Ambidextrous working in health and social care services: A configurational view

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Abstract

This study evaluates how middle and front-line managers contribute to organizational ambidexterity through their engagement with long-standing organizational dilemmas, supplementing earlier senior management focused work. Based on a multi-level exploratory study conducted within the UK health and social care sector, we investigate how middle and front-line managers were able to work on a collective and redistributive basis to address the tension between exploratory and exploitative innovation. Middle managers served as 'horizontal integrators' facilitating the emergence of shared understandings, learning capabilities and the distribution of knowledge-based resources, a process shaped by the constraints and opportunities provided by the broader intra-corporate environment. We conclude that the transition to ambidextrous working was impeded by restrictive bureaucratic dimensions, and facilitated by a distributed pattern of interaction, shared responsibility and more empowering bureaucratic forms.

1. Introduction

Senior management has long been seen as central to the process of developing firm-specific capacities for ambidexterity. The existing corpus of scholarship on ambidextrous organizations provides insights into how the higher managerial echelon serves as a significant locus for resolving the tensions between exploratory and exploitative innovation processes (e.g., Carmeli and Halevi, 2009; Smith and Tushman, 2005; Tushman and O'Reilly, 1996).

There is, however, widespread agreement that organizational capacity for forging links between senior management and more junior employees is an essential precondition for the effective implementation of ambidexterity (Jansen et al., 2009; Jansen et al., 2012; Junni et al., 2013; Raisch et al., 2009). There has been an increasing interest in how middle and/or front-line managers can play an active role in managing ambidexterity, especially in the context of managing transitions between exploration and exploitation (Zimmermann et al., 2015; Zimmermann et al., 2018). Whilst existing research has shown the separate contributions of senior managers and middle managers to managing these transitions, less is known about the dynamic interactions between senior management and middle or front-line managers and about how the relative roles and influence of these different managerial actors might change in the course of making these transitions.

Drawing on a multilevel longitudinal study, we argue that a capacity for developing unit-level ambidexterity can best be understood in relation to broader patterns of social interaction. We present evidence as to how the situated actions of senior, middle and front-line managers allowed two previously separate health and social care organizations to make the transition from loosely coordinated forms of exploratory innovation to much more integrated forms of joint production, in which new care services could be formalized, routinized and scaled.

Our study makes two specific contributions to the literature on organizational ambidexterity. First, we show how middle managers serve as 'horizontal integrators' who facilitate the emergence of shared understandings, learning capabilities and the distribution of knowledge-based resources (cf. Burgess et al., 2015; Wooldridge et al., 2008). Second, we provide insights as to how the capacity for building unit-level ambidexterity may be shaped dynamically within the broader intra-corporate environment. Here we build on and extend dynamic perspectives on ambidextrous charters (Raisch and Tushman, 2016; Zimmermann et

al., 2015). We show how the relational advantages that flow from such charters may be inhibited by 'charter loss' (Galunic and Eisenhardt, 1996) or renegotiated by senior managers who work proactively to defend, demarcate and develop the institutional context in which ambidextrous orientations are pursued.

2. Literature review

Organizations operating in a wide range of industrial and service sectors are increasingly confronted with complex paradoxical challenges (Miron-Spektor et al., 2018). Organizational ambidexterity (henceforth OA) can be understood as the ability to refine existing domain knowledge (exploitation) whilst exploring or creating new knowledge that can be transformed into useful products or services. The broader corpus of OA scholarship is weighted towards the role of senior management in fostering OA orientations within the firm, given its key role in setting and implementing strategy (Heavey and Simsek, 2017). More recently, there has been growing interest in how OA is realised on a localised basis within differentiated operating units (Raisch and Tushman, 2016; Zimmermann et al., 2015; Zimmermann et al., 2018). These units will typically contain a diverse range of skills, knowledges and a plurality of different viewpoints on how innovation capacity should be developed (Burgelman, 1994). Studies show that this plurality of viewpoint is particularly salient in professionalized organizations, where power is diffuse and objectives are divergent (9 Denis et al., 2001; Lusiani and Langley, 2019; Pettigrew et al., 1992). Building on this, our paper will make the case that OA can be understood as a collective accomplishment that emerges from broader patterns of social interaction. It will seek to extend our understanding as to how senior, middle and front-line managers contribute to the development of OA behaviours, and it will present an analytic framework that shows how persistent tensions and

contradictions faced by innovating firms were addressed through the configurational actions of unit-level managers working at different levels within the organization.

2.1 Senior management and the structural foundations of OA

The analytic focus on senior management in key strands of OA scholarship derives from the classical management view that legal–rational authority is exercised vertically by those who occupy formal positions of leadership at the apex of the organization (Weber, 1978). OA scholars have sought to establish a positive link between the ambidextrous orientations of the innovating firm and the leadership styles of CEOs (Li et al., 2015; Mom et al., 2009), the interaction of CEO leadership attributes and top management teams (Cao et al., 2010; Lubatkin et al., 2006), or the 'shared leadership' capacities of top management teams (or TMTs) (García-Granero et al., 2018; Mihalache et al., 2014; Umans et al., 2018). Indeed, the existing work on OA provides evidence that the higher managerial echelon is an important locus for resolving the tensions between exploratory and exploitative innovation processes (e.g., Carmeli and Halevi, 2009; Smith and Tushman, 2005; Tushman and O'Reilly, 1996). There is, nevertheless, widespread agreement that links between senior management and lower-order employees are a necessary condition for effective OA (Jansen et al., 2009; Jansen et al., 2012; Junni et al., 2013; O'Reilly and Tushman, 2013; Raisch et al., 2009; Turner and Lee-Kelley, 2013; Venugopal et al., 2020).

Structural differentiation helps organizations to 'buffer' the experimentation process and the development of new competences and capabilities from ongoing operations (Tushman and O'Reilly, 1996). OA scholars have maintained that this differentiation needs to be supplemented by efforts to integrate diverse knowledge sources across differentiated exploratory and exploitative units (Kogut and Zander, 1992; Smith and Tushman, 2005). Whilst the development of ambidextrous orientations is often associated with the importation

of external knowledge (Kogut and Zander, 1992; Smith and Tushman, 2005), Jansen et al. (2009) argue that acquiring dynamic capability for using this knowledge is predicated on the ability 'to mobilize, coordinate, and integrate dispersed contradictory efforts, and to allocate, reallocate, combine, and recombine resources and assets across dispersed exploratory and exploitative units'. Whilst the capacity for senior management engagement with those working at lower hierarchical levels is seen to depend on formal organization integration devices, Jansen et al. (2009) also suggest that this may occur 'within a larger pool of informal relations', as part of which a variety of organizational members 'may be able to exploit or explore to their advantage' (Jansen et al., 2009: 808; Lin et al., 2007). OA orientations are thus predicated not only on the formal characteristics of the organization but also on the ability to mobilize a diversity of constituents. Jansen et al (2009). draw on the social constructivist work of Carlile (2002) to underscore the ways in which OA is realized through complex social processes and heterogeneous actors who are likely to possess different skills, knowledge and learning capabilities (Carlile, 2002). Thus, Jansen et al. (2009) argue that boundary spanning contributes 'to the development of a common language and ensure the capture, interpretation, and integration of knowledge sources across differentiated exploratory and exploitative units' (Jansen et al., 2009:807).

Given the above, it can be argued that OA might best be understood as a widely distributed collective accomplishment rather than a fixed capacity that is concentrated in the cognitive abilities or leadership attributes of any one group. A growing body of empirical work on middle management (traditionally seen as passive recipients of top-down directives) suggests that this group might play a vital mediating role in the development of corporate strategies (Burgelman, 1983; Denis et al., 2001; Floyd and Lane, 2000; Floyd and Wooldridge, 1992; Sun and Anderson,2012). For example, Burgelman (1983) shows the active contribution of middle managers in shaping strategic ventures, whilst Floyd and

Wooldridge (1992) highlight the ways in which the situated knowledge of middle managers influences emergent strategy. Wooldridge et al. (2008) note that attempts by senior management to secure consensus are unlikely to improve firm performance in the absence of middle management involvement; rather, the success of strategic change initiatives are predicated on middle-level understandings 'that can build bottom-up support for strategic goals' (Wooldridge et al., 2008:1206). Raes et al. (2011) argue that the interaction between top management teams and middle managers is central to strategy formulation and implementation. These authors note the lack of high-quality evidence on these interactions and call for further qualitative research that can relate the contribution of middle managers to the overall pattern of relationships within the organization (Raes et al., 2011:122).

Existing research on the role of middle managers in the UK public healthcare system corroborates the argument that middle management roles need to be understood in relation to broader patterns of social interaction (Burgess et al., 2015; Currie and Procter, 2005). Burgess et al. (2015) found that middle managers working in hospital settings were able to 'forge workable compromises between exploration and exploitation to facilitate OA'. More specifically, these managers played a vital role in integrating exploration and exploitation capabilities both horizontally (i.e., between professional specialisms) and vertically to influence organizational policymaking. Middle managers may, on this view, be well positioned to mediate the imperatives that flow from the wider governance system down to those working at, or close to, the front line (Burgess et al., 2015:87). Such findings also suggest the need for a more distributed account of how players at different levels may influence OA.

2.2 Towards a configurational view of organizational ambidexterity

Given the above, it can be argued that OA might best be understood as a collective endeavour, whose success is predicated on the existence of relational contexts that allow local actors to share knowledge. We have suggested that OA needs to be understood not as a structural characteristic or as a fixed capability but as an ongoing collective accomplishment that is developed and maintained through social interaction. Zimmermann et al., (2015) highlight the need for inductive research to focus on how ambidexterity is initiated in the first place. They propose the idea of an 'ambidextrous charter' that reflects an organization's responsibility for, and commitment to, both exploitation and exploration (Birkinshaw and Lingblad, 2005; Galunic and Eisenhardt, 1996). Prior studies that have not acknowledged the process of charter definition assume that charters are 'built from the top down through largely stable formal rules of behaviour'. However Zimmermann et al. (2015) recognize that innovation may be initiated by actors outside the senior echelon, and they acknowledge that front-line managers may anticipate technical or market opportunities that lie outside the cognitive domain of senior management development (Sheremata, 2000).

