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Healthcare Leadership with Political Astuteness (HELPA): a qualitative study of how service leaders understand and mediate the informal 'power and politics' of major health system change: developing lessons on the acquisition, use and contribution of 'political astuteness' [NIHR HS&DR 16/52/04]

Principles Investigator:

Professor Justin Waring
Centre for Health Innovation, Leadership & Learning,
Nottingham University Business School,
Jubilee Campus, Nottingham, NG8 1BB, UK

Co-investigators:

Dr Simon Bishop, University of Nottingham

Dr Jenelle Clark, University of Nottingham

Professor Mark Exworthy, University of Birmingham

Professor Naomi Fulop, University College London

Professor Jean Hartley, Open University

Dr Angus Ramsay, University College London

Mrs Clare Ramshaw, University of Nottingham

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1. Abstract

Background: The implementation of strategic health system change is often complicated by localised contextual factors, which strategic leaders and change agents need to both understand and address if change is to be realised. Of these contextual factors, there is widespread recognition that the informal 'politics and power' of health organisations and systems can complicate change, such as competing interests and resistant groups. Although the informal small 'p' politics of healthcare services is sometimes interpreted in negative terms, there is increased evidence from other industries that 'political skill' or 'astuteness' can be exercised for constructive organisational and societal outcomes. The purpose of this study is to investigate the acquisition, use and contribution of 'political astuteness' **(PA)** by service leaders and other change agents in the implementation of strategic health system change with the aim of informing the co-production of materials and resources for the recruitment, training and development of existing and future leaders.

Methods: The qualitative study comprises four linked work packages (WPs). WP1 will involve completing two systematic narrative reviews on the 'state of the art' on political astuteness, and the existing health services research literature to identify exemplars of political astuteness. WP2 will involve semi-structured biographical narrative interviews with regional and national services leaders, and recent recipients of leadership training to understand their acquisition and use of political astuteness. WP3 will involve in-depth ethnographic research looking at the utilisation and contribution of political astuteness in three strategic system change programme. WP4 will involve a series of co-production activities and workshops to inform the development and testing of new learning resources and materials for future NHS leaders.

Discussion and Deliverables: This innovative research will produce ground breaking evidence about the relatively unspoken contribution that leaders' political astuteness makes in the implementation of strategic health system change. It intends to offer new understanding of these skills and capabilities that takes greater account of the wider social, cultural organisational landscape, and offers tangible lessons and case examples for service leaders. The study will inform future learning materials and processes, and create spaces for future leaders to reflect upon their political astuteness in a constructive and development way.

2. Background

The 'challenge' of implementing major health system change

The implementation of strategic change in healthcare services is notoriously difficult. Research on the introduction of service-wide changes in commissioning (Exworthy and Mannion 2016), the reconfiguration of regional acute services (Fulop et al. 2016), the diffusion of organisational innovations (Dopson et al. 2013), and the implementation of

evidence-based interventions (Cooksey, 2006; Greenhalgh et al. 2004), repeatedly shows that:

a) change processes are often protracted and can be wasteful of time, human capability and scarce financial resources;
b) delays in the implementation of change can sustain sub-optimal care; and
c) change processes often lead to variable, dysfunctional and unintended outcomes.

These issues are particularly significant in the implementation of large-scale or major health system change (Turner et al. 2016a; Turner et al. 2016b). Major system change aims to produce coordinated change involving multiple inter-connected care commissioners, providers and other stakeholders to realise improvement at the inter-organisational or system level (Best et al. 2012). Over the last decade, efforts to transform the organisation and delivery of care have increasingly involved major system change, often in the form of new regional specialist centres, networked services and new service models (Exworthy et al. 2009; Fulop et al 2016; Morris et al 2014; Waring et al 2017). In the English National Health Service (NHS) more major system change is described in the *Five Year Forward View* including the introduction of New Care Models (Vanguards) and the regional Sustainability and Transformation Plans (STPs) (NHS England, 2014)

The health services research literature shows that a number of prominent 'contextual' factors shape the implementation of strategic health system change (Bates 2014; Damschroder et al. 2009; Greenhalgh et al. 2004; Fulop and Roberts 2015; Kiston et al. 2008; Turner, et al. 2016). These contextual factors relate, for example, to financial and human resources, incentives, cultures, regulatory pressures, leadership styles, communication patterns, public opposition, and professional attitudes. In their influential study, Pettigrew et al. (1991) describe how the implementation of strategic change is influenced by the extent to which there is a 'receptive context' for change, including the coherence of policy, environment pressures, organisational culture, clarity of goals, managerial-professional relations and key people leading change. Significantly, research also shows that service leaders, change agents and other 'key people' often play a pivotal role in creating this 'receptive context', which entails recognising and mediating these various contextual factors (Best et al. 2012; Fulop et al. 2016; Pettigrew et al. 1991; Robert and Fulop 2014; Turner et al. 2016). The role of leaders in understanding and creating the necessary receptive context for change is the overarching focus of the proposed study.

