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Demands, instabilities, manipulations, careers: The lived experience of driving change

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ABSTRACT

This article explores the lived experience of change drivers involved in a whole-hospital re-engineering programme. As these drivers were not a select management group, but included staff from all organization levels, this illustrates a 'dispersed responsibility' model of change implementation. Other research suggests that many public and private sector organizations may similarly be blurring demarcations between change 'drivers' and 'driven'. The findings from this study indicate that, despite the pressures and unpredictabilities of strategic change, there can be significant personal development, and career benefit, for those in driving roles. Human resource management issues concerning the appointment, support, career progression and retention of change drivers may thus become critical.

KEYWORDS

change agency ▪ change drivers ▪ change roles ▪ human resource management ▪ re-engineering ▪ strategic change

Implementation and agency: The knowledge gap

The implementation of strategic change is a multi-layered process. The relevant literatures focus on strategy formulation and change implementation, and on typologies of change roles. However, strategic change is also a function of corridor conversations, confrontations, 'backstage activity',

influence attempts and negotiations. While the role of 'change champions' is widely recognized, the nature of the lived experience of those who implement change has attracted limited research attention. Why is the lived experience of change drivers of interest? To the extent that drivers influence the nature and pace of change, characteristics of their experience may have theoretical value. Given the significant contribution of change drivers to the substance, process and outcomes of change, understanding the features and demands of this role may be of practical managerial significance.

The term change driver is used here to describe those responsible for the day-to-day work of change implementation. The label change agent is generic and ambiguous, often implying an external role, whereas sponsor, champion and initiator suggest senior figures without 'hands on' responsibilities. Data are based on a hospital re-engineering programme which had five attributes. First, this was an ambitious change, to create 'the hospital of the future' within two years. Second, the programme was characterized by multiple and concurrent interlocking initiatives. Third, although senior management initiated the programme, the change drivers who identified and implemented re-engineering were drawn from all organizational levels. Fourth, staff were seconded into driving roles full-time for several months, rather than being involved on a transient or part-time basis. Fifth, most seconded staff had limited previous change experience. This can be termed a 'dispersed responsibility' model of change, in contrast with approaches using small select management groups or external consultants.

This research addresses two questions, concerning lived experience and implications respectively. First, what are the characteristics, demands and pressures of the change driving role in this 'dispersed responsibility' context? Second, what are the individual, organizational and theoretical implications of these characteristics?

Change implementation is widely regarded as problematic. Pascale et al. (1997: 128), for example, argue that the change literature, 'is either too conceptual and therefore too impractical, too inspirational and therefore too vague, or too company-specific and therefore too hard to apply to one's own situation'. This literature is fragmented, but can be explored under two headings, concerning implementation, and agency.

Change implementation

The implementation literature fragments into accounts that emphasize 'best practice', and theory development. Considering best practice, most commentators develop what Collins (1998) calls 'n-step guides'. Ulrich (1998) advocates a seven-step guide to change, Kotter (1995) offers eight steps, Eccles

(1994) presents fourteen. Alongside these 'n-step guides' lie management consultancy-inspired initiatives such as total quality management (TQM), business process re-engineering (BPR) and organization development (OD), presenting familiar themes while emphasizing 'added value' variations (customer orientation, rapid improvements, conflict resolution). The roles of project leaders and change champions are recognized, but little is revealed about the demands of these roles, except in the OD literature where the change agent is typically a lone individual external to the organization.

With respect to theory, processual–contextual perspectives have been influential (Dawson, 1994, 1996; Pettigrew, 1985, 1987, 1988; Pettigrew & Whipp, 1991; Wilson, 1992), arguing that to understand organizational change, it is necessary to consider how the context, substance and process of change interact. Context includes the external environment and internal history, culture, structure and goals of the organization, and the timing and pacing of change. Substance concerns the nature, scale and significance of the change agenda. Process concerns the flow of events concerned with implementation. Viewed through this lens, change is complex, iterative and politicized. Processual accounts advocate a multi-layered perspective, which tends to marginalize the role of the change driver through a preoccupation with macro-social factors and longitudinal explanations (Buchanan & Boddy, 1992).

Change agency

The literature of change agency fragments into accounts emphasizing role taxonomies, and competencies. This commentary is further divided between external and internal change agents. The weight of commentary lies with the former (Bessant & Rush, 1995; Ginzberg & Abrahamson, 1991). The focus here lies with internal change agency (Hartley et al., 1997).

