



What makes a socially skilled leader? Findings from the implementation and operation of New Care Models (Vanguards) in England

Journal:	<i>Journal of Health Organization and Management</i>
Manuscript ID	JHOM-02-2022-0037.R1
Manuscript Type:	Original Article
Keywords:	Distributed leadership, social skills, healthcare, New Care models, Vanguards

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Abstract

Purpose: We argue that the concept of 'distributed leadership' lacks the specificity required to allow a full understanding of how change happens. We therefore utilise the 'Strategic Action Field Framework' (SAF) (Moulton and Sandfort 2017) as a more sensitive framework for understanding leadership in complex systems. We use the New Care Models (Vanguard) Programme as an exemplar.

Design / methods: Using the SAF framework, we explored factors affecting whether and how local Vanguard initiatives were implemented in response to national policy, using a qualitative case study approach. We apply this to data from our focus groups and interviews with a variety of respondents in six case study sites, covering different Vanguard types between October 2018 and July 2019.

Findings: While literature already acknowledges that leadership is not simply about individual leaders, but about leading together, this paper emphasises that a further interdependence exists between leaders and their organisational / system context. This requires actors to use their skills and knowledge within the fixed and changing attributes of their local context, to perform the roles (boundary spanning, interpretation and mobilisation) necessary to allow the practical implementation of complex change across a healthcare setting.

Originality: The SAF framework was a useful framework within which to interrogate our data, but we found that the category of 'social skills' required further elucidation. By recognising the importance of an intersection between position, personal characteristics/behaviours, fixed personal attributes and local context, our work is novel.

Key words: Distributed leadership, social skills, healthcare, New Care models, Vanguards

Introduction

Healthcare systems around the world are under increasing pressure, due to aging populations and increased patient demands against a background of finite resources and unexpected challenges such as the current (COVID-19 / SARS-CoV-2) pandemic. It has been argued that better integration between health and care systems is the solution to managing these pressures. However, despite numerous pilot programmes to test integration initiatives in the UK and elsewhere, there is still no clear idea of how such programmes can best be led, developed, supported and sustained (Hughes et al. 2020).

Evaluations of [healthcare] system change frequently highlight the importance of leadership. There is an extensive healthcare management literature on this topic, and within this, 'distributed leadership' is increasingly referenced as an important model to be aspired to (Barker, 2001, Bolden, 2011, Fitzgerald et al 2013). However, the exact form such leadership should take is rarely specified, leaving it as a concept that has been widely promulgated but infrequently clearly defined and often criticised (Harris et al 2007).

In this paper we use Moulton and Sandfort's (2017) concept of 'skilled social actors' to help us to develop a more concrete characterisation of leadership across organisations and explore in more depth what it means to lead a cross-sector integration project and the conditions under which these can be facilitated, grounded in theories of social action. Moulton and Sandfort (2017 p146) argue that social skills are "the mechanisms by which active individuals seek to generate shared meanings and forge collective identities; and that socially skilled actors interpret and apply different sources of authority, responding to exogenous shocks, and using these to stimulate local action" (p154).

While literature already recognises that leadership is not only about individual leaders, but about leading together (Best et al 2012, Currie et al 2019), our paper emphasises a further interdependence that exists between leaders and their organisational / system context. The SAF framework (Moulton and Sandfort 2017) was a useful framework within which to examine our data, but we found that the category of 'social skills' required further explanation. By recognising the importance of an intersection between position, personal characteristics/behaviours, fixed personal attributes and local context, our work is novel. Furthermore, we provide an analysis which has the potential to support a more detailed exploration of what it means to enable 'distributed leadership' within an organisation.

Bearing in mind the complex interactions between national policy, regional and local levels in the English health and social care system, our focus in this study was at the local level as this is the level at which leadership in organisational change projects is generally enacted. We examine mechanisms by which the agency of local actors was enabled and/or constrained and explored how and why factors that are decisive in one context failed to generate change in an apparently similar one. We delineate who came to act in different leadership roles, recognising the importance of an intersection between position, personal characteristics/behaviours and fixed personal attributes but within specific local contexts, which is novel. As an exemplar we focus on the New Care Model (Vanguard) programme which ran in the English NHS from 2015 to 2018. We consider how findings from these integration pilots could usefully inform leadership development in the currently evolving Integrated Care Systems (ICSs) across England.

Integrated care in England

In 2014 a new vision for the English NHS was set out, focussing upon new ways of working and integration between primary, community, secondary and social care (NHS England 2014). This led to the establishment of New Care Model (NCM) or Vanguard pilots, which encouraged “diverse solutions and local leadership” to generate learning that would develop new ways of working and inform future policy development.

Under the NCM Programme, ‘Vanguard’ pilot sites were established to test new ways of providing services. A number of types of New Care Model (NCM) were proposed, narrowed down to five types: Primary and Acute Care Systems; Multispeciality Community Providers; Care Homes; Urgent and Emergency Care; Acute Care Systems (NHS England 2016a). The Vanguards set out to design, test and deliver a variety of scalable NCMs for the whole of England, with the expectation that success would be replicated elsewhere.