<u>The impact of 'politics and power'</u>

Research repeatedly shows that the 'politics and power' of health services significantly shapes change processes (e.g. Best et al. 2012; Turner et al. 2016). One of the most well-documented examples is associated with the power of healthcare professionals to challenge reforms perceived as changing their established ways of working (Addicott et al. 2007; Ferlie et al. 2005; Waring and Currie 2009). Such 'professional power' reflects the institutionalised authority of healthcare professions and the local strategies of professionals that complicate change (Waring and Currie, 2009).

With regards to the concept of organisational 'politics', the literature indicates varied interpretations and perspectives (Aberbach and Rockman 1988; Stoker 2006). In general, there is a distinction between formal (big 'P') politics and informal (small 'p') politics. The

former is associated with the formal institutions of government, elected politicians, policy directives, statutory obligations, and regulatory pressures (Best, et al. 2012; Greenhalgh et al. 2004). The latter is associated with the more subtle and often hidden forms of influence that shape the everyday organisation of services, such as the competing interests of stakeholders, the influence of powerful coalitions and the resistance of professionals (Buchanan and Badham 2009). The informal 'politics' of healthcare services are experienced all too frequently by those who work within the NHS, but are often regarded by practitioners as an irrational complication, rather than an integral and sometimes constructive feature of service organisation (Buchanan et al. 2013). This proposed research is concerned with the informal (small 'p') politics of implementing strategic health system change, and how this is manifest and managed in different health and social care 'arenas'. It is recognised that the formal and informal aspects of politics often interact, and local agendas are often rooted in formal statutory or sectoral differences, for example between health and social care (Hartley et al. 2014). We will consider this interaction, where relevant, but the primary focus is the influence of the informal politics of healthcare reform.

Research within the fields of organisational sociology and strategic management has long recognised the significance of informal politics in the implementation of organisational change (Buchanan and Badham 1999; Hardy 1996; Mintzberg 1985; Pettigrew 1973; Pettigrew et al. 1991; Pfeffer 1981). The management scholar Jeffrey Pfeffer (1981) suggested that all organisations are inherently 'political' with competing interests, workplace alliances, and power blocs that exert influence on the way work happens, often beyond formal authority structures. His work speaks to the problems of implementing change in healthcare services, particularly as he argues that the emphasis on top-level leadership and due process fails to recognise how change actually happens:

> "By pretending that power and influence don't exist, or at least shouldn't exist, we contribute to…the almost trained and produced incapacity of anyone except the highest-level managers to take action and get things done." (Pfeffer 1994: 10)

Although organisational politics is often seen as inhibiting change or as self-serving (Machiavellian) behaviour, a growing body of research shows it can have a constructive influence on change processes (Hardy 1996; Hartley et al. 2014). For example, the different interests of stakeholders need not result in destructive conflict, but can be a source of innovation, if effectively managed. For Pfeffer (1994), coping with organisational politics requires developing and utilising political influence or skill to affect change, which often extends beyond formal authority. He describes this as the ability to 'control resources', such as expertise or incentives, to 'formulate political strategies' by setting agendas, co-opting experts, fostering goodwill and building alliances; and 'crafting political language' to frame situations and shape meanings. In this sense, political behaviour, far from being inappropriate, is necessary for implementing change (Buchanan and Badham 2009). Significantly, this highlights the importance of 'political skills' to mediate competing interests and managing local politics, and also the recognition that those who resist planned changes might, themselves, be effective in utilising particular forms of political skill.

<u>The contribution of 'political astuteness'</u>

In recent years, researchers have developed the concept of 'political skill' to better understand how organisational politics is managed in the implementation of strategic

change (e.g. Ferris et al. 2005, 2007). The concept of 'political skill' highlights the types of skills, judgments and capabilities needed by leaders to affect change in their local political environment:

> "The ability to effectively understand others at work, and use such knowledge to influence others to act in ways that enhances one's personal and/or organizational objectives." (Ferris et al. 2005)

Drawing on Hartley's review of the literature and evidence-based framework (Hartley et al. 2013, 2014), political skill is operationalised along the following lines:

- **Personal skills**: to exercise self-awareness and self-control;
- **Interpersonal skills**: to influence the thinking and behaviours of others, even in the absence of formal authority;
- **Reading people and situations**: to think about the dynamics that can occur when stakeholders come together, and recognising wider social systems and processes;
- **Building alignment and alliances**: promoting collaboration or alignment where there are different interest and motives;
- **Strategy direction and scanning**: having a sense of the organisation's purpose and thinking about the long-term factors that may impact the organisation.

Such political skills are often recognisable in political leaders or diplomats, but they are arguably integral to all forms of organisational and policy change. In a recent survey of UK public servants, including NHS senior and middle managers, Hartley et al. (2014) found evidence supporting the existence of key political skills amongst practising managers, including the ability to shape priorities, influence decision-makers, build partnerships, manage risks, and compete for resources.