Front-line managers may influence the thinking of top management by advocating such opportunities (Dutton and Ashford, 1993), and this may in turn lead to a rethinking of what goals should be pursued by operating units (Galunic and Eisenhardt, 1996). Whereas 'mandated' charters are realized on a top-down basis, 'emergent' charters achieve consensus building on the basis of 'bottom-up relational processes' (Zimmermann et al., 2015:1119). Thus, unit-level managers may engage in constituency building and advocacy in order to secure corporate support for new ventures and/or product development projects (ibid.). Zimmermann et al. (2015) emphasize the normative character of such boundary-spanning activities and their role in fostering collaborative behaviours (see also Faems et al., 2008; Ness, 2009; Raisch and Tushman, 2016). This would add credence to earlier work, which

suggests that the capacity for collaborative working across organizational boundaries is defined and initiated not through formal contracts or bureaucratic rules but through shared understandings that define a given unit-level mission (Birkinshaw and Hood, 1998; Galunic and Eisenhardt, 1996).

The above brief review of Zimmerman et al., (2015) has suggested that capacity for developing unit-level OA is conditioned by emergent corporate charters. A subsequent study by Zimmermann et al. (2018) examines the ways in which OA is configured around the practices of personnel who work at, or close to the front line. This study found that front-line managers in four product development alliances played a proactive role in initiating ambidextrous strategies. Front-line managers 'may shape organizational systems and process to reconcile exploration-exploitation tensions' (Zimmermann et al., 2018:740). The idea that OA emerges dynamically from the configurational activities of front-line managers (cf. Van den Bosch et al., 1999) extends earlier work on how localized cultures of production can generate new routines that are subsequently codified and assimilated into formal systems (Adler and Borys, 1996; Farjoun, 2010; Gulati and Puranam, 2009).

Zimmermann et al., (2015) argue further that, OA emerges neither from behaviours that are induced by senior managers, nor from purely localised actions that are instantiated at the front line, but from more broadly distributed patterns of interaction. This echoes the above-mentioned study of Burgess et al. (2015), and it also accords with theoretical accounts of how 'distributed' (Buchanan et al., 2007) or enabling (Lusiani and Langley, 2019) forms of leadership operate in professionalized organizations. However, this leaves open the question of how precisely ambidextrous behaviours are 'orchestrated and integrated into firm-wide actions and practices' (Zimmermann et al., 2018:766). Given this, it can be argued that there is a need for further research that can investigate the following questions: i) What configurational roles do senior, middle and front-line managers play in mobilizing local

capacity for exploration or exploitation? ii) What boundary-spanning mechanisms and patterns of interaction facilitate the transition from exploratory innovation to exploitative innovation? iii) In what precise ways does the formation of joint ventures or alliances help to secure OA? iv) What project-level steering mechanisms facilitate the collaborative learning capabilities that underpin OA?

In order to address these questions, we draw on the analytic framework of Van den Bosch et al. (1999). Whilst these authors note that outside sources of knowledge are critical to the innovation process (Cohen and Levinthal, 1990; Kogut and Zander, 1992), they also emphasize the relational ways in which firm-specific knowledge is configured (Grant, 1996; Henderson and Clark, 1990) in ways that generate 'a mosaic of specific learning capabilities' (Van den Bosch et al., 1999:556). These authors acknowledge that the skills and learning capacities that underpin corporate renewal are typically distributed across different functions and personnel working at different levels within the organization (q.v. Carlile, 2002; Kellogg et al., 2006). Current and acquired knowledge resources may be combined or recombined in order to create new knowledge configurations (Crouch, 2005; Kogut and Zander, 1992; Van den Bosch et al., 1999:552). Van den Bosch et al. identify three particular configurational capabilities that are relevant to the present study: i) 'systems' capabilities that allow production regimes to be redefined; ii) 'coordination' capabilities (e.g., those that allow divergent skills or learning capabilities to be orchestrated) and iii) 'socialization' capabilities (e.g., those that allow new routines or emergent forms of best practice to be legitimated and disseminated throughout the firm). Van den Bosch et al. note that capacity for reconfiguration may occur not just within the organization but also across previously fixed inter-organizational boundaries. Moreover, the capacity for horizontal exchange can be overlaid on existing formal structures (Galbraith, 1973; Mintzberg, 1979; Van den Bosch et al., 1999:556).

3. Industry setting

The world's health and social care systems (which in many societies absorb a significant proportion of GDP) are currently facing significant demographic changes and profound shifts in the underlying pattern of demand for care services. The UK Department of Health and Social Care (DHSC) is facing strong societal pressures to develop more responsive high-quality care services and equally strong pressures to operate within acute resource constraints (Klein, 2019; Vickers et al., 2017). Recent years have seen a significant policy shift away from acute care services provided by hospitals to primary care services that are delivered directly to patients in local communities. Commonly cited problems in the UK primary care system include 'low-value interventions', unnecessary duplication of clinical and administrative work, and wide variations in care standards (Curry and Ham, 2010). UK patients with multiple long-term conditions and specialist social care needs might come into contact with as many as ten different care providers over the course of a year. These organizations will typically be subject to different financial incentives, structures and cultures of provision (Corrigan and Laitner, 2012). Thus it has been argued that 'the potential for disintegration within any pathway is significant, particularly when one adds in social care' (Corrigan and Laitner, 2012:7).

The UK National Health Service (NHS) has, from its foundation in 1948, been based on the principle of professional control that was juxtaposed with a system of standardized administrative procedures (Klein, 2019). From the 1980s onwards, successive UK governments sought to replace the 'old' NHS with market-driven reforms (Paton, 2016; Pollitt and Bouckaert, 2017) whose aims were to curtail costs, open up space for private providers and shift away from a public service to an individual customer-oriented approach (Pollitt and Bouckaert, 2017). Whilst professional control over clinical practice remains in

place, the operating environment for UK health and social care providers is strongly influenced by policy directives coming from the DHSC and central government. Two regulatory agencies, the Care Quality Commission (CQC) and the National Institute for Clinical Excellence (NICE), are responsible for defining and enforcing standards and levels of care quality (in the case of the CQC) and for maintaining standards of clinical practice (in the case of NICE).

The central feature of the 2012 Health and Social Care Act was that previously separate health and social care services should be designed and delivered concurrently. From early 2012 onwards, the DHSC and NHS England (an executive agency responsible for the formulation and implementation of UK healthcare policy) promoted the idea of more flexible care 'pathways', aimed at the most vulnerable patients, particularly those with multiple long-term conditions (Addicott, 2014; Curry and Ham, 2010). The existing administrative structures that had previously coordinated local primary care services were dismantled, and responsibility for purchasing healthcare services on behalf of patients was handed over to newly created clinical commissioning groups (or CCGs) [1]. Centralized efforts to standardize care quality have coalesced around 'evidence-based' approaches that draw heavily on statistical modelling, risk assessment and the construction of healthcare tariffs that match resources to the needs of different patient groups. Efforts to eliminate variations in clinical practice have also been framed around centrally defined performance measures (Van Dooren et al., 2015), with some researchers reporting an increased use of process re-engineering methods (McCann et al., 2015; McNulty and Ferlie, 2002). Many healthcare academics have argued that the application of 'neo-Bureaucratic' process controls is of limited usefulness in care settings in which clinical knowledge may be collaboratively constructed around the interlocking specialisms that make up particular care services (Dopson and Fitzgerald, 2005; Nylen, 2007; 2012) or dispersed across multiple disciplines

and professional jurisdictions (Gittel and Weiss, 2004; Heckscher and Adler, 2006; Maccoby, 2006). Centralized policy directives or quality measures (which are typically based on heavily codified representations of best practice) have thus far failed to provide an effective way of diffusing useful knowledge to NHS care professionals working in unit-level organizations (Burgess et al., 2015). Our case study investigation shows how the long-standing tension between the highly centralised NHS governance system and unit-level control over service innovation projects was played out as senior, middle and front line managers sought to overcome previously impermeable institutional barriers that divided health from social care services. Before turning to this we give relevant detail on research design, case study methodology, data gathering and data analysis.

4. Method

The paper seeks to investigate the dynamic ways in which firms acquire capacity for developing OA behaviours. Our earlier literature review has argued that the skills and learning capacities that underpin OA are typically distributed across different functions and personnel working at different levels within the organization (q.v. Carlile, 2002; Kellogg et al., 2006). We have argued on this basis that OA can be understood as a widely distributed collective phenomenon that emerges dynamically from broader patterns of social interaction.

4.1 Research design

We have adopted a single 'case in sector' research design that shows how local actors from four separate organizations developed new and more closely integrated care services. Our investigation is focused on a temporary project-based organization that allowed previously separate groups of care professionals from the four organizations to work collaboratively over a six-year period. Qualitative data was gathered through semi-structured

interviews with care professionals working in senior, middle and front line managerial roles. Data was also gathered through participant observation of project meetings and analysis of project documentation. Whilst single case study research designs cannot support statistical generalizations, they can provide the empirical basis from which to develop theory inductively (Eisenhardt, 1989; Eisenhardt and Graebner, 2007; Yin, 2017). Thus, we present case study findings on how firm-specific knowledge was configured and reconfigured as two organizations that participated in the project made the transition from exploratory innovation to exploitative innovation. In the concluding sections of the paper we draw on these findings to make a number of theoretical propositions on how capacity for developing OA behaviours is mediated by distributed patterns of managerial authority and control.

