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THE EMERGENCE OF CHANGE IN UNEXPECTED PLACES: RESOURCING ACROSS ORGANIZATIONAL PRACTICES IN STRATEGIC CHANGE

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In our longitudinal, in-depth case study of strategic change within the National Health Service in England, we compare three practices related to contracting health care services. Contrary to what we would have believed from the extant literature, we found that the most profound change did not emerge in practices that witnessed the greatest increase in the quantity of resources or in which change agents were given the highest degree of control. Instead, change emerged in a practice that was not treated as a priority and that subsequently attracted interest from a very limited number of individuals. Our findings contribute to the resourcing literature by showing that the ability to use resources is shaped by how they are valued and distributed, and that strategic change initiatives can act as triggers for resource revaluations and redistributions. Specifically, we demonstrate that strategic change initiatives may contribute to the emergence of favorable conditions for change in practices that do not become associated with valued resources. This is because a lack of valued resources attracts limited interest from stakeholders, thereby allowing changes to emerge as powerful agents face minimal coordination costs and scrutiny when attempting to align arrangements with their own interests. Our study thereby shows how and why change initiatives can trigger divergent developments across multiple practices and lead to change emergence in unexpected places. It also highlights the role of what we call "resourcing space" in contributing to emergent change.

Strategic change initiatives are costly. They involve committing financial, human, and other types of resources to parts of an organization that are targeted for change by senior managers. Failure to achieve strategic change objectives is consistently attributed to insufficient resource provision (Fernandez & Rainey, 2006). However, change can also emerge where it is least expected and without the provision of a large amount of resources (e.g., Mintzberg & Waters, 1985; Plowman, Baker, Beck, Kulkarni, Solansky, & Travis, 2007). Hence, providing resources appears to be critical for effective change implementation—but it is not always so. This suggests that our understanding of the relationships between resources and strategic change remains somewhat underdeveloped.

To explore these relationships, we examined the unfolding of multiple practices related to contracting public health care services following the initiation of strategic change within the National Health Service (NHS) in England. Faced with spiraling costs and the need to meet nationally mandated

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targets, executives at an organization we call "MgmtAgency"[1] launched an initiative to alter the way local hospital contracts were managed. Yet, even several years later, and despite the provision of a substantial amount of resources, the practice of managing hospital contracts remained largely unchanged. Instead, another practice—namely, the contracting of mental health services—changed to such an extent that it became the showpiece of strategic change efforts both internally and externally even though it had not been prioritized by executives or given more resources. In fact, this practice witnessed a withdrawal of administrative support, and was even referred to as "contracting crap" by the manager who was formally put in charge.

As we tried to make sense of these surprising developments, we were confronted with an unexpected finding: favorable conditions for change emerged at least in part due to strategic change initiators' direction of interests toward the hospital contract management practice and—crucially—*away* from the mental health contract management practice. Individuals involved in mental health contract management thereby benefitted from a general lack of interest in this practice, which provided sufficient space for them to rapidly implement a series of changes without the need to engage in lengthy negotiations.

Based on our findings, we conceptualize strategic change initiatives as triggers of potential resource revaluations and redistributions across an organization that direct agents' interests toward certain practices and away from others. Instead of inhibiting change, the direction of interests away from certain practices may (unintentionally) contribute to the emergence of what we term "resourcing space": a space characterized by low coordination costs, minimal scrutiny, and a willingness to challenge that allows for mutual adjustment and accommodation so as to enable and direct actions. We therefore argue that strategic change initiatives do not simply provide resources for change or influence how they are used. They also (intentionally and/or unintentionally) facilitate and inhibit the use of potential resources *across* different parts of an organization. These findings contribute to our understanding of the relationships between resources and strategic change in several ways.

[1] Pseudonyms are used throughout to maintain anonymity.

First, they highlight that change agents'[2] control over valuable resources is a necessary condition for change (Kellogg, 2009; Pfeffer, 1993; Walsh, Hinings, Greenwood, & Ranson, 1981), but that what is considered valuable in a particular context is not predetermined. By shifting and shaping what is and what is not valued, *strategic change initiatives can allow a few agents to gain control* of, and alter, practices that the majority of agents do not associate with highly valued resources.

Second, they build on the nascent resourcing perspective that highlights agents' skillful use, rather than the mere presence, of potential resources with regard to effecting change (Feldman, 2004; Howard-Grenville, 2007; Sonenshein, 2014). By taking into account revaluations and redistributions across an organization, we can account for why certain practices attract more or less scrutiny and higher or lower coordination costs than others, thereby *facilitating and inhibiting agents' ability to use* the potential resources at their disposal within them.

Third, our findings contribute to theorizing concerning the role of space in facilitating change (Kellogg, 2009; Rao & Dutta, 2012). We not only show that limiting interference allows change agents to negotiate and implement change via effective use of potential resources. Importantly, we also find that resourcing space *may emerge* in particular practices as a(n unintended) consequence of strategic change initiatives directing interests elsewhere.

RESOURCES AND RESOURCING IN STRATEGIC CHANGE

We start by discussing key streams of literature that have been influential in furthering our understanding of the relationships between resources and strategic change. First, research has focused on the availability and quantity of resources needed for facilitating strategic change. However, these studies have been inconclusive and ambiguous; for example, with respect to whether large amounts of

[2] We refer to "agents" and "change agents" rather than organization members throughout this paper to capture individuals and groups within and without an organization whose behavior may directly or indirectly shape organizational activities. Moreover, we use the term "agents" instead of "actors" to highlight that individual and group behavior is fundamentally shaped by socialization experiences rather than being the outcome of rational actions performed by fully conscious and autonomous individuals (cf. Chia & Holt, 2006).

resources enable strategic change. Second, the literature has examined how the distribution of resources across stakeholders can facilitate or inhibit strategic change. In particular, this work has emphasized that a shift in resource control is needed for organizational change to emerge in established organizations. Third, instead of attributing change outcomes to the presence or absence of large amounts or control of resources, recent work has examined how resources are used and how use, in turn, contributes to inertia or change over time. Our focus below is thus on these literature streams that were most relevant for our study of strategic change—studies of availability and quantity of resources, research on distribution and control of resources, and practice-based theories emphasizing the use of resources.

Resources have long been recognized as important in strategic change (see Kraatz & Zajac, 2001, for an overview). For instance, excess financial and human resources are proposed to facilitate change by providing room for experimentation (Nohria & Gulati, 1996). Without sufficient resources, organizations have limited opportunities to generate, test, and implement novel ideas. However, the presence of a very large number of (new) ideas within an organization is also known to generate challenges with regard to their selection and coordination, which can, in turn, hinder implementation (Brunsson, 1985; Kanter, 1996). Further, an abundance of resources is also theorized to generate inertia and inhibit change. For instance, the availability of large amounts of resources is proposed to lead to "competency traps" and "barriers to learning" by discouraging the search for, and development of, novel resources (Leonard-Barton, 1992; Levinthal & March, 1993). Given the unclear relationship between the availability of resources and change, as well the overall high rate of failure of strategic change initiatives (Beer, Eisenstat, & Spector, 1990; McNulty & Ferlie, 2002), scholars are increasingly interested in examining intra-organizational structures and dynamics to uncover why change initiatives rarely develop according to plan (Denis, Lamothe, & Langley, 2001; Pettigrew, Woodman, & Cameron, 2001).

Understanding how, why, or when strategic change may emerge thus also requires an understanding of who is in a position to influence the design, selection, and implementation of change initiatives (Greenwood & Hinings, 1996; Pettigrew, 1973). In other words, it is vital to know which stakeholders control the organization's resources. As resource dependency theory asserts (Casciaro & Piskorski, 2005; Pfeffer & Salancik, 2003), those who are able to solve an organization's problems and provide access to critical resources tend to have the highest degree of influence over organizational developments (Crozier, 1964; Perrow, 1970; Thompson, 1967), including stability and change. However, substantial organizational change is unlikely to emerge in established organizations without a shift in resource control. This is due to two principal reasons. First, those stakeholders who dominate an organization, or certain parts of it, may be unwilling to introduce changes that they could interpret as undermining their own authority, which derives in part from their control of resources. A vivid example is presented in Kellogg's (2012) study of status quo defenders' attempts to block hospital reforms. Second, dominant stakeholders may not recognize the need to respond to changing environmental conditions because they have become accustomed to the status quo (Pfeffer & Salancik, 2003: 234–235). Additionally, those who do not control large amounts of valuable resources may not only lack sufficient influence to initiate and implement change, they may even hesitate to push for change by accepting their own subordinate position. For example, Lockett, Currie, Finn, Martin, and Waring (2014: 1117) found that a nurse who was tasked with introducing and implementing reforms in the NHS "scaled down her ambition" because she was not willing to challenge doctors who were in control of high-status medical knowledge.

By contrast, practice-based theories (Feldman & Orlikowski, 2011; Golsorkhi, Rouleau, Seidl, & Vaara, 2010; Johnson, Langley, Melin, & Whittington, 2007) are particularly attentive to how resources are used, and how use, in turn, may shape subsequent developments. In particular, the "resourcing" perspective (Feldman, 2004; Feldman & Worline, 2012; Howard-Grenville, 2007; Sonenshein, 2014) builds on the practice turn in the social sciences to argue that it is how people use potential resources, not their distribution per se, that influences whether and how change will occur. Seen in this way, all things are consequently conceptualized as "potential" resources that only become "actual" resources through their use (Feldman, 2004; Sonenshein, 2014). Hence, the same potential resource can be used in many different ways (or not at all) and ultimately contribute to the emergence of change or toward maintaining stability. For example, as Feldman and Worline (2012) noted, breadcrumbs began being used in the production of meatballs in times of meat shortages. Therefore, depending on how bread is used, it can either act as a substitute for meat, and thereby replace practices of cooking and consuming meatballs, or, by being used as a supplement, it can maintain them. This emphasis on use, rather than the intrinsic

properties of resources, implies a change of thinking from resources as stable entities to understanding processes of resourcing.

In the context of strategic change, the resourcing perspective shifts attention away from attempts to understand how or why the provision, or withdrawal, of resources enables or limits change. It instead draws attention to how and when particular actions that are performed as part of strategic change initiatives can contribute to forms of resource use. This use, in turn, may trigger dynamics that facilitate or inhibit the emergence of change over time.

Broadening Resourcing to Understand Strategic Change across Practices

While the resourcing perspective is valuable in demonstrating how change unfolds "endogenously" (Feldman, 2004) within particular practices when agents (do and do not) make use of potential resources, it has yet to be applied to further our understanding of how a strategic change initiative may shape resource use and trigger developments across *multiple* organizational practices. The consideration of dynamics across multiple practices is important because we know that change in one practice may have potentially significant consequences for other coupled practices (MacKay & Chia, 2013; Pfeffer & Salancik, 2003: 40–43). We can therefore conceptualize organizations as "resource-sharing systems" (Pettigrew, 1973: 169) or interrelated practices within a social space (Bourdieu, 2005; Emirbayer & Johnson, 2008) in which multiple organizational projects or issues vie for organization members' contributions in terms of resource use (including time and effort) at any given time (cf. Cohen, March, & Olsen, 1972). To understand why change may emerge in certain practices and not others thus requires understanding how resource use is directed and what the consequences of this direction may be.

Howard-Grenville (2007), drawing on Bourdieu (1977), has shown that this direction is dependent on attracting sufficient interest from key stakeholders by successfully associating certain issues, potential resources, and practices with *value*. Yet, we still know relatively little about how the distribution of resources and their association with value may ultimately contribute to stability and change across an organization following the initiation of strategic change. We explore these dynamics via an analysis of developments across three practices related to the contracting of health care services within the NHS following the initiation of strategic change. This allows us to develop new insights concerning how and why change initiatives can trigger divergent developments across multiple practices and lead to change emergence in unexpected places.

