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Nobody in charge: Distributed change agency in healthcare

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ABSTRACT

This article illustrates how distributed change agency can implement complex organizational changes in the absence of formal management plans, roles, and structures. Distributed change agency typically involves small teams and senior groups. In this qualitative study of service improvements in the treatment of prostate cancer at an acute hospital, Grange, change roles were distributed more widely, with responsibilities 'migrating' among a large informal cast supporting four central characters. This distribution appears to have been triggered by the change goals and substance, and by the network organization through which services were delivered. Cross-case comparisons with other hospitals, Henley and Norwood, suggest that a combination of factors contributed to the development of a distributed approach. Analytical generalization invites speculation concerning the transferability of this model, with 'nobody in charge', to other settings. One policy implication concerns the provision of development in change agency competencies to staff other than those in senior positions.

KEYWORDS

change agency ▪ change management ▪ distributed leadership ▪ healthcare ▪ organizational change

Change agency and substance

This study focused on roles in change in healthcare. What roles might one expect in this context? Schön (1963), highlights the importance of the 'change champion'; Stjernberg and Philips (1993) refer to 'souls of fire', from the Swedish '*eldsjälar*' meaning 'driven by burning enthusiasm'. However, organizational change is rarely implemented by one person, and several commentators have developed role taxonomies. Ottaway (1983) identifies ten roles in three categories, of change generators, implementers, and adopters. Beatty and Gordon (1991) distinguish patriarchs, who originate ideas, from evangelists who implement them. Buchanan and Storey (1997) identify eight roles, arguing that the ability to perform several, and to switch between them, are critical competencies. Such taxonomies imply that change agency roles are limited in number and codifiable.

In healthcare, since the 1980s, there has been a widespread trend to involve doctors more closely in management (Davies & Harrison, 2003; Ferlie et al., 1996; Schneller et al., 1997). The heads of hospital services (clinical directors) typically have hybrid medical-managerial roles. Research has concentrated on the specification of hybrid roles (Bruce & Hill, 1994; Pearson et al., 2004), on the tensions between medical and professional managers (Griffiths & Hughes, 2000; Hoque et al., 2004), and on the problems of combining medical practice with managerial responsibilities (Fitzgerald & Dufour, 1997). There is now a substantial literature on change in healthcare (Buchanan et al., 2007; Iles & Sutherland, 2001; Locock, 2001; Øvretveit & Gustafson, 2003; Pettigrew et al., 1992) which focuses on process, context, and the need for medical 'engagement'. Less attention has been paid to change-related elements of hybrid and managerial roles, or to how relationships between these groups influence change processes.

Several commentators note the dispersed, decentred, or distributed nature of change agency. Pettigrew et al. (1992) describe team-based approaches to change in healthcare. In a hospital study, Brooks (1996) found that implementation involved the chief executive, a cadre of managers, and a diagonal slice of a dozen staff designated as 'networkers'. Denis et al. (1996, 2001) focus on a small 'leadership constellation', whose members play fluid and complementary roles. Buchanan (2003) describes a hospital re-engineering programme as a 'dispersed responsibility' model of change. Change agency can be regarded as a distributed phenomenon, an observation echoed in commentary on distributed leadership (Bennett et al., 2003; Bryman, 1996; Gronn, 2002a). These domains are conflated in the concept of 'change leadership' (Denis et al., 2001; Nadler, 1998). Gronn (2002a) suggests that the defining characteristic of distributed leadership is

'concertive action'; steps initiated by one individual are developed by others through the 'circulation of initiative' (Gronn, 2002b).

The content of change is also significant, but the influence of substance is under-theorized. Processual perspectives emphasize interaction between context, process, and substance (Dawson, 2003). Stace and Dunphy (1994) distinguish fine tuning, incremental adjustment, and modular and corporate transformations. Pettigrew (1985) argues that complex, long-term, large-scale, risky reorganizations incite opposition. Dawson (1994) argues that commitment to, and resourcing of, strategic change depend on centrality to organizational performance. The distinction between operational and strategic change overlooks the possibility that minor changes can accumulate into systemic shifts (Ichniowski et al., 1996). This article, therefore, explores the nature and antecedents of distributed change agency in a healthcare setting, suggesting how attributes of change substance affect change agency roles.

The cancer services context

Government-run, funded by general taxation, and providing free care at the point of delivery, the British National Health Service (NHS) in England, with 1.3 million staff, is one of the largest employers in the world, with an annual budget of £100 billion. Care is provided through 150 primary care organizations and 166 acute hospitals, monitored by 10 regional bodies. Responding to unfavourable international comparisons and domestic criticism, a modernization programme was launched in 2000, to develop a patient-focused service, reduce waiting times for diagnosis and treatment, and improve quality of care (Department of Health, 2000a, 2004). Cancer services were one of the priority areas in this programme.

The NHS is a professional organization, in which change requires the consent of powerful occupational groups (Ferlie et al., 2005; Mintzberg, 1979; Powell et al., 1999). Øvretveit (2000) argues that healthcare organizations are inherently difficult to change, due to complexity, professional resistance, and lack of incentives. However, this article reports the successful implementation of improvements in prostate cancer services at Grange hospital, outcomes that were achieved by a large and shifting cast of formal and informal change agents in the absence of management plans, roles, and structures. If there was nobody in charge of this complex process, how were those outcomes achieved?