A portfolio of NIHR research on the contribution of managers, and hybrid clinical-leaders, in the implementation of service innovations further shows the importance of managers' intuition in use of different forms of knowledge, their ability to understand local contexts, to balance priorities, shape local values, and mediate conflict (Bresnan et al. 2009; Buchanan et al. 2013; Edwards et al. 2013; Hales et al. 2013; Hartley et al. 2008; Storey and Holti 2013). Recent research on the reconfiguration of stroke service further shows how local political factors, from public pressures to competing interests, significantly influenced service change, and also the important role of senior leaders to manage and mediate these pressures (Turner et al. 2016a). Research also shows how the political skills of certain stakeholders can be less constructive through complicating or corrupting change processes (Waring and Currie, 2009). Although these studies allude to the idea of political skill or similar leadership attributes, few have systematically examined the concept or made explicit reference to or advance the importance of this concept.

Through our preliminary review of the literature, we suggest that the concept of 'political skill' is often used to describe, rather narrowly, individual abilities and competencies, linking these to technical proficiencies, psychological attributes or personality traits (Judge et al. 2009). However, studies that associate personality traits with leadership performance are often limited in their capacity to separate 'individual cause' from 'organisational effect', and over-emphasise individual competencies to the neglect of wider social and cultural contextual factors, including the importance of social acceptability and other status markers

(Buchanan 2008). This can also neglect the more subtle forms of acumen, judgement and wisdom that help leaders recognise and respond to organisational politics (Hartley et al. 2014), and has limited value for training and development of future leaders.

With the aim of developing a more socialised theoretical understanding, the proposed research adopts the concept of 'political astuteness' to both differentiate it from the more narrow 'political skill' and to reflect the idea that leaders' acquisition and use of such skills, judgements and capabilities is influenced by wider social and cultural factors (Hartley et al. 2014). In particular, the proposed study plans to extend existing theory by locating political astuteness within wider theories of social practice, interaction ritual and negotiated order (Bourdieu 1973; Collins, 2004; Strauss et al, 1963), to understand, for example, how the relative position of leaders within a field of practice, including their social and reputational capital, influences their negotiations with stakeholders. The study will also seek to re-conceptualise political astuteness in relations to Fligstein and McAdam's (2012) work on 'strategic action fields' and 'social skill'.

The proposed study also recognises that service leaders' development and use of political astuteness can be highly context specific. We suggest political astuteness is likely to vary in form, style and contribution within different 'arenas'. Drawing on Hartley and Bennington's (2011) analysis of political leadership, we use the concept of 'arena' to refer to the distinct domains where people, ideas, problems and resources come together, including physical or geographic 'places', as well as more dispersed and dynamic social 'processes'. These represent distinct political arenas, and require different types of political astuteness. For this proposed study, a distinction is made between:

- 'strategic' arenas of higher-level policy formulation, priority setting and resource allocation;
- 'operational' arenas of programme management and service re-configuration.

<u>Acquiring and developing 'political astuteness'</u>

The pedagogical literature on workforce development suggests the acquisition and development of leadership skills and capabilities typically occurs through a combination of, at least, three forms of learning (Freeman 2007). The first is through participation in formal education and training programmes, where abstract concepts or methods are taught in classroom or simulated environments. The second is through mentoring, coaching and action learning, where learners are guided through individual and group reflection on 'real world' challenges (Chopin et al. 2012). And the third, is through experiential and reflective learning in the context of making decisions and taking actions in relation to 'real world' situations (Blass and Ferris 2007). Research increasingly suggests effective leadership development occurs through a combination of these elements, where leaders address 'real world' challenges through applying generalised models to their specific context, where they are mentored in experimenting with ideas, and where they reflect on the processes and outcomes of their actions to inform subsequent learning. However, Hartley et al's (2013) research in the UK, Australia and New Zealand shows that public managers often acquire their political skills in a haphazard and sometimes painful manner. In their study, few managers reported learning political skills through formal development courses or mentoring. Instead, a worryingly high proportion, particularly in the UK, reported acquiring their skills through making mistakes in the workplace (88%), or through handling crises.

Interviews also suggested that those managers who participated in leadership development, including elements of political astuteness, reported beneficial learning, and a high number reported learning from an experienced manager. Nonetheless, more work is needed to both understand and meet the development needs of current and future leaders in the area of political astuteness (James 2011).

In the English NHS, a number of established leadership programmes aim to enhance the capabilities of the healthcare workforce to implement strategic change. For example, the *NHS Leadership Qualities Framework*, developed in the mid-2000s, described 15 aspects of leadership clustered around 'personal qualities', 'setting direction' and 'delivering the service'. This recognised the importance of 'political astuteness' in terms of a) the capacity to understand the climate and culture of the organisation; b) knowing who are the key influencers and how to involve them; c) being attuned to national and local strategies; and d) understanding the inter-connected role of leadership.