METHODS

Research Setting

The NHS was established in England in 1948, and consists of a variety of publicly funded organizations that are responsible for meeting the population's health care needs. It has witnessed a series of structural changes over the past decades in response to cost pressures driven by expensive treatments and increasing demand (Storey, Bullivant, & Corbett-Nolan, 2011). Below, we introduce the stakeholders and practices that comprise the particular focus of this study.

Stakeholders. From 1991 onwards, the English health care system has consisted of two types of organizations with formally distinct mandates; namely, (1) local and regional health care management agencies and (2) health care service provider organizations. The latter generally fall within one of the four following categories:[3] hospitals, community care organizations, mental health care organizations, and general practice surgeries.

Hospitals generally perform treatments within hospital settings and are usually associated with specialist doctors (i.e., "hospital consultants"), although they often employ a large variety of other occupational groups. Community care organizations, by contrast, perform a range of treatments and types of care outside of hospital settings, such as in people's homes, community clinics, and general practice surgeries. These organizations usually employ a large number of nurses who look after patients with long-term health conditions. Mental health care organizations employ psychiatrists, psychologists, and other mental health specialists of whom some provide services in purpose-built facilities (former asylums) and others in community settings. Finally, general practice surgeries are run and owned by medical doctors—general practitioners (GPs)—who diagnose patients, prescribe medication, provide some forms of treatment themselves, and refer patients to specialized services, including those

[3] Several other NHS-affiliated types of organizations, such as dental surgeries and pharmacies, exist that are not considered in the present study. Furthermore, mixed or hybrid organizational types also exist.

mentioned above. Individuals are usually not able to use the services of publicly funded specialized providers without a referral letter from a GP. GPs thus have a gatekeeper role in the NHS: a large portion of public funding is directly related to paying for the services to which they refer patients.

Health care contract management. The NHS is formally managed via contracts. Local and regional health care management organizations receive an annual budget that they distribute to health care service provider organizations on the basis of contracts that they negotiate with one another. Contracts with large providers are typically renegotiated once a year, and specify which services will be reimbursed as well as associated rates and conditions.

Apart from specifying contractual terms, health care management organizations are responsible for monitoring providers' performance in respect to (mostly nationally defined) health care quality indicators and service activity levels. For this purpose, health care management organizations review the latest indicators and forecasts with provider organizations at monthly performance meetings. Healthcare management organizations report these data to the U.K. Government's Department of Health and have an obligation to intervene when performance targets are not met. Providers who fail to meet targets or other contractual conditions may be penalized via fines and the termination of contracts. Moreover, due to an essentially "bottomless pit" of demand but a limited budget for local health care services, health care management organizations have an interest in ensuring that these are performed as efficiently as possible.

MgmtAgency. MgmtAgency was one of around 150 local health care management organizations across England. During the period studied (2009–2013), it employed around 250 staff[4] across divisions responsible for areas such as health care contract management, public health, medicines management, health care governance, and service redesign, alongside traditional finance, strategy, public relations, and human resources divisions. It distributed the majority of its total health care budget to a handful of large, quasi-monopolistic health care service providers in the region, including a university teaching hospital (referred to herein as "LocalTeachingHospital") employing more than 5,000 staff, as well as a district general hospital ("LocalGeneralHospital"), a community care organization ("CommunityProvider"), and a mental health care services provider ("MentalHealthProvider"), each of which employed between 1,000 and 3,000 staff. Moreover, it reimbursed about 800 local GPs affiliated with more than 100 GP surgeries across the region for their services under the predefined terms of the national GP contract.[5] Some of these GPs provided advisory services to MgmtAgency with regard to local service design and (as designated clinical representatives in the region) were able to veto proposed changes but were not directly involved in actual contract management activities.

Contract management at MgmtAgency was initially handled by two separate teams, labeled "hospital" and "out of hospital," with the latter being responsible for dealing with CommunityProvider, MentalHealthProvider, and several dozen much smaller organizations. An overview of relevant stakeholders and practices is provided in Figure 1.

Data Collection

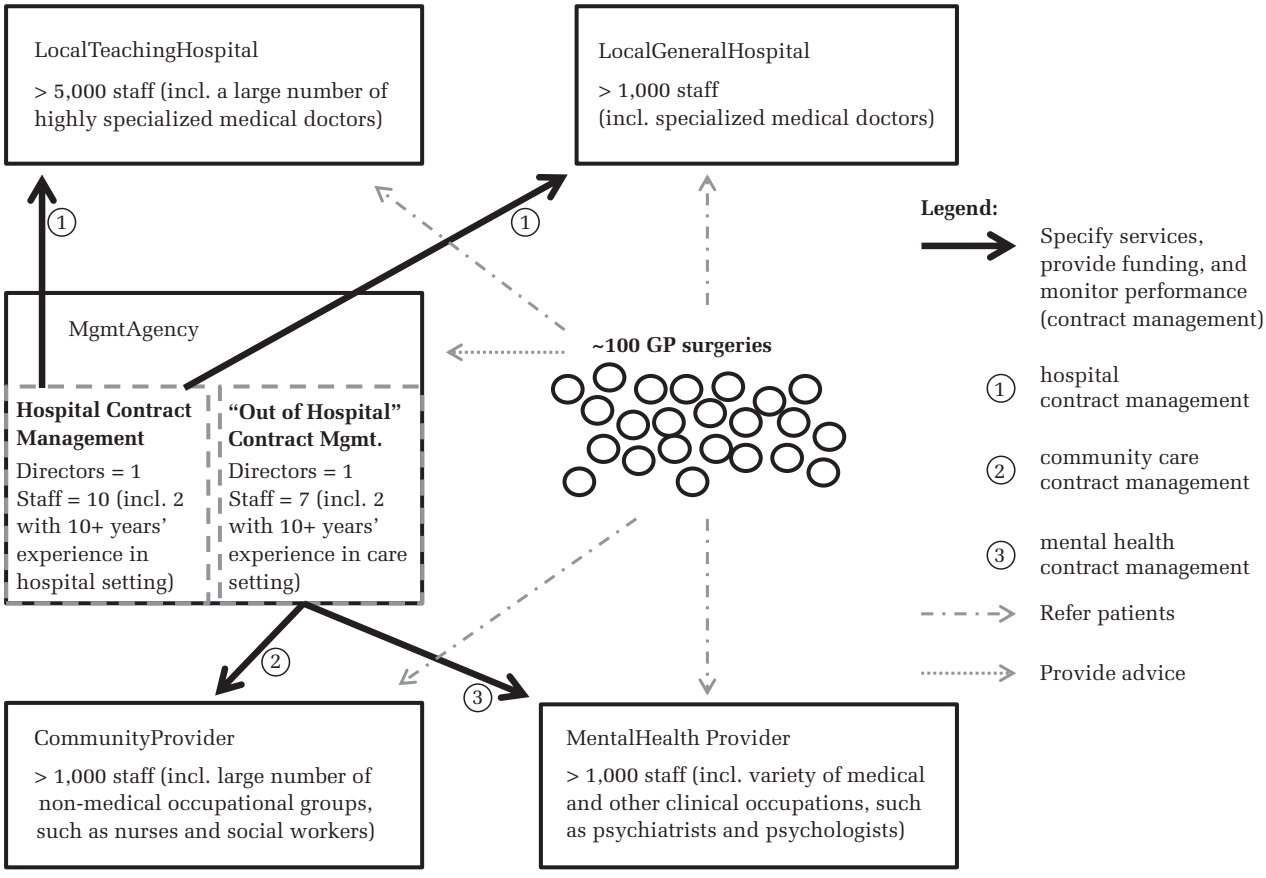
We began collecting data with regard to health care contract management immediately following the publication of the U.K. Government's proposal to reform the NHS by "liberating" it from unnecessary bureaucracy and empowering clinicians to make the service more responsive to patient needs (Department of Health, 2010). This appeared to be an ideal setting in which to study how the redistribution of formal control over budgets (i.e., potential resources) across stakeholder groups could shape organizational practices. Moreover, this shift of control intrigued us, given the fundamental alteration of existing organizational governance arrangements. However, interviews with MgmtAgency managers from September 2010 onwards revealed that their executives had already begun to attempt to increase clinical involvement in contract management before the reform proposals had been announced. Having identified a site where strategic change was being initiated, and given our interest in gaining a very detailed and thorough understanding of the phenomenon, we subsequently requested permission to conduct an in-depth case study concerning the evolution of contract management at MgmtAgency.

Consistent with a qualitative, longitudinal research design (Langley, 2009), we collected data

[4] Total staffing number converted to full-time equivalents.

[5] See http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services.

FIGURE 1
Relevant Stakeholders and Practices



from a wide range of sources, including more than 700 hours of direct observation, 66 semi-structured interviews, and over 20 GB of archival data. Apart from five interviews, all data were solely collected by the first author. The time period we focus on in this study is July 2009 to March 2013. We used July 2009 as a starting point because relevant contract management meeting minutes were available as of this date, and to ensure we had data that preceded the arrival of a new executive team at MgmtAgency (September 2009).

Observation. The first author attended more than 60 hours of meetings and events related to health care systems management and contract management between December 2010 and August 2012. Detailed notes concerning content, as well as dynamics between participants, were taken and exported to NVivo (qualitative data analysis software produced by QSR International) for analysis. This was followed by two shadowing studies (Czarniawska, 2007), each lasting three months, in which MgmtAgency contract managers were followed for three to four full workdays per week. This entailed attending a variety of meetings, observing managers working at their desks, and engaging in informal conversations to follow up on things the researcher did not understand and elucidate managers' perceived challenges. Apart from informal conversations, active participation was limited to a small number of administrative tasks, such as assisting with meeting minutes. Great care was taken not to be identified as a member of MgmtAgency so as to gain trust from members of provider organizations.

Interviews. Because our main objective was to understand how and why practices related to contract management were developing, we used a purposeful sampling strategy by interviewing those individuals who were most involved in these practices. These individuals were readily identifiable from meeting observations, meeting minutes, interviews, and informal conversations. Between July

2010 and October 2014, we conducted 26 interviews with MgmtAgency managers, 25 with members of local health care service provider organizations, 9 with GP representatives, and 6 with members of other public health care service related organizations in other regions. Several managers were interviewed twice to capture potential changes over time. Interviews lasted between 30 minutes and two and a half hours, averaging about one hour. Apart from a handful of exceptions in which we relied on handwritten notes, these were recorded, transcribed, and exported to NVivo for analysis. Interviews were semi-structured, containing broad questions about perceived changes and challenges.

Archival data. Finally, we gained access to a large amount of confidential documents. This included reports distributed at meetings, detailed meeting minutes, copies of contracts, MgmtAgency strategy reports and presentations, memos, letters, and diaries from 23 managers. Additionally, we collected publicly accessible information from relevant organizations' websites, such as annual reports, individual profiles, and conflicts of interest registers.

Data Analysis

As we followed developments related to health care contract management at MgmtAgency in real time, we began to notice that these differed across service areas. Specifically, *mental health* contract management appeared to have changed relatively quickly from an administrative practice with very limited clinical involvement toward "a successful clinically led commissioning model" (MgmtAgency meeting minutes, May 2012) consisting of frequent and coordinated interaction dominated by GP representatives and mental health care clinicians. These changes were also resulting in alterations to the provision of existing services in the region that were described as a "radical transformation" (draft trade journal article, September 2011).

Hospital and community care contract management, by contrast, did not change as rapidly or profoundly. Developments within mental health contract management were therefore at times described as "ahead of the game" (GP, observation notes, September 2012; MgmtAgency manager, observation notes, October 2012) and considered as a source of "learning" for other service areas (MgmtAgency meeting minutes, May 2012). These developments especially caught our attention because mental health contract management had evidently not been regarded as a strategic priority, and had even experienced a withdrawal of certain potential resources, as discussed below.