Whilst the New Care Model programme ended in 2018, other NHS integrated policy initiatives continue. These include the NHS Long Term Plan (NHS England 2019) of which Integrated Care Systems form an integral part, an Enhanced Health in Care Homes (EHCH) initiative, and the obligation for General Practices to work collaboratively as Primary Care Networks to provide better care to patients including those living in residential care (NHS England 2016b, 2020a). These initiatives require local areas to work in ways that align with the principles underlying the Vanguard programme, such as working across geographical areas to manage the health of populations; collaborating across boundaries between primary, secondary, community and social care; and facilitating multidisciplinary approaches to patient care. It is therefore important to understand how the Vanguards operated and enabled change and the factors that supported or hindered this, to learn lessons relevant to the ongoing developments set out in the NHS Long Term Plan (NHS England 2019) as well as to similar initiatives in other countries.

Following the establishment of the Vanguards, a later policy document, the NHS Long Term Plan (NHS England 2019), set out ambitions to develop:

‘great leadership at all levels in the NHS and do more to nurture the next generation of leaders by more systematically identifying, developing and supporting those with the capability and ambition to reach the most senior levels of the service’ (King and Mendez Sawyer, 2021 p1).

Following this, the Interim People Plan (NHS England, 2020b p28) committed the NHS and its partners to system leadership for delivering local health and care and it states:

‘All leaders in the NHS, particularly those who hold formal management and leadership positions, are expected to act with kindness, prioritise collaboration, and foster creativity in the people they work with’.

Approaches to fostering system-based, cross-sector, multi-professional leadership centred around place-based health and social care are set out, with the aim of integrating care and improving the health of the population. System leadership roles and governance structures are likely to continually evolve as systems (e.g. ICSs) develop, and King and Mendez Sawyer 2021 (p4) suggest this must take account of different contextual conditions present in specific individual systems and places.

In 2021 the new Health White paper (DHSC, 2021) made the case for a new legislative framework to facilitate greater collaboration within the NHS and between the NHS, local government and other partners. This will mean working across organisations and geographical boundaries at different

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3 levels of health and social care systems. Like the Long Term Plan (NHS England 2019) it suggests the
4 need for diverse skill sets to 'enable system leadership, build partnerships and work across
5 organisations and sectors' (Harris *et al.*, 2020 p1). Harris *et al* call for a greater understanding of
6 mechanisms for effective leadership across systems, the contexts that affect leadership and the
7 nature of outcomes. We aim to add to this body of understanding by examining leadership through
8 the concept of 'social actors' and ask what features and characteristics identified leaders throughout
9 the local system, in what contexts and how this impacted on the operation and outcomes of the
10 Vanguard developments locally. This in turn allows us to draw wider lessons for integrated health
11 and care service developments more generally.
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15 16 **Leadership in complex contexts**

17 *Types of leadership (from heroic to distributed)*

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19 Studies of leadership have tended historically to assume that leaders provide guidance and support
20 for members of single or uni-professional teams, often based on factors such as seniority, authority
21 and deferment (Reeves *et al.*, 2010). However, as the organisation of the health and care systems
22 becomes more integrated through cross sectoral working (NHSE 2014, DHSC 2021), leadership has
23 become more complex, having to span professions with different cultural identities, organisations
24 and geographical boundaries. These forms of leadership challenge the traditional, hierarchical, single
25 leader view of leadership and denote a move towards more collectivistic approaches (De Brun *et al.*
26 2019) particularly ideas of what is often called 'distributed leadership', working across boundaries
27 and at different levels.
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32 Leadership studies have often used 'Distributed Leadership' as a default recommendation when the
33 imperfect model of 'heroic leadership' (a model in which a single individual is perceived as driving an
34 organisation to success) fails to explain what has happened. This is problematic as such accounts can
35 fail to provide a clear definition of 'distributed leadership', other than situating it as the antithesis of
36 a traditional leader-centric approach or suggesting that 'team members' are also leaders (Boak *et al.*,
37 2015, Chreim and MacNaughton 2016). For example, in a narrative review of factors supporting
38 major system change, Best *et al* (2012) suggest the need for 'distributed leadership' without
39 explaining what this might be, or how it should be operationalised.
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42 Others have made even bolder claims, with Gronn (2008) for example, suggesting that the concept
43 of distributed leadership has achieved a high level of theoretical and practical uptake, arising from a
44 disillusionment with heroic models which emphasise individual behaviour. According to Bennett *et al*
45 (2003 p7) 'distributed leadership highlights leadership as an emergent property of a group or
46 network of interacting individuals' i.e. a group activity that works through and within relationships,
47 rather than via individual action.
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50 Lumby (2013, abstract) further proposes that distributed leadership 'offers an enticing suggestion of
51 including more [individuals] in leadership, and even sometimes including staff members equally'.
52 However he goes on to suggest that 'the resulting issues around distribution of power are largely
53 ignored or referred to [only] in passing'. This type of leadership may be used by senior managers to
54 engage others in activity, but it may also conceal imbalances in access to resources and sources of
55 power. Hatcher (2005) concludes that while leadership may be 'distributed', power often is not. It
56 appears that many commentators on distributed leadership avoid such discussions, preferring
57 instead to ignore the realities of power dynamics within any health and care system.
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3 Gilson (2016) calls for greater attention to be paid to organisational politics and political skill so that
4 leaders are better equipped to understand the multiple agendas and interests that impact on
5 everyday service organisation. She (p187) suggests that key elements of leadership include gaining
6 buy-in from other staff members for new / routine activities, the ability to operationalise centrally
7 dictated requirements and be listened to by actors outside their own organisations (including
8 patients and citizens). This was reiterated in a recent review where Clark *et al* 2021 used the idea of
9 political skill to look at implementation change in healthcare services, and suggested that such
10 concepts are now being included in leadership development programmes. For example the
11 'Leadership Qualities Framework' used by the United Kingdom (UK) NHS Leadership Academy (2011)
12 highlights 'political astuteness' including knowing who the key influencers are, how to engage them
13 and understanding the inter-connected roles of leadership within a local context. Increasingly,
14 academic theory points to leadership with political astuteness being deployed constructively for
15 social and organisational purposes (Waring *et al* 2018).
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21 **Functions of leadership**