The current NHS Leadership Academy utilises a new Leadership Framework. The first iteration comprised seven domains, across which aspects of political astuteness can be identified in 'developing self-awareness', 'building and maintaining relationships' and 'developing networks'. The subsequent *Healthcare Leadership Model* includes nine dimensions and again highlights the need for leaders to understand the culture and politics of healthcare, including the informal chain of command. This work suggests "*successful innovation involves the exercise of political astuteness*", including the cultivation of relationships and building of coalitions amongst competing interests (Storey and Holti 2013). Surprisingly, the new national framework for improvement and leadership development – *Developing People: Improving Care* – gives less attention to the importance of political astuteness (National Leadership Board 2016). In various places, these capabilities are addressed, such as 'system leadership' which involves building relationships and shared goals across organisational boundaries to help implement STPs and other care models. Yet, there is limited recognition of the need for service leaders to manage both the formal and informal politics of health and social care services when implementing strategic change.

Although political skill is acknowledged across these frameworks, there is little understanding of how it is best acquired or how it can contribute to effective change. Many of the attributes are poorly specified or subsumed within other behavioural competencies. Even where there is explicit reference to political skill, there is limited evidence upon which these qualities are based, and no explanation about how the concept has been adapted to the NHS context. To some extent, political astuteness remains an implicit aspect of strategic leadership. With the pressing need to implement major strategic changes across the NHS, especially the introduction of STPs, we argue there is a need to better understand the acquisition and contribution of political astuteness, and to inform the design and content of new recruitment and learning resources to develop the political astuteness of service leaders, and other change agents, inclusive of both clinical and managerial groups.

Major System Change in the NHS: Sustainability and Transformation Plans

This issues addressed in this study are particularly pressing in the context of current NHS pressures and improvement plans. As articulated in the *Five Year Forward View*, the NHS needs to make substantial financial savings, and at the same time realise a step change in

how services are organised and delivered. This has seen the introduction of various transformation and improvement initiatives, including new care models (Vanguards) and Sustainability and Transformation Plans (STPs). As with other major service change initiatives (Best et al. 2012; Turner et al. 2016), a variety of contextual factors will influence their success, including the informal political environment in which they are being introduced, and the political astuteness of service leaders. This proposed study focuses on service leaders' acquisition and use of political astuteness in the design and implementation of the recent STPs, as an exemplar of major system change.

Forty-four STPs have been proposed in England to transform the delivery of care services at the local level, with changes expected to last beyond 2020. These have been developed by NHS organisations working in partnership with local authorities and other care agencies, to strategically plan the future configuration of services. Reflecting current and longer term NHS priorities, the STPs cover a number of common transformation areas, including the provision of urgent care, integrated health and social care, centralisation of specialist services, efficient re-purposing of scarce resources and infrastructure, prevention of illness, and use of new technologies. As described above, the development and implementation of the STPs requires close consideration of the informal political environments within which change is to happen.

3. Aims and Objectives

The purpose of the proposed study is to investigate the acquisition, use and contribution of leadership with 'political astuteness' (PA) in the implementation of strategic health system change, focusing on the implementation of Sustainability and Transformation Plans. The findings of this research will inform the co-production of materials and resources for the recruitment, training and development of current and future service leaders.

The research objectives include:

1. To identify key theories and frameworks of PA within the social science literature, and apply these to recent evidence of health system change to understand how service leaders can constructively create the 'receptive context' for change;

2. To understand the perceptions, experiences and reported practices of service leaders, and other change agents, about their acquisition and use of PA in the implementation of health system change, taking into account differences in professional background, age, gender, ethnicity, geo-political context, and change context;

3. To understand how recent recipients of NHS leadership programmes think about, have acquired and make use of PA, to inform the development of new training resources;

4. To revise existing theoretical models of PA with reference to the wider social, cultural and relational context of health system change, and develop theoretical propositions;

5. To apply and elaborate the revised theoretical propositions through investigating how PA is used constructively by service leaders to create a 'receptive context' for

implementing health system change in three in-depth case studies, focusing on Sustainability and Transformation Plans;

6. To work with existing providers of NHS leadership training, NHS recruitment agencies, and PPI groups to co-produce recruitment and learning materials that support the acquisition, use, and development of PA for existing and future healthcare leaders to help them use politics constructively for service improvement and cost containment.

4. Research Design & Methods

The proposed study is designed with four linked Work Packages (WPs) which are broadly informed by a narrative methodology, which is concerned with investigating and interpreting the experiences and accounts of social actors as relating these to wider social and cultural processes (Czarniawska 2004; Gubrium and Holstein 2008).

WP1: Systematic narrative reviews

Purpose:

This work package addresses objective 1, and provides the foundations for objective 4. It involves completing two systematic narrative reviews of the research literature. The first will produce a 'review of reviews' to establish the 'state-of-the-art' theories and frameworks on political astuteness, and related concepts such as political skill, organisational politics and strategic leadership. This review will draw on the wider social and political science literatures to identify and clarify the main concepts and theoretical assumptions, and importantly to draw upon additional social science theories to develop a more socialised and practice-based view of political astuteness, e.g. Bourdieu's (1973) theory of practice, Fligstein and McAdams' (2012) theory of fields, and Bevir's (2013) decentred theory of governance.

