Deputy CEO in focusing on targets was emphasised highly by almost all interviewees.

"My leadership [an executive member of the Board] was very directional, very determine as we were in a state of chaos. I was very clear to the divisional directors and the general managers really clear that this is what we've got to achieve, we cannot say no. I guess in the first year it was very detailed, it was very direct, very focused on the results, it was very on a mission, it was less about developing and empowering people" (16:91)

On the other hand, the Trust's senior management team aimed to encourage and facilitate a participative style of leadership within the Trust in order to harness the skills of staff and delegate power to lower managerial levels within their divisional and clinical directorates. The role of the Director of Human Resources in encouraging more participative leadership was reported as a key driver of change, although the Trust was still only in the initial stages of developing devolution. It was also emphasised that although directorate managers were encouraged to develop and run their own units, the executive managers continued to monitor performance.

"I [an executive member of the Board] guess following year two and year three it's [leadership style] more about developing the team, more about developing the business units now, more about developing how they can monitor their own performance and more about self-development for some individuals. What we're doing now I guess is a lot more refined and it's about developing these divisions as business units getting them to run their objectives, getting them to manage their own performance, giving them the tools to do it and again that's transformational really because they're having to adapt to that model but we [executive members of the Trust] still kept our eyes on the results and still monitoring them from a distance" (16:91)

"I think there has been a style of leadership that has been to provide strategic leadership from the top and that has been coupled with an

approach grow staff and develop staff and empower staff and that is sort of developing further through the organisational development program hat the trust is rolling out, at the moment that you presumably are aware of." (12:43)

The switch of leadership style from transactional to more participative was clearly emphasised by senior managers:

"That you have a certain style of leadership that works within an organisation for a certain time period and it has been very much driven by the top at the top level and then it's about 4 years that you think about what is the style of leadership that is needed, you know, to further develop the organisation, so we're probably at a stage where we're ready for the brave new world or the next management style." (14:135)

Although senior managers maintained that the Trust Board had a positive view of participative leadership and devolving authority to lower levels of the organisation so that they could run their system as a mini-business, when the Trust received three stars, there were differing points of view among the members of the Board about the feasibility and extent of delegation and the reduction in the degree of central control. Two executive members believed that a performance management culture had become embedded within the organisation, which would facilitate future delegation within the organisation.

Role of non-executives:

The importance of the role of non-executive members of the Board in bringing different and broader perspectives from outside the Trust and contributing to the strategic decision- making process was highlighted by both executives and non-executive members. A good working relationship between executives and non-executives was reported by the members of the Board. Two non-executives said they supported the new management team in conducting their business, but at the same time were willing to challenge executives about important issues. One executive member of the Board gave an example that underscored the challenging role of the non-executives, reporting that non-executives raised concerns and asked questions about the possible effects on the quality of patient care of the cost-cutting strategies (retrenchment) introduced by the executive members. Some non-executive members chaired key committees, such as the clinical governance assurance committee. Generally, the role of the non-executive team was viewed as being more effective within the new Board, which was working in a more constructive and challenging way than within the previous Board.

"I think they are very useful because they're the only people involved in hospital management system who are basically the public and therefore they can pick up on areas where the hospital because it's a management system is/has very much of a narrow perspective on what's going on. And they have a broader perspective because they're looking at it from an over all view and they're looking at it from outside. They also obviously because they are non exec directors of the trust Board they also have the interests of the trust at heart and of the hospital at heart but they have a different perspective. I think that's very important" (47:31)

In addition to the executive members, accounts confirmed that the Trust recruited managers with good managerial skills for important positions such as general managers for clinical divisions, particularly surgery, and that a higher level of payment was set up to attract experienced and highly motivated managers. For example, one of the new general managers was described a very bright, confident person who had brought fresh thinking to one of the divisions. Junior managers believed that the role of general managers needed to be acknowledged in the turnaround process.

7.2.1.2 Development of Performance Improvement Plan (Action Plan)

It was reported that the SHA requested that the Trust develop an action plan to address their serious performance issues within relatively a short period of time. One interviewee stated that it was of paramount importance, in the first year, to achieve the access targets because the SHA insisted that the Trust should achieve a turnaround situation within six months. The Trust developed a very detailed action plan, covering all aspects of performance within the organisation (e.g. financial recovery, waiting list issues, data quality, clinical governance, human resources and operational delivery), referred to as the Performance Improvement Plan (PIP), to demonstrate how improvements could be made in relation to the performance concerns raised in external reports (especially the Audit Commission report, the SHA report and the CHAI report). The Audit Commission had provided 95 recommendations, following its 'spot check' investigation, which the Trust considered to be one of the most helpful sources when developing the PIP. The recommendations presented in the SHA investigation report were another important factor.. The CHAI report was used when developing the PIP in relation to clinical governance issues. Managers noted that the SHA had not been closely involved in the development of the PIP, explaining that the SHA were willing to leave this job to the Trust in the belief that the Trust was aware what to include in the action plan. However, the Trust

managers knew that the action plan should be signed off by the SHA, and that it would not have been completed unless the Trust addressed all the performance issues the SHA had identified. One of the external interviewees reported that there was a kind of 'panic' in the system as the Trust managers were not sure how they could best formulate and implement the action plan. So, the Trust used the format of the action plan of another zero star non-teaching Trust as a template for the development of its own action plan. Most interviewees insisted that it was a completely new plan and that there had not been a similar operational plan in the organisation before. Both internal and external interviewees emphasised the Trust's desire to 'own' the action plan, and affirmed that its managers were very proactive in developing it.

> *"There was enough detail in there [the performance action plan] to capture all the key areas of improvement that needed improvement basically, and captured everything that went towards the star rating system or the indicators in there, and covered I'd say, all the key departments within the hospital operationally and staff wise as well." (5:150)*

The Director of Operations and the Head of Modernisation were key to the development of the PIP, which covered major performance themes and was organised in 15 chapters. One of the interviewees likened the Director of Operations' office to "the engineer's room of the first PIP". A PCT representative also attended the development meetings, as suggested by the SHA. One interviewee reported that they viewed the role of the PCT representative as being to access the action plan from an external viewpoint and develop it in a way that was acceptable to the SHA. It was indicated that a key executive was assigned as a leader for each chapter, in order to assure ownership of the plan. Perceptions of middle managers were that the first draft of the action plan was very 'top down'.

> *"The original action plans were very much top down. This is what we've got to do. And I think it was born from the fact that we'd had external reviews. So it was very much external people had come and had looked at the organisation. There was a new executive team in that didn't know the history really of the organisation, and therefore I think they developed action plans and said that these are the things we have got to do as an organisation to improve our performance. So I think the early ones, as I remember were quite top down." (9:92)*

Several interviewees reported that the first draft of the plan was sent to relevant staff in different divisions and departments of the Trust, in order that they might provide their comments and develop their sections. It was reported that in cases of disagreement over the content, managers were mainly attempting to satisfy the requirements of the Director of Operations. Subsequently, all chapters were combined

into an overall plan, which senior managers maintained was a unique plan with ownership across the Trust. Some interviewees emphasised that they felt it was a good idea to pull all the chapters together rather than separate plans as they had had before. The last stage for the action plan, which had been approved by the SHA, was sent to the Department of Health for final approval.

> *"Well when I first started we had various action plans on the go. Basically the overall structure had been identified through the executive team and then they were distilled down to divisional level. Each of the individual middle management, my level, then had to break down within their own directorates the sorts of targets that were needed to go in order to achieve the objectives. So there was a sensible cascade of things" (29:76)*

Some interviewees reported that the action plan had strengthened the way that the Trust's managers worked within their management team. They insisted that it was not a plan which would 'gather dust' on the shelves, but was intended to be a a 'live' plan.

A middle manager stated: "Now, I'm intimately acquainted with the Performance Improvement Plan". In the PIP, each table showed the area for improvement, the lead person responsible for delivering the improvement, the timescale, the action plan required and the progress that had been made. The line of accountability was very clear, which encouraged ownership of the problem with the implementation of the plan under the overall control of the Director of Operations. One interviewee emphasised that the PIP worked as an internal framework of management control that monitored performance along different dimensions. All units and departments were required to deliver the targets set out and assigned to them in the action plan, with managers being asked to work with other departments on implementation. However, individual responsibilities, relating to each chapter, were clear because one person was appointed to be accountable to the executive Board. An example of how the action plan was working in practice was provided by a Trust manager:

> *"For example, the elective in-patient part of the performance improvement plan belongs to surgery, so the associated directors of surgery will work out with her team how that is going to be delivered because you can't be so dictatorial as to say, you will do X, Y and Z, it's dependent on local circumstances and how things change, so it's up to them to work it out themselves but they know that that is part of their responsibility. It's something that has got to be done anyway, you know, it makes sense that these are the things that need to be delivered within the organisation, so the divisions have to work out how it's best delivered." (14:48)*

It was reported that the Trust used the action plan as a document both to communicate performance to the SHA and for internal monitoring. One interviewee noted that the SHA was interested in the plan as it was a tool with which to monitor performance and evaluate how much had been implemented. There was a consensus among senior and middle managers that the development of the action plan had helped the Trust to clarify what it was doing, which performance indicators were the subject of focus, and what turnaround processes it was trying to implement.

> *"They (SHA) really just then kind of monitored that (action plan), I think they looked at it and said whether they were happy with it or not and then just monitored it and put timescales in, you know, you need to do this by then." (20:55)*

One interviewee perceived that the development of the PIP as a single document and its up-dating, reduced the risk that the SHA might wish to operationally manage the units and intervene directly in the running of the organisation. Any recommendations following the internal and external audits automatically went into the PIP. A general manager stated:

> *"But what we tend to do is get a report or get a problem and then convert that into an action plan and then try and get the monitoring - doing the actions to be embedded within the operational part of the organisation and get the monitoring of that into the performance review part of the organisation. For example, we had a staff satisfaction survey which we've not performed as well as we thought we might and maybe we've taken our eye off the ball, I don't know, but we've now got an action plan for that and that's separate from all the other action plans." (18:265)*

Several interviewees indicated that a year after the development of the action plan, the general strategic direction of the organisation and the revised corporate objectives were able to be incorporated in the action plan because the organisation was more 'settled'. It was reported that the PIP still exists and has been updated by the managers in order to ensure that each manager has his/her own chapter for reference.

7.2.1.3 Focus on performance management

A focus on performance management was a key strategy during the turnaround process. It was reported by all interviewees that, when the detailed action plan was developed, a robust and effective performance management system was set up by the new management team, particularly in relation to access targets and the monitoring and management of the performance of different operational units in the

organisation. Interviewees expressed a positive view that using a robust performance management system resulted in improvement of organisational performance and was key to the Trust's subsequent receipt of three stars. Interviewees also acknowledged that the regular attendance of the Director of Operations and CEO at the weekly and monthly meetings to report on performance was crucial in establishing good performance management processes. Some performance indicators were said to be monitored even on an hourly basis, such as the four hour A & E targets.

"Performance management is really driven within the organisation from weekly meetings we have with the Chief Exec around management of the waiting list to performance review meetings." (14:29)

"The Trust was already very focused on delivery and set up their own new internal performance management structures around reporting and analysis." (37:55)

"Monthly performance monitoring for divisions around HR indicators, finance activity, quality issues and that helped us really I guess if anyone of the divisions if we became concerned about the performance either financially or operationally in one of those divisions then we had time to deal with it, so we would get some results through every 3 months, we were getting results through on a month by month basis and we were looking at a trend and could really react quite quickly if it was de-engaging from the path it was supposed to be." (4:87)

As explained above, for each chapter of the PIP an individual was appointed to be accountable to the executive team. A senior manager was appointed as the Head of Performance. This represented a new post in the Trust, with a remit to ensure that the action plan was implemented, with relevant and timely data collected and presented in the monthly performance meeting. The performance reports were also presented to the Trust Board and were considered as a critical agenda item at Board meetings. Interviewees highlighted the fact that rewards within the organisation (such as performance related pay) were now based on meeting performance targets, especially in relation to the national performance measures.

"I suppose the monitoring; the intense scrutiny that you come under is the big factor in turning the hospital around. It certainly focuses the mind. That's really very important." (39:63)

"Again the key drivers for those targets, for example, your waiting times and emergency were coming down to weekly meetings and those weekly meetings had our Chief Exec, Director of Operations, plus divisional directors, plus the immediate directorate managers, those are what we called PTL meeting. So, on a weekly basis, you would be looking at scrutinising where you're going in terms of long waiting patients [lists], where you're going in terms of accident and emergency targets."(24:84)

Some senior managers reported that that they were now focusing not only on the 'hard' indicators (e.g. the level of absence because of sickness, the number of complaints and thank you letters) but also on 'softer' data and quality issues (qualitative information) particularly within individual divisions to track their performance such as quality of data, level of relationship with external organisations and level of awareness about what is happening inside and outside the organisation.

> *"I'm developing a much softer performance indicators that look at SMA rates, the number of complaints, the number of thank you letters, you know, those kind of things which are much more around some of the quality issues, look at some of the essence of care standards and so you send out to a clinical team both this in terms of, can you do your Government targets, have you got good governance, are your staff being inducted, what is your sickness rate and then actually are you thinking about some of the softer issues around some nutrition for your patients etc. So we then will have kind of a much rounder performance framework" (23:98) code 6.2*

7.2.1.4 Emphasis on Human Resources Management System

In the literature, Human Resources Management (HRM) has been considered an important factor in influencing organisational performance and clinical outcomes (Arthur, 1994; d'Arcimoles, 1997; Delery and Doty, 1997; Hoque, 1999; MacDuffie, 1995; Patterson et al., 1997; Terpstra and Rozell, 1993). West et al. (2002) argue that the main aims of new style of human resources policies, referred to as progressive HRM as opposed to traditional HRM – 'the use of jobs with low levels of skill variety and autonomy, and the minimization of expenditure on selection, training, development and compensation' - are to take advantage of the knowledge, abilities and extrinsic and intrinsic motivations of staff. The recruitment processes (e.g. scheduled interviews and psychometric tests), performance appraisal, inclusive education and training programmes, use of incentives, engagement in decision making, non-monetary benefits, team working and job enrichment are some examples of progressive human resources practices. The significant influence of human resources policies (particularly assessing the quality of the appraisal system) in the acute trusts, on the clinical outcomes (e.g. mortality rate) has been identified in the literature (West, 2002 cited in Mannion et al., 2005).

There was a general consensus among interviewees, that the new management team considered HRM issues were to be an important strategic priority and that significant improvement and innovation had been achieved in this regard. It was felt that the

previous management team did not focus on HRM and human resources managers' attention was focused on personnel issues rather than effective people management.

> *"Previously the focus has been on money and what we said was, hang on, you know, most of our money is spent on the cost of our staff, so let's make sure that we manage our staff properly and let's make sure that we use them effectively." (27:90)*

It was acknowledged by most interviewees (both clinical and non-clinical), that the new Director of Human Resources had a leading role in bringing strategic human resources issues to the attention of the Board (e.g. improving working lives, agenda for change, workforce modernisation, and organisational development) and that the HR strategies had been developed on the basis of the NHS plan. Participants emphasised that eight operational HR standing committees were responsible for implementing HR strategies within the Trust with progress reported to the HR strategy committee. A range of metrics, including a staff satisfaction survey, were also used as a tool to monitor the progress and implementation of HR strategies. In the organisation, improving 'people' management was supported by staff and one of the ward managers commented:

> *"We've got a new HR Manager who is very keen and she will offer her support and guidance in dealing with HR issues, she's very good with the PDPs and sickness and absence. The previous manager, she wouldn't contact you about it at all but this one is very, you know, what have you done about it? Do you want any help with it? she's very good." (30:138)*

There was a close working relationship between the HR Director and Medical Director, which it was felt resulted in the smooth implementation of the new consultant contract without the significant difficulties that other trusts had encountered. This was cited as an example of good joint working between managers and clinicians. The HR director was a member of the clinical governance assurance committee, which was an example of how the Trust viewed the importance of HR in mediating relations between managers and clinicians. Interviewees maintained that the HR directorate had a close working partnership with the Trade Unions, which was perceived as essential for implementing the 'agenda for change'. In addition, the HR managers were said to work closely with each division to assist them manage their staff more effectively.

> *"I think they've done a lot of hard work and with the new director, we didn't really have any direct links with HR unless there were problems within the work place, whereas I think now that the culture has changed*

because they've actually linked the HR manager with a different directorate or division." (29:107)

The following strategies were used by the new managers to manage staff more effectively.

Focus on Organisational Development:

One of the most important policies regarding people management, reported by interviewees, was the introduction of the Organisation Development (OD) programme. This programme was perceived as a effective way of empowering frontline staff, delegating operational autonomy to divisions and clarifying roles and responsibilities lower down the organisational hierarchy. Managers reported that the OD programme was an attempt to sustain a positive culture of change throughout the organisation. It was noted that the Trust also used an external facilitator to service a management development programme designed for the CEO and executive Board, general managers, divisional managers and doctors taking on new managerial posts.

"I think the executive team recognise that there has had to be a lot of hands on management from the very senior people and that's not ideal in an organisation of this size, so we've put together an OD programme starting initially with the divisional directors and general managers and that will roll out over a 3 year period so that there will be development at different levels of the organisation to encourage team working and team development, so that people are aware of the expectations of them in their role and people are now taking more accountability." (27:96)

Focus on education and training:

The Trust was perceived as being proactive in developing the skills and competencies of staff through the provision of a range of opportunities for education, training and career development. Internal facilities were used (e.g. the Trust's Education Centre), as well as external sources of support in the NHS (local and national training programme). Interviewees explained that the Trust was good at supporting staff who were undertaking post-graduate training relevant to their job by providing time off work and contributing to the payment of course fees. However, it was also reported that some staff were unable to get time off to attend mandatory training sessions because of inadequate staffing levels, particularly at ward level.

"I would say in defence of the Trust, again from a nursing perspective, there are lots of opportunities there both for in-house training and also higher education." (29:85)

> *"I mean, certainly, from a nurse practitioner point of view, there are people at all stages of development and within that some are very junior and some have been nurse practitioners for five years, so that's a continually rolling programme to educate people." (33:159)*

Emphasis was also placed on staff induction procedures that were used to introduce new entrants to the culture and ethos of the organisation. The induction meeting aimed to familiarise new staff with the 'can do' mentality and to clarify what was expected of them.

> *"When new doctors come now they have a couple of days induction, so all of the information about the 4 hour targets is discussed and kind of reinforced at that induction, which again will help." (33:215)*

Improving working lives:

One of the issues viewed as a HR priority by interviewees, particularly junior nursing staff, was the high level of attention the Trust paid to 'improving working lives' and supporting 'family friendly' initiatives. One interviewee explained that the HR managers tried hard to change traditional management thinking in the Trust by allowing staff to be more flexible in how they worked. Some interviewees placed a considerable emphasis on the importance of having flexible working arrangements. Two new senior managers indicated that the rate of sickness absence had been reduced, although not significantly, over a two year period. They explained that sickness absence was still high but they predicted that this could see further reduction with the implementation of new HR strategies.

> *"The report gives us a glowing report on our flexible working interventions and we've really managed to turn that around and I guess in terms of staff being valued, that if staff had the confidence to actually come to the organisation and say, I have a problem, you know, I have one or two ways of dealing with it." (4:121)*

> *"At ward level things have been implemented, really, I think which helped for instance in improving working lives you know for the staff which is good because it takes in a number of things, like regarding flexible retirement and improved training and development for nursing" (36:19)*

HR managers reported that the Trust did not face any serious problems regarding the recruitment and retention of staff in most key areas. Also, the quantitative data (percentage of the staff that had left the Trust) did not show significant difficulties in terms of staff retention. However, some interviewees maintained that some staff had

left the Trust because of the pressure associated with the new performance management culture and increased onus on staff to meet performance targets.

Staff appraisal:

A focus on conducting personal development plans and staff appraisals, was viewed as a key task of the HR directorate. Such arrangements were perceived as a good way to communicate what senior managers expected of staff, as well as providing opportunity for the staff to talk with their managers about their personal development records. Staff at different levels also supported the fact that there were now better induction procedures and appraisal systems.

> *"We've started to encourage the managers to actually to look at people management issues from a risk perspective, as well, because that seems to engage with making the divisions more effective. So what are the risks of our staff not having PDPs. Well the risks are that the staff don't know what's expected of them, they don't know what their objectives are, there are some other training and development issues around that, so are we actually preparing our staff to do the work that we want them to do? So we're saying to them to look at some of the risk aspects of that really and reducing risks." (27:213)*

Staff engagement:

Staff involvement was frequently stated as an important policy for the HR directorate. The management development programme was centred on encouraging managers to involve and consult staff in the early stages of new developments and give them the opportunity to present new ideas and solutions. There was a perception that the environment was now more 'open' and that staff could more easily communicate with Trust's managers. One of the staff representatives stated that staff now enjoyed a more open environment, with the ability to contribute to decision making:

> *"It now seems the doors are open and you can influence, sometimes it doesn't make a bit of difference but at the moment you can definitely lodge your objections, point out problems that may not have been picked up and hopefully before the final decision is made, it'll be more agreeable to everybody and hopefully if that's the case, there'll be no real turmoil, they'll be no people getting upset and it should be better for the patient if the decisions that are made are the correct ones and not the wrong ones that have to be altered later on, once they're introduced." (40:53)*

Staff support:

It was stated that the staff were also members of some operational HR communities, for example there were three places in the employment policy review group, which

provides the opportunity for staff to raise their concerns relating to HR issues and give their suggestions. One of the HR managers explained what they were trying to do:

> *"We say to our managers, some of the issues around ensuring that we support our staff effectively mean that their morale will be improved, they'll feel happier in the work place they were less likely to leave and if we can offer them some training and development as well, then they'll develop their skills to enable them to do their job more effectively and for us to implement changes that we need to do." (27:82)*

According to the CHAI report the previous management team did not pay staff during periods of sickness, which caused tension within the Trust. Several interviewees believed that new management team resolved this problem and improved the HRM within the Trust.

Celebrating success:

To show that success is valued and to encourage staff to share good practice it was reported that a range of 'award' ceremonies celebrating success, were held within the Trust. The HR director emphasised that they tried to recognise and acknowledge the attempts made by the staff towards improvement.

Some interviewees reported that there was plenty of scope for development in HR policy. They believed that the culture of working across different departments and different disciplines could be improved. Some staff argued that the HR strategies were related to targets set by governments rather than serving to enhance areas of performance of concern to staff locally.

7.2.1.5 Strategy Development

As outlined in Chapter 5, the Trust appeared to have suffered from a lack of strategic direction and this weakness was highlighted within the CHAI report. One member of staff stated, "We were a strategy free zone organisation". Several participants indicated that the development of strategies had been addressed by the new management team. The governance strategy, estates strategy, human resources strategy and education and training strategy had been drafted for the first time. In addition, some existing strategies, such as Information Technology (IT), had been revised. It was reported that all the executive members of the Trust Board were

involved in revising or writing the new strategies. The CEO was responsible for developing a corporate strategy for the Trust.

> *"So there was a sweep of strategies that developed from the whole team that everybody was involved in a lot of strategies were either recovered or written for the first time."(11:115)*

One clinical director highlighted the important role of the new management team in the development of strategies and providing general strategic direction for the organisation. It was believed by both clinical and non clinical interviewees that planning for different strategies would help the Trust to sustain its performance improvement.

> *"The new management has brought in a degree of clarity as to its purpose, as to its strategy. It's shown far more clearly than the previous administration did, where it wishes to go and what its priorities are, that has in some ways strained relationships as well built them because in showing what strategy the management team is, then it raises the possibility and it has happened where people have fundamentally disagreed with the direction that they're taking." (42:14)*

7.2.1.6 Improving lines of communication within the organisation among staff

An important issue, highlighted by staff at all levels (both clinical and non-clinical), was the emphasis of the new management team on upgrading communication practices within the organisation. It was apparent that the problems had been dealt with, and communication had become more evident both within and between departments. The interviewees indicated that this had helped improve relationships and build up a better understanding and support for staff, which they appreciated. Junior staff also viewed it as a good opportunity to learn what was going on inside the organisation. It was reported that the Trust communicated effectively with staff in order to show the importance of the national performance targets and to inform staff of why they were being asked to carry out particular roles and the consequences of their roles for the performance of their departments and the Trust.

> *"There's a lot more communication that goes on. We have not only business meetings but we have nurse meetings and we have team meetings and it actually does get cascaded down. We have identified people that will go to team briefs and actually cascade that information down and people seem to want to know more information" (44:83)*

> *"We have a vastly improved communication strategy, people actually know what's going on so it's so much easier for everybody to*

understand and that was one of the really important things that we did was improve our communication." (25:81)

"There is a huge flow of information now, which just wasn't there even four years ago." (32:43)

"It is certainly an easier organisation [in which] to get communication going than it was, you can go and talk to people and they will respond, they will call you back, they actually will engage." (42:89)

Participants reported that a range of different forms of communication were used to relay performance information to staff. These included:

- Posting the minutes of Board meetings on the Trust's website.
- Introducing an electronic 'rumour Board' linked to the Trust's intranet. This allowed staff to ask senior managers questions. Answers were received within a few days.
- Briefing of senior staff by a member of the Board to inform them what the Board had approved and what it intended to implement as new working processes and procedures.
- The use of the Trust's intranet as a two way communication system.
- Introduction of a team briefing process, at different stages, via e-mail.
- Scheduling more 'walkabouts' by executive directors to make them more visible to 'frontline staff'.
- Introduction of increased 'face to face' meetings between the CEO and clinical directors.
- Encouraging more 'team to team' meetings between clinical departments to inform each other about what they were doing.
- Introduction of staff news and bulletins, informing them of developments within the Trust and highlighting examples of departments with significantly improved performance.

Although many stressed, that communication within the Trust had improved significantly, some interviewees reported there was still room for development in communication procedures. An executive member referred to the issue resulting from the high level of work pressure within some divisions because of the extent of the necessary changes. It was reported that the flow of information was not equal among the divisions and directorates. In some directorates it appears that staff were better informed than in others. Another member of the Board pointed out that divisional managers and directors may need to develop better and more appropriate communication skills in order to relay information and decisions more effectively within their units. Another senior manager suggested that the Trust was trying audit

team briefings in order to remove blockages in that process and she believed that there was still some work to do on communication strategies. For example, staff in hospital B felt that they were isolated and that they were not informed about key developments in hospital A, although the Trust was aware of this and was now addressing these problems. Three interviewees reported that it was difficult for staff at a lower organisational level to communicate with senior managers, though the Trust was trying to address this issue. One interviewee believed that senior managers did not pay enough attention to their staff's views.

> *"I think it's got better and better since I've been here, I think the communication has actually got better. I think there are still areas where it's lacking but generally I think, as a whole, it's got better but I think it's probably got quite a long way to go." (20:243)*

One consultant reported that they appreciated the greater volume of information flow within the Trust, stating, "there is a huge flow of information now which just was not there even four years ago". However, he added that it was not clear whether the improvements were driven by improvement and investment in IT technology or driven by management. He also argued that communication between consultants was poor, as he believed that the consultants, especially the older ones, were not computer literate. With offices scattered in different buildings, they did not have too much opportunity to interact with each other.

It was argued by some interviewees that, despite the proliferation of information from a variety of sources, some staff were still not willing to read the material. One of the ward managers said:

> *"I mean there's team briefing but as I say, it's getting to it. Having time to read what's there, understanding what it means sometimes, what's on it because if it's all performance related people switch off because it doesn't relate to them on the ward." (30:190)*

Several nurses reported that they could not attend team briefings or even check the intranet, because of their very busy schedules, which appeared to limit the effectiveness of communication strategies. For this reason, they felt that there was not a major difference between current and previous communication, although they reported that they could download the minutes of meetings for later reading.

> *"No I don't think there's terribly good communication coming down from the top to the ground level, I think it's even worse the other way round from bottom to top, I don't think that there are good communication systems." (17:154)*

7.2.1.7 Internal reorganisation and restructuring

Some major organisational restructuring and development of new units was planned and implemented, and was perceived by several interviewees (both clinical and non-clinical) as a key contributor to performance improvement.

Three new directorates (Estates and Facilities, Human Resources and Information Technology) had been formed. The Board's composition had undergone a significant change and the directors of two of the newly formed directorates (Estates and facilities and Human Resources) became executive members of the Board. The senior managers believed that these changes showed the importance the CEO attached to the role of the new directorates in the process of performance improvement.
A Performance Team was introduced as a part of the Directorate of Operations, which was perceived as playing a key role in the process of performance measurement and monitoring, by providing timely and appropriate performance information to the Board.

Clinical divisions were also subject to a series of changes at managerial level. Both surgery divisions were given to the same general manager and it was stated that the these were now working as one division rather than two. The Board was planning to appoint a general manager for medicine and separate medicine from heart/lung divisions in order to have a more effective managerial process. Because of the importance of the A & E Department, the Board was planning to recruit a general manager for the A & E Department. In each clinical division, a Human Resources (HR) manager was appointed in an attempt to manage staff more effectively and to report on HR issues to the senior HR team.

In the previous management system, only one unit was responsible for producing and reporting performance information and this was believed to be a key reason that the misrepresentation of performance data had continued for so long. According to the Audit Commission report, waiting list data management was separated from the information performance structure. The staff who are now responsible for producing waiting list data report the data to the Head of Modernisation, who is not connected to the information structure. A Data Quality Department was set up, giving managers appropriate access to the patient administration system. These changes were made in order to clarify lines of responsibility, provide more accurate data and minimise the likelihood of future misrepresentation.

"I mean the difference then and kind of now really is that I'm responsible for the operation and performance within surgery, so basically it's around achieving the waiting targets. But the waiting list clerks who actually, the junior members of staff, who actually put people on waiting lists, you know, work with the clinical team, they actually report outside of my managerial control to somebody else. So we've got an assurance body then who go in and validate, who check what we are doing what we say we are doing, that we're not - because sometimes, I think, I don't think it's malicious." (23:27)

To mitigate the problems raised by the shortage of beds, a bed management team and a patient discharge unit were set up. Patients who were to be discharged over the next few hours were transferred to the discharge unit in order to provide more bed capacity. The hospital's bed management team was responsible for allocating patients to different wards to use all available capacity. However, some clinicians believed that the function of both teams was to meet performance targets and that it compromised the quality of patient care by discharging patients earlier than they should have been discharged or by allocating them to inappropriate wards.

To address the serious clinical governance problems highlighted in the CHI report, a new Clinical Governance Manager was appointed and the Medical Director took on responsibility for clinical governance. In addition, a clinical governance assurance committee was set up to scrutinize clinical governance arrangements and a non-executive member of the Board chaired the committee.

A senior manager stated that during the restructuring process, several managers with insufficient experience and skills were dismissed.

7.2.2 Retrenchment

The retrenchment strategy, as a generic turnaround strategy, was used within the Trust to stabilise its financial position, as the organisation had lost one of its 'stars' because of the financial deficit. Most interviewees emphasised that the Trust had developed a tight financial recovery plan, in 2002, to control financial costs, provide cash flow and balance the financial status, which subsequently created a lot of pressure within the organisation. The key role of the Director of Finance in understanding the Trust's financial status and working collaboratively with the SHA to handle the financial situation was stressed by some interviewees. However, the Director of Finance maintained that the general managers were involved in the financial plan from the outset and that they had collaborated with the financial managers in their clinical divisions in order to contribute to the drafting of the budget

and cost pressure schedule. It is necessary to explain that the SHA gave the Trust a period of three years to solve the historical debt problem, and during that time the financial priority of the Trust was to achieve financial balance.

Senior managers highlighted the fact that one of their attempts within the first few months of the turnaround process, was to make sure that staff understood the importance of financial issues and their impact on the quality of patient care. All the different parts of the Trust were asked to work on the budget in order to deliver the desired financial savings detailed in the financial recovery plan and it was stressed that all units and departments were clear about their contribution to savings. A close collaboration between operational and finance managers had been developed within each division when they were aiming to meet financial saving targets and this was said to be ongoing. It was reported that, if a unit was unable to meet its financial targets, its managers must explain to the CEO and Director of Finance why they had not done so and come up with strategies for remedying the situation.

Two senior managers explained that, in the first instance, they focused on poor financial control in some departments within the Trust. As outlined in Chapter 5, the Trust suffered from the high cost of overpayment of junior doctors and heavy expenditure on staff banking agency fees, particularly for nurses, costs which were not well controlled. One executive stated that both these issues were targeted by the financial recovery plan and that about £1.5 million was saved by better management of the junior doctors' rota. It was stressed that a reduction in the staffing level, or a 'vacancy freeze', was also used to reduce costs. A further example of a money saving strategy was the introduction of a group pharmacist whose aim was a 5% saving through the more cost effective purchasing of drugs. They were able to achieve their target. Units such as the heart and lung division, that were able to save money through more efficient purchasing of medical equipment and earning money by increasing work load and making contracts, were not subject to staff reductions as a cost cutting strategy. It is interesting that the Trust provided this opportunity for units which were able to earn more money. The Trust was successful in reaching financial balance within two years, which was to the result of accumulated cost saving across the Trust.

> *"We [executive member of the Board] had a plan almost from day one really that once the executive team were here, we had a very, very clear plan which was about financial performance. We had to turn round the finances of the Trust" (4:77)*

> *"We have taken a lot of money out of the system over the past few years, now in my division I've got budgets totalling £40 million pounds and over the last two years we've taken £2 million out, which I think is a pretty good performance. However, I've currently got a saving target of another 1.3 million. If you've been in financial recovery to the degree that we have in this organisation for as many years as we have then it all gets very difficult." (18:91)*

Several middle and junior managers pointed out that strict cost reduction had a deleterious effect on staff morale and harmed the quality of patient care. A clinical consultant believed that cutbacks in such areas as purchase of coffee, notepads, ballpoint pens and the use of the telephone cannot save a large amount of money, but do undermine morale. In addition, some interviewees reported that the PFI partners were not monitored in terms of financial issues as rigorously as the Trust's middle managers.

> *"I know staff do feel very, very pressured, you know, we're constantly looking at saving money, we're constantly looking at making cut backs which leaves little room for developing people." (44:55)*

> *"We've got a PFI agreement, which is a quarter of a million pounds per annum overspent, so I'd like to get in there and have a look at it because I suspect that's not being managed with the same rigour as I manage my budgets, not because somebody is doing their job wrong it's just a very difficult thing to do." (18:325)*

To deal with the historical debt, the Finance Director noted that two options were being considered. The first was through the sale of assets at hospital B with which he was hoping to create a 'one-off' surplus which might help the Trust. Another option was to re-finance the whole PFI scheme.

7.2.3 Repositioning

As outlined in section 2.9, Repositioning (renewal) strategies are activities used to reorient the strategic direction of an organisation and revitalise its vision, with the aim of assuring long-term survival (Walsh, 2004; Boyne, 2004a). A range of repositioning strategies were used by the Trust when attempting to sustain long term performance improvement.