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23 Leadership has different functions in specific circumstances. Some authors (e.g. Brookes and Grint
24 2010) suggest that the purpose of distributed leadership is to engage and empower, to allow a
25 vertical flow of power from the centre downwards, and often across a system including crossing
26 boundaries of organisations. This supports the argument for power being distributed more equally
27 than in a traditional hierarchy (Currie *et al.*, 2009) and empowering staff at a variety of levels to be
28 able to make decisions and act upon them (Gronn 2002). However this has possible implications for
29 accountability in such systems, as well as raising questions as to whether so-called empowerment
30 may also act as a disciplining force (McDonald *et al.*, 2004).
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33 Wilcocks and Conway (2021) suggest that distributed leadership may be appropriate when there is
34 requirement for 'a leadership constellation whereby the leadership role passes, informally or at
35 different phases, between different individuals and groups, with differing bases of expertise and
36 legitimacy at different times' (Hartley and Benington 2010, p33). Both these sets of ideas sit well
37 with the concept of developing new models of care under the English Vanguard Programme.
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39 However, 'implementation is rarely straightforward' (Gilson 2016) and involves frontline leaders
40 using their powers of persuasion and influence to gain buy-in from others to an idea, rather than
41 simply the declaration of 'magical' instructions by top-level leaders. This requires actors to use their
42 skills and knowledge of their local context, performing the roles of boundary spanners (where
43 practitioners from different organisations span the intellectual and practical boundaries that
44 separate them, Aungst *et al* 2012), interpreters and mobilisers.
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50 **The Strategic Action Field (SAF) framework.**

51 We argue that 'distributed leadership', as a concept, does not enable complete understanding of
52 how change happens due to its lack of specificity and the fact that in many definitions it simply
53 describes what happens when change successfully occurs. In other words, many accounts of
54 distributed leadership represent a retrospective description of success, rather than offering any
55 insights into the leadership practices which underpinned it. We therefore utilise the 'Strategic Action
56 Field Framework' (SAF) (Moulton and Sandfort 2017) as a more sensitive framework for
57 understanding leadership in complex systems. This framework is a useful way of thinking about
58 policy implementation, as it takes account of the multiple levels which influence how a particular
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3 policy is implemented. It also enables us to move past the need for 'good' or 'distributed' leadership
4 to explore, via the concept of 'socially skilled actors', exactly what was done by whom in making
5 change happen (REF removed 2021). The SAF framework consists of 3 components: programme
6 interventions, scale of analysis and drivers of change and stability. Within this last component,
7 sources of authority, social skills, and exogenous shocks are elements (see Figure 1). In this paper we
8 focus on the social skills element in relation to concepts of leadership.
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10 11 12 **Figure 1: Elements making up the SAF Framework.** 13

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16 According to Moulton and Sandfort (2016 p145) in the SAF framework "implementation actors [...] work within bounded social settings. They employ social skill to interpret and adjust a public service
17 intervention in ways that build common understanding and reconcile competing sources of authority
18 to enable collective action". Socially skilled actors use knowledge about field dynamics to influence
19 others to either reproduce the current order or make change and will influence how external events
20 will be received and integrated into a context. They play an important role in interpreting, framing,
21 and brokering. It is recognised that most field members (here in the local health and care economy)
22 are committed to prevailing conditions. However, if a particular actor understands or frames change
23 in relation to what already "makes sense" within the setting, social skill can be used to enable the
24 adoption of incremental changes (Moulton and Sandfort 2017). Relationships are important as
25 groups of actors, within or spanning organisational boundaries who know each other and have
26 previously worked together, will have developed collective interpretations and understandings
27 which then support them in utilising particular sources of authority. These include (perceived)
28 influence from political authority, economic authority, norms, beliefs and values. Within the SAF framework
29 it is the role of actors with social skill to activate, resolve and interpret signals from diverse sources
30 of authority to create collective understanding for action (Moulton and Sandfort 2017). Current
31 thinking on the SAF framework, however, does not sufficiently acknowledge that some sources of
32 authority are easier to mobilise than others, but the SAF framework does enable us to move beyond
33 an injunction that leadership needs to be 'distributed' to ask 'Who gets to lead in a given situation,
34 what did they do and what facilitated action?'.
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41 We applied the SAF framework to six Vanguard case study sites, and considered how it might be
42 modified to understand policy-driven system change where interventions are poorly defined as in
43 the Vanguard programme which comprised a collection of ill-defined interventions, different across
44 the different Vanguard models (Ref removed 2021). In this paper we investigate the fixed and
45 changing attributes of leaders that determined who exercised leadership; at what time and in what
46 circumstances; and what they did as leaders, providing evidence relevant to the practical
47 implementation of complex change across organisational boundaries.
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51 **Design and Methods** 52