The second review will examine the wider health services research literature on the implementation of organisational innovation and major service configurations (within last ten years) to more clearly specify the informal political environment of contemporary healthcare and to identify exemplars of political astuteness. This will apply learning from outside the healthcare sector, as developed through the first review, to develop new lines of enquiry. Together, the two reviews will provide the foundations for developing a new empirically-informed theoretical understanding of political astuteness, to be developed through WP2 and tested in WP3.

Approach:

There are a number of approaches for systematically reviewing research literature, including 'meta-analysis' reviews of trials with similar designs, 'realist' reviews that elaborate the mechanisms and contexts of change, and 'narrative' reviews that thematically review diverse literatures (Popay et al. 2006). A preliminary scoping review has shown that the relevant social science and health services research literatures are highly diverse, including different disciplinary and theoretical traditions (management, political science, public management, psychology, sociology), methodological positions (social experiments, cohort studies, qualitative case studies) and empirical evidence (surveys, interviews, observations).

For this reason, the two systematic reviews will follow a narrative approach that is inclusive of the diverse literatures and aims to produce a thematic synthesis of the literature.

Selection and Analysis:
We will follow established strategies for searching and mapping the literature on complex service change (Greenhalgh et al. 2005). For both reviews, an initial selection of search terms will be produced in collaboration with the study Advisory Board, and up to 20 experts in the field of implementation science, invited by email to contribute to the list of search terms. The identified terms will be used within electronic databases, e.g. ABI-Inform, PubMed, PsycINFO, Scopus, Google Scholar. Preliminary results will be reviewed according to title, keyword, location, date and journal quality (ranking/impact factor). Shortlisted papers will be subject to further abstract review by at least two members of the research team (including inter-rater reliability test) to produce a final selection. The selected papers will be summarised according to their core attributes (author, date, method, outcomes, conclusions).

For the narrative review on political astuteness, attention will be given to existing reviews papers (e.g. Vigoda-Gadot and Drory 2008), with the aim of producing a review of reviews. This will systematically summarise: a) the character of political astuteness (e.g. behavioural qualities, practices, contexts, barriers/drivers, outcomes), b) its acquisition and development (e.g. workplace learning, training, etc.); c) forms of measurement and assessment (e.g. surveys and constructs); and d) outstanding research questions and propositions.

For the review of the health services research literature, consideration will be given to exemplar studies of service organisation, strategic change, and the implementation of innovations where political factors and leadership attributes feature prominently in the analysis. This will involve applying the learning from the first review to the health services research literature to develop a secondary level of analysis. Together, the two reviews will identify assumptions and propositions to inform the subsequent research.

<u>WP2: Interview study with experienced and aspirant service leaders</u>

Purpose:
This activity addresses objectives 2 and 3, and will contribute to objectives 4 and 6, by investigating service leaders' experiences, perceptions and reported practices of 'political astuteness' in different strategic and operational 'arenas'. It will also investigate the views and experiences of NHS staff who have recently completed formal NHS leadership training to examine how political skills and astuteness were developed through such training. Analysis of these perspectives will also inform the development of new learning resources.

Approach:
The work package will involve qualitative semi-structured interviews with leaders and change agents working in different strategic and operational 'arenas'. The methodological approach follows in the biographical, narrative tradition (Czarniawska 2004; Kvale 2008; Wengraf 2001) of inviting participants to give detailed reflective accounts of situations and

events where political astuteness was involved in navigating the informal politics of implement strategic change; or where the lack of such astuteness derailed or slowed change; and how they learnt from these experiences.

Sampling:
The sampling strategy acknowledges that the acquisition, use and contribution of political astuteness will vary between different strategic and operational arenas, geo-political settings, and implementation processes. It is also recognised that acquisition and use might vary in terms of an individual's career background and length of service, as well as differences in gender, age, and ethnicity. Reflecting these considerations, a purposive sampling strategy will be followed to select between 40-45 service leaders working in different policy, professional, public and organisational settings. The proposed sample include:

- NHS England clinical leads (5)
- Leaders of recent major service reconfigurations, e.g. stroke, major trauma, cancer (5)
- Healthwatch and PPI representatives (5)
- Local authority leaders and senior managers (5)
- NHS Trust Chief Executives (5)
- Academic Health Science Network Directors (5)
- Representatives of professional associations or specialist societies (5)
- Regional leads for 'new care models' (Vanguards) (5)
- Leads for Sustainability and Transformation Plans (5)

A further sample of 20 recent participants of NHS Leadership training will be recruited to investigate their experiences of political astuteness and whether these skills were developed through completing leadership training. These will include representatives from the Mary Seacole, Elizabeth Garret-Anderson and Nye Bevan programmes, who have completed in the last two years.