After Schön (1963), most accounts emphasize the *product champion*, a senior manager with 'considerable power and prestige'. Peters and Waterman (1983: 40) argue that change champions 'damn the bureaucracy and take it on themselves to manoeuvre their projects through the system'. Maidique (1980) identifies the roles of *technological entrepreneur* (CEO), *sponsor* (senior manager) and *executive champion* (power broker). Stjernberg and Philips (1993) argue that change relies on a small number of committed individuals called *souls-of-fire*, from the Swedish 'eldsjälar' meaning 'driven by burning enthusiasm'.

Ottaway's (1983) taxonomy identifies ten roles in three categories; *change generators* (key agents, demonstrators, patrons and defenders), *change implementers* (external and internal), and *change adopters* (early

adopters, maintainers and users). Beatty and Gordon (1991) distinguish senior management *patriarchs* who originate ideas from *evangelists* who implement them. Hammer and Champy (1993) argue that re-engineering requires a *leader* (senior executive), a *process owner* (responsible for change), a *re-engineering team* (who diagnose and redesign), a *steering committee* (senior policy makers) and a re-engineering '*czar*' (co-ordinator). Buchanan and Storey (1997) identify eight change agency roles, arguing that 'role taking and role switching' is central to change driving expertise.

These taxonomies focus on a relatively narrow range of senior managers. Exceptions are Ottaway's 'change adopters', and the 're-engineering teams' of Hammer and Champy. The focus of these accounts is categorical, offering few insights into the nature of the roles identified. The change agents who form the focus for this article are not senior managers, but equate more closely with the change champions of Peters and Waterman, with the 'souls of fire' of Stjernberg and Philips, with Ottaway's internal change implementers.

What expertise do change drivers need? Kanter (1989) identifies seven competencies: self-confidence, work without management sanction, collaborate, develop trust, respect the process and content of change, work across functions, and stake rewards on results. Howell and Higgins (1990) found that change champions use transformational leadership behaviours, exhibit higher levels of risk taking, innovativeness and influencing, and use a variety of influence tactics. Beatty and co-workers (Beatty & Gordon, 1991; Beatty & Lee, 1992) argue that the change evangelist must combine pathfinding, problem-solving, vision, determination, technical expertise and interpersonal and political skills. Buchanan and Boddy (1992) identify five categories of competence concerning goals, roles, communication, negotiation and 'managing up'. Katzenbach et al. (1997) distinguish 'good managers' who analyse, organize, monitor and control, from 'real change leaders', who create, innovate, experiment and take risks.

Change drivers thus appear to be middle and senior executives with exceptional combinations of leadership, managerial, technical, interpersonal and political skills. However, Buchanan et al. (1999) argue that change has become a less well defined and more widely dispersed responsibility. Like n-step guides, these typologies and competency listings tend to be post hoc rationalizations, aprocessual and under-theorized, offering a static portrayal that may not reflect the dynamic reality of organizations undergoing strategic change. More significant, they fail to 'get inside', to capture the lived experience of those in change driving roles. The current study seeks to address this knowledge gap.

Research methods

The Leicester Royal Infirmary National Health Service (NHS) Trust was considered an appropriate research site for several reasons. It was subject to constant external pressures, and had a history of innovation. The re-engineering programme was the first of its kind in a British hospital, many staff were seconded to driving roles, and the change agenda continued after re-engineering. This site was thus chosen for instrumental reasons, offering significant potential for learning. However, it was also of intrinsic interest as a unique pilot investigation into hospital re-engineering (Stake, 2000; Van Maanen, 1998). A multi-methods qualitative approach was considered appropriate, to access the interpretations of change drivers, and to understand the lived experience in actors' own terms. Data sources included:

- internal hospital documents providing briefing and factual information;
- two Masters theses produced by hospital staff on university programmes;
- a doctoral thesis written by the re-engineering programme leader;
- repeat briefing meetings with and feedback from a senior management 'gatekeeper';
- interviews with 20 change drivers, 9 male and 11 female;
- feedback from a manager not interviewed, but qualified to comment on the research findings through sustained involvement as a change driver, initially as a nurse.

Documentation and student theses established the timeline of events, and identified dimensions of the internal and external context. Management briefings provided another source of timeline and context information. Interview questions focused on the characteristics, demands and pressures of the change driving role. Management feedback provided checks on factual accuracy, and on the interpretation of findings.