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54 Using a qualitative case study methodology we explored, in depth, factors that affect whether and
55 how local Vanguard initiatives were implemented in response to national policy. Having interviewed
56 national level actors at the Programme development level in 2017/18 (Ref removed 2019), we
57 worked with six Vanguard sites (across three different model types, 2018/19) – two Multispecialty
58 Community Providers (MCP) Vanguards, two Integrated Primary and Acute Care Systems (PACS)
59 Vanguards and two Enhanced Health in Care Homes (EHCH) Vanguards, to explore what had been
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3 achieved, identify factors influencing this and examining what happened after the end of the formal
4 programme. We selected six case sites: two MCPs, two PACS and two EHCH Vanguards. The other
5 types of Vanguard, Urgent and Emergency Care (UEC) and Acute Care Collaboratives (ACCs) were
6 excluded from this work. UECs were never fully embedded into the programme, were only formally
7 part of the programme for one year, and the model was a set of interventions that had already been
8 established. As such, they were not experimental in the same way as the other models and therefore
9 did not fall within the remit of our study, which focused upon evaluating the bottom-up
10 development of new population-based models of integrated care. Likewise, ACCs were separate
11 from others in the NCM programme, had specific support requirements, were less focused on whole
12 population health care design, and led by NHS Improvement and were not part of the national
13 support programme.

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17 Between October 2018 and July 2019, the research team carried out a series of focus groups and
18 interviews with a variety of respondents at the six case study sites. Interviews were a mix of face-to-
19 face or telephone: most on a one to one basis, but at several sites joint interviews conducted with 2
20 participants were also included. Four focus groups were conducted face-to-face: two of these
21 involved professionals and were conducted at the outset; and two involved patient / public
22 Involvement / engagement (PPIE) contributors (including professional, voluntary sector and public
23 members) and were conducted at the conclusion. Group size ranged from 3-8 participants (see Table
24 1).

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27 A total of 80 respondents participated at these Vanguard sites, including current and past
28 representatives (at that time) from Clinical Commissioning Groups (CCG), provider organisations,
29 local authorities, voluntary sector organisations, Vanguard programme leads, frontline staff and
30 patient/public contributors. 1 NHS employee participated in both an interview and a focus group.

31 32 33 34 35 **Table 1: Case study respondents**

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38 Focus groups and interviews were recorded and transcribed verbatim, followed by a thematic
39 analysis using a coding schedule based on previous literature including the theory of the SAF and our
40 previous work on Vanguards (Ref removed 2019) using NVivo software. To preserve anonymity,
41 each respondent was given a unique ID number. Ethical approval was obtained from the University
42 of XXX (2018-4359-6573).

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45 Focussing on the operation of Vanguards within their specific contextual setting, we explored who
46 became the leaders within the pilot programmes locally and how these socially skilled actors
47 mobilised support, accomplished change, and how they used knowledge and expertise to influence
48 others. We applied the SAF framework, which resulted in a more nuanced, theoretically interesting
49 approach rather than simply focusing upon the concepts of 'relationships' and 'leadership'.

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52 It was recognised from the outset that the Vanguard Programme required action at three levels:
53 system (macro) level, where policy was made and support was orchestrated; meso level, where
54 Vanguard sites competed for attention and implementation effort with other initiatives across a
55 local health and social care economy; and micro level, where individual local actors interpreted
56 policy and adapted it to their local context. For this paper our main focus is the micro level to
57 investigate individuals and groups of actors performing leadership roles at the Vanguard level.

Results

The focus on socially skilled actors offers interpretations and frames issues in order to ‘make sense’ of complexity in the fields in which they operate. Brokering, framing, translating, and active boundary spanning are all examples of the social skills we observed actors in the Vanguard pilots utilising to create a shared narrative and build relationships to support the development of the new initiatives and changes being proposed. We identified four main processes that allowed this to happen: leaders exploited existing relationships; leveraged their own established local credibility, acquired knowledge and behaviours; utilised their existing position (formal and earned) within and across organisations; and were enabled by being given licence and opportunity to operationalised actions to facilitate necessary change.

Exploiting existing relationships

Each Vanguard was initiated and led by a small group of individuals. Often these were people who had known each other over a period of time, who had an existing strong working relationship and had developed trust in one another. These could be leaders at the top of the hierarchy (strategic) and / or those who had worked together at the operational delivery level across organisational boundaries on previous projects. Respondents in all of our sites emphasised the importance of these relationships and the role of these early leaders:

I think we had a mini advantage, because the four of us [strategic level managers] all knew each other, we've known each other for more than a decade...So when the five year forward view came out, when the Vanguard started, we'd already got trust, relationships built up across the healthcare department [...] and I think it stood us in massive stead and got us through this... we were lucky because we had an element of that [trust] in place, which has allowed us, I think, to go even further than if you were starting from scratch. (S5 FGD)

At the same time, once selected to be a Vanguard, it became necessary for responsibility to be shared more widely across all organisations involved in the Vanguard and for new collaborators to be brought on board. This process was supported by the high profile nature of the Vanguard programme:

Definitely think a big bit that was important, was some of the personalities and relationships, and building on existing relationships, so without, 'cause while there was some funding, there was also a lot of goodwill, and that people drawn in, who became part of it, everyone had this shared vision and focus and wanting to make a difference and make a change. (S3R01)