4.2 Data gathering

A total of 76 semi-structured interviews (whose durations varied from 60 to 90 minutes) were conducted between early 2013 and early 2019. The geographical location of 'mid-County' and the identities of all the organizations that participated in the research have been anonymized, as have the identities of all interview respondents. A first tranche of data gathering was conducted between January 2013 and December 2014. This began with 15 exploratory interviews conducted with selected personnel from the mid-County Clinical Commissioning Group (henceforth CCG), 'CareCom' (a local community care provider) and two NHS England policy implementation specialists, both of which were closely involved with national- and regional-level initiatives aimed at improving capacity for the care of frail and elderly patients. We also conducted participant observation at meetings of the mid-County Frailty Project steering committee during this initial phase of the research. These meetings (held quarterly between spring 2013 and late 2014) were convened by the mid-County CCG. Participants who sat on the committee included care commissioners and

clinical staff from the CCG, the mid-County head of Adult Social Care services, the CEO of CareCom and an independent project chair (a former ministerial policy advisor and commentator on the UK health and social care system). Internal documentation relevant to the management of the Frailty Project was consulted and collated during each phase of the data gathering.

A second tranche of data gathering was conducted between late 2014 and summer 2015. The participant observation carried out in 2013/2014 allowed us to secure a series of in-depth interviews with the most senior decision makers who were involved in the Frailty Project (e.g., NHS care commissioners and senior executives from the provider organizations that participated in the project). A total of 37 semi-structured interviews were conducted in this second tranche of data gathering. Semi-structured interviews were conducted with a cross-section of senior managers, middle managers and supervisory grade (front-line) managers working in four provider organizations: i) mid-County Social Services, ii) 'CareCom' (a community health organization), iii) a mental health hospital trust and iv) a voluntary sector provider of care services to the elderly.

Our literature review has suggested that researching OA requires multilevel studies that can investigate dynamic interactions between actors who may work outside formal hierarchies. Our second tranche of data gathering was accordingly focused not just on the parent organizations noted above, but also on multidisciplinary teams (MDT's) of front line care professionals who had begun to work across fixed institutional and professional boundaries that had long divided primary, acute (hospital) and social care providers. We interviewed three general medical practitioners (known in the UK as GPs) working in three local surgeries that had been selected by the steering committee as trial sites for multidisciplinary team working. We also interviewed a cross section of care team

coordinators, nurses, physiotherapists and social workers who attended regular multidisciplinary meetings held in each of these surgeries. The second tranche of of data gathering also included participant observation of two 'frailty review' events (held in December 2014 and June 2015) during which changes in multidisciplinary working in the three trial sites were subjected to periodic review. These events were run by a Westminster-based charitable foundation providing facilitation services and change management expertise to UK public sector organizations. This organization has been anonymized for the purposes of this article as 'The Change Foundation'.

A third tranche of data gathering was undertaken between March 2017 and January 2018. Here we conducted a further 22 semi-structured interviews. All of those interviewed in this third tranche were Frailty Project participants who had been interviewed as part of the second tranche. Two provider organizations (the mental health trust and the voluntary sector provider of care services) had by 2016 withdrawn from the Frailty Project. The smaller number of respondents interviewed in the third tranche reflects staff turnover resulting from retirements, internal promotions within the participant organizations or other career shifts. Interviews were repeated in particular cases where detailed accounts of key issues or emergent processes relating to particular phases of the Frailty project could be augmented or enhanced.

We continued to monitor ongoing integration efforts on a regular basis throughout 2017, conducting participant observation at a series of confidential meetings that involved joint discussions between senior executives from mid-County Social Services, CareCom and the local CCG. We also attended the monthly meetings of a newly constituted integration

board that was established by senior executives from CareCom and the mid-County Social Services in November 2017. This participant observation continued throughout 2018; two final interviews were conducted (with the head of integration and partnerships for mid-County Social Services and a CareCom clinical care project manager in early 2019.

4.3 Data analysis

We followed a three-stage sequence of data analysis. Open coding was used to collate the raw interview data on how new organizational routines and learning capabilities were realised in our chosen research setting. Interview transcripts from the first, second and third tranches of data gathering were cross-checked for bias coming from individual interviewees. We controlled for bias by triangulating the accounts of multiple interviewees. We also checked our data on the emergence of integrated care services in mid-County through detailed consultations with independent industry commentators and NHS policy implementation specialists. We then developed a thematic content analysis (Bryman and Bell 2015; Silverman 2013) of how exploratory and exploitative forms of OA were managed at different stages in the development of the frailty project described above. This produced insights on the temporal dynamics of OA, and on the recurrent tension between unit-level service innovation initiatives and the broader NHS system of governance. A third and more finely grained stage of data analysis allowed us to identify the managerial practices that underpinned: i) 'systems level' changes in integrated health and social care services; ii) coordinative capabilities that allowed divergent skills and learning capabilities to be orchestrated as care services were redesigned and iii) 'socialization' capabilities that allowed new routines and emergent forms of best practice to be legitimated and disseminated to front line units

5. Case study: The mid-County Frailty Project 2013–18

5.1 Orientation

As noted in the preceding account of our chosen industry setting (see section 3.0 above), the UK Department of Health and Social Care promoted the idea of more flexible care 'pathways', aimed at frail, elderly or otherwise vulnerable patient groups, from 2012 onwards [2] (Addicott, 2014; Curry and Ham, 2010). Primary care trusts were dismantled, and purchasing functions were handed over to newly formed clinical commissioning groups [1] in 2012/13. The mid-County Frailty Project was launched in April 2013, when a local CCG (situated within a conurbation of 200,000 people) responded to an NHS England 'Year of Care' initiative that sought to develop more integrated health and social care 'pathways'. The case study begins by highlighting the organizational challenges faced by a small group of local care providers as they sought to develop their capacity for working across long-standing professional jurisdictions and institutional boundaries. These boundaries are schematized in our depiction of the mid-County health and social care system (see figure 1 below).

Figure 1: The mid-County health and social care system

{INSERT FIGURE 1 HERE}

5.2 Project phase I: Initiation governed by a mandated charter

The frailty project steering committee included senior executives from four care organizations providing acute care, community health care, social care and mental health services. The committee also included senior GPs and NHS care commissioners employed by the local CCG. The dominant assumption was that the project should be centred on the construction of a care tariff and statistical measures that would allow commissioners to match patterns of patient demand to the offerings of different providers. The initiation phase of the

project was characterized by formalized assumptions about the operating environment, an emphasis on written contract formulae and statistical modelling of patient populations. The chair of the steering committee argued that:

integrating previously fragmented patterns of care provision will depend on logistics operations that can overcome the different cultures and drivers within each organization. (Mid-County frailty project chair)

The project steering committee began by prioritizing the construction of a 'frailty tariff' that was designed to provide the basis for care commissioners to award contracts to different providers. Whilst formal modelling provided generalised insights on how provider organizations exploited existing knowledge of aggregate demand, participant observation conducted at quarterly committee meetings showed that the available data (which was sourced from incomplete G.P. records) shed little or no analytic light on how providers might bring new knowledge or expertise to bear on the construction of care 'pathways'. By late 2013, there was a growing awareness within the project steering committee that the concern with statistical measures was distracting from the practical accomplishment of creating new care services. Senior managers from the CCG and the mid-County Social Services began to reframe the project around a switch towards a more human, process-centred approach. Specialist advice was sought from 'The Change Foundation', a Westminster-based policy research organization. Discussions with the Director of Adult Operations at mid-County Social Services suggested that it might be possible to exploit the knowledge of frontline care staff. Thus:

We were interested in challenging idea that organizational change should be defined by formalised commissioning models. We have had integration of delivery before without

commissioning. At the moment we've got integration of commissioning and not enough integration of delivery.

The Director for Adult Operations stated further that:

The Change Foundation gave us the opportunity of utilising frontline's staff knowledge directly. Could we then, having worked out 'what works', then work backwards back into the commissioning system, into the more traditional, hierarchical approaches, to put governance around the outcome?.

The revised approach to project implementation also entailed a broader shift in the authority relationships that underpinned the overall governance of the project:

'We had very loose governance around the input from the Change Foundation. There was enough there though, I mean it's not too loose. So we kept an eye clinical stability and on or the social work side of it - all those things were covered by the frailty [project] *board, but with a big dollop of permission where we said to staff 'do whatever you feel is necessary, you know, and if you come up against a resource constraint we'll try to solve that for you without going through the whole bunch of governance and decision making processes'. So we had systems leadership at the level of the frailty board and above that myself and the Chief Accountable Officer of the CCG as sponsors. And then below that there are the front line care teams'.* (Mid-County Social services Director for Adult Operations)

Thus, front line care staff from GP surgeries, social services and community health care providers would be allowed to develop their own local solutions to specific care scenarios.

5.3 Project phase II: Exploration governed by an emergent charter

The second phase of the project saw the advent of an 'emergent' ambidextrous charter. From April 2014, the problem of designing more responsive care pathways was devolved to care professionals working at, or close to, the delivery of front-line services. Change foundation facilitators initiated a series of 100 day 'challenges' in which multidisciplinary team members were invited to identify key issues and known 'pinch points' in the service provision (for example when patients being discharged from hospital underwent follow up physiotherapy or other forms of patient 'reablement'). A CareCom manager for unplanned care noted that:

It started off as a '100 day challenge' where there were three [multidisciplinary care] teams pitted against each other... to see which team could come up with innovations that would reduce unnecessary admissions to acute care for frail, older people. So, we didn't know really which, what each other's initiatives were, the teams were mixed, made up from volunteers, social workers, and various professionals. And then we'd come together half way through the 100 days to share the innovations and the ideas and look at results - had fewer people gone into a hospital during that period or not and then could we attribute it to the work we were doing or not?