Cancer services in Britain were subject, since the mid-1990s, to a series of policy-driven changes. A national review advocated the creation of collaborative networks, linking primary and secondary care providers, to improve

access to and continuity of treatment (Calman & Hine, 1995). Cancer units performing low volumes of operations were to refer patients to centres where surgical teams performing more procedures would be better able to maintain and develop their skills. To improve the co-ordination of care, multi-disciplinary teams were advocated, including doctors, nurses, and other specialist staff. Each cancer unit and centre was to appoint a lead cancer clinician, and specialist nurses for each tumour site. These networks promise better coordination, but their structures are complex, and they have had mixed success (Addicott et al., 2006).

A white paper, *The new NHS* (Department of Health, 1997), established a policy for waiting times for diagnosis and treatment. In 1999, a national cancer director was appointed, a cancer collaborative initiative was launched, and 34 cancer networks were created across England (Parker et al., 2001). Also in 1999, a 'two-week wait' policy required that women diagnosed with suspected breast cancer should see a hospital consultant within two weeks of referral by general practitioner. *The NHS plan* (Department of Health, 2000a) consolidated this policy for the whole service, complemented by *The NHS cancer plan* (Department of Health, 2000b), and a manual of cancer services standards (NHS Executive, 2000). The two-week wait policy was applied to other cancers, including prostate, and annual peer reviews were introduced for all cancer service providers.

Affecting mainly the elderly, prostate cancer is a urological condition which kills around 10,000 men in Britain each year. Diagnosis first relies on measuring the level of the patient's prostate-specific antigen (PSA), followed by digital rectal examination in a hospital outpatient clinic, and a trans-rectal ultrasound-guided (TRUS) prostatic biopsy. Diagnosis is controversial and risky, and treatments range from radical prostatectomy to 'watchful waiting'. Traditionally, patients referred by a local doctor were added to a clinic waiting list, and were summoned at a time convenient to the hospital. In 2000, the average time from referral to treatment was over 140 days for urgent cases, and a year for non-urgent patients (Spurgeon et al., 2000). However, by 2004, one respondent in this study observed, when asked about reductions in waiting times, 'In terms of prostate on this site, over this network, they have done it at Grange. They have done it to death'. This article focuses on what was done (change substance), and on who did it (change agency roles).

Grange Hospital

Grange was one of 11 research sites in a wider study of roles and relationships in change in healthcare (Fitzgerald et al., 2006). Involving clinical areas

identified as national priorities, six case studies were in acute settings (three in cancer, three in maternity services), and five were in primary care (diabetes services). This article is based primarily on experience at Grange, complemented by comparisons with two other cancer settings, at Henley and Norwood hospitals. Grange was an acute hospital with an annual budget of £80 million, providing services to a population of 250,000 people, with 1600 staff and 440 beds. A new management team was appointed in 1999, with an ambitious chief executive intent on making a 'benevolent dictatorship' more participative and dynamic. However, there were five changes of chief executive between 2002 and 2003.

Like other hospitals, Grange faced regular monitoring with respect to national performance targets. This produced league tables, of 'star ratings', and (from 2004) led to the opportunity for 'three star' hospitals to apply for Foundation status, with increased autonomy. League tables appeared in national newspapers, and there was a need for 'improvement stories' to fuel constant media attention (reduced surgical waiting times, new facilities, acquisition of diagnostic equipment). The Grange 2003 'modernization plan' described its 'unashamed ambition' for improving quality of care. Awarded 'two stars' in 2001, and 'three stars' in 2003, Grange was reduced to 'two stars' in 2004, thus deferring their Foundation bid.

Following national guidelines, by 2003, Grange had appointed a lead clinician, a lead nurse, and a multidisciplinary team for each cancer tumour site. This structure was echoed at a corporate level with a cancer lead clinician, cancer lead nurse, and cancer lead manager. The hospital belonged to the Glenelg Cancer Network, whose membership included other acute and primary care organizations, social, community and hospice services, and the regional monitoring body. Based in a nearby primary care unit, this structure included a network lead nurse and two network lead clinicians, a network clinical director, a service improvement lead, and a network manager.

Responsibility for service improvements was thus spread across internal, external, clinical, and managerial roles at different levels, and in different organizations. A structure involving a cancer network board, multidisciplinary teams, and cancer site-specific groups, created tensions over the location of responsibility, accountability, and credit for improvements. Network collaboration divorced responsibility for decisions (reached in a network context) from implementation and accountability for outcomes (lying with hospitals). The network bodies were new, created since 2000, and were defining their own strategies, structures, roles, responsibilities, and external relations at the time of this study.