Longevity in the local area was also important in harnessing and retaining prior organisational learning and previously built relationships and trust, as described earlier:

It's having that longevity of staff and people who are around for a long time who can remember why we started out on this journey in the first place and we're not saying that we don't want new eyes and new blood, but actually sometimes too much staff turnover means that you forget why it is that we're here in this place that we are now, and the lessons that we've learned to get here. (S5R016)

The operationalisation of the Vanguard plans required complex engagement across organisational and sector boundaries, and, as predicted by the literature, leadership activity took place at a number of levels within each of our Vanguard sites. This could be difficult:

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3 *Everybody wanted to work together but I think there were almost split groups. And there was that period*
4 *of time of learning to trust each other and were there going to be winners and losers. It took a period of*
5 *time to almost say, and some people are better at it than others, let's be organisationally agnostic (S6R08)*
6

7 In the rest of this section we set out and explore the personal and contextual characteristics and
8 conditions which enabled individuals to be in a position to exercise of these social skills.
9

10 *Leveraging local credibility, knowledge and behaviours*

11 Social skill focusses on what actors do to contribute to 'creating and maintaining stable social worlds
12 by securing the cooperation of others' (Fligstein and McAdam, 2012 p7). Actors described as 'socially
13 skilled' successfully use tactics deemed appropriate in a given context in order to gain the desired
14 outcomes. Social actors, of different standings, utilised their various skills (vision, framing, levering
15 position, seizing opportunities, positive risk taking, flexibility, brokering), enhanced by the use of
16 strong communication engagement and boundary spanning, to 'sell' the rationale behind the
17 proposed changes; work through how to best make changes locally; and implement them to benefit
18 those delivering and receiving the health and care services. A shared vision of the end goal across
19 the whole system was important.
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21 In Site 6 the Patient Public Involvement Engagement (PPIE) lead could be described as a boundary
22 spanner, using both interpretation and mobilising skills. They described their role:
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25 *It was engagement in communication. I think that was different to other roles that I've done was there*
26 *was a much heavier emphasis on engagement and involvement... normally the emphasis is very much on*
27 *communicating the good news. But this was a lot more about the patient and public involvement and*
28 *engagement (S6R06).*
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30 Others reflected the importance of shared (collective) goals, created by framing a shared vision
31 across the health and care system:
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34 *You can have as much policy and guidance as you like but actually if you haven't got people wanting to*
35 *get to the end goal and end result, it's just a huge trudge, [...] you've got being able to get all your partners*
36 *to come together to agree the vision, the end result and the goal, and the bumpy, rocky ride that you're*
37 *going to have and that respect, trust, but also the challenge that you'll have amongst the partners.*
38 *(S2R017)*
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40 A key social skill was a range of mobilising activities. These included leaders' actions to gain support
41 from others in the system alongside agreement on a set of expected behaviours and routines. This
42 included engaging others in the system to help shape the emerging vision, committing time and
43 energy to changing organisational processes and systems, in turn creating trust, and recognising and
44 reducing resistance and inertia (Battilana *et al* 2010). These types of mobilising activities are aimed
45 at developing a co-operative environment enabling a commitment to the planned course of action /
46 change to services.
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49 We also found that enthusiastic skilled local social actors in most cases were committed to
50 continuing with an existing direction of travel, which had already begun or was well established
51 before the Vanguard Programme. A persuasive argument framed by an influential individual or
52 group as being obvious or difficult to argue with was seen as important (Jones and Exworthy, 2015),
53 along with shared commitment. For example, GPs advocating to their peers that changes proposed
54 would benefit their patients, playing into their fundamental beliefs and values:
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58 *So for the staff or the clinical workforce, it's truly that trusted relationship and collaboration that we're*
59 *in it together and how are we collectively going to solve or create solutions to better manage or case*
60 *manage patients for their benefit and what outcomes they want to achieve as well. (S5R015)*

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4 Respondents across the six sites spoke about the importance of supporting flexibility and
5 imagination while creating a permissive environment where calculated risks were allowed in order
6 to enable innovation and trialling new ways of working, while also enhancing trust within and across
7 organisations.
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10 *I think there was that ability to be creative. My messaging to my staff was if it doesn't cost more, if it
11 doesn't throw the organisation into disrepute, if it doesn't have any issues with your professional
12 registration or compromise any of that then give it a try. If it doesn't work we can go back to doing what
13 we were doing, but there's no harm in trying new things. (S6R08)*
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15 In all sites examples could be provided of individuals going above and beyond their general everyday
16 role in order to facilitate the developments under the Vanguard programme.
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18 *[Named person] has just been such a star... and he was a really dynamic individual. I think the problem
19 with his organisation, is it's quite hierarchical, so I think some of the higher powers that be in the LAs,
20 didn't necessarily support his work, and at times he would come in on his day off, to be a part of
21 meetings and so on, 'cause they didn't necessarily recognise the importance of it. So, that potentially
22 could have been a big problem, but he was just so committed, that he basically made himself available.
23 (S3R01)*
24

25 Thus social skills used were diverse and adapted to the context, highlighting the importance of
26 knowing how to do what, when to utilise positionality and in what way, and when to wield the
27 argument that vanguard status was important.
28

