

# Mobilising and organising for large scale change in healthcare

**'The Right Prescription: A Call to Action on the use  
of antipsychotic drugs for people with dementia'**

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# List of abbreviations

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<b>CQUIN</b>	Commissioning for Quality and Innovation
<b>DAA</b>	Dementia Action Alliance
<b>DH</b>	Department of Health
<b>GP</b>	General Practitioner
<b>MBS</b>	Manchester Business School
<b>NHS</b>	National Health Service
<b>PCT</b>	Primary Care Trust
<b>QIPP</b>	Quality, Innovation, Productivity and Prevention
<b>RPS</b>	Royal Pharmaceutical Society
<b>SHA</b>	Strategic Health Authority
<b>SMO</b>	Social mobilising and organising

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# Foreword

This report tells the story of a bold innovation by the National Health Service of England to try out methods and approaches from other change settings that offered the potential to help deliver big changes for the NHS.

The English NHS, like healthcare systems across the globe, faces unprecedented challenges to deliver higher quality care for its patients and meet greater demand for services in an era of financial constraint. What is clear is that many of the ways that we have led change in healthcare up until now, whilst they have delivered many improvements, are, on their own, unlikely to deliver at the speed and scale required in the future. We need to build on the strengths of what we have achieved but also need some new and additional ways of thinking about change.

The innovation that is the subject of this report involved taking the lessons of change from the great social movement leaders and applying them in a health setting; learning from leaders who typically had few economic resources and little power in a formal sense, yet were able to deliver profound change that improved the lives of thousands of people. What was the essence of this “mobilising and organising” approach? Would it work for healthcare leaders? How could it be adapted for an organisational setting where the nature of power was inevitably hierarchical?

This research report from Manchester Business School tells a fascinating story of the development and testing of these change methods for a healthcare context. It shows that there were a number of false starts and wrong moves but that a “blended” approach was developed. It built on existing NHS strengths in change management but added many elements of social organising and mobilising” that gave energy and breadth to the change. Most importantly of all, it enabled changes to happen that gave quality of life to people with dementia and their families that wouldn’t have happened without this initiative. It has also been successful in growing resources for change.

The relationships that were built and the commitments made have led to another effective call to action, “*The Right Care*”, focussed on improving the care of people with dementia in acute hospitals and has helped the Dementia Action Alliance to grow into an effective force for nationwide change, promoting dementia-friendly communities.

The researchers suggest that this “call to action” approach to change has strong potential across health and care settings. However, they say that it won’t work in every change context. It is as important therefore that we understand where it is unlikely to work as it is to understand where it will succeed.

We are proud to have been part of this initiative and have found the experience of it life changing. We will certainly never think about managing change in the same way again. As leaders of health and healthcare, we frequently challenge others to change but perhaps now is the time for us to reflect deeply about our own mindset for change and consider whether we need to open our minds to additional possibilities.

Thank you to the research team from Manchester Business School for capturing and sharing the learning. Thank you to the thousands of people who have contributed to The Right Prescription, helped to put right a terrible wrong and continue to do so. Most of all, thanks to the people with dementia and their families who inspire us and demonstrate daily that it is possible to have a wonderful quality of life, living with dementia without antipsychotic drugs.

**Helen Bevan**  
**Nadia Chambers**  
**Catherine Holmes**

**Core team**  
**‘The Right Prescription’**

# Section 1

## Executive summary

# Executive summary

*'There's a movement going on! It's all coming together now, change is finally starting to happen!'* Graham Browne, March 2012

This report presents the findings from an 18 month exploration of the use of a mobilising and organising approach to large scale change initiated by the English National Health Service (NHS). The focus of this study has been upon the project developed by the NHS Institute for Innovation and Improvement (NHSI); a national body (July 2005 to March 2013) to support the transformation of the NHS, through innovation, improvement and the adoption of best practice.

This project, entitled 'The Right Prescription: a Call to Action on the use of antipsychotic drugs for people with dementia' (The Right Prescription), aimed to act as an enabler for healthcare professionals (pharmacists, GPs, care homes) to achieve a common goal by releasing their shared values and commitment' (RPS, NHS Institute and DAA, 2012:3).

The common goal behind this project is that all individuals with dementia who have been prescribed antipsychotic medication will have '...undergone a clinical review to ensure that their care is compliant with current best practice and guidelines, that alternatives to the prescription have been considered and that a shared decision has been agreed regarding their future care' (ibid).

The project has been researched as a case study of the use of a social mobilising and organising approach to change, 'as a means of enhancing quality improvement and cost reduction at scale' (NHS Institute tender document, 2011).

## Summary of key findings

There has been an increase in reviews of anti-psychotic prescribing and a reduction in the inappropriate prescribing of this form of medication by 51.8% HSCIC (2012) in people with dementia. Whilst it cannot be claimed or proven that this improvement is a direct result of 'The Right Prescription – Call to Action', there is a belief amongst key stakeholders that it has been an important contributory factor.

The approach has been 'blended' to suit the context of the English NHS and the 21st century. Ways in which it has been blended include an adaptation of narrative; alignment with existing policies, organisational drivers and hierarchy; adaptation of training and language to be more sensitive to the English context and supplementation of leadership practices with a sixth practice of 'coaching'. The approach provides a new form of social movement, one which combines elements of rational actor and resource mobilisation theory, with elements of the European new social movements.

### The added value of the approach includes:

- the development of relationships, teams and communication networks. In addition these relationships are ones based on shared values, commitment and shared accountability and provide access to additional resources.
- development of new ways of working and a new conceptualisation of relationships.
- development of 'strong' and 'weak' ties.
- enhanced leadership, which is cascaded across professional, organisational and hierarchical boundaries. This form of leadership is expanded to include coaching and empowering of others to lead.
- enhanced commitment to take action.
- enhanced receptivity of the organisational context to enable the call to action to operate within organisations across a health and social care community.

# Executive summary

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## Recommendations

**Our research suggests that the effectiveness of the approach is maximised where:**

- There needs to be a clear, intolerable, situation, which galvanises people towards taking action.
- Resources are maximised through intensive preparatory work to align with performance levers and to identify role models and high level support.
- Flexibility is provided to allow the approach to evolve in response to the context.
- Strategy is utilised to enhance receptiveness of the organisation and resources available.
- Relationships are developed which cross organisational/professional/hierarchical boundaries.
- Reflection on the process is built in and becomes an iterative occurrence.
- Alignment is secured with organisational and performance drivers.
- Respected role models are identified.
- Coaching support forms one of the leadership behaviours.
- Social media can be utilised to enable additional access to resources and support.
- A baseline of data is provided.
- Metrics are identified at an early stage.
- Participants are drawn from a variety of organisations, dependent on the goals of the work. In addition that the participants involved are supplemented by those from additional organisations, professions, etc. through a process of iterative reflection.

## Acknowledgments

This research could not have taken place without the active co-operation of a number of parties.

We are particularly grateful to the staff, patients and carers who have been involved in the call to action and have so willingly given of their time and attention to support our study.

We are also particularly grateful to the staff of the NHS Institute who have shared with us their thoughts and journey, provided us with ongoing feedback and their suggestions for informative contacts during the research.





# Section 2

## Introduction

# Introduction

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This report begins by setting the historical and policy context, proceeds by describing key terms and themes from the literature and then describes the methodological choices made within the study. Following the methodology, the report goes on to describe its findings through providing a summary of key features and achievements of the approach and a description of some of the ways in which the approach has evolved during the past 18 months. A discussion follows to outline some of the tensions and key questions that have emerged during the study and this is then followed by conclusions, recommendations and an acknowledgment of limitations of the study.

## 2.1 Background

The NHS is currently facing some of the biggest challenges since its inception, with the need to respond to rapidly changing demographics, the growth of new technology and rising public expectations, whilst also improving the quality of care for those who use, and depend on, its services. Whilst these demographic and quality challenges are not new, they are larger in scope and impact, arriving during an economic downturn, a time in which staff are challenged to ensure, and improve, quality during a time of aggressive cost saving and turbulence and turmoil.

Whilst there are many examples and inspiring stories from the recent history of healthcare to demonstrate how NHS leaders have risen to the challenges which face them, the scale and speed of the change which is now required, necessitates the supplementation of existing leadership capacity, and capability, with additional knowledge, techniques and approaches. Hence, within this current context, there is the need for healthcare organisations to '...be creative and innovative' (Adil, 2012).

In recognition that the existing scale, and rate of improvement, created by structural (anatomical) changes introduced through the NHS plan (DH, 2000), were insufficient to produce the results needed within the current context, an international search was launched during 2009-10 in an attempt to enhance 'understanding of what accelerates improvement' (Interviewee Department of Health, June 2012).

It was during this search that the mobilising and organising approach of Marshall Ganz from The Kennedy School of Government at Harvard University was considered as a means of re-connecting with the values and emotions of stakeholders within the health service, as a means of stimulating transformational change, of acting to motivate and engage stakeholders to work together to ensure and improve quality, whilst also delivering cost improvements at scale (ibid).

This mobilising and organising approach has been instigated in recognition of the limitations of those methods of improvement which operate through formal, position-based authority structures, in conjunction with targets and associated sanctions/incentives/performance monitoring.

It is recognised that this more 'rational' approach to improvement, an approach which relies on extrinsic motivation is limited in its impact on quality, especially in cases such as the implementation of reviews of prescribing within the care of people with dementia, reviews which rely on the participation of multiple stakeholders, not all of whom are directly part of the NHS.

Furthermore, it is recognised that for true improvement in quality and cost, a change methodology is required which re-engages and energises staff, re-connecting them with values and emotions whilst also involving and valuing patients and carers.

# Introduction

## 2.2 Study aims

This study sought to explore the use of a mobilising and organising methodology as an approach to large scale change. We have chosen as an example of a mobilising and organising approach to change in action, the work of the NHS Institute for Innovation and Improvement to support the Department of Health Quality Improvement Productivity and Prevention (QIPP) programme, through acting as an enabler for a work stream which focuses on the prescribing of antipsychotic medication in people with dementia – part of the medicines management QIPP work stream.

The aim of this study is to identify key components, and areas of achievement, within the call to action, to tell the story of how this approach has evolved to respond to the challenges inherent within the English NHS, to identify how this approach might be utilised by others and to identify lessons for the future implementation of such an approach within the public sector.

## 2.3 Policy context

**This section outlines some of the recent policy drivers relevant to the focus of the study.**

### Quality Innovation Productivity and Prevention (QIPP)

The challenge currently facing the NHS due to the increasing healthcare needs of the population, changing demographics and expectations and coupled with the global financial crisis has impacted on funding for the NHS to the extent that it is predicted that the gap in funding for the 3 years from April 2011 is likely to require £20 billion in efficiency savings.

It becomes important therefore to offset the impact of this deficit through identifying, and addressing, areas in which improvements in quality and efficiency can be made. Hence, the Department of Health (DH) created a national programme, **Quality, Innovation, Productivity and Prevention** (QIPP) which was a national strategy involving all NHS staff, patients, clinicians and the voluntary sector.

This strategy aimed to improve the quality and delivery of NHS care, whilst also reducing costs and in order to make £20bn efficiency savings by 2014/15.<sup>1</sup>

From January 2011, the team from the NHS Institute was committed to supporting 3 QIPP work streams and to enabling the wider NHS community to take action to deliver the QIPP agenda. The QIPP work streams that were supported in this way were:

- a. **Medicines management** - reduction in the inappropriate use of antipsychotics in people with dementia, through the call to action (**The Right Prescription**). The goal of the call to action has been to ensure that all people with dementia who are taking antipsychotics receive a clinical review which aims to reduce or discontinue the use of antipsychotics wherever appropriate.
- b. **Right care: shared decision making in renal care** - for people with end stage kidney disease.
- c. **End of life care** - through the call to action to 'find your 1%' campaign. (NHSI QIPP review, 2012)

In June 2011, an additional call to action was launched, entitled 'The Right Care creating dementia friendly hospitals', with the goal of enabling 'every hospital in England (to) have committed to becoming a dementia friendly hospital, working in partnership with their local Dementia Action Alliance' by March 2013 (NHS Institute for Innovation and Improvement website, 2013).

The NHS Institute has worked to support these QIPP work streams by blending core principles from social movements, community organising, service improvement and organisational development into a unique approach that is aimed at capturing hearts and minds, building capacity, and enhancing resources for change. This unique approach is termed 'a call to action'.

<sup>1</sup> <http://www.improvement.nhs.uk/Default.aspx?alias=improvement.nhs.uk/qipp>.

# Introduction

## The Banerjee Report 2009

The call to action drew much of its impetus from an influential report, written by Professor Sube Banerjee in 2009. This report was commissioned by the Department of Health to examine the extent of current use, and potential impact of, antipsychotic medication for people with a diagnosis of dementia. The report identifies significant issues associated with the prescribing of antipsychotic medication, both in terms of quality of care and patient safety.

The report pointed to the overuse of antipsychotic medication in the management of the behavioural and psychological symptoms of dementia and stated that despite the existence of good practice guidelines; these guidelines have often not been translated into clinical practice. One of the major findings of the report was, that 'reviewing the evidence, these drugs appear to have only a limited positive effect in treating these symptoms but can cause significant harm to people with dementia.(p. 3)' Banerjee estimated that there were currently 180,000 people with dementia being prescribed antipsychotic medication in the UK and of this number 36,000 were likely to benefit, whereas use of antipsychotics at the current levels, given their potential harmful effects, could equate to the incidence of 1,620 cerebrovascular adverse events (stroke). Antipsychotics are too often used as a first-line response to behavioural difficulty in dementia, rather than as a considered second line treatment when other non- pharmacological approaches have failed.

In its response to the report (DH, 2009), the British Government expressed its commitment to improving the care and experience of people with dementia and their carers by transforming dementia services to achieve better awareness, early diagnosis and high quality treatment at every stage and in every setting, with a greater focus on local delivery of quality outcomes and local accountability for achieving them. Andrew Lansley, Secretary of State for Health, told the Dementia Action Alliance that there were few more important issues to health and social care than dementia, (DH Media centre, 2011) reaffirming government commitment to delivering the National Dementia Strategy for

England. The Dementia Action Alliance and all its members have published action plans for how they are improving quality of life for people with dementia (Dementia Action Alliance website).

Although the Banerjee report (ibid) highlighted that the 'assumed population' of people with dementia taking antipsychotics is around 180,000, assertions made by the Alzheimer's Society suggest that diagnosis rates are currently around 46% of the total expected population of dementia sufferers (Alzheimers.org.uk) (Thus, 50-60% of people are currently living with dementia but are undiagnosed). This has a massive impact on the ability to undertake clinical reviews for 'all people with dementia' because at the moment only those who have a diagnosis, and therefore appear on a register, or caseload, i.e. who are known to the system, get a clinical review. Subsequently, those who are taking antipsychotics and may have undiagnosed dementia do not have any way of accessing the alternatives that may be available to support behavioural and psychological symptoms of dementia. (Alzheimers.org.uk)

The Banerjee Report (DH 2009) is indicative of the growing awareness of the importance of the care of people with dementia. There are currently over 800,000 people with dementia in the UK, a figure estimated to rise to one million by 2021 (Alzheimers.org.uk). Dementia costs the UK £20 billion per year and it is now recognised as an important political priority. In 2009, a national dementia strategy for England, 'Living Well with Dementia', was published (DH 2009b). Not only is dementia now highlighted as an area requiring attention in the 2012/13 NHS Operating Framework, with particular focus upon the need to review anti-psychotic prescribing; but the Prime Minister's recent challenge, issued in March 2012, aims to build on the dementia strategy through a programme of awareness raising, quality improvement and research (DH website, Prime Minister's Challenge). These initiatives illustrate the growth of top level political commitment for this cause.

# Introduction

## The Big Society

Political commitment also lies behind the introduction of the Big Society ideal. The espoused Big Society ideals of increased voluntarism, philanthropy and community empowerment, introduced by the Conservative-Liberal coalition government in 2010, resonate with the ideals of connectedness and community empowerment which are embodied within a mobilising and organising approach to change.

Furthermore, in February 2011, it was announced that up to 500 senior 'community organisers' would be trained to 'ignite the impulse to act', making it perhaps natural to spot resonance with the language of a mobilising and organising approach within this language.

What perhaps the Big Society has failed to adequately consider is the problem of how to promote capacity and capability and how to resource and support its directives (Ballatt & Campling, 2011). With one of the perceived strengths of a mobilising and organising approach being that of enhancing capacity and capability, whilst also enhancing resources, it is perhaps not surprising that early explorations of the approach sought to identify linkages with the Big Society (cf account of introductory event for senior managers, Feb 2011).

## 2.4 What is a call to action?

A call to action is '...about solving a difficult problem, changing an intolerable situation or putting right a specific wrong, by uniting people with a shared goal to work together, by committing to take specific actions, through building energy, to achieve change within a specific period of time'.

The 'Call to Action' is in effect a form of social movement, adapted and blended to suit the needs of the English NHS. The aims behind these calls to action were to develop learning of leadership, organising and action in partnership with Professor Marshall Ganz and colleagues from the Leading Change team at Kennedy School of Government, Harvard University.

Within this research, we focus largely on the call to action to support the first of the QIPP work streams identified, that related to medicines management. The NHS Institute for Innovation and Improvement, in partnership with the Dementia Action Alliance (DAA) launched this call to action on the 9th June 2011, with the common aim of improving the quality of life of people with dementia and their carers, through reducing the inappropriate use of antipsychotics. The overarching aim of The Right Prescription was:

*'...to ensure that all people with dementia who are receiving antipsychotic drugs will have undergone a clinical review to ensure that their care is compliant with current best practice and guidelines, that alternatives to their prescription have been considered and a shared decision has been agreed regarding their future care by 31st March 2012.'*

(Dementia Action Alliance website)



# Section 3

Social movements: a brief  
introduction

# Social movements:

## a brief introduction

The intention of this section is to familiarise the reader with some of the concepts, and theory, surrounding social movements and social mobilising and organising; therefore serving as an introduction to some of the key themes which emerged throughout the conduct of this study. Given the limited space available, it provides only a selective outline of some of the most salient concepts associated with social mobilising and organising; with particular emphasis on the application of this approach within the context of the leadership of large scale change.