7.2.3.1 Improvement of external working relationship

The UK Department of Health (2000b) is placing increased emphasis on the notion that the NHS pursues a 'whole economy' approach, assessing and rewarding

performance. The implication is that NHS organisations are required to create effective networks across all key organisations within the local health economy, with leaders expected to nurture good relationships and work collaboratively with the other health and social care leaders to achieve the desired performance improvements (Mannion et al., 2005).

There was general consensus among the interviewees (both internal and external), that the new management team was indeed developing good working relationships and collaborating effectively with the key local organisations. In the local health economy the Trust senior managers stressed that the development of close working relationships between the Trust and other organisations, particularly the SHA and PCT, was a key priority because the Trust would benefit greatly from their support.

> *"When the new Chief Executive and team arrived, the culture of the organisation changed markedly. It became much more positive, much more friendly externally. Before it was never particularly a friendly organisation and the new Chief Executive particularly adopted a position of establishing partnerships that never play as external, which he saw as necessary for the organisation's strategic future." (21:104)*

> *"I do think the success in your organisation is about your own network as well. I would actually say, for a successful organisation the leaders need to have a very wide network because they can help you in times of difficulty. You need to have really good relationships with your SHA and PCT because when you've got those good relationships they actually start batting for you." (16:111)*

Several staff explained that the Trust had a 'wholesome' working relationship with the SHA, which enabled the SHA to receive more information on the Trust's performance related issues. When the Trust could not resolve its own problems it could seek additional support from the SHA. Indeed, they viewed the SHA as a support mechanism and affirmed that there were constructive meetings at different levels, between the SHA and the Trust. The SHA senior managers confirmed that the Trust was working collaboratively with them to address their performance problems. A member of the Performance Development Team (PDT) stressed the quality of the relationship between the SHA and the Trust.

> *"I personally am very encouraged by [name of the Trust] approach because they let us [the SHA] know about things that are going to happen, not that we've always had a problem. I think as I've hinted they're [the Trust] much more open and honest and opportunities to engage are greater" (22:29)*

> *"My impression [member of the PDT] was that the SHA had been supportive and the Trust was happy to work with them. Happy to work*

with them because they knew if they were working with them the SHA isn't working against them or breathing against them. It's supportive. It was almost like a symbiotic relationship." (37:145)

Most interviewees had a positive perception of the relationship between the new management team in the Trust and the PCT . It was emphasised that there are now regular team to team and Board to Board meetings, which had not happened previously. PCT managers also confirmed that the Trust had adopted a more open and inclusive attitude towards them and they viewed this as providing the opportunity to talk about joint priorities and strategic decisions, as well as for seeking solutions to thorny performance issues. The SHA viewed the relationship between the Trust and PCT as a good and close one -much better than that experienced under the Trust's previous management regime.

"So we [PCT and the Trust] now have more of a partnership arrangement than we used to do, so it's gone from being a traditional performance management and contracting role into more of, you know, there are things we need to do together in order to deliver and make sure that people are seen in the best place at the right time because that's kind of key, really." (8:25)

"There's been several instances when the medicines management committee has the PCT representatives on Board. So that when you're talking about prescribing the pharmacy budget you have your PCT representative who looks at it from the Primary Care Trust perspective and looks at purchasing of drugs both from primary and secondary care which makes it much easier. Because you can then; there's no point in having one set of rules for the Trust and then another set of rules for primary care. It's better to work together. And there's been lots of instances where things work well together." (47:35)

One member of staff, while conceding that relationship between the PCT and the Trust had become much better, maintained that the PCT still did not acknowledge some of their performance issues. An example was given by an interviewee of the GPs' referral rate to the Trust. This was set by the SHA and should not have increased, but the data showed a 12 per cent increase in referrals, which inevitably affected the Trust's performance and added to their performance difficulties. It was believed by some that the PCT did not view the Trust's problems as their problems. An interviewee reported that the Trust was inconsistent in the way in which it approached the PCT; the Trust viewed the PCT as a source of funding and backing, but does not deal with the PCT on several key issues. The interviewee believed that although it reflected a dynamic relationship, there was a power imbalance between the PCT, which was a small organisation, and the more powerful Trust, which was a large teaching hospital.

The Trust had developed good relationships with other hospitals. Several participants said that the new management team was willing to work with its neighbouring trusts in order to assist them to deliver services and develop specialist facilities. In like manner, the Trust received help from its neighbours, particularly in relation to developing a joint patient access policy.

None of the interviewees at the ward level was sufficiently aware of the working relationship between the Trust and the SHA or the PCT to have a well informed opinion. However, matrons noted that the Trust should work more closely with the PCT and Social Services to resolve patients' problems and social care needs, when discharged from hospital.

7.2.3.2 Cultural change

Respondents highlighted the important issue of senior managers' attempts to change the culture of the organisation. Although several interviewees expressed doubt that the culture could be changed in a short time, as it had been embedded in the organisation for many years, they said that a set of values and behaviour had been agreed by the Board, particularly the executives, to try to nurture a different performance culture. Senior managers emphasised that they were still in the process of trying to change the organisational culture and that it would take a long time for a new ethos to become embedded within the organisation.

Encouraging transparency and the development of an open and learning culture: Most interviewees stated that openness and transparency had been encouraged by senior managers and that staff were now much less fearful than they had previously been when reporting problems. Senior managers said they accepted the concept that staff were human and human beings actually made mistakes, so they had tried to move away from a disciplinarian approach with a 'blame culture' to a culture that essentially looked at why the system led to mistakes and errors and how staff could learn from these. An important example, given by interviewees, related to the transparency of the waiting list data. Management enabled all staff engaged in it to be very clear about the process, to know that deception would not be tolerated, but that they could now report freely in the event of any mistake or problem. Indeed, a 'whistle blowing' policy was introduced that helped the Trust to detect problems and any misrepresentation.

> *"There's a style of leadership now which is very open, fiddling will not be tolerated and I think there's openness among the top members of the Trust." (10:41)*
>
> *"One of the things that was very clear to me as a Director [name of position] was that I had an objective to develop an open and learning culture, which I think we've done in many respects." (11:77)*

Although the hospital was one of the first Trusts to establish a system of electronic instant reporting (as acknowledged in the CHAI report), it was noted that the number of incidents reported was not high, and that this might result from the presence of a 'fear culture' promoted by the previous management team. The internal documents show a very significant increase in the number of incidents (about 4000% over three years) reported by the staff, following the cultural change encouraged by the new management team. Within the system, clinical and non-clinical risks are integrated. Staff from different groups and at different levels of seniority within the groups, report mistakes and problems, providing a possible indirect measure of how effectively the Trust is developing an open learning culture. One of the matrons emphasised that there were now more opportunities to talk with senior managers about any problems:

> *"If something happened and I didn't feel that it was right, I could go to my chief nurse without any hesitation, I feel that we've got quite an open policy, I do think we've got quite an open approach really." (57:43)*
>
> *"I'm not afraid to raise an issue with them. No matter how difficult that issue is. I would say that of the CEO as well." (39:22)*
>
> *"I don't feel as though if anything goes wrong I'm not afraid of being blamed or being sacked, [...], I don't feel threatened by making mistakes." (17:126)*

The participants expressed the opinion that a strong culture of risk management within the Trust had been developed over the last couple of years. One described how the SHA had been provided with honest and open reports of certain, enabling them to assist the Trust in dealing with these problems. Such an open and transparent culture also helped the Trust to gain the trust and support of the SHA. A member of the Performance Development Team reported that the Trust's managers were very candid and willing to provide the information required by PDT members. The Trust managers tried to tackle the different problems openly rather than declaring that they would deal them by not involving other organisations.

Encouragement of a 'can do' culture:

Several interviewees stated that a 'can do' culture was encouraged by senior managers, who tried to support staff in carrying out their jobs. One of the external interviewees reported that the culture of the organisation was changing from a 'cannot do' culture to a 'can do' culture and she added that it had become unacceptable within the Trust, for clinicians and managers to say they were not going to do a particular task. The external interviewees confirmed the presence of the 'can do' culture and as one of them stated:

> *"Chief Executive and his team which communicated and modelled for the rest of the people in the organisation that performance improvement was important and conveyed a belief I think, a belief that we can do this, we can be successful." (45:89)*

> *"There has definitely been a development in a growing of a " can do " culture, here, you know solution focused rather that blaming and shaming which I think was how, maybe, you could have characterised the culture in the past." (12:45)*

Development of performance management culture:

It was reported that one of the most important cultural changes within the Trust was the development of the performance management culture among staff at all levels of the organisation. It was emphasised by some of the interviewees that staff (both clinical and non clinical) had more awareness of their own performance than before and were now trying to take ownership of their activities. One clinical director noted that, although clinicians did not recognise the zero star rating and believed the quality of care within the Trust to be good, they did acknowledge that things needed to be changed in order to gain a better star rating. In general, it was perceived that more awareness of performance had been created between different groups in the organisation.

> *"I think, as a Trust, there was a huge culture shift probably over the last 18 months in people actually taking ownership of this target [A & E target] and you know, the medical consultants appreciating that they had a part to play in achieving it." (33:71)*

The development of the performance management culture was perceived as an essential aspect of performance improvement. However, it was viewed as a short term strategy to meet the targets and not viewed as the key cultural change strategy that would probably maintain sustainable performance improvement.

Cultural change in ways of working:

Several interviewees agreed that there was an attempt to change the culture in ways of working. They stated that the executive team offered helpful suggestions and possible ways of working, with the emphasis on working together rather than instructing staff to carry out a task that they actually would be unable to complete. Staff perceived that their contributions were valued. An interviewee argued that now there was a constructive methodology in place and advice was being given about how things should be carried out. The CHAI report also highlighted this issue and suggested that the organisation should create a more open culture with more effective ways of working together. Several interviewees, from senior and middle managerial levels, believed that staff were now being encouraged to work differently, in ways that helped each other and that made the team more effective. Senior managers reported that the implementation of the Organisational Development programme (detailed in previous sections) was an attempt to sustain a positive culture of change throughout the organisation.

> *"It's a combination of change, certainly there's been a cultural change that is more about working to get the same ends, there's more working together, there's more partnership now. We appear to be less in conflict overall." (40:131)*

> *"So in terms of sustaining that culture change we've embarked upon a programme of organisational development which is really about empowering front line staff and empowering divisions and being very, very clear about roles and responsibilities." (4:39)*

One interviewee gave an example of the existence of a better working relationship between A & E and the clinical assessment unit, and believed that the 4 hours A & E targets are now perceived as a corporate issue rather than a departmental concern. One manager gave as an example, if a patient or relative complains, instead of staff pointing them to the complaints procedure, they would try to understand the problem and help resolve it.

> *"Yes huge amount (conflict between A&E and other wards) but it is so much better now and I think it's because it just takes a long time for change to be accepted but yes, initially we weren't really working that closely with the medical assessment unit and they would call for patients 5 minutes before the 4 hours is up, which doesn't give you time to get porters, organise yourself. So we now have an excellent working relationship with them and we know as soon as they have a bed ready, that they will ring us." (33:187)*

Alternatively, it was reported by interviewees that over the first two years of the turnaround process, the focus was a 'top down' performance management system and implementation of a transactional style of leadership. The organisation had not been concentrating on empowering staff. Some interviewees, particularly those from lower levels working in clinical units, believed that the dominant culture that had developed within the organisation was in the main concerned with short term gains (targets). They believed that in this environment, where the targets were the main focus, staff seemed 'frightened' of innovation. One interviewee noted that cultural change was the next step and that it was necessary to establish a performance focused organisation when trying to ensure sustained improvement.

> *"I think a lot of culture issues still remain and we're just starting on an organisation development programme with the divisions and the divisional directors to try and understand some of those issues and to try and help turn those around, so that we are very transactional in terms of [requiring staff] do as I say, as opposed to maybe being more transformational." (23:36)*

One of the middle managers believed that the organisation had difficulties in establishing its own identity when determining strategies to turnaround the situation. Because there were two different behavioural expectations, it meant that on one hand the organisation wanted to support staff and encourage organisational development, and on the other, being very target driven, it felt that targets could not be achieved without a very aggressive approach. The interviewee likened this to a case of 'schizophrenia'. However, he added that in order to meet the targets and gain stars, it seemed that there was no option than to use an assertive approach and, after the targets were achieved, the maintenance approach could be slightly softer. Most interviewees favoured tight management control.

> *"I think the organisation, over the full 2 years since I've been here has had difficulties in identifying which sort of organisation it really is and if you go into one meeting it will feel very positive and you go into the next meeting, it will feel very aggressive and difficult." (24:34)*

Cultural change takes time:

All interviewees held the common view that any change of culture would take a long time to become embedded within the organisation. A senior manager emphasised that the Trust embarked upon a programme of organisational development with its main focus on empowering frontline staff, empowering divisions and clarifying the roles and responsibilities of staff. The aim was to devolve authority to staff at lower levels,

enabling them to develop their own services, in accordance with the performance improvement plan, and to learn to use it as a tool to run their departments as small businesses but still with responsibility for meeting targets. It was expected that staff would develop their own strategies and chair meetings on performance improvement. Three senior managers felt that it was time that staff from lower levels of the organisation, experienced more ownership of some of the issues about which the Trust was concerned.

7.2.3.3 Extending services and modernisation

When the Trust received its three star status, the senior managers were attempting to implement a range of strategies. These included extending services (e.g. particularly day case services) and modernisation to increase the probability of a sustained performance improvement and enhancement of service quality. Some of these strategies were planned in order to respond to the new market based policies (e.g. Payment by Result, patient choice). The strategies planned by the Trust were:

The Modernisation Agency's 10 high impact changes:

The members of the Board stated that they were aiming to align and remodel the detailed performance plan into one that focused on the Modernisation Agency's 10 high impact changes, which would re-focus the direction of the Trust. It was believed this could provide the Trust with a better basis for future development and respond to the Payment by Results funding regime.

> *"I thought what we need to do is some kind of massive performance improvement programme across the organisation and make sure that the PIP is linked to our modernisation programme" (16:71)*

Some middle managers reported that, despite the good ideas inherent in the 10 high impact changes (e.g. extending day case surgery), they would be very unlikely to achieve the aim of 75% of all operations being carried out as day surgery. The pockets of very high deprivation in the Trust's catchments area produce a high incidence of co-morbidity that would make it difficult for the Trust to reach this target.

Extending day case services:

One strategy was to develop the day case services, enabling the Trust to be more efficient in competing with other Trusts and the private sector in the provision of clinical services.

Extension of specialist services to other neighbourhood organisations:

Three senior managers maintained that the Trust proposed to work with its neighbouring hospital, assisting in the delivery of services and likewise, working with neighbouring acute Trusts and PCTs developing specialist services for other units in the Trust's local area.

7.3 Impact of external organisations in the turnaround process

Most interviewees cited the role of a range of external organisations in initiating change, developing, implementing and monitoring the performance improvement plan. The role of external organisations in triggering change was explored in Chapter 6. Both the positive and negative impacts of external organisations on the turnaround process, are presented in this section.

These organisations were considered important resources, especially by new senior managers, in providing staff with a different perspective on the problems and helping the Trust to direct its focus and determine its priorities. The new management team were obliged to accept the external staff who came to the Trust's assistance, there being no alternative, certain members of the Board were emphatic that, should a similar situation occur in the future, they would invite these external organisations to come in, rather than wait for them to intervene.

Despite the fact that almost all interviewees viewed external organisations as supportive, some senior managers and clinicians perceived that there had been too many external staff in the Trust at the same time carrying out investigations. This had caused problems for the Trust when trying to focus on the process of change. One member of the Board likened it to a 'review city', and the executives felt that they were regularly required to deal with different groups, provide the necessary documentation and attend various meetings. Too much managerial time (on the part of both senior and middle managers) was being taken up with servicing external requirements. Senior managers believed that in some instances they had not been given adequate time to carry out their own work. The most prominent external organisations engaged

in this process were the Strategic Health Authority (SHA), the Audit Commission, the local PCT, the performance Development Team (PDT) of the previous Modernisation Agency, the Health Care Commission (CHAI) and the Department of Health. The role of each organisation is briefly as follows:

i) Role of the SHA

The SHA played an important role in triggering change by providing a report following their in-depth investigation. This had been requested by the new CEO when the waiting list irregularities became apparent. In the role they played as a performance management agent, the SHA followed a close monitoring and micromanagement of the process of implementation of the PIP through weekly meetings with some of the Trust's senior managers (executives and performance team) and the PCT representative during initial stages in the first year. One of the interviewees reported that the weekly meeting between the SHA and the Trust, was one of the strengths of the SHA, not only in terms of communication, but also in summarising the issues, reviewing performance problems and meeting requirements for dealing with the problems. A senior SHA manager stated that the data should be accessible for managers to review on a regular basis, which meant at least weekly, to monitor the performance; otherwise it was not thought to be beneficial. An information analysis team, based in the SHA, analysed the quantitative data forwarded by the Trust and produced a briefing report to aid in judging the level of performance. Subsequently, the SHA were said to have used this kind of meeting as a benchmark for other zero star trusts. One of its managers, described the SHA's role as providing challenge, clarity and coherence, ensuring that the Trust was focused on what it needed to do and managing situations where the Trust was under achieving.

Several interviewees, senior managers and clinical directors, perceived the SHA as being very supportive, noting that at the time the SHA recognised that the new management team faced considerable challenges and needed support rather than disciplinary action. They added that, at that stage, the Trust needed a 'hands on' approach to staffing, because there were not enough experienced staff in some areas to actually 'cover the ground' and get the 'work done'. The SHA sent some personnel who were based at the Trust for a week, to investigate and help the Trust with waiting list data, service redevelopment in the maternity unit and so forth.

> *"I think the SHA have been quite supportive, not financially as such, but I think psychological support and giving support as opposed to the new team and making it clear they were maybe supporting the new team*

and that I suppose gives you more credibility if you like in the organisation itself. So I think that was helpful." (46:68)

"They (SHA) were, I think quite supportive around the trust management, around the trust leadership. They certainly weren't trying to organize change in leadership. They were supporting those leaders. I think they then sort of backed off from my perspective and let the trust get on with it." (37:141)

"I think the Strategic Health Authority was offering expertise, advice in terms of understanding, say the waiting list profile. They offer analytical skills and that was at the time one of their strengths and I guess it's the sort of support that you can't turn down in that sense. " (45:69)

All the interviewees in clinical-managerial positions perceived the SHA as being supportive, although they believed that such close scrutiny was not always comfortable for the Trust's staff. Some managers did not completely support this belief, arguing that it was a difficult time for managers as they had to provide very detailed information for investigators and could not make decisions without first submitting them for checking. Managers reported that they needed to obtain SHA approval of everything they proposed to do, particularly in services development. They likened it to 'having big brother looking over your shoulder all the time' and added that the SHA wanted to ensure that the Trust was doing things correctly.

"The ability to make decisions on your own without checking them or being constantly asked for information at short notice, that was very wearing. It was like doing your job with like carrying somebody on your shoulders, they were stopping you from doing your job so it was kind of like a double life, which I guess I would have had less of that than my colleagues but I know [name of a director] when she was trying to sort out the problems with the waiting list and so on was constantly barraged with questions and checking of everything." (11:95)

Two managers had a negative view of this kind of SHA role and described it as a hindrance, especially in the first stage. They believed that the SHA did not allow the Trust to use its potential and capability to turnaround the situation. One also noted that the managerial ability of both the SHA and PCT organisations was limited to achieving only short term targets. They felt this inhibited the organisation's progress as the SHA challenged anything that threatened the achievement of targets. The Trust did not welcome the SHA, feeling they were continually negative and always highlighted aspects of performance that had not been delivered.

"I think initially they were quite a hindrance because they didn't trust us to get on with it" (23:52)

> *"So certainly the Strategic Health Authority was seen as a kind of pest really. I think they still see the Health Authority as a bit of a pest, [...] and as an external nuisance really." (8:111)*

A manager in the Directorate of Operations stated that they realised at the time that things would 'get worse before they got better'. After a year in which the Trust showed improvement in its performance, the number of meetings between the SHA and the Trust and the pressure from the SHA were reduced. However, the SHA transferred responsibility for meetings to the local PCT and expected the PCT to manage the Trust's performance, as opposed to the previous arrangement where both the PCT and the Trust went directly to the SHA. The aim of the SHA in one-to-one visits, was reported to be an attempt to develop more capability among managers, as they began to look at their systems and processes. The SHA currently meets the PCTs twice a month to receive information on the Trust's performance.

> *"We were like on weekly monitoring from the SHA. We had visits from the SHA as a regular occurrence, we were asked to do over and above what they were asking the organisation to do in terms of reporting monitoring and that's completely gone now. I mean they kind of leave us to it now." (23:40)*

> *"Well the monitoring was very close when the performance was poor but over time that monitoring has become substantially less" (18:177)*

The SHA behaved as a performance management agent, exercising close monitoring in the first two years and supporting the Trust by sending 'hands on' staff to help the Trust with key performance targets, such as waiting lists. Their objective was, nevertheless, to develop capability in the Trust rather than intervene directly. Their action prompted the Trust to focus its attention on targets and performance issues through regular weekly meetings.

ii) Role of the Audit Commission

The role of the Audit Commission was perceived as a strong trigger for change, and its recommendations, which were included in the report, played an important role in developing the action plan. Because of the nature of the Audit Commission Office, it did not have much impact on the implementation of the PIP, but it audited the Trust a year after the start of the implementation of the action plan, comparing its performance with that of the previous year.

iii) Role of the Performance Develop Team (PDT)

Background:

In the process of turnaround, the Trust was supported by a Performance Development Team (PDT) which was a part of the Modernisation Agency (MA). The precursors of the PDT were two different teams in the NHS Modernisation Agency (MA), namely the Clinical Governance Rapid Response Unit (RRU) and the Performance Improvement Team (PIT). These were merged to form the PDT. The PDT was working with all the zero star rated organisations, including primary care, acute, ambulance and mental health trusts to provide support and facilitate organisational turnaround. In 2002, the Modernisation Agency only assisted acute trusts to turnaround their poor performance (DoH, 2004; Harvey et al., 2005).

Before explaining the role of the PDT in the Trust under study, the routine schedule followed by the PDT should be clarified. A cluster leader co-ordinated the work of the PDT in each of the geographical clusters and a client manager was responsible for organising the work in each individual zero star rated trust. Following the appointment of a client manager, s/he arranged the first engagement meetings with the Trust and other relevant organisations, in order to reach an agreement on the action plan using different interventions and development programmes to turnaround the organisation. The diagnostic process was an important part of these meetings and the capacity of the organisation was also taken into consideration. A formal contractual agreement was then drawn up between the PDT and the Trust, which encompassed the process involved in the implementation of the plan, and the time that the PDT was scheduled to withdraw from the organisation. Subsequently, client managers of the PDT and other staff from the Modernisation Agency became responsible for delivering the plan. The PDT categorised zero star rated organisations into groups reflecting high, medium and low levels of intervention required to improve their performance. Their level of acceptance of the PDT, and the nature and size of the problems they encountered, affected performance, so it was stressed that the PDT was dealing with each organisation individually, rather than applying a 'one size fits all' solution (Harvey et al., 2005).

Initial engagement meeting arranged by the PDT client manager:

In this case, when the client manager of the PDT was assigned, he reported that he already knew the Trust's history and background, and he tried to engage with the Trust during the initial stage. A meeting Between the CEO and Deputy CEO of the

Trust, and the SHA and PCT representatives seemed to him an appropriate way of ascertaining the views of different relevant organisations regarding the Trust's situation and problems in the local health economy. However, he stressed that other strategies had been used to stimulate engagement with other organisations on the basis of their situations. The client manager reported that a' tailor-made' approach was pursued, responding to the special needs of the Trusts rather than a trying to effect a generic solution.

> *"When you (client manager) go to work with an organisation you have to make sure that you're going to work with them in the way that's specific to them. So I wouldn't come to that trust saying well but this is what I normally do. I do this every time for every organisation.' So I do the same thing all the time because the same things would not be necessarily what each organisation needs." (37:18)*

Role of the PDT in diagnosis and development of the action plan:

In this instance, the PDT did not play an important role in problem diagnosis, because that had already been done by the Trust following external reports (as previously outlined), before the PDT team entered the organisation, and in addition, the Trust had already developed its action plan. The members of the PDT, felt the action plan to be sufficiently robust and they did not see the need for a more formal review of the plan. The PDT team focused on the implementation of the action plan and its effects. The PDT client manager maintained that there was an audit trail, which had reduced their need for monitoring and reporting.

> *"They weren't in need of intensive support. They had a lot of work to do, but in terms of somebody describing what that was or diagnosing it, it wasn't that they weren't that bad. They've already done that. They were beyond that." (37:43)*

PDT members reported that the Trust's managers were very clear about what they wanted and needed to do and the Trust was viewed as a proactive organisation in developing an action plan. It was stated that the Trust's managers wished to own the action plan themselves so the PDT did not have to contribute to developing the PIP. The PDT client manager felt that the Trust could initiate its own turnaround process, so there was no need for external interventions to remedy the situation. That was also emphasised by some of the Trust's senior managers, one of whom said:

> *"We were being very proactive so that the Modernisation Agency didn't need to come and bring its own team in, which isn't what we wanted because we felt we could turn things around ourselves. We didn't want*

a team coming from outside, so we took the role on internally to make sure that things got turned around." (14:74)

Function of the PDT:

The PDT client manager stated that senior managers of the Trust requested skilled, 'hands on' staff to help the Trust, rather than the provision of training sessions. There were two different perspectives on the function of members of the PDT. Some were not viewed as very effective by several senior managers and clinicians within the Trust. They were seen as staff who did not have adequate expertise and skills, did not spend sufficient time within the Trust to understand the system, and they were thought to not to be 'hands on' staff. One interviewee criticised staff who came in on a one-off basis and gave their views or opinions (one-off diagnostic) on how the Trust's staff should do their jobs. He believed that such a short 'diagnostic' relationship rarely resulted in performance improvement and, even if it did, it would not be sustainable because behavioural change could not be embedded in such a short time. One interviewee argued that the PDT brought in nurses from the Modernisation Agency in order to facilitate change in A & E, but it seemed that the nurses were not helpful and the changes superficial. He added that neither nurses, nor the Trust, knew how to translate these suggestions into changed behaviour. For example, it was not clear whether to team up, do a ward round every day, or do proactive discharge planning. It was said that they presented general solutions in order to solve the problems without understanding what the problems were. This was not welcomed by the Trust, and some clinicians in particular responded in a less than positive way.

"I think there were a number of performance improvement assessors and teams in but clearly they were not effective. Now, in my judgement, they were not effective either because the people that came here were not terribly effective or, more likely, I think there are flaws around that one- off hit and I think it's something to do with the continuing relationship which is both facilitating and challenging and I think you're more likely to combine facilitation and effective challenge with a continuing relationship." (26:124)

"I think there were certain individuals [members of the PDT] who they felt came in and were supposed to do a job but maybe didn't have the skills or the understanding of the system before they could change it and didn't have the time to spend getting to know the system. So in some aspects they were welcomed but I think there were others where someone was supposed to come in and help but actually all they did was make the consultants angry or upset staff who were already upset, so I think the timing had to be right or the input had to be right and in some cases that wasn't the case." (8:127)

> *"We had an emergency care collaborative, we had an action arm, we had quite a few visits from the Modernisation Agency saying, what can we do to help you? But in actual fact, in terms of feeding them where you're up to, that consumed an awful lot of time, we didn't necessarily get the same benefit from them." (23:62)*

In contrast, one of the PDT members was perceived by both internal and external interviewees as an effective and supportive individual who focused on A & E and the discharge process. He was a consultant who had a medical background, was Deputy Medical Director in his own Trust at that time, and also had experience of working with other trusts as a member of the Winter Emergency Services Team, to help the trusts to achieve performance improvements in their emergency departments. Several participants reported that he was an enthusiastic and realistic individual who did not try to solve all the problems at once and spent an adequate amount of time (2 to 3 days a week) observing and gaining an understanding of how the services operated and listening to the staff, rather than just suggesting what they needed to do. The participants considered that that PDT member had relevant experience and skills and was the right person for the job.

Some interviewees reported that certain clinical directors were not willing to collaborate with him, but he identified those clinicians who were keen to cooperate and had a sense of the importance of the star rating for the organisation, whether they had signed up to it or not. The external consultant clearly placed emphasis on the role of those clinicians and stated: "We focused really on those individuals". The external consultant was working in the Trust for 18 months and he believed that the continuity of that relationship helped him to collaborate more effectively with clinical directors, arguing that performance improvement was fundamentally about changing behaviour and attitudes and that it required a better working relationship. He felt that an organisation needed to have a sense of local ownership of the issues that needed to be changed, in order to sustain those changes once the external improvement team exited the organisation.

The external consultant also explained that, during the first stage, he confronted the Trust's clinicians and managers about their own data, which demonstrated their problems, and then it was necessary to find ways to change behaviour without causing revolution in the ranks and unhappiness and tension. He reported that he tried to compare the function and behaviour of certain clinicians and their job descriptions and the resulting comparison revealed that they clinicians did not follow their job

descriptions, especially on ward rounds and when discharging patients. Rather than using a daily system for discharging patients, clinicians chose to use only two days per week. This system was perceived as a cause of bed blockage. The external consultant was reported to have raised the problem and tried to translate its recognition into changes in clinical behaviour. That would help eliminate the problem and provide a performance framework to sustain possible solutions. He argued that it was difficult to challenge the clinicians' belief system on a day-to-day, collegiate, on-going working relationship, because they wished to avoid conflict. He stressed that if the clinicians' belief systems were to be challenged it had to be on quite an evidential basis and should be carried out by an individual who knew how the clinicians behaved. He perceived himself as an individual who had those characteristics, and this was a significant help. He added that the clinicians in the Trust accepted him, as he was seen as a clinician who had made changes in his own organisation in terms of performance improvement. He saw his role as a challenging facilitator, encouraging people to implement change. In contrast, one of the Trust's consultants was negative about the discharge plan introduced by the external consultant, believing that it had affected the quality of care.

> *"I can only presume that, firstly, they have found me helpful and, secondly, the style I use is challenging but doesn't create revolution, but I am quite forthright and capable of confronting difficult colleagues with very rigid mindsets and trying to explore ways in which they might be prepared to contribute, in a kind of corporate way, to improve the quality of care that patients receive." (26:116)*

One of the A &E senior nurses stressed that the external consultant had an important role to play in helping the department to achieve the 4 hours target by presenting innovative ideas, engagement of staff and in particular clinicians, and encouraging staff ownership of the target. She stated:

> *"When he (external consultant) started to look at how the Trust was going to achieve the 4 hour target because at that stage we were a long way off it, he was very good at pulling everybody together and involving everybody. You know, there was a lot of reluctance from a lot of people who didn't feel A&E 4 hour target was their problem at all and they didn't see how they needed to contribute to it. he was very innovative and had a lot of ideas [...], he was very inclusive again and wanted people to participate" (33:71)*

PDT exit from the Trust:

The contract between the PDT and the Trust was for 6 months, in the first instance, but the PDT client manager realised that they did not need to renew the contract as

the Trust did not need further support. However, the Trust was willing to continue to collaborate with the external consultant on A & E issues and the discharge process. Some interviewees reported that the ultimate test of the external consultant's success was for the Trust to request he keep collaborating with it for longer than the period of the original contract.

iv) Role of the PCT

There were controversial views on the role of the PCT in the turnaround process. A senior manager of the PCT believed that it helped the Trust particularly through demand management within primary care. However, she added that there was a mixed relationship, because probably the PCT was seen by the Trust as 'a bit of nuisance' but they needed the PCT, as they knew it could help them with matters such as the process of patient referral, booking targets and choice. A Trust manager also emphasised the important role of the PCT and how it affected the performance of the Trust and she said:

> *"Obviously a lot of what we [the Trust managers] do is dependent on what happens in primary care, so they will be feeding things into it and there are joint responsibilities with primary care, it's dependent on what happens in primary care as well." (14:58)*

Some interviewees saw the two different roles of the PCT as including monitoring the performance of the hospital in order to make sure the that Trust was doing as it had said, and introducing changes were necessary in Primary Care and had an impact on the Trust's performance. For example, one of the problems confronting the Trust was the large number of patients attending A & E without referral, or that GPs referred to the Trust. It was argued that the PCT had different strategies for reducing referrals, such as providing greater and faster access to GPs and making the walk-in-centres more effective. Those were areas in which the Trust was reportedly willing to work with the PCT, because it left the Trust with more time to focus on real emergencies and specialised care. The Trust managers affirmed that there was a good working relationship with the PCT, and that an improved partnership had developed between the PCT and the Trust, which had gone from traditional performance management and a contracting role into a more collaborative arrangement. However, a trust senior manager stated that the PCT had not given sufficient consideration to the patient overload occurring in the Trust.

In contrast, certain Trust managers believed that, although the PCT was involved with the Trust, it was not particularly helpful because the PCT was fairly new organisation trying to become established and it could not help the Trust by reducing patients referral and facilitating the discharge of patients. For example, one reported that the PCT closed a walk-in centre to save money, without considering its affect on the hospital's A & E Department. In addition, a Trust manager did not have very positive view of the PCT's role as she felt they were setting unrealistic targets and expectations for surgery, from the governance point of view, when the new community hospital was opened at the old hospital (hospital B). She added that it seemed 'they don't live in the same world as me".

7.4 Unintended and dysfunctional consequences of turnaround interventions

A range of unintended and adverse consequences of implementing turnaround interventions were believed to have had a negative effect on the organisation and on service delivery to patients.

Pressure and stress perceived by staff due to high level of workload: Almost all interviewees stressed that staff had come under a high level of stress owing to the pressure of a high workload and continual change in order to achieve the performance targets. Staff reported that they were still under pressure to sustain the Trust's performance at a high level and to achieve the next target, which was obtaining Foundation status. Furthermore, they argued that the targets set by government and also by the Trust, were becoming more stringent and difficult to achieve. For example, it was reported that the Trust achieved the CNST Level 2 (The Clinical Negligence Scheme for Trusts), despite the fact that it was difficult to reach. The improvement was appreciated by the CEO but then the CEO expected achievement of CNST Level 3, which meant that there was constant pressure on staff to continuously improve their performance. The matter had caused serious concerns about staff morale, especially staff working in clinical areas such as A & E. Even staff at a junior level reported that they were not sure how moving from zero to three stars was relevant to them, or what difference it had made to them, apart from putting them under constant pressure to achieve targets. Staff were reported to have left the Trust due to this high level of pressure.

"The expectations will continue to grow and so all of the standards we've been measuring ourselves are going to get tighter and so how does an organisation continue to deliver against that background? Very, very difficult." (22:186)

Some middle managers reported that several posts were not filled when the staff took maternity leave or were being seconded, as the Trust was working under a financial recovery plan and other staff needed to work harder to cover the gaps. Some middle and junior managers said that they were under enormous pressure from senior management to achieve their targets, and that it had caused a high level of stress for them, which they inevitably transferred to those working for them. The nursing staff also highlighted the high degree of pressure related to the retrenchment and cost control strategies (detailed in section 7.2.2.). An executive member of the Board argued that it was a 'pressurised' system within which the staff were dealing with an increasing number of patients who were very sick. Senior managers believed that a certain amount of pressure was inevitable when trying to turnaround poor performance, particularly in the first stages. On the other hand, middle managers believed that the level of pressure imposed upon staff below them at organisational level should be reasonable; otherwise they were not able to work properly.