A senior manager was briefed to identify appropriate staff for interview. Selection criteria included sustained direct involvement in the re-engineering programme from the beginning, and continued employment in the hospital. This was, therefore, a purposely biased sample. One-hour recorded interviews took place in the final quarter of 1999, resulting in transcripts (around 250,000 words total) which were returned to respondents for checking. Table 1 lists interviewees (pseudonyms), with their current posts and their role when first involved in BPR.

The interview findings rely on a template analysis of the transcripts, a

Table 1 Leicester Royal Infirmary change driver interviewees (pseudonyms)

Interviewee	*Post at interview*	*Tenure (years)*	*Post at first BPR involvement*
Anne Alperin	BPR programme manager	6	outpatient project manager
Bill Barker	senior clinician	25	senior clinician
Derek Davis	senior manager	5	senior manager
Earnest Erskine	clinical director	6	clinical director
George Green	clinical director	16	clinical director
Helen Hancock	director of nursing	19	senior nurse
Harriet Hargrove	director of nursing	5	director of nursing and quality
Hannah Hubbard	head of midwifery	27	midwife and team leader
Jack Jarrett	head of service	10	consultant surgeon
Lewis Lloyd	change leader	13	training co-ordinator
Moira Morgan	process director	13	head, medical assessment unit
Paula Petrucciani	process director	11	ward sister
Ronnie Redman	assistant director	6	HR adviser
Rebecca Roney	process director	6	business manager
Sally Sheppard	process manager	3	outpatient services manager
Steve Stenson	process manager	14	nurse
Thomas Towns	management development advisor	17	training manager
Tanya Turner	team coach	8	facilitator
Teresa Tyner	process manager	18	senior nurse
Wilma Wheeler	project leader	7	midwife
	Combined experience: 235 years (mean 11.75)		

systematic method of text interpretation operating between content analysis, and the absence of precoding required by grounded theory (Crabtree & Miller, 1992; King, 1998). Coding was first based on interview themes, and was then developed (using three judges) to identify other recurring dimensions of the lived experience of driving strategic change (Table 2). This interpretative, constructivist perspective thus seeks to understand how social and organizational reality is understood and articulated by actors in context.

This methodology has limitations. Resource constraints precluded a larger sample. This is a retrospective study and perceptions may have altered with reflection. However, comments from this sample appear to be representative of the experience of change drivers across the hospital, judging from the consistent response pattern, and from feedback from other managers. Although individual differences cannot be discounted, the dimensions of the lived experience identified in this study appear to be widely shared.

A 'sample of one' prohibits statistical generalization. Several commentators argue, however, that single cases inform theory through analytical generalization (Buchanan, 1999; Butler, 1997; Dyer & Wilkins, 1991; Mitchell, 1983; Stake, 2000; Tsoukas, 1989; Yin, 1994). Tsoukas (1989) argues that studies of patterns of events in single cases can clarify structural aspects of social configurations, associated causal or 'generative' mechanisms, and contingent factors leading to observed behaviours. Dyer and Wilkins (1991) note that single case analysis can expose new theoretical relationships and question established thinking. It is reasonable to assume that the findings presented here could inform the analysis of similar strategic changes examined from processual–contextual theoretical perspectives.

Outrageous improvements

Leicester Royal Infirmary was one of the largest acute hospitals in Britain, with:

- an annual budget of £140 million;
- 1100 inpatient beds;
- 4200 employees;
- 110,000 inpatient and daycase visits a year;
- 130,000 accident and emergency attendances a year;
- 400,000 outpatient visits a year;
- a patient catchment area with a population of over 1,000,000.

A processual–contextual account requires analysis of the external and internal contexts, and the substance and process, of change, and the interrelationships between these factors.

External context

The NHS, with an annual budget of over £50 billion, and one million employees, is one of the largest employers in Europe. It has endured half a century of political intervention, coupled with intense media scrutiny. Change in the 1990s was triggered by The Griffiths Report (Department of Health and Social Security [DHSS], 1983) which argued that the service should be managed as a business. Healthcare units were invited to apply for 'Trust' status, giving managers a degree of local autonomy.

Media coverage of the NHS focuses on crises and tragedies. Political debate focuses on cost-effectiveness and funding. The (Conservative)

government of the 1990s encouraged consumerism, inviting patients to complain when service levels (e.g. waiting times in outpatient clinics) were not met. Since 1997, a new (Labour) government has launched several initiatives, such as reducing waiting lists for elective surgery. In 2000, a modernization initiative was announced, involving a ten-year programme of radical changes in working practice supported by significantly increased resources.

The external context thus generates a range of pressures and expectations, which shape perceptions and attitudes, and encourage significant change, within service provider units.