Fieldwork at Grange in 2003 and 2004 focused on prostate cancer services, in the directorate for general surgery and urology, with a budget of £4 million, diagnosing 200 cases of prostate cancer a year, employing five

consultant surgeons and two consultant urologists. Research methods included interviews, document collation, and informal discussions with managers. Interviews were structured to facilitate cross-case comparisons, and covered four themes; respondent background, role interpretation and relationships, and service improvements, including the nature and objectives of changes, who were involved in implementation roles, project management structures, and outcomes. Interviews were held with 21 hospital and network staff, including 14 in management roles, and seven in clinical positions (of whom five held 'hybrid' clinical-managerial roles). Four of the nine members of the urological cancer multidisciplinary team were interviewed. Interviewee selection was based on knowledge of and involvement in service improvements, and on availability (some staff had moved to other roles). Similar data collection methods were used at Norwood and Henley.

The sample of one

This article relies primarily on within-case analysis at a single research site. While this strategy precludes statistical generalization, several commentators note that a single case study can inform theory through analytical generalization (Buchanan, 1999; Butler, 1997; Dyer & Wilkins, 1991; Mitchell, 1983). Tsoukas (1989) argues that single cases can clarify structural aspects of social configurations, the associated generative mechanisms, and contingent factors leading to observed outcomes. Rueschemeyer (2003) supports the view that 'least likely' cases have significant theoretical implications when observations contradict expectations. The two other cancer case study sites in this project faced similar pressures, but neither made progress. Grange was thus a deviant case, or 'positive outlier'.

Success at Grange in implementing cancer service improvements appears to have relied on a widely distributed approach to change agency. This was not a planned management strategy, prompting questions concerning the factors triggering and supporting such an approach. The identification of those factors is explored through cross-case comparisons with Henley and Norwood hospitals. These comparisons are grounded in the data, are structured around core themes of the study, and are informed by a processual perspective. Table 1 summarizes contextual, structural, managerial, clinical, and processual attributes of these sites. This summary does not contrast 'more distributed' with 'less distributed' profiles of change implementation, because the question revealing the distributed pattern at Grange, 'Who were involved?', was redundant at Henley and Norwood where the answer to the previous question, 'What changes were implemented?', was 'Little or none'. These comparisons will be examined more

carefully after first considering the changes that were implemented at Grange, the cast of change agents, and the outcomes.

The multifaceted change agenda

Table 2 summarizes changes to prostate cancer services at Grange between 1999 and 2004. The substance of these changes echoes the 'proliferation' identified by Van de Ven et al. (1999) in studies of innovations, but was in this case convergent, rather than the divergent proliferation that Van de Ven et al. observed. Changes included new technology, facilities, processes, and patient information and support, affecting roles and role boundaries (lead clinicians, specialist nurses, team co-ordinators), goals (waiting times), micro-organization structures (multi-disciplinary teams and regional groups), macro-organization structures (collaborative networks), patient pathways (improved inter-organizational co-ordination), and medical practice (booking and pooling patients, relocating surgical procedures).

The most significant component was the 'two-week wait' target because, while all of these developments were subject to annual peer review, the percentage of patients seen within the waiting times target was monitored by the Department of Health. Problems arising in peer review led to advice for the clinical team. Failure to meet the waiting times target meant a reprimand for the chief executive. Key attributes of the change substance thus concerned the simplicity of the objective (two-week wait), and the convergent and multifaceted organizational, role, and process changes required to achieve that target.

The distribution of roles

Identifying roles in changes to urology services was complex for several reasons. First, the changes unfolded over five years (1999 to 2004) and some respondents could not recall full details of early events. Second, many staff, at different levels, and in different organizations, were involved in different ways, at different times. Third, changes were not implemented through formal management procedures. Fourth, overall responsibility 'migrated', from national initiative, to regional network, then to the local clinical directorate. Respondents were able to describe mainly those parts of the process in which they were directly involved. Here, the full cast of characters is first considered, based on the question, 'who were involved in implementation roles?' Then, four key roles are identified. Finally, we explore how those roles interacted and complemented each other.

Table 1 Cross-case comparisons – Henley, Norwood, and Grange

	Henley	*Norwood*	*Grange*
Contextual	Single site Close to community Three stars One of first Foundation Trusts Friendly, efficient, progressive organization culture High level of staff retention Financial balance Reputation for innovation	Merged hospitals on three sites Remote from community Complex interorganizational political issues with adversarial management relationships First financial deficit 2003 with loss of star Reputation as leading teaching hospital Past performance poor, some unsuccessful changes	Single site Close to community Two stars, three stars, two stars Chronic finance deficit New but small-scale teaching hospital Reputation as stable and benevolent dictatorship Many successful changes since 1999
Structural	Cancer network unimportant Network focus on other cancers Cancer part of large surgical directorate – a 'poor cousin' Project manager not replaced Service improvement facilitator role vacant	Cancer network unimportant Network unusually large and complex Cancer part of large surgical directorate No clinical leads for change Managers lack senior support	Cancer network central Urology a key component of surgery and urology directorate Collaborative project officer does groundwork for changes Key trust, network, and MDT roles filled
Managerial	Stable top management Internal promotion Priorities are Foundation Trust status and working time directive General manager has operational remit Management signal that cancer services are not priority	High senior staff turnover External recruitment Priorities are regional emergency services reconfiguration, and addressing deficit Senior staff delegate attendance to juniors who feel intimidated in board meetings General manager unsupported in role with weak clinical links	New ambitious management team appointed 1999 Multiple changes of CEO External recruitment Priorities are culture change and dynamic reputation Management focused on developing participative approach Management signal that cancer services are priority