"There's consistently this hill after hill that you've got to try and climb over and I seriously don't think you can maintain that for much longer than a couple of years " (24:118)

A high daily workload causes staff to loose their protected learning time, which means that the processes of staff development and training are affected adversely.

"You can't make people fill these things in, they are under enormous pressure in their day job and I think they also have probably not enough time; there's not enough protected learning time." (7:77)

The results of staff satisfaction surveys did not show any significant difference in satisfaction between the time that the Trust was rated as zero star (2003) and later on three stars (2004), though in general both surveys presented satisfactory results. Two senior managers of the Trust said that these results might echo the notion that the staff were under pressure, but another executive member of the Board stated that the results of staff satisfaction survey did not show the real picture owing to difficulties in measuring such a complex issue . On the other hand, some interviewees, particularly senior managers, noted that staff were proud of their achievements and their attitude towards their organisation was positive in terms of developing and improving

services. They reported that the staff accepted the pressure because they thought that the Trust was moving in the right direction in relation to improving its performance.

> *"But, you know, you are more confident to go out and say actually this is a great place and this is what we're doing. So I think it's been a real boost to people like winning the [name of award] performance award last year." (12:55)*

Several staff, especially those at junior level, reported that the Trust's senior management team rewarded the staff's attempt to assist in gaining three star status by giving them each a box of chocolates. They felt this compared unfavourably with another Trust in their area that had given its staff an extra day off when they had achieved three stars. He added that the staff perceived that they were not rewarded enough for the level of time and effort that they had shown, causing them to feel demoralised.

Tunnel vision and impact on quality of patient care:

Several interviewees, both clinical and non-clinical, highlighted that the focus of the Trust was on the measurable targets during turnaround, and a large amount of time was being spent on details of individual patients in order to move targets forward (e.g. waiting list targets). This left very little time to look at softer and more qualitative aspect of patient care.

> *"There are many critics of the targets and I don't feel that I'm a critic or a fan. I think they've changed the way we work. I feel that they've been positive at making improvements towards the NHS plan. But I think there's been a price to pay for that and I think that in some cases the price to pay has been the quality of care that patients receive. The quality of care that patients receive and I'm not really a fan of that. I feel that's not good." (39:150)*

> *"But the clinical teams feel a number of issues are being sidelined and ignored because of this concentration of effort and time on target achievement. Now, target achievement as well as taking us from zero stars up to three, can't argue with that, but it's at what cost and I think that is where a number of clinical teams including myself have an issue." (42:22)*

> *"Now it seems very split, it seems very, very competitive, people seem quite frightened of any innovation, much more focused on the targets as opposed to the patients and sadly at times it seems that the patients get in the way of the targets, whereas it should be the targets are there for the patients but it actually seems now that patients get in the way of the targets really." (20:23)*

For example, most 'clinical' respondents (clinicians and staff working in the wards) highlighted two negative side effects of focusing on the 4 hour A & E target, relating to patient care. Firstly, the interviewees believed that, as the Trust's managers proposed not to breach the 4 hour A & E target, an attempt was made to try to find beds for patients waiting in the A & E Department, even if it meant sending them to an inappropriate ward and transferring them later. These patients were reported to have been admitted to wards that may not have been equipped to cope with their conditions and whose staff were likely to have insufficient skills and knowledge to understand them. Some interviewees stressed that, when staff were under a high level of pressure, needing to make decisions more quickly and work faster, the process of appropriate patient care may be adversely affected, increasing the probability of the occurrence of errors (e.g. risk of being given wrong medication and risks associated with moving patients). The staff at the ward level stressed that they were distracted by middle managers, particularly bed managers, trying to provide beds for those patients. It was reported that sometimes the ward staff did not allocate beds to elective patients in order to accommodate patients from the A & E Department. A consultant reported that this led to a non-productive workload and demoralisation of staff.

> *"That can be a problem really because as I say, this is a cardiothoracic surgery ward and we find when we have empty beds, this is the big change you mean from a few years ago really, because of the targets in A&E the 4 hour wait and that type of thing, we find we get a lot of patients that aren't our own, such a variety of patients in fact at the moment." (36:98)*

> *"Wards continually feel they're being harassed and bullied into making decisions that clinically seem unsafe" (29:41)*

Secondly, clinical staff reported that managers asked them to maintain a higher turnover of patients in order to free up beds for emergency admissions and also to meet the waiting list targets for surgery. The staff felt that the patients were being discharged sooner than they should be, and that that was not satisfactory as some of them came back to the Trust because their care had not been completed.

> *"From time to time some people have been discharged too soon and that isn't good care. I'm sure they won't appreciate the fact that they've been discharged too early but we're doing it because if we don't do it we can't get the patient from A & E into a bed and it's a very dynamic system." (39:81)*

> *"I think probably again one of the biggest things that sticks in my mind*

that became obvious this year really is the A & E 4 hour target has had a real knock on effect on discharge and people being sent home before they feel they've got adequate support and then being re-admitted." (20:111)

An interesting point, raised by a senior executive, concerned increasing the admission rate of patients who wished to come to the Trust after it had successfully shortened its waiting list and met its four hour A & E target. He reported that patients preferred to come into the Trust straight away for minor problems to be dealt with, rather than go to their GPs, because they had learnt that by doing so they were not going to have to wait for more than 4 hours for attention. It was perceived that the success of the Trust had an impact on its A & E workload, which increased demand for extra services in other units such as x-ray and clinical laboratory services. He reported that the senior executive team now took such issues into account when planning new developments.

"We seem to be getting higher numbers of patients, as well, because they all know that they're going to be seen within the 4 hours, so sometimes it feels like, we'll go to A & E because we know we'll soon get sorted out within 4 hours, not 12 hours or a day like they used to be." (35:45)

Some interviewees reported that the the government's emphasis on the importance of targets and monetary issues caused staff, and particularly doctors, to think more about the cost of services, the amount of money that they spent every year and its impact on the organisation.

7.5 Facilitating factors

A range of factors were perceived as key elements that facilitated the Trust's turnaround:

Impact of receiving a zero star rating

Several interviewees reported that the zero star rating achieved by the Trust and other negative external reports about its performance helped stimulate the processes of change and turnaround. Both senior and junior staff believed that the Trust should not have been rated as a zero star organisation, but that such a low rating did provide the staff with the incentive to improve the situation. One interviewee stated:

"I think in some ways that external view actually did galvanize people internally." (15:55)

Impact of new management team

Most interviewees, including those from external organisations, viewed the new management team as having a positive effect on the success of the turnaround process. Strong leadership, exhibited by the new management team, was highlighted and many had a very positive view of the composition and balance of the Board.

> *"I think there is a very committed Director of Operations I think there were also some very good people in the team around that particular aspect of managing this organisation." (26:100)*

> *"I think strong leadership has really been the key to us moving from 0 to 3 as far as the senior team go." (27:134)*

Communication improvement

Interviewees at all organisational levels, believed that the communication within the organisation had improved and was a factor in helping the Trust to improve its performance.

> *"The biggest factor in helping us improve was changing the executive team and communication those two things have definitely been a boon to us." (25:192)*

> *"So, the factors for me are just the amount of information we're now cascading to all areas. You know the waiting list clerks for instance, they know the rules, they know how long patients can wait, before they just used to book them in."(44:71)*

Role of the action plan in developing clear lines of accountability and ownership of performance issues

Having created lines of clear accountability over the period of the turnaround process (explained in section 7.2.1.2), staff felt that ownership of the problems and responsibility for change were in place. In addition, a very clear reporting and measurement system had been defined for each issue and that was viewed as a facilitating factor.

> *"You've got to identify the people who are going to carry out the actions to the people that are permitted to the action that is theirs to do or be made to committed to do it in a performance way and then be carefully monitoring it. So individuals with dates that's to be completed by and you're to monitor it and make sure it's done." (18:269)*

Focus on targets

It was reported that there was no history of communicating the importance of key performance targets throughout the organisation and that 'cascading of information' helped the organisation to move forward.

> *"So we were quite clear what we were doing, where our focus was, which indicators we were looking at, what the processes we're trying to address because otherwise you can try to do everything and you just fail again." (23:48)*

> *"The management keeping on top of them, because it's all to do with the targets really, that's why you get three stars, so it's keeping on top of that, I think that's definite. I wouldn't say communication, I'd say somebody at the top or the middle making sure that you reach the targets." (31:263)*

Focus on performance monitoring and management

Several participants reported that the regular performance monitoring of divisions in relation to financial performance, HR indicators and quality issues, although it increased workload and pressure, helped the Trust to track fluctuations in the performance of the divisions and provided adequate time in which to sort out the problems. The senior management team, and particularly the Director of Operations, viewed information management as an important factor, in the provision of structured and timely data. Middle managers also stated that the data had become more accessible and accurate. It was reported that the Trust Board had been informed about the performance of the Trust in a very detailed performance report and that this kind of consistent information kept them aware of any trends and deviations. However, some staff, particularly middle and junior managers, suggested that such intense monitoring of performance may not be required in the long term.

> *"I have to say, whilst I find it [tight performance management] discomforting, which I do, it nevertheless has achieved our turnaround, so was it right? And the answer is, well it probably was." (18:237)*

> *"I think looking at the 2 years that I have been here I was surprised at how far we were able to go with the very specific aggressive management individual patient level detail and forcing it the system, it didn't feel comfortable but it did actually achieve what it was intended to."(24:92)*

Organisational restructuring and internal working relationship

Organisational restructuring (e.g. the change in several divisional and clinical directorates) and the development of new units and wards (e.g. discharge unit, CDU

unit) were viewed to facilitate the performance improvement process by helping to free up acute beds.

Development of open culture

Most interviewees argued that a significant factor in helping the Trust's performance improvement was the development of an open culture. It was reported that staff no longer 'sat on' problems and that the performance concerns were being openly reported and discussed. Staff at different levels highlighted the fact that individuals were now willing to share more information and were more communicative with each other.

Committed staff

Senior managers reported that the commitment of staff helped to move the organisation forward. One expressed the opinion that the staff were working with the management team in a positive way rather than seeking to resist or undermine the required changes in working practices. It was also noted by senior managers that doctors and consultants working in the Trust were helpful and keen to support the management team during the process of change. This was regarded as a very positive factor that many senior managers had not experienced in their previous organisations.

Development of better clinician-manager relationships

It was reported that the Trust senior management team was keen to engage clinicians in decision making processes. An executive member of the Board noted that the most significant thing that the executive members of the Board did was gaining the confidence of the consulting body, and then being clear with them about the Trust's priorities. The new management team included key clinical consultants and encouraged them to get involved in contributing to the solution of problems. For example, clinicians were invited to be involved in the negotiation processes of developing targets for the local delivery plan, introduced by the Department of Health. They were given the opportunity to contribute and negotiate in the development of targets for policies (e.g. transfer of some activities from secondary to primary care). This was seen as a new process, as previously they had been given targets rather than taking part in developing them. A senior manager felt that the consulting body worked more flexibly in the change process because they saw that the new management team was concerned not only with financial issues, but also about

the quality of patient care. Even a senior manager from the SHA, believed that the incoming management team developed a new internal relationship, focusing principally on the relationship between managers and doctors. Several interviewees maintained that the younger consultants were more willing than older ones to align themselves with the targets and engage openly with the management team.

> *"I think probably one of the most important things was getting some of the clinicians to become opinion leaders and champions of change." (26:104)*

> *"I think clinicians realised they couldn't work in their little boxes any more they had priorities and targets to meet. I think that managers realised the same and people started to work together more, be more open, you know, I'd say those were probably the main things." (28:147)*

A clinical director supported better clinician engagement from the senior management team and stated:

> *"When you make a decision that is unpopular for Chief Exe and Chairman to invite you to the office to discuss it. So it makes me feel that I am being acknowledged, so I feel as though I'm a player in a good team and I hope that will grow and ideas like how to reorganise the hospital and the Chief Executive asked me how would you reorganise it and I said well you need accountability, you need theatres, it may not happen but at least I know I've made effort to give a clinicians view. So I think the fact that there is good dialogue, which is constructively critical." (38:37)*

Role of the external organisations

Some interviewees stated that the external organisation had had a positive impact on the turnaround process. For instance, there were positive views about the latest CHAI report, which provided clear guidance for the executive team. As reported above, the guidance and documents from the government (e.g. the NHS Plan and 10 high impact changes provided by the Modernisation Agency) helped to clarify the Trust's strategic direction. The role of the national audit programme in bringing staff together, increasing multidisciplinary working, and raising awareness of issues, was also seen as a facilitative factor by a few interviewees. Some regarded external medical consultants, recruited by the PDT, as helpful agents in recovering A & E targets. The role of the SHA was also significant in the turnaround process as it used a closer performance management system, which provided more support and improved working relationships. The SHA also effected changes at senior management level. However, some interviewees reported that these external reports (CHAI, the SHA report, and National Audit report), on their own, did not enable the Trust to achieve three star status.

Development of external relationships

Some participants expressed the opinion that better relationships with external organisations at local and national level, and trying to work in partnership, ensured the Trust had more support, particularly in times of difficulty. One of the executives indicated that the development of a wide working network across other organisations played an important role in the success of the Trust. It was also emphasised that the Trust was willing to extend its working relationship with the local university, and particularly the medical school, to increase the extent and quality of the medical research conducted in the Trust.

Focus on Human Resources Management

Focus on human resources management was seen as a factor that contributed in performance improvement. Some interviewees, particularly junior staff, viewed it as a facilitating factor in legitimising training and allowing staff to attend training.

Change in external environment

More focus on performance measurement, improvements within the public sector and presenting more tools to assess performance and conduct audits were provided by central government, making more opportunity for the senior management of the Trust to use these tools in order to evaluate their performance improvement.

> *"We just had more tools, you know, the Government had given us more tools and the Trust executive were using those tools and asking us questions and that was good and so that contributed really to the shift." (28:51)*

7.6 Hindrance factors

i) Insufficient resources

Financial issues: In the Trust, the size of the financial challenge, particularly the historical financial deficit, was perceived as a very significant barrier to progress because improvement in some areas (e.g. day case surgery services) needed financial investments which were not forthcoming. The financial issues were viewed as a significant barrier which had an impact on sustaining performance improvement. Some interviewees also reported that although the Trust had improved its operational performance, in some areas there was no financial rigour, so a more rigorous approach to the management of financial resources was necessary.

"The biggest obstacle to making really good sustained progress is money." (39:141)

"Cost has been a very important and significant factor, money is always leading. It's a big driving force for being here and clinical services are very much affected by financial issues. In the last couple of years that seems to have got worse rather than better, even though we achieved 0 to 3 stars in one year". (17:15)

"We're looking very actively both from an SHA point of view and a Trust point of view at improving day case surgery figures, but it needs to have money put into it. You can't just change services with the same facilities. with the same equipment, we have problems about." (47:59)

Inadequate number of and increasing demand for beds:

Several interviewees stressed that the bed requirement was always an important issue affecting the ability to meet key performance targets, relevant to the star rating. The bed occupancy of the Trust was very high (about 97%), leaving little slack in the system. Some interviewees reported that an increase in the number of patients attending the A & E Department (more demand) or were referred to the Trust, exacerbated the situation.

Information Technology issues (IT issues):

Some interviewees reported that, although attempts had been made to improve the IT system, the current system was not able to satisfy the needs of the different departments. The IT system was viewed, by some interviewees, as limiting performance improvement. For example, they reported that, if this new system could not generate appropriate and timely data with regard to the core business of the Trust, required by the "Payment by Result" policy introduced by central government, the hospital would face difficulties in generating sufficient funds.

"We don't have IT, so all we're doing is a paper trail so we don't have the ability to be proactive; we are reactive to meet government or local pressures." (38:13)

High workload and lack of time:

Certain participants emphasised that staff were under enormous pressure owing to the high workload required to complete their daily tasks and meet the performance targets. As a result, they may have suffered from a lack of enthusiasm and a shortage

of time (particularly insufficient protected learning time). This may have affected sustained performance improvement.

> *"They're [staff] already dealing with as much as they possibly can, so realistically you can't give them more and just expect them to do it." (24:102)*

> *"I don't think any hindrance (in terms of managerial and organisation factors) really other than probably time to do certain things, you know, there are things that I would want to introduce and develop within my role and it's just that I haven't got enough hours in the day." (33:199)*

> *"we [ward managers] have the team briefs that are done on a monthly basis but it's getting the time to go to meetings away from the ward, you know, when you're needed on the ward it's very difficult. I don't have any spare time especially when you're short staffed and it's a busy environment." (30:63)*

ii) Poor partnerships between the Trust and other relevant organisations:

One of the barriers, an issue indicated by the Trust's managers, was the level of dependency of the hospital on external organisations for several areas of their performance. For example, an executive member of the Board reported that the Trust's discharge arrangements were very much dependent on the PCT and Social Services, and beyond the control of the Trust's managers. When they were not able to transfer patients, it caused bed blockage and delayed the patient flow. Two external interviewees pointed out although the Trust had developed its relationship with external organisations, it still suffered from insularity and external relationships should be better developed.

iii) Impact of continuous change:

The pace of continuous change was pointed out by both internal and external interviewees, as the main barrier to performance improvement, as it caused difficulties for staff in maintaining their motivation to improve matters. It was argued that the system needed a period of stability, although it was thought this would be difficult for the Trust. Constant change, for example, as a result of the Trust's proposed application for Foundation Trust status, would involve a great deal of effort and even more changes, not ideal conditions for stability. In addition, the 'cut off point' used to assess targets are changing every year, which makes them harder for the organisations to plan to meet.

"People say lack of resources but I would guess management of change, battle fatigue, too much change at once. I would say battle fatigue more than resources, resources come second." (16:143)

"So maintenance you can maintain what was the base line to get to 3 stars, so it's not only maintain that but work even harder because the waiting list targets have gone down, 4 hour targets have gone up, so I think that has been one of the more stressful things because it's having to do even more. So there's been no period of almost like stability, it's just been work harder." (14:123)

"The problem is that there is no sustainability because everything changes, so like A&E the target is different than it was last year so they sustained last years performance, try to improve to reach this years but I suppose there's only so far you can go before the system is as perfect as it can be but still can't deliver it and I think that's a problem in the NHS, we never sustain because what's the next thing, there's always continual improvement, so my frustration is my star rating indicators are never the same year after year, they change, you know, there's two drop off and another three come in or three drop off and you get two completely new ones that you didn't have any idea about and at least in a hospital I think they stay more or less the same but it's the measure that changes." (8:173)

iv) PFI agreement issues:

Some interviewees (both clinical and non-clinical) viewed the PFI agreement as an important factor that can affect performance improvement and the standard of services. They believed provision of service through the PFI scheme to be more expensive. Several interviewees reported that the whole PFI project was not well received by staff, as they believed it was not good value for money and that the PFI partner was only looking for profit. The Trust's managers were reported as having less expertise in writing detailed PFI agreements than the PFI managers. Consequently, some important issues had not been dealt with, and when things were put into practice, problems were caused in the routine work of the hospital. The PFI was seen by some of the Trust's managers, as being more complex in terms of setting up the concession agreement and monitoring arrangements. Some found it odd that the PFI partner was monitoring its own performance and reporting it to the Trust, which meant that the Trust usually received a perfect performance report from them. Invoices were sometimes sent to the Trust for work that the PFI partner perceived as extra work and that again increased the cost of the services provided by the PFI partner. Two participants argued that if they were to do it again it would be probably be done differently.

"It's been absolutely cast-iron proved without any shadow of a doubt that PFI is more expensive and it's completely unjustifiable. But, operationally it's a disaster and financially it's a disaster [...] they have just got one thing

on their minds and that's to maximise their profits." (2:66)

"I think the PFI area is a problem because we can't control it, managers can't manage it, you have a third party doing your work and they're in it for profit, they're looking at what the agreement says, they're experts in handling contracts and agreements, whereas the people on the NHS side don't necessarily have these skills and the staff who implemented PFI, a lot of people who were involved at a high level have all gone, they've been replaced by other staff who are not familiar with what the content of the contract was, so we're not quite sure what services we can expect from the PFI partners and if you want anything else which is out with that contract, the Trust has to pay early and sometimes you can't even get it done. But there are restrictions that you can't bring outside contractors in for certain things because the PFI won the rights to provide that service. In fact we're [staff side] *not even sure what agreements we have entered into with the private companies, so we feel we're being misled and deluded somewhat" (40:135)*

v) High level of micro management:

Several interviewees, particularly middle managers, stated that senior managers had used a high level of micro management when the Trust had been rated as a poor performing organisation and, even after it had gained three stars, micro management was still being exercised (although the middle managers stated that this had recently been reduced). They viewed this tightened managerial control as a source of increased stress and pressure, which interfered with effective operational management and sustaining performance improvement. Even an executive member of the Board accepted that they should not be involved in that level of detail, which distracted them from focusing on strategic issues. The divisional managers stated that they would like to have boards, within their divisions, in order to run things autonomously on the basis of an agreed system of reporting to the executives.

"If you try to run at that sort of level of intensity for more than a couple of years, you're going to have operational difficulties." (24:110)

"The executive team are there for a purpose, they're there to manage the Trust as an entity, not to micro manage each individual specialty and basically they should keep their hands off because it can be very disruptive to have a member of the executive team telling you how to do things. They're hindering us because we have to justify why every single decision is made and, you know, sometimes you make a decision that the executive team aren't going to like, but it's for a reason." (25:178)

On the other hand, several managers stated that they were aiming to put in place an organisational development programme to encourage more team working and delegate power to managers of clinical divisions. However, they believed that the

system still should be monitored carefully, and from a distance, to prevent any future drifts in organisational performance.

> *"I think that probably the time is right now to delegate control to the operational teams to give them more autonomy and more lateral ability to be creative and to come up with new options for sustaining and achieving progress. I think that time is now. But I would do that with caution, in the sense that, yes, we've passed control on but we need to in parallel increase monitoring and accountability because those controls will become incompletely ineffective if we fail to drive accountability through that. Because the way the NHS works if we pass control to lots of people and then stop the monitoring then they will not get half [the work] done. You'll lose performance in my view anyway, because there'll be so many other different things being priorities that you'll lose control of it. So it's almost like for me that the transformation of the leadership is to be done in parallel." (39:53)*

vi) Policy change:

The interviewees noted that the introduction of several new national policies such as 'Patient Choice' and 'Payment by Result' were likely to affect the performance of the Trust because of the increased competition within the NHS. It was reported by both internal and external interviewees that the changing policy context in which NHS organisations were now performing, might affect the performance improvement of the Trust over time. Interviewees placed strong emphasis on recent policies: 'Patient Choice', 'Payment By result (PBR)' and 'Plurality of Provision' as factors likely to affect the performance of the Trust. It is necessary to explain briefly the above mentioned policies in order to clarify why the Trust's managers considered the impact of those policies on their performance.

Payment by Result introduced a significant change in the financing of acute hospitals, reflecting the market oriented reform established by the Government for the NHS in England (Mannion and Street, 2006). The aim of Payment by Results (PbR) is:

> *" to provide a transparent, rules-based system for paying trusts. It will reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity and adjusted for casemix. Importantly, this system will ensure a fair and consistent basis for hospital funding rather than being reliant principally on historic budgets and the negotiating skills of individual managers. Under the reforms to NHS Financial Flows, instead of being commissioned through block agreements as previously, hospitals (and other providers) will be paid for the activity that they undertake; so Primary Care Trusts (PCTs) will commission:*
>
> *the volume of activity required to deliver service priorities, adjusted for casemix (i.e. the mix of types of patients and/or treatment episodes)*

> *from a plurality of providers on the basis of a standard national price tariff, adjusted for regional variation in wages and other costs of service delivery." (DoH, 2004)*

The PbR encourages health care providers to increase their activities, as by so doing, they can increase their revenue. The Government proposes to implement the PbR to pay for 90 per cent of inpatient, day case and outpatient activities (Mannion and Street, 2006).

According to the Patient Choice reform, patients should be given more choices to decide about how, where and when they want to receive care from the NHS. This policy provides the opportunity for patients to choose from between four or five hospitals or clinics for elective procedures. The "choose and book" policy, which is a national choice scheme, enables patients to select a specialist in a hospital that they have chosen and book their outpatient appointments electronically using a booking service (DoH, 2005). As reported above, the national tariff is the basis for the calculation of the cost of services, so the NHS commissioners are not faced with a greater level of cost due to the introduction of patient choice. However, the NHS providers are likely to be at financial risk because it is difficult to predict their income, which means they may not be able to meet their financial targets or provide sufficient income to complete their service development plans (Plumridge, 2005).

Plurality of Providers places emphasis on a "mixed economy" of public and private sector healthcare provision (Plumridge, 2005). The Department of Health has tried to encourage the NHS to make contracts with the existing UK independent sector (private and voluntary sectors) in a more planned way, in order to use their spare capacity (DoH, 2004).

Some interviewees argued that health services management is going to be more complex in five years time, because the environment is likely be more volatile and unpredictable owing to the government's introduction and implementation of market based reform. NHS organisations, as a consequence, may face financial instability and uncertainty. More competition between healthcare providers, particularly with the private sector, was predicted by the interviewees and they noted that organisational failure might come to the fore over the next few years because not every current NHS CEO and team of directors will make the transition from where they are now to where they need to be in five years time. As a result, the need for the development of teams of staff who are experienced in turning around crisis situations seemed a necessary provision for the future. They believe, there will be associated costs and unintended

political consequences for the government of the time, as governments will implicitly accept that such a team is needed because more failure will occur.

> *"I* (an executive member of the Board] *think with choice and with the independent sector coming on-line this year, again you're not quite sure where your organisation is going because 20% of activity could maybe moved down to it, so I guess they'll still be an element of focus of what direction are we going in" (21:171)*

> *"That is a massive risk for us now with Payment by Results because we cannot expand into dusty unused dilapidated wards if we decide we can do things and earn money we simply cannot do that on this site, we've no way to go." (2:42)*

As a consequence of the introduction of these policies, there was a consensus among interviewees, particularly managers, that the Trust should focus on improving efficiency and develop their activities especially in terms of day case surgery, so that it could compete with the other providers, particularly the private sector. It was reported that a private sector provider had invested significantly in the day case activities in the local area and that they were able to choose particular patients for activities it prefers to carry out rather than admitting patients with all kinds of needs, especially complicated cases. This situation was also noted by the interviewees as a reason for competition being more difficult for the Trust.

> *"The other things around are what do our other health care partners provide and then the competition from the private sector and there's a push around doing day care surgery now, we don't do enough day care surgery. So that's one of the areas that we need to improve, so if we do improve that, what impact does that have on the rest of the organisation?" (27:195)*

> *"You need to focus into those areas that can take the Trust forward into the future into the Payment By Results regime that we're going into and we need to focus on those areas like day surgery, improving the efficiency and literally high impact areas where minimum intervention can make maximum effort and that's an affect and literally drive those through to middle management. " (6:83)*

> *"These days of PbR, Payment By Results, everybody is acutely aware that if we don't perform against contract then we don't revenue. We don't get revenue then we can't do what we want to do, we can't develop service. So our service development and our establishment of service are all dependent on the revenue. If we're seen to be not achieving and we don't achieve then we can't develop because we don't have the revenue to back that up." (25:41)*

On the other hand, some managers reported that the PbR systems would increase involvement and engagement of clinicians and managers in meeting targets, as both know that income will be generated by increasing activity.

"The whole income aspect is now becoming just as key really and it's essential that the clinicians are signed up to that [the PBR] and are fully aware of; OK they may be meeting their access targets however they may not be getting the income for some other reason and it's a matter of making sure they're all tied in together really. So I can definitely vouch for the involvement and engagement issues." (5:182)

The Human Resources Managers of the Trust raised an important issue concerning the impact of PbR on the staff and staffing levels. They believed that if the Trust was not able to increase its activities and if a proportion of its activities were transferred to other providers, the Trust might not need the number of staff currently in its employ. In addition, private sector providers may also offer a better working environment and remuneration than the Trust, causing staff to leave the Trust.

"So those are the sorts of things, not just around how these units are going to be staffed and the implications of that, it's also really what affects it has on our services and our provision of service and whether or not we will have the demand to need the number of staff that we've currently got because if somebody else is treating half of our patients, we don't need as many staff. So, [...] we don't know for sure, so all of these things are going to effect us, so what does that mean for our service and then what does that mean for our staff, so we've started to look at that." (27:190)

"That is a massive risk for us now with Payment by Results because we cannot expand into dusty unused dilapidated wards if we decide we can do things and earn money we simply cannot do that on this site, we've no way to go." (2:42)

"I think it will be interesting to see what [name] does and also I think with choice and with the independent sector coming on-line this year, again you're not quite sure where your organisation is going because 20% of activity could maybe moved down to it, so I guess they'll still be an element of focus of what direction are we going in."(16:171)

vii) Resistance to change:

Some interviewees reported that although there was greater clarity and understanding of performance targets and the level of clinical engagement was reasonable in the Trust, there were still some health professionals, in particular older consultants, who were resistant to change (e.g. reconfigurations in clinical departments) and showed little interest in meeting performance targets. It was reported that there was still some conflict between clinicians and the management team. In addition, staff, especially nurses who had been working in their posts for a long time, were unwilling to

consider new ways of working. Resistance to change was viewed as a key hindrance factor, delaying performance improvement.

> *"There was obviously a lot of resistance. In fact some of the changes, for example we take urology, as I mentioned as an example. Urology has a network between [name of hospital] and between the [name of hospital]. But some of the consultants still work at [name of place] in the community hospital. And they didn't want to move from [hospital B]. Now actually to run a service on 3 separate sites is from a managerial point of view, a nonsense. A total nonsense. It should be on one site, it should be; and there have been problems but the consultants don't want to know." (47:55)*

> *"there was quite a strong nimby culture amongst the medical staff here, you know, this wasn't quite my problem, you know, I [external consultant] do my bit and it's all fine and I can't see what I can do to help and again that's quite a common theme when you are trying to stimulate performance improvement, people don't actually think it's their performance that needs to improve." (26:28)*

viii) Lack of corporate identity:

Some interviewees, mostly middle managers from both clinical and non-clinical sides, believed that no corporate identity existed among different divisional directorates. It was reported that although middle managers were trying to avoid developing a silent mentality, circumstances made it difficult to take a wider view of matters.

> *"I think we all work a bit fragmented. Although we have team meetings, we all seem to be doing different things, we could work together more, communicate more and make sure that each other knows what they're doing and it's a uniform approach really." (31:167)*

7.7 Summary

This chapter presented the findings of the study in relation to the specific turnaround strategies used within the Trust and their impact on organisational functioning and performance. It was revealed that all three major turnaround strategies (reorganisation, retrenchment and repositioning – '3Rs') were being used by the Trust.

A range of reorganisation interventions were used in the Trust. The replacement of the CEO and other senior managers was perceived by the interviewees as most important intervention that contributed to facilitating a successful turnaround

process. The new senior managers were viewed as appropriate managers, who had sufficient experience to form a cohesive and effective senior management team. A detailed action plan was developed by senior management team within the organisation, covering all aspect of performance in order to demonstrate how improvement could be made in relation to the performance problems raised by different external organisations (e.g. the Audit Commission). The leadership style of the new management team, particularly in early stages of turnaround process was a directive, 'top down' transactional approach with a focus on building a robust and effective performance management system. This system was perceived as a key factor in improvement of organisational performance. Focus on Human Resources Management, strategy development, improving lines of communication within the organisation, internal reorganisation and restructuring were the most important reorganisation strategies used by the Trust.

The retrenchment strategy, as a generic turnaround strategy, was used within the Trust to tackle its financial problems. A detailed financial recovery plan was used to control financial costs (e.g. using a series of cost cutting interventions), provide cash flow and balance the Trust's financial status. The strategy was perceived as successful as the Trust was able to balance its financial books, however several staff argued that strict cost cutting had a deleterious effect on staff morale and harmed the quality of patient care.

A range of repositioning strategies was used by the Trust, when attempting to sustain long term performance improvement. The focus of reorganisation strategies were on the improvement of external working relationship, cultural change in terms of development of an open and learning culture, and extending services and modernisation in order to respond to the new market based policies (e.g. Payment by Result).

This Chapter also presented impact of external organisations (e.g. the PDT and the SHA) in the turnaround process. The Trust showed many characteristics of a 'self initiating' organisation which was able to initiate the turnaround process by itself. It was reported that the Trust was given the support and encouragement by both, the SHA and the PDT, for a self-managed turnaround and a regular monitoring was used by the SHA to evaluate performance improvement ('relational approach').

At the end of Chapter, a range of factors that were perceived as key elements that facilitated or hindered the Trust's turnaround was presented.

The next Chapter (Chapter 8) presents discussion and interpretation of the findings of this study in the context of relevant literature on organisational failure and turnaround processes.

Chapter 8 Discussion

8.1 Introduction

As outlined previously, the aims of this study were threefold to: i) better understand the causes, consequences and responses to organisational failure and the effectiveness turnaround processes in health care settings, ii) place the findings of the empirical study in the context of the wider literature on organisational failure and turnaround, and iii) draw lessons from both the literature review and empirical phase of study for the development of health policy, and management and the focus of future research.

The previous three chapters presented rich qualitative evidence pertaining to the symptoms and causes of organisational failure, triggers for change, and turnaround strategies used by the Trust and their impact on the Trust's performance and its staff. The aim of this chapter is to discuss and interpret the findings of the study in the context of wider literature on organisational failure and turnaround processes, presented in Chapter 2 (for-profit sector literature) and Chapter 3 (public sector literature), using stage theory as set out by McKiernan (2002). The findings of this study largely reinforce the results of the existing research studies in this area, but also raise some new issues and questions for further investigation. The lessons for the development of health policy and recommendations for further research are presented in the next chapter (Chapter 9).

8.2 Organisational failure

A range of symptoms, internal and external secondary causes of failure and primary cause of failure were identified. In line with the stages of McKiernan's model, symptoms and causes of failure explored in this study are discussed below.

8.2.1 Symptoms of failure

As outlined above, McKiernan differentiates between symptoms (the initial observable indicators of a problem in an organisation) and the causes of failure,

although these concepts are inter-related. As in McKiernan's classification of symptoms of failure, four different types of markers of failure (financial, physical, managerial and behavioural) were identified, in this case study. It should be borne in mind that the official perception of failure signalled by the star rating (zero star) was the most evident marker of failure.

Inability of the Trust to balance its annual financial situation and the legacy of a large financial deficit were important markers of poor performance which resulted in the Trust losing a star in the national performance rating over two successive years. These markers were also found to be the most important symptom in the majority of studies in the for-profit sector. In addition, Fulop et al. (2004) and Protopsaltis et al. (2002) found that these were the most common markers observed in their study of acute Trusts. Fulop et al. (2004) relate these markers to poor managerial leadership, which was also, highlighted by several interviewees in this case study. However, studies conducted in state schools in the UK did not report these markers as being of importance (Harris and Chapman, 2002; Wilmott, 1999; Harris et al., 2003).