We compared changes concerning the level of clinical involvement in contract management before and after the initiation of strategic change using a range of measures, including lists of attendees at contract management meetings, interview accounts, the number of scheduled meetings between provider account managers and local GPs (from available diaries), and (confidential as well as public) documents. We used October 2010 as the beginning of the period "after" change initiation because MgmtAgency's contract management division witnessed major restructuring during this time. Our results are summarized in Tables 1a and 1b.

To understand why contract management practices had developed differently, we coded our data for facilitating and inhibiting conditions for change. Two central themes emerged. First, we noticed that GPs were generally willing to challenge nonmedically trained service provider representatives, but that they largely refrained from challenging hospital doctors. We coded this theme as "*designated change agents' (un)willingness to challenge*." Second, our analysis pointed to problems associated with reaching agreements among a large number of highly interested individuals concerning issues related to hospital and community care contract management. By contrast, mental health care contract management was conspicuous due to the absence of participation and monitoring. We coded this theme as "*coordination costs and scrutiny*." Selected evidence for these themes is presented in Table 2.

We then analyzed our data to identify why and how these conditions had emerged. With regard to "designated change agents' (un)willingness to challenge," we drew on existing literature that highlights that agents generally adopt a subordinate position relative to those they associate with *highly valued resources*. We therefore examined our data to understand which potential resources were valued highly by GPs and with whom they associated these valued resources.

With regard to differing levels of coordination costs and scrutiny, we analyzed our data to identify GP representatives' and MgmtAgency managers' interests, strategies for satisfying these interests, and with which practices they were associated (see Table 3). For instance, we identified that GPs were

TABLE 1a
Comparison of Contract Management Practices before Strategic Change Initiatives

	July 2009–September 2010		
Evidence of lack of clinical participation	**Hospital contract management**	**Mental health contract management**	**Community care contract management**
Attendance at contract management meetings by practicing clinicians (sources: official contract management meeting minutes, CVs)	MgmtAgency = 2 meetings (1 local GP attended two meetings)	MgmtAgency = 0 meetings (provider account manager had some nursing experience)	MgmtAgency = 0 meetings (1 MgmtAgency manager who was not a practicing clinician but had some nursing experience attended regularly; 2 CommunityProvider nurses attended 3 meetings)
GP involvement in contract management (source: interviews)	Very limited: "I was vaguely horrified that you could be commissioning services on such a huge scale without clinical input ... The managers here are very good, there's some excellent people, and they have spent their life contracting medical services. Hats off to them. But they've never seen that service work and they don't know what the pitfalls of it are." (GP, interview, Sep. 2013)	Very limited: "What will the GPs realistically do? ... They're saying to us: 'We will need people like you to do the . . . contracting.' ... They're not going to sit in three-hour contract meetings." (MgmtAgency manager, interview, Dec. 2010)	Very limited: "I had very few conversations with the GPs from a contractual business development point of view . . . Contact with them was quite limited, historically." (CommunityProvider manager, interview, Aug. 2013) "You need that clinical input [but GPs have had] a limited role [in managing the health care system and] a limited understanding of contracting processes." (MgmtAgency manager, interview, Oct. 2012)
Involvement of clinicians in managing the health care system (source: documents)	"Our existing system is too far removed from clinicians on the ground who make decisions every day about the treatment individuals receive, in particular GPs. This means there is a disconnect between clinical and financial responsibility, and that the group that probably knows most about patient needs—GPs—are not fully involved." (MgmtAgency strategy document, Dec. 2009) "[Historic] attempts by MgmtAgency to engage GPs in actively managing budgets have had some success, but not sufficient to achieve the needs of MgmtAgency. The costs associated with this engagement are not insubstantial and there is no clear return on this investment." (letter from GP representative to MgmtAgency, Nov. 2009)		

TABLE 1b
Comparison of Contract Management Practices after Strategic Change Initiatives

	October 2010–March 2013		
Evidence of change (or lack thereof)	**Hospital contract management**	**Mental health contract management**	**Community care contract management**
Involvement of clinicians and change (source: interviews)	"It has been easier for the [community and mental health services] to get GP engagement than the acute [hospitals]." (MgmtAgency manager, interview, Dec. 2012) LocalTeachingHospital account manager notes that he has been trying to increase the frequency of the clinical forum to monthly meetings, but, apparently, there is some resistance from GPs. (Informal conversation notes, Sep. 2014)	"The amount of meeting time that has gone on between MentalHealthProvider and GPs . . . has been phenomenal. [It has changed from only having] these contract monitoring meetings where we just sit there and talk about [levels of treatment] activity." (GP, interview, Feb. 2012) "[The GPs] bring a level of rigor to the discussion that I don't think we would necessarily have had before, because we have moved down to a micro level of management" (MentalHealthProvider manager, interview, Aug. 2012).	"Personally, I haven't seen any real changes. My involvement has been limited to having pre-emptive discussions with [a couple of GP groups] about where they see one service going. And we haven't really engaged with [other GPs]." (CommunityProvider manager, interview, Aug. 2012) "[The chair of our GP community care group] basically got pissed off with the whole thing and resigned ... and it went into hiatus for a few months and then we started up again, slightly lower key and more as a sort of information sharing group." (GP, interview, Oct. 2012)
Mentions of successful change related to service areas (source: documents, observation)	Continued frustration about not being able to reduce hospital expenses at contract overview meetings. (Observation notes and meeting minutes, Sep. 2012–Mar. 2013). *Example:* MGMTAGENCY MANAGER A: We've got a £Xm cost pressure on the [LocalGeneralHospital] contract. That's a serious issue—what's causing it? MGMTAGENCY MANAGER B: We've had lots of explanations about why they're not being able to deliver their cost improvement plans ... but I absolutely agree . . . MGMTAGENCY MANAGER D: It is really disappointing. (Contract overview meeting observation notes, Mar. 2013) Success stories are limited to "progressing development of integrated care" and "dermatology re-design." (External presentations, Jul. and Sep. 2012)	"By encouraging senior clinicians to work together we have been able to set out plans for a radical transformation of mental health services ... Following the success of this model ... MgmtAgency and local GP representatives have agreed to adopt a similar approach [for] community services in the area." (Trade journal submission, requested by MgmtAgency executives, Sep. 2011) Developments concerning mental health care services are mentioned as the first of four "current successes" to demonstrate MgmtAgency was now "clinically led at every level." (External presentations, Jul. and Sep. 2012)	Success stories are limited to mentions of "progressing development of integrated care." (External presentations, Jul. and Sep. 2012)

generally concerned with attracting financial income (in contrast to several MgmtAgency managers who told us that they had accepted lower wages as part of moving from the private sector into public health administration). However, what especially caught our attention was how elements of the strategic change initiative were attempting to direct stakeholders' interests toward particular practices. We consequently analyzed our data in this respect and identified actions that strategic change initiators took to direct interests (see Table 4).

We then engaged in efforts to "link the content, contexts, and processes of change over time to explain the differential achievement of change" (Pettigrew, 1990: 268). This entailed the compilation of an event-history database to detect potentially relevant incidents and the construction of a detailed narrative. This narrative guides the presentation of our analysis below that focuses on the strategic change initiative at MgmtAgency and links it, together with agents' existing interests, to subsequent developments across the three contract management practices. Finally, abstracting from this particular case, and informed by resourcing theory and Bourdieu's (1986) emphasis on the interplay between behavior and the distribution of highly valued resources (that he called "capitals"), we generated a model of resourcing across practices in strategic change.

FINDINGS

To understand how strategic change unfolded, it is necessary to understand the pressures faced by MgmtAgency executives. On the one hand, they were responsible for ensuring health care services met certain regional and nationally defined quality criteria. Hospital services were especially scrutinized following reports concerning poor standards of quality and high mortality rates that received widespread media attention from 2009 onwards (Francis, 2010). On the other hand, the NHS faced unprecedented financial challenges. These were especially acute in the region studied, where MgmtAgency and local hospitals had accumulated a large amount of debt.

Strategic Change Initiators Direct Valued Resources toward Designated Change Agents

In September 2009, MgmtAgency hired a new executive team whose chief strategist recommended that responsibilities for contract management decisions be transferred toward groups of GPs in the area. GPs were perceived as being more able to reduce debt effectively (and, hence, as more powerful) than MgmtAgency managers because they had access to, and control over, several highly valued resources. First, they possessed *medical knowledge* that granted them authority in the field of health care. As one MgmtAgency manager commented:

> [Doctors] do command respect ... Politicians will throw darts at people like me, but they will not throw darts at the doctors . . . [At a recent meeting with politicians, the doctors] said, "This is better for the patients, what do you know about it?"
>
> (MgmtAgency manager, December 2010)

This authority had always been lacking at MgmtAgency because its managers did not possess medical qualifications. Specifically, MgmtAgency managers had backgrounds in health care administration, had worked in other sectors, and/or had social care or nursing experience in community care settings. The lack of medical authority had made it difficult to challenge service providers and alter their existing practices, even if these practices were uneconomical.

Second, GPs regularly received feedback concerning services from their patients that MgmtAgency managers, who relied on standardized formal reports, might not have been aware of. They were also in a better position than MgmtAgency managers to find ways of replacing expensive services with cheaper alternatives, due to their clinical knowledge.

Third, GPs prescribed medication that was subsidized by the government and referred patients to public health care service providers for specialist treatment. This meant that GPs had a direct influence on the health care costs that MgmtAgency had to pay for its local population, especially because many hospital-based services were reimbursed per treatment episode.

MgmtAgency executives sought to gain access to the above-mentioned resources in order to increase their bargaining position relative to service providers and generate favorable conditions for change across the local health care system. MgmtAgency executives therefore defined the strategic change objective as transforming existing contract management practices from largely administrative sets of tasks performed by managers into "clinically led" activities (MgmtAgency strategy presentation, December 2009). Clinical knowledge thereby formally became a prerequisite for making significant

TABLE 2
Change Facilitating and Inhibiting Conditions across Contract Management Practices