Table 1 continued

	Henley	*Norwood*	*Grange*
Clinical	Clinical director has administrative focus, not interested in change Lead cancer clinician has limited interest in service improvement Cancer services group is operations-focused Management duties seen as burdensome by urologists	Urologists resigned over merger New urology group not cohesive Urologists do not attend trust or network meetings Lead urology consultant role purely clinical Clinical director focused on operational and human resource issues, not change	Clinical director is site lead cancer clinician Lead urology consultant proactive in driving changes Lead cancer nurse active in service improvement Cancer nurse specialist active in service improvement
Processual	Lead cancer nurse develops ideas, but there are no organizational forums in which to advance these No representatives sent to cancer network board	Change seen as corporate responsibility, not role of clinical services Medical director becomes lead cancer clinician but role is restricted to chairing meetings Information and action plans requested but not produced Meetings arranged, not attended	Cancer network and multi-disciplinary teams working well CEO is first chair of cancer network board Many change agents engage with process over time Individuals encouraged to implement changes without waiting for management direction
Substance and outcomes	Slow and limited improvements in cancer services, while corporate strategic agendas progress	Change attempts abandoned Management want to complete major service reconfiguration before tackling other issues	Multiple interrelated service improvements implemented Targets met, quality of patient care significantly improved

1) The cast of characters

Those nominated in interview are listed in Table 3, which identifies 23 individuals, and (with overlap) 26 managerial, administrative, and clinical groups, patients, representatives, and other organizations. This distribution is much wider than the leadership constellations of Denis et al. (2001) or Gronn's (2002a) small groups.

Table 2 Changes to prostate cancer services at Grange

national expectations	*The cancer plan*, manual of cancer standards, improving outcomes guidance Two-week wait for urgent referrals
technology, facilities	Purchase of a second ultrasound machine New urology unit for daycase activity
roles	Appointment of a specialist urology nurse practitioner Creation of multidisciplinary teams Appointment of multidisciplinary team co-ordinators Nurse-led clinics
processes	Urgent patient referral by fax Review, mapping, and redefining patient pathways Booked appointments, protected slots for urgent referrals Direct access to diagnostics New radiography work rota to increase capacity Agreeing referral protocols with general practitioners Quarterly network reviews of referral protocols Relocation of surgical procedures to 'high volume' centres Agree standardized treatment pathways across the network
other	Patient information Patient support group

2) Key roles

Identifying significant roles among that cast was problematic. Most respondents listed those who were involved without assessing their contribution, and counting the number of 'mentions' is misleading. However, respondents who offered some assessment appeared to identify four roles that were key. This judgement is supported by the narrative of the change process (sourced from documents, management briefings, interview responses), and by the language of those assessments ('pretty pivotal', 'key catalysts', 'driving that forward', 'the most important', 'had the most influence', 'the idea came from there', 'very proactive'). This judgement was also supported by respondents at a subsequent feedback meeting. The four roles that appear to have been significant, at different stages in the change process, were:

1) prostate cancer project manager, cancer services collaborative;
2) lead cancer nurse;
3) consultant urologist and lead cancer clinician;
4) urology cancer nurse specialist.

Table 3 Involvement in change implementation

individuals (23)	
14 Managerial and administrative staff	9 Clinical staff
Chief executive (to 2002)	Director of nursing
Director of strategic change and development	Medical director
Director of operations	Lead cancer clinician
General manager, surgery and urology	Consultant urologist
Outpatient manager	Lead cancer nurse
Operations manager	Urology clinical nurse specialist
Modernization projects manager	Multidisciplinary team research nurse
Booked admissions manager	General practitioners, primary care cancer leads (two)
Prostate project manager, cancer services collaborative	
Multidisciplinary team co-ordinator	
Multidisciplinary team audit and quality assurance clerk	
Booking clerk	
Primary care trust commissioning manager	
Secretary	
groups (26)	
9 Managerial and administrative groups	7 Clinical groups
Hospital management team	The urology clinical team
General managers	Most of the clinicians
Managers	Clinical directors
Finance	The surgical team in general
Medical records	Radiology (diagnostic services)
Medical secretaries	Pathology (diagnostic services)
Clerical team	Nurses
Administrative team	
Patient services call centre	
2 Multi-professional groups	8 Organizations
Multidisciplinary team (trust)	Cancer Services Collaborative
Site-specific urology group (network)	Glenelg Cancer Network
	Network development conferences
	Cancer network strategy board
	Primary Care Unit
	Regional Cancer Review Group
	Strategic Health Authority
	Patient Forums

The *prostate cancer project manager* was a member of the Glenelg Cancer Network team, and conducted the initial urology process mapping, identifying bottlenecks. Later changes to the patient pathway stemmed from this groundwork, carried out in 1999 in conjunction with the urology team, as part of the cancer services collaborative. As the service improvement lead observed, the local process benefited, 'because the changes that make a difference have been identified in exactly the same way in so many areas, and because the collaborative meets nationally and we share, and we talk about what makes things work'. The collaborative, sponsored by the Modernisation Agency, ran dissemination workshops. As one consultant urologist remarked, 'cancer services collaborative meetings, I went to so many of them, talking with colleagues – their information was very helpful, how others are doing it'.