Nick Crossley (2002) informs us that social movements are one of the most extensively studied areas in the social sciences and reminds us that 'social movements are extremely prevalent in contemporary western societies (with) evidence of their activities everywhere'. As an area which has been the focus of so much study, it is not surprising to find that there are many definitions and several schools of thought. Bate, Bevan and Robert (2004) identify 'three broad schools of thought' within the history of social movement theory:

Figure 1: Social movement theories

THEORY	TIMESCALE	KEY CHARACTERISTICS
Collective Behaviour Theory	1940s-60s	Focus on role of emotion and non-rational behaviour. Mainly located in American school of movements.
Rational Actor Theory	1970s	Focus on: <ul style="list-style-type: none"><li>• Individual actors; the private and social desires that motivate them to act (Crossley: 2002).</li><li>• Opportunities and constraints for action.</li><li>• Capacity of agents to identify action which would enable realization of desires and evaluation of opportunities and constraints.</li></ul> American.
Resource Mobilisation Theory	1980s	Widens focus to include action on behalf of the 'collective'. Maintains that rational actors, incentivised by selfish desires can be 'led' to take action on behalf of collective through use of 'selective incentives'. Raises importance of 'leader' who can provide or mobilise incentives. American.
New Social Movements	1990s	Focus upon framing and sense making. Centre upon public debates about matters of public concern which translates into pressure for change. Originate from Europe.

(Adapted from Bate, Bevan and Robert (2004) and Crossley (2002))



# Social movements: a brief introduction

## 3.1 Defining social movements

There are many definitions of social movements and our purpose here is to concentrate on those definitions of social movements which relate most closely to the context in which this research is situated.

Blumer (1969:99) suggests that

*'Social movements can be viewed as collective enterprises seeking to establish a new order of life. They have their inception in a condition of unrest, and derive their motive power on one hand from dissatisfaction with the current form of life, and on the other hand, from wishes and hopes for a new system of living. The career of a social movement depicts the emergence of a new order of life.'*

Within this description, Blumer highlights the antecedents and motive power of a movement and in doing so, has relevance to the current context. Bibby et al. (2009:25) provide a useful working definition of a social movement as:

*'...a voluntary collective of individuals committed to promoting or resisting change through co-ordinated activity, to produce a lasting and self generating effect'.*

This definition circumvents the usual assumption that social movements tend to be located outside established institutions and their structures and offers a more inclusive conception in which social movements are potentially 'for everyone'. In this context, the main influence on social movement thinking in recent years, and the source of much of the impetus to the NHS Institute's practical development of these ideas, has been the work of Professor Marshall Ganz at the Kennedy School of Government at Harvard University.

Ganz describes a social movement as follows:

*'Social movements emerge as a result of the efforts of purposeful actors ...to assert new public values, form new relationships rooted in those values and mobilise the political, economic and cultural power to translate those values into action.'*

(Ganz, 2010)

Ganz identifies four key components of what he terms the 'social mobilising and organising' approach; framing, public narrative, mobilising and organising. These are described briefly below.

# Social movements: a brief introduction

## 3.2 Framing

Benford and Snow (2000) describe framing as a process of 'meaning construction' through which groups and individuals make sense of the world. More specifically, these two authors define framing as:

*'..the process by which leaders construct, articulate and put across their message in a powerful and compelling way in order to win people to their cause and call them to action'*

(Snow & Benford, 1992).

The relevance of framing to social movements is that it:-

- Allows participants to develop shared understandings of the problems faced by the group and, furthermore, to assess what actions to take and why.
- In addition, framing has importance in its ability to convey a message in a manner which appeals to people's motivation to act, of maximising desire and creating 'selective incentives' (Figure 1).

Thus framing is a means of gaining support, of drawing people to the cause and as such, is a central component of mobilising action.

Effective framing takes place by connecting with individuals' ideals, values, needs and aspirations, so that effective frames are positive, optimistic, aligned with the desired action and relevant to the target audience.

Framing connects with people's hearts and minds as much as or more than their intellects. The importance of framing is not just confined to the field of social movements. Scholars in the fields of management and leadership view framing as a crucial skill for leaders of organisations.

Jay Conger (1991:34) suggests that:

*'Effective framing of an organizational mission will ensure emotional impact particularly in terms of building a sense of confidence and excitement about the future.'*

## 3.3 Public narrative: telling the story

A second key component behind the social mobilising and organising approach is 'public narrative', or 'telling the story'. The story, in this context, relates to the current 'intolerable' situation and draws people together to the cause.

Change is more likely to happen if employees are able to tell their own stories, so that employees are not passive recipients of management messages, but active sense makers (Weick et al. 2005). The story told may have within it a sense of injustice, but people will not engage in action to alleviate the situation without the leader also conveying a sense of hope and the sense that action can be taken.

Public narrative draws upon framing therefore and is described by Ganz as:

*'...a leadership art. Leaders learn to draw on narrative to inspire action across cultures, faiths, professions, classes, and eras.'*

For Ganz,

*'... public narrative is composed of three elements: a story of self, a story of us, and a story of now. A story of self communicates who I am – my values, my experience, why I do what I do. A story of us communicates who we are – our shared values, our shared experience, and why we do what we do. And a story of now transforms the present into a moment of challenge, hope, and choice.'*

(Ganz; 2008:1).

# Social movements: a brief introduction

## 3.4 Mobilising

The process of mobilisation involves building a critical mass, from which comes a greater level of momentum or energy and the capacity to build teams of committed individuals. Mobilisation involves bringing together the people who are supporting the cause, moving individuals from bystander to participant, drawing on people's passion, energy and personal commitment in order to prepare people to become activists and agents for change.

The process moves people along a continuum that ranges from engagement to commitment to the development of a full scale movement and therefore action.

Bate Robert and Bevan (2004), define mobilising as:

*'...the concrete actions taken by a person in the direction of change while, at the organisational level, mobilisation refers to the process of rallying and propelling segments of the organisation to undertake joint action and to realise common change goals.'*

## 3.5 Organising

The role of organising is to translate the energy developed through framing and mobilising, into purposeful and effective action. Within organising, leadership takes a central role and consists of the **'practices which enable others to achieve purpose in the face of uncertainty'** (Ganz 2011).

Such leadership is distributed at a number of levels e.g. core team, extended team, local organisers and is characterised by its focus upon enabling **'a group to turn its resources into the power to make change'** (ibid), it is, above all else therefore, a relational practice and one which is closely linked to Ganz's ideas about the practices of structure, strategy and action outlined below.

In addition to the prominence of leadership and its root in relationships, organising requires a community capable of exercising collective agency and of utilising resources (time, energy, materials) to create purposeful change.

As opposed to the more traditional form of 'organisation', organising in social movements (community organising) is not based on a hierarchical structure, but rather, on a network of activists of largely equal status.

Community organising can therefore be summarised as:

*'...enabling people to combine resources to act strategically to achieve a common purpose... Organisers lead by developing leadership; building community around that leadership; and building power from the resources of that community'*

(Ganz; 2010).

# Social movements: a brief introduction

## 3.6 Salient features of mobilising and organising

In a telephone interview with Professor Marshall Ganz in May 2012, the Professor identified the following as key features of the mobilising and organising approach.

**i) Three key questions:** three key questions are described as lying at the heart of a mobilising and organising approach. These questions are as follows:

1. Who are my people/my constituency?
2. What are the challenges that they are facing?
3. How can the resources of that constituency be mobilised to create the capacity to deal with that challenge(s)?

**ii) Centrality of the constituency**

Core to a mobilising and organising approach are the people, the stakeholders who form the 'constituency'. Through this focus on the 'constituency' and the resources available to that constituency, Ganz's mobilising and organising approach places a consideration of power dynamics in the centre of the frame;

*'I'd say the ...key piece here, is taking power seriously and understanding that so much of what goes on within organisations, between organisations and outside in the world and so forth, lies less in the technical question or even informational questions than the way in which power is configured and linked and structured and so forth.'*

(Marshall Ganz in conversation 23rd May 2012)

**iii) Development of leadership**

Through the juncture between the focus on people and a consideration of power, the other key component of this approach is

*'...one of developing leadership, exercising leadership in conditions of uncertainty, which treats uncertainty not as ...something to be fled or confronted with control, but rather to be engaged with, learned from, adapted to and moved through and in a purposeful way.'*

(Ganz, *ibid*)

Leadership within a mobilising and organising framework is not only practiced through the 5 key components or 'leadership practices' described in 3.7. i.e., creating relationships, narrative, strategy, structure and action, it is **developed**, it evolves in **response to** the turbulence, helping people to embrace change; *'It provides a ring around the turbulence!'* assistant chief executive in conversation, August 2012. In doing so it provides, what one of our interviewees, a consultant nurse, describes as *'a narrative of hope and empowerment'* (Nov 2011).

**iv) Resources**

In traditional NHS change programmes, leaders draw upon, and allocate, a finite amount of resource to support the change process. This resource might take the form of monetary funds, people, management support systems and/or technology. In this context, resources are *finite* and they *diminish* over time.

From an organising and mobilising perspective, resources can be perceived, and therefore mobilised, in a different way. Since social movement leaders are traditionally located outside of the organisation, they lack access to the kinds of resources that organisational leaders have available and therefore need to be "strategically resourceful". In effect, this means that rather than *allocating* resources, they have to *build* resources.

These resources are typically made up of relationships and commitments to a shared purpose. People get engaged in the change because they make an emotional connection with it, a connection linked to their values and shared purpose. They are willing to take action because they want to, not because they have to, hence the change is rooted in commitment, rather than compliance.

# Social movements: a brief introduction

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## 3.7 Social movements in organisations

Our review of the literature surrounding social movements, conducted as part of this study (cf Appendix 4), highlighted numerous cases of social movements developing outside of established organisational and institutional structures. It is clear that this seems to be the recurrent characteristic of social movements in general; they develop in response to some unmet need or grievance, a grievance which is perceived by those in that movement as not being met by the institutions and they are examples of where movement participants are in some way excluded from the change process (Scott, 2001).

In contrast, evidence from the literature for the development of social movements within organisations seems limited. However examples do exist, and these have most frequently been in the form of industrial actions, for example the 1968 Ford sewing machinists' strike, which later paved the way to the Equal Pay Act of 1970.

Thus social movements within organisations share many common characteristics in that they usually focus on the achievement of a particular goal or set of goals which the organisation has the power to fulfil, that they are a response to a particular grievance and arise where the organisation seems hostile to the changes sought and therefore unwilling to change its policies and practices (Arthur 2008).

Movements within organisations can be initiated in response to the actions of wider movements outside the organisation. In the case of healthcare organisations this might include pressure from health interest groups and professionals within institutions to change organisational practices such as the campaign for access to medicines for HIV in South Africa, led by the Treatment Action Campaign (TAC) between 1998 and 2008.

Examples of previous social movements within healthcare organisations are distinct from the call to action which is the focus of this research in that they were movements which involved collective action by members within the organisation, but did not result in sanction and support from the organisation as an integral part of the movement.

# Social movements: a brief introduction

## 3.8 Leadership

The importance of the role of leadership in the development, and activities of, social movements is paramount. However, the conception of leadership which relates to social movements goes beyond notions of the stereotypical, heroic individual and extends to encompass leadership as a collective process. Collective leadership relates to a ***'property and consequence of a community rather than the property and consequence of an individual leader'*** (Grint, 2005:38), it extends across organisational boundaries and is exercised both with and without formal authority (Heifetz, 1994). Of particular relevance in this context are the concepts of shared and distributed leadership (Gronn, 2002; Pearce & Sims 2000).

A key characteristic of distributed leadership is the pooling of leadership capacity across the boundaries of a system, to enable results greater than the sum of what individual leaders may achieve alone. Distributed leadership reflects the complex realities of modern organisational life in which new forms of governance are required to work across organisational boundaries, such as multi-agency partnerships, with a high level of interdependencies between partners and with none holding absolute authority over the others.

It emphasises 'concertive action' (Gronn, 2002) and an openness of the boundaries of leadership to a wider range of constituencies. Support for this position is given by Raelin (2011) in what he called 'leaderful practice'. Leaderful practice acknowledges the importance of the emotional and relational character of leadership and the value of broad democratic involvement and engagement.

Further support for the need for distributed leadership in the NHS, came from a report from the King's Fund (2010), subtitled 'No More Heroes' which argued that in order to address the challenges of diminishing resources and financial austerity, leadership was needed at all levels of the organisation, not just at senior levels, or in their words; from 'board to ward.' More recently another report for the Kings Fund (Hartley & Bennington, 2011), makes particular reference to public management, eschewing the traditional 'heroic' conceptions of leadership, for leadership as a dynamic process ( 'leadership as a verb'), one in which leadership is shared, depending on the context and the type of challenge facing the group.

Similarly, with reference to social movements, Ganz (2010) states that command and control structures alienate participation, inhibit adaptation to local and often rapidly changing conditions and curb organizational learning.

Social movements are thus organised by identifying, recruiting, and developing leadership at all levels. Hence leadership is distributed among many rather than the few. Leadership in this context does not require formal authority, nor does leadership resort to the use of coercive force to secure compliance, As Ganz states:

*'In the context of social mobilising and organising, leadership is the practice of accepting responsibility to enable others to achieve shared purpose under conditions of uncertainty'*

(Ganz 2010)



# Social movements: a brief introduction

For (Ganz 2010), leadership is exercised through the interaction of five core practices:

- **Building relationships committed to a common purpose;**

Because social movements are emergent systems, leaders within social movements are often required to build new relationships and networks, whilst also maximising existing relationships and networks. Relationship building is central to the creation of collective capacity and requires the identification and development of shared interests.

- **Translating values into sources of motivation through narrative;**

As referred to earlier, for Ganz (2001), narrative is a central 'leadership practice' and one through which leaders

*"...articulate the experience of choice in the face of challenge, sharing the values that enable us to manage the anxiety of agency, as well as its exhilaration. It is the discursive process through which individuals, communities, and nations make choices, construct identity, and inspire action"*

(Ganz, 2008). As such it plays a key role within a social mobilising and organising approach.

- **Strategising:**

The third function of social movement leadership is what Ganz calls 'creative strategising'. Just as storytelling is key to meeting the motivational challenge, so strategy is key to dealing with the challenges inherent in taking action. Strategy is described by Ganz as

*'...how we turn what we have into what we need to get what we want', how structures are created and how the resource challenge is met'*

(Ganz, 2010)

Strategy involves identifying resources through relationships and through identifying political, economic and cultural opportunities to create a structure for action.

- **Structuring:**

Ganz (2010) suggests that social movement leadership requires coupling a deep desire for change with the capacity to make change and informs us that for this to happen, not only must leaders adapt to the rhythm of change, but they also have responsibility for creating structures;

*'...that create the space within which growth, creativity and action can flourish'*

(2010: 512)

In many ways structure lies at the heart of organising, in so far as it is the means by which drift is translated into purpose. In this context, leadership is structured around teams rather than individuals and leadership capacity is developed within the team so that the skills developed are directly relevant to the task of the team.

- **Action:**

A key role of social movement leaders lies in mobilising emotions to enable agency and thereby, action. This means producing specific, observable, and measurable results to evaluate progress, exercise accountability, and adapt strategy based on experience. Leaders enable action through countering feelings of isolation through enhancing a feeling of belonging or solidarity.

# Social movements: a brief introduction

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## 3.9 The role of values

Heifetz (1994) in his book 'Leadership without Easy Answers' argues that the role of leadership is very much to engage with peoples' values. This view is supported by Clawson (1999) who maintains that honesty and integrity form the moral foundation of effective leadership through the four key values of: truth telling; promise keeping; fairness; and respect for the individual (pp. 46-9). Similarly, according to Ganz (2010), the means by which social movement leaders share those values is through storytelling. Specifically, as previously outlined, through the story of self, a story of us and a story of now.

A story of self communicates those values that call the group to action. A story of us communicates the values shared by those in action and a story of now communicates an urgent challenge to those values that demands action now. More recently Haslam, Reicher and Platow (2011) also emphasise the role of leaders in expressing the norms and values of the group.

Much has been written over the years regarding the need to align organisational and individual values, usually from the culture perspective. The main argument is that effective organisations are ones where goals and values are congruent and shared by the leadership and staff of the organisation (Kouzes & Posner, 2007).



# Section 4

## Methodology

# Methodology

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## 4.1 Methodological aims and objectives

Consistent with the aim of following the emergent story of this approach in action, and the lack of extant literature on mobilising and organising within organisations, an inductive research design was undertaken.

At the heart of this research design was an appreciation of the centrality of narrative, both within the goals of the evaluation and within the approach to mobilising and organising developed by Marshall Ganz and colleagues. Our goal therefore was to capture the narrative accounts used by individuals to make sense of their experience, whilst also seeking to identify the connections between events. Hence our terms of enquiry are personal and social (interactions); past, present and future (continuity and temporality); combined with the notion of context (place).

Quite early within the study, the focus evolved, with a corresponding decision made by the research commissioners (the NHS Institute for Innovation and Improvement) that the focus should be upon a particular 'call to action', in this case, 'The Right Prescription'.

# Methodology

## 4.2 Data sources

The research design comprised a number of components and these are listed below.

### 4.2.1 Participant observation

In an attempt to understand both the approach to change and the experience, of participants, we undertook participant observation which included participation in training events, meetings, launch events and evaluations. In so doing, we sought to capture both the experience of participants, and our own experience and sense making, through the use of field notes to capture aspects of the narrative.

These field notes provided contemporaneous reflections of members of the team, both on, and in, action. Individually we also sought to enhance our understanding of the mobilising and organising approach to change, through utilising aspects, such as public narrative and 1 to 1s, within our own spheres of action, again capturing the experience through field notes. Due to the limited space available within this report, we have selected the data which seems most informative for the purpose of this research.

Members of the research team occupy a wide variety of roles, come from very different backgrounds and have correspondingly variant perspectives. It was hoped that this diversity would enable a range of perspectives on research data and enhance reflection. Members of the research team participated in the following events:

- Introduction to the mobilising and organising approach for senior leaders – London February 2011
- Introduction to the mobilising and organising approach for middle managers – Coventry March 2011
- Celebration of work carried out so far – Coventry March 2011
- Evaluation of work to date – Coventry April 2011
- Launch of the dementia call to action, London June 2011
- Attendance at ‘train the trainers’ training event, July and September 2011
- Attendance at dementia call to action strategy meetings
- Attendance at dementia call to action WebEx: monthly 2011-12
- Attendance at launch of shared decision making in renal care call to action: Dec 2011
- Attendance at strategy meetings, London Feb and May 2012
- Attendance at launch of, and follow up meeting of, call to action to improve care of patients with dementia within acute care: June 2012

# Methodology

## 4.2.2 Literature review

The aim of the literature review was to build on those publications which had appeared in the early 2000s (e.g., Bate, Bevan & Robert, 2004), seeking to update and complement this work with an exploration of related concepts and theories, particularly those relating to the leadership of large scale change. As part of this review contemporary policy documents relating to dementia and change within the public sector were also analysed.