Four different physical symptoms were reported by interviewees, including: inability to hit core targets, poor public and press image, poor working relationships with external stakeholders and a high turnover of senior managers. These findings are supported by other studies in the health sector (e.g. Fulop et al., 2004; Protopsaltis et al., 2002). It is important to note that poor external relationships should be treated as an important symptom because in the current context of the NHS, collaboration and partnership working across the whole local health economy is a key requirement of all NHS organisations. The Trust did not display two important physical symptoms (a high level of staff turnover and recruitment problems) identified in the literature from the for-profit sector (McKiernan, 202) and public sector (Fulop et al., 2004; Gray, 2000; Mannion et al., 2005; Eitel, 2002). Mannion et al. (2005) argue that ghettoisation is one of the potential unintended consequences of the star rating system which means that low performing Trusts may find it difficult to recruit and retain high quality staff. However, in this case study, despite some managers leaving the Trust, and attributed to the autocratic leadership style of the CEO, the organisation was still perceived by staff (especially clinicians) as a good place to work and Human Resources data did not show significant problems with regard to these issues. It can be argued that the perception of staff about their willingness to work in an organisation may not necessarily be affected, at least in the short term, by the level of their organisations' overall performance.

Employee distrust (particularly among staff who collected and reported waiting list data), internal conflict, and centralised decision making were perceived as key managerial symptoms of failure. The first two markers were also commonly reported in previous studies in the public sector (e.g. Fulop et al., 2004; Turner and Whiteman, 2005; Eitel, 2004; Wilmott, 1999). However, centralised decision making was seldom reported as being a problematic symptom and in only two studies (Fulop et al., 2004; Eitel, 2004) was it explicitly reported. One possible explanation for this is that some studies may have categorised this factor as a managerial cause of failure rather than a symptom.

Behavioural symptoms, identified in this study (low staff morale, ignoring and hiding problems, and blaming others for problems), were one of the most commonly perceived symptoms of failure by interviewees. These findings are congruent with the findings of previous research in terms of behavioural symptoms in both the for-profit and the public sector (e.g. Turner and Whiteman, 2005; Fulop et al., 2004; Protopsaltis, 2002; McKiernan, 2002; Slatter, 1984). A common behavioural symptom reported by almost all studies conducted in the public sector, was low staff morale. Low staff morale was due to several factors, including problems associated with an ineffective IT system, difficulties around merging of two hospitals and a general lack of support from the previous senior management team during a period of intensive organisational disruption (due to the scale and pace of organisational change and also changes in the senior management team).

Senior managers of the Trust, similarly, showed all the 'ignorance phases', 'blaming others' and 'information disguise', which McKiernan (2002) refers to as commonly observed behaviour of senior managers in poorly performing organisations in the for-profit sector. The Trust's senior managers had concealed and manipulated the actual performance of the Trust through purposeful manipulation of the waiting list data and had reported that the waiting lists were shorter than they actually were. In addition, when the problem became evident to both internal and external stakeholders, several senior managers had tried to abrogate their responsibilities and, instead, had blamed others. These patterns of behaviour are consistent with the four stage model developed by Slatter (1984), to explain crisis development. He claims that crisis is developed through four stages: crisis denial, hidden crisis, organisational disintegration and organisational collapse. Although, in this case, organisational

collapse did not mean a threat to the existence of the Trust, but receiving a zero star rating was perceived by most as a clear sign of organisational failure.

Fulop et al., (2004) categorise symptoms of failure into 'multiple' clusters rather than 'singular' events in their nine poorly performing English acute Trusts (detailed in section 3.6). Two main clusters were identified. They argued that zero star rated trusts usually represent cluster type 1 (such organisations are characterised as insular 'fortress' exhibiting poor media image, poor external relationships, low staff morale, high turnover and recruitment problems) and that organisations 'at risk' of failure more commonly exhibit cluster type 2 (inability to implement core targets and presence of financial problems). This case study represents both clusters 1 and 2, except for, as explained above, high turnover and recruitment problems.

Therefore, the findings of this case study appear to support **proposition 1** (a range of markers and symptoms of failure of the Trust, under study, will be shown to be similar to those identified in the literature review). Although, there were some small differences in the sub-categories of symptoms found in this study and previous research, which might be related to the specific characteristics of the organisation.

8.2.2 Secondary causes of failure

A range of secondary internal and external causes of failure was explored in this study. McKiernan (2002) categorises all secondary causes of failure, identified in the for-profit sector, into three groups: i) financial, ii) 'demand' (external environment) and iii) managerial. In this study, the internal causes of failure have been classified into four key categories including: i) managerial, ii) financial, iii) cultural, and iv) organisational.

Along similar lines to Mellahi and Wilkinson (2004), the findings of this study reveal that the combination of both internal management (voluntaristic perspective) and external factors (deterministic perspective) contribute to failure, although, the interviewees placed more emphasis on internal rather than external factors. Mellahi and Wilkinson (2004:34) argue that, 'any attempt to explain organisational failure will not be complete unless the interplay between contextual forces and organisational dynamics is taken into account'. This study supports the results of previous studies, emphasising the role of both internal and external factors in

contributing to organisational failure, although different categorisations are used to classify internal causes of failure (e.g. Turner and Whiteman, 2005; Fulop et al., 2004; Protopsaltis et al., 2002; Andrews et al., 2006).

8.2.2.1 Managerial factors

The Trust's performance problems, perceived by the majority of interviewees, closely associated with the behaviour of the previous CEO and senior management team.

i) Poor leadership

Poor leadership was viewed as an important internal secondary cause of failure. The leadership style of the CEO was perceived as very autocratic. Centralised decision making, insufficient attention to the external environment and performance targets, bullying behaviour, unwillingness to devolve decision making to middle managers, poor flow of information in the organisation, and a lack of managerial capability and capacity managerial traits that had been associated with the CEO and senior management team. Staff believed that ineffective leadership affected negatively the performance of the organisation. Similarly, a lack of good managerial leadership was one of the most common factors reported in previous studies in the public sector. Protopsaltis et al. (2002) found that Chief Executive Officers (CEOs) of poorly performing NHS acute trusts were a key contributor to the performance problem. Lack of leadership, unwillingness to make decisions, reluctance to distribute power (delegation), working in isolation from managers in other organisations, and the inability to challenge internal vested interests were found to be key managerial problems. Andrews et al. (2006) also found a significant relationship between poor managerial leadership and the likelihood of failure in local government settings. Turner et al. (2004) report that poor managerial leadership was found in poorly performing local authorities. Joyce (2004) highlighted the importance of both managerial and political leadership as important factors in preventing continuing failure. The importance of political leadership was rated more highly than managerial leadership because of the power of politicians, who can approve or veto decisions made by managers (Andrews et al., 2006). They also argued that good political and managerial leaders were unlikely to be attracted by poorly performing organisations, creating a vicious circle, where poor leadership resulted in poor performance.

ii) Distraction

Another factor, perceived by interviewees that contributed to performance decline of the Trust was the distraction of the senior management team away from the day-to-day management of the organisation due to having to complete large projects (merging of two hospitals and the PFI project). Indeed, it was widely believed that the senior management team had taken their 'eyes off ball' concerning key access targets. This finding is supported by the finding of previous research in the NHS (Protopsaltis et al., 2002). Likewise, McKiernan (2002) argues that too much focus on a major development plan, in for-profit sector, is viewed as one of the contributors to organisational failure.

iii) Lack of performance management systems

Lack of a robust performance management system within the Trust was identified as an important factor contributing to the Trust's performance decline. There were no feedback cycles in existence through which to report how different parts of the organisation were operating. That was attributed to the inability of senior managers to develop an effective and responsive performance management framework. Thompson (2002) argues that performance measurement and control system are necessary for service providers in order to enable them to know how the systems are performing and which targets are achieved. Andrews et al. (2006) argue that there is insufficient empirical evidence regarding the relationship between failure and the performance management system. However, they showed a significant relationship between poor performance management and organisational failure in English local government. They argue that the development and use of a robust performance management system require clear, unambiguous and realistic goal setting agenda for an organisation. Mannion et al. (2005) state that low performing hospital Trusts in their sample did not view the establishment of a performance management system as an important priority. Similarly Fulop et al. (2004) and Protopsaltis (2002) showed that poor performing acute Trusts suffered from the lack of a robust performance management arrangements. The lack of a performance system or the incomplete implementation of such a system were also shown to be contributors to the failure of public organisations, in a report provided by the Office of the Deputy Prime Minister (2004).

In addition, insufficient attention to the national performance targets, a slow response to targets, and lack of a general communication about their importance throughout the organisation by senior managers, were also perceived as managerial factors that had contributed to performance problems. Mannion et al. (2005) found that hitting national targets was not a high managerial priority for low performing hospital Trusts and not hitting performance targets was treated as a taboo by high performing trusts. Similarly, Kelly (2004) argue that successful organisations in the for-profit sector (e.g. Lloyds TSB) had a clear focus on their core business, but unsuccessful organisations are likely to focus on ambiguous targets which do not provide a route for performance improvement. The Audit Commission (2002) argue that both the development of performance management systems and clearly defined objectives of the organisation, which are well communicated throughout the organisation, are two key requirements, for an organisation wishing to meet performance targets, set at local or national level. These issues are also congruent with the findings of previous studies (e.g. Fulop et al., 2004; Protopsaltis et al., 2002; Turner and Whiteman, 2005).

iv) Lack of strategy

The Trust suffered from the lack of central strategy and poor strategic planning in several areas which was perceived as a factor that had a negative effect on the performance of the Trust. No clear central direction had been set by senior managers for several key areas including human resources, clinical governance and external relationships. According to Kotter (1990), poor leadership was viewed as the main reason of this matter because the main function of a leader is to set a direction and provide a clear vision. A meta analysis conducted by Miller and cardinal (1994) shows a positive relationship between planning and performance of firms in the for-profit sector. Similarly, a positive impact of planning on the performance in the public sector has been shown by Boyne et al. (2003) and Hendrick (2003).

iv) Poor relationships with external stakeholders

Poor working relationships between the Trust and external stakeholders were perceived by the interviewees as prominent contributor to failure. Indeed, the Trust was viewed as an inward looking and insular organisation that had not benefited

from the support of external organisations such as the SHA during the rapid process of change. However, the quality of relationships with users of services was not identified explicitly by interviewees. Mellahi and Wilkinson (2004) argue that poor relation with external stakeholders is viewed in the theories of failure as a factor that leads to organisational decline. For example, Mellahi et al. (2002) report that the failure of Mark & Spencer was related to the inattention of its senior managers to the information provided by customer surveys and over confidence in their own experience and long established market position. A reactive engagement with the local health economy by poorly performing trusts was reported by Mannion et al. (2005). However, Andrews et al. (2006) did not find a statistically significant association between the quality of external relationships and the performance of local authorities. Only the development of a relationship with the private sector was considered to be an external relationship in their study and relationships with other public and governmental organisations had not been included in their assessment. There is insufficient evidence about the impact of greater focus on user preferences on the likelihood of failure or success of organisations for a robust conclusion to be drawn. Within the current NHS context, which highlights Patient Public Involvement, the impact of such relationships on the performance of trusts, particularly foundation Trusts should be a focus of future research.

8.2.2.2 Financial factors

Several interviewees attributed the financial problems of the Trust to poor financial management and control and the presence of an inbuilt high cost structure. For two successive years, CHI had removed one star from the Trust's performance ratings due to the inability of the Trust to meet its financial target. There was little awareness of financial issues throughout the organisation. In addition, increased financial pressure was experienced by the Trust due to the lack of experience in drafting the PFI contract with the private contractor. This study reinforces the findings of previous research conducted in the health sector (Protopsaltis et al., 2002; Fulop et al., 2004; Audit Commission, 2006). Fulop et al. (2004) found that a high cost structure, poor financial control and financial instability, and overspends in key clinical directorates as examples of financial factors that had contributed in organisational failure in acute Trusts. An Audit Commission report (2006) argued that financial failure of the NHS organisations can not be separated from wider organisational failure. The report attributes the origin of the financial problems to ineffective management and weak or

inadequate board leadership. In addition, the board's eye being 'off the ball' was reported as another factor contributing to financial problems. These finding are reinforced by the finding of this study as interviewees related financial problems to the lack of good financial discipline established by senior managers. In addition, the board of the Trust was perceived as not a highly effective team that was not able to challenge decision made by the CEO and senior executives.

Similarly, several studies in the for-profit sector draw similar conclusions about the impact of financial factors on performance decline and organisational failure (McKiernan, 2002).

8.2.2.3 Cultural factors

As explained in section 5.3.3.3, a range of cultural issues (a culture of fear and blaming, a culture of denial and hiding problems, a lack of performance culture, cultural issues following the merger of two hospitals) perceived by the interviewees, led the organisation towards performance decline. Most of these cultural issues were attributed to the behaviour of the CEO and senior management team. This accords with in accordance with Schein's (1985) assertion that 'the unique and essential function of leadership is the manipulation of culture'.

It was argued that a culture of 'fear' and 'blame' was prominent in the organisation. In addition, the presence of culture of 'denial' and 'hiding' of problems exercised by senior managers (e.g. hiding and manipulating waiting list) was also reported by interviewees. In such an organisational environment problems are not likely to be reported by staff and learning from the mistakes are blocked. This promotes a vicious circle, which means that increased reluctance from staff to report problems. The presence of blame culture as secondary cause of failure is also represented by Fulop et al. (2004) and Eitel (2004).

In addition, a range of problems resulted from the merger of two organisations with very different cultures. Due to the cultural differences between the two hospitals, conflict between the staff of two hospitals occurred, which resulted in increased anxiety and stress that had a negative impact on the performance of the organisation. Similarly, the negative and unintended consequences of hospitals merger on the

delivery of the services due to the cultural differences have been reported by Fulop et al. (2002).

Similarly, a lack of 'performance culture' was attributed to organisational failure in previous studies conducted in the public sector (Turner and Whiteman, 2005; Protopsaltis et al., 2002; Mannion et al., 2005; Joyce, 2004, Andrews et al., 2006).

8.2.2.4 Organisational factors

A range of organisational factors including lack of robust information system, poor communication system, lack of corporate accountability system and method of working were found as contributors to the organisational failure. The Trust was not able to monitor its performance properly due to the lack of a robust information system. The Trust suffered from a poor communication system which had impeded flow of information within the Trust and was viewed as an important barrier to the performance improvement. Some interviewees highlighted the presence of inappropriate method of working and internal conflict within the trust under the previous management regime. Similarly, previous research shows tense employee relationships and internal conflicts as factors that contributed to the failure (Fulop et al., 2004; Turner and Whiteman, 2005; Eitel, 2004; Harris and Chapman, 2002). It was highlighted that the Trust was suffering from the lack of corporate identity and some kinds of separation was reported between departments within the Trusts, which is consistent with the findings of other studies indicating the presence of poor corporate structure in their sample (Turner and Whiteman, 2005; Eitel, 2004; Protopsaltis et al., 2002). However, Andrews et al. (2006) did not show the relationship between organisational failure and internal relationships. It was noted that the study measured joint working and cross cutting working in order to evaluate internal relationships, though these two factors are only one form of internal relationship and did not present significant correlation with failure. The other elements of internal relationship, which may show a relationship to failure, were not included in this study.

8.2.2.5 External secondary causes of failure

Several interviewees placed emphasis on the impact of structural and policy changes within the NHS as factors that had contributed to the Trust's performance decline.

They added that the pace of change was too quick and it was difficult for the organisations to deal with them. This finding support findings of the previous research (Fulop et al., 2004; Protopsaltis et al., 2002). Fulop et al., (2004) argue that structural and policy changes occurred during 1999-2001 within the NHS context, such as introduction of the Performance Assessment Framework, were viewed as contributors to failure of some NHS organisations because their managers had reported that it was difficult to both transform their roles and also respond properly to the new expectations of partner organisations. Turner and Whiteman (2005) also argue that policy changes and introduction of the CPA had contributed to performance problems experienced by some local governments.

Therefore, the findings of this case study appear to support **proposition 2 (**A range of secondary external and internal factors, which also contributed to failure, will be identified).

8.2.3 Primary cause of failure

According to McKiernan (2002), dysfunction in relation to the organisational learning process is viewed as the primary and main cause of organisational failure. Over confidence, lack of experience, complacency and rigid thinking are reasons that disrupt organisational learning processes (McKiernan, 2002). Two different reasons, organisational introspection and organisational arrogance, were perceived as factors that had impeded the Trust's learning process. It was reported that a sense of arrogance existed among the previous senior management team, as they believed that it was a teaching hospital with an excellent history of working in clinical areas and that the decisions made by them were correct and could not be contested. This arrogance led them to ignore difficulties or to respond inappropriately to changes in the external environment. Indeed, the lack of a culture of change and blockage in the learning process was attributed to this arrogant stance. The theory of the 'curse of success' (detailed in section 2.6.4.3), is based on the notion that previous success may breed overconfidence and arrogance among managers. As a consequence, those managers may maintain their previous operating assumptions related to the dominant ideas associated with success in the past (Jas and Sckelcher, 2004). This attitude may result in ignorance about the changes in the external environment or

inattention to signs of performance problems and performance decline (Mellahi et al., 2002).

The findings of this case study in relation to the primary cause of failure reinforce the findings of previous research (Fulop et al., 2004; Turner and Whiteman, 2005; Eitel, 2004). Fulop et al. (2004) found four reasons for organisational learning process being impeded in acute trusts, including organisational introspection, organisational arrogance, organisational trauma and organisational myopia. In addition, Turner and Whiteman (2005) found similar reasons to those found in this case study. Finally, Eitel (2004) argues that the lack of double loop learning, explained in section 3.8, was the main cause of organisational failure in a US regional governmental office.

Therefore, the findings of this case study appear to support **proposition 3 (**the primary causes of failure as the main source of organisational decline, will be identified.

8.3 Triggers for change

As outlined above, a range of factors are required to trigger the turnaround process when organisations are not able to perform at an acceptable level. Within the context of stress-inertia theory (Huff et al., 1992) discussed in section 2.8, strategic change may occur by decreasing the resistance stemming from inertia or by increasing the stress levels originating from dissatisfaction with the status quo. Thus, change may arise when the levels of stress exceed the levels of resistance and inertia to change (Barker et al., 2001). Similar to the findings of the other studies (e.g. Grinyer et al., 1990; Fulop et al., 2004; Turner et al., 2004; McKiernan, 2002), several internal and external factors were identified as contributing to heightening stress in the case study. The key internal factor was the replacement of the senior management, which is consistent with the literature from the for-profit sector which suggests that the most important factor in initiating change is the replacement of the top team (Slatter, 1984; Bibeault, 1982; Schendel and Paton, 1976; Grinyer et al., 1990). The key external factors were investigations by outsider agencies, a zero star rating, hostile local media coverage and support provided by the government to help turnaround failing organisations.

The findings of the present study on triggering change align closely with the theory developed by Barker et al. (2001), which posits that performance decline is not in itself a strong enough stress to initiate change and that the presence of internal factors (e.g. change in senior management) and/or external interventions seems necessary. The present study confirms that, although receipt of a zero star rating was an important factor in turning around the Trust, both the establishment of a new senior management team and external investigations and interventions were also required to affect the performance of the organisation. The findings of other studies in relation to the role of external investigation is an important factor in the diagnosis of problems and for triggering change (Jas, 2004; Eitel, 2004; Wilmott, 1999; Fulop et al., 2004), and it was strongly supported by this study.

The findings of the present study reinforce those of recent studies conducted in the NHS (Protopsaltis et al., 2002; Fulop et al., 2004) relating to triggers for change. Although the role of external stakeholders, such as the SHA in raising its concerns in relation to the Trust's performance, was evident in facilitating change, the role of the external community of user groups, which Fulop et al. (2004) found to be an important trigger for change, was not clearly evident in this study.

Similarly, Mannion et al. (2005) found that a low star rating and a critical CHAI report, acted as triggers. However, opposition between managers in relation to making key decisions, and conflict among different professional groups within the organisation, attempting to maintain their autonomy, were found by Jas and Skelcher (2004), to be important internal triggers for change. However, these factors had not played important role in initiating change in this case study.

Therefore the findings of this study appear to support the **proposition 4** (A range of internal and external factors, which triggered the process of change, will be identified).

8.4 Turnaround interventions

Analysis of the turnaround interventions in terms of the '3Rs' Strategies (Boyne, 2004a) reveals that all three interventions (reorganisation, retrenchment and repositioning) were used simultaneously by the Trust and were widely perceived as

successful in aiding the recovery of the organisation. However, most of the interventions were focused on reorganisation strategies. Retrenchment strategies (tight financial control) also played an important role in performance improvement, at least during the first two years following the arrival of new senior managers. The findings of this study show that the use of the '3Rs' strategies, derived from the for profit sector, is feasible in the public sector, and is likely to lead to turnaround, although the implementation and duration of the use of these strategies may need to be adopted. Turner and Whiteman (2005) argue that the level of cognition, capability and capacity of an organisation (detailed in section 3.12.1) when beginning the turnaround process, can affect the effectiveness of interventions. Evidence in the public sector, shows that the most commonly used '3Rs' strategies is reorganisation. In addition, it was demonstrated that the findings of this study regarding the success of the turnaround interventions, accords with the evidence for–profit organisations. It was perceived that the Trust selected these strategies on the basis of the diagnosis of the causes of failure, as set out in the external reports. Pearce and Robins (1993) argue that strategies that do not focus on the causes of failure may not achieve the desired results or that only short-term successes are accomplished. The Trust was compelled, by the SHA, to develop an action plan and to turnaround the organisation in a short period of time (six months). The literature, from the for-profit sector, also places emphasis on the importance of developing a timely action plan (Hambrick, 1985). Similarly, Boyne (2004b) argues that highly visible public organisations are likely to be under pressure to produce a recovery plan quickly. This means that the organisations, in critical situations, are not given sufficient time to analyse the situation. Organisations, that are not highly visible and/or are not a under high level of political pressure, are often afforded more time to plan their strategy. It should be emphasised that more comprehensive investigation is required to examine the extent and impact of the use of these interventions in turning around failing organisations in the public sector.

8.4.1 Retrenchment

As explained in section 7.2.2, one of the most important strategies, selected by the Trust's senior managers to turnaround financial failure, was the use of a retrenchment strategy. The focus of the retrenchment strategy was on cost cutting rather than asset reduction. Tight financial control, aiming to balance the annual

financial budget and deal with the historical financial deficit, was planned using a series of cost cutting interventions, such as reduction in staffing (lower use of banking agency staff), tight control of junior doctor's rotas, further control of purchasing and use of medical and administrative stuff. The strategy was perceived as successful because the Trust was able to balance its financial books for two successive years, although historical financial issues had not been addressed. Involvement of operational managers in helping to draft of the financial action plan and the close working relationship between operational managers and financial managers, and clear communication with staff throughout the organisation regarding the importance of the financial plan, were perceived as important factors that resulted in successful financial turnaround.

The findings of this study are compatible with the empirical evidence in the for-profit sector that supports retrenchment as an effective turnaround strategy (McKiernan, 2002; Boyne, 2004a; Pajunen, 2005). The Trust, under study, was not efficient, and Boyne and Meier (2005) and Robins and Pears (1992) argue that, when high cost or low efficiency are the causes of problems, which are internal to an organisation, then a retrenchment strategy is likely to lead the organisation toward recovery. The existing evidence on the turnaround process in the public sector, particularly in school settings, shows that cost reduction is a less frequently used strategy. However, in several studies conducted in the public sector, retrenchment was reported as a strategy selected by managers (e.g. Fulop et al., 2004; Protopsaltis, 2002; Turner and Whiteman, 2005; Boyne and Meier, 20005; Eitel, 2004). Fulop et al. (2004) showed that, in most of their samples, acute trusts were successful in meeting the financial targets by employing a financial action plan. Boyne and Meier (2005) argue that more emphasis on cost cutting and increasing efficiency, by the superintendents of the public schools in their sample, was unlikely to result in performance improvement. They question the effectiveness of the retrenchment strategy in turning around of organisations. In the for-profit sector, although some studies did not find a positive relationship between retrenchment and performance improvement, no study reported a negative relationship. Therefore, further study is needed to examine the effectiveness of the retrenchment within the public sector.

However, tight financial control had a deleterious impact on Trust staff and caused a lowering of staff morale and, in some cases, a resistance to financial control, particularly by clinical staff. Likewise, some commentators argue that although the retrenchment strategy is viewed as an effective instrument in stabilising the

organisation, too much financial control may reduce staff morale and increase staff resistance to change (Sutton et al., 1986; Hardy, 1987; McKiernan, 2002).

To tackle the historical financial deficit, the sale of assets at hospital B and refinancing the whole PFI scheme were two strategies that the Trust's managers were proposing to use. It is important to note that, when the Trust was unable to tackle the financial historical deficit using cost cutting strategies, then asset reduction (selling land and/or equipment) was viewed by them as another alternative. This supports the idea presented by Hofer (1988) and Robins and Pearce (1992) that when the first response (cost cutting) is applied to financial problems but does not result in recovery, asset reduction should supplement it.

In addition, a focus on core performance targets was cited by interviewees as a factor that helped the Trust to improve its performance. Similarly, other studies, conducted in the public sector, show the effectiveness of this intervention, at least in the short term, in meeting performance targets (e.g. Fulop et al., 2004; Protopsaltis, 2002; Turner and Whiteman, Boyne, 2006).

8.4.2 Reorganisation

A range of 'reorganisation' strategies (replacement of senior managers, a focus on performance management) was used by the Trust to turnaround the organisation, which corresponds with the evidence from both the for-profit (e.g. McKiernan, 2002) and public sectors (e.g. Fulop et al., 2004; Turner et al., 2004; Gray, 2000; Protopsaltis et al., 2002; Boyne, 2006).

The most important and effective reorganisation intervention, perceived by the interviewees, was the replacement of the CEO and senior management team. This is consistent with the literature, suggesting that the most common turnaround intervention is the replacement of the CEO and/or members of the senior management team (Walshe et al., 2004; Boyne, 2006). Although different impacts of succession on organisational performance are identified in the literature (Mellahi and Wilkinson, 2004), Barker et al (2001) view top management team replacement as a crucial requirement for a successful turnaround in the for profit sector. Similarly, Virany et al. (1992) show the positive impact of succession on the performance and survival of an organisation, particularly in turbulent environments. Dailey and

Schwenk, 1998) also show that replacement of senior management team had stronger performance effects than replacing only the chief executive. These reflect an assumption that failure is influenced by poor leadership. The majority of interviewees related performance improvement to key individuals (senior managers, particularly Deputy CEO). Harvey et al. (2005a), similarly, argue that performance improvement in some organisations is determined by specific individuals, such as the CEO or a director. In this case study, senior managers also placed an emphasis on establishing a performance culture throughout the organisation. However, it is important to note that embedding and maintaining an appropriate organisational improvement culture in an organisation takes considerable time and effort.

Therefore, the findings of this empirical study appear to support **Proposition 6** (Although a range of turnaround interventions are used within the Trust, reorganisation strategies will be the most important deployed)

The 'Upper Echelon' theory (Hambrick and Mason, 1984) explains the relationship between the characteristics of the senior management team of the organisation and organisational outcomes (e.g. organisational performance). All the new senior managers came from outside the organisation (external succession), which means that they were not linked to the previous managerial team and the organisation's performance problems. The literature suggests that when an organisation proposes to turnaround poor performance, new senior managers introduced from inside the organisation are more likely to recover the organisation because they know more about the performance difficulties of the organisation, particularly when a speedy response is needed (McKiernan, 2002). However, other researchers argue that new managers introduced from outside the organisation are not linked to the previous management team and to the existing culture of the organisation and its performance problems, and for that reason, they are more likely than outsiders to be able to turnaround the situation as they can bring fresh ideas and a constructive approach towards performance improvement (McKiernan, 2002). Similarly, Helmich (1974) shows that outsider successors are likely to be more successful than those internal to the organisation. However, the differences between 'insider' and 'outsider' succession has not been scrutinised in the public sector. In this case, although, external succession occurred, the reports provided by the external organisations facilitated identification and diagnosis of the performance problems. Therefore, the organisation benefited from the presence of new managers with different perspectives, who became immediately aware of problems.

In addition, several interviewees highlighted that the new CEO placed a great deal of emphasis on recruiting staff with considerable senior management team experience. Both internal and external interviewees reported that the new executive team was composed of appropriate personnel, who had sufficient experience to form a cohesive team with good working relationships and had played a key role in facilitating a successful turnaround in performance. This is consistent with findings of the previous research highlighting the important role of experienced and capable senior mangers in the process of turnaround (Joyce, 2004; Fulop et al., 2004). Furthermore, Zimmerman (1989) highlights the important role of the functional background of senior managers on organisational performance. Mellahi and Wilkinson (2004) also emphasise that a cohesive and homogenous group is likely to make decisions more quickly in a crisis situation, when timely decisions are crucial. Therefore, the findings of this case study appear to support **proposition 7** (In the process of replacement strategy, the appointment of an appropriate managerial team, with sufficient skills and capabilities, is an important factor in initiating turnaround interventions).

A directive, 'top down' transactional leadership style, was exhibited by the newly appointed senior management team, particularly during the first year following their appointment, and a strong performance management system and tightened managerial controls were also introduced. Although, the long-term aim of the senior management team was to nurture a more participative and democratic leadership style and to empower middle and lower level managers, more mechanistic (directive) leadership was perceived as a factor that enabled the focus to be on the achievement of centrally set performance targets in the early stages of the turnaround processes.

The findings of the literature review indicate that a varied range of leadership styles have been used by senior managers during the process of turnaround, relevant to each stage of the turnaround cycle. The findings of this study are compatible with the findings of Mannion et al (2005) who note that high performing trusts (three stars) in their sample exhibited a top down 'command and control' style of leadership. They report that a long tradition of strong directional leadership from the centre, along with setting clear performance objectives for the organisation and establishing a robust performance management system which had a close monitoring system were

features of these organisations. A high level of commitment to continuously improving the measured performance was shown by the CEO of these organisations.

Fulop et al. (2004) state that new mangers exhibited a range of leadership styles from participative, facilitative and risk taking to more mechanistic approaches based on the hierarchical principles had been deployed. A broad range of leadership styles from directive leadership to participative, people oriented and dispersed leadership, was shown by the head teachers in the school setting. Although more emphasis was placed on using a people-oriented leadership approach (Harris et al, 2003; Harris and Chapman, 2002; Gray, 2000), Harris and Chapman (2002) argue that directive leadership was likely to be needed during the initial stage of the turnaround process. For example, they state that head teachers demonstrated more autocratic leadership styles during the pre inspection phase made by the OFSTED. On the other hand a more supportive leadership style was displayed during the inspection phase.

Therefore, the findings of this empirical study appear to support **Proposition 10** (The Trust's managers will use more mechanistic (directive) leadership during the first phase of the turnaround process).

8.5 Role of external organisation in the process of turnaround

In this study the role of a range of external organisations (the Audit Commission, CHAI, the SHA, and the PDT), were perceived by interviewees, as a crucial factor in initiating change an turnaround process. The role of the Audit Commission, CHAI and the SHA in diagnosing and triggering change was discussed above. Theses organisations were viewed by the new management team as important resources in helping the Trust to improve its performance.

The role of the PDT in diagnosis of the performance problems and development of an action plan was less important because the Trust had already developed its own action plan, following external reports, prior to the PDT involved with the organisation. The Trust was seen by the PDT client manager as a proactive organisation that was very clear about its priorities and its senior managers knew what they wanted to achieve.

According to Meyer and Zucker (1989), who classify organisations into two groups in terms of other ability to initiate the turnaround process (self initiating organisation

and permanent failing organisations) [detailed in section 2.11], the Trust could be categorised as a self-initiating organisation. Jas and Skelcher (2004) compare the characteristics of these two organisations (see Table 2.3) and according to their comparison, the Trust under study showed the characteristic of a self initiating organisation. The Trust's senior managers were able to start and move forward the turnaround process by themselves and in addition there was changing the culture presenting very low level of 'threat rigidity effect' in a way that the flow of information was encouraged and different methods of communication and distribution of information throughout the organisation were used. The new management team had required authority to initiate change by themselves, although they wished to receive extra help in terms of 'hands on' support in some area such as waiting list management and dealing with A & E 4 hour targets and the process of discharge of patients.

As detailed in section 2.11, Jas and Skelcher (2004) use principal-agent theory to explain the effect of different types of turnaround interventions, depending on the relationship between the principal (intervening body) and the agent (organisation which requires intervention). Three alternative types of intervention (episodic, relational/mutual, and mandated) [see Table 2.4] were categorised by them. The relationship between principal (intervening bodies such as the SHA and the PDT) and the agent (the Trust) could be categorised as a relational approach, which means that the Trust was given the support and encouragement for a self-managed turnaround and a regular monitoring was used by the SHA to assess the process of performance improvement. It was noted that the SHA was not willing to use direct intervention (mandated approach) in order to motivate the Trust to conduct the process by itself and also to reduce the financial cost and political risk. Because, as Jas and Skelcher (2004) argue, the mandated approach causes a high level of financial cost and political risk to the principal if it can not turnaround the situation. In addition, the senior managers of the Trust were willing to conduct turnaround process by themselves. It is important to note that a good relationship between the trust and the SHA had a positive impact on the progress of relational approach, which is consistent with the findings of Harvey et al. (2005a). Likewise, Turner and Whiteman (2005) showed that the use of a relational approach reduced the level of resistance by authorities against ODPM involvement. Similarly, Harvey et al. (2005a) argue that the PDT embraced a relational approach, in their sample, due to its philosophy and partnership working style which actually encouraged self-managed turnaround. This study revealed that self initiating organisations such as the Trust

under study do not necessarily require a huge degree of external support (particularly in terms of the presence of an in-house performance support team). The Trust was viewed by the PDT client manager as an organisation that had required a low level of interventions.

This study showed that the SHA played an important role in turning around the organisation as it was able to provide an appropriate balance between its two different roles at the same time firstly as the performance management agent and secondly as supporting agents. Harvey et al. (2005a) highlight this issue as an important role of the SHA in the turnaround process.

This study reinforces the findings of the study conducted by Harvey et al. (2005a) in relation to the function of the PDT and its relationship with poorly performing NHS organisations. This study revealed that the timing a PDT enter an organisation is important in terms of diagnosis and development of an action plan because the PDT arrived in the Trust when the Trust managers had already developed their plan.

This study also revealed that the use of inexperienced staff in the PDT or the presence of staff that did not spend sufficient time inside the organisation to understand the problems did not result in effective outcome. On the other hand, this study found that the presence of experienced consultants in the PDT who spent a long time observing and gaining an understanding of the problems and dealing with staff rather than just suggesting what they needed to do, was perceived very to be effective by the Trust's staff. It seems that the type of relationship between members of the external performance supporting team and the staff of the organisation, particularly clinicians, is likely to be affected by the type of profession, duration of contact between these staff, quality of relationship between them and extent of acceptance by clinicians. Burke et al. (1994) similarly argue that the characteristic of mentor and mentee and the quality of relationship between them are important factors that influence the mentor relationship outcomes. Turner and Whiteman (2005) also suggest that the level of experiences and skills of political mentors were perceived as important factors to assist poorly performing local government authorities in reducing resistance to change and developing positive attitude to continuous performance improvement.