29 *Importance of position (formal vs earned)*

30 As we have highlighted, applying to be a Vanguard and initiating the programme required action by
31 (groups of) individuals with formal positions within a hierarchy. This formal positioning being
32 another important factor in addition to the social skills themselves. Such individuals in our case study
33 sites included, for example, senior managers within NHS organisations, or high level positions within
34 local authority (LA) or voluntary sector organisations. For these individuals, their work title conveyed
35 seniority, a leadership role and associated status.
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38 At times, this hierarchical position was an important and necessary component of exercising
39 leadership. For example, in one Vanguard, the CCG Chief Officer was described as having a very clear
40 vision for the whole health and care economy and its future development. They utilised status
41 driven power and prior reputation for getting things done. Similarly, individuals were chosen to lead
42 Vanguards if they had a track record in leading successful system change. In the quote below, tribute
43 is played to this person's skills as a leader.
44

45 *[They] combine an incredible strategic brain, and a vision, and exercise a particular mode of leadership
46 that they need, or you would need in order to do what they've done. And is also able to operate
47 nationally, to understand what procurement might require, at the same time as being able to build
48 relationships within the system. (S2R011)*
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52 However, we also found that some individuals without formal positions within a hierarchy were also
53 able to act as leaders. In each case we found that these individuals had in some way *earned* a
54 respected position within a local context. A number of personal characteristics seemed to be
55 important in this process, with two characteristics standing out: a relevant clinical background; and
56 longevity in a particular place. Operational clinical experience could have occurred many years
57 previously, but it seemed to be important in giving credibility to individuals, which in turn enabled
58 those individuals to exercise their social skills. Examples included a team leader who had previously
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3 delivered front line services as a nurse and a public health consultant who had worked in the health
4 service before moving to the LA.
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6 In some cases individuals with this long experience were able to leverage this local knowledge and
7 experience very directly.

8 *When I was having difficulty with some of the GPs, They'd pick up the phone to them and say, come on,
9 and use them by their first name, because (s)he was used to that relationship. What are you playing at,
10 (they'd say.....So actually, I think the combination of us both was very good because they just knew them
11 of old and having worked with them, they had a different relationship. (S1R02)*

12
13
14 There was evidence across sites of individuals acting to influence due to the position in which they
15 found themselves. For example, in several sites (e.g. sites 1, 4 and 5) lead GPs or other 'clinical
16 champions' acted to gain buy-in from other clinicians. This was seen as an 'easier sell' from clinician
17 to clinician, than from a manager to clinician, and those with strategic oversight encouraged these
18 processes.
19

20
21 *We're a team with a strong leadership, and you know, persuasive people who were happy to stand up in
22 a room full of people and, you know, sing the message. [...] And, you know, enthusiasm is infectious, as
23 is cynicism. So you have to try and get the enthusiasm to outweigh the cynicism. And then, when you
24 start to get results, then it becomes easier to promote it. (S1R03)*

25
26 Thus, the ability to 'leverage' effectively was also directly linked to the importance of an individual's
27 position.
28

29
30 There were also examples of 'dynamic new individuals' (e.g. support workers, LA workers),
31 supported by management in their organisations, who were able to move past historical challenges
32 as they weren't identified with previous difficult relationships. Additionally, some individuals had a
33 personal quality identified by others that made them stand out and gain buy-in for their ideas. This
34 could not always be replicated in other contexts as it was highly specific to an individual e.g. those
35 with charisma, allure and personal appeal, but was highlighted as important in several of the sites.
36 For example, in Site 3 one individual from the CCG was described as a very charismatic facilitator
37 who "added the sparkle".
38

39 *Licence opportunities and context to make change*

40 In addition to the social skills of individual actors and the hierarchical position(s) they held, perceived
41 licence and opportunities to make change were important facilitators for implementation. It should
42 be remembered that whilst it is possible for individuals to act beyond their role and span boundaries
43 out of personal conviction or skills, the formal recognition of the importance of boundary spanning,
44 and the creation of space/time/positions by those in authority is an important part of the local
45 context. For example, an individual in Site 4 was encouraged and allowed the necessary time by their
46 manager to build relationships within and across the organisations involved in facilitating the
47 Vanguard developments. This included the LA and voluntary sector where relationships were made
48 to utilise the skills of others to gain information, carry out surveys and the necessary local evaluation
49 of the Vanguard, as well as working with Vanguard account managers and developing meso level
50 Integrated Care System (ICS).
51

52
53
54 *They had a lot of capacity to be able to manage and develop and do the networking, go to meetings. So
55 I think to have that, well, it's almost like having a project manager as well isn't it? (S4R08)*
56

57
58 The prior existence of collaborative working structures was often associated with longevity of
59 leaders, for example inter-organisational boards, which in many cases had been in existence before
60 the 'Five Year Forward View' (NHS England 2014) and the development of Vanguards and was

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3 highlighted by respondents as providing opportunity. It is notable that these type of factors could
4 potentially disrupt the straightforward spread and scale of initiatives that work in one place being
5 straightforwardly implemented elsewhere.
6

7
8 A further opportunity was provided through the integral support system (from NHS England) and
9 additional resources available, which enhanced the whole overarching context of Vanguard work.
10 This included extra finances, advice and support (10 work streams) from NHS England and additional
11 personnel (e.g. account managers at the regional level) (NHS England 2016). Taken together this
12 implies a necessary system architecture which encourages local managers to be alert to potential
13 opportunities, be supported to take risks and to feel empowered to act when such opportunities
14 arise.
15
16