	Hospital contract management	Mental health contract management	Community care contract management
	− (change inhibited)	**+ (change facilitated)**	**+ (change facilitated)**
Designated change agents' (un) willingness to challenge	"It has been easier for [community and mental health services] to get GP engagement than the acute [hospitals]. Now, wouldn't you think that it would be the other way around? So, in terms of quality [reviews], I am still having to drag GPs into these [monitoring] meetings, kicking and screaming . . . so I am still struggling for GP engagement at LocalTeachingHospital and, given this huge interest, . . . I find that really quite surprising. " (MgmtAgency manager, interview, Dec. 2012) RESEARCHER: "Initially, it was said that this change . . . would alter the power dynamics between budget holders and hospitals. Have you seen that happen?" LOCALTEACHINGHOSPITAL MANAGER: [*laughs*] "Not really." (Interview, Sep. 2014)	"[What] has changed as a result of GP involvement is the clinical support and challenging of MentalHealthProvider ... This has been very beneficial." (MgmtAgency manager, interview, Jun. 2012) "GPs are able to clinically challenge some of the ideas and concepts that MentalHealthProvider come up with." (MgmtAgency manager, interview, Mar. 2012) "'A little knowledge is a dangerous thing,' I think, would fit with [the local GPs] really well ... [They say about mental health care services]: 'Well, yeah, I know this.'" (MentalHealth clinician, interview, Jan. 2013)	"Everybody [at MgmtAgency] was moaning about CommunityProvider, particularly [GP X]." (GP, interview, Nov. 2012) "Some of our senior staff, our clinical staff, were in a forum with GPs the other day and . . . GP leaders [were] at the front badmouthing what we were doing." (CommunityProvider manager, interview, Jul. 2013).
	− (change inhibited)	**+ (change facilitated)**	**− (change inhibited)**
Coordination costs and scrutiny	"[T]here are things that would work [in terms of] process changes which you cannot get through until you have convinced a clinician . . . and sometimes these are management and procedural things that actually you don't need clinical input for . . . And [the slow pace of decision making also arises] because . . . for some things, there are simply too many decision-making bodies and too many groups with delegated authority." (MgmtAgency manager, interview, Aug. 2013) "With the new structure of [GP-led contracting groups], basically those individual [groups] can set up whatever they want . . . A lot of what we're pushing at the moment is to say to [them], 'Look guys, just come together and get a consensus and agreement.'" (LocalTeachingHospital manager, interview, Sep. 2014)	"We are a very tight unit . . . we're sort of a perfect team . . . there is never any [real tension]. . . There are only really four of us . . . The others are really quite peripheral." (GP, interview, Aug. 2012) "Most [GP colleagues] haven't really got the time ... The projects I am involved in require a lot more input than most of them, in all honesty, are probably providing, but that's fine. . . because, we don't need everyone to do it all. We just need one or two people to hold it together, really, and everybody contributes what they can." (GP, interview, May 2012) "The GPs are not that interested [in becoming involved in mental health contract management] actually; they're quite interested in playing with the hospital, really." (MgmtAgency manager, interview, Oct. 2010)	"[GPs are] impossible to talk to as a group and, even when you got them . . . as a group, they talked about their individual problems . . . Conversations seem to be around, 'What can we [contract] that will help our [own] GP practice perform?' . . . That is their starting position." (CommunityProvider manager, interview, Aug. 2013) "There will be different winners and losers . . . For example, if you were to change the anti-coagulation testing and put a unified service in [across the region], then ... the GPs in area A would lose out on their local enhanced service agreement, which would take resources away from them. So, straightaway you have got your ... colleagues disadvantaging the on-the-ground GPs. So, that can cause conflicts of interest and resentment." (GP, interview, Oct. 2012)

TABLE 3
Stakeholders' Existing Interests

Stakeholder	Interested in. . .	Supporting evidence	Strategy used to satisfy interest	Supporting evidence	Associated practices
GPs	Medical knowledge and being part of medical community	"If we want people [*note*: GPs] to go to a meeting . . . to talk about, you know, dressings, or whatever . . . it's nursing, you see? We are doctors." (GP, interview, Aug. 2014) "GPs won't listen to you unless you're a doctor." (Provider clinician, informal conversation, May 2014)	Maintain close relations with hospital doctors	"If you have somebody who is particularly unwell, what you would really like to do is to speak to a specialist about them." (GP, interview, Aug. 2014) "[GP representatives] would want to negotiate contracts with the consultants [*note*: hospital doctors], not providers' management." ("Brief notes and issues for further consideration" documented by MgmtAgency chief strategist following "big conversations" with local GPs, Oct. 2009)	Mainly **hospital services**
	Responsive care for local patients	"As a GP, you care about the patient in front of you. You care about your practice. You can care about a bigger area, but, as soon as it becomes too big, you don't care." (GP, interview, Nov. 2012)	Closely monitor care arrangements	"[GPs] are desperate to have better community services . . . So, yes, they want to make a lot of noise about it, but kind of understandably, actually, [because] it causes us potentially the most grief." (GP, interview, Aug. 2014) "District nurses and social care and GPs look after the same population . . . and particularly the vulnerable and the sick. You know, there is no difference. We are seeing the same patients; we have got the same aims in terms of trying to keep them healthy." (GP, interview, Nov. 2012) Listed health care management priorities across local GP rep. groups: (a) shifting treatment from hospitals to community	All health care services, especially **community care** (due to high level of frail and elderly patients in the region)

TABLE 3
(Continued)

Stakeholder	Interested in. . .	Supporting evidence	Strategy used to satisfy interest	Supporting evidence	Associated practices
				settings = 16, (b) community care services = 5, (c) prescribing medicine = 5, (d) hospital services = 4, (e) mental health = 2.	
	Financial income	"It is about the remuneration . . . GPs are quite well paid in general, so, if they work [in contract management], they need to be paid the same, otherwise they will be less willing to do so . . . they are not so keen to lose money." (GP, interview, Aug. 2014)	Provide additional services	Of the registered "GPs with a special interest" in the region, 95 declared an interest in services that were also provided by local hospitals (e.g., dermatology), 76 in services provided by CommunityProvider (e.g., family planning), and 11 in mental health-related issues. "Some GPs are quite commercial in their outlook [and] want to run this as their own service . . . So, there is a [GP who tried to] set up a sort of enlarged GP practice as a model, even though we have a 20% used [building with community care facilities] right next door." (CommunityProvider manager, interview, Nov. 2012)	Mainly **community care**
MgmtAgency managers	Reducing debt	"[MgmtAgency's] pressure was to get itself in balance." (Former MgmtAgency manager, interview, Aug. 2013)	Monitor increasing costs	". . . so, the board's focus ... was a very dominant acute player [i.e., hospital] and activity growing." (Former MgmtAgency manager, Aug. 2013) "Everything, all the time in [this place], has been, 'We have historical debt that we have to pay off!' . . . So, we have spent all this time paying off all this debt and . . . trying not to give LocalTeachingHospital money." (GP, interview, Nov. 2012)	Mainly **hospital contract management**

TABLE 3
(Continued)

Stakeholder	Interested in. . .	Supporting evidence	Strategy used to satisfy interest	Supporting evidence	Associated practices
	Meeting national targets	"[MgmtAgency Directors] have been wedded to central government targets." (MentalHealthProvider manager, interview, Feb. 2011)	Monitor service providers' performance reports	"It tends to be ... follow the leader, who's also following his leaders and ... so on, about whatever the latest sort of drama is. Like hospital infections, you know. [MgmtAgency Directors] will ask me, 'What's going on about hospital infections in the mental health ward?' and you think, 'Well, I'm not really quite sure ... but it's not really a big deal.' But it is, because it's the top thing, you know, and that's how it kind of works." (MgmtAgency manager, interview, Oct. 2012)	Mainly **hospital contract management**
		"[The important targets are] very much the ones that the Board, or the Department of Health, or whatever are worried about. Are they okay?" (MgmtAgency manager, interview, Sep. 2011)		"You're really making sure that the things that might cause trouble from the center are covered ... Data can be good or bad, but as long as it's not the thing the Department's worried about, then we're okay." (MgmtAgency manager, interview, Sep. 2011)	
	Leveraging own experience	"Before [becoming a contract manager], I was working in long-term conditions in a provider organization . . . I've always preferred [contract management to working at a provider]; I'm a nurse by background and I used to actually get quite frustrated with some areas of professional practice: why aren't we doing things better?" (MgmtAgency manager, interview, Nov. 2010)	Work in service area related to own experience	MgmtAgency managers who gained **clinical** experience at. . . hospitals = 0; mental health care providers = 0; community care providers > 10 (including social care) [*note*: MgmtAgency had provided the majority of local community care services prior to contracting them from CommunityProvider]	Mainly **community care contract management**

TABLE 4
Strategic Change Initiatives' Direction of Stakeholders' Interests

Actions	Supporting evidence	Direct interests toward
Associating control of financial health care budgets with responsive care for local patients *(associating with potential gains and losses)*	"We are about to fall off a financial cliff . . . Our current commissioning [*note*: contract management] system is broken." (MgmtAgency presentation to local GPs, Dec. 2009) "[MgmtAgency's new chief strategist] came in and we had these big conversations and we [GPs] understood that, unless we had [control of] real budgets, nothing would change . . . We had quite a few of us who were quite keen to do it." (GP, interview, Nov. 2012) "The initial reaction . . . was 'why should we take on a . . . budget?' However, when posed with the question 'what would you do with a budget of £X?' this made people think and change their minds." (GP group meeting minutes, Oct. 2009)	**Health care contract management practices**
Associating hospital expenses with responsive care for local patients *(associating with potential gains and losses)*	"[MgmtAgency managers] had been coming ... to tell us about the problems at MgmtAgency ... and saying: 'This is the problem. Maybe we could do something for referrals?' ... I started off doing a bit of [hospital] admission avoidance work." (GP, interview, Feb. 2012) "[MgmtAgency] went into large historical debt ... So that involved me ... trying to get general practice [GPs] to play its part in recovery [by] optimizing referrals and prescribing ... And one thing I did was I started up a [hospital] referral management service." (GP, interview, Aug. 2013)	**Hospital contract management**
Allocating executive time and internal meetings toward certain stakeholders and issues *(allocating space on the organizational agenda)*	MgmtAgency's new chief strategist's meetings with local provider representatives: hospitals = 31; community care = 4; mental health = 1 (public calendar entries over 12-month period) "Contract Oversight Group" meetings regularly begin with lengthy review of hospital-related expenses (sources: observation notes; meeting minutes; audio recordings)	Mainly **hospital contract management**
Assigning formal roles and responsibilities *(organizational restructuring)*	2009 Organizational Chart: hospital contract management = 1 director + 9 managers; out-of-hospital (community services and mental health) contract management = 1 director + 7 managers 2012 Organizational Chart: hospital contract management = 3.5 directors + 13.1 managers; community care contract management = 0.5 directors + 4.6 managers; mental health contract management = 0 directors + 2 managers	Mainly **hospital contract management**

decisions and hence appreciated in value. Potential resources in the form of formal control of (several billion pounds worth of) financial budgets for local health care services were consequently redistributed from MgmtAgency managers to local GP representatives. Moreover, several experienced MgmtAgency managers (i.e., human resources) were formally allocated to these GP representatives to provide them with contract management expertise and administrative support.

Strategic Change Initiators Direct Valued Resources toward a Designated Practice

Because MgmtAgency executives primarily associated economic pressures with *hospital* services, they directed resources toward hospital contract management. They did this in several ways, including (a) allocating space on the organizational agenda, (b) associating hospital contracts with potential gains and losses, and (c) organizational restructuring.

In terms of allocating space on the organizational agenda, executives dedicated much of their own time toward negotiating with hospitals, relative to other service providers in the region. For instance, according to his public diary, MgmtAgency's new chief strategist met 31 times with hospital representatives, compared to four times with members of community care and once with mental health care service providers, in his first year. Additionally, contracts related to hospital services were discussed at internal weekly meetings first and at much greater length than those related to other service providers. On occasion, MgmtAgency's director of contracting forgot to request updates regarding mental health care services (observation notes, September 2012–March 2013).