Therefore, the findings of this case study appear to support **proposition 5** (Organisations, able to 'self' turnaround, do not necessarily require a huge degree of

external support, particularly in terms of the presence of an in-house performance support team.

8.6 Effect of external and contextual factors on organisational failure and turnaround processes

The findings of this study suggest that the characteristics of users of public services (e.g. socio-economic status, ethnic diversity) can affect the extent of local need for services, which may affect the performance of the organisation. A high level of healthcare need was reported in this study as a large population of very poor people lived in the area covered by the Trust. This resulted in there being a higher number of patients seeking the Trust's services and patients from populations, on average need to stay in hospital for a longer period, both of which could affect the capacity of the organisation, and its performance (e.g. meeting the 4 hour A & E target). One of the factors, perceived by the interviewees that had contributed to difficulties in meeting performance targets and in turning around the situation, was the very high level of need generated by the poor socio-economic characteristics of users of the services.

Although the impact of contextual factors on organisational failure has not been investigated in the health sector, this study reinforces the findings of previous studies conducted in other public sectors (local government and schools) on the impact of contextual factors and the characteristics of the consumers of services on organisational failure (Wilmott, 1999; Andrews et al., 2006; Gray, 2000; Harris et al., 2003; Turner and Whiteman, 2005).

Andrews et al. (2006) showed that the diverse service needs (higher ethnic diversity) and poverty had contributed to the failure of 120 UK upper tier local authorities measured by the CPA score. Similarly, Turner and Whiteman (2005) claimed that the possibility of failure of English local authorities was higher in the areas that had populations which needed a variety of services. Three studies (Gray, 2000; Wilmott, 1999; Harris et al., 2003), conducted in the English education sector, showed that the poorly performing schools in their samples were located in areas with a high level of poverty and deprivation. It may be concluded that a high level of poverty and deprivation are likely to negatively affect the performance of public organisation. However, Andrews et al. (2006) did not show a significant statistical relationship between social class and failure in UK local government.

It seems that, in some situations, the performance of the organisations is related to factors that are beyond their control. Therefore, to assess the performance of the public organisations, the impact of contextual factors (particularly socio-economic circumstances), on the performance of the organisations, should be taken into account.

8.7 unintended consequences of turnaround interventions

A range of unintended consequences of implementing turnaround interventions was found in this study. A majority of interviewees referred to the high level stress related to the pressure of achieving the performance targets. Consequently, it resulted in lowering staff morale. In addition, it had affected negatively the learning time for staff as they did not have time to attend development and training programmes. The interviewees also perceived that too much focus on measurable targets had a negative impact on the quality of patient care. Mannion et al. (2005) refer to this as 'tunnel vision'. This finding is supported by another study (Mannion et al., 2005), conducted within NHS context. However, the trust studied, did not represent serious problems in terms of recruitment and retaining high quality staff (Ghettoisation) that Mannion et al. (2005) found in their study. It is necessary to note that staff at lower levels, although were under pressure, did not report bullying under the new management regime.

Similarly, unintended consequences were reported in local government setting. Turner and Whiteman (2005) argue that achieving a better CPA score had been the key priority for some local authorities. Two negative consequences were explored: first, the local authorities were reluctant to criticise the government (Compliance); and second, local authorities focused on meeting centrally, set targets (heavily oriented to the CPA score possibly incompatible with the requirements of their local communities.

Therefore, the findings of this case study appear to support **proposition 8 (**A range of unintended consequences and barriers related to implementing turnaround interventions, within the Trust, will be apparent).

8.8 Applicability of 'stage theory' in the public health sector

The use of exercise of analytical generalisation (Yin, 2003) requires a consideration of the phenomena that are expected to happen in relation to organisational failure and turnaround, based on the theory derived from the for-profit sector, and a comparison of empirical findings with theoretical expectations to evaluate whether they confirm or reject the theory. The case study supports the turnaround stages framework (McKiernan's model) developed in the for-profit sector and confirm applicability of this framework to the public sector. However, there are some minor differences in the nature of the different stages. For example, the action plan developed by the Trust had to be approved by the SHA and following that by the Department of Health before it could be implemented. It also suggests that senior managers working in public service organisations do not have as much authority as senior managers in for-profit sector. The need for external approval for the outline of the action plan needs to be considered in McKiernan's model when it is applied to the public sector. Table 8.1 summarises the match between the categories of the turnaround stages framework and the data gathered in the case study.

Table 8.1 The match between the categories of the turnaround stages framework and the case data

Theoretical pattern	Case pattern
Causes stage	
Symptoms	
Financial	√
Physical	√
Managerial	√
Behavioural	√
Secondary Causes	
Managerial	√
Financial	√
Demand/external environment	√
Multiple, interrelated cause	√
Primary causes	
Dysfunction in organisational learning	√
Triggers stage	
Internal triggers (new top management)	√
External (external intervention)	√
Diagnostic stage	
Diagnosis process and development of action plan	√
Retrenchment	
Priority given to cost reduction and core target achievement	√
Recovery	
Reorganisation/Repositioning	√
Renewal	
Priority given to growth (performance improvement)	√

Therefore, the findings of this case study appear to support **proposition 9 (t**he 'stage' model theory, developed in the for-profit sector, is applicable in the public sector, particularly the health sector).

8.9 Limitation of the study

There are several limitations to this study. As outlined in section 4.3.1.3, case study research is subject to a number of limitations and the following should be borne in mind.

First, according to Murphy et al. (1998) the merits and limitations of qualitative study constrain the findings of research (validity and reliability). One area of concern is the issue of generalisation. The generic limitations of qualitative methods do not allow for direct generalisation of the findings to other settings. However, as explained in section 4.3.1.3, the aim of the case study method is not statistical generalisation but analytical generalisation, i.e., the testing of theory (Yin, 2003). Therefore, due to the lack of sampling logic, it is not necessary to consider whether the findings apply to other settings. Nonetheless, the reader may feel tempted to extrapolate findings to other settings, in which case make it would be necessary to enter some caveats in place before attempting such generalisation.

Second, the research is conducted by a single student, in which all the processes of data collection and analysis have been carried out by one researcher, may increase the likelihood of subjectivity in the findings (researcher bias) [Mays and Pope, 1995]. With regard to issues of validity and reliability (Section 4.7), different strategies were used to minimise the likelihood of bias. The findings of this study were presented at two seminars and advisory meetings and the feedback received was used in reconsidering the analysis process. The verbatim quotations from interviewees were also presented in order to support the validity of the findings and show the link between interpretation and original data. However, the possibility of bias remains.

A third limitation is respondent bias. It should be borne in mind that interviewees did not necessarily have to disclose their true perceptions in their answers. In fact, their answers might have been strategic, highlighting an issue for their own benefit and minimising or hiding other aspects, as well as giving answers that were more likely to please the interviewer. An attempt was made to mitigate such respondent bias by using triangulation strategies, explained in section 4.5.2 in detail.

Another limitation is lack of control. The case selected for this empirical study was a unique case and its situation justifies its selection and the subsequent, investigation using an in-depth qualitative case study. However, in terms of the aetiology and

causation of performance problems and turnaround process (establishment of cause and effect), it may not be possible to present definite cause and effect evidence about the case under study. For example, the effectiveness of different selected turnaround strategies cannot be conclusively proved because there was no comparison between this case as an organisation that recovered, and other similar organisations that continued to fail. The latter might use similar strategies but they were not able to improve their performance. On the other hand, it was difficult to find a case, directly comparable to this in terms of important background criteria, such as teaching status, experience of merging, and the size of the hospital. In addition, due to lack of resources (time and money), it was not possible to investigate another case as much depth as the organisation used in this study. The researcher chose to investigate a case in greater depth rather than deciding to include additional cases. Selection of this unique case helped to maximise the amount of information about the organisational failure and turnaround process and it provided the opportunity to achieve deeper insights into the processes under study. In addition, Borins (2001) argues that the studies of the turnarounds can be viewed controlled experiments in that they compare decline and success in a particular organisation, with the essential difference being is leadership.

The other limitations of the case study approach set out in section 4.3.1.3, should also be borne in mind in regard to interpreting the findings of this study.

The next Chapter (Chapter 9) presents the lessons for the development of health policy and recommendations for further research.

Chapter 9: Conclusion

This study aims to contribute to a wider understanding of organisational failure and turnaround processes in health care organisations. Its findings are broadly comparable with other research findings and theories in this area of research. Thus, this study reinforces the limited evidence already available and adds new insights to this applied area. Nevertheless, much more still needs to be learnt about the organisational dynamics underpinning performance decline and turnaround, particularly how organisations are able to better diagnose performance failure, halt organisational decline, and sustain continuous performance improvement over the long term. In the NHS these issues will be brought into sharper focus as market mechanisms are increasingly applied to the finance and management of NHS trusts.

Based on the findings of the empirical case study and review of the theoretical and evidence base, the following lessons and policy implications are drawn for policy makers, regulators and health care organisations wishing to turnaround their performance.

9.1 Policy implications and lessons for turnaround

- **Tracking an organisation's performance and early diagnosis of performance problems**

Comprehensive diagnostic mechanisms and tools need to be developed by policy makers and regulatory agencies to track trends in the performance of organisations over time and provide early warnings of potential performance failure. This will allow the focusing of external interventions and remedial action. A range of soft intelligence (qualitative data) and hard information (quantitative data such as core performance indicators) is available to facilitate early diagnosis of problems. It is also important to observe the continued progress of more successful organisations so that lessons can be learned and shared across the NHS.

Over the past five years the performance of NHS organisations has been assessed by a 'star' rating system. Since 2005-2006, however, the Healthcare Commission has used a new system, the 'annual health check', which aims to produce a more 'balanced scorecard' of quality and performance using a four-point scale ranging from

"excellent", "good", "fair" or "weak". Trusts are now rated on two major dimensions: 'quality of services' and 'use of resources'. To assess the quality of services, a range of areas that matter to patients are assessed using three measures including: meeting 'core standards' of care (covering safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, the care environment and amenities, and public health), meeting targets set by governments (both existing and new national targets), and reviewing of specific services or topics (e.g. tobacco control, management of admissions and diagnostics services). This new system should improve on the problems araised with the star rating, but nevertheless require careful monitoring and evaluation to guide the development of policy. The introduction of new market based and competitive policies in the NHS (e.g. Payment by Results and patient choice) the number of failing health care organisations is likely to increase in the future. As the environment is likely to be more volatile and unpredictable, the NHS organisations, may face financial instability, uncertainty and service difficulties. Therefore, these issues again highlight that the organisations need to track their performance more carefully and the necessity for the existence of turnaround teams consisting of experienced staff in financial and operational fields became more evident.

So more focus on identification of poorly performing organisations and assisting them to turnaround the situation appears to be an increasingly important issue. NHS organisations should track their performance using both hard and soft data. The range and type of hard and soft data may vary between different types of organisations. Harvey et al. (2005) draw out some examples of hard and soft intelligence, which could form the basis of monitoring and assessment:

Hard information includes performance indicators in the following areas: the achievement of key performance targets; the maintenance of financial balance; complaints (the level of complaints, seriousness of reported complaints and the level of satisfactory resolution of complaints); medical incidents (the level and severity of patient safety incidents); the findings and conclusions of audit studies and external reviews (e.g. Healthcare Commission, staff and patient surveys, national audit programmes, and Audit Commission investigation); the level of staff turnover; and the severity of recruitment and retention problems.

Soft information (qualitative and informal intelligence) that may be gathered includes: the level of staff morale; the level of the accuracy and availability of the data

relating to organisational performance; the use of available data by the organisation; the organisation's level of awareness of what is happening both internally and externally; the level of distraction caused by major projects being undertaken within the organisation (e.g. PFI, mergers, major restructuring); the quality of the organisation's response to the signs of decline; the quality of relationships with external organisations (e.g. the SHA, commissioners and other stakeholders); the quality of relationships between managers and clinicians; and the relationship between the organisation and local media.

- **Diagnosis of problems**

This study has shown that diagnosis of the cause of performance problems within the Trust, undertaken by its managers and by external organisations, facilitated the selection of appropriate programmes and strategies to address and turnaround the poor performance. To increase the success of turnaround interventions, the underlying factors (both internal and external), contributing to performance decline should be identified and an appropriate action plan developed on the basis of the correct identification of these factors. Policy makers need to develop better bespoke tools to aid the early diagnosis of organisational failure and decline.

- **Turnaround requires investment in resources and skills**

The findings of this study and a review the relevant literature, indicate that although the replacement of the senior management team appears to be a requirement for performance improvement in poorly performing organisations, any incoming managers need to process broad blend of core managerial skills, as well as ready access to financial resources and external assistance (e.g. use of mentors or consultants). This issue is more important when organisations seek to sustain over the long term their hard won performance improvement. It should be borne in mind that, although the number of failing organisations is small percentage in the NHS, those that are under-performing affect service delivery across the local health economy and absorb a greater proportion of resources.

- **Turnaround takes time**

Remedying a crisis situation takes an extended period of time, and policy makers, external agencies and regulators need to allow sufficient time to assess the effectiveness of turnaround strategies and interventions. External stakeholders must

have realistic expectations, although it remains a fact of life that for political reasons, performance improvement is often sought within a very short period of time.

- **Leadership skills**

As this study and the literature review have revealed, competent leadership is a crucial factor in the success of the turnaround process. The NHS suffers from a lack of talented managers who are able to assist organisations in crisis situations (Ham, 2005), and policy makers should employ mechanisms to develop appropriate leadership capabilities in senior management. It is vital that senior managers have both management and leadership capabilities and skills.

- **Development of an 'open' culture**

This study, as well as the literature review, illustrated that in organisations with a 'fear culture', staff are not willing to raise concerns regarding performance problems or report mistakes because of the risk of being blamed or 'scapegoated' by senior managers. Alternatively, it was shown that the development of a more transparent and open culture helped the Trust to improve its performance. This kind of culture provides opportunities for staff to disclose performance difficulties (e.g. constructive discussion during meetings) and report mistakes which occur in the workplace, and is likely to lead to the development of a learning environment within the organisation. Development of an open, 'no blame' culture by the organisations' managers is recommended, as this may help to sustain their organisational performance and prevent the occurrence of similar difficulties in future.

- **Secure engagement of clinical staff**

This study showed that involving clinical staff in the decision making process and management of the Trust appeared to help improve the organisation's performance. Policy makers should encourage organisations to engage the interest of their clinical staff, particularly clinical consultants and by so doing, to decrease the risk of resistance to change and provide more commitment and ownership of problems among clinical health professionals. One way of addressing this issue would be to integrate into external performance assessment systems measure of the quality of clinical staff engagement with the 'corporate vision'.

- **Work with external stakeholders**

This study, and the findings of the literature review, have shown that it is important for acute trusts to develop and enhance their relationships with external stakeholders within the local health economy in order to avoid performance decline and sustain performance improvement. Doing so may bring more support for the organisation from external stakeholders, and also expand working partnerships and mutual collaboration with these organisations. Hospital managers should be encouraged, perhaps by use of incentives, to proactively develop their working relationships with other organisations in the local health economy. Moreover, increased community and user perspectives should be sought by acute trusts during the turnaround process, to try to ensure that their requirements are met and that change does not adversely affect their interests.

- **Development and improvement of recruitment policies**

Because of the importance of the role of senior managers, particularly CEOs, in the process of organisational turnaround, it is crucial when a replacement intervention is planned, for an organisation to recruit to key posts, appropriate managers with relevant core managerial skills and capabilities. In a poorly performing organisation, replacement of incumbent managers with inappropriate managers is unlikely to result in a successful turnaround, although even replacement with appropriate people does not necessarily guarantee success.

- **Focus on performance management system**

This study and literature review showed that the lack of a robust and effective performance management system contributed to performance decline within the Trust. A greater focus on the development and implementation of a performance management system helped the organisation to turnaround the crisis situation, at least in terms of short term performance improvement. Such a performance management system would help provide ownership of performance issues and develop a clear line of accountability. The policy makers should invest more in the development of an effective performance management system, by investing in and developing good information systems, which provides timely and accurate data relating to key aspects of organisational performance.

- **Internal award systems**

As this study has shown, the staff were not satisfied with the rewards they received when the Trust was rated as three stars, in comparison with those awarded by another Trust situated in their neighbourhood. They felt that that their efforts had not been sufficiently appreciated and this affected their morale. Appropriate reward systems need to be developed to motivate staff and show that senior managers value and appreciate their efforts in turning around under performance.

- **Avoiding duplication in deploying inspection and support mechanisms**

In order to avoid duplication, confusion and waste of resources, only a limited number of inspectors, auditors and external assessors should be sent to a failing organisation at any one time. As this study has shown, the Trust's managers perceived that the presence of a large number of investigators was sometimes an impediment to virtuous performance improvement.

- **Contextual factors should be taken into account**

This study indicated that the Trust's performance had been affected by the low socio-economic background of patients and the resulting high workload was beyond the control of the Trust's managers. The impact on an organisation's performance of contextual factors (e.g. deprivation), which are beyond the control of the organisations' management team, should be considered by central government when offering rewards or impose sanctions on organisations. It is recommended that the national performance measurement system takes into account the impact of contextual factors on organisational performance.

- **Tailor-made approaches**

Since the causes of performance decline, the local context, and the level of capability, capacity and cognition (explained in Chapter 3) are unique to each organisation, so a series of generic and 'one size fits all' turnaround prescriptions is unlikely to result in performance improvement for all types of organisations. A tailor-made approach, which uses a range of specific tools tailored to local circumstances and contingencies, is required when attempting to increase the chance of successful turnaround. For example, the use of interim managers may not be appropriate in an attempt to turnaround poor performance.

- **Enhancing quality of external audit**

This study has shown that, when less than rigorous audit was carried out by external auditors they were unable to discover data misrepresentation within the organisation, thus allowing Trust to continue this malpractice. Therefore, a more robust and comprehensive auditing system is required to ensure the quality and accuracy of data presented by different organisations at local and national level. Heavy penalties could also be applied to deter such behaviour at the local level.

- **Use of experienced staff in external performance improvement teams**

The use of an experienced external consultant helped the Trust to diagnose and solve several key performance problems. Policy makers are advised to develop mechanisms which enable the use of such experienced people when dealing with poorly performing organisations. Indeed, the development of performance improvement teams (turnaround teams) with experienced staff who are able to work with organisations (but not in the capacity of inspectors) seems useful in the future as the number of failing organisations is likely to increase under the financial pressures and recent policy changes in the NHS.

- **Diagnosis and mitigating the impact of dysfunctional consequences of interventions during the turnaround process**

This study and the literature review showed that focusing mainly on performance targets set by central government during the turnaround process distracted managers from considering issues that were not subject to the performance measurement system (e.g. quality of services) and might hinder performance improvement over the medium or longer term. Therefore it is recommended that policy makers develop mechanisms to monitor and mitigate such dysfunctional consequences. More involvement of service users is recommended to ascertain their views, which may thereby disclose performance weakness.

9.2 Research implication

Based on the findings of the empirical case study and literature review, further research is recommended in the public sector particularly in NHS organisations:

- Longitudinal studies are required to track the performance of organisations following implementation of turnaround interventions and to record which performance improvements become embedded and are sustained over the long term. Thus longer-term performance fluctuations could be investigated, so that dynamic the issues affecting sustainable performance improvement can be better identified and targeted. It should be borne in mind that longitudinal approaches also have limitations. For example, to carry out longitudinal work, the research team needs allocate a more significant amount of time and effort.

- Organisational failure and turnaround are complex, multifaceted and dynamic processes, so multi-method (both quantitative and qualitative) and multi-disciplinary research is suggested when exploring this complexity in the natural setting. It is recommended that studies be conducted to compare both successful and unsuccessful attempts at turnaround.

- As the literature review showed, theoretical frameworks have generally not underpinned in studies conducted in this area, so research underpinned by sound theoretical frameworks is required in order to provide better guidance for policy makers.

- According to McKiernan's model, symptoms, secondary, and primary causes of failure are interdependent. When trying to gain a better understanding of the nature of organisational failure, further research is recommended in order to scrutinise the relationships between markers and causes of failure and to identify links to turnaround interventions within the public sector. In addition, the complex interplay between the various secondary causes of failure should be further explored.

- More comparative studies are recommended across health systems and between other public services to identify similarities and differences in relation to organisational failure and the turnaround processes among public organisations.

- As there is limited evidence of the impact of contextual factors, which are beyond the managerial control, on the process of organisational failure and the turnaround process in the public sector, particularly the health sector, further research is recommended to evaluate the impact of these factors (e.g. socioeconomic factors, size of the organisation) on the level of failure or success of public service organisations, especially in the health sector. Moreover, examination of how the

management strategies can mitigate the negative impact of these factors is recommended.

- Further research, particularly using a longitudinal approach, is needed to examine the role and effectiveness of external supporting agents in the process of turnaround and to explore the interaction between the key change agent roles and the organisations' managers during the period of turnaround. It is also helpful to explore the impact of the levels of expertise, skill and the style used by the members of the external supporting agencies when approaching the organisation, on the outcome of the turnaround interventions they suggest. This kind of research may reveal how long and how closely the external agents need to work with poorly performing organisations. This empirical research showed that the Trust's senior managers were willing to retain contact with a member of the external supporting agency for a long period of time, so it may be useful to explore why and how willingly the organisations in the health sector, and other public sectors, keep their contact with external agencies.

- As the literature review revealed, permanently failing organisations are unable to initiate the turnaround process by themselves and external intervention and support is necessary to initiate the process of change. More research is needed to explore how government agencies need to react to permanently failing organisations, the kinds of intervention likely to be effective, and the length of time such interventions may be needed.

- As this study and literature review highlighted, 'self regulating' organisations are able to initiate turnaround interventions by themselves without receiving direct intervention from outside, and need less external support and resources than 'permanently failing' organisations, although the former may absorb scarce resources. As a consequence, further research is required to develop tools to distinguish between those organisations that are self regulating and those that are permanently failing. This would provide the opportunity for external supportive organisations to focus their support and extra resources to those organisations unable to initiate turnaround by themselves.

- Owing to the political context within which public service organisations operate and the continuous change in the policy landscape, research is required to examine the impact of external environmental change, such as governmental policy reforms on performance of NHS organisations (e.g. Payment by Result, Patient Choice, new

financial scheme for organisations and practice based commission) and on the process of failure and turnaround, over time.

- The role of leadership in the turnaround process is vital and further research is recommended to explore the impact of the role of the CEO and senior management team and their leadership style on the effectiveness of the turnaround process and sustaining performance improvement. This may reveal the type of leadership style likely to be effective during different stages of the turnaround, particularly when leaders seek to sustain performance improvement. The leadership style could be evaluated using comparative studies between and within successful and unsuccessful organisations, in terms of the turnaround process.

- There is limited evidence to show whether insider or outsider succession is more effective in the public sector, and further research is recommended to investigate this issue more broadly. As the review showed, in some circumstances interim managers were appointed during the turnaround process, so more research is needed to evaluate their roles and how they are perceived by other managers at different levels of the organisational hierarchy. Moreover, it is helpful to explore the solutions to the conflicts that might have happened between different stakeholders and interim managers.

- More research is required to explore the impact of user involvement and consultation on the decisions made by the organisations and how those decisions may contribute to organisational performance, failure and turnaround processes.

- The prescription of a series of generic and 'one size fits all' turnaround interventions is unlikely to result in performance improvement for all types of organisations, so further research is needed to show the kinds of turnaround strategies (reorganisation, retrenchment and repositioning) that are more effective and under what circumstances in the public sector.

- As found by this research and the literature review, turnaround interventions and efforts to attain targets caused a range of unintended consequences (e.g. tunnel vision and distortions of clinical priorities; bullying, intimidation, stress and anxiety; erosion of public Trust and reduced staff morale). Further research is needed to evaluate how these unintended consequences of turnaround interventions, particularly the increased level of stress and anxiety among staff, affect performance improvement in the long term.

- Further research is recommended to explore the types of intervention strategies central government agencies and the local SHA should attempt with high performing organisations when they start to show a downward trend in performance.

- An interesting point is that the Trust gave permission to the researcher to conduct his research when the performance of the Trust had improved and the pressure and stress on the Trust had decreased. The Trust was not willing to allow research to be carried out when it was under investigation by a range of teams from various organisations. So, they refused to give permission for research to be done by a team who were conducting a large project on the turnaround process in different organisations. Refusing access may be related to the lack of time that the managers had at that crucial stage or some managers may have viewed the research team as other investigators or as an unwanted distraction or hindrance factor. Therefore, it seems that organisations are more likely to grant permission for research to take place when they have been successful in turning around situations than when they are still involved in crisis situations. This is an issue which needs to be factored into the design of future research in this area.

References

Aldrich, H.E. & Auster, E.R. (1986). Even dwarfs start small: liabilities of age and size and their strategic implications. In B.M. Staw and L.L. Cummings (eds). Research in Organisation Behavior. JAI Press, 165–198.

Alexander, J.A. & Lee, S.Y.D. (1996). The effects of CEO succession and tenure on failure of rural hospitals. Journal of Applied Behavioral Science, 32(1), 70–88.

Altman, E. (1983). Corporate Financial Distress: A Complete Guide to Predicting, Avoiding, and Dealing with Bankruptcy. New York: John Wiley & Sons.

Anderson, P., Tushman, M. (2001). Organizational environments and industry exit: the effects of uncertainty, munificence and complexity. Industrial and Corporate Change, 10, 675–711.

Andrews, R., Boyne, G., Enticott, G. (2006). Performance Failure in the Public Sector: misfortune or mismanagement? Public Management Review. 8,2, 273-296.

Anheire, H., Moulton, L. (1999). Studying organizational failure. In Anheire, H. (Ed), When things go wrong – organizational failure and beakdraws, Thousands Oaks, Sage publications, 273-290.

Appleby, J., Devlin, N., Deeming, C., Harrison, A. (2002) A critical appraisal of NHS systems of performance measurement. London: Commission for Health improvement.

Arogyaswamy, K., Barker, V., Yasai-Ardekani, m. (1995). Firm Turnarounds: An Integrative Two-Stage Model. Journal of Management Studies, 32, 493-525.

Argyris, C. & Schon, D. A. (1978). Organizational learning: A theory of action perspective. Reading, MA: Addison-Wesley.

Arthur, J.B. (1994). Effects of Human Resource Systems on Manufacturing Performance and Turnover. Academy of Management Journal, 37, 670–87.

Atkinson, P.E. (1990). Creating culture change. Management services, 34 (7), 6-10.

Audit Commission. (2006). Learning the lessons from financial failure in the NHS. London: Audit Commission.

Bache, I. (2003). Not Everything That Matters Is Measurable And Not Everything That Is Measurable Matters: How and Why Local Education Authorities "Fail"' Local Government Studies, 29 (4), 76-94.

Balgobin, R., Pandit, N. (2001). Stages in the turnaround process: The case of IBM UK. European Management Journal, 19, 301–316.

Barker, V., Mone, M. A. (1994). Retrenchment: Cause of Turnaround or Consequence of Decline? Strategic Management Journal, 15, 395-405.

Barker, V. III., Duhaime, I. (1997). Strategic change in the turnaround process: theory and empirical evidence. Strategic Management Journal, 18, 13–38.

Barker, V. L. III., Mone, M. A. (1998). The mechanistic structure shift and strategic reorientation in declining firms attempting turnarounds. Human Relations, 51(10),1227–1258.

Barker, V.L. III, Patterson, Jr. P.W., Mueller, G.C. (2001). Organisational causes and strategic consequences of the extent of top management team replacement during turnaround attempts. Journal of Management Studies, 38(2), 237-269.

Barker V., Patterson, Jr. P.W. (1996). Top Management Team Tenure and Top Manager Causal Attributions At Declining Firms Attempting Turnarounds. Group and Organisation Management, 21, 304-336.

Blaxter, M. (1996) Criteria for evaluating qualitative research. Medical Sociology News, 22, 68-71.

Barr, P., Stimpert, J., Huff,A. (1992). Cognitive Change, Strategic Action and Organisational Renewal. Strategic Management Journal, 13, 15-36.

Baum, J.A.C. (1996). Organisational ecology. In S.R. Clegg et al. (eds). Handbook for Organisation Studies, 77-114. London: Sage.

Bibeault, D. G. (1982). Corporate turnaround: How managers turn losers into winners. New York: McGraw-Hill.

Borins, S. (1998). Innovating with Integrity: How Local Heroes are Transforming American Government, Washington: Georgetown University Press.

Borins, S. (2001). Innovation, success and failure in public management research: Some methodological reflections. Public Management Review, 3(1), 3-18.

Boulding, K.A. (1950). A Reconstruction of Economics. New York: Wiley.

Bowling,A. (2002). Research methods in health: Investigating health and health services. 2nd edition, Buckingham: Open University Press.

Boyne, G.A. (2002). Public and Private Management: What's the Difference? Journal of Management Studies, 39, 97-122.

Boyne, G. & Dahya, J. (2002). Executive succession and the performance of public organisations. Public Administration, 80(1), 179-200.

Boyne, G.A. & Gould-Williams, J. (2003). Planning and Performance in Public Organizations: An Empirical Analysis. Public Management Review 5, 115-32.

Boyne, G.A. (2003a). What is Public Service Improvement? Public Administration, 81,2, 211-228.

Boyne, G., Martin, S., Reid, S. (2004). Learning from the experience of recovery policy paper 3: Strategies for organisational recovery in local government: retrenchment, repositioning and reorganisation. Cardiff Business School, Cardiff University.

Boyne, G. (2004a). A '3Rs' strategy for public service turnaround: retrenchment, repositioning and reorganisation. Public Money and Management, 24(2), 97-103.

Boyne, G. (2004b). Strategies for public sector turnaround. working paper, Cardiff Business School.

Boyne, G. & Meier, K.J. (2005). Good luck, good Management and organisational turnaround in the public sector. Working paper, Cardiff Business School.

Boyne, G. (2006). Strategies for public service turnaround: lessons from the private sector. Administration and society, 38,3, 365-88.

Boynton, P.M. & Greenhalgh, T. (2004). Selecting, designing and developing your questionnaire. British Medical Journal, 328, 1312-1315.

Bruton G.D., Oviatt, B.M., White, M.A. (1994). Performance of acquisitions of distressed firms. Academy of Management Journal, 37(4), 972–989.

Bruton, G., Wan, J. (1994). Operating Turnarounds and High Technology Firms. The Journal of High Technology Management Research, 5, 261-78.

Bruton, G., Ahlstrom, D, Wan, J. (2003). Turnaround in East Asian Firms: Evidence from Ethnic Overseas Chinese Communities. Strategic Management Journal, 24, 519-40.

Bryman, A. (1984). The debate about quantitative and qualitative research: A question of method or epistemology. The British Journal of Sociology, 35(1), 75-93.

Burke, R.J. (1994), "Mentors in organizations", Group and Organization Studies, 9, 353-72.

Burrell, G., Morgan, G. (1979). Sociological Paradigms and Organisational Analysis. London: Heinemann.

Burns, A.C. (1990). The use of live case studies in business education: Pros, cons and guidelines. In Guide to business gaming and experiential learning, edited by James Gentry, 201-215. London: Nichols/GP Publishing.

Cameron, k.S. (1986). Effectiveness as paradox: Consensus and conflict in conceptions of organizational effectiveness. Management Science, 32, 539-553.

Cameron, K.A., Sutton, R.I. and Whetten, A.D. (1988). Readings in Organisational Decline: Framworks, Research, and Prescriptions. Cambridge, MA: Ballinger.
Carroll, G.R. (1984). Dynamics of publisher succession in newspaper organisations. Administrative Science Quarterly, 29, 303–329.

Chowdhury, S., Lang, J. (1994). Turnaround Actions, Contingency Influences and Profitability: The Case for Slack and Capital Intensity. Canadian Journal of Administrative Sciences, 11, 205-13.

Chowdhury, S., Lang, J. (1996). Turnaround in Small Firms: An Assessment of Efficiency Strategies. Journal of Business Research, 46, 169-78.

Chowdhury, S. (2002). Turnarounds: A stage theory perspective. Canadian Journal of Administrative Sciences, 19, 249–266.

Cochrane Handbook for Systematic Reviews of Interventions - version 4.2.5. (2005). http://www.cochrane.dk/cochrane/handbook/hbook.htm

Connolly, T., Conlon, E.J., Deutsch, S.J. (1980). Organizational effectiveness: A multiple-constituency approach. Academy of Management Review, 5, 211-217.

Contino, R. & Lorusso, R. (1982). The Theory Z Turnaround of a Public Agency. Public Administration Review, 42, 56-72.

CRD (2001). Undertaking systematic reviews of research on effectiveness: CRD's guidance for carrying out or commissioning reviews, 2nd Edition, University of York.

Crow, S.M. & Hartman, S.J. (2003). A case study of organisational decline: Lessons for health care organisations. Health Care Manager, 22 (3), 256-264.

D'Arcimoles, C.H. (1997). Human Resource Policies and Company Performance: A Quantitative Approach Using Longitudinal Data. Organization Studies, 18, 857–74.

Dailey, C., Schwenk, , C. (1998). Chief Executive Officers, top management teams and board of directors. Journalof management, 22, 185-208.

Daily, C.M. & Dalton, D.R. (1994). The role of governance in corporate decline: A review and research agenda. Advances in Applied Business Strategy, 5, 239–60.

Davies H.T. & Lampel, J. (1998). Trust in performance indicators? Quality in Health Care, 7 (3), 159–162.

Davies, HTO., Mannion, R., Jacobs, R., Powell, AE., Marshall, MN. (2003). Does organizational culture influences hospital performance? Paper presented in Academy Health annual meeting, Nashville (TN).

D'Aveni, R.A. (1989). The aftermath of organisational decline: A longitudinal study of the strategic and managerial characteristics of declining firms. Academy of Management Journal, 32, 577–605.

D'Aunno, T. & Sutton, R. (1992). Organizational responses to financial adversity: a partial test of the threat rigidity hypothesis. Journal of Management, 18, 117–131.

Dawley, D., Hoffman, J., Lamont, B. (2002). Choice situation, refocusing, and post-bankruptcy performance. Journal of Management, 28 (5), 695-717.

Decker, J. & Paulson, S. (1988). Performance Improvement in a Public Utility. Public Productivity Review, 11, 3, 51-65.

Delery, J.E. & Doty, D.H. (1997). Modes of Theorizing in Strategic Human Resource Management: Tests of Universalistic, Contingency and Configurational Performance Predictions. Academy of Management Journal, 39, 802–35.

Denzin, N. (1984). The research act. Englewood Cliffs, NJ: Prentice Hall.

Department of Health. (2000). The NHS Plan: a Plan for Investment; a Plan for Reform. London, Department of Health.