Internal context

Conditions in the internal context, coupled with external factors, encouraged a radical approach to change. The conditions for 'punctuated' change (Tushman et al., 1986) appeared in 1994 to be favourable; strong external pressures, a history of medical engagement with management, dissatisfaction with the status quo, high management aspirations, successful experience with process innovation, enthusiastic change champions and a subsequent injection of funding.

Leicester Royal Infirmary was one of the first hospitals in Britain (1986) to adopt the clinical directorate structure developed in Baltimore, at the Johns Hopkins Hospital, and subsequently at Guy's Hospital in London (Buchanan & Wilson, 1997). Clinical and support services in this model are run by senior doctors (clinical directors, who sit alongside the chief executive on the hospital management board), supported by business and nurse managers. Leicester Royal Infirmary thus had an established tradition of medical involvement in hospital management. A new chief executive (CEO) was appointed in 1991. Leicester Royal Infirmary became an NHS Trust in 1993.

Leicester Royal Infirmary had a history of under-funding. In the early 1990s, many new staff were recruited, and were critical of the facilities. A senior member of the medical staff said, 'When I came to Leicester, there were a lot of people coming in, medical staff, nursing staff, support staff, all of whom were saying, what we have here is not acceptable. This isn't modern healthcare. We want to change it. We want to improve it.' The chairman of the health authority, and the new CEO, and hospital staff thus supported the need for change. Their aspirations were high.

In 1992, the chairman of the local health authority (Trent) challenged hospitals to undertake initiatives resulting in 'outrageous improvements'. Leicester Royal Infirmary launched five projects. Three failed, but two were 'spectacularly successful' (Bevan, 1997), an assessment based on the following evidence. Time to diagnosis for non-urgent neurology patients was cut from twelve weeks to five hours. Turnaround for patients requiring

hearing aids was cut from one year to six weeks. Could similar improvements be achieved in other hospital services?

Substance

Re-engineering was to lead to the development of 'the hospital of the future'. To co-ordinate the pilot projects, the CEO had recruited a manager whose analysis showed that the projects which had failed had 'tinkered', while the successful initiatives had taken a holistic approach; benefits had apparently been gained by process re-engineering (Davenport, 1993; Hammer & Champy, 1993). Late in 1993, Leicester Royal Infirmary submitted a bid to the NHS Executive to fund whole-hospital re-engineering. The new recruit became re-engineering programme leader in November. Leicester Royal Infirmary was given £4.5 million to support the initiative over two years. About £2 million was spent on management consultants, and a similar amount covered secondments, and a central re-engineering team to co-ordinate the programme. The rest was spent on redundancy and early retirement, affecting 24 staff, and on office costs, training and travel (Bowns & McNulty, 1999). Over 1000 employees were engaged in process redesign work, hundreds more moved into new roles (Leicester Royal Infirmary [LRI], 1997) and the jobs of most staff were affected.

The initial aim was to identify generic processes, such as patient visit, test and stay, whose redesign could be applied across the hospital. However, the variety of patient pathways and professional groupings encouraged instead the development of an approach based on patient flows through clinical specialties. The main organizational changes involved the appointment of process managers, heading multidisciplinary teams responsible for patient flow from admission to discharge, rather than previous narrow functional tasks. Administrative tasks were also redesigned. Previously fragmented clerical activities were combined into single roles, creating more varied jobs while reducing the number of 'hand-offs' between different departments, saving staff time spent document handling, and reducing clerical errors.

The external and internal contextual conditions thus apparently stimulated radical rethinking, and the transformation of organization structures and work design through re-engineering.

Process

The programme ran through two broad phases, from August 1994 to May 1996. First, three re-engineering laboratories were formed to redesign the hospital's generic processes (visit, test and stay). Around six people were

seconded to each laboratory, full-time, for six to nine months, along with the programme leader and an external management consultant. Seconded staff included therapists, doctors, porters, nurses and clerks, as well as managers. With the exception of the managers, few staff had previous experience of change implementation, but were recruited for their knowledge of the processes to be redesigned. The number of laboratories was increased to four in February 1995 and by that summer there were 100 projects running. The programme was controlled by the Trust board which had reporting to it a re-engineering steering group chaired by the Trust chairman. In February 1995, a re-engineering management group was formed, chaired by the CEO, including managers, clinicians and team leaders, reporting to the steering group. Also in 1995, a re-engineering team leaders review group was established, chaired by the programme leader, involving team leaders, directors and the CEO. This structure appears cumbersome, but had to monitor and control multiple initiatives over a two-year period.