One GP stated that:

The CCG realised that more should be done around the frailty [patient] *cohort. The idea was to bring health and social care and the voluntary sector together, to really look at those patients and see what we were all doing.... perhaps engaging with* [these patients] *but not coordinating the care and certainly not sharing information. So that's how it started…those first few events* [in which] *we all came together, it was just such an enormous learning curve'.*

Locally generated integration measures that emerged from the 100 day challenge events included enhanced multidisciplinary team working , a 24-hour helpline that would provide a single point of access to patient services, and a patient-held record that could be accessed by different care organizations. Interviews carried out with GPs and MDT coordinators show the rich potential for horizontal exchanges and team working between previously separate bodies of expertise.

Vignette 1: Horizontal knowledge exchange between previously distinct professional groupings

An integrated care team manager who participated in fortnightly MDT meetings emphasised the knowledge exchanges arising from team working, stating that:

We're talking about how we can best care and support somebody to ensure their health remains as good as it's going to get. No admissions to hospital. If we can reduce ambulance call-outs, GP call-outs, great. Everybody will say what their bit can do. Patients are often known to the community matron and/or the community nurse so they will say their bit. And then others, people like me, will say [to the GP] ... have you ever thought about this? Keeping [patients] *independent, keeping them autonomous, keeping them healthy, keeping them away at all costs from the acute and putting together a patchwork of services that will serve them properly.*

A GP working in the same surgery stated that:

I have learned a tremendous amount about the services that are out there and because you're part of a team and you see the same faces each time, I can now phone people and ask advice whereas before you know, there was this great wall that you couldn't get through – you didn't know how to reach services. I mean there were always little ways in, little gateways but they were never transparent. Whereas now, I can ask somebody...I might phone the head of unplanned care at [CareCom] about something or I might phone an MDT coordinator and we can sort something out quite rapidly for patients'.

The CCG head of unplanned care suggested that community healthcare and social care professionals were working together in approximately 60 % (N= 48) of GP surgeries identified by the CCG in in mid-2015. However one of the GPs we interviewed noted that:

'I think for GP's to get involved it's almost a sub specialism. I don't think it's something that your average GP can fit into their work because we have so many other things that we're supposed to be doing'

A statistical analysis presented to the June 2015 frailty project review event by a senior commissioner sounded an equivocal note. Whilst the number of hospital admissions saw a reduction in two of the three trial surgeries involved in the frailty project (see pages 13-14 above), the statistics on these reductions needed to be seen as 'highly selective snapshots' rather than evidence of a major shift in working practices or cultures of provision. Whilst the new explorative capabilities had created a positive relational context for a range of service innovations, middle managers raised questions about how these would be combined with the effective – and larger-scale – exploitation of existing procedural capabilities.

Vignette 2: Middle management and the pursuit of explorative and exploitative service innovations

A CareCom clinical manager for unplanned care queried the Change Foundation approach to the frailty project stating that:

I'm not sure what we should be embedding because they have so many projects going on, little projects, and actually they're not very quantifiable…We've had lots of those meetings, but I don't think we ever do the comparing and contrasting. We just do the celebrating, something's working, what are the next initiatives, are we all committed to the next 100 days…but I'm not clear there's ever a comparing and contrasting.

Two of the three MDT coordinators interviewed in 2015 noted that these changes drew heavily on the resources of front line staff. This was of particular concern to the CareCom clinical manager for unplanned care:

The positives are that you've got genuine conversations going on between people that wouldn't normally officially communicate with each other, wouldn't actually be round the table informally having a cup of coffee saying 'what can we do, we've all got the same issues, how can we solve this and let's think outside of the box' and then being able to test it. But the testing is, if you like "on top of the day job"…the commissioners are now saying actually, as well as keeping the day job going and meeting your key performance indicators, we also need you to release time, thinking, creativity and energy to actually do something different.

5.4 Project phase III: Transition triggered by charter loss and project reversal

The transition phase of the project was characterized by a major disjuncture in the management of the frailty project. Two senior respondents at the CCG reported that the introduction of an NHS Sustainable Transformation Plan (STP) had turned attention back to a procedural-exploitative focus that derived from the need to meet centrally imposed metrics. High level support from NHS care commissioners was scaled back from 2016 onwards, as the attention of NHS policymakers and the UK government shifted from the primary care system to widely publicised failures of hospital units in the acute sector. Two such units in mid-County had fallen below centrally defined performance targets on patient admissions and waiting times. Movement of senior staff was cited as a factor that had contributed to this loss of project momentum. One of the two project sponsors (the senior CCG Chief Accountable Officer) was drawn into highly formulaic planning exercises for large scale 'systems transformation'. Thus a senior GP stated that

'I think the frailty project showed results – we had evidence that it showed results. But it hasn't been sustained. The NHS brought in the STP success regime so you get key people being pulled into other areas because of this. Then of course, the focus is lost. And you need that leadership to keep on driving it through and to have services effectively commissioned'.

One consequence of the STP was that a highly valued single point of patient access (SPA) that had been introduced by the frailty project was disbanded. A senior clinical manager at CareCom noted the centralised nature of the commissioning process, stating that:

We don't know whether the SPA can continue because it actually sits outside of what we're commissioned for...[and]...there's no other money to continue supporting it.

The Interim director of clinical commissioning observed that:

'As a leader, you have a responsibility to make sure that the environment that surrounds it remains supportive of innovation...the leadership, commissioning and operational environment...wasn't conducive to sustainability'

The Director of Adult Social Care at the county council argued that the original Frailty project had some major strengths that were not fully recognized. The project:

Was one that empowered front line workers - senior management could step in as problem solver to blocks, as opposed to steering the process… where they got it right in Mid-County was the collaborative stuff…what they didn't do was follow up on how you solidify and consolidate and provide an environment where you can replicate it

This respondent noted the highly centralised, strongly interventionist nature of the STP 'success regime'. Thus:

When stuff goes wrong, the top brass descend on the shop floor and tell everybody how badly they're doing their job. It's a severe culture and a punishment culture. It's about reprimand and a culture of escalation - it's exactly the opposite of everything that we learnt by introducing the Change Foundation model.

The above statement recalls the Adler and Borys (1996) contrast between 'enabling' and 'coercive' bureaucratic forms. Whilst the loss of support from senior commissioners that occurred in project Phase III can clearly be equated with charter loss (Galunic and Eisenhardt, 1996), subsequent discussions between CareCom and Mid County Social Services were wide in scope, and they created a new context for discussions on how localised interpretations of the service integration agenda might be pursued. The mid-County head of Adult Social Care argued that what was required was:

'A new social contract that would cohere around a properly socialised and effectively integrated care system…developing an appropriately broad vision would of necessity need to be based on the shared expectations of local providers'

The joint venture that emerged from these discussions was based on a broadly specified memorandum of understanding that committed both organizations to joint working on enhanced service provision. Participant observation conducted at a specially convened integration meeting held in November 2017 gave us access to confidential discussions between two senior executives from CareCom and mid County Social Services. These discussions suggested that the two organizations could establish a dedicated stand-alone unit whose purpose would be to facilitate the emergence of jointly designed integrated community health and social care services. Whilst the minutes from the first meeting of the new body (held in March 2018) stated that a physical programme office might 'signal commitment from both organizations', the minutes also record that the new venture would be coordinated through a ' temporary flexible organizational structure'.

5.5 Project phase IV: Charter reconfiguration and concurrent exploration/exploitation

The preceding account of project phase III showed how charter loss provided the context for the creation of a joint venture that allowed senior executives to reassert unit-level control over the integration project. Our account of project phase IV shows how capacity for exploration and exploitative innovation was further developed within a reconstituted ambidextrous charter. We show how bureaucratic silos were broken down as critical service interfaces were reconfigured, and we show how new organizational forms that emerged were underpinned by both horizontal working and shared meanings. The multidisciplinary team working that had first emerged in project phase II was matched by more rigorous project steering, statistical mapping and scaling of joint services. The interview transcripts presented

below suggest that explorative and exploitative innovation were closely interleaved and pursued concurrently by senior and middle managers.

Vignette 3: Systems-level changes in the provision of integrated care services

Project phase IV saw renewed efforts by CareCom and mid-County social services to reinstate and reconfigure the SPA (single point of access) for patients. The head of integration and partnerships at mid-County Social Services noted that:

This is about how we can avoid having two front doors to our services. If somebody is referred to adult social care they will approach us through our website or via our contact phone number. If the case requires an assessment by a social worker, the adult social care team will then channel the person appropriately…it's a bit ridiculous that some people are being referred by their GP to CareCom and the same case is then referred again through a separate social services front door. Wouldn't it make sense if you could take the separate adult social care team out of the game entirely and have one joined up front door, so that referrals go to a single point of access that would enable the referral to be picked up by the most appropriate professionals?

We now have one joined up front door, so that referrals go through a single point of access that allows these to be picked up by the most appropriate professionals. So rather than it land just on the desk of adult social care or just on the desk of [*CareCom], it effectively lands on the desk of both of us, and we can bring our resources around that case in a multi-disciplinary way.*

Interviewer – Right, and has that helped to consolidate trusted joint assessment of cases?

Interviewee: *Yes, and hopefully create a more efficient process. Because we know there are some cases that we should be working on together and others where we should not - we also know that sometimes the process involves unnecessary handoffs between one* [care] *provider and another.*

Interviewer: I heard something about appointing a joint director to oversee this process?

Interviewee: *Of course we can have a joint director … but there's no point in having a joint director if there isn't join-up on the ground, if there isn't operational join-up. So what we are doing with CareCom is looking at how we can create more of a common culture, more connections, a common language, working together on how we design our approach to early intervention, prevention, referrals and a single point of patient access.*

Vignette 4: Language, meaning and project identity

Middle managers working on the project implementation committee gave the following account of how different professional identities impinged on efforts to reconfigure capacity for early intervention:

Interviewer: Can you give us an example of how differences in language and meaning were addressed by the project work on early intervention?

Interviewee: *when we first started having conversations about what types of things we should integrate, there was so much time spent on what this list was and what that list was and what things should be called.*

So we had this whole conversation about early intervention – early intervention in social services means something completely different in community healthcare. Early intervention in social services is much more around citizen rights and access to statutory services whereas in community health terms, early intervention is about why people get sick in the first place….we were completely ham strung on early intervention.