17 18 19 **Discussion and conclusions**

20
21 The strength of our study lies in our use of a strong theoretical framework to guide data collection
22 and analysis and our case study design allowed us to explore leadership behaviours in context. The
23 SAF framework (Moulton and Sandfort 2017) focuses upon social skills used to initiate and maintain
24 policy-driven change programmes in public sector settings. We explored with respondents the
25 factors which they felt had supported their work programme, and the things which had made their
26 task more difficult. During the analysis we looked across the cases for shared examples of particular
27 social skills. However, there are some limitations. Given the timing and resources we were only able
28 to look at 6 Vanguards (3 of 2 model types). Whilst we did experience data saturation, in that new
29 interviewees in each case study site tended to reinforce existing interpretations rather than
30 generating new themes, it is possible that a larger variety of case study sites would have drawn
31 attention to additional relevant contextual and personal conditions and behaviours. Our research
32 also commenced part way through the Vanguard programme, hence there had already been
33 changes to Vanguard guidance, our interviewee's recollections of early events may have been
34 incomplete, and some personnel had changed / moved on.
35
36

37
38 Sensitised by our use of Moulton and Sandfort's (2017) SAF framework, we tried to gain a better
39 understanding of the social skills being utilised by those undertaking this leadership work at different
40 time periods of the Vanguard programme. However, we found that the exercise of skills (e.g.
41 brokering, framing, translating, and active boundary spanning) alone did not fully explain what we
42 were seeing. The notion of 'distributed leadership' implies that anyone with the requisite skills can
43 and should take on leadership roles in facilitating complex organisational change. However, analysis
44 across our cases suggested that, in addition to their social skills, individuals effectively undertaking
45 leadership work also tended to have some common characteristics. At the same time, we found a
46 number of contextual conditions, the presence or absence of which appeared to play an important
47 role in the individual exercise of social skill.
48
49

50
51 Distributed leadership is often heralded as an important approach in fostering sustainable change
52 (Jones, 2014). However, it is hard to define and the concepts used are not always tangible or easy to
53 operationalise. According to Bolden (2011), descriptive and normative perspectives which dominate
54 the literature on distributed leadership should be supplemented by more critical accounts which
55 recognise the rhetorical and discursive significance of distributed leadership in (re)constructing
56 leader-follower identities, mobilising collective engagement and challenging or reinforcing
57 traditional forms of organisation. By using the SAF framework we have been able to contribute to
58 this debate by examining the role of leaders as social actors in the Vanguard programme in England.
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5 The key assumption in the SAF framework (Moulton and Sandfort, 2017) is that the same initiative
6 implemented in two different places will vary according to the local context, due to change being
7 interpreted differently by those involved. We found that the SAF framework was a useful framework
8 within which to interrogate our data, but that the category of 'social skills' required further
9 elucidation in order to consider how and why actors do what they do, in any given situation. Local
10 'leaders', at different levels within organisations and across healthcare systems, are the socially
11 skilled actors involved and this framework helped to move our discussion beyond the idea that
12 sustained change requires 'strong' or 'distributed' leadership to ask 'what did the leaders do in this
13 particular situation?', explore exactly what is done by whom in making change happen and identify
14 factors in the local context that help / hinder their effectiveness.
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17
18 The expected social skills of brokering, framing, translating and active boundary spanning were
19 identified in all sites, along with efforts to mobilise others through a shared vision to commit time
20 and energy to the desired change. Our research, suggests that 'leaders' at all levels mobilise sources
21 of authority (political, economic and social), using experience alongside position (formal or earned),
22 personal enthusiasm and charisma to support or inhibit the exercise of that leadership, to enable
23 change to happen (Ref removed 2021). Other skills such as the desire to try new things (flexibility),
24 seizing opportunities (e.g. use of extra funding), taking positive risks, risk sharing and willingness to
25 act beyond their role expectations were also necessary.
26
27

28 However, having these skills alone was not enough. At the local level, individual positionality
29 amongst those driving change was seen to be important. Success seemed to link to support from
30 those in hierarchical positions (licence), who had decision making power and the ability to designate
31 resources (financial or otherwise) in the wider healthcare system, and / or involvement of individuals
32 at an operational level, who were perceived to have credibility as a result of their personal
33 attributes. The characteristics fostering this credibility included front-line clinical experience and
34 longevity in a local healthcare system, which fostered good relationships and trust, as well as
35 perceptions of being committed to the local area.
36
37

38 Our research shows that in systems that operate well across organisations, different people will
39 need to have different combinations of attributes – hierarchical status or earned status as well as
40 having the skills to enact what their status allows, in the context of support from others, to make use
41 of their political astuteness, previous relationships, gained trust, and ability to work as boundary
42 spanners gaining buy-in from others at different hierarchical levels. This could be through support
43 and freedom to try things out and take risks; the provision of resources; and / or support from
44 frontline staff enacting the changes required. In any given context, this cannot necessarily be
45 planned and will naturally evolve with people taking appropriate leadership and ownership at
46 different times over a programme of change.
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49 Our findings suggest the need for leaders who have the necessary hierarchical (formal) position to
50 allow positive risk, commitment of resource, and flexibility, alongside longevity in local organisations
51 / systems, expertise to know what is possible/what works in given circumstances, and personal
52 qualities which inspire others. This matters both within and across organisations and across wider
53 health and care systems, and is impacted by the local context in which such collaborations operate,
54 shaping how organisations work together and impacting what they can achieve collectively
55 (Alderwick *et al.*, 2021).
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58 We found that individuals working in an area for a considerable time built a history, which helped to
59 foster trust between actors. This in turn facilitated an environment that enabled testing and piloting
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3 as a joint venture, between different organisations, sharing both potential gains and risks. Fitzgerald
4 *et al.* (2012 p236) cite Pierson (2003) who 'argues that not all organizational processes can be
5 explained through simple causal links, but that observed outcomes often depend on accumulations
6 of factors or pressures' which 'build into a gradual trend such that events move in a particular
7 direction over time', suggesting a cumulative effect type model, which requires time to develop in a
8 specific local context.
9