Department of Health (2000b). An Organisation with a Memory: Report of an expert Group on learning from Adverse events in the NHS chaired by the Chief Medical Officer. London, Department of Health.

Department of Health (2001). NHS Performance Ratings Acute Trusts 2000-2001, Department of Health, London.www.doh.gov.uk/performanceratings/performance.pdf

Department of Health (2002). NHS Performance Ratings, Acute Trusts, Specialist Trusts, Ambulance Trusts, Mental Health Trusts 2001/02, Department of Health, available at: www.doh.gov.uk.

Department of Health (2004). Departmental report: Modenisation Agency. www.DoH.gov.uk/Publications and Statistics/Publications/AnnualReports.

Department of Health (2004). Increasing plurality of provision: Patients need a range of different services to exercise choice. Department of Health report.

Department of Health (2005). Patient Choice. http://www.dh.gov.uk/Policyand guidance/patientchoice/fs/en. Department of Health.

Dess, G.G., Beard, D.W. (1984). Dimensions of organisational task environments. Administrative Science Quarterly, 29, 52–73.

Dobrev, D.S., Kim, T.Y., Hannan, M.T. (2001). Dynamics of niche width and resource partitioning. American Journal of Sociology, 106, 1299–1337.

Donaldson, L. (1999). Performance Driven Organisational Change, London: Sage.

Dumaine, B. (1990). The new turnaround champs. Fortune, 122(2), 36-44.
Easterby –Smith, M. Thorpe, R. & Lowe, A. (1991). Management Research: an introduction. Sage, London.

Edwards, N., Protopsaltis, G., Fulop, N., Meara, R. (2003). Failure and turnaround: dealing with failing hospitals. London: NHS Confederation.

Edwards, P., Shaoul, J., Stafford A. and Arblaster, L. (2004). Evaluating the operation of PFI in roads and hospitals. ACCA Research Report No. 84, Executive summary.

Egger, M. & Smith, G.D. (1998). Meta-analysis bias in location and selection of studies. British Medical Journal, 316, 61-6.

Eisenhardt, K. M. (1989). Building theories from case study research. Academy of Management Review, 14(4), 532-550.

Eitel, D. F. (2004). The dynamics of chronic failure: A longitudinal study. Public Money and Management, 24(4), 243-250.

Evans, J. & Green, C. (2000). Marketing Strategy, Constituent Influence, and Resource Allocation: An Application of the Miles and Snow Typology to Closely Held Firms in Chapter 11. Bankruptcy. Journal of Business Research, 50, 225-231.

Ferrier, W., MacFhionnlaoich, C., Smith, K., Grimm, C. (2002). The impact of performance distress on aggressive competitive behavior: a reconciliation of conflicting views. Managerial and Decision Economics, 23, 301–316.

Ferrier, W., Lyon, D. (2004). Competitive repertoire simplicity and firm performance: The moderating role of TMT heterogeneity. Managerial & Decision Economics, 25: 317-327.

Finkin, E.F. (1985). Company turnaround. Journal of Business Sratetgy, 5, 40, 14-24.

Fisher, C., & Alford, R. (2000). Consulting on Culture. Consulting Psychology: Research and Practice, 52(3), 206-217.

Flyvbjerg, B. (2004). Five misunderstanding about case-study research. In Handbook of qualitative studies. In C. Seale et al. (eds): Qualitative Research Practice, 420-34. London: Sage.

Fox, P. (2003). Learning From the Experience of Recovery Policy Paper 1: Good practice and recovery planning. Institute of Local Government Studies, University of Birmingham available from http://www.inlogov.bham.ac.uk/research/recoveryresearch.htm.

Fulop, N., Scheibl, F., Edwards, N. (2004). Turnaround in Health Care Providers. London: London School of Hygiene and Tropical Medicine.

Gaffney, D., Pollock, AM., Price, D., Shaoul, J. (1999). NHS capital expenditure and the private finance initiative: expansion or contraction? British Medical Journal, 319, 48-51.

Glaser, B. & Strauss, A. (1967). The discovery of grounded theory. Chicago: Aldine.

Goddard, M., Mannion, R., Smith P.C. (1999). Assessing the Performance of NHS Trusts: The Role of 'Hard' and 'Soft' Information. Health Policy, 48, 119-34.

Goodman, S.J. (1982). How to manage a Turnaround. New York: Free press.

Gray, J. & Wilcox, B. (1995). In the aftermath of inspection: the nature and fate of inspection report recommendations. Research Papers in Education, 10(1), 1–18.

Gray, J., D. Hopkins, D. Reynolds, B. Wilcox, S. Farrell and Jesson (1999). Improving Schools: Performance and Potential. Buckingham: Open University Press.

Gray, J. (2000). Causing Concern but Improving: A Review of Schools' Experiences on Special Measures, London: Department for Education and Employment Research Series.

Green, J., Thorogood, N. (2004). Qualitative Methods for Health Research. London: Sage Publications.

Greenhalgh, L. (1983). Organisational Decline. Research in the sociology of organizations, 2, 231-76.

Greenhalgh, T., Robert, G., Bate, P., Kyriakidou, O., Macfarlane, F., Peacock, R. (2004). A systematic review of the literature on diffusion, dissemination and sustainability of innovations in health service delivery and organisation. Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO), London.

Griffiths, C., Kaur, G., Gantley, M., Feder, G., Hillier, S., Goddard, J., Packe, G. (2001). Influences on hospital admission for asthma in south Asian and white adults: qualitative interview study. British medical journal, 323, 962-962.

Gulland, A. (2002). Health professionals question "star ratings" for NHS. British medical journal, 325, 236.

Grinyer, P., Mayes, D., McKiernan, P. (1988). Sharpbenders. Oxford: Basil Blackwell.

Grinyer, P. & McKiernan, P. (1990). Generating major changes in stagnating companies. Strategic Management journal, Summer volume, 131-146.

Hall, W.K. (1980). Survival strategies in a hostile environment. Harvard Business Review, September-October, 75-85.

Hambrick, D.C. (1985). Turnaround Strategies. In W. Guth, (ed). Handbook of Business Strategy, Boston, Warren, Gorham and Lamont.

Hambrick, D. C. & D'Aveni, R.A. (1988). Large corporate failures as downward spirals. Administrative Science Quarterly, 33, 1–23.

Hambrick, D. & Mason, P. (1984). Upper echelons: the organization as a reflection of top managers. Academy of Management Review, 9, 193–206.

Hambrick, D., Schecter, S. (1983). Turnaround Strategies for Mature Industrial – Product Business Units. Academy of Management Journal, 26, 231-48.

Hannan, M.T., Freeman, J.H. (1988a). The ecology of organisational mortality: American labor unions, 1836–1985. American Journal of Sociology, 94, 25–52.

Hannan, M. & Freeman, J.H. (1988b). Structural inertia and organisational change. In K. Cameron, R. Sutton and D. Whetten (eds). Readings in Organisational Decline: frameworks, research and prescriptions, Cambridge, Mass.: Ballinger.

Hannan, M. T., Freeman, J. H. (1989). Organizationalecology. Cambridge, MA: Harvard University Press.

Hardy, C. (1987). Investing in retrenchment: avoiding the hidden costs. California management review,29, 4, 111-25.

Harker, M., Sharma, B. (1999). Leadership and the Company Turnaround Process. Leadership and Organisational Development Journals, 31(6), 36-47.

Harrigan, K. (1980). Strategies for declining industries. Journal of Business Strategy, 1(2), 20–34.

Harris, J. (1998). Performance models: enhancing accountability in academe. Public productivity and Management Review, 22, 2, 124-35.

Harris, A., Chapman, C. (2002). Leadership in schools facing challenging circumstances, Nottingham, National College for School Leadership.

Harris, A., Muijs, M., Chapman, C., Stoll, L., Russ, J. (2003). Raising attainment in schools in the former coalfields areas, London: DfES.

Harvey, g., Hyde, P., Walshe, K. (2005a). Investigating 'turnaround' in NHS organisations supported by the Performance Development Team (PDT) of the Modernisation agency. Final research report, Centre for public policy and management, Manchester Business Scholl, University of Manchester.

Harvey, G., Hyde, P, Walshe, K. (2005b). Recognising, understanding and addressing performance problems in healthcare organisations providing care to NHS patients: A developmental resource. Working paper, Centre for Public Policy and Management, University of Manchester, UK.

Hauck K, Street A. (2007). Do targets matter? A comparison of English and Welsh national health priorities. *Health Economics*.16, 275-90.

Healthcare Commission (2004). Assessment for Improvement: Our Approach. London.

Helmich, D.L. (1974). Organizational growth and succession patterns. Academy of Management Journal, 17, 771–775.

Henderson, A.D. (1999). Firm strategy and age dependence: a contingent view of the liability of newness, adolescence, and obsolescence. Administrative Science Quarterly, 44, 281–314.

Hendrick, R. (2003). Strategic Planning Environment, Process, and Performance in Public Agencies. Journal of Public Administration Research and Theory, 13(4), 491-519.

Hertz, R. (1997). Reflexivity ad voice. In Reflexivity and voice. R. Hertz (ed) pp Vii-XViii. Thousand Oaks, CA: Sage.

Hofer, C. W. (1980). Turnaround strategies. Journal of Business Strategy, 1, 19–31.

Hoffman, R.C. (1989). Strategies for corporate turnarounds: What do we know about them? Journal of General Management, 14 (3), 46–66.

Holloway, I. (2005). Qualitative Research in Health Care. Maidenhead: Open University Press.

Holzer, M. (1988). Productivity In, Garbage Out: Sanitation Gains In New York. Public Productivity Review, 11, 3, 37-50.

Hoque, K. (1999). Human Resource Management and Performance in the UK Hotel Industry. British Journal of Industrial Relations, 37, 419–43.

Huff, J.O., Huff, A.S., Thomas, H. (1992). Strategic renewal and the interaction of cumulative stress and inertia. Strategic Management Journal, 13, 55-75.

Hughes, M., Skelcher, C., Jas, P., Turner, D. and Philip Whiteman. (2004). Learning from the Experience of Recovery: Paths to Recovery – 2nd Annual Report, London: Office of the Deputy Prime Minister.

Ingraham, P.W., Joyce, P.G., Donahue, A.K. (2003). Government performance: why management matters. Baltimore, Johns Hopkins.

Inkson, K., Heising, A., Rousseau, D.M. (2001). The interim manager: Prototype of the 21stcentury worker? Human Relations, 54(3), 259- 284.

James, D. (2002). The trouble I've seen. Harvard Business Review, 80(3), 42–49.

Janis, I.L. (1972). Victims of Groupthink. Boston: Houghton-Mifflin.

Jas, P. (2004). The role of interim managers in local authorities recovering from poor performance, Birmingham: Institute of Local Government Studies.

Jas, P. & Skelcher, C. (2004). Performance Failure and Turnaround in Public Sector Organisations: A theoretical and empirical analysis. Birmingham: University of Birmingham, Institute of Local Government Studies.

Jas, P. & Skelcher, C. (2005a). Performance decline and turnaround in public organisations: A theoretical and empirical analysis. British Journal of Management, 16, 195-210.

Jas, P. & Skelcher, C. (2005b). Envisaging performance futures: How cognition, capability and capacity shape public sector turnarounds, Institute of Local Government Studies, University of Birmingham available from http://www.inlogov.bham.ac.uk/research/recoveryresearch.htm.

Jaye, C. (2002). Doing qualitative research in general practice: methodological utility and engagement. Family Practice, 19, 557–562.

Johnson, R. (1996). Antecedents and Outcomes of Corporate Refocusing. Journal of Management, 22, 439-83.

Johnson, G., Scholes, K. (2002). Exploring Corporate Strategy. Prentice-Hall, Europe.

Joyce, P. (2004). The Role of Leadership in the Turnaround of a local Authority. Public Money & Management, 24, 4, 235-242.

Katz, D., Kahn, R. (1978). The social psychology of organizations (2nd Ed.). New York: John Wiley & Sons.

Kaufman, H. (1976). Are Government Organizations Immortal? Washington D.C., Brookings Institution.

Kelly, J. (2004). Corporate leadership: reflections of a CEO and CEO advisor. Long Range Planning, 37, 5, 389-398.

Ketchen, D. (1998). Turnaround Research: Past Accomplishments and Future Challenges. London: JAI Press.

Kimberley, J., Norling, R., Weiss, J.A. (1983). Pondering the performance puzzle: effectiveness in inter organisational settings, in Hall, R.H., Quinn, R.E. (Eds),Organisational Theory and Public Practice, 249-64, Beverly Hills, CA: Sage.

Klepper, S. (1997). Industry life cycle. Industrial and Corporate Change, 6, 145–179.

Kotter, J.P. (1990). A force for change: How leadership differ from management. New York: Free press.

Kravchuk, R., Schack, R. (1996). Designing Effective Performance Measurement systems under the Government Performance and Results Act 1993. Public Administration Review, 56, 4, 348-358.

Lacey, A., Luff, D. (2001). Trent Focus for Research and Development in Primary Health Care: An Introduction to Qualitative Analysis. Sheffield, Trent focus Group.

Lee, T. W. (1999). Using Qualitative Methods in Organizational Research, London: Sage Publications.

Lincoln, Y., Guba, E. (1985). Naturalistic inquiry. New York: Sage.

Lohrke, F., Bedeian, A. (1998). Managerial Responses to Declining Performance: Turnaround Investment Strategies and Critical Contingencies in Ketchen, (ed), Turnaround Research: Past Accomplished and Future Challenges.

Lohrke, F. T., Bedeian, A. G., & Palmer, T. B. (2004). The role of top management teams in formulating and implementing turnaround strategies: A review and research agenda. International Journal of Management Reviews, 5/6, 63-90.

MacDuffie, J.P. (1995). Human Resource Bundles and Manufacturing Performance: Organizational Logic and Flexible Production Systems in the World Auto Industry. Industrial and Labor Relations Review, 48, 197–221.

Mannion, R., Goddard, M. (2002). Performance measurement and improvement in health care. Applied Health Economics and Health Policy, 1(1), 13-23.

Mannion, R., Davies, H.T.O., Marshal, M. (2003). Culture for performance in health care: evidence on the relationship between organizational culture and organizational performance in the NHS. Working paper.

Mannion, R., Goddard, M., Kuhn, M., Bate, A. (2004). Earned autonomy in the NHS. A report for the Department of Health.

Mannion, R., Davies, H., Marshall, M. (2005). Impacts of performance rating in England acute hospital trusts. Journal of Health Services Research Policy, 10(1), 18-24.

Mannion and Street (2006). Managing Activity and expenditure in the new NHS market, Discussion Paper, Centre for Health Economics, University of York.

Martin, S. & Boaz, A. (2000). Public Participation and Citizen-centred Local Government: Lessons from the Best Value and Better Government for Older People Pilot Programmes. Public Money and Management, 20(2), 47–54.

Martin, S.J., Davis, H., Bovaird, A., Downe, J., Geddes, M., Hartley, J., Lewis, M., Sanderson, I., Sapwell, P. (2001). Improving Public Services: Final evaluation of the Best Value Pilot Programme, London: The Stationery Office.

Mason, A., Street, A. (2005). Publishing outcome data: is it an effective approach? Journal of evaluation in clinical practice, 12, 37-48.

Mays, N., Pope C. (1995). Qualitative research: rigour and qualitative research. British Medical Journal, 311, 109–112.

Mays, N., Pope, C. (2000). Quality in qualitative health research. In C. Pope and N. Mays (eds), Qualitative research in healthcare, (2nd edn), London: BMJ Books, 89 –101.

Mays, N., Roberts, E., Popay, J. (2001) Synthesising research evidence. In N. Fulop, P. Allen, A. Clarke and N. Black (eds), Studying the Organisation and Delivery of Health Services: Research Methods, London: Routledge, 188-220.

Mays, N., Pope, C., Popay, J. (2005). Systematically reviewing qualitative and quantitative evidence to inform management and policy-making in the health field. *Journal of Health Services Research & Policy*, 10 (Supp 1), 6-20.

MacDonald, G. (2003). Using systematic reviews to improve social care. Social Care Institute for Excellence, SCIE Reports: No. 4.

MacNealy, M. S. (1997). Toward better case study research. *IEEE Transactions on Professional Communication*, 40,3, 182-196.

McCurdy, H. (1991). Organizational Decline: NASA and The Life Cycle of Bureaus. Public Administration Review 51, 308-315

McKiernan, P. (2002). Turnarounds. In Faulkner, D. and Campbell, A., eds, The Oxford Handbook of Strategy Oxford, Oxford University Press.

Meier, K., Bohte, J. (2003).Not with a Bang But a Whimper: Explaining Organizational Failures. Administration and Society., 35, 11 – 18.

Melin, L. (1985). Strategies for managing turnaround. Long Range Planning, 18(1), 80–86.

Mellahi, K., Jackson, P., Sparks, L. (2002). An Exploratory study into Failure in Successful Organizations: the Case of Marks & Spencer. British Journal of Management, 13, 1, 15 -30.

Mellahi, K., Wilkinson, A. (2004). Organizational failure: A critique of recent research and a proposed integrative framework. International Journal of Management Reviews, 5/6, 1, 21–41.

Merriam, S. (1988). Case study research in education: A qualitative approach. (1 ed.). California: Jossey-Bass.

Meyer, A. (1982). Adapting to environmental jolts. Administrative Science Quarterly, 27, 515–537.

Meyer, M.W., Zucker, L.G. (1989). Permanently Failing Organisations, London: Sage

Micheli, P., Kennerley, M. (2005). Performance measurement frameworks in public and non-profit sectors. Production planning & control, 16,2, 125-34.

Miles, M. B., Huberman, A. M. (1994) Qualitative data analysis: an expanded source book (2nd edn), Thousand Oaks, CA: Sage.

Miller, D. (1991). Stale in the saddle: CEO tenure and the match between organization and environment. Management Science, 37, 34–52.

Miller, D. (1994). What Happens After Success: The Perils of Excellence. Journal of Management Studies, 31, 325-58.

Miller, C., Cardinal, L. (1994). Strategic Planning and Firm Performance: A Synthesis of More Than Two Decades of Research, Academy of Management Journal. 37, 6, 1649 – 65.

Milliken, F., Lant, T. (1991). The effect of an organization's recent performance history on strategic persistence and change: the role of managerial interpretations. In Dutton, J. (ed.), Advances in Strategic Management. Greenwich, CT: JAI Press, 129 –156.

Mone, M. A., McKinley, W., Barker, B.L III (1998). Organizational decline and innovation: A contingency framework. Academy of Management Review, 23: 115–132.

Moore, M. (1995). Creating Public Value Harvard, Harvard University Press.

Mordaunt, J. & Cornforth, C.J. (2004). The role of boards in the failure and turnaround of non-profit organizations. Public Money and Management, 24, 4, 227-234.

Mordaunt, J., Otto, S. (2004). Crisis, failure and recovery and the governance of public and nonprofit organizations: the effects of participation, Paper for the International Society for Third Sector Research.

Morrow, J., Johnson. R., Busenitz, L. (2004). The Effect of Cost and Asset Retrenchment on Firm Performance: The Overlooked Role of A Firm's Competitive Environment. Journal of Management, 30, 189-208.

Mueller, G., Barker, V. (1997). Upper Echelons and Board Characteristics of Turnaround and No turnaround Declining Firms. Journal of Business Research 39, 119-34.

Murphy, E., Dingwall, R., Greatbatch, D., Parker, S., Watson, P. (1998). Qualitative research methods in health technology assessment: a review of the literature. Health Technology assessment, 2.

Neumair, U. (1998). A general model of Corporate Failure & Survival: A complexity Theory Approacj. PhD Dissertation, University of St Gallen.

Office of the Deputy Prime Minister (ODPM). (2004) Learning from the Experience of Recovery, London: ODPM.

Office For Standard in Education. (1996). Report of an inspection carried out under Section 9 of the Education Reform Act 1992.

O'Neill, H. (1986a). Turnaround and Recovery: What Strategy Do You Need? Long Range Planning 19, 1, 80-88.

Palfrey, C., Thomas, P.; Philips, C. (2004). Effective health care management: an evaluative approach. Blackwell Publishing.

Pajunen,K. (2005). Comparative Causal Analysis in Processual Strategy Research: A Study of Causal Mechanisms in Organizational Decline and Turnarounds. Advances in Strategic Management, 22, 419–461.

Pandit, N. R. (2000). Some recommendations for improved research on corporate turnaround. Management 3(2): 31-56.

Pant, L. (1991). An Investigation of Industry and Firm Structural Characteristics in Corporate Turnaround. Journal of Management Studies 28, 623-43.

Paton, R., Mordaunt, J. (2004). What's different about public and non-profit "turnaround"? Public Money and Management, 24, 4, 209-216.

Patterson, M., West, M.A., Lawthom, R. and Nickell, S. (1997) Impact of People Management Practices on Business Performance. London: Institute of Personnel and Development, Issues in People Management, No. 22.

Pawson, R.& Tilley, N. (1998). Realistic Evaluation. London: Sage.

Pearce, J.A., Robbins, K., Robinson, R.B. (1987). The impact of grand strategy and planning formality on financial performance. Strategic Management Journal, 8(2), 125-34.

Pearce II, J.A. & Robbins, D.K. (1993). Toward improved theory and research on business turnaround. Journal of Management, 19, 613–636.

Pearce, J.A. & Robbins, K. (1994). Retrenchment Remains the Foundation of Business Turnaround' Strategic Management Journal, 15, 407-17.

Peterson, S.R., Owens, D.P., Tetlock, E.P., Fan, T.E. , Martorana, P. (1998). Group dynamics in top management teams: groupthink, vigilance, and alternative models of organizational failure and success. Organizational Behavior and Human Decision Processes, 73(2/3), 272–305.

Peterson, R.S. & Behfar, K.J (2003).The dynamic relationship between performance feedback, trust, and conflict in groups: A longitudinal study. Organizational Behavior and Human Decision Processes, 92, 102–112.

Pettigrew, A. (1990). Longitudinal field research on change: theory and practice, Organizational Science, 1, 3, 267-292.

Pettigrew, A. (1988). The Management of strategic change. Basil Blackwell, Oxford.

Pitcher, P., Smith, A. (2001). Top management team heterogeneity: personality, power, and proxies. Organization Science, 12, 1–18.

Plumridge, N. (2005). Payment By Results: The new finding system for the NHS in England- Practical support for Allied Health Professionals. Chartered Society of Physiotherapy, London.

Poister, T. (1988). Success Stories in Revitalizing Public Agencies. Public Productivity Review, 11, 3, 27-36.

Pollit, C., Bouckaert, G. (2000). Public Management Reform. Oxford: Oxford University Press.

Pollock, A.M., Dunnigan, M., Gaffney, D., Macfarlane, A., Majeed, FA. (1997). What happens when the private sector plans hospital services for the NHS: three case studies under the private finance initiative. British Medical journal, 314, 1266-1271.

Pollock, A.M. , Shaoul, J., Vickers, N. (2002). Private finance and "value for money" in NHS hospitals: a policy in search of a rationale? British Medical Journal, 324, 1205-9.

Popay, J., Rogers, A., Williams G. (1998). Rationale and standards for systematic review of Qualitative literature in health services. Qualitative Health Research., 8, 341-351.

Pope, C., Mays, N. (2000). Qualitative Research in Health Care. (Second edition), BMJ Publishing Group.

Pope,C., Ziebland, S., Mays, N. (2000). Analysing qualitative data. British Medical Journal, 320:114-116.

Propper, C., Wilson, D. (2003). The Use and Usefulness of Performance Measures in the Public Sector. Oxford review of Economic Policy, 19, 2, 250-267.

Protopsaltis, G., Fulop, N., Meara, R., Edwards, N. (2002) Turning around failing hospitals, London, The NHS Confederation.

Punch, K.F. (2005). Introduction to social research: quantitative and qualitative approaches, (2nd edition), London: Sage.

Quinn, R. E., Rohrbaugh, J. (1981). A competing values approach to organizational effectiveness. Public Productivity Review, 5, 122–140.

Quinn, R. E., Rohrbaugh, J. (1983). A spatial model of effectiveness criteria: Towards a competing values approach to organizational analysis. Management Science, 29, 363–377.

Ragin, C.C. (1992). Casing and the process of social inquiry. In Charles C. Ragin and Howard S. Becker (eds), what is a case? Exploring the foundation of social inquiry. Cambridge: Cambridge University Press.

Rainey, H.G. (1997). Understanding and Managing Public Organizations (2nd edn). San Francisco: Jossey-Bass.

Rainey, G., Rainey, H. (1986). Breaching The Hierarchical Imperative: The Modularization of The Social Security Claims Process' in D. Calista (ed), Bureaucratic and Governmental Reform, London, JAI Press.

Rainey, H., Bozeman, B. (2000). Comparing Public and Private Organizations: Empirical Research and the Power of the A Priori. Journal of Public Administration Research and Theory, 10, 447-69.

Ranger-Moore, J. (1997). Bigger may be better, but is older wiser? Organizational age and size in the New York life insurance industry. American Sociological review, 62 (6), 903-920.

Ritchie, J. and Spencer, L. (1994). Qualitative data analysis for applied policy research. In, Bryman, A. and Burgess, R.G. (eds.) Analyzing Qualitative Data. London: Routledge.

Robbins, D., Pearce, J., II (1992). Turnaround: retrenchment and recovery. Strategic Management Journal, 13, 287–309.

Schein, E.H. (1985). Organizational Culture and Leadership. San Francisco: Jossey-Bass.

Schein, E.H. (1992). Organizational Culture and Leadership (2nd ed.). San Francisco: Jossey-Bass.

Schendel, D.E. & Patton, G. R. (1976). Corporate Stagnation and Turnaround. Journal of Economics and Business, 28, 3, 236-41.

Schendel, D.E., Patton, G.R., Riggs, J. (1976). Corporate turnaround strategies: a study of profit decline and recovery. Journal of General Management 3, 3–11.

Scott, W.R. (1992). Organizations: Rational, Natural and Open Systems. Englewood Cliffs, NJ: Prentice Hall.

Shaw, C. (2003). How can hospital performance be measured and monitored? Health Evidence Network, World Health Organizations.

Sheaf, R., Schofield, J., Mannion, R., Dowling, B., Marshall, M., McNally, R. (2003). Organisational Factors and Performance: A review of the literature. Report for NHS Service Delivery and Organisation Research & Development Programme, London.

Shekelle, PG. (2005). The English star rating system- Failure of theory or practice? Journal of Health Services Research Policy, 10(1),3.

Shook, C.L. (1998). Turning around turnaround research: The value of process in advancing knowledge. Advances in Applied Business Strategy, 5, 261–80.

Silverman, D. (2004). Qualitative research – theory, method and practice. (2nd edition), London: Sage publications.

Silverman, D. (2005). Doing qualitative research. (2nd edition), London, Sage.

Skelcher, C., Hughes, M., Jas, P., Turner, D., Whiteman, P. (2004). Learning from the Experience of Recovery: Paths to Recovery – first Annual Report available from.
http://www.inlogov.bham.ac.uk/research/recoveryresearch.htm.

Slatter, S. (1984) Corporate Recovery. Harmondsworth, Penguin.

Slatter, S., Lovett, D. (1999). Corporate Turnaround: Managing Companies in Distress. London, Penguin.

Sloma, R.S. (1985). The turnaround manager's handbook. New York, Free Press.

Smith, P.C., Mannion, R., Goddard, M. (2003). Performance management in Health care: Information, Incentives and Culture; HM Treasury Public Services Productivity, Discussion Paper, London, HM Treasury.

Smith, P.C. (2005). Performance Measurement in Health Care: History, Challenges and Prospects. Public Money and management, 25(4), 213-220.

Snelling, I. (2003). Do Star Ratings really reflect hospital performance? Journal of Health Organisation and Management, 17(3), 210-223.

Stake, R. E. (1988). Case Study methods in educational research: seeking sweet water. In R.M. Jaeger (Ed.), Complementary Methods for Research in Education, Washington, DC: American Educational Research Association, 253-265.

Stake, R. E. (1995). The art of case study research . Thousand Oaks , CA : Sage.

Starbuck, W. H., Hedberg, B.L. (1977). Saving an organization from stagnating environments. In Thorelli, H. (ed) Strategy + Structure = Performance, Bloomington, IN: Indiana University Press

Stark, M. (1998). No slow fixes either: how failing schools in England are being restored to health, in Stoll, L, and Myers, K. (eds.) No Quick Fixes: Perspectives on Schools in Difficulty, Lewes: Falmer Press.

Staw, B.M. (1981). The escalation of commitment to a course of action. Academy of Management Review, 6, 577-87

Stead, E., Smallman, C. (1999). Understanding business failure: learning and unlearning lessons from industrial crises. The Journal of Contingencies and Crisis Management, 7,1, 1-18..

Steers, R. M. (1975). Problems in measurement of organizational effectiveness. Administrative Quarterly Science, 20, 546-558

Stephens, J. (1988). Turnaround at the Alabama Rehabilitation Agency. Public Productivity Review, 11, 3, 67-84.

Stopford, J., Baden-Fuller, C. (1990). Corporate Rejuvenation. Journal of Management Studies, 27, 399-415.

Strauss, A.L., Corbin, J. (1990). Basics of qualitative research: Grounded theory procedures and techniques. Newbury Park, CA: Sage.

Sudarsaman, S., Lai, J. (2001). Corporate financial distress and turnaround strategies: An empirical analysis. British Journal of Management, 12, 183–199.

Sutton, R.I., Eisenhardt, K.M., Jucker, J.V. (1986). Managing organizational decline: lessons from Atari. Organizational Dynamics, 14, 4, 17-29.

Tellis, W. (1997a). Introduction to case study. The Qualitative report [On-line serial], 3(2): http://www.nova.edu/ssss/QR/QR3-2/tellis1.html

Tellis, W. (1997b). Application of a case study methodology. The Qualitative Report [On-line serial], 3(3): http://www.nova.edu/ssss/QR/QR3-3/tellis2.html

Tellis, W. (1997c). Results of a case study on information technology at a university. The qualitative report, 3(4): http://www.nova.edu/ssss/QR/QR3-4/tellis3.html

Todd, A.M. (2003). Barriers to smoking cessation in pregnancy: a qualitative study. British Journal of Community Nursing, 8, 2, 56-64.

Terpstra, D.E., Rozell, E.J. (1993). The Relationship of Staffing Practices to Organizational Level Measures of Performance. Personnel Psychology, 46, 27–48.

Thompson, W. (2002). Managing Change to Improve Public Services: Top Down or Bottom Up?, London: Office of Public Service Reform. Available at www.opsr.gov.uk.

Trochim, W.M.K. (1989). Outcomes Pattern Matching and Program Theory. Evaluation and Program Planning, 12, 355-366.

Trochim, W. M. K. (2000). The research methods knowledge base. Retrieved February, 13, 2006, from http://www.socialresearchmethods.net/kb

Thietart, R. (1988). Success Strategies for Business that Reform Poorly. Interfaces, 18, 32-45.

Turner, D., Skelcher, C., Whiteman, P., Hughes, M., Jas, P. (2004). Intervention or persuasion? Strategies for turnaround of poorly performing councils. Public Money and Management, 24 (4), 217 – 226.

Turner, D., Whiteman, P. (2005). Learning from the experience of recovery: the turnaround of poorly performing local authorities. Local Government Studies, 31, 5, 627- 654.

Venning, P. (2002). Analysing Strategic Change in Greater Manchester. Working paper, Manchester Centre for Healthcare Management (MCHM), University of Manchester, Manchester.

Virany, B., Tushman, M.L. & Romanelli, E. (1992). Executive succession and organization outcomes in turbulent environments: an organizational learning approach. Organization Science, 3, 72–91.

Walshe, K., Harvey, G., Hyde, P. & Pandit, N. R. (2004). Organisational failure and turnaround: Lessons for public services from the for-profit sector. Public Money and Management, 24(4), 201-208

Weiss, K. (1995). Sensemaking in Organizations. London, Sage.

Weitzel, W., Jonsonn, E. (1989). Decline in Organizations: A Literature Integration and Extension. Administrative Science Quarterly, 34, 91-109.

West, M. (2002). How can good performance among doctors be maintained? British medical Journal, 325, 669-70.

West, MA., Borrill, C., Dawson, J., Scully, J., Carter, M., Anelay, S., Patterson, M., Waring, J. (2002). The link between the management of employees and patient mortality in acute hospitals. International Journal of Human Resource Management, 13(8), 1299-1310.

Whetten, D.A. (1987). Organizational growth and decline processes. Annual Review of Sociology, 13, 335-358.

Whetten, D. (1988). Organisational growth and decline processes. In Cameron, K., R. Sutton and D. Whetten (eds), Readings in Organizational Decline: frameworks, research, and prescriptions. Boston, MA: Ballinger Books.

Whiteman, P. (2004). The role of political mentors in local authorities recovering from poor performance, London: Office of the Deputy Prime Minister.

Wiersma, M. (1992). Strategic Consequences of Executive Succession Within Diversified Firms. Journal of Management Studies, 29 (1), 73-94.

Wiersema, M. F., Bantel, K. A. (1993). Top management team turnover as an adaptation mechanism: the role of the environment. Strategic Management Journal,14, 485-504.

Wiersema, M. and Bantel, K. (1992). Top management team demography and corporate strategic change. Academy of Management Journal, 35, 91–121.

Willmott, R. (1999). Structure, agency and school effectiveness: researching a 'failing' school. Educational Studies, 25(1), 5-18

Wilson,D., Hickson,D., Miller, S. (1999). Decision overreach as a reason of failure: how organisations can overbalance, in H. Anheier (ed.) When things go wrong: organisational failure and breakdown, London: Sage.

Witteloostuijn, A.V. (1998). Bridging behavioral and economic theories of decline: organizational inertia, strategic competition, and chronic failure. Management Science, 44, 501–519.

Yin, R.K. (2003). Case Study Research: Design and Methods. (3rd edition), Beverly Hills, CA: Sage Publications.

Zimmerman, F. (1989). Managing a successful turnaround. Long Range Planning, 22, 3, 105-124.

Zammuto, R.F., Cameron, K.S. (1985). Environmental decline and organisational response. In L.L. Cummings and B.M. Staw (Eds), Research in Organisational behaviour, Greenwich, CT: JAI Press, 232-62.

Appendices

Appendix 3.1 Search strategy in HMIC (via Ovid)

1 fail$.mp.

2. declin$.mp.

3. cris$.mp.

4. recover$.mp.

5. renew$.mp.

6. rejuvenat$.mp.

7. success$.mp.

8. 1 or 2 or 3 or 4 or 5 or 6 or 7

9. exp organisations/

10. exp ADMINISTRATION/

11. organi?ation$.mp.

12. exp performance/

13. 9 or 10 or 11 or 12

14. 13 and 8

15. (Organi?ation$ adj6 mortality).mp.

16. (Organi?ation$ adj6 exit).mp.

17. (Organi?ation$ adj6 death).mp.

18. retrenchment$.mp.

19. turnaround.mp.

20. turn$ around.mp.

21. 15 or 16 or 17 or 18 or 19 or 20

22. 21 or 14

23. exp HEALTH CARE/

24. healthcare.mp.