The literature review and the participant observation of the initial launch and training events, were utilised in shaping the interview guide (see Appendix 2) for a series of semi-structured interviews. In addition, literature was regularly searched in order to peruse emergent literature, through alerts set up on related databases in the field and key policy documents in the field of anti-psychotic prescribing and dementia were also included in the ongoing review. The literature review is included with this report as Appendix 4.

## 4.2.3 Interviews

Between the months of August and December 2011 and June and August 2012, a range of managers, clinicians and patients, engaged in positive action around the call to action, were interviewed by the MBS team to capture their stories of their experience in the area of reviewing prescribing of antipsychotics to people with a diagnosis of dementia.

These practitioners came from a wide variety of backgrounds and locations and from a cross section of the eight commitment groups and included amongst others, a care homes pharmacist, a senior project manager with responsibility for dementia, a psychiatrist working in an acute mental health trust, a chief nurse, a nurse consultant from a large teaching hospital, a GP, an assistant director of a regional Strategic Health Authority (SHA), policy advisor for the Alzheimer's Society, an individual with a diagnosis of dementia and an assistant Chief executive from

a large acute Trust. Interviewees were chosen by:

- recommendation from the NHS Institute who highlighted those individuals who had been particularly actively involved in the call to action
- recommendation from interviewees, who suggested those whom they thought could be helpful in providing insights
- contact with individuals at call to action/ training events.

In total 25 individuals participated in the interviews. The majority of individuals were interviewed twice, although for five of our initial interviewees, restructuring meant that they were no longer in the same role and were not available for a second interview. In order to counter the potential for 'self-reporting bias' (Fadnes, Taube and Tylleskaar, 2009), efforts were made to triangulate interviews with secondary material, including official reports and literature.

As part of the interview process, participants were asked to sign a consent form. Within this, participants were informed that they would not be named and for that reason, participants are referred to by their job title within this report. Where interviewees were members of the NHS Institute team, they are given a distinguishing letter and roles are listed in appendix 3... the gentleman whose words open and conclude this report has very kindly given permission to be named.

The themes focussed upon in the interviews are listed below and include those issues covered in both the initial and follow up interviews:

# Methodology

Figure 2: Interview format

INTERVIEW	INITIAL	FOLLOW UP
THEMES COVERED	<ul style="list-style-type: none"> <li>Antecedents to the participant’s involvement in the call to action</li> <li>Action taken in response to the call to action</li> <li>Understanding of the ‘call to action’ approach</li> <li>Experience with an mobilising and organising approach to change, including attendance at any training events</li> <li>Relationship with the NHS Institute</li> <li>Relationships with other stakeholders</li> <li>Impact of their context</li> <li>Key challenges encountered</li> <li>Responses to these challenges</li> </ul>	<ul style="list-style-type: none"> <li>Key achievements</li> <li>Challenges encountered</li> <li>Responses</li> <li>Development of relationships</li> <li>Role of NHS Institute</li> <li>Use of a mobilising and organising approach</li> </ul>
METHOD	Face to face.	Face to face or telephone depending on availability and interviewees preference.
	Interviews lasted between 60 and 120 minutes and were recorded and subsequently professionally transcribed.	

In addition to the interviews with practitioners and patients involved in the call to action described above, regular interviews and conversations were held with members of the NHS Institute team in order to understand the story of the development of their approach to mobilising and organising as a method of large scale change within the English NHS.

Regular calls with the NHS Institute Lead for the Dementia Call to Action, have been a key component of the data gathering process and enabled information on the emergence of the approach and key events within the story of its evolution to be recorded. Regular calls were held with the NHS Institute’s head of research and evaluation and these calls were useful in providing access to both resources and feedback.

# Methodology

## 4.3 Data analysis

Where interviewees had given permission, their interviews were recorded and transcribed. Where permission to record was not given, the interviewer made notes during and following the interview. In this way, all of the interview data was converted into type-written text.

This enabled it to be analysed using similar processes as the textual data that was gathered from other sources, including field notes of observations, training evaluation reports, notes of WebEx meetings, postings to the forums on the web platform for the call to action and NHS Institute reports and presentations.

The methodology used for data analysis was a form of framework analysis (Richie & Spencer, 1994). The researchers initially read a selection of the early interview transcripts in order to familiarise themselves with the data, and on that basis, together with insights from the literature review and from discussions with the research commissioners about their interests, devised a hierarchical coding framework of topics to investigate (Figure 3). It was considered important to have a structured approach in order to be able to draw together a large, and diverse, set of data which spanned many perspectives and sources.

As in the interviews, a priority was to focus on aspects of the extant theory in use by the NHS Institute during the call to action, which was based largely on contemporary conceptions of social mobilising and organising developed by Marshall Ganz and colleagues, in particular the 5 key principles: frame to connect with hearts and minds; energize and mobilise; organise for impact; making change a personal mission; keep forward momentum (Bate & Robert 2010) and the 5 leadership practices (relationships, structure, strategy, story and action).

These leadership practices can be thought of as the practical, more specific things that need to be done in order to follow the key principles, adherence to which can be regarded as an output.

The leadership practices, as the 'nuts and bolts' of social mobilising and organising, would therefore be expected to be particularly visible in the data and therefore formed sub-categories in the coding framework, within more general categories which were constituted by the principles.

### Figure 3: Coding framework

- Dementia Action Alliance
- National dementia strategy
- Motivation-Rationale
- NHS Institute role in the call to action
- o National Field
- o Training
- Social mobilising and organising activities (explicit)
- o Mobilising
  - § Change as a personal mission
  - § Frame to connect with hearts and minds
- Intolerable condition
- Telling stories
- o Story of me
- o Story of us
- o Story of now
- § Building relationships
  - House, or larger group meetings
  - One-to-ones
- o Organising
  - § Creative strategising
    - Commitment of resources
    - Common interests
    - Mountain top goals
    - Stakeholder analysis
  - § Team level organising
  - § Decision making, deliberation and accountability

# Methodology

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NVIVO™ qualitative data analysis software was used to assist the data coding and analysis process. Queries were devised in order to automatically code the themes that could be identified through specific phrases ('one to one' for example).

The query construction erred on the side of being specific, i.e., on being certain that irrelevant text was ignored rather than that all relevant text was coded. Uncoded paragraphs were therefore checked and coded as appropriate by means of a manual 'second pass' through the data.

All text relating to a particular code was allocated to a single researcher for analysis, with related codes being analysed by the same researcher. This facilitated an in-depth and integrated analysis that could pick up links between themes.

The text for each code was first summarised at the individual/document source level and circulated to all research team members for comment, further facilitating coherence in the overall analysis. These summaries were then displayed in a matrix to enable comparisons between related themes/ codes and across individuals and groups of individuals.

Through this process, an overall summary was produced for each code, identifying both what participants perceived to be positive aspects of the call to action and social mobilising and organising approach, and challenges that might need to be addressed, supported by quotations from the texts. These summaries were then synthesised by the lead researcher, and, following comments on the synthesis by the other researchers, the final report was produced.

Some additional quantitative analysis of the frequency of instances of different terms included in the coding framework was also conducted using NVIVO. This quantitative analysis was used primarily to generate a hierarchy of ideas to be investigated further as part of the qualitative analysis.





# Section 5

Findings: Evolution of the approach within the context of the English NHS

# Findings:

## Evolution of the approach within the context of the English NHS

This section describes the ways in which the mobilising and organising approach to change has evolved within the English NHS, before progressing to identify key achievements of the call to action. Within this section of the report, we will describe how the mobilising and organising approach pioneered by Marshall Ganz has evolved and been 'blended' within the call to action to suit the context and language of the English NHS, using the example of 'The Right Prescription: A Call to Action on the use of anti-psychotic drugs for people with dementia'.

Our focus will be upon the questions and components which typify a mobilising and organising approach as described by Marshall Ganz in the interview referred to above, and upon the ways in which these have evolved in practice within the call to action used as a case study.

The use of a mobilising and organising approach to action within the English NHS appears to have evolved through a series of overlapping stages, which we have conceptualised as discovery, laying the foundations, blending the approach, securing and sustaining.

### 5.1 Discovery phase

Prior to the launch of The Right Prescription and to the use of a mobilising and organising approach within the National QIPP workstreams, a mobilising and organising approach had been piloted by a number of NHS and local authority organisations. These organisations utilised this approach to tackle, local and individual challenges, supported by the NHS Institute.

In the methodology advocated by Ganz, this type of campaign is referred to as a 'deep' campaign (Ganz, 2002). A deep campaign is one which is focussed on building local networks, across a local geographical area, enabling the formation of deep relationships as opposed to wider networks across a wider geographical area.

A deep campaign is also focussed upon local projects of work. Ganz advocates that ideally campaigns will be deep and wide. These early projects formed part of a wider, national campaign, aimed at recruiting 25,000 activists in leading change and entitled 'Our NHS'.

The stage described within this report as the 'discovery phase', refers to this stage of initial learning and piloting of the social mobilising and organising approach with these local projects. The stage is one which occurred before the research referred to in this report began. Projects included, amongst others, work to reduce pressure ulcers in London, work to enable choice at the end of life within NHS Worcester and a project to reduce unscheduled care in Trafford.

# Findings: Evolution of the approach within the context of the English NHS

In March 2011, the research team attended an event held to celebrate the achievements of these pilot organisations. During this event, participants highlighted the following challenges and learning:-

1. The challenge of working within an organisational and hierarchical context. Participants reported that it had been challenging to deliver narrative 'upwards' within the hierarchy. This was reported as particularly so where the 'sense of urgency' within, what at this stage was termed the 'campaign', was at odds with the organisational urgency created by organisational and external drivers. Participants highlighted the need to manage this challenge through:-

- Linking 'campaign' objectives to policy drivers;
- Identifying, and obtaining support from, individuals in key leadership and management roles within the organisation; in particular, obtaining high level support in order to provide support within the system for staff to engage without fear of repercussions
- Linked to this, participants highlighted the importance of respected role models in gaining support for the cause

2. A number of participants described how management cost efficiencies had meant that many leaders were having to rethink their priorities and had created the risk that the work of the 'campaign' could be seen as extra work and of not being prioritised. It was important therefore to:-

- Align 'campaign' work with the 'day job'
- Frame objectives in a manner which could connect with the organisations objectives

Participants mentioned the need to have clarity in what they were asking people to commit to 'in order not to waste time and energy'. In addition, participants mentioned the importance of meeting with individuals individually, in one to ones, in order to secure commitment.

3. It was felt by several of the participants that the work would have been easier if they had all been working on one national, rather than separate local, campaigns; enabling shared learning, more momentum and energy from shared objectives. This could be seen as the need to combine the 'deep' campaigns with a 'wide' campaign.

4. Some participants highlighted that some staff members were uncomfortable with what they perceived as the very emotional language and American models within both the approach and the narratives told. This discomfort was experienced both by those telling, and by those hearing, the narratives.

5. Some participants highlighted the need to be able to measure success through the use of metrics.

6. Participants also pointed out the importance of celebrating successes, however small and of remaining positive, despite potential setbacks.

# Findings: Evolution of the approach within the context of the English NHS

## 5.2 Laying the foundations

The stage conceptualised as 'laying the foundations' refers to the early work taken to learn from the pilot sites and to create a structure for the use of the mobilising and organising approach within the QIPP workstreams.

The learning from the pilot, and discovery, stage was clearly utilised within the early stages of the call to action; in particular work was undertaken to secure support from upper levels of the hierarchy, to respond to different understandings of the language of mobilising and organising and to build the flexibility to respond to ongoing feedback from stakeholders.

### 5.2.1 Securing high level support

In recognition of the need to secure high level support, an introductory event was held in February 2011 and attended by members of the research team. This event was targeted at key figures within the top levels of the NHS, e.g. chief executives, assistant chief executives, Department of Health personnel, national clinical directors, senior staff from deaneries, senior medical consultants and senior managers from the NHS.

Speakers at this early event included the Department of Health's National Director for Improvement and Efficiency, National clinical directors, a senior academic, Luke Bretherton who discussed links with the Government initiative, 'the Big Society', and leading figures from what was then termed, 'the thought leadership team' of the NHS Institute.

The aim behind this early event was to introduce the approach to senior leaders, to secure support from those at the upper levels of the NHS hierarchy (Department of Health, Chief Executives, Clinical Directors, etc.) and to identify links with policy as a means of aligning with system drivers.

### 5.2.2 Favourable political opportunities

Ganz (2000), Jenkins and Perrow (1977) and Smelser (1962) all highlight the importance of 'favourable political opportunities' and from an early stage there was a recognition of the importance of drawing on, and enhancing political priorities, as part of the strategising process. The identification of linkages with the Big Society at the initial event in February 2011 was part of this effort to use political opportunities to maximise support and resources.

Aligning the work with policy drivers and securing the support of figures at upper levels of the organisational hierarchy can be viewed as a key part of the strategising, of *'mobilising the political, ...and cultural power to translate values into action'* (Ganz, 2010). As the call to action evolved, the Big Society lost its prominence within the public sphere and as part of the flexible nature of the approach, this early attempt at alignment was not pursued further. However, it indicates an important step in early work to lay foundations for the approach, seeking to align with political interests and policy and thereby drawing upon opportunities to enhance the receptiveness of the context.

A decision was made early in 2011, in recognition of the feedback from the early 'cohort' that the focus of the use of social mobilising and organising should be upon a national, 'broad', campaign, as opposed to the local 'deep' campaigns. This decision also made it easier to align the approach with political priority. The recognition of dementia as an increasingly important political priority, and the focus of a ministerial pledge, has played a role in maximising resources and therefore in enhancing capacity for the call to action.

This concept of political opportunity has a role to play in providing an 'opportunity structure' (Crossley, 2002; 120), one which provides the space and access to resources to facilitate action and one which is therefore a key component of the strategy building process.

# Findings: Evolution of the approach within the context of the English NHS

## 5.2.3 Securing permission within the system

In addition to identifying areas of alignment with policy drivers; as part of the process of 'maximising opportunity structures' (Crossley, 2002) it was important for the call to action to align with existing levers in the system, thereby providing permission within the system for action to occur.

This was one of the lessons that had been identified by the earlier cohort during their work on local campaigns and examples of this alignment include work undertaken to identify drivers within the National Dementia Strategy 2009 and National Dementia Strategy Implementation plan 2009-14; the Quality and Outcome framework 2012 and the National CQUIN for dementia, 2012-13.

Through working to gain the support of key figures within the NHS hierarchy and through aligning with levers within the system, the challenge of working within a large hierarchical organisation was minimised:

*'..the thing was, well we don't really need another structure, we are already working within a hierarchy within the NHS, ...so it just wasn't practical'*

(Member E - NHS Institute team, August 2012)

*'It's about starting with a connected sense of outrage and then connecting the values level through that, then developing collectively your strategy... it's then about how do we use what exists in the NHS to kind of mirror some of that?'*

(Chief Nurse, July 2011)

# Findings: Evolution of the approach within the context of the English NHS

## 5.2.4 Identifying key relationships and networks

This work to identify key drivers and figures within the NHS hierarchy was described by members of the NHS Institute team as an important part of the work which went on behind the scenes to identify key stakeholders who would be key to achieving the goal of the call to action. This work appears to have resonance with Ganz's emphasis upon the constituency and upon the power dynamics within it:

*'I'd say the ...key piece here, is taking power seriously... success lies less in the technical question or even informational questions than the way in which power is configured and linked and structured and so forth.'*

(Marshall Ganz in conversation 23rd May 2012)

Forming a successful working relationship with the Dementia Action Alliance appears to have been a central goal which was identified in this early analysis of the constituency. The Dementia Action Alliance, formed in October 2010, is '...an organisation made up of over 100 organisations committed to transforming the quality of life of people living with dementia in the UK and the millions of people who care for them' (Dementia Action Alliance website).

The Dementia Action Alliance (DAA) was significant for achieving visible high level support for the issue of creating change for people with a diagnosis of dementia. This support included that of the NHS and Department of Health, with the Secretary of State for Health speaking to the Alliance at one of its early events.

The high level support obtained by the DAA was of symbolic value, providing a stamp of approval from the hierarchy and provides another example of ways in which opportunity structures were enhanced and maximised. However, the value of the partnership with the DAA appears to have been more than just symbolic, since the alliance also provided practical resources e.g. funding for training sessions for homecare workers and can be seen as a central part of 'creative strategising' (Ganz, 2010), a means of creating resources, where resources comprise both relationships and funding opportunities:-

*'This training was supported through the Dementia Action Alliance, so that was where the funding originally came from – and they had something like 80K or something to look at – so what they did between January and April was to run 20 one-day sessions; and they've got through something like 1,200 people through these training sessions'*

(Care Home Co-ordinator, June 2012)

The start up of the Dementia Action Alliance, and the publication of the Banerjee report, were seen by some of our interviewees as providing the opportunity to highlight the need for change in the prescribing of anti-psychotic medication. However, it was feared that this would not be sufficient on its own:

*'X was very keen to see if we could use the approach around medicines and medicine usage. The Dementia (Action) Alliance was starting up, we had the Banerjee Report and people were wondering how we could drive change for dementia, to make a change. It was thought that this could have a measurable, big impact, but we needed everyone to come together, needed people at different levels to connect.'*

(National Clinical Director for Pharmacy, August 2011)



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A way of mobilising a large, and varied, range of stakeholders, bringing them together and organising them to take action was also needed and a partnership between the Alliance and the NHS Institute was seen as a possible way to achieve this. Whilst the NHS Institute provided resources in terms of techniques in mobilising and organising, links to organisations and a knowledge base, the Banerjee report provided an evidence base for change and the DAA provided access to both relationships and funding.