Social services were like 'no, that can't be early intervention – this activity needs to sit here – you can't call it this, let's call it that…in the end we all agreed to put different activities into bucket lists. What joint service would come under bucket number 1 and which would be in bucket number 2? Forget it's called anything just put it in this bucket…'

Interviewer: So you jointly filled the buckets?

Interviewee: *yes jointly filling the buckets was a much easier way forward than getting hung up on a word. That's how we removed the blockage on early intervention.*

Interviewer: I suppose if an existing practice had been fixed for a very long time then the language got in the way?

Interviewee: *Yes the* [pre-existing] *language is fixed, it's who people are, how they think about the project and how they look at things. Early intervention is an example where keeping the existing language would have absolutely stopped any further progress.*

Participant observation conducted at successive meetings held in 2019 showed that critical service interfaces were reconfigured in ways that delivered enhanced capacity for rapid response and crisis prevention for the most vulnerable patients as well as the jointly managed call centre providing a single point of access to care services. Metrics for the effectiveness of the reconfigured services were developed by middle managers who were later empowered to

conduct ‘real-time’ evaluation and monitoring as these services were rolled out and introduced into front line operating units. Whilst the service innovations described above can be understood as examples of exploratory innovation, concurrent capacity for exploitation was also evident as middle managers who sat on the implementation committee worked to develop the replicability of services and the statistical mapping of different patient cohorts with complex social and healthcare needs. This concurrence was apparent as the mid-County Social Services head of integration and partnerships responded to questions about the use of big data to model patient populations.

Vignette 5: Concurrent exploitation and exploration of population health data

Interviewer: can you tell us about your current use of big data? How is this helping with costs? I know that the project has to demonstrate efficiencies and effectiveness over the next two years.

Interviewee: *I would say we have two broad approaches to what we’re doing, one is using the data that we've already got and the second one is thinking about the data in which we might need and new approaches to it. On the first one, the project team go through each of the different projects and programmes, what are the relevant data sets that will add value? So what is our data telling us, and how are we measuring success? We’ve done a piece of analysis with* [*CareCom*] *to look at our KPI’s, so that we can agree a common set of KPI’s to measure success.*

Interviewer: So this is the existing data??

Interviewee: *Yes, this is the existing data. Now we are doing a piece of work around how we can effectively develop a more predictive approach. We’re bringing together all of the key players from across the system - from* [*Care Com*], *from two more CCGs, and from the hospitals because out of that we want to agree what are the opportunities, how we might use data differently, what are the challenges? What are the things we might want to focus on, what we would like to do in* [*mid-County*]*? You can start with population health [but] that’s a really big thing – you can boil the ocean and get nowhere fast.*

Or we can say ‘let’s just choose an actual [patient] *condition’ - it might be falls prevention. How do we prevent falls in* [*mid-County*]*? If there’s a particular issue or condition we can start to identify what I would call the guiding coalition. We can then do a pilot with* [*Care Com*] *or with a hospital bringing our data sets together to produce more predictive approaches. We can’t do this on our own…we need people from each of the organisations to be committed together to develop the approach.*

The above vignette suggests that the effective management of aggregated population health data was dependent not only on abstract judgements and formalised knowledge but also on inter-professional collaboration and the 'effortful practical accomplishments' (Salvato and Vassalo, 2018) of unit-level actors. Whilst the search for new systems-wide capabilities in falls prevention would entail more formalised use of aggregated patient data, the excerpt highlights the relational context in which joint capability for using big data is developed. The reference to the formation of a 'guiding coalition' suggests that capacity for constituency-building and socialisation (Van den Bosch et al., 1999) were regarded as critical to effective working across previously fixed institutional boundaries.

6. Theoretical insights

6.1 Managing the exploration-exploitation transition: ambidextrous charters and configurational practices

The case study has investigated the ways in which senior, middle and frontline managers contribute to the management of ambidexterity, particularly in the context of managing transitions between exploration and exploitation. Zimmermann et al., (2015) propose that ambidextrous charters are formulated in ways that reflect an organization's responsibility for, and commitment to, both exploitation and exploration (Birkinshaw and Lingblad, 2005; Galunic and Eisenhardt, 1996). Whereas mandated charters are realized on a top-down basis, emergent charters operate on the basis of 'bottom-up relational processes' (Zimmermann et al., 2015:1119).

Table 1 shows how efforts to combine exploratory and exploitative innovation unfolded over a six year period in the mid-County health and social care sector. The table also shows a series of temporal shifts in project governance, knowledge management and changing modes of bureaucratic coordination. Thus, the mandated charter that we observed in

the initiation phase of the project was based on explicit knowledge that typified the formalized bureaucratic structures of the UK health and social care system. The emergent charter that we observed in the exploration phase saw a shift from formalized knowledge to the tacit knowledge that inhered in the skills and experience of front-line care staff (Nonaka and Tackeuchi, 1995). The experimentation we observed in this phase was not, however, matched by formal capacity for the systematic exploitation of new routines or forms of work organization. In project phase III, capacity for localized knowledge sharing was undermined: formal targets that were imposed on a top-down basis had the effect of marginalizing locally articulated efforts to integrate health and social care services. Only in phase IV were we able to observe locally enacted, deformalized capacity for front-line service innovation being linked directly to formalized capacity for project steering, monitoring or evaluation (Adler and Borys, 1996; Farjoun, 2010; Gulati and Puranam, 2009). Our case study evidence suggests that the charter loss we observed in phase III provided a contextual reference point (Johns, 2006) that allowed the original mid-County Frailty Project to be reframed and reconfigured around a boundary-spanning joint venture (Tiwana, 2008). Localised control over service innovation was reasserted by unit-level senior managers *contra* the centralized planning directives imposed by NHS England (see Table 1).

The above analysis has shown how the transition from exploratory to exploitative forms of innovation was mediated by a distributed pattern of managerial authority and control. Whilst OA capabilities may inhere in the configurational practices of those who work at the front line, Zimmerman et al., (2018) also call for studies that can investigate how these capabilities are 'orchestrated and integrated into firm-wide actions and practices' (Zimmermann et al., 2018:766). Table 2 shows how a number of long-standing organizational tensions were addressed by configurational practices. The table highlights the ways in which senior management capacity for making 'systems wide' changes in the

provision of integrated health and social care services was facilitated by, and configured around the construction and demarcation of the organizational boundaries within which these services would operate. Table 2 also shows the role of middle managers in coordinating previously separate bodies of professionalized knowledge and it highlights the key role of front-line managers in formulating, legitimating and disseminating new forms of best practice. These 'socialization' capabilities allowed middle managers to work with front line managers in bringing deformalized front-line knowledge to bear on newly codified routines and emergent forms of best practice (Adler and Borys, 1996; Farjoun, 2010; Gulati and Puranam, 2009; Zimmermann et al., 2018).

6.2 Observations and Implications

The above analysis has drawn out some theoretical implications for dynamic studies of ambidextrous charters and localised configurational practices. Whilst our study provides support for the idea that an emergent charter influenced the pursuit of ambidexterity at unit level, our findings also show that this charter was subject to shifts in the broader intra-corporate environment. Further, our evidence shows that the relational advantages that flowed from this charter were undermined by 'charter loss' (Galunic and Eisenhardt,1996). We have shown how the charter was subsequently renegotiated by senior managers who worked proactively to defend, demarcate and develop the institutional contexts in which ambidextrous orientations were pursued (Santos and Eisenhardt, 2009). It can thus be argued that ambidextrous charters are inherently dynamic, and may be readily subject to amendment or renegotiation by senior managers who proactively defend, or re-demarcate the space in which ambidexterity is pursued.

Our case study evidence shows several distinctive ways in which middle management contributed to the integration of care services in mid-County. First, middle management were prescient in recognising that the exploratory innovation pursued in phase II of the project

represented a necessary, rather than a sufficient condition for the effective routinization and exploitation of newly redesigned care services. Second, middle managers facilitated the involvement of front-line managers from both CareCom and mid-County Social Services in phase IV of the project. The relational context provided by the PMO facilitated the orchestration of divergent skills and learning capabilities as the project progressed. Middle managers provided a two-way connection that linked the work of the implementation committee to the broader steering mechanisms of the joint venture (cf. Burgess et al., 2015). Finally, middle managers worked closely with front-line managers to develop 'socialization' capabilities that would allow new routines or emergent forms of best practice to be articulated and legitimated locally before being disseminated to the front-line operations of both parent organizations. Taken together, these aspects corroborate the argument that middle managers operate not just as 'vertical links' but also as horizontal integrators who facilitate the emergence of shared understandings and learning capabilities and the distribution of knowledge-based resources (Burgess et al., 2015; Wooldridge et al., 2008).

Our study corroborates and complements the Zimmermann et al. (2018) study of how the configurational practices of front-line managers can facilitate both exploratory and exploitative innovation. We have extended this work to show how managerial capacity for addressing the tension between exploration and exploitation emerged interactively within an 'enabling' bureaucratic form (Adler and Borys, 1996; Lusiani and Langley, 2019) that emerged in project phase IV. Here our case study findings suggest that explorative and exploitative orientations emerge concurrently from localized configurational practices (see vignettes on pages 26 and 28-29).

Finally, our study corroborates and extends the Raisch and Tushman (2016) argument that OA initiatives are facilitated by the construction of shared identities (Raisch and Tushman, 2016:1254) and shared meanings (Carlile, 2002; Kellogg et al., 2006).

Collaborative working by middle managers built on a long-standing tradition of responsible autonomy and on the indigenous workplace culture of front line care professionals. Services were redesigned from the bottom up (cf. Zimmermann et al., 2015; Zimmermann et al., 2018) in ways that reflected both existing professional specialisms and occupational identities. Shared project identity evolved dynamically as collective capacity for systems-level changes, service redefinition and service redesign was developed cumulatively through organizational learning (Vera and Crossan, 2000), distributed change agency (Buchanan et al., 2007) and an 'enabling' bureaucratic form (Adler and Borys, 1996; Lusiani and Langley, 2019).