Data collection:
Through existing national and regional research partnerships, lists of potential participants will be collated and individuals will be invited in writing to participate in the study. The preference is for face-to-face interviews to facilitate rapport and detailed understanding, which is expected to be important when discussing the informal politics of health system change. All interviews will be digitally recorded with the informed consent of participants. Where consent is given, video recording with a small number of participants (5-10) will be made during post-interview debriefing to be used in online and educational materials. The narrative interviews will be semi-structured with a topic guide to promote consistency across interviewers, informed by the findings of WP1. Anticipated topics include:

1. Professional/career background: including leadership experiences;
2. Context of change: the significance of the reform agenda to the geo-political context;
3. Political astuteness 'in action': personal skills, interpersonal skills, reading people and situations, building alliance, and strategic direction;
4. Teams, groups and partners: the influence and contribution of other groups involved in or affected by the change initiative and the interpretation of the interests and goals of those groups;
5. Barrier and drivers to utilising political skill: countervailing forces; power blocs; competing interests and institutions;

6. Outcomes and impact: cases of change where political astuteness has played a part, and worked illustrations.

Analysis:
Interviews will be transcribed verbatim for the purpose of interpretative data analysis (using nVivo). Interview data collected as part of WP2 will be analysed from a narrative perspective with a particular focus on the biographical narratives and identities of participants, their stories of political astuteness, and an understanding of the broader organisational and cultural factors their influence their narratives. The analysis will involve a preliminary phase of more general qualitative data analysis (close reading of transcripts, open coding, identification of themes). Commensurate with the narrative approach, the data will be further analysed to understand the different ways participants experience and make sense of their informal 'political' environment, especially what they see as the skills or activities needed to navigate the political environment. The emphasis of the narrative analysis will be on 'content' rather than 'form', i.e. what people say rather than how they say it – but it is recognised that how people talk about themselves and their environment will provide important understanding. The analysis will focus on the 'stories' or accounts produced by participants, as representative of their 'sense-making', their 'positioning' of themselves in relation to events or other actors, 'moralising' about the perceived norms and virtues of their environment, and 'identity' or how they see themselves. Through these accounts participants' sense of cognitive ordering or reasoning will be examined in relation to prevailing cultural and social norms and values, will incorporate findings from WP1, and will thereby link the individual to wider social and organisational influences. A key objective of the analysis is to revise or deepen existing theories and frameworks with reference to the specific forms of political work used within healthcare services.

<u>WP3: In-depth case studies of political astuteness 'in action'</u>

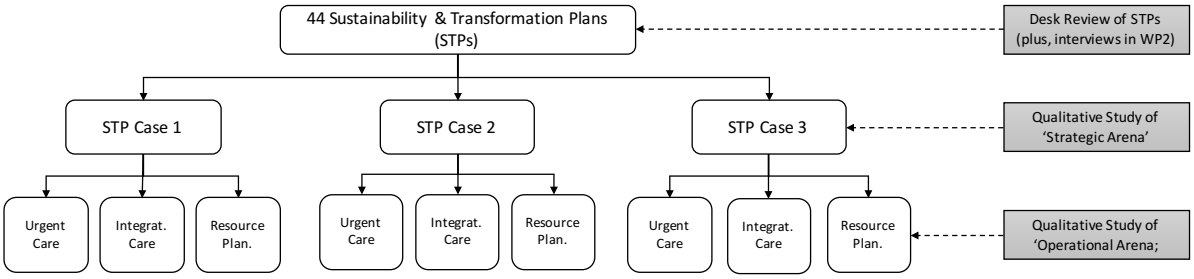
Purpose:
This activity addresses objectives 4 and 5 through undertaking three qualitative studies of the utilisation and contribution of political astuteness in the leadership of major system change initiatives as specified within three different STPs. As outlined above, STPs represent a key health policy issue and a major strategy for NHS change. The findings of this activity will help elaborate the tentative theoretical propositions developed in the preceding WPs.

Approach:
This work follows in the ethnographic tradition (Fetterman 2009) and aims to develop a rich description (Ponterotto 2006) of the informal politics of health system change, and the use and contribution of political astuteness by different service leaders and change agents, working within and across different 'arenas' to implement change. There are many styles of ethnographic research (e.g. realist, critical, institutional) (Hammersley and Atkinson 2007), but most are concerned with direct observations of social practices and situations, and the analysis of these in relation to broader social, cultural and political institutions. Consistent with the preceding WP, the proposed study adopts a narrative ethnographic approach of combining traditional methods of observation with narrative analysis to examine the storytelling and meaning making of participants in their local contexts (Gubrium and

Holstein 2008). This will involve focused observations of key situations and interactions, combined with 'in situ' ethnographic interviews, and further narrative interviews with local participants.

The research will be carried out with three 'cases' of health system change, e.g. three regional STPs. Case study research aims to produce a detailed analysis of a given, exemplary case of a broader phenomenon, where the intention is depth of analysis, the elucidation of processes over time and in context, and explaining differences, rather than generalisation (Hartley 2004; Yin 2009). Reflecting the idea that political astuteness will vary between and across different 'arenas', data collection will also focus on three sub- or internal cases within each the three STPs, specifically the thematic programmes for service transformation (see below). As such, the planned approach is to 'zoom-in' and narrow the focus of data collection to develop a find-grained analysis of political astuteness 'in action' (see figure 1).