The *lead cancer nurse* was responsible for monitoring the application of national guidelines across all cancer services. She became network lead cancer nurse and lead cancer manager for 18 months between 2002 and 2003, before becoming the network IT lead. As the director of finance observed, 'she's been involved in driving it through all the various cancer sites', and she played a key role in establishing the network. Her role was part implementation, and part influencing others. The medical director noted, 'there is quite a way to go in terms of educating the clinical team, the consultants, about the need for a multi disciplinary team [MDT], and that wasn't easy. The clinician involved didn't see the need for it. There was a bit of work to do in convincing him to see that it can't just be a consultant-based service, and you have to involve all of the team, and accept that they have an important role'.

The *consultant urologist and lead cancer clinician* role was also pivotal, as he and his colleague could veto changes to clinical practice which they saw as inappropriate. While both were involved, one promoted change, while the other was initially sceptical. The lead clinician was described as 'very proactive', and 'of all the clinicians here, the most service-improvement driven'. As the network lead cancer clinician observed, 'You've got to think of the clinicians first, because unless they're on board, it simply doesn't happen'. And they've got to change the way they practice, which means they've got to see that there is a better way, and preferably another clinician who is doing it who says, no, it's much easier this way.' This contribution thus included 'role modelling', demonstrating benefits to colleagues.

The *urology cancer nurse specialist*, or nurse practitioner, worked closely with the clinical team, and in particular with the consultant urologist. Her role was not exclusively clinical, but included administrative and managerial components, with regard to patient booking and diagnostic test

arrangements. Comments from colleagues concerning her role included, 'she was very keen driving that forward', and 'picking that person out, has been a real driving force that has enabled us to have a focus within that team, to co-ordinate the work that's done there, and to drive the rest of the team forward in terms of standards'. The acting head of clinical information argued, 'I think it is to do with [the nurse specialist], and not just to do with the job, that has been the biggest service improvement in prostate cancer'.

The prostate cancer project manager's role was a national position, based in the cancer network. The lead cancer nurse role was a hospital position, linked to lead network roles. The consultant urologist and cancer nurse specialist were hospital positions, based in the surgical directorate. Commenting on how the locus of responsibility shifted, a general manager explained that previously, 'a lot of people felt that modernization was being done to us', while now, 'that's been disseminated over the last two or three months to the general manager. I've got to take ownership of it, making sure that it is being driven forward. So we are involved in the front line of change now'.

The context in which staff worked was affected by external demands, including performance monitoring, and regional review. It is further significant that the chief executive had signalled the priority given to cancer services, along with his personal involvement, through chairmanship of the cancer network strategy board until he left Grange in late 2002. The medical director also emphasized the influence of regional review: 'We call [the review group] the cancer police. It was like the CIA, looking at how you are delivering care. They are very critical about what's being delivered and that was quite difficult for clinicians'.

3) Partnerships, snowballs, evolutions

How did those roles interact? Respondents were asked to describe the project management structure underpinning these changes. No such structures were used. The director of human resource management explained how changes were achieved by, 'individuals being given an objective and getting on with it'. A clinical director said, 'I don't think there was any formal project management. This person just started to do some work, and then they said, we can do it this way, and the outpatient manager got involved, the cancer nurse, and that's the way it happened'. Another respondent said:

> [Our cancer nurse specialist] was never put in as a project manager. It's just that, what we've always tried to do is, have lead clinician–lead nurse partnerships. They're the ones in charge of driving the change

> within their site. That then tends to be lead nurses, who end up doing it, because they're much more doers than the operational ones. So, no, not a conventional project management structure.
>
> (Acting director, clinical information)

What is distinctive in this case is the informal, fluid, 'non-managerial' and migratory manner in which changes to prostate services were implemented. The partnership between lead clinician and nurse was important, but their contributions were complemented by the network project manager and the urology nurse specialist, and also by the contributions of many other staff, managerial, clinical, hybrid, administrative, internal and external to the hospital and network. One respondent used the term 'snowballing' to describe how others became involved. Listing the various national initiatives, the network lead clinician commented that, 'they've all produced, not a smooth improvement, but step-wise'. The deputy director of nursing said that, 'From the point of view of changing roles, there wasn't a project plan. There was a gradual evolution of what needed to happen'. While these concertive actions did not occur simultaneously, the 'snowballing' and 'gradual evolution' reflect Gronn's (2002b) concept of the circulation of initiative.

Fluid roles and relationships

Respondents were asked how their roles had changed since 1999. Of 18 respondents answering this question, around one-third (five: two managerial, two clinical, one hybrid) held similar positions from 1999 to 2004. The others had either changed roles and/or been promoted over this period, in some cases several times, and thus had difficulty in describing changes to a current role which may have been held for only a few months. In answer to this question, wider changes to roles and responsibilities were thus reported. One implication is that, for many staff, engagement with parts of the change agenda was often transient.