10
11 Focusing upon the practical implications of our findings for future integration programmes, we
12 suggest the need to prioritise keeping people in organisations and local systems for the long term,
13 even if their roles change, and nurturing their development to make the most of their skills and the
14 relationships they have developed. They need to be given opportunities to boundary span and there
15 is a requirement for structures, which facilitate working together over a prolonged period of time, to
16 build trust.
17

18
19 We have shown that there is a need for 'leaders' with a mix of skills and standing across the health
20 and care system. Those with hierarchical power need to provide the clout, play the political game,
21 provide resources and foster a context with permission for testing out different ways of working and
22 encouraging positive risk taking. There is also a need for those with established connections,
23 previous relationships and knowledge of local history to use that to gain buy-in from others across
24 the system. Those with operational knowledge are required to explain what will work and how, in
25 the local context, as well as garnering support and commitment from frontline staff. Others at
26 various levels will use often intangible personal qualities to inspire others in the system. This
27 suggests the need for a system architecture which encourages local managers to be alert to
28 potential opportunities and feel empowered to act when they arise. A supportive approach to risk
29 taking, in which performance management processes reward and encourage activity beyond narrow
30 role specifications, may also be valuable.
31
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33
34 While literature already acknowledges that leadership is not simply about individual leaders, but
35 about leading together, this paper emphasises that a further interdependence exists between
36 leaders and their organisational context. Good leaders require an organisational / system context
37 that enables existing hierarchies, positionality and temporality/longevity to work in the leaders'
38 favour, in order to achieve success. Our findings point to the need for longer term investment in
39 resources, people and workforce, alongside a locally agreed strategic direction of travel, which
40 leaders across different organisations can support. This could be built into the way Integrated Care
41 Systems are developing across England, allowing systems to grow organically without over-relying on
42 individuals; providing longer term budgets and planning; and for the system to be regulated as a
43 whole rather than as individual organisations.
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49 **Disclaimer**

51 **Acknowledgements**

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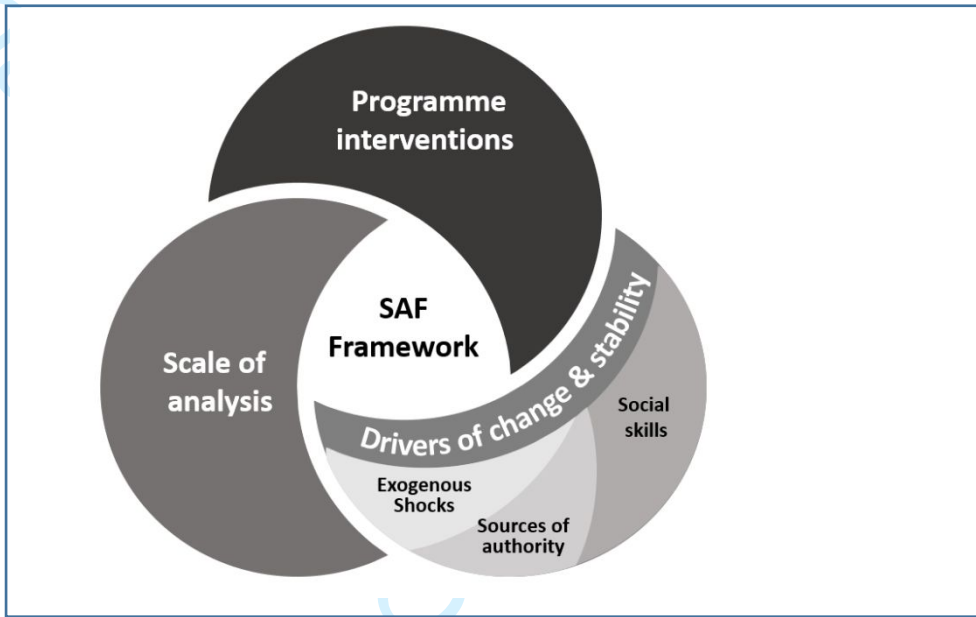
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Figure 1: Elements making up the SAF Framework.



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Table 1: Case study respondents

Respondent type	Numbers interviewed	Numbers in focus groups
NHS employees (current / past)	48	14
Local Authority (LA)	4	-
Private/Community/Charity sector	9	1
Public contributor	1	4
Total	62	19

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3 **Disclaimer:** This paper is based on independent research commissioned and funded by the NIHR
4 Policy Research Programme "National evaluation of the Vanguard New Care Models Programme",
5 PR-R16-0516-22001. The views expressed in the publication are those of the author(s) and not
6 necessarily those of the Policy Research Programme, NIHR, or the Department of Health and Social
7 Care.
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10 **Acknowledgements** We are very grateful to our participants, who were generous with their time.
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