25. hospital$.mp.

26. exp NHS TRUSTS/ or exp HEALTH TRUSTS/ or exp PRIMARY CARE TRUSTS/ or exp COMMUNITY TRUSTS/ or exp TRUSTS/ or exp TEACHING PRIMARY CARE TRUSTS/ or exp CARE TRUSTS/ or exp INTEGRATED SERVICES TRUSTS/ or exp ACUTE HOSPITAL TRUSTS/ or exp SOCIAL WELFARE TRUSTS/ or exp MENTAL HEALTH TRUSTS/

27. trust$.mp.

28. exp HOSPITAL CARE/

29. secondary care.mp.

30. exp PRIMARY CARE/

31. 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30

32. 22 and 31

The search strategies for other databases were modified from this search strategy.

Appendix 3.2 Data extraction form

ID number	
Title	
Author **Year** **Country** **Source**	
Aims and Objectives	
Type of organisation and setting	
Design	
Participants	
Outcome measures	
Sample size	
Data collection: Source & Period	
Data analysis	
Results	
Limitation and strength	
Research implications	
Policy implications	
Comments	
Quality issues	

Appendix 3.3 Quality Appraisal of Qualitative Studies

1 Question
- Did the paper address a clear research question and if so, what was it?

2 Design
- What was the study design and was this appropriate to the research question?
- In particular, was a qualitative approach suitable and was the right design used?

3 Context
- What was the context of the study?
- Was the context of the study adequately well described that the findings can be related to other settings?

4 Sampling
- Did the study include sufficient cases/settings/observations so that conceptual rather than statistical generalisations could be made?

5 Data collection
- Was the data collection process systematic, thorough, auditable and appropriate to the research question?
- Were attempts made to identify and explore disconfirming cases?

6 Data analysis
- Were data analysed systematically and rigorously?
- Did the analysis take account of all observations?
- Were sufficient data given to present evident relationship between evidence and interpretation?
- How were disconfirming observations dealt with?

7 Results
- What were the main results and were those clearly stated?
- Were there any unintended consequences and, if so, what were they?

8 Conclusions
- Did the authors draw a clear link between data and explanation (theory)?
- If not, what were the limitations of their theoretical analysis?

9 Reflexivity
- Were the authors' positions and roles clearly explained and the resulting biases considered?
- Were the authors' preconceptions and ideology adequately set aside?

10 Ethics
- Are there any ethical reservations about the study?

11 Transferability
- To what extent are the findings transferable?

12 Worth/relevance
- Was the research worth doing at all, and has it contributed usefully to existing understanding?

Source: Adapted from Mays and Pope, 2000

Appendix 3.4 Quality appraisal of questionnaire based survey studies

1 Research question and design

- Was there a clear research question, and was this important and sensible?
- Was a questionnaire the most appropriate research design for this question?

2 Sampling

- What was the sampling frame and was it sufficiently large and representative?
- Did all participants in the sample understand what was required of them, and did they attribute the same meaning to the terms in the questionnaire?

3 Instrument

- What claims for reliability and validity have been made, and are these justified?
- Did the questions cover all relevant aspects of the problem in a non-threatening and non-directive way?
- Were open-ended (qualitative) and closed-ended (quantitative) questions used appropriately?
- Was a pilot version administered to participants representative of those in the sampling frame, and the instrument modified accordingly?

4 Response

- What was the response rate and have non-responders been accounted for?

5 Coding and analysis

- Was the analysis appropriate (e.g. statistical analysis for quantitative answers, qualitative analysis for open-ended questions) and were the correct techniques used?
- Were adequate measures in place to maintain accuracy of data?

6 Presentation of results

- Have all relevant results ('significant' and 'non-significant') been reported?
- Is there any evidence of 'data dredging' (i.e. analyses that were not 'hypothesis driven')?

Source: Boynton and Greenhalgh (2004)

Appendix 3.5 Detailed summary of the methods and findings of the studies included in the comprehensive review

ID number	1
Title	Turning around failing hospital
Author **Year** **Country** **Source**	Protopsaltis,G.,Fulop,N.,Meara,R.and Edwards,N. 2002 UK NHS Confederation Report
Aims and Objectives	To explore causes and patterns of failure among failing NHS acute trusts. In addition to explore responses to impending and actual failure, type of turnaround strategies and their impact on different stakeholders (e.g. patients, staff, public)
Type of organization and setting	NHS acute trusts, UK
Design	Case study method using interview technique and focus group with managers
Participants	Previous and new mangers in 4 failing acute trusts and 5 trusts at different stages of turnaround; interview with key external stakeholders (e.g. related PCTs, Regional Offices)
Outcome measures	Perspectives of hospital managers (clinical and non-clinical) and external stakeholders (e.g. PCT, Regional offices) regarding performance improvement in acute hospital trusts
Sample size	Number of interviewees had not been reported.
Data collection: Source & Period	The data was collected over few months through interview and focus group
Data analysis	It was not clearly reported but it seems that the thematic analysis method has been used

Results	Markers (symptoms) of failure were: poor performance on core targets; financial deficit, poor public image; poor working relationships with local media and external stakeholders; and low staff morale. The study has explored five main reasons that cause failure among studied trust including (i) poor leadership (a failure of leadership, unwillingness to delegate, failure to challenge internal vested interest, being isolated from colleagues in other organisations, reluctant to make decision, too comfortable board), (ii) Poor operational management; (iii) strategic and external problems; (iv) Problems with internal culture and lack of clinical engagement; v) Distraction by major projects (eyes off ball). The study has recognised that replacement of senior managers occurred in all the five turnaround cases. In all of them, the CEO had been changed. In two of the Chair of the trust and in three of them, the entire or most of the members of the trust board had been replaced. Triggers for change were replacement of senior managers, inspection or intervention introduced by external organisations and low performance level. The study has explored different turnaround strategies that had been adopted by the trusts, including: i) Internal reorganisation (more structured management teams, reconfiguration of posts and responsibilities); ii) Improving operational performance; iii) Focus on human resources; iv) Financial analysis and control v) Attempts to change organisational culture (introduction of 'can do' culture through promoting transparency, clarity of process, goal setting and aspiration for meeting performance targets); vi) Development of relations with external stakeholders. The five trusts under study represented some impacts of turnaround strategies on patient care: more focus on clinical governance; more transparent with patient complaints and risk assessment and stress on reduction of waiting lists. All the cases has reported positive impact of turnaround strategies on the trust's public image and working relation with external stakeholders. Some clinician had shown resistance against some changes in the management of clinical practice introduced by new managers. In general the impact of turnaround strategies were positive on the staff but in some cases staff had shown some extent of resistance to the new managers' plan because they felt more workload pressure and stress derived from these plans.

	Result of turnaround: three out five trust presented performance improvement in terms of changes in star rating and two of them received lower performance rating over a year.
Limitation and strength	The study has recruited star rating (2001-2002) to evaluate the effectiveness of the turnaround strategies adopted by these organisations. However, It seems that it was early (only about a year after introducing turnaround strategies) for the researchers to conclude the effectiveness of adopted strategies for sustained performance improvement. More longitudinal studies are needed.
Research implications	The study revealed that more longitudinal research in the health sector is needed to evaluate the process of organisational failure and the effectiveness of turnaround processes.
Policy implications	The study highlighted that policy makers need to develop a comprehensive diagnosis system using different markers to detect the problems at the early stages to prevent entire failure of the orgainsations. In addition The authors warned that although replacement of management is necessary but it is insufficient. They note that managers replacement may not be the best approach when problems are related to the external or strategic factors. More emphasis on the communication across the organisation and changing management and involving staff were addressed. Time should be given to the organisations to improve performance (realistic expectation).
Comments	More longitudinal studies are needed to show the effectiveness of turnaround strategies that can gaurantee sustained performance improvement.
Other details	
Quality issues	Good

ID number	2
Title	Turnaround in Health Care Providers
Author **Year** **Country** **Source**	Fulop, N., Scheibl, F., Edwards, N. 2004 UK Report, London School of Hygiene and Tropical Medicine
Aims and Objectives	To improve the understanding of management change (franchising) leading to turnaround as a policy intervention for addressing 'failure' in NHS hospitals. The study specifically sought: to identify markers for failure beyond the NHS star rating, to identify different interventions used to turnaround failing organisations, to identify which interventions are successful and in which context, to explore both intended and unintended consequences of turnaround strategies, and to draw lessons for the NHS on how 'failure' might be prevented in the future.
Type of organization and setting	Poorly performing English acute Trusts - according to the star rating system (zero star trusts or trusts that were at risk of becoming zero star and were subject to intervention by the Modernisation Agency) or on the basis of the perceived 'failure' identified through replacement of senior managers prior to the introduction of star rating - that had experienced replacement of senior manager(s) as a turnaround intervention.
Design	Multiple case study
Participants	internal and external stakeholders at nine NHS Hospital Trusts
Outcome measures	Perception of interviewees regarding the organisational failure and turnaround process, views of patients on the basis of national patient surveys, and performance rating on the basis of star rating system.
Sample size	Nine Poorly performing English acute Trusts
Data collection: Source & Period	Three types of data: semi-structure face-to-face interview with 106 internal and external stakeholders at nine NHS hospital Trusts over two years, data from a sample of local media reports from the web, and finally data from national patient survey programme and the NHS performance rating.
Data analysis	Interview data was analysed using Atlas-ti software, data collected from media was analysed manually and additional analysis completed using Atlas-ti.

Results	Symptoms, secondary and primary causes of failure were identified. Three main clusters consisted of **markers (symptoms)** including: inability to hit core targets and financial problems; distraction by the major development (merger with another trust and/or PFI) ('eyes off the ball'); and organisation was as insular 'fortress' exhibiting poor external relationships, low staff morale, poor media image, high turnover and recruitment problems. **Secondary causes**: secondary internal causes include financial (financial mismanagement, high cost structure such as agency staff and drugs, overspend in key clinical directorates, duplicating services across two or more sites), managerial (lack of engagement of clinicians, lack of systems, process and procedures (lack of data management system, operational mismanagement, lack of leadership, no response to external challenges from managers, lack of planning vision or strategy), and organisational issues (instability within the organisation triggered by poor industrial relations and major incidents). Secondary external causes were major policy changes in the NHS (e.g. introduction of Performance Assessment Framework) and increased competition as services relocated to PCT and mental health trusts). **Primary cause** was an inability to learn and adapt due to the organisational introspection (management took on the stance of a closed system and were unable to deal with external challenges), organisational arrogance (no need for change of attitude of managers due to the previous success), organisational trauma (removal of CEO following high profile negative media coverage and clinical investigations), and organisational myopia (presence of a complacent management team who lacked the ability to scan the environment resulting in a conservative and risk/change averse organisation). **Triggers for change:** triggers for change came from managers internal to the organisation (chair contacting DoH or Regional Office to raise concern, new managers took the CHI report as a trigger to support his/her radical action) and the concerns of external stakeholders highlighted in the local or national media. **Turnaround interventions:** Different interventions were used by the managers to impact on a range of organisational issues including management structure, finance, human resources, organisational culture, external relationships, systems and protocol, strategic vision and operational performance. A range of different leadership styles from participative, facilitative and risk taking to more mechanistic approaches based on hierarchical principals were employed. The turnaround process was planned to be run over a period of three years: <u>first six months</u> (**strategy**: focus f consultation on strategy; **organisational culture**: increasing visibility of top team, use of 'quick wins'; **Management**: re-organisation management structure to improve clinical engagement,

	reduction of number of clinical directorates, create and fill new posts for key directorates; **Finanace**: increase financial control; **HRM**: communication strategies to gain staff commitment toward national targets; **External relationship:** better media relationships, better working relationship with external stakeholders; **systems process and policies**: data management; **operational performance**: prioritise operational performance targets); between 7 to 12 months, **strategy**: development of strategic vision using bold slogans; **organisational culture:** more focus was to complete new buildings/PFI to demonstrate management ability and commitment; **Management**: re-organisation of middle management and leadership programme; **HRM**: develop staff training and staff reward system; **External relationship:** improvement of external relations, development of PALS, set up clinical networks; **systems process and policies:** modernise procedures. The aim of the manager over the third phase was to implement organisational learning programmes, decision making, celebrating success, create clinical networks encourage ownership of the strategic vision throughout the organisation. **Impact of turnaround interventions:** Five trusts showed consistent improvement in their performance assessed by the 'star rating' system over the study period which means that these organisations were 'self regulating' organisations', however four organisation presented either stagnation or a decline in performance. Two out of four cases could be classified as 'permanently failing' organisations'. Various constraints on turnaround and organisations' access to the resources required for the turnaround can explain difference among these organisations. **Constraints on turnaround:** Some factors constrained the turnaround interventions including: cultural diversity (competing sub-cultures), complexity (multie-layer nature of hospitals), lack of leadership and external influences (impact of government policy and pressure about public image). Resistance from the clinical body and middle managers created resentment and was due to the cultural diversity and complexity. **Resources required for turnaround:** The success of the managers to turnaround was contingent upon them to the having certain core skills (developing change agenda, ability to communicate and provide clear vision, ability to grasp detail required to deliver core targets, and having strategic perspective) and access to financial, temporal (time and stability), and external (support from SHA/ PCT/ MA) resources.

Limitation	
Research implication	
Policy implication	Identifying 'at risk' organisations by the organisations charged with inspecting, managing and improving performance such as SHA and the Healthcare Commission using both soft and hard indicators; providing required financial, temporal, and external resources (money, time, stability); development of sustainable improvement takes time (5 years); diagnosis of the problem is needed before to plan any turnaround programmes; development of an open attitude which accepts responsibility for the organisation's difficulties; establishment of clear leadership; encouraging involvement of clinical staff; developing work with external stakeholders; having an appropriate recruitment policy to have the appropriate people at right posts at top level; negotiating access to financial resources; using internal reward system; using external support system (e.g. from MA).
Comments	Some factors were taken into account for both symptoms and causes of failure such as lack of leadership, financial mismanagement. That may cause some confusion.
Other details	'Failure' and 'decline' have been used.

ID number	3
Title	Investigating 'Turnaround' in NHS organisations supported by the Performance Development Team (PDT) of the Modernisation Agency
Author **Year** **Country** **Source**	Harvey, G., Hyde, P., Walshe, K. 2005 UK Centre for Public Policy and Management, Manchester Business School, University of Manchester
Aims and Objectives	To examine the role of the Performance Development Team (PDT), a part of the Modernisation Agency, as an external intervention agent in promoting and facilitating turnaround of the zero star rated NHS organisations; To evaluate the experience of the trusts concerned and the impact of PDT interventions on their performance; to increase understanding of effective turnaround strategies and their situational appropriateness (when and how to use which interventions).
Type of organization and setting	NHS organisations from the 2003 cohort of zero-star trusts (an SHA, an acute trust, a mental health trust, a PCT and an ambulance trust), selected NHS organisations from the 2002 cohort of zero star trusts, UK.
Design	Formative evaluation design, supported by the principles of 'realistic evaluation'. Case study method using interview and review of documents.
Participants	Five cases study sites chosen from the 2003 zero-star trusts (interview with 38 people from the trusts' senior mangers, PDT staff working with the trust and related Strategic Health Authorities) and zero star rated trusts in 2002 (interview with 14 senior managers and related strategic health authority).
Outcome measures	Perspectives of organisations' managers and external stakeholders (e.g SHA) and members of the PDT team regarding performance improvement in selected NHS organisations

Sample size	52 interviewees (38 interviewees from the 2003 cohort of zero-star trusts and 14 interviewees from the 2002 cohort of zero-star trusts).
Data collection: Source & Period	Three main data sources using interview method and review of documents. (i) The total cohort of 2003 zero-star trusts (documentary review); (ii) Five cases study sites chosen from the 2003 zero-star trusts (review of documents and interview with 38 people from the trust's senior managers, PDT staff working with the trust and related Strategic Health Authorities); (iii) Number of zero star rated trusts in 2002 (interview with 14 senior managers and related Strategic Health Authority).
Data analysis	It was not clearly reported but it seems that they have used the thematic analysis method.
Results **Results (continued)**	**i) Nature and content of PDT interventions:** The main aim of the PDT was to help trusts to obtain long-term and sustained performance improvement (through changing organisational culture and development of whole system working) rather short term success. The role of the PDT was consistent with the 'relational approach' of Jas and Skelcher's principal-agent framework (Jas and Skelchere, 2004) rather than episodic or mandated approaches. The PDT focuses on main causes of failure (secondary and primary) rather than concentrating on the symptoms of the failure. However, this aim was in contrast with the initial will of some trusts and their external stakeholders in particular the SHA which seeks quick performance improvement (through hitting essential targets) and gaining one or more star in the next round of ratings. Only one year contract between PDT and failing organisations raises a debate about how the PDT can assure sustained performance improvement for a long-time because Fulop et al (2004) argue that literature shows such changes take more than five years to achieve. **ii) Impact of PDT intervention:** The focus of the PDT activities was on the retrenchment and renewal interventions because the PDT did not have the authority to replace key managers (replacement intervention). Although the initial purpose of PDT was to apply flexible and responsive interventions according to the needs and situation of each organisation (tailor-made approach), the strategies that they have used for organisations were not so diverse. Some organisations declared that this limited the breadth of available interventions. In general, most of the organisations studied presented a positive feedback on the function of the PDT such as it providing required skills and experiences to apply change, external confirmation for initiating changes; facilitating development of external network; giving advice as a critical friend; assisting with concentration of efforts across the organisation. Most of the PDTs (86%) delivered their

	agreed commitment on time. There was an improvement in star rating of 80% of the zero star organisations studied. However, attribution of such improvements in terms of star rating to the activity of the PDT, which is as one factor among several factors, is difficult. Some organisation alleged that they (especially new managers) could turnaround situation without help from the PDT and in some situation they even asserted that the PDT was as an interfering factor in process of changes. **iii) Facilitating factors in achieving successful turnaround supported by an external agent(the PDT):** Authors address some factors that enhance the effectiveness of the PDT functions and achieving success such as role of client manager of the PDT which was affected by the level of maturity, background and experience of the client manager; how the organisation is willing and ready to accept the PDT help; the clearness of the role and the quality of the relationship between the PDT, trust, and other related organisations such as Strategic Health Authority (SHA);the type of approach adopted by the PDT and its flexibility, along with establishing realistic expectations and managing them. **vi) Impeding factors in progressing the turnaround process**: Some factors have been judged as hindering factors in the progress of turnaround processes: insufficient required resources (especially financial); inadequacy of the PDT skills and experience in some areas (e.g. financial problems); poor relationship between the trust and external organisations such as SHA; shortage of time that the PDT works with the Trust. The Trust also perceived that a huge level of pressure and stress on a zero-star organisation inhibited the organisation from moving forward.
Limitation and strength	
Research implications	(i) Development of methods to differentiate self-regulating organisation from permanently failing organisations (ii) Conducting more longitudinal research to evaluate the turnaround process supported by the external agents over longer time (iii) Evaluation of the effect of changes in the external environment on the organisational failure and turnaround process in the health sector (e.g. effect of governmental policy on the NHS organisations).

Policy implications	Need for external agency, such as PDT, with adequate skills and expertise to produce tailor-made work plans; focus for external interventions needs to be on organisations that are not able/or willing to initiate turnaround and these organisations need longer term support; resources needed for turnaround should be considered.
Comments	
Other details	Ethical issues had been considered
Quality issues	Good

ID number	4
Title	Learning from the experience of recovery: the turnaround of poorly performing local authorities
Author **Year** **Country** **Source**	Turner, D and Whiteman, P 2005 UK Local Government Studies
Aims and Objectives	To track the process of turnaround and seek to identify the key theories of turnaround adopted and implemented in a sample of 15 English local authorities that were categorised as poor performers. In particular, this study aims to answer the following questions: Why do some councils perform in such a way that they are labelled as poor performers? What approaches are used in recovery (or turnaround) work, in what situation, and why? What is the impact of turnaround strategies on levels of performance?
Type of organization and setting	English poorly performing local authorities
Design	Three year longitudinal study using case study methodology within the grounded theory approach. A realistic evaluation methodology was adopted using context-mechanism-outcomes (CMOs) which sought to identify the Context for poor performance-Mechanisms for recovery- Outcome for local authority performance.
Participants	The key stakeholders of selected local authorities (managers, staff, politicians and external advisors) and key actors at national level (who were involved in development and implementation of the Government's policy towards turnaround in local authorities.
Outcome measures	- The results of the Comprehensive Performance Assessment (CPA) over three years to measure the performance of the local authorities. - Perceptions of key stakeholders regarding performance improvement among poor performing local authorities. - Staff attitude measured through survey

Sample size	15 English Poorly performing local authorities
Data collection: Source & Period	Each of the 15 organisations provided a range of qualitative and quantitative data collected through a series of interviews with key stakeholders and analysis of documentary evidence. In addition two round of surveys measured the staff attitude at two stages (first year and third year)
Data analysis	Five out of 15 local authorities acted as core cases that the theories for turnaround were developed and the rest of the cases (10 cases) were used to examine and refine the result which derived from the core cases.
Results	**Context (causes) of failure:** The common contexts which contributed to the poor performance and service failure were: **political context** (poor political leadership (8 organisations); stagnant political environment (old style politics or inert); volatile political environment (frequent changes in control, poor inter-party relations and internal political dispute); parochial politicians with lack of strategic focus; complex decision making at the senior management level)- **Organisational context** (inertia- living on past achievements reputation; inertia- political/managerial conflict (fear amongst managers driven by political intimidation); poor performance management; departmentalism and lacking corporate structures; weakness in relationships with the changing external environments)- **Managerial context** (silo management; lacked leadership skills; lacking corporate vision; lacking managerial skills and capacity)- **Cultural context** (unaware of need to turnaround; insular-arrogant; no performance culture; willing to turnaround but lacking focus on achieving it or lack of political support due to new rules and political context or lack of management capacity; resistant to turnaround due to lacking management/political will)- **External Context** (lack of engagement with the needs of community or with local authority; mismanaged priorities and selection of services; problems of diverse population reflected in demands on services, poverty and deprivation; resisted external pressure (e.g. not taking on board modernization and change). In six of the case studies, the need for turnaround had been denied at least for some periods by different people in the organisation. **Triggers for change:** Some factors were perceived as triggers for changes including: the departure or the replacement of the CEO or the council leader and the CPA process itself are two important factors. The public announcement of the CPA score was as a trigger. Seven out of 10 authorities stated that CPA process had influenced turnaround. However, two authorities believed that the CPA had no effect on the turnaround (these trusts lacked an achievement culture) and one case defined the role of the CPA as a delaying factor in the turnaround process.

	Turnaround strategies: Relatively similar approaches were used to turnaround the organisation: Replacement of managers (CEO or senior management team) and/or politicians (60% and 90% respectively); use of political mentor in steering politicians (90%); focus on introducing new corporate management working (60%); the use of interim managers appointed by government following the departure of permanent senior managers and directors; help in directing councils by government officials particularly by Lead Officials; Overseeing the recovery plan by the Government Monitoring Boards; and government funding. Strategies to turnaround local authorities were divided into those enforced by the government and those adopted by the organisations themselves. The range of activities open to the government was from use of legal powers (intervention-) to supervision and guidance (engagement- motivation and support of organisation to turnaround but leaving the main responsibility for owning this process with the authority itself). The 'engagement' strategy was the first choice for the government as the modus operandi that effectively ensured co-operation and coalition. However, in one case a direct intervention was used by a minister because the local authority was reluctant to cooperate with engagement. **Outcomes:** Six organisations showed good progress and they presented a forward-looking, turnaround-oriented plan initiated by a (new) dynamic leadership at both managerial and political levels. The ODPM reduced engagement or even disengaged with those organisations, however, it continued this policy for other local authorities. Three organisation did not improve their CPA score which fit with the 'permanently failing organisations'.
Limitation and strength	The generalisability to other public sectors has not been discussed
Research implications	To test the propositions and findings of this study in cross institutional and cross-national studies to better understand the contributory impact of governance arrangement, scale of organisation, regulatory environment and nature of service responsibilities on performance profiles, and specifically decline and turnaround.

Policy implications	The strategies for public services improvement should consider the location of an organisation on its performance profile. More quantitative longitudinal studies to test and refine the model presented for both self-initiating and permanently failing organisations are needed.
Comments	
Other details	The theoretical model used for this study was Context (context for poor performance- causes)-Mechanism (mechanisms for recovery)-Outcomes (performance) (CMOs).
Quality issues	Good

ID number	5
Title	Performance Failure in the Public Sector: misfortune or mismanagement?
Author **Year** **Country** **Source**	Andrews, R., Boyne, G., Enticott, G. 2006 UK Public Management Review
Aims and Objectives	To develop and test a model of the impact of both misfortune (bad circumstances faced by some public organisations, which are beyond the control of the organisation) and mismanagement of the performance of the public organisations.
Type of organization and setting	Upper-tier Local Authorities, England, UK
Design	Electronic questionnaire survey
Participants	Officers and politicians from English Local Authorities
Outcome measures	Measurement of performance using CPA score published in 2002. Measure of misfortune using five measures: population of the area as measure of size; two dimensions of diversity of service needs: ethnicity (using a calculated index) and social class; prosperity of local residents by using two proxies for the capacity of local citizens to co-produce services: number of single parent households (%) and the percentage change in the population between 1991 to 2001. Measure of mismanagement using seven measures: performance management (2 questions: management information system at corporate and service level); having clear priorities (single question); internal partnership (2 questions: joint working and cross cutting working); link with users (three questions: the importance of users' needs, the importance of users' demands and the involvement of external stakeholders in strategy making); external partnership (single question); managerial leadership (single question); and political leadership (single question).

Sample size	An electronic questionnaire was sent to 386 authorities for completion by 4184 officers and politicians working in English local authorities at corporate and service level (education, social support, benefit and leisure, environment, housing and libraries)
Data collection: Source & Period	The data were collected using an electronic questionnaire survey sent via e-mail and a range of secondary data sources.
Data analysis	81% of authorities replied (314/386) and 56 % the was response rate at individual level (2355/4184). However, statistical analysis using descriptive and regression analysis was conducted in only 120 local authorities with 1257 informants because the CPA results for 2002 are available for only 120 of the authorities that replied to the survey. A single factor was constructed for some measures that consisted of more than one question using principal component analysis and Cronbach's alpha was calculated to assess the reliability of the factor.
Results	Around 55% of the variation in the relative success and failure of different local authorities was collectively explained by the twelve misfortune and mismanagement variables. The results showed that among misfortune variables the diverse service needs (supported by higher ethnic diversity (T= -3.779, $p<0.01$) and poverty (supported by number of lone-parents household (T= - 3.267, $p<0.01$) and population change (T= 6.522, $p<0.01$) contribute to the organisational failure. This means that organisations with ethnically diverse population or higher levels of poverty (more lone-parents household or declining population) are more likely to be classified as poor performers. The size of the local authorities and financial resources directly available to the local authorities had no significant impact on performance. There was significant association between three out of seven mismanagement variables (performance management (T= 2.602, $p<0.05$), managerial leadership (T= 3.527, $p<0.01$) and political leadership (T= 2.881, $p<0.01$)) and performance of the local authorities. However, clarity of priorities, internal relationship, link with users and external relationships did not show significant impact on the performance of the local authorities. It was shown that English local authorities are more likely to fail if they have poor performance management systems and poor political and managerial leadership, as internal characteristics. Those authorities are also more likely to be vulnerable to failure if they face diverse services needs and have economically deprived populations.
Limitation and strength	Strength: The measurement of the mismanagement measures was conducted 18 months before releasing the CPA results, so the mismanagement measures were not contaminated by the CPA results.

	Limitation: i) Some questions about some management measures were not very clear and the terms 'managerial leadership' and 'political leadership' may not have been clear to the respondents. ii) A limitation of the study is that the cross-cutting and flexible working relations are only one form of internal relationship was included in this study and other elements of the internal relationship may show relationship with failure. iii) Development of relationship by only the private sector is considered as an external relationship and relationship with other public and governmental organisations has not been considered. iv) More qualitative research is needed to explore management problems that may be specific to county councils which might be different from the local authorities.
Research implications	Andrews et al (2006) did not find relationship between clarity of priorities and performance of the local authorities. They found link between service and corporate objectives. It might be concluded when the service priorities are very close and perhaps artificially tied in corporate priorities, they are distorted. However, further research is suggested by the authors to test this hypothesis. Further research was suggested to explore the influence of the user consultation on service decisions and how those decisions may contribute to the organisational performance and failure.
Policy implications	i) The policy makers should notice that some circumstances (e.g. socioeconomic factors) beyond the control of managers may result in poor performance of public organisations and so a more sophisticated performance measurement regime should be designed to take into account theses external factors. ii) More investment in development of leaders and performance management system is recommended.
Comments	
Other details	Failure and decline have been used. Performance measured by the CPA was carried out in 2002 which classified organisations into five categories (poor, weak, fair, good, and excellent).
Quality issues	

ID number	6
Title	The dynamics of chronic failure: A longitudinal study
Author **Year** **Country** **Source**	Eitel, D.F. 2004 USA Public Money and Management
Aims and Objectives	To scrutinize why the repeated improvement strategies failed to turnaround a regional government office which was seen as underperforming for more than 25 years (chronic failure). To identify why such an organisation with an intelligent and committed workforce who provide infrastructure services suffered such negative results.
Type of organization and setting	A regional office of a national agency in a major metropolitan city, USA
Design	A longitudinal case study
Participants	
Outcome measures	
Sample size	
Data collection: Source & Period	Review of a range of archival and documentary sources (internal and external) and also tracking the changes by the researcher as he had worked as both internal and external consultant to the organisation
Data analysis	
Results	**Symptoms of failure:** Under-performing on targets (approximately 200 indicators assessed quarterly), loss of reputation from national office point of view; bad press image; employee distrust, internal conflict between managers and employees and good staff leaving, low staff morale **Cause of sustained failure:** Different unsuccessful turnaround attempts (downsizing) was reported over 25 years (1976, 1982 actions in response to national office directive; 1988 to 1992 decisions on reducing staff levels made only by top managers without input from staff which resulted in scepticism and distrust between managers and staff and encouraged resistance against the redundancy plan among staff) It was a 'siloed organisation' (each department followed its own functioning and decision making pathways with counterparts in the national office) and the highly bureaucratic. The management style was command and control without a risk taking culture. Appointment of inappropriate leaders (poor leadership) who were often on their journey to retirement and used a command and control management style. Their focus was on local politics rather

	than national directives and decision made by them were made independently from the national office (representing poor corporate citizenship) which resulted in receiving weak support from the national office. Lacked corporate vision, lack of good external relationships, lack of communication and staff involvement in the decision making process, lack of involvement with national office the long-term failure in this domain caused the regional office to be closed by the national office. The trust between managers and employee was lost due to the repeated downsizing despite a vocal trade union. A culture of failure resulted due to the sustained poor performance. However, the 'freelance' and flexible approach of the organisation pleased local clients. Eventually, however, and in spite of the clients' vocal support, the allegiances of the clients were shifted to the other offices to maintain their programmes when they became aware of the extent of the problems faced by the regional office. It resulted in financial decline due to the shifting of the fund to other offices in the merger bid, which and it enabled the merging process. Managers blamed others for the failure of change initiatives and they did not take into account their part in the failure. **Turnaround interventions:** Reduction of staffing level and refocusing the organisation's efforts were used repeatedly. The former interventions were not successful in the first two rounds of turnaround due to local political pressure and the resistance of unions to changes in working conditions and loss of staff positions. The reduction in staffing level policy suffered from the lack of a clear plan and it was not apparent which people would leave the organisation. As some staff rapidly left the organisation and were not replaced, this attrition was used to encourage staff to leave. However, a heavy workload and the need to learn new duties were other factors perceived by the remaining staff which led to more people leaving. In 1994 when the government proposed to close two regional offices due to financial issues, this organisation was as one of the main ones selected. As a result the duties of the local organisation were given to other offices and finally a merger was enacted. **Triggers and Constraints of turnaround activities:** Triggering: role of national office in seeking changes, Constraints: External pressure (local political activity, resistance of unions) **Internal factors:** Serious resistance by staff against changes **Outcome of turnaround:** The organisation did not survive, so it was merged with another organisation and the cultural differences were clearly evident.
Limitations and strengths	

Research implications	
Policy implications	Organisational turnaround is a messy activity and managers may perceive working in this environment to be as unpleasant. The role of the national office in the appointment of not a very rigorous and appropriate leader and insufficient attention to the results of staff survey were important in contributions to the failure. Using the reduction of staffing levels as a turnaround strategy meant that the staff knew they would lose their jobs. Although the problems faced by the organisation seemed to be obvious to those outside the situation, for managers trapped inside the situation, the difficulties were immense.
Comments	The organisation was categorised as having a high level of persistence and low performance (permanently failing organisation). According to the cognition approach to failure (Anheire and Moulton, 1999), the organisation did not learn from its mistakes and used only **single loop learning** (Stead and Smallman, 1999). Both the organisation and its staff suffered from the lack of **double loop learning** when facing organisation's problems.
Other details	Organisational survival is traced as organisational success in this study.
Quality issues	

ID number	7
Title	The role of leadership in the Turnaround of a local authority
Author **Year** **Country** **Source**	Joyce, P 2004 UK Public Money and Management
Aims and Objectives	To examine managerial leadership behaviour (a Chief Executive's experience) during a successful turnaround in a public services organisation.
Type of organization and setting	Newham Council.
Design	Case study
Participants	A chief executive of a local authority (London borough of Newham)
Outcome measures	
Sample size	
Data collection: Source & Period	Data collected using an interview with the Chief Executive of a local authority in 2003 and contemporary documents produced by the local authority during the late 1990s. The interview was tape-recorded and transcribed.
Data analysis	The interview data was analysed using software for analysing qualitative data. The analysis was organised around the idea that 'management' and 'leadership' behaviour are different.
Results	The study shows that the effective CEO needs to present both characteristics of leaders (e.g. work through strategic vision and ability to organise this thinking into activities that can be undertaken, communication and empowerment) and managers (e.g. need to pay attention to operational details and to the context that the organisation working; have the ability to take staff into uncomfortable areas particularly in the performance management system; invest time in planning and control). Attention to detail was an important factor shown by the CEO when working to turnaround the organisation. The CEO and management team were visible. The CEO learnt about how the organisation was doing through visits and careful listening. On the basis of this knowledge she formulated a vision. Support from local politicians and external stakeholders was viewed as a very important factor in supporting top manager team's decisions. Strategy development, performance management and focus on human resources management and organisational development were three major strategies followed by the CEO. These strategies were viewed as a set of activities that all needed to be done. Also, the CEO challenged the resistance

	of some managers to new vision through argument and persuasion. The CEO presented a significant level of energy and resilience when developing performance management though the process was uncomfortable for staff. A considerable level of emotional energy was invested in dealing with the resistance against the process of change.
Limitations and strengths	Data was not collected from people external to the organisation or people who did not agree with the new visions.
Research implications	
Policy implications	Effective leaders should also be capable managers. They need to create strategic vision and also pay attention to planning and control (performance management). Therefore, a clear contrast between management and leadership, is defined in the literature break down and the CEO is viewed as a mixture of Kotter's manager and leader. Effective leader need to know their organisations and related details. The leaders should deal with resistance and conflict due to the presence of disagreement among different stakeholders.
Comments	The study only focused on the behaviour of a CEO during the turnaround period.
Other details	Success in turnaround was assessed using a basket of performance indicators from the Audit Commission (moving from 31st to third out of 33 London boroughs during three years (1996 – 1999) and also on the basis of the increase in the level of willingness of people to live in the area
Quality issues	