For the second phase, from September 1995, responsibility was transferred to clinical directorates. The laboratories were disbanded, with some members leaving the hospital, some returning to former jobs, and some appointed to the new process management roles. The smaller central team became the 'Centre for Best Practice' responsible for capturing and disseminating the findings of the programme. Around 140 re-engineering projects were undertaken between 1994 and 1996. These were not the only changes during this period. Bevan (1997) identified 68 other parallel initiatives linked to re-engineering.

Process, substance and context

This analysis implies a linear causal chain, leading from attributes of the external context, through the internal context, to the change substance, to implementation. Processual–contextual theory (Dawson, 1994, 1996; Pettigrew, 1985, 1987, 1988; Pettigrew & Whipp, 1991; Wilson, 1992) emphasizes *interactions* between these factors. Attributes of the internal context generated external pressures; for example, perceived underperformance led the regional chairman to launch the 'outrageous improvements' project, and local incidents adversely involving patients generated media calls for change. Key players were concerned to find factors in the internal and external context to legitimate the substance of the changes they wished to implement. With experience, the implementation process redefined the substance of the changes. Implied linearity is thus a consequence of a sequential presentation mode which does not adequately reflect the complexity of the relationships between these factors.

The lived experience

Characteristics of the change driving role were derived through template analysis, a method of qualitative data reduction, resulting in a categorization or coding scheme, based on recurring themes. These themes represent features of the lived experience regarded as significant by respondents. In contrast to taxonomic approaches, they do not represent discrete and static change roles. As with similar inductive methods, category labels expressing the meaning of each theme, and consequently structuring data presentation, must be selected. The choice of category labels is informed by a combination of theoretical concerns and the language of informants. Table 2 identifies the category labels and the language associated with each theme. The following discussion summarizes each theme, incorporating interview quotes, thus inviting assessment of the appropriateness of category labels.

Flexible drivers

Two respondents, Anne Alperin and Derek Davis, had previous change experience. For the others, this was a new role. Most were unsure about what would be involved. For many respondents, even those who knew what to expect, their contributions changed often and unpredictably as the programme unfolded. One typical comment was:

> [Anne Alperin] [My role] changed, and it kept evolving. I think one of the key aspects was to keep evolving with it. So you could define the responsibilities at any point in time, but if you were going to look at the responsibilities in November 1993, and look at the role three years later, it was a completely different role. There were aspects of it that were consistent, but I'd say it was about 20 percent consistent and 80 percent evolving.

The category label 'flexible drivers' was thus considered appropriate. One reason why change driving roles are not well defined or widely understood may concern their dynamic, shifting, contingent nature. Demands appear to be shaped by the formal position of the change driver, the substance of the proposed changes, the perceptions of those involved and affected, and the development stage of particular initiatives. However, a more significant reason concerns the interpersonal and micro-political tensions inherent in the role. These are most clearly exposed in considering the question, 'an agent for what, or for whom?'. Respondents were variously acting as agents for themselves, for their occupational group, for a senior manager, for a

Table 2 Characteristics of the lived experience

Theme label	*Description*	*Language*
Flexible drivers	The fluid, evolving nature of the change driving role and the need for constant flexibility	'it changed and it kept evolving'; 'a completely different role'; 'I became communicator, persuader, politician'; 'role change over time'; 'I had several roles – supportive, encouraging, aiding, abetting, bullying'
Determined contributors	Range of strong personal and organizational motives for involvement in change implementation	'I was desperate for change'; 'I was a visionary, a shaper'; 'I've always had a passion'; 'put my agenda forward'; 'wanted to make sure I knew what was going on'; 'something I wanted to do'; 'I just fell in love with it'; 'I wanted to have some control'; 'really a high'
Pain absorbers (1)	Exposure to challenge, pressure, stress and 'pain'	'much more painful than anticipated'; 'misery'; 'stressed out and wanted to cry'; 'the stress of the work, the breadth of the job'
Pain absorbers (2)	Dealing with the pain of others	'many people are scarred'; 'casualties'; 'a lot of hurt and bruised people'
Political manipulators	Influencing and negotiating with more senior staff and staff in other occupational groupings	'finding your way around the politics'; 'playing the game'; 'manipulation'; 'credibility'; 'resisters and blockers'; 'ulterior motives'; 'vested interests'; 'key stakeholders'; 'getting people on board'; 'backstage roles'
Career enhancers	Significant personal knowledge and skills development leading to novel career opportunities	'lots of people got wonderful posts'; 'opened things out, people moved on'; 'I learned an awful lot'; 'huge learning curve'; 'I am a lot more confident'; 'learned more than most people in their careers'; 'it opened up lots of doors'; 'I developed loads of new skills'; 'much wider exposure to what went on in the Trust'; 'gave me a whole new view of life'; 'unique experience'; done things that nobody else has'; 'you can't get what I've got very easily'