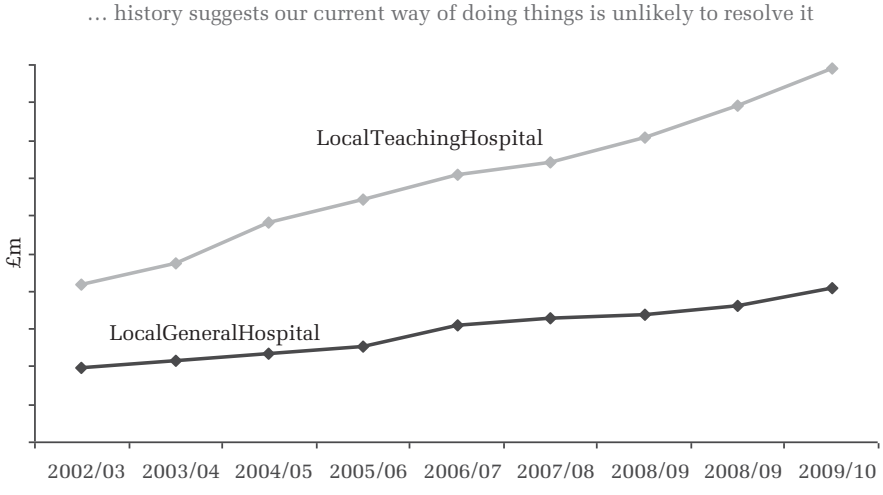
Second, MgmtAgency executives focused discussions at meetings on issues related to hospitals. This becomes especially apparent from archived PowerPoint presentations in which hospital-related costs were consistently singled out as the major problem for the local health economy (see, e.g., Figure 2). Comments from local GPs suggest that these presentations were very effective in terms of highlighting hospital contract management as an issue that had to be dealt with urgently in order to avoid the deterioration of local services:

> I wanted to help MgmtAgency to turn around their debt . . . So, that was the challenge. They had been . . . doing presentations to the GPs and . . . I just felt I wanted to be part of the solution, not part of the problem anymore . . . I started off doing a bit of [hospital] admission avoidance work.
>
> (GP, interview, February 2012)

Moreover, GPs were promised the ability to alter local services to suit their preferences. Control over health care budgets was thus associated with potential gains in the form of more locally responsive services:

> The initial reaction . . . was "Why should we take on a . . . budget?" However, when posed with the question "What would you do with a budget of £X million?" this made people think and change their minds.
>
> (GP group meeting minutes, October 2009)

FIGURE 2
Excerpt from MgmtAgency Strategy Presentation



As a result of successfully associating budget control with potential gains and losses, a number of GPs across the region expressed their interest in becoming involved. According to the chief strategist's secretary, "GP engagement . . . was the biggest challenge, but it actually quickly came around" (interview, December 2012). Strategy presentations at the time highlighted that the idea of transferring budgets to GPs ultimately resulted in a "surprising level of interest" (January 2010).

Finally, as part of the formal handover of budget responsibilities to GPs, the organization was fundamentally restructured. Whereas previously two contract management teams had existed—namely, one for hospital contracts and another for "non-acute service provider" contracts—the new structure consisted of four separate contract management teams. Each of these was headed up by a director who had the name of at least one hospital in their title. One of these directors was also formally responsible for managing the relationship with the largest community care service provider, while none of them was officially responsible for mental health care services. The total number of full-time staff assigned to the three areas was as follows: hospital services = 13.1; community care = 4.6; mental health = 2.

In summary, hospital contract management received a substantial amount of space on the organizational agenda, was directly associated with a high level of potential gains and losses of valued resources, and witnessed an increased number of human resources. Having outlined the principal elements of MgmtAgency's strategic change initiative, we now turn to subsequent developments and provisional outcomes concerning hospital contract management.

The Hospital Contract Management Practice

The inclusion of local GPs in contract management resulted in the proliferation of new projects. Local GP groups' websites mentioned that they had initiated 27 new projects related to hospital services. For example, several GPs across the region became involved in assessing how to reduce unnecessary hospital admissions. Conditions for change with regard to hospital contract management thus initially appeared to be favorable.

(Un)willingness to challenge. However, despite formal control of financial budgets and possession of clinical knowledge and frontline experience, GPs' willingness to actively monitor hospital performance was limited. Communication by GP representatives suggests that they were to some extent intimidated by the thought of having to negotiate with prestigious hospitals:

> In truth, there may not be many of us who would relish intense meetings with LocalTeachingHospital.
>
> (Letter from local GP committee to members, July 2010)

Notably, because they generally accepted hospital physicians' authority, GPs at times shied away from attempting to persuade them to alter existing procedures:

> When you get [hospital] consultants and GPs in the room, they are falling over each other to be . . . deferential to each other. And that does . . . slow down decision making . . . For example, . . . we have discussions about the ways in which LocalTeachingHospital is failing to deliver a good service ... but, then, when we get to the meeting, our GP lead is so desperate to show proper regard to this very senior [hospital] consultant . . . that he doesn't actually say: "You are not doing your job properly. Get it sorted out!" . . . Whereas, as a manager, actually, you could say, "Look! We are expecting X number."
>
> (MgmtAgency manager, August 2013)

This reluctance to challenge hospital doctors was confirmed by a GP:

> It's difficult, isn't it, because you can't ask dumb questions and you can't challenge, and you can't say, "Hang on, what's that all about?"
>
> (GP, interview, September 2013)

In fact, one hospital representative claimed that he was in favor of having more meetings with GPs because they largely accepted hospital physicians' advice rather than demanded changes:

> The GPs, when they come in front of a hospital consultant who has spent their last 20 years focusing on a particular specialty ... It's very difficult for a GP to understand what is actually happening, very difficult to contribute to the discussion, and they basically rely on the consultant to tell them what needs to happen.
>
> (LocalTeachingHospital manager, September 2014)

In sum, hospitals did not even appear to have to actively assert their dominance to block change. GPs, as designated change agents, refrained from using the potential resources at their disposal to instigate changes. They instead allowed hospital doctors to assume a central role in activities related to hospital

contract management and to thereby maintain the status quo.

Coordination costs and scrutiny. Apart from failing to substantially alter existing relations of power between organizations, another issue quickly became apparent: although local GPs had many ideas concerning how to alter existing contractual arrangements, the implementation thereof was often hampered due to the difficulty of reaching agreements among themselves. According to one MgmtAgency manager:

> [T]here are things that would work [in terms of] process changes which you cannot get through until you have convinced a clinician ... and sometimes these are management and procedural things that actually you don't need clinical input for ... And [the slow pace of decision making also arises] because ... for some things, there are simply too many decision-making bodies and too many groups with delegated authority.
>
> (MgmtAgency manager, interview, August 2013)

Technically, the establishment of four separate hospital contract management teams, each responsible for negotiating with one particular hospital, should have limited the need to reach agreements among all GP representatives across the region. However, GPs at times objected to any arrangements that appeared to favor one hospital over another, making it difficult to align their views:

> GP1: Can I just point out that we're actually treating these two [hospitals] differently—for one of them, we are withholding money...
>
> GP2: ... one of them [*note*: LocalTeachingHospital], we're withholding money and they're performing great. The other [*note*: LocalGeneralHospital] is performing badly and we're not...
>
> GP1: We need to be consistent...
>
> (Observation notes, October 2012)

Despite the lack of change, executives presented their strategic change initiative internally and externally as a success by emphasizing the increased participation of clinicians. However, the major achievements they consistently highlighted, such as a "radical transformation" of local services, were related to *mental health* contract management (trade journal article draft, September 2011). This is despite the fact that MgmtAgency executives initially had shown little interest in altering mental health care contracting arrangements. We now turn to developments concerning mental health contract management to see how and why change emerged there.

The Mental Health Contract Management Practice

As noted above, MgmtAgency's strategic change initiative involved restructuring. Several members of the "non-acute" contract management team were assigned new tasks. The remaining members argued successfully to the executive team that they did not possess sufficient resources to manage all non-hospital related contracts. While some had gained nursing experience and were familiar with many aspects of community care, none had training in mental health care.

The responsibility for contracts related to mental health care services was subsequently passed on to a MgmtAgency manager outside the team, whom we refer to hereafter as "Kate." Kate, along with a junior staff member, had been responsible for managing service redesign projects related to mental health care, learning disabilities, substance misuse, and prison health care services, but had not been directly involved in contract management. Her lack of enthusiasm for assuming this additional responsibility is evident from her description of these duties as "contracting crap" (observation notes, September 2012). In sum, no one at MgmtAgency appeared to be interested in mental health contract management. However, lacking experience in hospital or community care contract management and facing the prospect of being made redundant, Kate had little choice but to become responsible for this practice.

Coordination costs and scrutiny. Kate attended a final monthly contract monitoring meeting between MgmtAgency's non-acute contract management team and MentalHealthProvider representatives with five other MgmtAgency members. In the first meeting after the restructuring, attendance dropped to just Kate and her assistant, along with one MentalHealthProvider representative. Kate used the meeting to agree changes on how contract management was performed by "streamlining communications" between the organizations and developing "the most efficient agenda format for monthly meetings" (meeting minutes, October 2010).

Furthermore, Kate altered contract monitoring by requesting senior MentalHealthProvider clinicians to attend and present updates concerning their services at future monthly meetings so that reasons for shortcomings could be discussed. This method of discussing issues departed substantially from exclusively reviewing quantitative performance

indicators. Kate also invited local GP representatives to contract management meetings and responded to their suggestions concerning how to improve existing processes further. For instance, she merged historically separate meetings after one GP representative complained that they were "not joined up," making it difficult to align quality of clinical services with performance outcomes:

> It is absolutely amazing. You have performance management of the contracts here, and you have quality [review] over there. Huh?!
>
> (GP, interview, May 2012)

Such issues were not unique to mental health contract management, but appeared to be much more difficult to resolve in other service areas:

> The battle that I have had to suggest that actually that is ridiculous and they need to be joined up . . . So, then there is agreement: "Yes, it is ridiculous." And then actually translating that, so it is joined up . . . You wouldn't believe it. You go round and round and round in circles. We are . . . closer to it in mental health than we are in any other [service area].
>
> (GP, interview, May 2012)

Kate acknowledged in interviews that the above-mentioned changes were attempts to align contract management with the interests of GP representatives, who preferred to discuss specific service issues and spend as little time as possible in formal meetings. Moreover, by demonstrating that she was accommodating GPs' interests, Kate received positive feedback from her "new masters" (interview, December 2010) and was able to secure her position within MgmtAgency.

Notably, the number of MgmtAgency managers and GP representatives that became directly involved in mental health contract management was much lower than in other service areas. Of the GPs that became members of the emerging "GP-led mental health network," several resigned during the course of this study. In at least one case, this was triggered by the decision not to reimburse the individual's time spent on work related to mental health contract management because it was "not considered a priority" by the local GP group's board (MgmtAgency manager, informal conversation, September 2012). The official priority across all MgmtAgency-affiliated GP groups (as stated on their websites) was reducing hospital admissions. It appeared that MgmtAgency's executives had successfully directed both MgmtAgency managers' and local GPs' efforts toward hospital contract management—and away from mental health contract management.

Kate and the few GP representatives who did become involved in mental health contract management at times lamented the lack of financial resources to support GPs' efforts and the general lack of interest in this area:

> GP: [The GP in area Y] is apparently concerned that she doesn't have enough time [to become a mental health representative].
>
> . . .
>
> KATE: If you're gonna have GP-led commissioning, then you need funding! The house is going to fall down if we don't fund the GP leadership!
>
> . . .
>
> GP: The danger is you'll just be left with me; and, when I expire, you'll be left with no one.
>
> (Observation notes, September 2012)

However, the general lack of interest from most MgmtAgency managers and local GP representatives allowed making and implementing decisions, and thus effectively using available (albeit limited) potential resources without lengthy negotiations. In contrast to other service areas, disagreements or tensions among and between GPs representatives and MgmtAgency managers were rare, as members were able to accommodate one another's views. As one GP representative commented in an interview:

> We are a very tight unit . . . we're sort of a perfect team . . . there is never any [real tension] . . . There are only really four of us . . . The others are really quite peripheral.
>
> (GP representative, interview, August 2012)

In fact, we were surprised by what appeared to us as complete absence of tensions between GP representatives, which departed from what we were commonly told about GPs generally being unable to work together and reach agreements beyond small partnerships. For instance, one local provider manager noted:

> You have lots of dynamics with the eight local GP groups. I don't know if you have seen it, but it is almost like they should come together in four groups; but, in each area, you have two groups that don't particularly get on with each other. It would be funny if it wasn't that serious.
>
> (CommunityProvider manager, interview, November 2012)

The same manager also noted that the speed of change with regard to mental health services had taken him by surprise:

> I [was a] representative on a group that MgmtAgency's chief strategist put together ... that was a group of finance directors from the [largest health care] providers [across the region]. When the GPs eventually joined our group ... it was interesting to see what themes got pushed. So psychiatric liaison services . . . suddenly was pushed through in about June; it had only been mentioned in passing in April.
>
> (CommunityProvider manager, interview, November 2012)

In summary, a relatively small number of projects related to mental health contract management were initiated, but changes emerged quickly—changes that ultimately attracted MgmtAgency executives' attention and were communicated both internally and externally to highlight the (partial) achievement of strategic change objectives. However, and in contrast to the hospital representative quoted earlier, MentalHealthProvider managers had some reservations about GPs' increased involvement in contract management:

> We were slightly cautious about engaging [with GP representatives]. And I still remember [two GPs] wanting to straightaway get into the details about our management costs and our capital charges and everything else . . . And those were very challenging meetings; and, because of those meetings, we were slightly more cautious about, you know, taking that forward.
>
> (MentalHealthProvider manager, interview, December 2012)

As a consequence, MentalHealthProvider managers responded to what they perceived as threats to their autonomy. These responses tested GP representatives' willingness to challenge the status quo, as we elaborate below.