ID number	8
Title	Raising attainment in schools in former coalfield area
Author **Year** **Country** **Source**	Harris, A., Mujis, D., Chapman, C., Stol, L., Russ, J. 2003 UK London (DfES)
Aims and Objectives	To explore the strategies used for raising and sustaining attainment of English schools over 5 years
Type of organization and setting	English schools (primary and secondary schools) in former coalfield
Design	Multiple in-depth case studies
Participants	Head teachers, senior and middle managers, teachers, non-teaching staff and group of pupils of the selected schools.
Outcome measures	Improvement of performance measured by change in the GCSE score (A to C)
Sample size	8 English schools (2 primary and 6 secondary)
Data collection: Source & Period	Semi-structured interviews with participants, review of inspection data and contextual data (socioeconomic data) were also collected
Data analysis	Not reported clearly
Results	**Symptoms of low performance:** Presence of low expectation culture **Role of external factor** on the performance of the schools: All schools accept that the disadvantages faced by the pupils who attend their schools inevitably affects their performance. Additional resources and support through external interventions or projects; changes in the social mix of the pupil population and having a specialist status designated to the school were found to be positive external factors. Role of **internal factors in improving performance**: **The role of leadership** of the head teacher was found to be important and the prevailing leadership style was distributed leadership (especially for secondary school) and Heads' Leadership values and visions were primarily moral (dedicated to pupil and staff welfare) and reflected core personal values such as honesty and fairness; **setting high expectations** for pupils and staff through diary speech, award ceremonies, celebratory events and award schemes; **Generating positive relationship** (both internal working

	relationships and development of relationships with community and external stakeholders); **Focus on teaching and learning**; **focus on professional development** through mentoring, coaching, and peer review (half of the schools set up new peer review systems); focus on targets; **Use of learning mentors**; **Performance tracking and Use of data** (about pupil performance, their progress and potential) **to inform decision making;** and finally sustaining of the performance was on the basis of building capacity through empowering, involving and developing teachers to deliver high quality teaching and through providing a conducive learning environment.
Limitation and strength	
Research implications	
Policy implications	
Comments	
Other details	
Quality issues	

ID number	9
Title	Effective leadership in schools facing challenging circumstances
Author **Year** **Country** **Source**	Harris, A., Chapman, C. 2002 UK London (DfES)
Aims and Objectives	To explore leadership processes and approaches in ten schools facing challenging circumstances that have shown gradual performance improvement.
Type of organization and setting	English schools (schools were selected on the basis of the trend in their performance; Those schools in which 25%, or less, of their pupils achieved five or more grades A* to C at GCSE in both 1999-2000 and 2000-2001 were faced with challenging circumstances and also those schools In which over 35% of their pupil receive free school meals (indicating low socio-economic status) even if above 25% of their pupils achieved five or more grades A* to C at GCSE.
Design	Multiple case study.
Participants	head teachers, middle managers, and classroom teachers of the selected schools.
Outcome measures	Change in pupil achievement measured by the GCSE scores.
Sample size	10 English schools in a range of socio-economic and cultural situations (inner-city, rural and mixed catchments areas) that have shown gradual performance improvement and head teachers with different characteristics (gender, time in post, and previous experience).
Data collection: Source & Period	Collection through face-to-face semi-structured interview with head teachers, and focus group with middle managers, and classroom teachers; review of contextual performance data (e.g. raw GCSE data and league table data), inspection data (e.g. OFSTED reports), and data from school management conditions rating survey (to provide an insight to the school culture).
Data analysis	Thematic analysis method
Results	**Symptoms of failure**: bad physical appearance of schools, poor relationship within school among staff, pupils and parents; presence culture of low expectation and mistrust; insufficient professional confidence and capability; poor external support; inadequate external relationship; It was revealed that these schools need leaders who have a

	broad range of leadership approaches underpinned by a core set of personal and professional values and a strong moral purpose. A broad range of leadership styles was presented by the head teachers with regard to the circumstances; however, there was a greater emphasis upon the leadership approaches that were people-oriented, transformational and empowering. A more autocratic leadership style (e.g. focus on policy implementation and consistent standards of teaching) was addressed by the head teachers during the pre-inspection phase (e.g. OFSTED inspection) but they show a more supportive leadership style during the inspection phase. The leaders led through enhancing organizational capacity by the generation of individual capacity through staff empowerment, involvement and ownership; encouraging collaboration and the investing in the quality of relationships and raising commitment within the school. Eight different strategies (short-term tactical approach and long-term strategies) have been applied by the head teachers to improve school performance: **improving the physical appearance of the schools** (e.g. painting of walls) a symbolic action to show that the school is starting changing; **development of internal relationship** within school between staff and pupils and parents (e.g. developing team working and collaboration, organizing social events, arranging staff-student committees); **Provide clear vision (**clear vision around some core values such as honesty, fairness and equality, promoting respect for individuals; caring for the well-being and whole development of students and staffs) **high expectation** (clear strategy in cultural change through setting high expectation levels); **focus on consistent professional development** (e.g. through mentoring, coaching, visiting other schools, in-service training, and a peer support scheme to maintain staff moral and motivation); **focus on teaching and learning** (pupil mentoring and tracking; monitoring the teachers' performance quality; providing learning opportunity for both children and teachers; encouraging discussion about teaching quality among staff); **applying distributed leadership**; **development of external relationship** (engagement of community and involvement of parents in school life); **Creating an information-rich environment to encourage change** (development of a robust internal evaluation process to collect and analyze data from different sources) These schools received external support (e.g. OFSTED, LEA) which through development of external networks facilitated the generation of ideas, professional development and dissemination of good practice. The study placed emphasis on the dispersed leadership and distribution of power, which means that leadership can be practised at different levels in school (teachers as leaders)

Limitation and strength	The authors have not reported whether those leaders were as new head teachers or not. There is not any information about the differences among these cases.
Research implications	Further studies were suggested to highlight exactly how leaders generate and sustain school improvement. It was recommended that there should be an exploration of which leadership styles are needed during different stages of change.
Policy implications	
Comments	No specific failure or turnaround theoretical framework was used. The leadership theories were used to explain head teachers' behaviours.
Other details	While firm, directive leadership may be required at the outset of turning around a school in difficulty, it would appear that a more democratic form of leadership is needed as the school begins to move forward and improve.
Quality issues	Good

ID number	10
Title	Structure, agency and school effectiveness: researching a 'failing' school'.
Author **Year** **Country** **Source**	Wilmott, R 1999 UK Educational Studies
Aims and Objectives	To scrutinize the ways in which a Local Education Authority (LEA) advisor team (as an external turnaround agent) has responded to the needs of a `failing' school delineated by the OFSTED auditors and how the school mediated such LEA strategies.
Type of organization and setting	English school
Design	Single qualitative case study
Participants	
Outcome measures	Use of OFSTED report to evaluate the school performance improvement
Sample size	Staff of the selected staff
Data collection: Source & Period	Data was collected using both participant observations almost immediately after the inspection by LEA advisors, and interviews with staff about their experiences of the LEA inspection.
Data analysis	Not clearly stated
Results	**Contextual environment:** the catchments area has mainly local authority housing and `high levels of economic and social deprivation. **Symptoms of failure:** The OFSTED report in June 1996 highlighted the problems of the school including poor achievement of targets (the school was at the bottom of the 'league table' in its area); poor management, confrontation among staff, inappropriate match between managerial responsibilities of staff and their expertise, lack of staff development and support, poor monitoring of performance such as insufficient monitoring of both the teaching and the progress of individual pupils. Although the school was funded generously, the pupil achievements were not satisfactory (not value for money). **Turnaround process:** Development of an action plan was

	carried out following the OFSTED report under the supervision of the LEA advisory team and the implementation of the action plan was evaluated by three LEA advisors over three days in a OFSTED style inspection in June 1997. After the inspection by the LEA advisors, the head teacher decided to take early retirement and one of the senior members of staff has been appointed as temporary head. The new head teacher used the following strategies: 1) Reorganised staff meetings to reduce the high level of confrontation among staff. However, that did not result in a positive outcome, 2) Focusing on SATs as the most important target **School effectiveness evaluation by the LEA advisors (as agent)**: The only real focus was on measurable outcomes and lesson attention being paid to the planning with less focus on the reality of the socioeconomic backgrounds of the pupils which can affect their achievements. They rejected the idea that social reality is differentiated and structured and thus deals only with constant conjunctions of observable events. Lack of communication, constructive discussion and feedback between advisors and staff caused disbelief and anger among staff. Staff reported that the assessment was not enough in-depth. **Role of external environment constraints:** Environmental constraints such as the level of deprivation should be taken into account when the outcome of the turnaround process is considered.
Limitation and strength	One of the principal limitations of this case-study is, of course, the lack of interview data from the LEA advisors. It would be useful to have data on other `failing' schools in the process of receiving LEA advice. There was not any report about the how the school developed and implemented the turnaround strategies, the relationships between schools and the LEA during the implementation of the action plan.
Research implications	

Policy implications	Environmental constraints such as the level of the deprivation should be taken in to account when the outcome of the turnaround process is considered.
Comments	
Other details	Failure was defined on the basis of the Office for Standards in Education (OFSTED) report. The key indicators of the school's OFSTED report centred around the SATs attainment, attendance, and exclusion and teaching quality, all of which were subject to numerical tabulation.
Quality issues	

ID number	11
Title	Not with a bang, but a whimper
Author **Year** **Country** **Source**	Meier, K.J., Bohte, J. 2003 USA Administration and Society
Aims and Objectives	To examine the process of failure, defined as micro failure (pattern of suboptimal performance for a periods of time, in public schools in Texas). In particular the study aims to explore why some school districts consistently present poor performance with regard to three key indicators. To test four hypotheses that examine the impact of constraints on organisational performance. The hypotheses suggest that **greater task diversity**, **inadequate resources**, **more bureaucracy**, and the **failure of incentives** would all result in more micro-failures.
Type of organization and setting	1000 public school districts in Texas
Design	Quantitative survey
Participants	
Outcome measures	**Measure of** task diversity **through using both average district performance score on standardised achievement tests, measured at 1 and 2 year time lags and client diversity through measuring of the percentage of African American, Hispanic and low income students per district.** Measure of **resources** through measure of instructional expenditure per pupil and average class size. Measure of **bureaucracy:** number of central bureaucrats per 100 student and number of – campus bureaucrats per 100 students. Measure of **incentives** (adequate salaries) through measuring of teacher turnover and the district's budget surplus as a percentage of total spending. School districts can fail their children in three ways: absenteeism (measured through the percentage of students who are absent from school on any given day), classes failure [retention] (measured through the sum of the percentage of students retained in each of the eight grades) , and dropouts (comparing the number of juniors in year 1 with the number of seniors in year 2 and adjusting for overall the growth in enrolment.

Sample size	1000 public school districts
Data collection: Source & Period	Data is available for 4 years from 1995 to 1998 and pooled data resulted in a total of 4172 cases.
Data analysis	Pooled time series analysis to analyse the factors, which contributed to organisational micro-failure covering the years 1995-1998. The analysis has been conducted at the organisational level (school district).
Results	The rate of absenteeism (mean 4.1% with SD 1.0); retention with the mean 15.4% and SD 16.1 (skewed positively); dropout with mean 25.2% and SD 34.4. The regression analysis showed that of the four hypotheses, only **task diversity/goal conflicts** are positively correlated with micro-failure measures (absenteeism, retention and dropout) [11 out of 15 measures] and only one of its relationship was significant negative. **The resources measure** showed very mixed findings. Class size is always significant in the correct direction. Resources committed to classroom instruction, however, are unrelated to absenteeism and retentions. and positively linked to dropouts. Perhaps the weak relationship with instructional resources reflect variations in costs of educational inputs and, thus, the relationship are spurious. **The competitive disadvantage** variables may also be picking up these mixed resources relationships. In two cases, surplus funds are associated with fewer organizational failures. Teacher turnover never matters in the predicted direction. **The bureaucracy** relationships are generally *inconsistent* with the ideal stereotypical model of public organization. It is suggested that the bureaucracy is a reaction to problems not a cause of them. An increase in bureaucracy was generally *not* associated with greater organizational failures. Organisations that experienced high dropout rate also experience greater absenteeism and greater retention which means that dropout could actually be the start of the next set of micro-failures. It is suggested that the public organisation micro-failure in the long run might be associated with macro-failure of governance.

Limitations and strengths	**Strength:** The diversity of the schools in Texas gives more confidence that the findings are not the result of a limited set of organisations.

	This article explored the nature of organization micro-failures, the inability to produce valued outputs. Because micro-failures are likely to occur more frequently than macro-failures in the public sector, only by focusing on micro-failures can sufficient cases be generated for systematic analysis.
Research implications	More systematic examination of micro-failure in public organisations was suggested.
Policy implications	Policies will be less likely to fail if an organization can deal with a relatively homogeneous set of problems. Although the political process is unlikely to recognize this principle, it might accept the corollary that organizations facing diverse tasks need to be given additional support in other areas. This might not be resources, as the above findings suggest, but might be greater autonomy or the ability to deal with cases in heterogeneous ways.
Comments	Although the schools are not typical public organisations, they are common ones and the largest employer of public servants in Texas, so the findings of the study are likely to have some generalisability.
Other details	The emphasis of the study was not on macro failure (the collapse and demise of the organisation). The focus of the study was to examine the failure to produce the outputs sought by politicians (micro failure – consistent patterns of poor organisational performance for extended periods of time).
Quality issues	Good

ID number	12
Title	Good luck, good management and organisational turnaround in the public sector
Author **Year** **Country** **Source**	Boyne, J., Meier, K. 2005 US
Aims and Objectives	To test a new model of turnaround that evaluate the impact of both a range of turnaround strategies chosen by managers and good luck which refers to the change in the external circumstances beyond the managerial control of the success of turnaround processes.
Type of organization and setting	Texas school districts. A good place to examine because the organisations were from a single industry within a singe state which were under the same rules and regulations, directly comparable organisations, school district are the most common public sector in the USA, superintendents have substantial discretion in playing a role in improving performance through retrenchment, reorganisation and repositioning.
Design	
Participants	150 Texas school districts that were performing in the lowest quartile on the primary assessment criterion scale in 1995
Outcome measures	Evaluation of failure and turnaround was on the basis of the Texas assessment of academic skills (TAAS), assessing the function of students (retrospectively) from 1995 to 2002. **Organisational environment:** Munificence (change in financial resources) and environmental hostility (the socio-economic characteristics of school children which make it easier or more difficult to teach them) measured by the proportion of minority (black and Hispanic) and low income students (good luck is defined as the lower proportion of minority and low income students). **Three measures of retrenchment:** Using a survey of school superintendents as the most powerful stakeholders in the planning and implementing strategies: the level of priority of lowering cost/increasing efficiency by superintendents, the extent of focus on the exam results (TAAS), and the percentage of the superintendents' time spent on internal management. **Three measure of repositioning:** Through a survey of superintendents: extent to which superintendents are seeking change; seeking private funding; initiation of contact and interaction with external stakeholders. **Three measures of reorganisation:** New superintendent

	insider, new superintendent outsider, changes in staff allocated to teaching (core staff), and changes in teacher experience as the marker of quality of core staff. **Control variables:** The size of the schools measured by the number of pupils enrolled in 1995; tenure measured by the number of years that the superintendents have spent in the current school districts; and the extent of failure.
Sample size	Not mentioned but 50% response in 2000 and 60% response in 2002 which was in total 600 useable responses.
Data collection: Source & Period	The data on organizational strategies and context are derived partly from secondary sources and partly from surveys of school superintendents in Texas in 2000 and 2002 (mailed survey with three follow ups)
Data analysis	Multivariate analysis of 141 out of 150 school districts (no difference between respondent and non-responding districts).
Results	The statistical evidence supports our argument that turnaround is associated with good luck as well as good management. Performance improvement was greatest in districts with the worst baseline performance and the impact of superintendents is non-linear. The size of school had a negative correlation but only significant at .01 level. Increase in munificence and decrease in hostility are likely to lead to better performance. The extent of turnaround is also significantly influenced by all three types of managerial strategies but not always in the direction predicted by prior theory and empirical evidence. Two of the three retrenchment variables, which focus on core business and time spent on internal management, have no significant effect on performance change. Schools that placed emphasis on lowering costs and increasing efficiency were substantially less likely to produce better results. In contrast to the private sector, this form of retrenchment appears to be a route to further failure rather than rapid recovery. The results ofa strategy of repositioning are broadly consistent with hypothesis 3. Two of the three repositioning variables are positively related to the extent of turnaround: superintendents who seek change, and who initiate interactions with a wide range of stakeholders, are more likely to lead their districts towards performance improvement. The third element of repositioning, the emphasis on acquiring private funding, has no significant impact on recovery from failure. Taken together, the results for retrenchment and repositioning suggest that 'financial' turnaround strategies (cutting costs and seeking revenues) are not effective in school districts. A strategy of internal reorganization has a significant positive effect on performance improvement. School districts that replace their superintendent with an insider are more likely to achieve turnaround, but the appointment of an outsider is insignificantly different from persevering with the superintendent who led the district to failure.

	Districts that raise the proportion of their staff who are teachers, and recruit more experienced teachers, have significantly better prospects of recovering from failure. Thus the results for reorganization are consistent with the proposition that turnaround is associated not only with top management change but also with a human resource strategy that pays particular attention to core staff.
Limitations and strengths	As a set of poor performing schools was selected, the data did not meet the standards of Gaussian distributions. Such extreme cases in the data distribution are likely to create situations where a single point or set of points exerts undue influence on the results, thus rendering the regression estimates unstable. To avoid this problem, the model was estimated with robust regression techniques that rely on an iterative process of downweighting extreme cases but converge to OLS estimates when data meet the assumptions of OLS regression. The specific technique was Andrews (1974: 523) sine approach which is "resistant to gross deviations of a small number of points and relatively efficient over a broad range of distributions". Although we included luck in our analysis of turnaround in Texas School districts, our operationalisation of this concept is incomplete. First, our measures of the task environment covered munificence and hostility, but we did not have data on changes in the complexity of the conditions confronted by school superintendents. Second, our analysis focused on the technical but not the institutional environment of turnaournd (for example changes in support from external stakeholders and shifts in judgements concerning the legitimacy of different responses to failure). Subsequent studies of turnaround should seek to extend our analysis of good luck by including these variables.
Research implications	

Policy implications	
Comments	
Other details	Prior work on turnaround has suggested that the impact of managerial strategies may be contingent on the severity of performance problems and the extent of environmental munificence. Cost-cutting may work if an organization is facing only moderate decline, but a radical repositioning strategy is required if decline is severe (Hambrick and Schechter, 1983; Robbins and Pearce, 1992). Similarly, retrenchment is necessary in an environment of low munificence, whereas a strategy of repositioning is more feasible when munificence is high (Dawley et al; 2002; Thietart, 1988). The validity of these arguments was tested through interaction terms that captured the combined effects of managerial strategies, performance problems and environmental munificence. None of these extra variables, however, produced a significant improvement in the explanatory power of our turnaround model. Furthermore, measures of all three generic have been included turnaround strategies in the same statistical model. Prior research has typically examined only one or two strategic responses to poor performance. For example, retrenchment alone is examined by Chowdhury and Lang (1994), Morrow et al, (2004) and O'Neill (1986); and reorganization is omitted from the turnaround models in Bruton and Wan (1994), Dawley et al, (2002), Evans and Green (2000), Hambrick and Schechter (1983) and Robbins and Pearce (1992).
Quality issues	Good

ID number	13
Title	What's different about public and non-profit turnaround?
Author **Year** **Country** **Source**	Paton, R., Mordaunt, J. 2004 UK Public Money and Management
Aims and Objectives	To explore the process of turnaround in different public and non-for profit sectors
Type of organization and setting	Four organisations including three different public organisations (a local authority, a health care trust, a school) and a non-for profit organisation (a large disability charity, Ablecare)
Design	Multiple case study method
Participants	A person who led the turnaround in the local authority, Chief Executive of the health care trust, an academic who was also a member of the governing body for a period of time for the school, and Chief Executive of Ablecare
Outcome measures	
Sample size	Four senior managers of above mentioned organisations
Data collection: Source & Period	Interviews with above mentioned participants. For both the health care trust and Ablecare, documents and internal data were also gathered.
Data analysis	Was not reported
Results	**<u>Symptoms of the failure</u>** **local authority:** Poor appreciation of services by the clients, few services with good quality, divided organization marked by factionalism. **Health care trust:** Serious financial deficit, low morale level, significant clinical weaknesses, a substantial net export of the patients to the surrounding hospitals (inadequate competition), those weaknesses caused the trust to be merged with another trust. **Merged school in deprived area:** poor financial balance, school was rated as 'special measure' (unable to provide acceptable standard of education) by OFSTED, poor behaviour in over half the classes, poor progress in Key Stage 1, poor quality teaching in almost half the classes and lessons, unsatisfactory provision for the under fives, failure to fully implement the National Curriculum. **<u>Causes of failure</u>** **Local authority:** Poor internal organization and operations, in-fighting and power-broking.

Merged school in deprived area: lack of leadership and strategic direction by the head teacher, inappropriate development plan and lack of clarity in the school priorities.

Acceptance of failure

Local authority: The need for the changes has been accepted by the some senior staff but there was not agreement on the nature of the change.

Triggers for changes

Local authority: the triggers for change were internal (replacement of senior managers)

Merged school in deprived area: The local education authority appointed an experienced mentor (the head teacher of another middle school) to help the school to provide an action plan (external trigger).

Turnaround strategies

Local authority: The newly appointed CEO adopted two main strategies including replacement of the senior management team during the first year (half of the new team members were women) and an attempt to bring about cultural change was made with considerable self-awareness. Other strategies were client-centred focus, more communication within the organization and changing the silos management and empowerment of people were the key aspects of change.

Health care trust: The newly appointed CEO (Reorganisation) adopted a plan which involved renewing the senior team and changing how it worked; determination in tackling difficult issues (removing the suspended clinician, cutting staffing levels or altering staff positions to reduce costs - Retrenchment); initiatives with a definite symbolic dimension (building car parks; introducing a (mobile) state-of-the-art MRI facility; more clinical involvement in the series of review of services; later, introducing the Trust's own 'Academy'; and giving much more attention to external marketing ('playing the NHS system') and reputation building. Creating clinical networking and partnership with the surrounding hospital (Repositioning).

Merged school in deprived area: Appointment of an acting headteacher, The acting head teacher left the school after two terms and another temporary head teacher led the school for two terms before the substantive head teacher was appointed. During the acting head's period of office, recovery activity was attempted twice but attention was focused on more minor building improvement (improvement of financial management, changes in staffing). But in terms of shared ideas and values, the staff and head teacher found it difficult to sustain morale, cope with stress, and to recruit new staff.

Outcome of turnaround

Local authority: Considerable success in terms of service delivery and in terms of internal processes and relationships, the cultural change had been largely achieved and it had

	become a happy working environment. It was rated as excellent on its CPA **Health care trust:** Successful turnarounds, 5 years after appointment of the new CEO no financial deficit, reorganizations of major services, expansions of key staff grades, reversal in patient outflow (the trust was now a net importer rather exporter) and it was the least-cost acute centre in the county, considerable institutional recognition and professional recognition. the health care trust continued to perform reasonably well, but for a raft of reasons merged with another trust **Merged school in deprived area:** appointment of a acting head teacher. The acting head teacher left the school after two terms and another temporary head teacher led the school for two terms before the substantive head teacher was appointed. During the acting head's period of office, recovery activity was attempted twice but attention was focused on further minor building improvement (improvement of financial management, changes in staffing). But in terms shared ideas and valued, the staff and head teacher found it difficult to sustain morale, cope with stress, and to recruit new staff. The school was removed from 'special measure' and achieved stability at senior management level.
Limitations and strengths	
Research implications	
Policy implications	Owing to the political environment of public service organisations, politicians and funders seek a 'quick win' following turnaround. That may constrain the time that an organisation needs to achieve proper changes related to recovery.
Comments	
Other details	Turnaround is referred to as substantial and rapid performance improvement sufficient to restablish business viability in the face of actual or impending failure. **Theoretical framework: A** two stages model (Argyowasamy, 1995) was used to explain the turnaround strategies used in this study.
Quality issues	Good

Annex4.1 Invitation letter for the Trust to take part in the study

THE UNIVERSITY of York

Sciences

Department of Health

HYMS Building- second floor
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22 March 2005

Mr
Chief Executive

Dear Mr

Turnaround and Organisational Performance Improvement in NHS Hospital Trusts

I am a PhD student under the supervision of Dr Russell Mannion at the Centre for Health Economics, University of York. I have recently received ethics committee approval to undertake an empirical study exploring turnaround and performance improvement processes in your organisation. As part of this study I need to interview staff at various levels of the hierarchy in the Trust.

Given your role as Chief Executive I believe you would bring a valuable perspective to this topic and wondered whether you would be willing to be interviewed for the study. The interview would last no longer than 60 minutes and would be arranged for a time convenient to your self. Enclosed are relevant background details for your information.

I will contact your secretary in a couple of weeks time to see if you are willing to be interviewed for the study and if so to arrange an interview.

I do hope that you are interested in taking part in the project and look forward to meeting you. If you require additional information about the study please do not hesitate to contact me.

Yours Sincerely

Dr Hamid Ravaghi
PhD Research Student

Annex 4.2 Participant information sheet

THE UNIVERSITY *of York*

PARTICIPANT INFORMATION SHEET (version 2) **12.03.2005**

This research is being conducted to study "**Turnaround processes and performance improvement in an acute hospital Trust**". You are invited to participate in this study outlined below. Thank you for taking the time to read this information.

What is the aim of the research?

The aim of the research is: To identify the key themes in the processes of performance improvement in a zero 'star' acute hospital Trust and to provide empirical evidence to support wider understanding of organizational failure and turnaround in health care organizations.

Who is carrying out the research?

The study is being conducted by Dr Hamid Ravaghi, a PhD student, and will form the basis for the PhD degree at the University of York under the supervision of Dr Russell Mannion, Senior Research Fellow at Centre for Health Economics (CHE). The researcher has previous experience of organizational studies in health care.

Who should take part?

A range of participants will be invited to take part in the study, including:

- Members of the senior management team and a number of other key staff working in South Manchester University Hospital Trust (SMUH) since at least 2001.
- Staff at different levels and professionals from external organizations related to the performance or regulation of South Manchester University hospital (SMUH).

Is participation voluntary?

Yes, Participation is voluntary. You are free to withdraw from the research at any time without giving a reason and without any detriment to yourself.

What does taking part involve?

If you decide to take part in the research, you will be interviewed. The semi-structured interview will take a maximum of 1 hour and a half and, with your

permission, will be audiotaped. After transcribing of the tape, transcriptions will be sent to you in order to verify their accuracy.

What is the likely benefit to me?

Although there is no direct benefit to you for participating in this study, it is expected that the findings will be of value to your organisation and the wider NHS in understanding the processes and mechanisms for 'turnaround' in under performing organizations.

What is the possible risk or inconvenience to me?

There are no risks attached to this study. Your interview scripts will be kept confidential; available only to the researcher. The only tangible cost to the participant will be the inconvenience derived from the time required to attend for interview.

What will happen to the information you provide?

Interview tapes will be transcribed by the principal researcher. Interview tapes and transcriptions will be locked in a safe place. All the information collected during the course of the study will be viewed by the researcher, and his supervisor if requested, and remain strictly confidential.

This information will be used to write up a PhD dissertation, as well as articles for journals. However, the names of the people who have taken part in the research or any other information that could identify them will not appear in the thesis or in other articles written after the project is completed.

All who take part in the research will be sent a summary of the final report.
When the study is completed, all the information will be kept in locked filing cabinets in a storeroom of the Department of Health Sciences of University of York for 5 years and will then be destroyed.

What is the next step?

If you decide to participate in this study, Please sign the attached consent form and return by the pre-paid envelop enclosed or e-mail your willingness to participate and the consent form will be signed on the day of interview. Please choose from the stated dates below the most convenient for you. The consent form will not be used to

identify you. It will be filed separately from all the other information. You can keep this sheet for reference.

Further information:

If you have any questions about this study, you can contact the principal researcher, Dr Hamid Ravaghi, Department of Health Sciences, University of York on **01904 321916** or e-mail **hr122@york.ac.uk**

Dr Hamid Ravaghi

Appendix 4.3 Interview Topic guide

A. Employment background

A1. Can you tell me a bit about yourself and your experience of working in the NHS? For example how long have you been working in the NHS? Who for?

A2. How long have you been with this organization and in which positions/jobs?

B. Organisational background and performance of the Acute Trust

B1. Tell me what you know about the history of the hospital's performance

B2. Have there been any concerns regarding the performance of the hospital? When? What?

B3. Tell me about the general performance problems in the hospital and external awareness.

B4. Tell me about the factors that in your opinion have caused or contributed in specific problems in the performance of the Trust.

C. Triggers for changes

C1. When and how did the hospital become aware of the problems?

C2. Were there any external agencies involved? Who? What did they do?

C3. How did the hospital react to the external reports about the problems?

C4. Were there any factors that particularly helped or hindered the recognition of the hospital's need to adopt a recovery process?

D. Turnaround process

D1. Was there any recovery plan? How did the recovery plan get developed?

D2. Who was involved in developing it?

D3. Was it based on a previous performance plan?

D4. What interventions have been adopted to deal with the problems? short and long term interventions?

D5. How did these interventions work? Who and how did lead the implementation of the recovery plan? What was Leadership style during the turnaround process?

D6. What was the role of external organisations (e.g. SHA, PCT, and MA) in development of action plan and during the turnaround processes? What were the advantage and disadvantage of their involvement? Could they conduct things better? What is your Suggestions in regard their roles for future?

E. Impact of Turnaround interventions

E1. What were the results of the turnaround interventions? Do you think the performance has been improved? How performance improvement has been measured and monitored? Has improvement gone according to recovery plan?

E2. What were the unintended consequences of these interventions? Is there any conflicts between targets?

E3. What factors do you think helped or hindered achieve those results?

E.4 Do you think that performance improvement will be sustained in the future? Why? How?

At the end, Would you like to add anything that has not been pointed out already?

Annex 4.4 Consent form

THE UNIVERSITY *of York*

Department of Health Sciences
HYMS Building- second floor
University of York
Heslington, York YO10 5DD
Tel: 01904 321916
Fax: 01904 321920

Email: hr122@york.ac.uk

Consent form

Please sign the form showing your consent to all of the following.

- I am willing to be interviewed about the turnaround processes and performance improvement in an acute hospital Trust.
- I understand that the interview will be audiotaped.
- I understand that I am free to withdraw from the research at any time without giving a reason.
- I understand that only the researcher (Hamid Ravaghi) and his supervisor have access to the information collected during the study.
- I am aware that the information collected during the interview will be used to write up a report on the project, as well as articles for journals.
- I understand that information collected during the course of the research project will be treated as confidential. This means that my name, or any other information that could identify me, will not be included in anything written as a result of the research.
- I understand that when this research is completed the information obtained will be retained in locked filing cabinets at storeroom of the Department of Health Sciences of University of York for 5 years and then will be destroyed.

Interviewee's signature **Date**

Interviewer's signature **Date**

Appendix 4.5 research Ethics Approval Letter

Local Research Ethics Committee

17 March 2005

Dr Hamid Ravaghi
Room 213 second floor
HYMS Building
Department of Health Sciences
University of York
Heslington
York YO10 5DD

Dear Dr Ravaghi

Full title of study: Turnaround processes in NHS Acute hospital Trusts
REC reference number: 05/Q1401/11

Thank you for your letter of 14 March 2005, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice-Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

The favourable opinion applies to the research sites listed on the attached form.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document Type:	Version:	Dated:	Received:
Application	1	20/01/2005	24/01/2005
Investigator CV	CV for Dr Hamid Ravaghi	25/12/2004	24/01/2005
Investigator CV	CV for Russell Mannion		24/01/2005
Protocol	1	10/06/2004	24/01/2005
Covering Letter	2	14/03/2005	14/03/2005
Letter from Sponsor	-	19/01/2005	24/01/2005
Interview Schedules/Topic Guides	1	20/10/2004	24/01/2005
Participant Information Sheet	2	12/03/2005	14/03/2005
Participant Consent Form	1	20/12/2004	24/01/2005
Response to Request for Further Information	1	14/03/2005	14/03/2005

Management approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final management approval from the R&D Department for the relevant NHS care organisation.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Notification of other bodies

The Committee Administrator will notify the research sponsor and the R&D Departments for the NHS care organisations that the study has a favourable ethical opinion.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

05/Q1401/11	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project,

Yours sincerely,

Mrs

Vice Chair

Enclosures: **Standard approval conditions**

Site approval form (SF1)

Appendix 4.6 Research Governance Approval Letter

South Manchester University Hospitals NHS
NHS Trust

Research & Development Directorate
Ground Floor, Education & Research Centre, Wythenshawe Hospital
Tel: 0161 291 5777/5770, Fax: 5771
Email: lhine@fs1.with.man.ac.uk

Wythenshawe Hospital
Southmoor Road
Wythenshawe
Manchester
M23 9LT
Tel: 0161 998 7070

Ref: AM/LH/ProjApp/Apprv0086 (2005MG001)

18 March 2005

Dr Hamid Ravaghi
Room 213, HYMS Building
Department of Health Sciences
University of York
Heslington
York YO10 5DD

Dear Dr Ravaghi

Re: Turnaround processes in NHS Acute hospital Trusts
R&D Ref: 2005MG001
LREC Ref: 05/Q1401/11

Thank you for providing us with a copy of the letter confirming ethical approval for the above study. This research project has now been given R&D Management Approval.

We are required by the Department of Health to report research carried out within this Trust to the National Research Register (NRR). This is carried out on a quarterly basis, ***and is published on the Internet***. The details for this project are shown on the attached summary. If you have any changes to make, or **you do not wish these details to appear on the NRR**, please reply to Laura Hine, R&D Information Officer, at the address shown above.

Please note it is a requirement of the approval given by the Trust that the research project is being conducted in line with the guidance given within the Research Governance Framework as issued by the DoH: (http://www.doh.gov.uk/research/rd3/nhsrandd/researchgoverance/gov/home.htm) Alternatively from the R&D website http://www.smuht.man.ac.uk/rd/, click on the governance link.

May I also draw to your attention the need to comply with both the Health & Safety at Work Act and the Data Protection Act.

Thank you for your assistance. If you require any further information please do not hesitate to contact us on the above numbers.

Yours sincerely

Dr Andrew Maines
Head of Research & Development
Enc.