7. Discussion

The paper has shown the complex ways in which local actors strive to cope with the tension between organizational continuity and change, flexibility and control, and exploration and exploitation (Lewis and Smith, 2014; Smith and Lewis, 2011). Whilst our empirical findings are necessarily partial and subject to the obvious limitations of a single case study research design, we have presented a theoretically informed analysis that asserts the primacy of managerial agency whilst showing the micro-foundational ways in which senior and middle managers interact with broader contexts and social collectivities (cf. Barney and Felin, 2013; Felin et al., 2015). A key substantive finding arising from our study is that the tension between exploratory and exploitative innovation was managed on an interactional and distributed basis within an 'enabling' bureaucratic form (Adler and Borys, 1996; Buchanan et al., 2007; Child and McGrath, 2001; Clegg, 2011; Lusiani and Langley, 2019). The primary and secondary evidence presented in this paper suggests that the deep contradictions observed in our chosen empirical setting could not be addressed through 'coercive' bureaucratic forms.

7.1 Theoretical implications

We have argued that the tensions between continuity and change, flexibility and control, and exploration and exploitation can be addressed by 'enabling' bureaucratic forms that embrace nominally separate formal and informal modes of organization. Whilst there is widespread agreement that OA is positively associated with superior firm-level performance, there is much less consensus on how this is achieved and sustained, given incomplete evidence as to its underlying mechanisms, architectures and dynamics (Malik et al., 2019). Our findings have corroborated Zimmermann et al. (2018) on the importance of configurational practices. Our study further suggests that locally enacted configurational practices provide the basis for generative change mechanisms (cf. Welch and Yates, 2018; Pettigrew, 2012) and learning capacities that underpin OA at different levels of the organization. Our analysis of these practices resonates with the micro-foundational view that firm-specific routines and dynamic capabilities are aggregated on an emergent basis by the 'effortful social accomplishments' of local agents (Salvato and Vassalo, 2018:1728; c.f. Barney and Felin, 2013:149; Felin et al., 2015). In other words, dynamic capabilities represent more than the activities of a few senior managers (Salvato and Vassalo, 2018): of critical importance is the dialogic and deliberative space accorded to middle and lower level management to sustain existing and help generate new ones.

Whilst exploration and exploitation can be seen as fundamentally distinct activities that require substantially different structures, processes or cultures (Lannon and Walsh, 2019), our study suggests that the complex, context-dependent and dynamic nature of the process makes it difficult for researchers to identify fixed features that explain outcomes in constantly evolving organizational settings. Following Turner and Lee-Kelley (2013), we would argue that this shifts the burden of explanation from formal structures or fixed capacities to a more agentic perspective that centres on qualities of emergence and learning that occurs between multiple communities of practice (c.f. Ahammad et al., 2019; Malik et

al., 2019). In other words, building capacity for OA is about the generation of new ways of doing things that are compatible with existing organizational processes (Malik et al., 2019). We also concur with the view that analytically distinct categories of exploration and exploitation are closely interrelated and mutually constituted (Turner and Lee-Kelley, 2013:180; Zimmermann et al., 2018:765). Finally, our evidence supports the view that acquiring ambidexterity is a recursive process that may require 'continuous cycles of contextualization and implementation' (Zimmermann et al., 2018:762).

7.2 Managerial implications

Our study highlights the cumulative nature of the learning that supports OA, and it also emphasizes the difficulties that local health and social care managers faced in initiating and maintaining collaborative learning between different professional groupings and/or partner organizations (Addicott et al., 2006; Adler and Kwon, 2013; Gittel and Weiss, 2004; Nylen, 2007; Nylen, 2012; Swan et al., 2016). The evidence presented in this paper suggests that managers seeking to pursue ambidextrous strategies need to develop collaborative relationships that allow routinized forms of sense-making to be superseded by dialogue-based sense-making.

Our study underscores the need to develop middle management expertise in managing disparate bodies of expertise, and it also underscores the need for multidisciplinary teamworking at different organizational levels. These points corroborate existing work on the role of human resource management policies and practices in creating a propitious environment for innovation (cf. Junni et al., 2013; Mom et al., 2018; Xing, 2020). Again, whilst middle managerial work is often undervalued, it is evident that middle and front-line managers have a potentially vital role to play in sustaining ambidexterity. The case study evidence presented in the paper confirms that capacity for developing OA over time was

contingent on holistic professional orientations and inter-professional relationships (cf. Burgess et al., 2015). Hence, middle managers may use their professional status to ensure the optimal usage of exploitative knowledge during senior managerial drives to promote greater experimentation.

7.3 Limitations of the study and directions for future research

Our study has sought to show how ambidextrous capacities are identified, acquired and developed dynamically in the context of two public health and social care organizations. Single case study research designs cannot be generalized to larger populations, and we recognize the highly particularized character of the evidence presented in this paper. Single case studies can, however, provide the basis for theory building and analytic generalization (Eisenhardt, 1989; Eisenhardt and Graebner, 2007; Yin, 2017; Malik et al, 2019). This article makes the case that the acquisition and development of capacity for ambidexterity is dependent not on the objective features of the operating environment but rather on micro-level interpretations of this environment, managerial sense-making and the selection of contextual reference points that inform managerial action (cf. Malik et al., 2019; Johns, 2006; Pettigrew, 2012; Weick et al., 2005). These aspects of our study raise a number of conceptual issues that need further cross-disciplinary analysis and elucidation. Whilst a full exposition of these issues lies outside the immediate purview of a single paper, we can identify three strands of research where there is a need for more conceptual integration and empirical investigation. First, we have shown how OA is developed in ways that transgress previously fixed and impermeable institutional or organizational boundaries. In turn, this would suggest the need for further enquiry on how those responsible for OA-related innovation projects claim, define and demarcate specific territories and institutional spaces. Second, we have highlighted the need for theoretically robust, empirically well-grounded qualitative research on how the learning that underpins unit-level OA is achieved micro-foundationally within

practical project- and/or team-based operations. We would suggest, finally that there is a clear need for more studies that can show how project-level learning is played out in different industrial and organizational contexts. Whilst project-based organizations are currently providing novel ways of addressing complex multi-causal problems in a wide range of different settings, it would appear that boundary-spanning initiatives remain vulnerable to shifting political alignments and conflicting agendas in public sector contexts (Sjöblom et al., 2013; Van Marrewijk et al., 2008).

Endnotes

[1] Clinical commissioning groups (CCGs) were created following the passing of the UK Health and Social Care Act in 2012, replacing UK NHS Primary Care Trusts in 2013. CCGs are constituted as clinically led statutory NHS bodies responsible for the planning, commissioning and purchasing of local healthcare services (including mental health services, urgent and emergency care, elective hospital services and community care) on behalf of patients. A total of 195 CCGs accounted for approximately two-thirds of the total NHS England budget (or £75.6 billion) in 2018/19.

[2] Patient frailty has been defined as 'a distinctive health state relating to the ageing process in which multiple body systems gradually lose their inbuilt reserves'. An estimated 10% of UK citizens aged 65 or over were categorized as frail as this research was conducted, rising to 50% of those aged 85 or over (Clegg et al., 2013).

References

Addicott, R., 2014. Commissioning and contracting for integrated care. King's Fund, London.

Addicott, R., McGovern, G., Ferlie, E., 2006. Networks, organizational learning and knowledge management: NHS cancer networks. Public Money and Management, 26 (2), 87–94.

Adler, P.S., Borys, B., 1996. Two types of bureaucracy: Enabling and coercive. Adminstrative Sciences Quarterly, 41 (1), 61–89.

Adler, P.S., Kwon, S.W., 2013. The mutation of professionalism as a contested diffusion process: Clinical guidelines as carriers of institutional change in medicine. Journal of Management Studies, 50 (5), 930–962.

Ahammad, M.F., Glaister, K.W. and Junni, P., 2019. Organizational ambidexterity and human resource practices. *International Journal of Human Resource Management,* 30 (4), 503-507

Alderwick, H., Dunn, P., McKenna, H., Walsh, N., Ham, C., 2016. Sustainability and transformation plans in the NHS. King's Fund, London.

Andriopoulos, C., Lewis, M.W., 2009. Exploitation-exploration tensions and organizational ambidexterity: Managing paradoxes of innovation. Organization Science, 20 (4), 696–717.

Barney, J., Felin, T., 2013. What are microfoundations? Academy of Management Perspectives, 27 (2), 138–155.

Birkinshaw, J., Hood, N., 1998. Multinational subsidiary evolution: Capability and charter change in foreign-owned subsidiary companies. Academy of Management Review, 23 (4), 773–795.

Birkinshaw, J., Lingblad, M., 2005. Intrafirm competition and charter evolution in the multibusiness firm. Organization Science, 16 (6), 674–686.

Bryman, A. and Bell, E., 2015. Business Research Methods. Oxford University Press, Oxford.

Buchanan, D.A., Addicott, R., Fitzgerald, L., Ferlie, E., Baeza, J.I., 2007. Nobody in charge: Distributed change agency in healthcare. Human Relations, 60 (7), 1065–1090.

Burgelman, R.A., 1983. A process model of internal corporate venturing in the diversified major firm. Adminstrative Science Quarterly, 28 (2). 223–244.

Burgelman, R.A., 1994. Fading memories: A process theory of strategic business exit in dynamic environments. Administrative Science Quarterly, 39 (1), 24–56.

Burgess, C., Currie, G., Strauss, K., Wood, G., 2015. Organizational Ambidexterity and the Hybrid Middle Manager. Human Resource Management, 54 (S1), s87–s109.