(Un)willingness to challenge. As noted above, none of the members of MgmtAgency's non-acute contract management team had any direct experience in mental health care services. Moreover, in contrast to hospitals, MentalHealthProvider only employed one group of medical doctors—namely, psychiatrists. Congruent with the literature (e.g., Calnan & Gabe, 1991), we identified a more balanced relationship between GPs and mental health clinicians than between GPs and hospital consultants. For instance, GP representatives at times did not hesitate to use an assertive tone and demand changes. In the following observation notes, not only is this assertiveness evident, but also the GP's concern to accommodate the views of other colleagues to whom he needs to "sell this service":

> MentalHealthProvider manager X gives an update on the new service . . . Two of the GP representatives frequently interrupt with questions . . . One GP notes: "I cannot sell this service to my colleagues." . . . Kate's assistant highlights to meeting attendees the large amount of work that staff at MentalHealthProvider have contributed . . . He tells me after the meeting that MentalHealthProvider manager X looked very stressed and that it is a shame that GPs kept cutting him off instead of letting him speak.
>
> (Observation notes, March 2012)

MentalHealthProvider managers responded to this situation by involving their most senior psychiatrists (i.e., those individuals who they believed controlled resources in the form of knowledge that was valued most highly by GPs) in contract negotiations, partly in an attempt to deflect from issues such as management costs and "steer it more towards the clinical":

> Essentially . . . our organization put the clinical directors forward as, not as pawns, but kind of . . . So, our organization in a way used us, well, not used us, but put us forward to negotiate with GPs.
>
> (MentalHealthProvider clinician, interview, November 2012)

Mental health clinicians, meanwhile, recognized that, by becoming more involved in contract-related discussions, they could potentially influence the distribution of funding and raise their profile within their organization, or at least counteract such attempts by other divisions:

> [M]embership of that core group [consisting of the GP network, MgmtAgency and MentalHealthProvider representatives] . . . enables the membership and influence in other areas [and] jockeying, not just for [financial investments], but for time on the agenda.
>
> (MentalHealthProvider clinician, interview, December 2012)

Senior mental health clinicians therefore regularly attended meetings and shared detailed information concerning services formally, as well as informally "in the car park" (MentalHealthProvider clinician, interview, November 2012). As a consequence, mental

health contract management was being transformed from a largely administrative set of tasks performed by managers toward frequent, regular, sustained, and coordinated "clinically led" activities.

One important question remains, however: If the strategic change initiative was so successful in directing interests toward hospital contract management, thereby limiting coordination costs and scrutiny in other practices, then why did the most favorable conditions for using resources to implement change emerge in mental health rather than, for instance, in community care contract management? Notably, as we elaborate below, existing relations of power were altered to a much greater extent in the latter, resulting in a high level of willingness to challenge incumbents and the status quo, and yet change was not forthcoming. This suggests that conditions for change were rather different across these practices. We elucidate these below to conclude our presentation of the findings.

The Community Care Contract Management Practice

As already noted, the non-acute contract management team shrank as managers were redeployed to support the strategic change initiative. However, because all mental health contract-management responsibilities were shifted to Kate, the total number of managers responsible for community care did not actually decrease significantly: The new community care contract-management team consisted of more than four full-time equivalent members, compared to seven of the former team (that had had the larger remit of covering all non-hospital based services).

As also noted above, many of MgmtAgency's managers were trained nurses or social workers with experience in community care. This resulted in a relationship between MgmtAgency and CommunityProvider that was quite equally balanced because both had access to in-depth knowledge concerning services and occupied similar positions in health care's social hierarchy.

(Un)willingness to challenge. The balance of power shifted considerably when GPs formally assumed MgmtAgency's contract management responsibilities: GPs not only had extensive experience in community care but, as noted earlier, also had medical qualifications that provided authority. As one GP representative commented:

> Secondary care [i.e., hospitals] is at the top, commissioners [i.e., health care management organizations] are underneath, because, even though we should be above secondary care, we are not, but community services are right at the bottom. So, those are the ones you can really kick at.
>
> (GP representative, interview, November 2012)

This was confirmed by a CommunityProvider manager (and former nurse) who stated that "community nurses . . . always bow down to GPs" (interview, August 2013).

In stark contrast to the service areas described above, GPs did not hesitate to challenge CommunityProvider clinicians in meetings. In fact, they at times even criticized them publicly:

> Some of our senior staff, our clinical staff, were in a forum with GPs the other day and . . . GP leaders [were] at the front badmouthing what we were doing. Our staff were [just] sitting there.
>
> (CommunityProvider manager, interview, July 2013).

It thus appeared that MgmtAgency now had access to sufficient resources (in the form of GPs' authoritative medical knowledge) and willingness to challenge incumbents to fundamentally alter community care contract management and existing services in the region.

Coordination costs and scrutiny. However, attempts to make changes—such as simply streamlining existing monitoring meetings—regularly failed. According to one GP representative, a major issue was the involvement of experienced MgmtAgency managers who tended to rely on existing procedures:

> They were really the old-school contract management. All the meetings we were going to [that were related to] contract management and so-called "quality" [were] a complete tick box exercise and didn't mean anything . . . And thus it has continued. I just couldn't cope with it anymore.
>
> (GP representative, interview, November 2012)

Meanwhile, the same GP, along with other GP representatives and MgmtAgency managers, noted that the greatest difficulty resulted from incompatible interests among GPs across the region. Notably, GPs were, to varying degrees, directly invested in community care services: GPs regularly relied on community care services due to an ageing and thus increasingly housebound population. Several GPs also provided certain community based services themselves that extended beyond traditional general practice. Specifically, 76 GPs in the region officially declared a "special interest" in particular community-based services. Their

interest also became apparent in a meeting on the provision of annual flu jabs in the community, which ended when a GP reminded his colleagues that "we all make money on flu jabs" (observation notes, September 2012).

In summary, many MgmtAgency managers and GPs were highly invested in practices related to community care contract management. In the case of MgmtAgency managers with community care experience, this was their sole area of clinical expertise: a move to another service area (such as hospital or mental health contract management) would result in the inability to use this resource. They therefore had an interest in remaining involved and exerting influence. Similarly, GPs felt that they had much to gain from becoming involved and much to lose if they did not:

> [GPs] are desperate to have better community services . . . So, yes, they want to make a lot of noise about it, but kind of understandably, actually, [because] it causes us potentially the most grief.
>
> (GP, interview, September 2014)

As a result, the strategic change initiative, which focused on hospital contract management, did not direct agents' interests away from community care contract management. This resulted in a relatively large number of agents monitoring and attempting to influence developments in the latter, which naturally incurred substantial coordination costs. Attempts to introduce change concerning community care contract management thus required extensive negotiation. Favorable conditions for using potential resources to implement change therefore failed to emerge there.

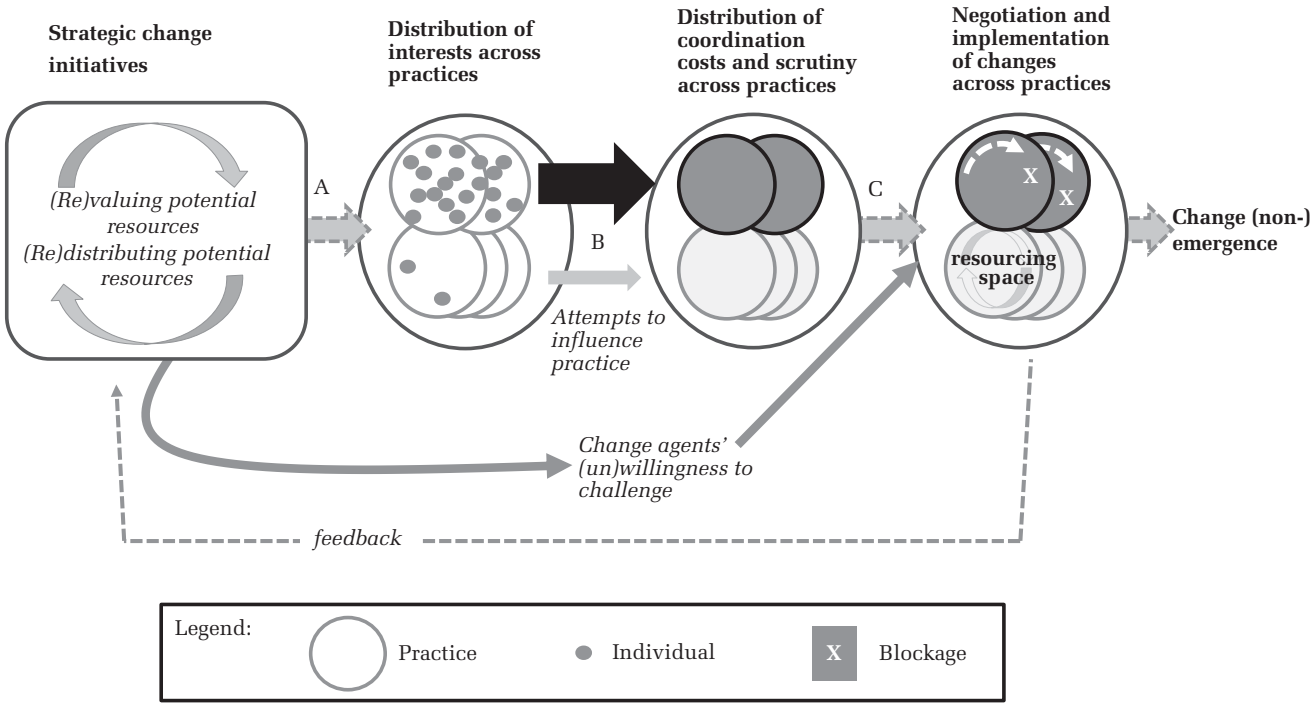
RESOURCING ACROSS PRACTICES IN STRATEGIC CHANGE

On the basis of our analysis, we sought to develop an understanding of the emergence of change in unexpected places. To do so, we elaborated a model of resourcing across practices in strategic change (see Figure 3). This model consists of three interrelated sub-processes (labeled A, B, and C, respectively) that link the emergence of (un)favorable conditions for change across practices during strategic change.

Sub-Process A: Strategic Change Initiatives Direct Agents' Interests by Triggering Revaluations and Redistributions of Potential Resources

As we show in the box at the left of Figure 3, the first sub-process entails the possible revaluing and

FIGURE 3
Resourcing across Practices in Strategic Change



redistributing of potential resources. This involves attempts by strategic change initiators to (a) prioritize targeted practices and to (b) ensure that change agents are in control of sufficient resources to implement changes therein. Practices are prioritized by associating them with valued resources, thereby effectively selling them as issues that demand attention (Dutton, Ashford, O'Neill, & Lawrence, 2001; Howard-Grenville, 2007). This may entail shifting staff, budgets, space on the organizational agenda, and other potential resources toward them (and thereby away from others).