Roles and relationships shifted with agendas and priorities. For example, one manager expressed concern about 'keeping issues alive', maintaining links across a network organization, and signalling how issues were perceived in terms of priority and ownership. Problems arose in her view from individuals protecting their roles, concern around the relative importance of comparable roles, 'pulling strings at director level', and 'keeping hold of my patch'. The complexities, ambiguities, and fluidity of the organizational context thus generated a culture in which staff jockeyed for positions as structures and roles evolved.

Relationships between managerial and clinical roles were also explored. One indication of the nature of those relationships was revealed through responses to the question concerning tactics used to influence others to join service improvements. The 16 respondents answering this question identified 49 influence tactics, revealing that:

1) managers used a broader repertoire of influence behaviours than clinical staff;
2) clinical staff tended to rely on a narrow range of formal and public influence tactics;
3) managers combined the use of formal methods with more subtle 'back-stage' behaviours;
4) managers were more likely to tailor influence tactics to the person concerned.

One of the tactics identified by Kipnis et al. (1984), 'rational appeal' (detailed plan, presenting information, explaining reasons), was identified as a tactic by four of the nine managers, and by four of the seven clinicians. If 'attending meetings' is classed as rational appeal (involving a presentation), this represents half of all the tactics identified by clinicians, but only 10 per cent of the tactics identified by managers. While clinical staff identified formal meetings, provision of information, and rational appeal most frequently, the nine management respondents between them identified over 30 different tactics, including reconnaissance, linking agendas, personality tailoring, networking, exploiting external influence, interpreting for others, road shows, targeting teams, management by walking around, flattery, joint problem solving, volunteering assistance, using key players, delivering wins, and 'proactive lunching'. Managers described tailoring their approach to the person; no clinical staff mentioned the use of contingent tactics. One explanation for these differences in approach to influencing concerns the lack of exposure of clinical staff to management development. Kipnis et al. (1984) argue that effective influencers use a range of methods tailored to each situation. Clinical staff may be at a disadvantage, with a limited repertoire, heavily dependent on rational appeal.

The notion of concertive action implies a degree of consensus among those involved in change agency roles. However, it appears that consensus over change substance and goals was accompanied by tensions concerning priorities, responsibilities (for actions and outcomes), the need to protect personal roles, and manoeuvring for position in evolving structures. Along with the circulation of initiative (Gronn, 2002b), the 'circulation of influence' seems also to have shaped the change process.

Outcomes

From 2002 to 2004, Grange met all of the nine 'key targets' contributing to the hospital's 'star rating'. This included the target for patients to be seen in an outpatient clinic by a specialist within two weeks of urgent referral by a general practitioner for suspected cancer, and then to wait no longer than one month for treatment to begin. The hospital was also achieving the standard in outpatient and elective (inpatient and daycase) booking, with respect to the pre-booking of first outpatient appointments, and elective inpatient and daycase admissions, giving patients a choice of times within a maximum guaranteed waiting time.

The 'effectiveness' of organizational change is a socially constructed notion. The subjective interpretations of those involved are therefore significant, and those judgements, summarized in Table 4, indicate that the changes were perceived as successful. While those views could be seen as biased, respondents also identified issues that could have been handled differently, with some suggesting that results could have been achieved more quickly. Nevertheless, the changes appear to have generated quantitative and qualitative benefits. Bottlenecks remained in radiology and oncology, due to staff and equipment shortages, but those were national problems not unique to this setting. Consequently, this appears to be a relative success story.

Nobody in charge

While process theoretical accounts depict change as an untidy, iterative process, the prescriptive literature advocates detailed planning, defined roles, prior communication, formal consultation, and in healthcare efforts to engage clinical staff (Iles & Sutherland, 2001). Following such advice raises expectations that changes will be successful. But management at Grange did not follow textbook advice, and it is instructive to compare their experience with such guidelines in order to establish the extent to which those expectations were confounded. The model developed by Gustafson et al. (2003) is appropriate to this purpose, for four reasons. First, unlike most prescriptive accounts (Beer et al., 1990; Kotter, 1995; Locock, 2001), this model is normative, identifying factors which, if present, are more likely to lead to success. Second, this is an elaborate model, based on expert panel advice, literature, and testing, and incorporates 18 factors (compared with Beer's six-, Kotter's eight-, and Locock's 11-factor models). Third, the model is derived from, and is designed to inform, healthcare practice. Fourth, the advice is consistent with other generic guidelines.

Table 4 Assessing changes in prostate services

Acting head of clinical information	It's been very good. They've certainly met all of the standards. They've got recognition around [this region] for the work that they do, and to some degree they've got recognition nationally.
Consultant urologist	It has worked well. There has been a big improvement for cancer patients from where it was three or four years ago.
Service improvement lead	Overall, I would say they have been successful. That is not just the clinical team, your administration staff, ward staff, cancer collaborative, clinicians, surgery, pathology, radiology, absolutely everybody that is in that team.
Urology nurse specialist	The overall change has been immense. We used to do patient referrals, then wait four weeks for a biopsy, then three weeks for their results. Now they are getting biopsy results within a fortnight. It's a lot better for the patients, and it's better for us as we are meeting the targets.
Clinical director	I think it's a brilliant thing. One of the best things that has happened in cancer services. It has meant a sea-change in the management of cancer patients.
Clinical director	It is definitely much improved. Very streamlined. It's a real improvement, a real change.
Director of finance	I'd have to say, if I was a cancer patient, looking at how we handled cancer patients three years ago, to how well we handle them now, I'd be delighted with the improvements and the progress that's been made.