committee or project team, for external agents (politicians, health authority), for 'the corporate good'. Caught in this contradictory web of corporate and political agendas, they were agents ('double agents') for a plurality of interests. Static taxonomies fail to capture the fluctuating demands of change driving roles.

Determined contributors

Most respondents indicated strong desires to make an impact, to influence the change agenda. One typical comment was:

> [Derek Davis] I came up to meet [the CEO] who was talking about a *very innovative* approach to the management of change. When [he] first talked to me about the job, what was very clear was that there was an *exciting prospect* to be *centrally involved* in a change management programme that was going to be *very high profile*, and if successful would demonstrate *dramatic improvements* in the delivery of healthcare that would be transferable to other hospitals and I saw that as presenting an *enormous challenge* to the human resource function such that I was *desperately keen* to be offered the job. My ego was such that I wanted to be involved in what I was sure was going to be a *big success*. It was nice to have that approach, but I think in truth that I *desperately wanted* it. There were too many *challenging*, *exciting* and *important* issues for me to simply stand at the side (emphasis added).

Three respondents had been reluctant to become involved (Jarrett, Petrucciani and Sheppard). Sally Sheppard (manager) commented: 'I was not very happy at all to go into it, I think because I am not a blue skies type of person, and some of the ideas coming out of re-engineering to me were a load of rubbish. So it was a very, very difficult time for me.' By the time of interview, however, she was positive about the benefits achieved. Jack Jarrett (doctor) also claimed that he had, 'become a cautious convert to the idea that we need to continue innovation in service delivery. It can deliver real benefits, and I've seen that'.

Some respondents were enthusiastic. Lewis Lloyd claimed that the re-engineering laboratory teams, 'had some great parties and social events'. Bill Barker said that, 'I have never taken drugs in my life, ever. But I imagine, my experience in the last five years is what junkies get when they give themselves heroin or something like that. It is really a high.' For most, however, this was a traumatic experience, as the comments on 'pain absorption' reveal.

Pain absorbers

As other commentators have noted (Hutton, 1994; Katzenbach et al., 1997) respondents reported exposure to stress. Stressors (predictably) included:

- uncertainty about the role;
- heavy workload and long hours;
- continuing to function normally while implementing change;
- lack of organizational support;
- pressure to deliver results;
- handling colleagues whose jobs were being changed or made redundant;
- permanently damaged relationships with some colleagues.

This theme has two sub-dimensions concerning personal stress, and dealing with the stress of colleagues. These issues were reported without bitterness or regret, as taken-for-granted aspects of a challenging and rewarding role. One typical comment was:

> [Teresa Tyner] There were a lot of colleagues who were severely damaged, and who left as a result of that. Yes, I think everybody has to have been affected, and yes it did affect me. Every manager has to make unpopular decisions and perhaps take through things that you know are not popular. That's what happens when you move into this type of job.

The label 'pain absorbers' reflects the language of respondents, which included sentiments such as, 'I've learned that it is all very much more painful than it seemed when we started out'; 'One of the most negative things was the pain that we all felt when we had to reorganize members of staff'; 'We had a lot of casualties, a lot of very hurt and very bruised people'.

Political manipulators

All respondents emphasized the political dimension of the change driving role. Most used the term 'manipulation' to describe their approach to influencing colleagues. A lot of work in establishing support and agreement was carried out 'backstage'. Also important were issues concerning personal credibility, physical appearance and language.

Many 're-engineers' were relatively junior staff, and some were (female) nurses. They found themselves working with other clinical professions with whom they had limited credibility. They also found themselves dealing with more senior and powerful (male) doctors who felt that their professional

autonomy was being challenged. Suggesting ways in which doctors could improve service quality was interpreted by some as criticizing their practice. Doctors could block change simply by refusing to co-operate. As Sally Sheppard commented, 'I think it takes a very brave person to question consultants and their practice. Re-engineering gave us a license to question things and they had to answer'. Change drivers were thus 'empowered', but without guarantees of compliant responses. One typical comment was:

> [Wilma Wheeler] I don't like to use the word manipulate, but you know, you do need to manipulate people. And I think I have strengthened those skills, which might be a bad thing. It is about playing the game. I remember being accosted by a very cross consultant who had heard something about one of the changes and he really wasn't very happy with it. And it was about, OK, how am I going to deal with this now. And it is about being able to think quickly. So I put it over to him in a way that he then accepted, and he was quite happy with. And it wasn't a lie and it wasn't totally the truth. But he was happy with it and it has gone on.