Certain designated agents, meanwhile, are formally granted a degree of control over particular organizational decisions. Their authority stems from being associated with particular potential resources, such as certain types of specialized knowledge. In our case, GPs formally gained control over financial budgets because medical knowledge appreciated in value by becoming a prerequisite for making many decisions related to health care contract management at MgmtAgency. In other cases of strategic change, lawyers or management consultants may gain control based on their recognized access to particular forms of knowledge.

Importantly, our model highlights, via the circular arrows in the first box, that these processes of revaluing and redistributing potential resources are ongoing, recursive, and not completely controllable by strategic change initiators (cf. Tsoukas & Chia, 2002). Members of the organization, including designated change agents, *enact* the distribution of valued resources and may associate certain practices and agents with valued resources in addition to (or instead of) those that strategic change initiatives have prioritized. This is because organizations do not start with a blank slate: agents are predisposed to associating particular resources with value as a result of socialization experiences (Bourdieu, 1985). Our case vividly demonstrates this enactment and strategic change initiators' lack of control over the process: once GPs were responsible for health care budget decisions, the value of medical knowledge in contract management appreciated yet further as they valued this potential resource particularly highly. Consequently, this made it difficult for anyone without control of this potential resource—including MgmtAgency managers—to influence practices and implement change. Similar dynamics have been documented in other settings, such as the inability to direct efforts toward sales and marketing if research and development activities are valued much more highly by organization members (Nag, Corley, & Gioia, 2007). It follows that strategic change initiatives act as potential triggers for resource revaluations and redistributions, but that they may not fully succeed in directing interests and shifting power relations according to plan.

As the circles with the many dots at the top in Figure 3 suggest, certain practices, and not necessarily (only) those that are initially prioritized as part of strategic change initiatives, consequently attract interest from a relatively large number of individuals. Meanwhile, as depicted by the circles at the bottom that contain few dots, other practices do not.

Sub-Process B: The Distribution of Interests Shapes Coordination Costs and Scrutiny across Practices

The arrows labeled "B" in Figure 3 suggest that the (uneven) distribution of interests across practices tends to generate a corresponding (unequal) distribution of coordination costs and scrutiny. Practices that attract interest from a large number of individuals witness more attempts to influence them, especially if many individuals become directly engaged in them. Direct engagement is likely to be especially high in practices that are prioritized by change initiators and designated change agents. This is because these practices generally witness an increase of staffing levels, and because their future becomes the subject of debate among a wider audience. Effectively excluding individuals from these practices can be difficult to justify, especially in modern times of increasing transparency and "open strategy" in contexts beyond the public sector (Whittington, Cailluet, & Yakis-Douglas, 2011). Both coordination costs and scrutiny associated with these "interesting" practices are consequently high. This is highlighted by the dark shading of the top circles in Figure 3.

In our case, developments with regard to hospital contract management were closely scrutinized by MgmtAgency executives, while developments concerning community care contracts attracted much attention from local GP representatives and several managers. The relatively large number of change proposals that local GPs devised with regard to these two service areas naturally required coordination. Thus, coordination costs and scrutiny can influence resourcing actions both across one's own peer group (e.g., colleague GPs) and from seniors in formal authority (e.g., MgmtAgency executives) (Dutton et al., 2001; Howard-Grenville, 2007).

On the other hand, practices that attract only very limited interest fail to generate efforts from many

individuals to actively influence them. Expending much time and effort in these practices is generally not viewed as worth it. Hence, potential change agents may disengage from these practices, either by limiting their active involvement, or by exiting them altogether. In our case, this was most evident when MgmtAgency's "out-of-hospital" contract team members handed over mental health contract management responsibilities to others.

Sub-Process C: Coordination Costs, Scrutiny, and Change Agents' (Un)Willingness to Challenge Shape the Negotiation and Implementation of Changes across Practices

As the arrow directly under the label "C" in Figure 3 suggests, the level of coordination costs and scrutiny associated with each practice shapes the ability to implement changes therein. For instance, the need to coordinate efforts among, and get "buy-in" from, a relatively large number of strongly interested individuals, including peers, inhibits rapid decision making (Goodstein, Gautam, & Boeker, 1994; Wiersema & Bantel, 1992). Negotiations concerning proposed changes may be difficult and stall as interests across the multiple stakeholders become problematic to align. This was most apparent in our case with regard to community care contract management, and is also commonly noted in the strategic change literature in the form of "escalating indecision" (Denis, Dompierre, Langley, & Rouleau, 2010) and "dilemmas of participation" (Kanter, 1996), especially in public sector contexts (Brunsson, 1985).

Meanwhile, implementing changes in practices that exhibit a low degree of coordination costs and scrutiny is less difficult, provided that—as depicted in Figure 3 by the other arrow coming up from below—there are change agents who are *willing to challenge* incumbents and the status quo. The limited availability of "traditional" resources, such as budgets and staff, is thereby offset by a relatively low level of interference (cf. Tushman & O'Reilly, 1999). Furthermore, change agents' willingness to challenge is shaped by their (not necessarily conscious) assessments of who controls potential resources that they particularly value (cf. Lockett et al., 2014). Strategic change initiatives play an important role in shaping this willingness by setting in motion resource redistributions and revaluations. Importantly, despite formally controlling certain potential resources such as budgets or strategic decision-making authority, designated change agents may rely on the advice of others whom they associate with (other) valued resources.

In our case, GPs especially valued specialized medical knowledge and being part of the medical community. Consequently, GPs representatives, as designated change agents, defined medical knowledge as valuable in the context of contract management and associated specialized hospital doctors with highly valued resources. GP representatives were not comfortable challenging the latter in contrast to agents who they did not associate with high-status medical knowledge. Thus, strategic change initiatives may trigger developments that ultimately increase the influence of certain agents apart from, or beyond, those who are initially granted formal (designated) control over potential resources.

In other settings, newly hired change agents, such as "outsider" CEOs, may value fresh perspectives and therefore allow members who are relatively new to the firm or industry to influence important organizational decisions (Fondas & Wiersema, 1997). Alternatively, they may value organization members' experience very highly and therefore grant particularly experienced members a high degree of organizational influence. Our model therefore incorporates the possibility that strategic change initiatives reinforce and reproduce existing relations of power as a result of change agents valuing those resources that are controlled by historically dominant stakeholders (cf. Bourdieu & Passeron, 1990).

We refer to the favorable conditions for change that are related to agents' interests and the values they associate with potential resources as providing "resourcing space": an emergent space that allows for mutual adjustment and accommodation so as to enable and direct actions. As we have shown, strategic change initiatives may (intentionally and unintentionally) both enable and constrain the development of resourcing space as a result of simultaneously providing and withdrawing (i.e., redistributing) potential resources, as well as setting in motion the appreciation and devaluation of certain potential resources, within a field of practices.

Naturally, change may emerge in practices that exhibit different conditions. However, the negotiation and eventual implementation of profound changes therein is likely to be more difficult because they require an abundance of skill in terms of overcoming or circumventing potential blockages (such as in the form of additional bureaucracy and/or

active opposition to change proposals), and ultimately simply demand more time.

Finally, as the dotted feedback line at the bottom of Figure 3 suggests, developments in and across practices may feed back into strategic change initiatives, potentially triggering further attempts to redistribute or revalue potential resources. For instance, failure to achieve change in particular practices may generate attempts to allocate more financial or human resources toward them or further emphasize their strategic importance, thereby increasing their symbolic value. Successful change in a practice may, in turn, trigger attempts to replicate developments in other practices by transferring potential resources, such as knowledge, across practices. Such was the case with the mental health contract management practice in our study, which was highlighted by MgmtAgency executives as a success story and which was regarded as a source of learning for the community care contract management team and GP representatives.

DISCUSSION

In this paper, we have developed a resourcing lens to analyze divergent and unexpected developments across contract management practices for hospitals, mental health, and community care following the initiation of a strategic change attempt within the English NHS. Our study allows us to elaborate theory as to the role of valued resources in strategic change, and, in so doing, furthers our understanding of a resourcing perspective. Below, we describe how our findings contribute to strategic change and resourcing literature streams and develop the concept of resourcing space as an important elaboration of the resourcing process in strategic change.

Contributions to Research on Resources in Strategic Change

Studies have highlighted that the emergence of profound change is often associated with a shift in control of valuable resources toward agents who have not traditionally occupied dominant positions within an organization or wider field (e.g., Battilana, 2011; Kellogg, 2009; Pfeffer & Salancik, 2003). By gaining control, agents who are not wedded to existing arrangements have the opportunity to shape practices according to their own interests. This paper extends this insight in a fundamental way by highlighting the role of strategic change initiatives in shaping what is, and what is not, considered valuable. Hence, we argue for shifting our thinking away from a consideration of the role of resources in shaping strategic change toward examining the *role of strategic change initiatives in shaping resources*. Importantly, rather than merely allocating potential resources across an organization, strategic change initiatives also play an active role in shaping the values that are associated with potential resources, such as by prioritizing certain issues and solutions over others (Howard-Grenville, 2007). As our findings demonstrate, this can trigger dynamics that can contribute to both intended and unintended outcomes.

Such a reconceptualization of the relationships between strategic change and resources emphasizes the agency of strategic change initiators and change agents—not just in terms of using potential resources but also in constructing the values with which they are associated. This highlights that values are not externally determined, thereby limiting the ability to predict developments on the basis of the initial distribution of potential resources alone (Kraatz & Zajac, 2001). This is because potential resources can appreciate and decline in value, thereby shaping power relations and attracting different levels of interest that can enable and constrain change. In other words—and departing from resource dependence theory explanations (Pfeffer & Salancik, 2003)—just because an organization is, for instance, facing increased litigation threats does not mean that its lawyers will automatically become more powerful and align existing organizational practices with their own interests. Although such an outcome is conceivable, executives and other stakeholders who are associated with valued resources may respond differently (depending on their own interests). For example, in the case presented in this paper, MgmtAgency executives could have prioritized non-acute providers and non-clinical forms of knowledge, setting in motion developments across contract management practices that potentially would have departed substantially from those that we observed.

Such a perspective also differs from more traditional conceptualizations of values and interests in the organization literature. For instance, while interests have been conceived as related to agents' "view of the appropriate allocation of scarce resources" (Ranson, Hinings, & Greenwood, 1980: 6), agents' values have often been treated as distinct from interests and not tied explicitly to potential resources (e.g., Cha & Edmondson, 2006; Hinings, Thibault, Slack, & Kikulis, 1996). Drawing on Bourdieu's

relational framework, we consider values as forming an essential part of the relations between agents and potential resources, which in turn shape interests, as well as their willingness to challenge others. Thus, resource value is not fixed or predetermined but varies for each agent, depending on their existing interests that are shaped by socialization experiences (including strategic change initiatives) and investments in wider fields of interconnected practices (Bourdieu, 1986, 1990).

Contributions to Research on Resourcing

Our findings also contribute to the literature on resourcing in two important ways. First, a resourcing perspective divides all things into potential resources and resources-in-use (Feldman & Orlikowski, 2011: 1246; Feldman & Worline, 2012: 630). Use is shaped by a potential resource's innate qualities, agents' associations of meaning with practices, and skills (Feldman, 2004; Feldman & Worline, 2012; Sonenshein, 2014). Our case suggests that a focus on direct use limits the ability to recognize how potential resources may shape behavior and relations in other ways that can be important in understanding how and why change may (not) emerge.

We highlight that the value that agents associate with potential resources plays an important role in terms of shaping their willingness to associate themselves with them, appropriate them, challenge others, and participate in certain practices. Thus, taking into account the value that agents attribute to potential resources extends resourcing theory by providing an enhanced understanding of how, when, and why agents use resources. From this perspective, potential resources are not only tools that agents can use to pursue their interests, but, depending on associated value, *entities that may attract interest*.