Figure 1: Illustration of Work Package 3 Case Study Design:



Sampling & Data collection:
The study will focus on examples of major system change formulated and implemented **within three STPs**. A preliminary review of all 44 STPs proposals has identified key similarities and differences, in terms of strategic objectives and leadership. Building on this review, selection of STP case studies will take into account anticipated differences in geo-political context (population, metropolitan, rural), strategic priorities, and leadership arrangements. It is planned that two STPs will be selected in the East Midlands and one in London. This will enable comparison between STP based in distinct geo-political settings (London and East Midlands) and also the interaction of STPs working in adjacent areas (the two East Midland cases).

As described above, the case study research will be undertaken at different levels (strategic and operational) involving three (operational) sub-cases **within each STP**. Informed by the preliminary scoping review, a number of common priority areas are identified across the proposed STPs, and this research intends to focus on three of these: i) changes to **urgent care** planning and provision; ii) health and social care **integration**; and ii) (efficient) **resource prioritisation and allocation**. These are prominent programme themes or project areas for the majority of the STPs that are likely to involve different combinations of stakeholders with differential levels and sources of power and with varied interests. In addition, the research will focus on the key aspects of system change identified in the existing literature

(e.g. Best et al. 2012), including 'public involvement', 'clinical engagement', 'communication and framing' and 'use of evidence', with additional themes identified during WP1. Analysis of these themes is likely to provide transferable lessons to other STP priorities and major service changes in the future.

The field researchers will investigate the role of political astuteness in the 'strategic' arena of high level STP formulation and planning. This will build on the interviews with STP leaders from WP2, and look at the development and continuing formulation of high level strategy. This will involve both semi-structured interviews, and informal in-situ interviews with the strategic leaders and key partners of the three STPs. We anticipate this include between **5-10 key leaders** from each STP area, including Chief Executives and senior leaders from NHS Trusts, local CCG leads, Local Authorities, Healthwatch, and other regional stakeholders. Estimated maximum is **24-30 interviews**. The research will also involve non-participant observations of 'high level' STP meetings and public forums where these leaders may be in attendance (**estimated 5 per STP: 15 in total**). Particular consideration will be given to the role of PPI representatives in these strategic arenas, and the distinct forms of political astuteness used by these individuals and groups.

As outlined above, the research will focus on **three** common thematic programmes or project areas **within each STP**. The research will therefore investigate the role of political astuteness in the 'operational' arena of programme leadership and change management. This will involve semi-structured interviews, and in-situ interviews with the service leaders and teams leading the change programmes for urgent care, health and social care integration, and resource allocation. It will also involve interviews with staff and patient representatives involved in these change areas to understand their perceptions of political astuteness. For each of the three areas, we anticipate interviewing around **5-7 key people** involved in project management, plus a further 5-10 staff and patient representatives. This will result in a total sample of **c45 interviews per STP** (**estimated 135 in total**). This will also include observations of project meetings and events (**estimated 5 per theme: total 15**), and shadowing of service leaders (**1-3 days**). As with all ethnographic research, it is not possible to plan in advance all the settings to be observed or individuals to interviewed, and it is likely that many in site ethnographic interviews will also be undertaken.

The proposed study involves **concurrent data collection over a 6-10 month** period with each STP, over a period of 17 months. Interviews and observations involved will aim to examine, and compare, the informal political environments of change, and the lived experiences of different service leaders as they seek to formulate and implement change. It is recognised that researching the informal political environment might bring to light ethical interpersonal and organisational issues. The research team will ensure the confidences and anonymity of participants and will work to build trust and rapport with participants and researchers will be mindful and sensitive to ethical issues.

Analysis:
All observational and 'in situ' interview data will be recorded in field journals and electronically reproduced for data analysis. Analysis will produce three in-depth case report and comparative case analysis (Yin 2009) that will: a) identify and evidence activities that support the development and utilisation of political skill; b) understand how the political

landscape varies between settings and the different skill needed; and c) revise the existing theories and frameworks of political skill and their application to the healthcare context. Interview data will be analysed as with WP2.

WP4: Co-production of new learning activities

Purpose
This activity aims to use the study findings to inform the development of new learning and recruitment resources for use by the NHS and leadership education providers. Given the planned outcomes for each WP, it is anticipated preliminary learning frameworks can be developed following WP1 and WP2, to be shared with educators and the wider research community, which will then be further specified and developed through a series of co-production workshops following WP3.

Approach
It is recognised the translation and implementation of research into routine practice is rarely a linear process; rather it is iterative and facilitated through co-production (Bason 2010; Davies et al. 2000). In line with this view, the study team includes current providers of NHS leadership education (e.g. Hartley, Open University; Exworthy, Birmingham University; and Waring/Bishop, Nottingham University), and aims to provide timely and formative feedback from the study findings into the on-going development of teaching and learning materials.