In interview, a member of the Dementia Action Alliance secretariat described the benefits accrued through working with the NHS Institute and through utilising a social mobilising and organising approach. He described the approach as acting as 'both a glue and a lubricant', acting to bring people together and to create a common identity, something which he describes as being searched for by many of the member organisations of the Alliance. He goes on to explain how the approach was able to

*'..convert that to a common purpose and commitment to action'.*

In this interview, he explained that,

*'Having the energy there I think is really important and we try to use that approach too, because we don't have any authority with our members, the only way we can do anything is to encourage them and to keep it on the to do list and the NHS Institute seem to work well at that'*

(May 2012).

This quote highlights the basis of the approach and its basis in commitment, as opposed to compliance; the need to motivate through encouragement, relationships, opportunity and by inspiring the will, and energy for change in membership organisations. His point about the NHS Institute being able to keep dementia high on people's priorities is also an important one.

In addition, in the interview with the policy advisor for the Alzheimer's Society, this interviewee explained that the partnership with the NHS Institute also strengthened links to the NHS, something which individually member organisations of the Alliance had struggled to achieve. It appears from these comments, interviews and observations, that an early, and ongoing part of this work involved gaining strategic and resourceful support with key stakeholders and in strengthening both 'strong' and 'weak' ties.

These resources in terms of both practical resources and resources in terms of relationships appear to have been secured through the interdependence between the NHS Institute and the Dementia Action Alliance, with the sum of these two organisations being greater than the individual parts and with each acting to enhance the other's access to stakeholders and resources. Through this relationship, the development of 'weak ties', the building of common ground between disparate groups and individuals, was enhanced and as a consequence access to new perspectives, new ways of working and the resources within the wider system, was initiated.

The partnership with the Dementia Action Alliance was key to the launch of the call to action and played a key role in securing significant media coverage for the launch of the Right Prescription, on the 9th of June 2011. This media coverage included coverage on national and local radio, national newspapers and websites and television, with an estimated media audience of 40 million. During the 48-hour period following the launch, over 700 healthcare professionals contacted to 'sign up' to the call to action, demonstrating a role for the media in providing access to resources.

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The launch event was an early demonstration of the need to combine both rational, clinical, data and emotional subjective stories – the hearts and minds! Professor Sube Banerjee reminded attendees of the evidence base for the work, whilst the use of narrative was also in evidence, with a carer, an individual with a diagnosis of dementia and a GP all providing narrative accounts of their own experience with dementia and anti-psychotic prescribing.

In this way, this event drew on evidence to appeal to both hearts and minds, on both rational, clinical data and emotional and value revealing, data in the form of narrative.

In recognition of the centrality of the constituency, an early step within this call to action lay in identifying the constituent groups who would be able to contribute to making the goal of the call to action a reality.

This formed an important part of the 'creative strategising' through providing access to the resources necessary to turn values into actions. At this stage the constituent groups identified as those who required 'organising' were identified as:-

- the clinical decision makers who prescribe and review therapeutic interventions
- those who we want to shift power to (e.g., people with dementia and their carers)
- those who can give voice and advocacy to people with dementia and their carers
- those with authority who can promote and ensure best practice and challenge the practice of the clinical decision makers (where it doesn't fit with our goals).

From this, the following eight groups were identified as those who had interest in working together in response to the 'call to action':-

- People with dementia and their carers and voluntary sector and advocacy groups (local and national)
- Leaders of care homes
- General Practitioners and primary care teams
- Psychiatrists and mental health teams
- Pharmacists
- Hospital doctors and multidisciplinary teams
- Commissioners of health and social care services
- Medical and nursing directors of acute and foundation trusts

It was recognised that each of these different groups had different objectives, drivers and interests and so another key focus at this early stage, lay in working with these groups to identify the commitments and actions which would enable them to contribute to making the call to action a reality.

As part of this initial process of identifying key relationships and stakeholders, a core steering group was also created. This steering group comprised key decision makers within the NHS Institute and Royal Pharmaceutical Society (RPS) and was followed by securing the involvement of the National Clinical Director for Primary Care and Community pharmacy as a project sponsor.

Through working to develop this relationship with this National Clinical Director, the call to action was therefore aligned to national level priorities, again another part of the strategising and of 'maximising opportunity structures' (Crossley, 2002).



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## 5.2.5 Building a community of leaders

Ganz's work on mobilising and organising puts emphasis on the importance of securing strong and diverse leadership. In recognition of the need for strong, multi-agency leadership, another one of the early steps involved in laying the foundations for the call to action, was to build a community of committed change leaders from both inside and outside of the NHS.

These leaders came together to share their commitment to achieve the call-to-action goal within the Dementia Call to Action National Taskforce Leadership Team. The aim of this taskforce was to develop leadership across the NHS, Social Care, Independent and Voluntary Sectors and to work to mobilise leaders within these sectors to take the specific, targeted action identified by the various commitment groups, action which would enable them to support the reduction of inappropriate anti-psychotic prescriptions and thereby improve the quality of life for people living with dementia.

Members of the taskforce included the National Clinical Directors for Dementia and for Pharmacy, a GP lead, strategic commissioning lead, policy officer from the Alzheimer's Society, a social care and dementia lead from the Department of Health, a lead from the Royal College of Nursing, a lead from the QIPP medicines management work stream, a lead from the English Community Care Association (ECCA), a care home dementia lead, a hospital doctors lead and leads from the NHS Institute. Each of these taskforce members had access to a wide constituency and resources in the form of relationships and knowledge. Hence these members brought strategic capacity to the work, which could enable the work to quickly mobilise a broad constituency of support.

To achieve their goal, the taskforce needed to secure this broad support, including voluntary sector and other stakeholders, to help them to build relationships quickly with each other, and help them to develop their own commitments which would contribute towards the overall goal. Hence, a central role of the taskforce was to mobilise by mobilising others, who would then, in turn, mobilise others themselves.

This aim of building relationships and securing support amongst others was achieved across the 8 key commitment groups. As part of their role, each member of the taskforce group, excluding NHS Institute and Department of Health, in turn agreed to lead one of the 8 commitment groups. In this manner, what Ganz refers to as a 'snowflake' model of leadership is created, where

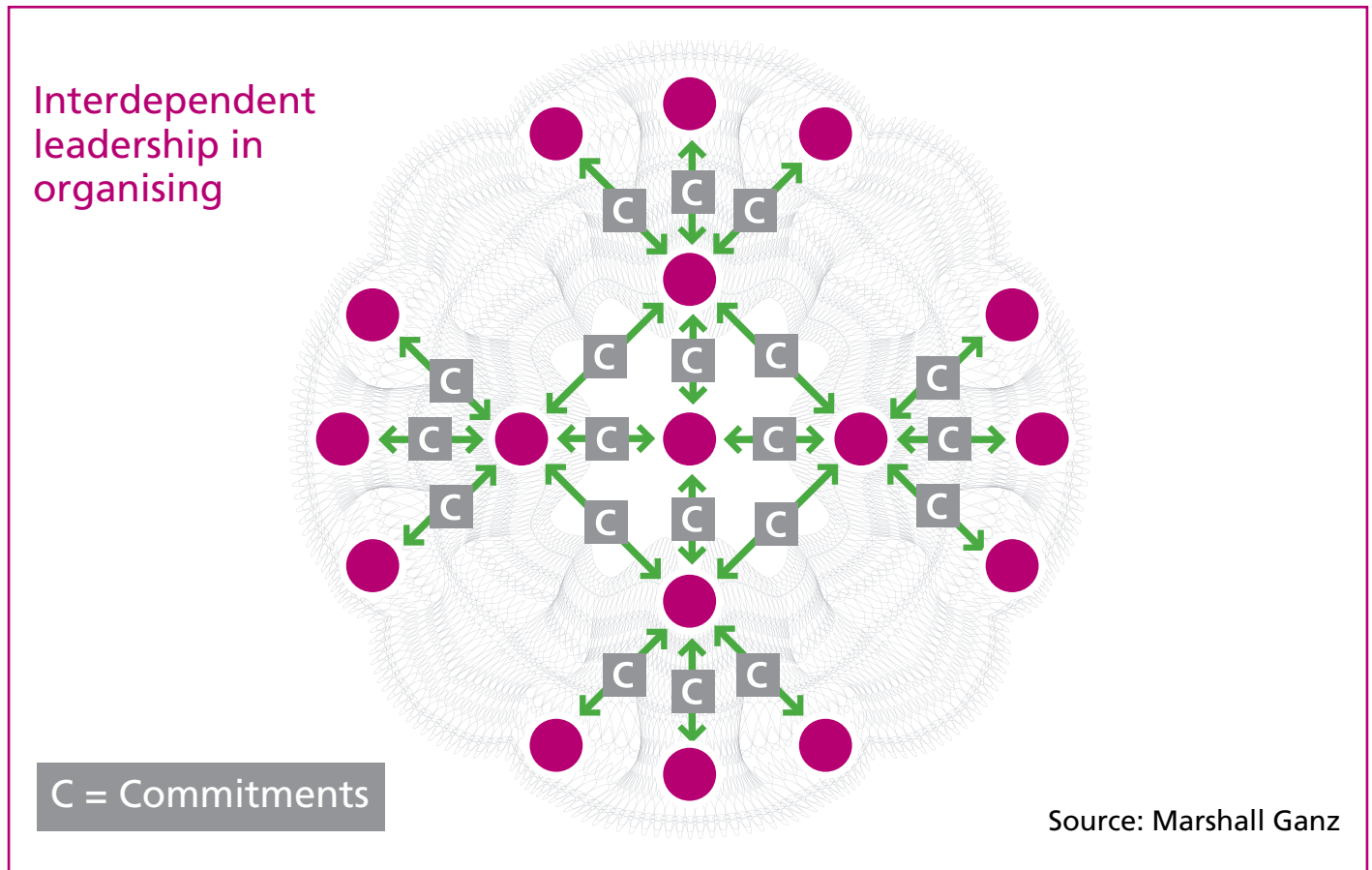
*"Leadership is accepting responsibility for enabling others to achieve purpose in the face of uncertainty"*

(Ganz, 2010)

and where the leadership team of the taskforce has provided what can be conceived of as central nodes which then build on 'strong ties' (those they know well) and to a lesser extent 'weak ties' (those they do not know well) to distribute and extend the leadership team out across the community contained within the commitment groups (see figure 4.)

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Figure 4. A 'snowflake' model of leadership



In this way leadership cascades from the central taskforce, here represented by the central node in the diagram, out across the varied stakeholders. Recognising the importance of pharmacists in tackling the issue of anti-psychotic prescribing, in November 2011 the Royal Pharmaceutical Society (RPS) and the NHS Institute joined forces to support the call to action by engaging and activating the RPS network of pharmacists across the UK.

## 5.2.6 Establishing a clear case for change and a clear narrative

An additional part of this initial process of laying the foundations through scoping, involved establishing a clear case for change, one which combined economic and rational motivations for change, with emotional and value based rationale. One of our interviewees made reference to an early risk analysis carried out to identify, and justify, the need for change around anti-psychotic prescribing and framing the need for action in economic and clinical terms:

*'We scored it with a very 'high risk' because we knew we were doing harm...and therefore it would be our duty to help fix it. It was costing us vast amounts of money. If we left it to its own dynamics it could break the system as it were'*

(Strategic Commissioning Lead, July 2011)

Another interviewee, a member of the leadership taskforce, referred to the emotional and value based justification for the work:

*'...we're doing it because it's the right thing to do and we continue to do it because it's the right thing to do and we look at that population group as an area of need because they are our most vulnerable people probably within society'*

(G.P. July 2011)

An additional part of the strategy at this stage involved the careful crafting of a clear, considered and engaging directional story. Ganz's approach to social mobilising and organising places a strong emphasis upon the delivery of a powerful 'public narrative' and is clear about the requirements of a public narrative to include the 'story of self', 'story of us' and 'story of now'. In each 'call to action' event attended by members of the research team, we witnessed a clear modelling of public narrative, and its components, by speakers from the NHS Institute team. Early training on the use of a social mobilising and organising approach delivered by the NHS Institute also placed a significant focus upon the development of a public narrative.

*"...one of the significant components of the programme is public narrative and we deliver this in quite a lot of our programmes, the NHS Vanguard programme for emerging leaders for instance - we had one cohort last year and we have another one this year – and we had two webinars devoted to the whole of the mobilising and organising approach, so that is the only place where we give 'the full Monty'. Public narrative, as I said, I delivered it in Australia and we use it in a number of developmental programmes, for example, we're doing a developmental programme for healthcare scientists and we delivered public narrative for them'.*

(Member F - NHS Institute team, September 2012)

In further interviews with members of the NHS Institute team, they described how they had learned at an early stage that the narrative needed to:-

- deliver a strong sense of an intolerable condition,
- be clear about what commitment, and what action, was being asked for
- combine the strong emotional dimension of the narrative with elements of the clinical/rational justification.
- emphasise ***'the "good" that this effort was intended to achieve that could not be achieved otherwise'***.
- be capable of adaptation to suit different audiences

### 5.3 The evolution of a 'blended' approach

An early lesson to emerge from the use of a mobilising and organising approach within the call to action, was the importance of iterative reflection upon action:

*'I think one of the key things I learnt is that in the beginning there was not enough reflection and so it is important to build time in for that'*

(Member F - NHS Institute team, August 2011)

Importantly, as the approach developed, each phase of action became followed by, a period of reflection, a period during which the processes of strategy, strategy which would lead to action could be prepared and during which learning could be considered and utilised to inform future development. As a consequence of this reflection and building on feedback from participants and observers, there was an early appreciation of the need to adapt the approach to suit the context of the English NHS.

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*'...things like strategy and different leadership models are things that already exist in the NHS and you need to align closely to what already exists.'*

(Member D - NHS Institute team, D August 2011)

As the approach evolved it was therefore 'blended' and adapted to suit the context of the English NHS. Some of the ways in which the approach was adapted and blended are listed below:

## 5.3.1 Adaptation of the language of the approach

Participants at the February introductory training event for senior leaders had commented that they found some of the language 'too American' and too emotional, something also highlighted by members of the early 'cohorts'. Whilst all of those whom we spoke to described being moved by the narratives they had heard, a number also explained that they found the emotional language and emotional openness within the narratives slightly uncomfortable and described some of the approach as being 'very American'. In conversation, one of the participants reflected on these reactions:

*'We're not used to this type of language in the NHS! You have to remember it's predominantly clinical, there is a very (perhaps overly) rational mindset, in which emotions are closely controlled.'*

(Assistant Chief Executive, Feb 2011)

There was a responsive recognition that sensitivity was required regarding different uses of vocabulary within the context of the English NHS, as opposed to within a mobilising and organising framework. It was not always perhaps that words were emotional or American, sometimes there was just a different understanding from that of the American context e.g. 'campaign' was perceived as political and 'cohort' as clinical.

It was decided therefore to eliminate the use of the word 'campaign' and to replace it with 'call to action', a term which provided a stronger sense of practical steps to improve the experience of dementia, rather than suggesting a somewhat political process. Similarly, the word 'cohort', previously used to identify those involved in the social mobilising and organising work was abandoned for its clinical connotations.

## 5.3.2 Utilisation of English examples of mobilising and organising approaches

Similarly, models, and examples, of mobilising and organising from the American context e.g. the Montgomery Bus Boycott used in early training and Barack Obama's election campaign (sometimes received unfavourably by those whose beliefs were at odds with the Obama administration), were replaced by examples from the UK e.g. the example of the Ford Sewing Machinists action for equal pay in the film 'Made in Dagenham' (2010). Participants reported that this adaptation, and use of more familiar examples, made the approach and style more accessible.

*'So for us we sort of feel in terms of the journey for the content and translating it from the States to UK, we think we've done that very effectively now. Then all of their examples were American examples, we've now got either English or neutral examples to illustrate it with, and that's been helpful.'*

(Member D - NHS Institute team, Feb 2012)

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## 5.3.3 Evolution of public narrative

There was early recognition that

*'public narrative offers a genuinely unique contribution to the NHS, providing an effective and popular tool for connecting staff at the level of their values and developing their motivation'*

(Our NHS campaign: summary of Evaluation Materials and Interviews, NHS Institute, 2011).

However, some interviewees reported anxiety about sharing a story of self in public, especially within the clinical culture of the NHS.