Experience at Grange is compared with this model in Table 5. Of the 18 predictors, none were wholly present, eight were absent, and 10 were present in part. This analysis nominally predicts that the success of these changes should have been partial, at best. Observing that this prediction would have been false, it is important to note that this does not necessarily refute the model, which may be appropriate in other contexts. However, this suggests that, *under certain conditions*, a model of change agency that departs significantly from this approach may also be effective. The change process in some contexts may benefit from being dispersed, fluid, migratory, and influence-based, rather than well-defined, planned, and stable in definition and location. The corollary is that change in some settings may be less effective where a small number of formally appointed change agents with defined roles follow standard procedures. What factors trigger distributed change agency, and what conditions support this phenomenon?

Table 5 Gustafson predictors and Grange experience

Gustafson predictors	*Grange experience*	*Summary*
The innovation		
Needs assessment and user involvement	National review and recommendations, government targets, local process mapping	Mixed
Change not seen as radical departure	Major departures from tradition	Absent
New process adaptable to local conditions	National guidelines, fixed targets	Absent
Simple, widely understood implementation plan	No plans	Absent
Concrete evidence of effectiveness elsewhere	No evidence base for targets; process effectiveness demonstrated widely	Mixed
The adoption decision		
Clear advantages to staff and patients	Mixed benefits; no clinical basis for targets	Mixed
Prior assessment of staff needs by change team	No change team, no needs assessment	Absent
External links		
Outside ideas tailored to fit	Experience shared with other sites	Mixed
Organizational antecedents		
Structures, leadership roles, reward systems and staffing designed to support the changes	Not done	Absent
Organizational readiness		
Staff welcome change to unacceptable situation	Reduced waits and patient information welcome; targets widely criticized	Mixed
Changes aligned with goals of leaders who are consulted frequently	Policy-driven change; no involvement of local leaders	Absent
Management provide financial support	National funding, no local earmarking	Mixed
Changes aligned with goals of middle managers who are supportive	Policy-driven change, mixed management support	Mixed
Supporters stand to gain more than opponents	Rewards and sanctions unclear	Absent
Job changes few and clear; training available	Several new roles and role relationships; national agency workshops for some staff	Mixed
Measures to obtain staff and patient feedback	Monitoring of processes and waiting times	Absent
Change agency		
Project leads endorse change and change agent	No project leads or formal change agents	Mixed
Change agent has prestige, commitment, power	No dedicated powerful change agents, but those involved are committed	Mixed

Triggers

How can the emergence of distributed change agency be explained? Caldwell (2003, 2005) attributes this to the fashion for 'empowerment'. Denis et al. (1996, 2001) argue that the leadership constellations which they observed arise in organizations (such as healthcare) characterized by shared and ambiguous leadership, divergent objectives, and diffuse power. For Gronn (2002a), distributed leadership is encouraged by information-intensity and networked computing, which generate novel forms of interdependence.

The distribution of roles in this case is perhaps better explained by the combination of three sets of triggers. The first concerns heightened political and public expectations expressed in the performance targets and standards of care that cancer services were expected to achieve. A second set of triggers prompting distributed involvement concerns the multifaceted substance of the changes required to achieve those standards and meet the performance target. While the main target was simple to articulate ('two-week wait'), complex changes to structures, roles, technologies, processes, and inter-organizational arrangements were required to meet it. This agenda displayed the proliferation observed by Van de Ven et al. (1999) in their study of innovations, but proliferation in this instance was convergent, not divergent, as components contributed in mutually reinforcing ways. It is perhaps inevitable that the implementation of those changes was not going to be the rapid result of the efforts of a small project team, but was going to draw on a range of expertise over time.

A third set of triggers concerns the network organization through which services were delivered. These structures were new, evolving, unstable, and at the time of writing undergoing further reorganization. Creating, maintaining, and developing novel inter-organizational collaborations is likely to involve more staff than changes limited to a single organization or clinical service.

Conditions

Triggered by heightened performance expectations, a complex change agenda, and evolving network structures, what conditions contributed to the sustained efficacy of distributed change agency? Beyond articulating goals and priorities, Grange management had no formal implementation plans or structures, and (as Gronn, 2002a suggests) a distributed model appears to have developed spontaneously. Why? Provisional clues may be found in the comparisons between Grange, Henley and Norwood (Table 1). The external context for these hospitals was similar, emphasizing clinical priorities, processes, and performance metrics. Comparing internal contexts, Henley

appears better placed to meet those challenges, with high performance and a history of successful innovation. Norwood had a poor record with change, and a merger generated professional tensions. Grange had fluctuating performance, a finance problem, and a history of dictatorial stability. Henley's apparent advantage, however, appears to have been insufficient to progress cancer service improvements.