The category label 'political manipulators' again reflects respondents' language. Space constraints preclude a wider consideration of perspectives on organization politics (Buchanan & Badham, 1999; Mintzberg, 1983; Pfeffer, 1992). Political tactics included building credibility, working incrementally with one individual at a time, careful use of language and information, using fact-based and indirect influencing tactics, and developing novel benchmarks against which current practices could be assessed. Also critical were the visible and 'backstage' roles played by senior staff, including the CEO, medical director, Trust chairman and re-engineering programme leader.

Career enhancers

Respondents reported considerable personal development, in change management, interpersonal, influencing, negotiating and political skills, and increased self-confidence. Of nine men interviewed, six were in the same or similar jobs by 1999. Of eleven women, only one was in the same job, two had more senior national and regional change roles, and eight had been promoted. There are several possible explanations for this gender contrast. Some men in this sample already held senior positions in 1994. This group of women assumed change driving roles while in relatively junior positions, most experienced difficulty returning to their occupational bases, and sought

alternative career paths. The hospital workforce is over 80 percent female, thus providing more female than male candidates for vacancies that arise. Women may be more effective in roles requiring interpersonal skill, diplomacy and political sensitivity. Typical comments included:

> [Moira Morgan] It has helped my career because of the development I went through in that year. My learning curve was huge. You were suddenly doing lots of presentations. I mean, you don't do that as a ward sister. I did external presentations, which a year before you would not have got me anywhere near. I was a ward sister when I went into it and I am Process Director now. I did not intend ever to be a Process Director. So I learned a lot of skills and I developed confidence.

> [Thomas Towns] In terms of career development, it has helped me to be exposed to areas of knowledge and management that I would never have come across in any other job.

These reported career implications explain the category label used for this theme.

Conclusions and implications

What are the characteristics, demands and pressures of the change driving role in a 'dispersed responsibility' context? The lived experience appears to have four features, concerning the demands and instabilities of the role, political 'manipulation', and personal development.

Demands

Change drivers face multiple demands and pressures; adapting to the constantly shifting nature of the role, coping with stress, dealing with stressed colleagues, using influencing tactics, negotiation skills and political manipulation with more senior figures and colleagues in unfamiliar disciplines. This role seems to appeal in particular to those who are (and who become) strongly committed to radical organizational change, and who respond positively to these challenges. The stressful nature of change agency has been well documented (Hutton, 1994; Kanter, 1989; Katzenbach et al., 1997). The concepts of 'souls of fire' (Stjernberg & Philips, 1993) and 'evangelists' (Beatty & Gordon, 1991), appear particularly apt in relation to the 'determined contributors' theme. However, many of the change drivers in this case

were nurses, midwives, trainers, team leaders, doctors, clerks and representatives of other clinical occupations, not the relatively narrow groups of middle and senior managers on whom most research into change agency has traditionally been based.

Instabilities

Change driving roles were fluid and unstable, making contingent demands based on changing circumstances, requiring sensitivity to events and shifts in emphasis. This fluidity appears to have taken most incumbents by surprise. Even Anne Alperin, with previous change experience, spoke at length about the need for flexibility in the role. These were not the relatively static and well-defined positions of 'champions' (Peters & Waterman, 1983), or 'implementers' (Ottaway, 1983), or 're-engineering teams' (Hammer & Champy, 1993). The unpredictable nature of the role requirements placed demands on change drivers, in terms of flexibility and adaptability, but also added to the developmental nature of the experience.

Manipulations

Driving strategic change requires political sensitivity, and the ability and will to persuade and 'manipulate' colleagues, observations which appear to support the findings of Howell and Higgins (1990) and Beatty and coworkers (Beatty & Gordon, 1991; Beatty & Lee, 1992) concerning the significance of influence and political skills. For some commentators, politics is a 'taken for granted' dimension of organizational reality (Frost & Egri, 1991; Kumar & Thibodeaux, 1990; Pettigrew, 1985). Others argue that political behaviour should be avoided (Ferris & King, 1991; Hutton, 1994; Ward, 1994), particularly in the context of organization development which puts a premium on conflict resolution and consensus (French & Bell, 1995). From the evidence presented here, advice to avoid 'playing politics' could threaten ability to implement strategic change.