Attention to values and interests in terms of shaping behavior does not rule out the possibility of agents experimenting with potential resources and only recognizing their value during or after processes of improvisation (cf. Barrett, 1998; Chia & Holt, 2011; Sonenshein, 2014). However, it highlights that agents are primarily drawn to those things they value highly, either because they are personally dependent on or familiar with them (as per the GPs' interest in community care), or because they are deemed valuable in the wider field (such as medical knowledge in the field of health care). As we have shown, strategic change initiatives and change agents' internalized values may strongly *direct resourcing* as well as with whom they may cooperate or be willing to challenge. This perspective furthers our understanding of how power can be channeled (or not) to resource the ability for new approaches to be implemented (Lockett et al., 2014; Reay, Golden-Biddle, & Germann, 2006). It also highlights that, while skill is undeniably important in terms of being able to effectively resource, the skills required to implement change within a practice are partly shaped by the level of interest the available potential resources attract, as well as change agents' associations of themselves and others with valued resources.

Second, the resourcing literature has tended to examine practices individually rather than relations between them (e.g., Feldman, 2004; Howard-Grenville, 2007; Sonenshein, 2014). The focus on dynamics within individual practices has resulted in an enhanced understanding of how potential resources are transformed, rather than assuming that the provision of certain potential resources produces specific outcomes (Feldman & Worline, 2012). However, our findings show that potential resources (such as staff) may also be shifted *across* practices. Our analysis suggests that, like organizations and organizational divisions, practices compete for scarce resources within a field, and should therefore not be treated in isolation. Those practices that do not accumulate valued potential resources witness relatively little engagement from the majority of agents within the wider field. By examining redistributions and revaluations, our model sensitizes us to the fact that the provision of potential resources equates to a relative withdrawal elsewhere and that the appreciation of certain potential resources has consequences for other potential resources. Hence, our model encourages the adoption of a relational view of practices as embedded within a wider field (Emirbayer & Johnson, 2008) that captures developments beyond practices that are specifically targeted as part of strategic change initiatives.

Several scholars have, in the past, highlighted that organizations are relational systems, and that subunits, divisions, or practices both share and compete for scarce resources (Hickson, Hinings, Lee, Schneck, & Pennings, 1971; Pfeffer & Salancik, 2003; Walsh et al., 1981). The prioritization of one part of an organization may therefore trigger politically motivated responses from other parts (Mintzberg, 1985; Pettigrew, 1973; Pfeffer, 1993). We show that this competition need not take the form of explicit power struggles and political behavior. As per Bourdieu (1984, 1990), disadvantaged agents may know their place rather than engage in active resistance. This

was, for instance, especially apparent in our case from the behavior of community nursing staff and MgmtAgency managers in terms of accepting medical doctors' authority in health care contract management. Interestingly, our findings indicate that agents who participate in practices that witness a decline of valued resources, and hence "lose out" to others (Buchanan & Badham, 1999), may paradoxically also "win" by gaining the ability to shape these deprioritized practices according to their own interests.

Resourcing Space

Our findings further suggest that space is an important and productive aspect of relations of power in resourcing strategic change. Social movement literature has shown the importance of *free* space in enabling subordinate groups to develop the capacity to engage in political challenges (Rao & Dutta, 2012). Within these spaces, reform agents are shielded from interference from defenders of the status quo (Kellogg, 2009), allowing them to engage in mobilization as they collectively gain a sense of oppositional efficacy and identity (Fantasia & Hirsch, 1995). Our research shows how resource (re)valuations and (re)distributions may (unintentionally) contribute toward such openings by creating what we term "resourcing space," which we define as *an emergent space that allows for mutual adjustment and accommodation so as to enable and direct action*. Rather than space being an independent condition that facilitates change implementation (Kellogg, 2009; Rao & Dutta, 2012), we find that such resourcing space may emerge as strategic change unfolds, with the space itself functioning as a potential resource that enables mobilization and experimentation. Hence, analogous to the resourcing perspective that argues that resources are not given but *enacted* in ways that may produce unexpected results (Feldman, 2004), we find that resourcing space can be generated as an unintended byproduct of purposive actions.

While earlier work on free space has focused on mobilization (Rao & Dutta, 2012) or relational aspects of inclusion (Kellogg, 2009), our understanding of a resourcing space builds on work (Feldman & Worline, 2012) that emphasizes the central role of action in generating the value of resources and how mutual adjustment within an emerging context shapes resource use. Specifically, Feldman and Worline (2012) suggested that mutual adjustment, as a mechanism for resourcing, involves agents evaluating and comparing relevant knowledge to shape resource use. In this way, resourcing space enables interdependent actors to modify their individual responses as they interact with each other so that efforts in reshaping the practice become coordinated and aligned (Barnes, 2001). Our analysis of mental health contract management shows that, where actors are motivated to mutually adjust their practice so as to accommodate the interests of others, negotiation of resource use and collective action are empowered (Oborn, Barrett, & Davidson, 2011). Moreover, as our findings highlight, this accommodation of interests may emerge over time as a result of individuals pursuing their own interests—such as the increased amount of clinical discussions being shaped by Kate attempting to secure her job and MentalHealth clinicians "jockeying" for time on the agenda—rather than from explicit negotiation between stakeholders (cf. Smets, Morris, & Greenwood, 2012).

Resourcing space provides favorable conditions for mutual adjustment by (a) limiting coordination costs among change agents, (b) granting them the willingness to challenge the status quo, and (c) limiting scrutiny from powerful stakeholders (including peers). Taking the first of these points, our model reveals the role of *coordination costs* in enabling action. High coordination costs hinder mutual adjustment. In a congested space where a large number of agents are involved in producing action, accommodation and adjustment may be hindered due to the need to negotiate many potentially divergent interests. This inhibits effective resource use. Even in contexts where a stakeholder group controls a much larger quantity of valued resources than another, such as in the case of GP representatives relative to community care workers, high coordination costs may stymie the capacity to act (Brunsson, 1985; Denis et al., 2010). This is because control may be spread out across multiple agents with competing interests, thereby making it difficult to achieve a common understanding (Okhuysen & Bechky, 2009) and inhibiting the development of the microprocesses that constitute effective coordinating (Jarzabkowski, Lê, & Feldman, 2011). Hence, change may fail to emerge even when "reformers" substantially outnumber "defenders" of the status quo (cf. Kellogg, 2009).

Second, our model also emphasizes the importance of *willingness to challenge* in respect of how the resourcing space enables change emergence. As our findings highlight in the case of hospital contract management, potential resources may lay idle if change agents are unwilling to use them in ways that

could upset the established social hierarchy (Lockett et al., 2014). Hence, historically dominant agents may not even need to actively defend the status quo, such as by engaging in tactics to undermine change attempts (Kellogg, 2012). Designated change agents may thereby (unwittingly) hinder the formation of resourcing space *themselves*. This demonstrates the value of taking into account relatively subtle and invisible aspects of power relations in the context of change initiatives (Oakes, Townley, & Cooper, 1998) that go beyond clashes between reformers and defenders.

Third, when agents are able to remain "in the shadows" (Dutton et al., 2001: 729) or "shielded from inspection" (Smets et al., 2012: 890), rapid and potentially radical change may emerge due to a *lack of scrutiny*. In contrast to conventional views of free space, there may not be any need to secretly mobilize (Cress & Snow, 1996) and operate "below the radar" (Reay et al., 2006: 994). Change agents do not necessarily need to be protected from potential interference, for instance, by intentionally separating them from the rest of the organization (Andriopoulos & Lewis, 2009; Tushman & O'Reilly, 1999). Instead, space for resourcing may simply arise from the lack of interest and engagement associated with the practice. This may help establish mutual adjustment, especially in contexts of trust and accommodation (Rao & Dutta, 2012), thereby allowing for experimentation and new forms of resourcing.

Practical Implications, Limitations, and Future Research

A number of practical implications emerge from our study. Our view of resourcing in strategic change allows us to uncover why strategic change initiatives may fail or succeed. On the one hand, they may fail to induce change by unsuccessfully altering existing relations of power and/or by attracting a high degree of interest that can result in high coordination costs and scrutiny. On the other hand, they may succeed by (unintentionally) providing space for experimentation in practices not associated with highly valued resources. The latter has implications for agents who may feel neglected and disempowered when the practices they participate in are faced with a relative withdrawal of traditional resources, such as financial capital and personnel, during strategic change. These organization members can benefit if they are able to perceive the resulting space as a potential resource that they can use to their advantage. It also has implications for strategic change initiators who may benefit from being aware of the ripple effects their initiatives may trigger across an organization (and beyond).

While we believe that our model of resourcing across practices in strategic change is applicable to a range of settings, our case is undoubtedly extreme in several respects, warranting the specification of boundary conditions. First, the significant changes that emerged in mental health contract management, and that eventually caught the attention of MgmtAgency executives, did not rely on large financial investment. These changes were thus limited to relatively small-scale, bottom-up creative changes (Sonenshein, 2014). Nevertheless, developments that are later recognized as dramatic "macro changes" may originate from small initiatives that gain momentum (Kanter, 1996: 18; Plowman et al., 2007; Smets et al., 2012).

Second, the involvement of a relatively large number of individuals and groups in terms of shaping strategic change, and the lack of a clearly accepted hierarchy among them, are features that may predominate in pluralistic and public contexts. Not every strategic change initiative involves the opening of strategy (Whittington et al., 2011) to individuals or groups who have the ability to pursue their own interests. In other settings, participation may be more effectively restricted, thereby limiting coordination costs. It may also be more difficult for organization members to direct their participation primarily toward those practices they are personally interested in, but which are not necessarily aligned with strategic change objectives. However, we believe that the general implications of our model still hold—namely, that strategic change initiatives inevitably involve some form of re-prioritization, which results in some part(s) of the organization simultaneously witnessing a relative decline of perceived value. The resulting lack of interest has the potential to generate a vacuum that can be used by skilled agents to implement change without the need to engage in extensive negotiation and coordination efforts. In fact, the ability to introduce change in practices that (initially) attract little interest is well documented across the popular and academic management literature (e.g., Reay et al., 2006; Smets et al., 2012). For instance, organizations are known to stimulate innovation via the creation of "skunk works"—units that receive only limited funding and are purposefully isolated so as to limit interference (Peters & Waterman, 2004; Tushman & O'Reilly, 1999).

Finally, not every strategic initiative includes attempts to transfer budget control toward members of

a particular occupational group. However, strategic changes often involve a shift of control over an organization's potential resources across organizational subunits or divisions (Greenwood & Hinings, 1996; Hickson et al., 1971), and these subunits are often directly associated with particular occupational groups (such as lawyers, accountants, or engineers).

Our study has some key limitations. For instance, despite the use of multiple data sources, we cannot rule out all alternative explanations for the dynamics that we identified. Moreover, some parts of our analysis rely on data not captured in real time. Finally, although we have used intra-case comparisons, the use of a single case study necessarily limits the ability to generalize from our findings. Since studies of strategic change generally examine developments in those areas of the organization that are considered change priorities, we call for more research that investigates the dynamics across practices, including those that do not feature prominently on the executive agenda. This will provide an enhanced understanding of the complex dynamics triggered by strategic change initiatives, and how change may emerge in unexpected places.

CONCLUSION

Our model of resourcing across practices in strategic change provides an in-depth understanding of relationships between strategic change initiatives, resources, and changes across organizational practices. It demonstrates that change is linked to processes of resource redistributions and revaluations that may both facilitate and inhibit effective mutual adjustment and accommodation so as to enable and direct action. These insights provide an enhanced appreciation of how strategic change initiatives may contribute toward developments that extend beyond successfully changing, or failing to change, practices that are explicitly targeted. They thereby help us understand how and why change can emerge in unexpected places.

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