Grange appears to have structural advantages. Lead roles were filled, prostate services were the responsibility of an innovative directorate for surgery and urology, and the cancer network was seen as a valuable resource. Grange suffered no shortage of change champions, and while this may be dismissed as an accident of recruitment and personality, culture change since 1999 encouraged a climate in which those committed to service improvement were 'allowed to get on with it'. Bennett et al. (2003) emphasize the management role in supporting distributed leadership by encouraging autonomy. At Henley and Norwood, the urology agenda was submerged by a larger directorate, the network was seen as unimportant, Norwood had no clinical leads for cancer, and key posts at Henley were unfilled.

Top management at Norwood and Grange was unstable. However, stability at Henley was accompanied by three other factors; senior management were a) distracted by 'whole hospital' initiatives (as at Norwood), b) leaving general managers with little incentive or support to progress other changes, and c) not signalling that cancer services were a priority. Management at Grange, despite changes of chief executive, consistently wanted to develop a participative, innovative culture, and signalled that cancer was a priority service. Only at Grange were clinical staff actively involved in trust and network roles related to service improvements for prostate cancer. At Henley, doctors holding 'burdensome' management roles concentrated on clinical and administrative responsibilities. The new team of urologists at Norwood distanced themselves from management, and the clinical director's management role covered operational and human resource issues.

Although Grange had no project management arrangements, multidisciplinary teams and the cancer network provided forums and support that were absent at Henley and Norwood. One member of staff at Henley thus had problems progressing ideas, and clinical staff at Norwood did not engage with a process which they saw as a management responsibility. Comparing outcomes, improvement at Henley and Norwood was weak, while Grange implemented multiple changes (Table 2), meeting national targets, and improving quality of care (Table 4).

One of the main theoretical implications of this analysis concerns the combination of factors contributing to the concertive action of distributed change agency in this case, including:

- consistent signalling of priorities by top management;
- autonomy for those engaged in service improvement;
- absence of distracting strategic initiatives;
- good clinical–managerial relationships;
- structural independence and visibility of target service;
- key hospital and network roles populated;
- change champions in key positions;
- external resources recognized and utilized.

This is an example of *conjunctural causation* (Goldstone, 2003), where outcomes are generated, and explained, by a combination of factors which together appear to be necessary and sufficient to support the phenomenon of interest. This combination is not necessarily unique, and it is possible that different conjunctures could produce similar outcomes in other settings. It is important to note that this configuration omits factors often identified as critical, such as a team of powerful change agents (Kotter, 1995; Locock, 2001), or stable senior management and a successful history of change (Pettigrew et al., 1992). The evidence on which these conclusions rely is clearly limited, and it will be necessary to explore the role of conjunctural causation with respect to distributed change agency in other contexts.

Beyond taxonomy: Implications for theory and practice

Although focusing on leadership elites, Denis et al. (2001: 835) observe that, 'There is a need to broaden the collective leadership perspective vertically as well as horizontally to people and processes at other levels who are crucial to stimulating and implementing substantive change'. They also note (p. 834) that 'nobody has full control' of change in the professional organization. Similarly, Cleveland (2002) argues that, with increasing complexity and freedom of information, nobody can possibly know enough to be in general charge of anything interesting or important. The implication is that anyone who wishes to assume responsibility has a chance to be involved. The concept of 'nobody in charge' perhaps puts too liberal an interpretation on events at Grange. The numerous, transient, fluid, migratory, ambiguous, and distributed contributions to the change agenda for prostate cancer services operated within local organizational and national regulatory frameworks. In the midst of this apparent disorder sat a series of clear and quantified targets and standards.

What is striking in this case is how widespread the distribution of change agency was. Also striking is the way in which different contributions were significant at different times, as responsibility 'migrated' from national, to regional network, to a local level, and how the agenda appears to have

been driven and sustained by a 'partnership pair', a 'core of four', and numerous other supporting roles. That fluid spread of roles cannot be captured by static typologies (Buchanan & Storey, 1997; Ottaway, 1983). The profile which emerges has more in common with the innovation process characteristics identified by Van de Ven et al. (1999) who note that many players engage and disengage over time in a variety of roles.

The traditional response to untidiness is to advocate structure. However, the flexibility created by ambiguity and blurred boundaries may have contributed to the effectiveness of service improvement in this context. These conclusions have implications for the skill and knowledge requirements of a distributed population of change agents. Given the complexity of the context and the pace of structural and role changes, understanding how to operate effectively in such a fluid setting may be of more value than knowledge of conventional change management methods. In settings where ambitious staff jostle to advance ideas and protect positions, influencing skills are at a premium. The evidence suggests that clinical staff, disadvantaged by a narrow behaviour repertoire and lack of diagnostic flexibility, could benefit from skills development in this area. The NHS has focused the development of leadership and change skills on senior management (Department of Health, 2002). One policy implication of this study would be to widen access to those opportunities.

Don't appoint a project manager

One benefit of distributed change agency may be organizational capability (Gronn, 2002a). While lending support to this observation, experience at Grange suggests that another advantage lies with the resilience of an approach that does not depend on one individual, or on a small project team. Recent studies of other service improvements in healthcare suggest that dependence on temporary project managers produces sustainability problems when those contracts come to an end, and those managers move on (Buchanan et al., 2007). Counter-intuitively, it may sometimes be advantageous not to appoint a dedicated change agent, to encourage ambiguous, fluid and migratory responsibilities, to have 'nobody in charge'.

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