*'I don't think they want to hear about me and my life and why I'm standing there. I don't! I think they want, what are the facts? What are the outcomes? They don't need to have their heartstrings pulled...and as nurses if we get a bit carried away people will say you know, don't get emotional dear... so I just wasn't sure that it, even though you change your narrative whether that style suited everybody that was my concern.'*

(Nurse consultant for dementia, December 2011)

*'I suppose I would say I'm a bit mixed on some of this stuff. When you listen to Helen Bevan, she will just enthuse people, because that's her personality and the way she thinks and reacts. But actually in the real world of working, we've got to be quite sensitive how we do it; and, yes it would be great to have a Helen in every team, but we need to build that confidence in people to do that'*

(Regional Assistant Director NHS, July 2012)

Others referred to similar challenges in using public narrative within the clinical context:-

*'...telling stories can be difficult within a clinical environment and this approach professionalised storytelling and thereby made it more acceptable, easier to do'*

(Pharmacist, September 2011)

At the launch of the call to action and at some of the training events attended by the research team, a minority of participants commented to the team that they felt an element of discomfort in hearing such openly emotive stories;

*'I worry about that, what was that about really? I feel a bit uncomfortable with it'*

(Nurse consultant, launch event February 2011)

At the same event, a number of other participants reported being enthused by the approach, describing it enthusiastically as **'restoring humanity to the NHS'** (Chief Executive Feb 2011) and providing a new source of energy, one which enabled stakeholders to reconnect with values. In interview, the National Director of Performance and Efficiency for the Department of Health, described how narrative was filling a need experienced by leaders in the NHS:

*"... many many leaders right now are hungry for 'how can I create change?' and also, they're running out of road in that 'the government has told me to do this and we just have to do it'. So mostly leaders are hungry for how do I raise people's energy and commitment, which is always quite a difficult task and we can't beat people in to doing this, so I think this public narrative is quite a powerful driver for that change!"*

(June 2012)



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Public narrative as developed by Marshall Ganz is a clear craft and skill, with specified components; hence another concern expressed by some interviewees and participants at events, was that public narrative might come across as a 'script' and lack authenticity. As the approach evolved, members of the training and NHS Institute leadership team, recognised these concerns and undertook coaching with those involved in the call to action to enhance their confidence. One of our interviewees acknowledged this concern about narrative being a script and gave the following explanation of the evolution of the approach:-

*'...public narrative isn't a script, public narrative is about really understanding your story and how that articulates your own values, and then having the skill to understand who's in my audience and how do I reach out to them and get them to connect with my values in a way that will make the sense of urgency that I feel suddenly become their sense of urgency. – there's a skill there but you've all got to believe in what you're doing. It's not a script 'cause your audience will always be different, the sense of urgency that you're applying it to, may be different. So you could – it's not a kind of pick off the shelf and do, kind of thing. You've got to think and feel it, really, in my personal view.'*

(Member A - NHS Institute team)

Perhaps as a result of this type of reflection on the process, as a result of feedback from participants, from greater confidence in the use of the technique, through coaching and training or from a combination of all three; narratives delivered, and observed by the research team, at later stages in the evolution of the approach, (for example the launches of the acute care and shared decision making in advanced renal care, call to action events), provide evidence of the evolution of public narrative to a more natural and authentic use of story, with a less obviously crafted, but equally powerful narrative. Central to this adaptation has been the use of patient and carer stories to enhance democracy and to amplify the

voice of those who had previously felt unheard and to thereby increase impact. Those patients who were interviewed by the team had not received training in public narrative but spoke naturally and effectively to engage emotions and values. Public narrative therefore appeared to have developed to embrace a variety of narrative structures, with support offered through the resources developed by the NHS Institute and leadership team where desired, but also with the flexibility for elements of an authentic, less crafted, personal story. Through the evolution of the narrative in this way, public narrative appears to be developing to be inclusive of a wide range of speaker, to have enhanced authenticity and to enable patients and carers to be given a central role:

*"...actually it's also a platform for people to have a voice, often those people who don't traditionally have one and to share their passion and enthusiasm."*

(Member E - NHS Institute team, August 2012)

On initially sharing reflections about the evolution of public narrative to this more natural form amongst the research team, team members expressed concern that perhaps the evolution of the narrative in this way, was only occurring at large scale events/launches. In order to discover if this was the case, members of the team went to witness interviewees delivering their version of public narrative in local and organisational events, which included board meetings and local third sector association meetings. From these observations we noted a wide discrepancy in the style and manner of delivery, echoing the observation previously made of the emergence of a natural and flexible narrative structure. It should be noted however that our sample was statistically small and further research is required in this area.

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## 5.3.4 Supplementation of five leadership practices with a sixth practice of coaching

*"...that is why it appeals to me 'cause it's fundamentally about how you use people to bring about change. And if you need to – if you understand you need to use people to bring about change, then you've got build people first and that's what this does"*

(Member A - NHS Institute team, April 2011)

The five leadership practices identified by Ganz were supplemented within the call to action by a sixth skill of coaching, where coaching is understood as

*'...helping others discover more of who they really are'*

(association of coaching.com).

Members of the NHS Institute team described how they spent time in the early stages of the engagement with stakeholders, building relationships and identifying motivational needs and preferences. From the mixed response to early training events conducted by the NHS Institute, the discovery was made that it was important to spend time prior to events identifying individual's context, role and needs

*'the one to ones are absolutely critical to have beforehand'*

(NHS Institute team member, June 2011).

Through these early one to ones, in the form of telephone conversations and personal meetings, it became easier to identify those individuals whose situation and role would not be suited to a social mobilising and organising approach and to identify support needs of those to whom it could be suited. Similarly, time was built into all events held as part of the call to action, to reflect upon the achievements, challenges and learning of the event. Through participation in, and observation of events the research team observed how a form of coaching for teams and individuals evolved, with space devoted to the process for teams and individuals, both at the beginning of events and at the end.

At the heart of this process was the use of an 'asset based approach', celebrating achievements and challenges met, whilst also recognising areas for improvement. In developing an asset based approach the focus was on areas of opportunity rather than on the challenges, presented through the selective use of framing and the development of narrative to present and maximise these opportunities. One of our interviewees articulated this very clearly when he described how he considered narrative to have evolved to embrace three narrative strands:

- 'an emotional vision' – the painting of an intolerable condition to engage with emotions and values, to awaken a sense of injustice and thereby motivate action,
- 'a strategic vision'; the vision of what that action needs to be taken and the opportunities existing in the current context to enable that, and
- 'a vision of empowerment': the embodiment of these visions within the narrator's personal experience and achievements, to demonstrate efficacy, the enhanced access to resources and the facilitation of new relationships to enable action for change. This vision creates a sense of empowerment within the audience which has further enhanced motivation. (Member of taskforce Aug 2012)

Part of this stage of evolution of an assets based approach has also involved seeking out and celebrating achievement as it occurred and sharing stories of success through the online community, National Field and webinars. The webinars have evolved to allow interactive discussion of issues with an initial 'presentation' followed by a question and answer session and the chance for ongoing feedback. Webinars have emerged in response to growing awareness of the needs of the audience and allow for the further spread of ideas and examples of good practice.

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The wide range of roles, professionals and individuals, who had the potential to be involved in and to impact upon the call to action, meant that there was a wide and diverse range of values and motivating factors. To mobilise this diverse audience it was necessary therefore to spend time working with stakeholders to identify these values at an early stage and to support individuals and teams to utilise these values in preparing their own public narrative.

*'...public narrative is about really understanding your story and how that articulates your own values, and then having the skill to understand who's in my audience and how do I reach out to them and get them to connect with my values in a way that will make the sense of urgency that I feel suddenly become their sense of urgency'*

(Senior Project Manager, NHS, July 2012)

The development of individuals and teams in response to this recognition came about in a number of ways, through the use of coaching and the provision of targeted resources. Part of this coaching role within the evolution of the social mobilising and organising approach involved enabling individuals to develop confidence and skills in delivering their own public narrative, through helping them to make sense of the approach within their own context and realm of action. One of our interviewees powerfully described this role as one of 'translation':

*'The role of the leader here lies in enabling this translation, this personal sense making and helping the individual's personal story to emerge and to connect to the call to action!'*

(Pharmacist, August 2011)

Several participants referred to the role of leadership in refining the message and the commitment requested in order for it to make sense for different audiences.

*'Calls to action were very clear, but what does that mean for me is where translation was needed'*

(National Clinical Director, August 2011)

In supporting and enabling individuals in this way, Ganz's leadership practices were also supplemented with a role for the leader in modelling behaviours and thereby providing a scaffolding to support the development of leadership behaviours in others;

*'I mean, one of the biggest challenges is – but it's the thing that I am kind of trying to live by – is that we shouldn't be asking other people to move forward in a different way and to be behave and practice leadership in a different way if we can't do it'*

(Member A - NHS Institute team)

This modelling of behaviours by members of the NHS Institute and Dementia Call to Action Leadership taskforce, was something which the research team observed in all of the events which we attended. Throughout there was a clear modelling of practices of public narrative and of appreciative and asset based approaches.



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## 5.3.5 Alignment with existing hierarchies and organisational incentives

This report has already made reference to how the approach has made use of existing hierarchies and national/organisational drivers as part of its strategy to create opportunities within, and across, the system. This became an iterative process which was further developed as part of the blending of the approach to suit the organisational and societal context in which it was seeking to operate. One of our interviewees describes the need for this alignment, as part of the creation of a blended approach, below:-

*"...one member of the team, particularly, went into the training as a complete sceptic, came out as probably an evangelist. And then quickly became grounded again, back in the NHS and kind of said, hang on a second, you know, I think that's really powerful but I've got my boss, I've got my QIPP targets, I've got the SHA, we've got our financial lists and, you know, we can't just go running rough-shod and developing... all over the place. I need some authority, I need to get the chief exec to sign it off. So very back into NHS language"*

(NHS Regional Project Manager, July 2011)

As part of this ongoing process of securing permission from levels of the NHS hierarchy and alignment with organisational drivers, the work was aligned with the national operating framework 2012/2013, the quality and outcome framework 2012, the national CQUIN for dementia 2012/2013 and the dementia declaration 2010/2014.

This was an iterative process which was underpinned by the development of strong working relationships with policy makers and clinicians and the work of the National Dementia Leadership Taskforce to scope possible areas of alignment, through conversations with professional bodies, clinical directors and the department of health, drawing on the strong alignment with QIPP.

In addition, the development of working relationships with professional bodies such as the Royal Pharmaceutical Society, Royal College of Nursing, Royal College of Psychiatrists, Royal College of General Practitioners and English Community Care Association gave important professional endorsement of the work, something which can again be seen as a way of 'maximising opportunity structures' (Crossley, 2002).

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## 5.3.6 Evolution of training

The emergence of a blended approach is perhaps also reflected in the development of the training in mobilising and organising. Initially training was offered by the NHS Institute as a package involving an initial 2 day workshop followed by follow up days and support. Members of the research team attended two of these early training events. The first of these was on 5th/6th July 2011 and the 2nd on 26th/27th July 2011. Between these two events it was clear that the approach had been modified to suit the context of the NHS. The title of the training changed from 'train the trainers' to 'coaching the trainers' and this change in title was also reflected in the content, which during the second iteration of the training was expanded to include several elements of coaching.

More English examples were utilised in place of the American examples and although the training delivered the components of the Ganz approach to public narrative, there was a recognition of the need for flexibility in how it was utilised. The response of participants to this training was somewhat varied, with some voicing previously heard concerns about the integrity, and authenticity, of the narratives and one participant expressing concern that many were already involved in work aligned with the calls to action and that it could therefore be perceived that those involved in calls were seeking 'to piggy back on top of existing work and steal the glory'. This concern about a perception of some that the work was already being done, was acknowledged within the NHS Institute:-

*'...in actual fact, I think it's unwise to try and piggy back on an existing piece of work. And it's often not at the centre where there's problems, it's actually out with those who are more removed from those leadership team meetings and things like that, so...it's like, you know, "Back off sunshine, we've done all this hard work by ourselves and we've got our own approach, go away."'*

(Member F - NHS Institute team, August 2011)

Subsequently, work was undertaken to seek out and acknowledge work already being undertaken and care was taken when choosing future 'calls to action' to develop the work in areas where there was limited activity.

Overall, there was an excellent level of engagement and energy within training events and the opening establishment of ground rules by the team delivering the training, seemed to work to develop the confidence to leap in and share experiences and narratives.

This early training was attended by disparate individuals who were assigned to teams on the day. However, when these individuals returned to their workplace, they faced the challenge of seeking to utilise and mobilise from scratch, making it difficult to implement what they had learned in practice. Future training events built upon this by recruiting readily prepared teams with pre-identified work streams which could then be further developed back in the work place through drawing on these existing relationships.

*'Key learning for us has been, It's so much better if people come as part of a team and it's so much better if they come with a call to action in mind'*

(Member F - NHS Institute team, August 2011)

In order to enhance the applicability of the approach in practice, the training was also changed to facilitate members of the NHS Institute team going out to the workplace and delivering the training in situ. This enabled a greater understanding of contextual challenges, objectives and strategy during the training, so that work could be undertaken to provide a more secure structure for action within the working context and practice.

In addition, there was an early recognition that this approach to change would not suit everybody and that in order to maximise the benefit and appropriateness of the training for those who attended, it was decided to hold early telephone conversations (one to ones) to establish whether or not the training would be suitable.

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*“Because we all know there’ll be some people who will never engage with that kind of thing, because that’s not for them. And I sort of think, that’s actually okay, you know, we’re all different creatures, we’ve all got different elements of it. And so for me, this training, no matter how we ratify the content, unless you ratify the individuals who will attend and check out with them whether this particular approach is for them, actually it will really clunk with some of them. And that’s why we think the one to ones are so much better.”*

(Member F - NHS Institute team member, November 2011)

In response to feedback about particular skills that were required the training was also developed to offer days specifically around the delivery of public narrative.

The NHS Institute had responded in this way after much consideration, since this meant isolating aspects of a mobilising and organising approach and ignoring some aspects of mobilising and organising within the training. However, it was felt that it was important to tailor the training to suit needs of individuals and demands of the context, hence the evolution to public narrative days.

## 5.3.7 Developing an inclusive approach to quality improvement

*‘...the mobilisation piece is not the solution, its one critical component of the things that we need to do in a joined up way in order to accelerate change and that’s why when you look at this change model that we are producing, you see that this is one critical chunk of the change model... it is about the connection between that and the other things we are doing that we think is particularly important.’*

(Department of Health National Director of Improvement and Efficiency; June 2012)

As part of the ongoing development of a blended and flexible approach to social mobilising and organising, there has been an ongoing recognition of the need to combine principles, and techniques, of mobilising and organising, with aspects of other approaches to quality improvement, depending on the context and requirements of the quality objectives.

*‘I think we’ve come to a point where we actually see that all of the five leadership practices are absolutely relevant and integral to the work that we’re doing, but we understand much more clearly now how they sit within the wider sort of arena of leading large-scale change and what drives and motivates people. The sort of blended approach has become much more grounded and we all have a shared understanding of that’*

(Member H - NHS Institute team, May 2011)

In line with the recognition of the value of an asset based approach and of building on what was already in existence within the context of the NHS, there was an awareness of the need to combine aspects of a social mobilising and organising approach with aspects of leadership for large scale change which were already being used to effect.

This recognition has culminated in the production of the NHS Change Model; a model which brings together improvement knowledge and experience from across the NHS into eight key components:

This model provides resources for use by practitioners and managers within the NHS and which can be adapted to suit their own particular context and challenges. Aspects of social mobilising and organising form the ‘engagement to mobilise’ and ‘shared purpose’ components.

# Findings: Evolution of the approach within the context of the English NHS

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## 5.4 Working to secure and sustain the call to action

Within this section of the report, work undertaken to secure and sustain the call to action is described. It should be noted, that this was an ongoing and iterative process, emerging from the learning and reflection and ongoing development of relationships with stakeholders, rather than a distinct and separate phase.

The work described, also forms a key part of the 'creative strategising' and of creating structures to support the ongoing and sustained development of work to improve the experience of people with dementia and their carers.

Aspects of this work to be discussed within this section, include the production of resources, the use of social media, work to enhance accountability and commitment, and the development of new relationships and teams.

# Findings: Evolution of the approach within the context of the English NHS

## 5.4.1 Production of resources

Resources produced include education, information and audits. Examples of these resources are as follows:

- Education support programme for junior doctors and hospital teams, rolled out in August 2011 to coincide with the new junior doctors intake.
- Education campaign launched on Drs.Net and targeted at 5000 GPs to improve understanding of symptoms of dementia and alternatives to anti-psychotic prescribing.
- Regional pharmacy and medicines management leads are actively engaged in co-design of an education and development programme for pharmacists to support them in leading the clinical review process.
- Leaders of the major care homes have come together to share information about improving practice in care homes and audit data. An audit of 1990 care home residents living across 7 care organisations identified that 72% had had a clinical review since May 2011, that 11.8% had had their anti-psychotics reviewed and 25% had had them stopped.
- Directors of nursing and medical directors: The call to action now has a regular column on the Chief Nursing Officer's newsletter, with a circulation of 25,000.
- People with dementia and their families: The call to action has seen people with dementia and their families co-presenting with professionals. An example of this is the Annual Agents for Change Conference for Junior Doctors, a workshop which was jointly facilitated by carers for people with dementia. The antipsychotics page on the Alzheimer's Society website was viewed 10,486 times between June and Sept 2011 and over 2,500 copies of the Society's guide for carers have been ordered and distributed.
- Psychiatrists and Mental Health Teams: Psychiatrists working in the area of 'old age', are those most likely to prescribe anti-psychotics and a number of recent audits have investigated where these prescriptions have been initiated. This process is highlighting wide variance in discharge profiles of trusts of similar size and as a consequence, further investigation and targeted education on the appropriate use of anti-psychotics in people with dementia has taken place.  
(NHS Institute document 'Our success to date' received by email: Dec 2012)

Key to the production of all of these resources has been the development of relationships with individuals and organisations and responding to the feedback from the various commitment groups around their challenges and how they could be supported in meeting these. The national clinical director for community pharmacy describes the evolution of the pharmacy resource below, explaining how this work was developed in partnership with the Royal Pharmaceutical Society and in response to feedback from pharmacists:

*'...it's to help any healthcare professional really but it was for pharmacists, to help them in having difficult conversations with... particularly GPs, ...and that's because the sort of conversations we were asking pharmacists to have were very much outside their comfort zone, and what we are asking pharmacists to do was to challenge the clinical decision, ...and this is a very difficult conversation and..., there were a lot of people saying 'Yes, we agree, there's a problem' but it was how do we go about it, what can we do to make a difference; because challenging somebody, a GP, a pharmacist challenging a GP on their prescribing habits is a different discussion and it is one which people weren't particularly comfortable with and we picked up on that very early on'*

(Clinical Director for Community Pharmacy, August 2012)



# Findings: Evolution of the approach within the context of the English NHS

## 5.4.2 Utilisation of social media

An online community (National Field) was created by the NHS Institute in June 2011. The goal of this community was to enable the sharing of support, best practice examples, audit, local protocols and guidance. The National Field product was thought to align well with social mobilising and organising because people could only join through invitation and because it had a structure for community organising, with the facility for people to “report up” through “hierarchies” to their ‘leaders’. National Field also allowed members to create metrics that would enable reporting on progress towards numerical goals, such as those of The Right Prescription. A separate evaluation of the development of online communities has been commissioned by the Institute for Employment studies (IES, 2012) and has not therefore formed a significant focus of our research. However, we note the following points:

- Importantly, the use of social media, such as the online community provided by the National Field and webinars has been developed as a means of creating an online community with six hundred members, who are able to share knowledge, support and resources.
- In conversation with one of the NHS Institute team members with responsibility for this resource, it was explained that it is a slow process and one which has drawn upon processes of one to ones, relationship building and the use of Twitter to develop the community and to mobilise participation on the site.
- The most positive aspects reported include obtaining new information, making new contacts and learning from these contacts. The network appears to have been less successful however at building skills and confidence in managing change, which are also important issues for members.
- Lack of time and other resources were reported as a barrier to active membership.