Cao, Q., Simzek, Z., Zhang, H. 2010. Modelling the joint impact of the CEO and the TMT on ambidexterity. Journal of Management Studies, 47 (7), 1272–1296.

Carlile, P.R., 2002. A pragmatic view of knowledge and boundaries: Boundary objects in new product development. Organization Science, 13 (4), 442–455.

Carmeli, A., Halevi, M.Y., 2009. How top management team behavioral integration and behavioral complexity enable organizational ambidexterity: The moderating role of contextual ambidexterity. Leadership Quarterly, 20 (2), 207–218.

Child, J., McGrath, R.G., 2001. Organizations unfettered: Organizational form in an information-intensive economy. Academy of Management Journal, 44 (6), 1135–1148.

Clegg, A., Young, J., Iliffe, S., Rikkert, M.O. and Rockwood, K., 2013. Frailty in elderly people. The Lancet, 381 (9868), 752–762.

Clegg, S. (2011) Under reconstruction: Modern bureaucracies. In: Clegg, S.R., Harris, M., Höpfl, H. (Eds.), Managing Modernity. Beyond Bureaucracy? Oxford University Press, Oxford, pp. 202–29.

Cohen, W.M., Levinthal, D.A., 1990. Absorptive capacity: A new perspective on learning and innovation. Administrative Science Quarterly, 35 (1), 128–152.

Corrigan, P., Laitner, S., 2012. 'The Accountable Lead Provider: Developing a powerful disruptive innovator to create accountable and integrated programmes of care'. NHS RightCare Casebook series, available at: www.rightcare.nhs.uk/downloads/Rightcare_Casebook_accountable_

Croft, C., Currie, G., Lockett, A., 2015. Broken 'two-way windows'? An exploration of professional hybrids. Public Admininstration, 93 (2), 380–394.

Crouch, C., 2005. Capitalist diversity and change: Recombinant governance and institutional entrepreneurs. Oxford University Press, Oxford.

Currie, G., Finn, R., Martin, G., (2008) Accounting for the 'dark side' of new organizational forms: The case of healthcare professionals. Human Relations, 61 (4), 539–564.

Currie, G., Procter, S.J., 2005. The antecedents of middle managers' strategic contribution: The case of a professional bureaucracy. Journal of Management Studies, 42 (7), 1325–1356.

Currie, G., White, L., 2012. Inter-professional barriers and knowledge brokering in an organizational context: the case of healthcare. Organization Studies, 33 (10), 1333–1361.

Curry, N., Ham, C., 2010. Clinical and service integration: The route to improve outcomes. The King's Fund, London.

Denis, J.L., Lamothe, L., Langley, A., 2001. The dynamics of collective leadership and strategic change in pluralistic organizations. Acad. Manag. J. 44 (4), 809–837.

Dopson,S. and Fitzgerald, L., 2005. Knowledge to action: The diffusion of innovations in healthcare. Oxford University Press, Oxford.

Dutton, J.E., Ashford, S.J., 1993. Selling issues to top management. Academy of Management Review, 18 (3), 397–428.

Eisenhardt, K.M., 1989. Building theories from case study research. Academy of Management Review 14 (4), 532–550.

Eisenhardt, K.M., Graebner, M.E., 2007. Theory building from cases: Opportunities and challenges. Academy of Management Journal, 50 (1), 25–32.

Eisenhardt, K.M., Martin, J.A., 2000. Dynamic capabilities: what are they? Strategic Management Journal, 21 (10–11), 1105–1121.

Faems, D., Janssens, M., Madhok, A., Looy, B.V., 2008. Toward an integrative perspective on alliance governance: Connecting contract design, trust dynamics, and contract application. Academy of Management Journal, 51 (6), 1053–1078.

Farjoun, Moshe, 2010. Beyond dualism: Stability and change as a duality. Academy of Management Review, 35 (2) 202–225.

Felin, T., Foss, N.J., Ployhart, R.E., 2015. The microfoundations movement in strategy and organization theory. Academy of Management Annals, 9 (1), 575–632.

Floyd, S. W., Lane, P. J., 2000. Strategizing throughout the organization: Managing role conflict in strategic renewal. Academy of Management Review, 25 (1), 154–177.

Floyd, S.W., Wooldridge, B., 1992. Middle management involvement in strategy and its association with strategic type: A research note. Strategic Management Journal, 13 (S1), 153–167.

Galbraith, J.R., 1973. Designing complex organizations. Addison-Wesley Longman Publishing, Boston.

Galunic, D.C., Eisenhardt, K.M., 1996. The evolution of intracorporate domains: Divisional charter losses in high-technology, multidivisional corporations. Organization Science, 7 (3), 255–282.

García-Granero, A., Fernández-Mesa, A., Jansen, J.J., Vega-Jurado, J., 2018. Top management team diversity and ambidexterity: The contingent role of shared responsibility and CEO cognitive trust. Long Range Plan. 51 (6), 881–893.

Gittell, J.H., Weiss, L., 2004. Coordination networks within and across organizations: A multi-level framework. J. Manag. Stud. 41 (1), 127–153.

Grant, R.M., 1996. Toward a knowledge-based theory of the firm. Strateg. Manag. J. 17 (S2), 109–122.

Gulati, R., Puranam, P., 2009. Renewal through reorganization: The value of inconsistencies between formal and informal organization. Organization Science, 20 (2), 422–440.

He, Z.L., Wong, P.K., 2004. Exploration vs. exploitation: An empirical test of the ambidexterity hypothesis. Organization Science, 15(4), 481-494.

Heavey, C., Simsek, Z., 2017. Distributed cognition in top management teams and organizational ambidexterity: The influence of transactive memory systems. Journal of Management, 43 (3), 919–945.

Heckscher, C.C., Adler, P.S. (Eds.), 2006. The firm as a collaborative community: Reconstructing trust in the knowledge economy. Oxford University Press, Oxford, pp.11–106.

Henderson, R.M., Clark, K.B., 1990. Architectural innovation: The reconfiguration of existing product technologies and the failure of established firms. Administrative Sciences Quarterly, 9 (30)

Jansen, J.J., Simsek, Z., Cao, Q., 2012. Ambidexterity and performance in multiunit contexts: Cross-level moderating effects of structural and resource attributes. Strategic Management Journal, J. 33 (11), 1286–1303.

Jansen, J.J., Tempelaar, M.P., Van den Bosch, F.A., Volberda, H.W., 2009. Structural differentiation and ambidexterity: The mediating role of integration mechanisms. Organization Science, 20 (4), 797–811.

Johns, G., (2006) The essential impact of context on organizational behavior. Academy of Management Review, 31 (2), 386–408.

Junni, P., Sarala, R.M., Taras, V., Tarba, S.Y., 2013. Organizational ambidexterity and performance: A meta-analysis. Academy of Management Perspectives, 27 (4), 299–312.

Kellogg, K.C., Orlikowski, W.J., Yates, J., 2006. Life in the trading zone: Structuring coordination across boundaries in postbureaucratic organizations. Organization Science, 17 (1), 22–44.

Klein, R., 2019. The new politics of the NHS. Taylor and Francis, London.

Kogut, B., Zander, U., 1992. Knowledge of the firm, combinative capabilities, and the replication of technology. Organization Science, 3 (3), 383–397.

Lannon, J. and Walsh, J.N., 2019. Paradoxes and partnerships: a study of knowledge exploration and exploitation in international development programmes. *Journal of Knowledge Management,* 24 (1). Early online at: https://www.emerald.com/insight/content/doi/10.1108/JKM-09-2018-0605/full/html

Lewis, M.W., Smith, W.K., 2014. Paradox as a metatheoretical perspective: Sharpening the focus and widening the scope. Journal of Applied Behavioral Science, 50 (2), 127–149.

Li, C.R., Lin, C.J., Tien, Y.H., 2015. CEO transformational leadership and top manager ambidexterity. Leadership and Organizational Development Journal, 36 (8), 927–954.

Lin, Z., Yang, H. and Demirkan, I., 2007. The performance consequences of ambidexterity in strategic alliance formations: Empirical investigation and computational theorizing. Management Science, 53 (10), 1645–1658.

Lubatkin, M.H., Simsek, Z., Ling, Y., Veiga, J.F., 2006. Ambidexterity and performance in small-to medium-sized firms: The pivotal role of top management team behavioral integration. Journal of Management, 32 (5), 646–672.

Lusiani, M., Langley, A., 2019. The social construction of strategic coherence: Practices of enabling leadership. Long Range Planing, 52 (5), 1–23.

Maccoby, M., 2006. Health care organizations as collaborative learning communities. In Heckscher, C.C. and Adler, P.S. (Eds.), The firm as a collaborative community: Reconstructing trust in the knowledge economy. Oxford University Press, Oxford, pp.259–280.

Malik, A., Pereira, V. and Tarba, S., 2019. The role of HRM practices in product development: Contextual ambidexterity in a US MNC's subsidiary in India. *The International Journal of Human Resource Management*, *30*(4), 536-564.

McCann, L., Hassard, J.S., Granter, E., Hyde, P.J., 2015. Casting the lean spell: The promotion, dilution and erosion of lean management in the NHS. Human Relations, 68 (10), 1557–1577.

McNulty, T., Ferlie, E., 2002. Reengineering health care: the complexities of organizational transformation. Oxford University Press, Oxford.

Mihalache, O.R., Jansen, J.J., Van den Bosch, F.A., Volberda, H.W., 2014. Top management team shared leadership and organizational ambidexterity: A moderated mediation framework. Strategic Entrepreneurship Journal, 8 (2), 128–148.

Mintzberg, H., 1979. The structure of organizations: A synthesis of the research. Prentice-Hall, Englewood Cliffs.

Miron-Spektor, E., Ingram, A., Keller, J., Smith, W.K.,Lewis, M.W., 2018. Microfoundations of organizational paradox: The problem is how we think about the problem. Academy of Management Journal, 61(1), 26–45.