Influence attempts in healthcare are rendered problematic by power and status inequalities, and by gender differences. Some influencers were (junior female) nurses, attempting to persuade (senior male) doctors that they should improve their working practices. Such approaches can imply that current practices are deficient, and can be seen by medical staff as criticism if not presented diplomatically. Change drivers also may have limited credibility in the perception of members of other clinical occupations, each of which has its own sphere of expertise and autonomy, allied with a sense of professional status. In such contexts, influence attempts based on rational

appeal may have limited impact, and political manipulation may become appropriate.

Personal and career development

Driving change in this context appears to have significantly enhanced personal skills and career prospects. Staff were seconded from relatively specialized roles and exposed to strategic change methodologies, to training and development from external management consultants, to hospital process-wide analysis and problem-solving, to corporate strategic issues, to multidisciplinary teamwork, and to high level organization politics. Medical, nursing, administrative, and many hospital managerial staff are rarely exposed to such a pattern of issues in such a systematic and intense manner.

The new skills and knowledge profile propelled many, particularly women, into new career trajectories. Although perhaps obvious with hindsight, these were unanticipated consequences of the re-engineering programme, both for hospital managers and for change drivers. Human resource management policies to deal with these outcomes were not in place.

Abrahamson (2000) argues for 'painless change', a combination of less radical and more carefully paced initiatives, to avoid the frustration and 'burnout' that typically accompany radical strategic transformations. Change at this site was not painless. This 'dispersed responsibility' model has disadvantages. Some change drivers felt that, moved into a role for which they were unprepared, under pressure to achieve rapid results, their inadequacies were exposed. Many lost friends in their clinical occupational bases, experienced a loss of profession and belonging, and had problems with 're-entry' to the roles they had left behind. An additional problem concerns the uneven nature of the opportunity pattern; subsequent research exposed the complaint that nurses had been favoured with re-engineering positions and promotions at the expense of administrative staff (Parker, 2000).

Survey research on a sample of around 100 middle and senior managers, male and female, in public and private sector organizations in Britain, suggests that this hospital may not be idiosyncratic in its approach (Buchanan et al., 1999; Doyle et al., 2000). Almost 80 percent of managers in those studies disagreed that change should be carried out by 'full-time professionals'. Only 30 percent indicated that their organizations appointed specialist change agents. Over 50 percent agreed that all levels of staff are involved in change implementation, whereas only 10 percent agreed that 'the role of the change agent is well defined and widely understood'. This suggests that driving change has perhaps become a more fluid and ambiguous role, and that a 'dispersed responsibility' model, although not pervasive, may not be unique.

These findings have at least two theoretical implications. First, static change role taxonomies do not appear to reflect accurately the fluidity of strategic change driving roles. Although some change 'championing' roles, such as 'initiator' and 'sponsor' may remain relatively stable, change driving roles, involved with implementation, appear to be more fluid. Categorical approaches to change agency may thus be of limited value as descriptive or explanatory devices. Second, processual–contextual perspectives perhaps need to be more sensitive to the potential influence of change drivers on the substance and process of change, and also to the reciprocal implications for the development of those in driving roles. Although change driving roles have not been ignored in processual accounts, the nature of these roles has not been a significant focus of investigation, and the impact of drivers on strategic change has been subordinated to concerns with the interaction over time of context, process, substance and politics (Dawson, 1994, 1996; Pettigrew, 1985, 1987).

There are several implications for human resource management. First, improved understanding of the lived experience of change driving roles directs attention to selection criteria concerning aspirations, resilience and adaptability, in addition to skill and knowledge. Second, the fluid scope of the driving role indicates a need for systematic training, development and support. Third, the training and development need perhaps extends to influencing, negotiation and political skills. Fourth, personal development implications indicate a need for career planning for those in driving roles. Evidence suggests that many organizations do not provide training, development, support, recognition and career planning for change drivers (Buchanan et al., 1999). Finally, dispersed responsibility could jeopardize the coherence of organization-wide change, a threat addressed at Leicester Royal Infirmary through an architecture of control involving the main board, a steering group, a management board and a team leaders review group. Organizations neglecting these issues may be unable to maintain a coherent strategic change programme, or to retain the driving capabilities which they have developed. These appear to be some of the consequences of opening 'driving' roles to staff who traditionally might expect to be 'driven'.

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