Lessons that were learnt about adapting and blending the use of the mobilising and organising approach, were also applied to the use of social media:

*‘When we first commissioned the network, the call to action was very much aligned with very pure principles around community organising and so the network really supported that, it was very hierarchical, you had your managers, you had your peers and your team members and it was bordering more on a performance management site, rather than a traditional social networking site and then from having some discussions with members of the team and as they rolled out the call to action approach in the real world, the first thing was, well we don’t really need another structure, we are already working within a hierarchy within the NHS’*

(Member E - NHS Institute team, August 2012)

During the interview referred to above, the use of strong and weak ties, through the extension of existing relationships as in the call to action more generally, was also described as a factor drawn upon in establishing an online community:

*‘...when we have been running our expert webinars, they were great for a number of reasons, so they generated unique resources, so we could say ‘this is the only place you can get this resource’ and we encouraged the presenters to join a network, so whilst we were on the webinar, we would say ‘If you have any questions afterwards for people on the network’ continuing and framing it so that the network was seen as a way of continuing the dialogue and discussion and relationships which had been built on those webinars. Some of the active people that were on the webinars, we would then have one to ones and follow up with them and that worked quite well’.*

(Member E - NHS Institute team, August 2012)

# Findings: Evolution of the approach within the context of the English NHS

## 5.4.3 Enhancing accountability

A variety of methods have been utilised to enhance accountability, including the development of requests for specific commitments as part of the approach, metrics to measure progress and identify areas for improvement, the creation of new relationships and networks, and the development of strong, diverse leadership. A key component of a mobilising and organising approach is asking people to commit to specific action by a specific time. Where this component is requested by someone whom you identify as sharing the same values as you and with whom you have developed a professional relationship, based on those values, accountability begins to emerge. Where this is different in a social mobilising and organising approach is that accountability emerges through commitment, rather than through compliance:-

*'The call to action is very specific, when, how many, etc. ensures a commitment and a commitment can be measured. Stories succeeded in bringing people together, in enabling people to recognise that they needed to commit to do something different, 'to work together for the ultimate goal' '*

(Clinical Director for Pharmacy, Sept 2011)

The development of metrics was subject to much debate amongst members of the National Leadership taskforce, how could metrics be used to enhance quality of the experience of people with dementia, rather than just to measure cost improvement and how could improvement really be identified when many people did not even have a diagnosis of dementia and were therefore off the radar?

A number of responses were made to this debate and included the commissioning of an economic cost-benefit analysis of the use of anti-psychotic medication as opposed to cognitive stimulation therapy as a means of demonstrating the economic case for change (NHS Institute and Matrix Evidence; 2011).

A number of audits have also been identified and commissioned and these include both local and national audits. Examples of these audits include the recent audit of anti-psychotic prescribing by the Health and Social Care Information Centre HSCIC (2012), an audit which puts the reduction of anti-psychotic prescribing at 51.8% at between 2008 and 2012.

The lack of an established consistent national baseline of prescribing at the commencement at the call to action has drawn attention to the need for ongoing systems to determine, and agree, a baseline from which to measure work going forwards and this is currently being established. (NHS Institute 'Our success to date' received by email, Dec 2012).

This is a challenging area because of the real benefits of working using a social mobilising and organising approach e.g. enhanced commitment, enhanced relationships are those elude measurement. At the same time within a clinical and highly regulated environment, such as that of the NHS, metrics are essential in securing support and demonstrating impact. The area of metrics is one which requires additional research and exploration.

The development of new relationships which cross professional, hierarchical and organisational boundaries and which are based on shared values has been reported as enhancing the energy for change and creating commitments to the work and to each other which have then fostered accountability.

# Findings: Evolution of the approach within the context of the English NHS

## 5.4.4 Sustainability

The issue of sustainability of the approach and work, is a concern which has been mentioned by a number of interviewees. The current reorganisation of the NHS and closure of the NHS Institute in its current form in March 2013, heightens these concerns.

A number of 'structures' have been put in place during the past 2 years, which it is hoped will enable sustainability of this approach. These include the following:

- The leadership provided by the NHS Institute, the Dementia Action Alliance and the taskforce, has worked to cascade knowledge, resources and techniques to others and worked to create new leaders within the NHS, third sector and social care.
- In addition, it is now expanding beyond the boundaries of healthcare with similar initiatives to improve the care of patients with a diagnosis of dementia being adopted by museums (conversation with NHS Institute National Lead for Dementia, March 2012). Work now seems to be gaining its own momentum, with the recent expansion of The Right Prescription into the care of patients with dementia within acute care providing an example of the energy which is now attracted to this work and which it is hoped will enable it to sustain.
- The use of information and data to create a baseline for anti-psychotic prescribing and the provision of metrics to identify progress in the field, provides the opportunity for ongoing measurement of progress.
- The alignment of the work with existing policy and performance levers also enhances the possibility of sustainability.
- Importantly, the formation of new relationships and teams which cross traditional boundaries provides new opportunities for dialogue, learning, sharing of resources and can therefore also enhance sustainability. A key feature of this approach has been the strength of the relationships formed and it is this strength, interdependence and mutuality which may allow the approach to continue and to be sustained.
- The adaptation of the approach to a 'blended' approach which aligns aspects of mobilising and organising with the language, existing hierarchies and policy and performance levers operating within the national and organisational context; combined with the flexibility of the approach and its evolution to work alongside other change methodologies within the NHS Change Model, may also enhance its potential for sustainability.
- Crossley (2002) suggests that a social movement is becoming established when it extends beyond its boundaries, acquiring a life of its own. There has been a recognition within this work, that for it to be sustainable alternatives to anti-psychotic prescribing are necessary. The work undertaken by Liverpool museum to deliver a 'house of memories' is **'...a new and innovative training programme that is making a real difference to health and social care staff and the people with dementia they care for'** (House of Memories evaluation report, 2012). Members of the leadership taskforce worked with the museum in creating this resource and this both provides a way of responding to dementia which is an alternative to prescribing, as well as providing evidence of the spread of the movement and call to action.



# Section 6

## Conclusions

# Conclusions

Within this section of the report we will examine the implications of the main findings and explore some of the tensions to emerge from the adoption of this new paradigm of mobilising and organising within the English NHS. In doing so, we seek to identify some of the core achievements of the approach to change.

## 6.1 Mobilising and organising within the context of a changing NHS

This report began by describing the extraordinary challenges facing the NHS and those whose lives it touches. To meet this challenge a mobilising and organising approach to change has been utilised to help organisations and systems to achieve their goals. This report has sought to tell the story of the use of this approach within a particular call to action, that of The Right Prescription, within the context of the English NHS.

Yet mobilising and organising traditionally operates outside of organisations, challenging the system and the hierarchy, so that utilising such an approach within an organisation of the scale and complexity of the NHS could be seen as a brave, and challenging mission.

### The Blended Approach

'The Right Prescription' responded to these challenges by developing a 'blended approach' to mobilising and organising. As a way of exploring key aspects of this 'blended approach', this report will now consider the way in which this approach addresses the three questions set out by Marshall Ganz in our conversation of May 2012.

#### i) Who are my people, my constituency?

Within the call to action, the 'constituency' has evolved to cross professional, hierarchical, organisational and geographical boundaries. Key to this approach has been the development of new networks, teams and relationships; ones which share a commitment to working together to enable a review of anti-psychotic prescribing for people with a diagnosis of dementia. Just as the approach to mobilising and organising has evolved within this call to action, so too has the constituency evolved as people have begun to be mobilised.

An important part of the initial laying of the foundations of this approach, consisted of identifying key stakeholders and organisation, yet it is those who they managed to enthuse and mobilise who then become the extended constituency. This has included some obvious people and groups e.g. pharmacists but also the inclusion of other less obvious stakeholders e.g. museums as the call to action has extended beyond its initial boundaries in response to the needs of people with dementia. In many ways therefore, a mobilising and organising approach has necessitated not only new ways of working, but also new ways of conceptualising, and responding to relationships within the care pathway, pushing and widening the boundaries of care.

At the heart of this process lies an iterative process of reviewing the constituency and an open mind about just who that constituency might be. Just as flexibility has been required in the use of mobilising and organising as an approach, so too has flexibility been essential in developing the constituency. Leadership within this context involves the choice and commitment to take action to make a difference and to develop new associations, based in turn upon commitment and which are not pre-determined.

# Conclusions

## ii) What are the challenges which the constituency face?

Challenges have been identified on the macro (system wide/societal) level, meso (organisational) level and (micro) individual level.

- Macro level: Changing demographics. Financial challenge. Identification of suitable metrics, lack of baseline data on prescriptions, lack of awareness of alternatives to anti-psychotics.
- Meso level: Challenge of working in new ways. Challenge in aligning with organisational drivers. Lack of resources. Challenge in aligning with organisational role.
- Micro level: Having confidence to challenge practice of others, especially where these 'others' may be higher in the contextual hierarchy, challenge of delivering narrative up the hierarchy, feelings of insufficient power/capacity.
- Permeating all levels: lack of resources, competing pressures and priorities, low morale, turbulence and change.

## iii) How can the resources of the constituency be mobilised to create the capacity to deal with that challenge?

Within this call to action, power to create change and to respond to challenges has arisen from relationships. In mobilising resources to meet the challenges associated with large scale change in the prescribing of anti-psychotics, an 'extraordinary leadership response' (Bevan, 2010) has been required.

This leadership response is one which has taken the five leadership practices developed by Marshall Ganz (story, structure, relationships, strategy and action) and supplemented these with a sixth leadership practice of coaching, the development of supportive, empowering, yet also challenging relationships. Within this sense the role of the 'leader' lies in empowering others to be the authors of change themselves.

This particular form of 'coaching' has involved the combination of one to ones and time spent encouraging participants to 'check in' before and after meetings and key events alongside the development of an 'asset based approach', one which focuses upon achievement and opportunity.

Through the use of these individual and group meetings, participants have been supported to identify how they can utilise a social mobilising and organising approach to create capacity for change within their own context. The relationships developed in this way involve the creation of inter-dependence and shared accountability to each other and it appears to be this mutuality which lies at the heart of this use of social mobilising and organising.

This creation of new relationships, new ways of working and behaving, within a fairly rigid, hierarchical system such as the NHS is a significant challenge and a transformative change. Argyris (1968, 1970) suggests that change, especially where it involves a change in behaviour involves 'unlearning' and that for this to occur it is important to create the right conditions for change to occur, conditions in which defences of both individuals and the organisation can be lowered.

Ways in which a social mobilising and organising approach has created optimum conditions for change include, amongst others, the alignment with policy and organisational drivers, the identification of resources and metrics, the development of new teams and networks, preliminary work to obtain support from upper levels of the NHS hierarchy and the strengthening of relationships. Defences have, of course, emerged and have been expressed as an objection to the language and emotionality of the approach. The 'blending' of the approach has enhanced both the development of the approach to suit the contextual demands and the development of the approach to assuage people's anxieties and concerns.

# Conclusions

Social movements traditionally operate against organisations and against the hierarchy, so that it was challenging to imagine how a social movement might operate within an organisational hierarchy, such as the NHS.

*'...what is very interesting I think, is that most of his (Marshall Ganz's) examples are community leadership – challenging a system – because social movements challenge an established order and of course, to some extent we are the established order and so, I think it is interesting the extent to which an organisation can harness these approaches and I don't think we quite know that!'*

National Director for Improvement and Efficiency,  
June 2012

However, the target of this social movement has been the 'problem of inappropriate anti-psychotic prescribing' to people with dementia, so that one of its apparent strengths lies in the extent to which it has appreciated, and utilised, the extent to which agents are embedded in the social structure, working to challenge the limits within the organisational hierarchy upon the individual, or group's, scope of agency to change the condition.

This has evolved into a new form of social movement, one which is able to challenge the constraints of the system, without becoming a heretic within it. Through appreciating the extent to which agents are embedded within the social structure, this approach to change has also drawn on the emotional power of narrative to enable agents to rise above institutional norms; the work undertaken to support pharmacists in challenging GP prescribing is an excellent example of this.

This potentially creates a tension however between creating a strong sense of discontent through the use of powerful narrative and working within the system and there is perhaps a balance to be achieved between 'rocking the boat' and 'staying in it'. The success achieved in 'rocking the boat', whilst also remaining in it, is indicative of the work undertaken to blend the approach to suit the context of the NHS and to

maximise the opportunities for change. It could be argued however, that participants have only been able to 'rock the boat' to the extent to which the 'boat' (the NHS) allows itself to be rocked.

In part 2 of this report we referred to aspects of the history of social movements. Let us return to this for a consideration of where the use of a mobilising and organising approach to change as typified by The Right Prescription Call to Action, sits within this trajectory. It appears that this approach draws upon aspects of both the US model of rational actor theory and resource mobilisation theory through its focus upon aligning with rational incentives, and on mobilising resources, and combines this with aspects of European New Social Movements, with its focus upon framing and meaning. Hence what we appear to have is a Euro-American hybrid, combining features of both types of approach within a new blended movement.

The evolution of the mobilising and organising approach to fit the context of the English NHS and in response to feedback and learning, has enabled it to begin to enter the mainstream of change methodology for the NHS. As the approach has gained in strength and momentum it has begun to gain its own identity and to deviate from the original, pure movement to suit the context and audience.

Whilst this is to be commended, there is a delicate balance between evolution and variance and this is particularly so where a movement is operating INSIDE an institution. As part of this, it seems important to identify what is meant by a mobilising and organising approach to change, so that its potential can be maximised and fully utilised and there is a tension here between standardisation and variance.

# Conclusions

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## 6.2 What is the added value of this approach?

### 6.2.1 Development of weak and strong ties

Key to the ability of the call to action to secure resources and facilitate change has been the formation of new relationships through deliberately seeking to build bridges between previously disparate groups and individuals, creating relationships based not on pre-existing similarities, but on commitments that people make to each other to take part in, and deliver, change.

The development of these 'weak ties' has worked to bring together individuals and organisations who had previously not worked in partnership, acting as a boundary spanner to draw together colleagues from across organisational, professional and hierarchical boundaries; in order to enable the sharing of information and knowledge and provide access to previously inaccessible resources. The opening up of communication channels to enable dialogue with the NHS for a large third sector organisation, one which reported that it had previously struggled to gain an audience with the NHS is one example of this development of weak ties.

These relationships between 'weak ties' have been vital to the creation of additional resources and capacity. However, strong ties have also played a key role in the evolution of the approach, with recognition at an early stage of the importance of drawing on existing teams. An example of this is noted in the training around mobilising and organising, training in which team attendance has been encouraged with positive results.

Through the development of these weak and strong ties, the call to action has enabled the formation of new relationships through a process which has brought together individuals and organisations who had not previously worked together, with the blended mobilising approach, acting as a boundary spanner to enable the sharing of resources across a variety of boundaries. In this way new teams have also been created, both virtual and non-virtual. These teams have been characterised by interdependence and mutuality.

# Conclusions

## 6.2.2 Enhanced leadership

In examining our analysis for indications of added value, the most densely populated pages were those relating to leadership and this is perhaps indicative of the importance of leadership within an mobilising and organising approach to change. What we seem to see emerging within the call to action is a new expanded form of leadership, one in which the boundaries are redefined and extended, to respond to the new context in which current leaders are positioned. Part of the power of the mobilising and organising approach is described as stemming from its ability to bring together individuals from different professions to break down barriers and enable stakeholders to view events from an alternative perspective:

*'...what you're actually doing is getting people to reframe the problem from another perspective by bringing people together in more of a network sense'.*

(NHS Commissioner, November 2011)

*'One of the powers of a call to action is the bringing together of different professions and getting them to understand each other's role with regard to the issue. It breaks down barriers and makes people realise that they are not the only ones with a difficult job.'*

(Project Manager, November 2011)

A number of those interviewed referred to how the approach has supported them in forming new relationships and not only new relationships, but new teams too. We could say that in this way, what the call to action has achieved is the creation of a new form of leadership, or at least the expansion of the boundaries of leadership, to enable the creation of a new sense of us, one which is continually expanding and which will continue to do so to provide a potentially huge pool of leadership talent, encompassing social care, community leaders, service users, voluntary sector and clinical leaders.

An example of the expansion of the leadership boundaries to enable co-design was provided within the launch events for both the anti-psychotics call to action and the acute care call to action, events in which centrality was given to the patient and carer voice. This is perhaps particularly noticeable as a shift in the role for patients with dementia.

*'One of the successes of the call to action is that it gives dementia a voice and where it has been successful is in enabling people to be empowered because they are not alone and they start to have options/alternatives'*

(Pharmacist, September 2011)

*'And I think it's how we change the mindset of professionals,...to actually look beyond, well, this is just my job and I only do this bit because this is the tick box I've got to do. We've got to think actually we've got to share information. And that is true integration, it's understanding integration in its widest sense'*

(NHS Commissioner, July 2012)

Leadership has evolved within the call to action into a model which utilises a core group of people within the centre to provide the nodes (in this instance provided by the taskforce and also by existing structures and hierarchies within the NHS) but one which is supplemented by the development of authentic relationships, relationships which cut across and connect traditional boundaries and silos, to redefine the boundaries of leadership. Leaders within the call to action come from a wide variety of roles and occupations, with patients, carers and consultants all sharing the same stage.

Communication lies at the heart of a mobilising and organising mode of leadership; communication which has been described as 'professionalised' through the provision of techniques in narrative.



# Conclusions

These techniques in using narrative to engage with people's values, and emotions and to inspire them to action are described as novel and as adding value:-

*'...we have always understood that what we would call communication is a really important part of any change effort and we had been relatively professional about that in terms of written material and product, but we didn't apply the same discipline in terms of our own narratives'*

(National Director for QIPP, July 2012)

A number of those interviewed also made reference to the need for a supportive, but permissive leadership, one which would enable them to develop their own leadership skills within the call to action and within some boundaries. This lies at the heart of this form of leadership, empowering other to take action through an asset based and appreciative approach. As part of this approach, a sixth leadership skill has been added to the five Ganz leadership skills, that of coaching and the use of coaching to provide a scaffolding to assist individuals in developing their own leadership capacity.