Mom, T.J., Chang, Y.Y., Cholakova, M., Jansen, J.J., 2018. A multilevel integrated framework of firm HR practices, individual ambidexterity, and organizational ambidexterity. Journal of Management 45 (7), 3009–3034.

Mom, T.J., Van Den Bosch, F.A., Volberda, H.W., 2009. Understanding variation in managers' ambidexterity: Investigating direct and interaction effects of formal structural and personal coordination mechanisms. Organization Science 20 (4), 812–828.

Ness, H., 2009. Governance, negotiations, and alliance dynamics: Explaining the evolution of relational practice. Journal of Management Studies, 46 (3), 451–480.

Nonaka, I., Takeuchi, H., 1995. The knowledge-creating company: how Japanese companies create the dynamics of innovation. Oxford University Press, Oxford.

Nylen, U., 2007. Interagency collaboration in human services: Impact of formalization and intensity on effectiveness. Public Administration, 85 (1), 143–166.

Nylen, U., 2012. Boundary preservation or modification. The challenge of collaboration in health care. Scandinavian Journal of Public Administration, 16 (2), 115–142.

O'Reilly III, C.A., Tushman, M.L., 2013. Organizational ambidexterity: Past, present, and future. Academy Management Perspectives, 27 (4), 324–338.

Paton, C., 2016. The Politics of Health Policy Reform in the UK: England's Permanent Revolution. Palgrave MacMillan, London.

Pettigrew, A.M., 2012. Context and action in the transformation of the firm: A reprise. Journal of Management Studies, 49 (7), 1304–1328.

Pettigrew, A.M., Ferlie, E., McKee, L., 1992. Shaping Strategic Change: Making change in large organisations, the case of the NHS. Sage Publications, London.

Pollitt, C., Bouckaert, G., 2017. Public management reform: a comparative analysis into the age of austerity. Oxford University Press, Oxford.

Raes, A.M., Heijltjes, M.G., Glunk, U., Roe, R.A., 2011. The interface of the top management team and middle managers: A process model. Academy of Management Review, 36 (1), 102–126.

Raisch, S., Birkinshaw, J., Probst, G., Tushman, M.L., 2009. Organizational ambidexterity: Balancing exploitation and exploration for sustained performance. Organization Science, 20 (4), 685–695.

Raisch, S., Tushman, M.L., 2016. Growing new corporate businesses: From initiation to graduation. Organization Science, 27 (5), 1237–1257.

Salvato, C. and Vassolo, R., 2018. The sources of dynamism in dynamic capabilities. *Strategic Management Journal*, *39*(6), 1728-1752.

Santos, F.M., Eisenhardt, K.M., 2009. Constructing markets and shaping boundaries: Entrepreneurial power in nascent fields. Academy of Management Journal, 52 (4), 643–671.

Sheremata, W.A., 2000. Centrifugal and centripetal forces in radical new product development under time pressure. Academy of Management Review, 25 (2), 389–408.

Silverman, D., 2013. Doing qualitative research: A practical handbook. Sage Publications, London.

Sjöblom, S., Löfgren, K., Godenhjelm, S., 2013. Projectified politics–temporary organisations in a public context. Scandinavian Journal of Public Administration, 17 (2), 3–12.

Smith, W.K., Lewis, M.W., 2011. Toward a theory of paradox: A dynamic equilibrium model of organizing. Academy of Management Review, 36 (2), 381–403.

Smith, W.K., Tushman, M.L., 2005. Managing strategic contradictions: A top management model for managing innovation streams. Organization Science, 16 (5), 522–536.

Sun, P.Y., Anderson, M.H., 2012. The combined influence of top and middle management leadership styles on absorptive capacity. Management Learning, 43 (1), 25–51.

Swan, J., Newell, S., Nicolini, D. (Eds.), 2016. Mobilizing knowledge in health care: challenges for management and organization. Oxford University Press, Oxford.

Tiwana, A., 2008. Do bridging ties complement strong ties? An empirical examination of alliance ambidexterity. Strategic Management Journal, 29 (3), 251–272.

Turner, N., Lee-Kelley, L., 2013. Unpacking the theory on ambidexterity: An illustrative case on the managerial architectures, mechanisms and dynamics. Management Learning, 44 (2), 179–196.

Tushman, M.L., O'Reilly III, C.A., 1996. Ambidextrous organizations: Managing evolutionary and revolutionary change. California Management Review, 38 (4), 8–29.

Umans, T., Smith, E., Andersson, W., Planken, W., 2018. Top management teams' shared leadership and ambidexterity: the role of management control systems. International Review of Administrative Science. https://doi.org/10.1177/0020852318783539.

Van Den Bosch, F.A., Volberda, H.W., De Boer, M., 1999. Coevolution of firm absorptive capacity and knowledge environment: Organizational forms and combinative capabilities. Organization Science, 10 (5), 551–568.

Van Dooren, W., Bouckaert, G., Halligan, J., 2015. Performance management in the public sector. Routledge, Abingdon.

Van Marrewijk, A., Clegg, S.R., Pitsis, T.S., Veenswijk, M., 2008. Managing public–private megaprojects: Paradoxes, complexity, and project design. International Journal of Project Management, 26 (6), 591–600.

Venugopal, A., Krishnan, T. N., Upadhyayula, R. S., Kumar, M., 2020. Finding the microfoundations of organizational ambidexterity - Demystifying the role of top management behavioural integration. Journal of Business Research, 106, 1–11.

Vera, D., Crossan, M., 2000. Organizational learning, knowledge management, and intellectual capital: An integrative conceptual model. In: Easterby-Smith, M., Myles, M. A. (Eds.) The Handbook of Organizational Learning & Knowledge Management. John Wiley, Chichester.

Vickers, I., Lyon, F., Sepulveda, L., McMullin, C., 2017. Public service innovation and multiple institutional logics: The case of hybrid social enterprise providers of health and wellbeing. Research Policy, 46 (10), 755–1768.

Weber, M., 1978. Economy and society: An outline of interpretive sociology (2 Vols.). University of California Press, Berkeley.

Weick, K.E., Sutcliffe, K.M., Obstfeld, D., 2005. Organizing and the process of sensemaking. Organization Science, 16 (4) 409–421.

Welch, D. and Yates, L., 2018. The practices of collective action: Practice theory, sustainability transitions and social change. *Journal for the Theory of Social Behaviour*, *48*(3), 288-305.

Wooldridge, B., Schmid, T., Floyd, S.W., 2008. The middle management perspective on strategy process: Contributions, synthesis, and future research. Journal of Management 34 (6), 1190–1221.

Xing, Y., Liu, Y., Tarba, S., Wood, G., 2020. A cultural inquiry into ambidexterity in supervisor–subordinate relationship. International Journal of Human Resource Management, 31 (2), 203–231.

Yin, R.K., 2017. Case study research and applications: Design and methods. Sage Publications, London.

Zimmermann, A., Raisch, S., Birkinshaw, J., 2015. How is ambidexterity initiated? The emergent charter definition process. Organization Science, 26 (4), 1119–1139.

Zimmermann, A., Raisch, S., Cardinal, L.B., 2018. Managing persistent tensions on the front line: A configurational perspective on ambidexterity. Journal of Management Studies, 55 (5), 739–769.

Table One: A dynamic view of charter definition knowledge management and changing bureaucratic forms: mid-County health and social care providers, 2013–2019

Ambidexterity mode and project phasing	Project steering and governance	Knowledge search	Changing bureaucratic forms
Phase I Initiation 2013–14	Mandated charter (Zimmerman et al., 2015) Top-down management by senior management	Search for formal knowledge directed by senior management	Bureaucratic hierarchy
Phase II Exploration 2014–15	Emergent charter (Zimmerman et al, 2015) Importation of specialist expertise on participation and involvement of front-line care teams in service redefinition	Exploratory innovation supported by deformalized knowledge sharing (Vera and Crossan, 2000)	Complex organizational hybrids (Croft et al., 2015)
Phase III Transition 2016–17	Charter loss (Galunic and Eisenhardt 1996). Localized innovation halted by centralized NHS directives	Centralized planning directives marginalize localized knowledge sharing and organizational learning (Burgess et al., 2015)	Coercive bureaucracy (Adler and Borys, 1996)
Phase IV Exploitation 2018–19	Charter redefinition and reconfiguration New inter-organizational alignment Creation of structurally separate project management organization Local control of integration process reasserted	Deformalized capacity for service redefinition supported by formalized capacity for project steering (Farjoun, 2010)	Enabling bureaucracy (Adler and Borys, 1996; Lusiani and Langley, 2019)

Table Two: Paradox resolution, configurational practices, and 'aggregated' organizational forms

Nested paradoxes, tensions, and contradictions	**Key roles, responsibilities, and situated actions**	**Configurational practices**	**Aggregated organizational forms**
Unit- level autonomy vs. centralised control within broader NHS intra-corporate domain	Senior management collaboration on reassertion of project parameters and jurisdictions Senior management constituency building, advocacy, and outreach to internal and external stakeholders	Joint construction, claiming, and demarcation of organizational boundaries (Santos and Eisenhardt, 2009)	Joint venture creates systems-level capacity for integration of care services
Balancing existing professional specialisms with integration of redefined care services	Senior/middle management collaboration on service redefinition	'Temporary' organizational form creates relational context for horizontal knowledge exchange and extended dialogue (Adler and Kwon, 2013) Construction of shared project identity (Raisch and Tushman, 2016) Construction of shared artefacts (Carlile, 2002)	Project management organization creates coordinative capacity for orchestrating and managing disparate bodies of expertise
Deformalized front-line knowledge underpins newly codified routines	Middle/front-line management collaboration on service redesign	Project implementation coheres around recombinant innovation (Van den Bosch et al., 1999) Deconstruction/ reconstruction of organizational routines	Self-organizing implementation team creates socialized capacity for formulation, legitimation, and dissemination of new routines