Following data collection and preliminary analysis, a series of co-production workshops will be organised with the aim of developing and refining new learning materials and recruitment resources. These workshops will invite representatives of different stakeholder communities to reflect upon, deliberate, and prioritise the study themes, drawing upon their distinct experiences of, and priorities for, health system change. The stakeholder workshops include:

1. **Expert workshop**: a one-day workshop comprising research and practice leaders in the fields of health services research, implementation science and organisational change, to review the study findings and draw out key lessons and evidence for policy and practice;
2. **Service provider workshop**: a half-day workshop to discuss the study findings with regional and local service leaders to develop recommendations for supporting learning and change in different practice situations;
3. **PPI workshop**: a half-day workshop to review the distinct political challenges and forms of political astuteness experienced and used by PPI representatives;
4. **Educator workshop**: full-day workshop for existing leadership programmes providers to review their current curricula, to discuss understandings, models and frameworks on political skill, to consider the application of research findings to revise existing learning activities and materials;
5. **Appraisal and development workshop**: a full-day workshop with leadership providers to design and iterative learning resources, organised before and after pilot activities with regional leadership provider (East Midlands Leadership Academy).

Stakeholders will be facilitated to co-design new materials and resources following creative engagement methodologies, through the use of visual aids, games and role-play to devise, test-out and model potential outputs. It is anticipated the following materials and resources will be considered:

- Detailed case studies of political skill 'in action'
- Learning exercises and scenarios based on 'real world' examples
- Workbooks for learners to explore decision-making options
- Biographies and personal testimonies of political leadership
- Online resource and social media
- Videos and audio packages which can be placed on iTunesU or other platforms
- Materials for a MOOC on "An introduction to political astuteness in healthcare" which would be of value to clinicians, managers and patient representatives.

The materials and resources developed through the workshops will be piloted by Nottingham University Business School, working in collaboration with the University of Birmingham's Health Services Management Centre and the East Midlands Leadership Academy (a formal concordat arrangement exists between Nottingham and Birmingham Universities). It is anticipated that this testing will be organised as two one-day non-residential courses offered to up to 20 middle-managers and project managers (some drawn from current student cohorts) in the East Midlands. The pilot will assess the relevance and acceptability of the learning materials through feedback survey of participants and short telephone interview, with feedback reviewed in the final workshop to update materials.

Summary of outputs

1. Project website and digital resources: This will be developed within the first 6 months of the study to collate and communicate existing literature and emerging findings for the study team, collaborating organisations and wider stakeholders. It will include: links to emerging literatures, details of NHS leadership development schemes, existing and revised surveys and tools, developed case studies and 'best practice' examples, and the option for 'talking head' video biographies from frontline service leaders. This will be of benefit to educators and researchers.

2. Co-produced learning and recruitment resources: The study will co-produce new materials to help assess and support the development of political astuteness for aspirant service leaders. For educators and learners, this will include, for example, 'workbooks' and online support materials with illustrative scenarios and problems. For coaches and mentors, there will be practical examples to provide reflective learning, based on the feedback of participants. These will be developed and piloted in partnership with existing NHS leadership development providers and shared through online platforms. For recruiters, the study will produce 'problem case' or 'simulations' for use in interview or assessment centre, as well as guidance on the 'hallmarks' of political astuteness. Additional materials will be produced for PPI organisations detailing the particular types of political astuteness used by PPI groups to influence change.

3. Project reports and support materials: The study will produce interim and final reports, including co-produced learning materials, revised surveys, and larger data archive.

4. Academic publications and conferences: The research will produce an academic monograph on political astuteness for health service leaders. Additional academic outputs will include: two review papers targeted for prominent HSR journals (JHSRP, Milbank). A number of linked empirical and theoretical papers on the practices and contributions of political astuteness and public service organisations change targeted at leading public management, social science journals (Public Admin, SocSciMed, Org Sci, Leadership Qrty).

5. Formative learning and feedback to STP service leaders: The study will provide unique insight about the informal political environment faced by STP leaders, and the contributions of political astuteness in mediating the local challenges. All feedback will be thematic and generic, accounting for the common and cross-cutting factors experienced by STP leaders, and will **not** single out individual STPs or leadership teams to ensure their confidentiality. These will initially take the form of interim reports and presentations, but additional feedback will be provided at national learning forums and conferences.

Patient and Public Involvement

A lay/PPI representative is a full member of the project team and will provide on-going input into study design, and will assist the team in its appreciation of the distinct forms of 'political astuteness' used by PPI representatives and related groups. Working with regional NIHR CLAHRC East Midlands PPI infrastructure and the EM Leadership Academy PPI lead, a PPI Project Group will parallel the main Advisory Board, and contribute to study design and progress. The group will have particular responsibility for the identification of PPI participants, clarification of interview questions, co-designing learning workshops and the development of learning materials aimed at service leaders and managers with regards to the involvement of patient and public groups in local change initiatives. As such, PPI input will be actively sought in the early stages on project design and especially in the development of learning that is relevant to the needs of PPI groups as part of WP4. All PPI involvement will be fully costed to include remuneration and expenses.

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