## 6.2.3 Enhanced receptivity of organisational context

Part of the role of the leader, and a key strength within the 'call to action' has emerged from the work undertaken to enhance receptivity of the organisational context and to lessen resistance to the call to action, what Crossley (2002) refers to as 'maximising opportunity structures'. A number of factors appear to have contributed to this and include:

- The time spent in exploring the context, in scoping and analysis both in between, and prior to, action.
- The use of existing hierarchies, national and organisational levers to 'maximise opportunity structures' (Crossley, 2002).
- Provision of clear and coherent narrative, adapted in response to reflection and analysis of power relations, motivational incentives.
- Commitments tailored to professional needs and requirements.
- Translation of policy to enable sense-making within individual and organisational context partly through a coaching role.
- Identification of respected role models who have credibility within their respective professional groups.
- A combination of top-down pressure (policy, targets, etc) with bottom up concerns.
- Blending of 'mobilising and organising' approach to utilise existing hierarchies, incentives and language. Whilst it has been considered key to utilise existing roles, hierarchies and motivators, some participants also referred to a tension which could result from being seen to 'piggy back' onto existing work, so that this is an aspect which needs to be handled with sensitivity.
- The role of the NHS Institute as a boundary spanner. The unique role of the NHS Institute as a body which connects with both policy makers and front line staff has enabled it to act as a boundary spanner; a position it has utilised to bring together stakeholders from across boundaries, professions and disciplines in the formation of new working relationships and teams. In this way the NHS Institute has acted to enhance collaboration between hierarchical levels of the NHS, professions, historical divisions and geographical regions.

# Conclusions

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Despite this, it should perhaps be acknowledged that the approach is not for everyone and that some individuals require significant amounts of support and coaching in order to be able to use it comfortably.

*'...public narrative isn't a script, public narrative is about really understanding your story and how that articulates your own values, and then having the skill to understand who's in my audience and how do I reach out to them and get them to connect with my values in a way that will make the sense of urgency that I feel suddenly become their sense of urgency. So that's the – there's a skill there but you've all got to believe in what you're doing. You can't just think – it's not a script 'cause your audience will always be different, the sense of urgency that you're applying it to may be different. So you could – it's not a kind of pick off the shelf and do, kind of thing. You've got to think and feel it, really, in my personal view.'*

(Project Manager, July 2011)

For these individuals it is important to remember that it can be used in partnership with other approaches to large scale change, as for example within the NHS Change Model. However, Argyris (1968) and Lewin (in Burnes, 2004) would tell us that for any real change in behaviour to occur, old patterns of enacting need to be 'unlearnt'. It will be interesting to see therefore the extent to which this new approach can co-exist alongside change methodologies.

Similarly, whilst the evolution of the approach to develop close links with other areas of the NHS Change Model may be seen to increase its flexibility and range of application, it is important not to lose the mobilising and organising aspects. Further development of training material, creation of assessment processes and development of independent learning material is recommended as a means of ensuring skill progression.

## 6.2.4 Co-existence of universality and individuality

A key tension in using an organising and mobilising approach lies in creating a motivating and inclusive goal, whilst also responding to individual incentives and preferences. One of the key achievements of the call to action appears to lie in its ability to manage this tension through tailoring the main goal, that of reviewing anti-psychotic prescribing, to individual motivators.



# Conclusions

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## 6.3 Recommendations

### **Maximising the potential of a social mobilising and organising approach**

This section of the report suggests conditions for maximum utilisation of a social mobilising and organising approach.

Our research suggests that a social mobilising and organising approach to change operates effectively where:

- There is a clear, definable, 'intolerable' condition
- Where there is a specific 'ask' (goal(s))
- Where there is alignment with national and organisational drivers
- Where the 'high level' leadership team is supportive, stable and bounded
- Where the 'ask' and approach does not conflict with existing goals or workstreams

Our research also suggests that the effectiveness of the approach is maximised where:

- Resources are maximised through intensive preparatory work to align with performance levers and to identify role models and high level support
- Flexibility is provided to allow the approach to evolve in response to the context
- Strategy is utilised to enhance receptiveness of the organisation and resources available
- Relationships are needed that cross organisational/professional/hierarchical boundaries
- Reflection on the process is built in and becomes an iterative occurrence
- Coaching forms one of the leadership behaviours
- Social media can be utilised to enable additional access to resources and support
- A baseline of data is provided
- Metrics are identified at an early stage



# Section 7

Limitations of this research

# Limitations of this research

## 7 Limitations of this research

Limitations of the research include a difficulty in knowing whether the effects we have observed are a result of a mobilising and organising approach or the call to action, challenges in identifying causal factors and challenges encountered from people's different understandings of the approach. More detail follows:-

Within eighteen months, change has occurred across the healthcare system to enable a reduction in the prescribing of anti-psychotic medication (HSCIC 2012). However, it is not clear from this audit the extent to which this reflects the number of **reviews** of prescriptions or purely a reduction in prescribing, although it would seem likely that there is a strong connection between the two. Local audits have been more helpful in this respect, since they do provide indications of an increase in reviews. However, a perusal of all of these audits has been outside of the boundaries of this research.

Our initial remit was both to tell the story of the call to action and to evaluate the use of a mobilising and organising approach. However, it is not clear the extent to which these two goals coalesce, since it is not clear whether the extent to which action has been taken is the result of the 'call to action' or the result of a mobilising and organising approach to change. Hence one of the limitations of our research has been difficulties in distinguishing between the call to action and the mobilising and organising approach. One of the reasons for this difficulty in making this distinction lies in the range of acquaintance with, and understanding of, mobilising and organising amongst those involved in the call to action. Whilst some of our interviewees had undertaken comprehensive training in the approach first developed by Marshall Ganz, other interviewees had no explicit awareness of the methodology at all.

From our interviews and observations, it appears that the call to action has enabled engagement, and action, across all levels of the health system; from the macro level (Department of Health, QIPP agenda) to the meso/organisational level and the micro level of individual agents. Furthermore, within the call to action there is evidence of communication both within, and across, these levels of the healthcare system, across professions and across care pathways, with the formation of inter-dependent relationships across boundaries which have then become self-perpetuating and reinforcing.

The relationship between pharmacists and GPs is a striking example of this and has enabled the creation of a resource to assist with critical conversations, which through support from the Royal Pharmaceutical Society, is now reported to have been accessed by 40,000 pharmacists. However, this coalescent effect does make it problematic to identify isolated causal pathways, since part of the strength of the approach appears to stem from its ability to bring together very disparate parties and factors in combination, indeed this coalescence of factors is part of the essence of the blended approach.

# Section 8

A final note

# A final note

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## 8 A final note

This report opened with the words of a gentleman who had received a diagnosis of dementia. It seems fitting to finish with the words of that same person.

*'When you come out of hospital the doctor won't take you off of anti-psychotic medication. You have to break down barriers that's what you have to do; barriers of not having enough time, or enough awareness of dementia. You can't catch it and you can't see it. You say 'disease' and people think you can get that...We're starting to make progress now, there's a movement going on!'*

Graham Browne, March 2012

Graham went on to say that a lot of progress had been made, but that so often this progress is halted by staff leaving, structures changing. He said that he hoped it wouldn't be the case this time!

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# Appendices

# Appendix 1

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## The eight commitment groups

- People with dementia and their carers & voluntary sector and advocacy groups (local and national)
- Leaders of care homes
- General Practitioners and primary care teams
- Psychiatrists and mental health teams
- Pharmacists
- Hospital doctors and multidisciplinary teams
- Commissioners of health and social care services
- Medical and nursing directors of acute and foundation trusts

# Appendix 2

## Interview guides

### A. Initial interview

#### PURPOSE OF INTERVIEW

To capture stories of individuals involved in the call to action. To seek to understand...

- Theories of social mobilising held by individuals
- Theories in use within the organisational setting
- The challenges faced when trying to use these theories within the English NHS?
- How this relates to previous experience/ knowledge?
- The impact of this approach (envisaged and actual)
- What factors enable impact

The interview(s) will be semi-structured, guided by the following questions:-

#### KEY QUESTIONS

1. What is your name and role?
2. Would you tell us how you are currently involved in the call to action to review anti-psychotic prescribing?
3. To what extent have you been involved with, or are you aware of, the NHS Institute's approach to review anti-psychotic prescribing medication for people with a diagnosis of dementia?
4. What were the processes which led to your involvement?
5. Which elements of this approach have appealed to you?
6. How has this approach resonated with your own experience and values, if at all?
7. How have you used this approach in action?
8. What plans, or strategy, have been put in place to support the implementation of this 'call to action'?
9. Which resources in terms of people, structure, finance, etc. have you drawn upon to support your approach?
10. To what extent do you feel you have been involved in the design and organising of this approach?
11. What have you achieved and what do you hope to achieve using this approach?
12. Is there anything which this approach offers which has not been offered by previous approaches for large scale change?
13. What impact if any, do you anticipate this approach may have on the organisation...on the stakeholders involved in the organisation...on the wider community?
14. How has the context within which you work been a support or challenge?
15. How have you met any challenges that you have encountered?
16. How do you think this approach might be transferred to other work streams/areas of public sector?
17. Do you think you will be able to sustain this approach within your field of work?
18. What, if any, do you see as the limitations of this approach as a catalyst for improvement in the English NHS?
19. Are there any questions or issues which you think require further consideration, study?

# Appendix 2: Interview guides

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## B. Follow up interview

### KEY QUESTIONS

- When we spoke in December you talked about the work you were undertaking to facilitate reviews of anti-psychotic medication. Can you tell me how that has been developing?
- What have been the main challenges with that work?
- How have you responded to those challenges?
- Looking back over the last year and in particular since the launch of the calls to action, what would you consider to be your main achievements?
- We discussed the training from the NHS Institute in our earlier meeting. Do you feel that training has contributed in any way to the work you have been doing in this field?
- What would you say has been the contribution of the NHS Institute? Call to action? Dementia Action Alliance, policy support?
- Is there anything within the current context, individual, organisational and wider, which has presented a particular opportunity or constraint?
- Has the National dementia CQUIN had any impact?
- You seem to have achieved a lot in a short period of time. How have you achieved this? What do you think have been the antecedents of that, if any?

# Appendix 3

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## Roles of members of NHS Institute for Innovation and Improvement

Within this report, members of the NHS Institute for Innovation and Improvement are referred to by an initial. These initials and corresponding roles of the individuals referred to are given below.

- A Associate in Thought leadership
- B Lead Associate
- C Head of Research and Evaluation
- D Chief of Service Transformation
- E Social Media Community Developer
- F Director of Learning and Development
- G Lead Associate and National Lead for Dementia and 'The Right Prescription: Call to Action on the use of antipsychotic drugs for people with dementia'
- H Associate in Thought leadership

# Appendix 4

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## Literature review

### Social Mobilising and Organising: A Review of the recent Literature Relating to Leadership of Large Scale Change in Organisations

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Management

September 2011



# Appendix 4: Literature Review

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# Appendix 4: Literature Review

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## Introduction

The context for this review is the current work of the NHS Institute for Innovation and Improvement (NHSI) in applying core principles of social mobilising and organising (SMO) to enable practitioners and leaders, within the context of the British NHS, to rise to the current financial and quality challenges and to 'build the foundations for a commitment based quality and productivity strategy (Bevan et al., 2011:2).

As part of the NHS Institute's commitment to using this approach to 'enable cost improvements through, and hand-in-hand with, better quality' (Bevan; 2010), this review of the recent literature on social mobilising and organising forms part of an evaluation of the approach in action within the English National Health Service which has been undertaken by a team from Manchester Business School.

Key to this contemporary use of social mobilising and organising principles is the recent work by Marshall Ganz (2001; 2010); work which brings to social movement theory, principles of community organising and explicit theories relating to facilitating motivation, strategy and organising which in order to create the conditions to enable large scale change.

The aim within this review, therefore, is to build on this work through a synthesis of the recent literature along with the identification of theories and evidence relating to the leadership of large scale change.

# Appendix 4: Literature Review

## 1 Background and context

### 1.1 Setting the scene

The work of the NHS Institute in facilitating a social mobilisation and organising approach to improving quality within the NHS, is positioned within the current context of health policy; policy which calls on NHS leaders to make large scale, rather than incremental change.

The aims of this policy, as articulated within the coalition government's White Paper, *Equity and Excellence: Liberating the NHS* (DH; 2010a), are to put patients first and improve health care outcomes. The scope of these proposals, the speed with which they have been developed and the urgency with which they are being implemented means that they are much more ambitious than earlier reforms (Dixon and Ham 2010).

In addition, large cuts in management costs, coupled with huge economy savings and the abolition of Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs), means that traditional change management approaches can no longer be relied upon to implement the change required. It is for these reasons, that it could be argued that this is 'an extraordinary inflection point in the history of the NHS' (Bevan et al., 2011:1), one which presents great opportunities but also great challenges, 'a time of both possibility and uncertainty'.

### 1.2 Aims and scope of this review

This literature review was conducted between June and September 2011 with a focus on the organisational application (within the health sector in particular) of Social Movement and Community Organising (SMO) theories. The aim of this review is to further develop a basis of knowledge in the area of social movements and community organising and to examine this within the context of contemporary change in organisations, with particular regard to healthcare organisations such as the NHS.

This review builds on a number of publications which appeared in the early 2000s (eg, Bate, Bevan & Robert, 2004), publications which explored the possibility of utilising a social movement approach in the context of bringing about large scale change in the NHS Institute. Since this landmark review, there has been a great deal of progress made by the NHSI and its collaborators in further exploring and testing the possibility of applying core practices of a social mobilising and community organising approach to healthcare improvement. This review aims to supplement this work through an exploration of related concepts and theories relating to the leadership of large scale change.

#### 1.2.1 Aims

The aims of this review are:

1. To gain an overview of and to review the relevant literature in the field of social movements and organising in organisations published since the review by Bate, Bevan and Robert (2004).
2. To identify from the literature, organisational examples of the application of social movement and community organising theory.
3. To identify, from the field of leadership and organisational change, and not directly framed as social movement theory, concepts, questions and theory which may add value to the field.

It should be remembered that this review forms part of an ongoing evaluation of the use of social movement theory and organising principles within the NHS. The reviewers are of the opinion that theory and practice should be mutually reinforcing and intertwined.

Therefore this review is contextualised within the practice of the NHS 2011. Our aim throughout is to thereby contribute to the theoretical story of the application of this approach within the English NHS.

# Appendix 4: Literature review

## 1.2.2 Scope of the review

A full exploration of the recent literature on social movements and organising and related theories of leadership is not possible within the timeframe available for this review. Hence this review is not purporting to offer a systematic review of all literature in the field, but rather to provide evidence which the reviewers feel has the potential to offer insights into or is of relevance to the current calls to action for delivering quality and cost improvement within the NHS. Our scope is therefore upon that literature which appears most relevant to the practice of leadership within the NHS and with lessons which can be applied to leadership practices advocated by Ganz (2010).

## 1.3 Review process

In developing this review, the review team were mindful of the relative lack of evidence within the literature for the application and implementation of a social movements approach to large scale change 'within' organisations. However, there is strong evidence of alternative frameworks within OD and Leadership literatures, and which share some, or all, of the core elements of the social movements and organising change paradigm.

As such it is hoped that they may offer evidence of support for specific aspects of social movements and organising, which might then be identified as critical to the success of SMO approaches to large scale change. This approach, of course, changes the nature of the literature review and would require a substantially greater resource to complete a systematic review in all of these fields.

The key focus of the review team, has been upon contributing to the observations, and story, of the project as it unfolds. In this spirit, and given the dearth of evidence based literature available, we consider it useful to include fields of inquiry where the approach to change shares significant characteristics with that of social movements and organising and where useful insights could be

gained. In addition, the review team note the observation of Arthur (2008) that the study of social movements within organisations raises particular questions, such as:

What enables movements to have an impact?

What particular forms of repression are most difficult to overcome?

What methods have been found to be useful in overcoming resistance in order to mobilise change within an organisational context?

Within our review, we first identified what have been described in the background reports and documents, as the core elements which comprise a social movements and organising approach. We used these elements to select into the review, approaches to change leadership that could be described as broadly comparable, to social movements and organising, either through sharing similar values, aims, and characteristics or which have specific material to offer as design frames for stimulating change in social systems.

## Summary of section 1

This literature review has been initiated as part of an evaluation of the use of social mobilising and organising within the NHS to deliver quality and cost improvement. The review seeks to identify literature relating to the leadership of large scale change within an organisational setting published since 2004.

# Appendix 4: Literature review

## 2 Key terms and concepts

The terms and concepts described below have been chosen because they are considered central to an understanding of a social mobilising and organising approach.

### 2.1 Social movements

Social movements have been defined by Goodwin and Jasper (2009:3) as

*"...conscious, concerted, and sustained efforts by ordinary people to change some aspect of their society by using extra-institutional means".*

Arthur (2008:1014)

suggests *"...that social movements consist of organised contention undertaken by a group or collectivity that shares some sort of common goal and that this contention is engaged in by those who are in some sense excluded from politics as usual".*

The prominence of a sense of dissatisfaction with the current order of things and a vision of positive change are common within many conceptions of social movements:

*"Social movements can be viewed as collective enterprises seeking to establish a new order of life. They have their inception in a condition of unrest, and derive their motive power on one hand from dissatisfaction with the current form of life, and on the other hand, from wishes and hopes for a new system of living."*

(Blumer 1969: 99)

These definitions pose an interesting question within our current context through locating resources for action outside of the institution.

By contrast, Bate and Robert's (2009) definition locates social movement thinking in the English NHS and removes the emphasis on this externality, through their description of a social movement as

*"A voluntary collective of individuals committed to promoting or resisting change through co-ordinated activity"*

Bate and Robert (2009) in Bibby et al (2009:25).

Similarly, Eyerman and Jamison's definition of social movements as 'temporary public spaces, moments of collective creation that provide societies with ideas, identities and even ideals. (1991; 4) can be seen to have resonance with the public space of the NHS.

# Appendix 4: Literature review

## 2.2 Social movement theory

Crossley (2002; 7) informs us that social movement theory is one of the most extensively studied areas in the social sciences and reminds us that 'social movements are extremely prevalent in contemporary western societies (with) evidence of their activities everywhere'. Buechler (2000:xi) describes how

*"Social movement theory and research have recently become some of the most active areas within the discipline, producing a tremendous volume of work on diverse aspects of collective action".*

The importance of social movements as social phenomena, is reinforced by Zald, Morrill and Rao (2002) who observe that most large scale changes in society have come about by the actions of social movements (e.g. the Solidarity movement in Poland) rather than planned programmes. Examples of this work in practice are usually drawn from fields external to organisations such as the Civil Rights Movement in the United States or the Anti-Psychiatry Movement (Laing, 1970 Cooper 1967).

The wealth of definitions of social movements can create ambiguity when seeking to consider their usage within an organisational setting and it may be helpful therefore to look towards identifying key features of a social movement. Bate, Bevan and Robert, 2004 identified core features of a social movement as:

Public protest and use of radical and unconventional means of political persuasion.

Collectivity and commonality: The other characteristic of social movements is by definition their collective nature. People have to come together, celebrate collective identity (churches, for example) or assert public voice (advocacy groups). They have also been linked to what has been described as the "expressive revolution" (Parsons, 1978) the increasing communication about personally and concretely experienced needs which have become embedded within wider cultural structures.

They have also been seen as being, not a retreat from the political, but an opportunity to open up the political sphere to groups and issues that have previously been overlooked or excluded (Cohen, 1990).

Transformative events, not incremental programmes of change.

Voluntary – spontaneous and self-organising  
Examples of both organisation and disorganisation: come into being without being organised but require organisation to maintain their existence.

Contentious – participants usually 'protesters' or 'heretics'. Relate to under life of an organisation, usually unwelcome, subversive or forbidden.

Kind of change which movements pursue requires sustained, organised activity.

Bate and Robert refined this list of characteristics in 2010, rephrasing their explanation of a social movement through the use of 5 key principles:

- Frame to connect with hearts and minds
- Energize and mobilize
- Organise for impact
- Making change a personal mission
- Keep forward momentum

Three key concepts which are of central import to any consideration of social movements and organising are framing, resource mobilisation and organising.



# Appendix 4: Literature review

## 2.3 Framing

Framing is generally viewed as the first fundamental step in social movement thinking and practice and is the first of Bate and Roberts' (2010) key principles of social movement theory and an aspect of social movement thinking which is particularly important to orchestrated social movements. Indeed the NHS Institute's own work in the area of social movements describes framing as

*"the single most important aspect of social movement thinking in healthcare"*

(Bibby et al., 2009: p63).

The concept of framing has a long history within the social sciences and is not solely confined to the social movement literature. It is not clear when the concept came into being, however many writers attribute this to either Gregory Bateson or Erving Goffman. Goffman (1974) saw framing as a collection of anecdotes and stereotypes - that individuals rely on to understand and respond to events. Building on Goffman's (1974) conceptualisation of frames, social movement scholars have emphasised the importance of the interpretive schema, or 'frame' (Snow et al. 1986) used for mobilising collective action. Benford & Snow (2000) describe framing as a process of 'meaning construction' by which groups and individuals make sense of the world. More specifically, they defined framing as:

*"..the process by which leaders construct, articulate and put across their message in a powerful and compelling way in order to win people to their cause and call them to action"*

(Snow & Benford, 1992).

The relevance of framing to social movements is that it allows participants to develop shared understandings of the problems faced by the group and, furthermore, to assess what actions to take and why. Thus framing is a means of drawing people to the cause and gaining support and is a key component of mobilising action. Effective framing takes place by connecting with individuals' ideals, values, needs and aspirations, so that effective frames are positive, optimistic, aligned with the desired action and relevant to

the target audience. Framing connects with people's hearts and minds as much as or more than their intellects.

A frame should be based on hope and be empowering so that it gives people a belief that they can do something about the situation. In terms of the psychological processes underlying framing, it is described as a different form of persuasion to, for example, belief change (Nelson, Oxley & Clawson, 1997). A number of strategies can be used in framing—words, stories, slogans, visual images, humour and irony. The important thing about framing is that it is not the objective situation, but the way it is described which gives the message power. Conger (1991) gives an engaging example:

"This ability to describe is captured by the simple story of two stone masons who, while working on the same project, were asked what they were doing. The first replied: "I am cutting stone;" the second: "I am building a great cathedral." The latter was able to describe his work in a more far-reaching and meaningful way. Work for him had a higher purpose (p 31). Snow and Benford (1991) distinguish between three types of framing employed in the social movement literature.

The three tasks are:

- a) diagnostic framing for the identification of a problem and assignment of blame,
- b) prognostic framing to suggest solutions, strategies, and tactics to a problem, and
- c) motivational framing that serves as a call to arms or rationale for action.

Furthermore, credibility in framing is important (Bibby et al. 2009) and Bevan et al (2011), similarly talk of the importance of the frame's 'resonance' with the group. Credibility can be viewed as operating on a number of levels. For example, the credibility of the messenger is crucial. Nelson Mandela created such an effective frame for equality and power sharing in South Africa because we know he had suffered long years of incarceration for defending the cause.



## Appendix 4: Literature review

Framing also needs to be salient to the needs and experiences of the group in question. People are much more likely to embrace change if it is framed as something that builds positively on what they are familiar with than something that seems abstract or unachievable. Frames must also possess congruence between the underlying message and the group's experiences, beliefs and values (resonance). Rather than providing people with new pieces of information, framing works by increasing the salience of, or highlighting, information or beliefs that people already hold: it involves looking at the same situation or problem and focusing on specific aspects of it to create a greater sense of engagement and commitment to the cause (Cox & Garrow, 2010). Framing should be a dynamic ongoing process, rather than a single statement, where the frame constantly changes on the basis of new information. For example, positive framing of successes so far should not lead to complacency and should maintain a 'sense of urgency' (Kotter, 2006) so as to keep up momentum. Winston Churchill's "Now this is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning." speech exemplifies 'hope' but also the need for maintained vigour and effort even in the light of initial success in victory.

The importance of framing is not just confined to the field of social movements. Scholars in the fields of management and leadership view framing as a crucial skill for leaders of organisations. Conger (1991) suggests that:

*"Effective framing of an organizational mission will ensure emotional impact particularly in terms of building a sense of confidence and excitement about the future."*

Kotter (2002) similarly talks of the need for leaders to connect with peoples' hearts and minds when asking them to change rather than purely their rational thoughts and many management writers have emphasised that the greatest impact that leaders may have is not on the bottom line as much as the evocation of human emotions and motivations beliefs and commitment especially in the context of helping people in organisations make sense of and engage with radical change

(Bryman, 1992; Conger 1991; Weick 1979). Through framing as a motivating process within an organisational context, the leader thereby takes a role in 'defining organisational reality' (Bryman, 1996; Alimo-Metcalfe and Alban-Metcalfe, 2005), a role which we will return to later within this document.

### 2.4 Resource mobilisation

Resource mobilisation theory changed the focus of social movement research from why to when through the question "Why do aggrieved people protest WHEN they do?"

McCarthy & Zald (1977) suggest that movements emerge when the level of resources available to the aggrieved population rises to a sufficient level. Movement involves bringing together the people who are supporting the cause, moving individuals from bystander to participant, drawing on people's passion, energy and personal commitment in order to prepare people to become activists and agents for change. The process moves people along a continuum that ranges from 'engagement' to commitment to full scale movement and therefore action. The process of resource mobilisation also involves building a critical mass, from which comes a greater level of momentum or energy and the capacity to build teams of committed individuals.

Whilst resources of time and finance can play an important role, resources are wider than this and can be represented by a fivefold typology (Edwards and McCarthy; 2004) to encompass moral, cultural, social-organisational, human and material resources. Central to the resource mobilisation perspective is a focus upon the social and organisational structures within which social movements form and grow (Crossley, 2002).

# Appendix 4: Literature review

## 2.5 Organising

Organising translates the energy developed through framing and mobilising into purposeful and effective action. Within organising, leadership takes a central role and consists of the 'practices which enable others to achieve purpose in the face of uncertainty' (Ganz 2011) <http://www.davidbill.org/archives/1175>).

Such leadership is distributed at a number of levels e.g. core team, extended team, local organisers and characterised by its focus upon enabling 'a group to turn its resources into the power to make change', it is, above all else therefore, a relational practice and one which is closely linked to the practice of structure, strategy and action.

In addition to strong leadership and sharing the root in relationships, organising requires a community capable of exercising collective agency and of utilising resources (time, energy, materials) to create purposeful change. As opposed to the more traditional form of 'organisation', organising in social movements is not based on a hierarchical structure, but rather, on a network of activists of largely equal status. Community organising can therefore be summarised as:

*"...enabling people to combine resources to act strategically to achieve a common purpose... Organizers lead by developing leadership; building community around that leadership; and building power from the resources of that community"*

(Ganz, 2010).

## Summary of section 2

This section has sought to describe key concepts in social movement theory. Concepts described include social movements, framing, resource mobilisation and organising.

# Appendix 4: Literature review

## 3 Potential limitations of social movement theory

Some of the potential limitations of social movement theory were highlighted by Bate, Bevan and Robert (2004:44), who pointed to the difficulties in predicting the emergence of, or being able to consciously construct a social movement, as key limiting factors in terms of the application to the NHS. In addition, Bate and Robert (2010) describe how social movement theory and theorists have received allegations of being 'disconnected' or 'disengaged' from the real world needs of organisation practitioners. In moving on to look at the work of Ganz and literature on leadership, these potential limitations will be borne in considered in more detail.

## 4 Marshall Ganz: Organising and social movements

The recent work by Marshall Ganz (2000, 2008, 2010) sees a significant shift in focus, creating a new movement, referred to by Exley (2008) as the 'New Organisers' and addressing these earlier accusations in three key ways:-

- 1) Mixing traditional discipline of good organising 'with new technologies of decentralization and self organisation' (Exley; 2008),
- 2) Through an emphasis upon the actors and their action, and
- 3) Through providing tools and techniques which can be utilised in practice, (closely related to emphasis upon actors and action).

In addressing the lack of earlier focus upon actor centred aspects of social movement theory and the previous lack of consideration of the influence of actors on mobilising resources, Ganz places leadership at the centre of the frame. Central to the work of Ganz is a focus upon enabling leaders who can draw on the practice of story, or narrative, exercise agency, develop individual and collective identity and mobilise emotional and moral resources to provide motivation for action. Ganz also places a strong focus on action, addressing the accusations of a disconnect from practice and identifying tools and techniques under the heading of his five key leadership practices (referred to later in this text).

Wilson (2010:22) highlights how Ganz's work positions the telling of stories within an organising, as opposed to mobilising, tradition. This organising approach places an emphasis upon action, and upon strategy to enable action, engaging listeners in the narrative in order to find ways to become part of the story through their own actions. This emphasis placed upon strategy and action as part of the organising tradition, potentially brings an element of control over the direction and outcomes of social mobilising and organising as a means of motivating change within an organisational setting and provides a model of empowered and shared leadership, a leadership with relationships at its heart.

Importantly, within the current context of diminished resources, particularly pertinent within an NHS which is tasked with making efficiency savings of £20bn between 2011-2014, Ganz places an emphasis upon using story to access emotional and moral resources as a source of motivation for action (Ganz, 2010).

# Appendix 4: Literature review

## 4.1 Five leadership practices

Ganz (2010) outlines the main requirements of leadership in the context of social movements, through reference to five inter-connected leadership practices: relationships, structure, strategy, story and action.

**1. Relationships:** Because social movements are emergent systems, leaders within social movements are often required to build new relationships and networks, whilst also maximising existing relationships and networks. These relationships can only be based on creating a sense of mutual commitment, since social movements more often than not lie outside bureaucratic control structures and therefore also outside of the associated penalties associated with non compliance.

Relationship building is central to the creation of collective capacity and requires the identification and development of shared interests. Further to this, Ganz proposed that such relationships develop as a function of a mutual commitment of resources from which the aim of a shared future is forged.

**2. Structure:** Within social movements generally, structure is provided through a 'campaign', a structure which provides an opportunity for time to be managed, so that opportunities and challenges can be met and commitments honoured. A campaign structure targets specific objectives and emerges as an unfolding narrative. Ganz argues that traditional command and control structures alienate participation, inhibit adaptation to local and often rapidly changing conditions and inhibit organisational learning. However, quoting Jo Freeman (1970), antipathy to any kind of structure creates a 'tyranny of structurelessness' in which authority is unclear and has a lack of accountability.

Ganz argues for applying structure to social movements on three fronts – the organisation of leadership; processes for effective deliberation and decision making; and mechanisms of genuine accountability.

In Ganz's perspective on developing leadership capacity within the context of social movements, the emphasis is on developing leadership at the team level. Members develop leadership skills in the context in which they would use them. This is akin to Mintzberg's (2004) view that leaders should be developed in the context of their own organisations - by their own organisations and in the context of the roles they possess. The skills to be learned are mainly collaborative; accountability and motivation within the team setting helps ensure the sustainability of new practices. Establishing bounded, stable and interdependent teams with a common purpose, specified roles and clear norms encourages goal attainment and learning.

Ganz (2010) suggests that social movement leadership requires coupling a deep desire for change with the capacity to make change and informs us that for this to happen. Not only must leaders adapt to the rhythm of change, but they also have responsibility for creating structures; *"...that create the space within which growth, creativity and action can flourish"* (2010: 512).

In many ways structure lies at the heart of organising, in so far as it is the means by which drift is translated into purpose.

## Appendix 4: Literature review

**3. Strategy:** The third function of social movement leadership is what Ganz calls 'creative strategising'. Just as storytelling is key to meeting the motivational challenge, so strategy is key to dealing with the challenges inherent in taking action. Strategy is "how we turn what we have into what we need to get what we want", how structures are created and how the resource challenge is met.

**4. Story:** The importance of recognising the role of emotions such as hope are seen by Ganz as fundamental qualities in the leadership of Social Movements (Ganz, 2001). Exley (2008) in his description of social movements and organising in action within the Obama campaign also highlights the important role of hope;

*"In the end, win or lose, you have built something that gives you hope for the future – hope that humanity can, as it turns out, work co-operatively towards a better future and succeed".*

Related to this hope, Ganz also emphasises the importance of public narrative, in effect 'telling the story'. He stresses the importance of 'storytelling' rather than framing since it is seen as a more collaborative process. Change is more likely to happen if employees are able to tell their own stories, likewise employees are not passive recipients of management messages, but are active sense makers (Weick et al. 2005), thereby enabling empowerment and the hope that that brings.

The story told may have within it a sense of injustice, but people will not engage in action to alleviate the situation without the leader also conveying a sense of hope and the sense that action can be taken collectively by them (efficacy) to change things. It is the role of leaders of social movements therefore to convey the 'story' for change. Ganz (2001) refers to three stories; a story of self, story of us and story of now.

A story of self conveys the person's values and how the need for change is driven by those values. A story of 'us' calls to others in order to create a sense of collective identity and the need to collaborate on a shared course of action. A story of 'now' challenges peoples values and communicates the urgency of the task in hand to demand immediate action.

**5. Action:** A key role of social movement leaders lies in mobilising emotions to enable agency and thereby, action. Ganz (2010:517) identifies action barriers and action catalysts. A key action catalyst is urgency, created through creating a 'story of now', a story which mobilises a sense of urgency, often through appealing to other emotions, such as hope, anger, solidarity and through countering the self-doubt of others by enhancing their sense that they can make a difference. Finally, social movement leaders enable action through countering feelings of isolation through enhancing a feeling of belonging or solidarity.

### Summary of sections 3 and 4

Potential limitations of social movement theory have been identified as:

- the difficulty in predicting the emergence of or in being able to control the direction of a social movement.
- Being disconnected from needs of practitioners.
- The work of Marshall Ganz has addressed these limitations to some extent through a focus upon tools and techniques which can be utilised in practice.

Key to the work of Marshall Ganz are the five leadership practices of

- Story
- Relationship
- Structure
- Strategy
- Action

# Appendix 4: Literature review

## 5 Mobilising and organising within organisations

### 5.1 Social movements within organisations

As the earlier description of social movements suggests, social movements have classically been depicted as groups formed outside of normal establishment structures and organisations and particularly those excluded from political participation.

The study of social movements within organisations does not necessarily relate to political exclusion, but rather more to those groups who experience structural exclusion from particular decision making processes, and are otherwise marginalised within organisations (Scott, 2001). As a consequence, our search for a substantial body of literature in the intersecting areas of social movements and organisations found a dearth of evidence in this area. And yet, as the aim of our study is to support the application of social mobilisation and organising within the institution of the NHS, organisational application of this theory within organisations was seen as important.

Why do movements emerge within organisations? The defining characteristic of movements 'within' organisations, is that like social movements in general they usually focus on the achievement of a particular goal or set of goals which the organisation has the power to fulfil (Arthur 2008).

In considering social movements within organisations, a key consideration is organisational readiness for a movement and hence the question of why social movements emerge gains particular import.

One suggested reason (Arthur, 2008) why movements emerge within organisations is as a response to an event or grievance, to the extent that members of the organisation feel compelled to mount a challenge to an aspect of the organisational identity, construction or practice, as part of a push towards organisational change. Another perspective (resource mobilisation) is that even if a constant level of grievances exists within the population, it is the availability of resources that enables a movement to emerge (McCarthy & Zald 1977). Others suggest that movements may emerge when it is realised that the organisation has the capacity to respond to such grievances and yet seems unwilling to move to address these. In some cases the entrance into the organisation of new members is key, since it is newly orientated members, uncovering problems with the organisation, which may have hitherto passed as 'normal' practice, who identify a grievance, (Arthur 2008).

Arthur also suggests that changes in organisational policies or practices can act as a motivating factor for the emergence of a movement, since these can act as a presenting grievance. An additional view is that movements emerge most readily within organisations when those organisations are seen as resistant or hostile to the changes sought, perhaps due to countervailing forces within the organisation (Arthur; 2008). Relevant to a consideration of the emergence of social movements within organisations is the social networks through which people are mobilised into the movement, with the existence of social ties viewed as a pre-requisite for the emergence (Goodwin and Jasper: 2009; 12).



## Appendix 4: Literature review

Movements within organisations can also be initiated in response to outside social movements, perhaps through individual activists' joint membership in both political and organisational movements or alternatively due to direct pressure from outside social movements on organisations and their members. This might include the pressure put on healthcare organisations by health interest groups and professionals within institutions and organisations to change practices. In summary, movements are likely to emerge within organisations in situations where the change sought is particularly difficult for the organisation to come to terms with and when the organisation itself experiences considerable ambiguity about its goals, structure, or identity.

### 5.2 Social movements in healthcare

The first instances of social movements organising around health issues date at least back to the Industrial Revolution. More recently, women's health activists have greatly altered medical conceptions of women, broadened reproductive rights, expanded funding and services in many areas, altered many treatment forms (e.g. breast cancer), and changed medical research practices (Brown & Zavestoski 2004). Users' interests in health care have traditionally been represented by voluntary bodies, or by professionals working with relevant user groups. However, since the 1980s and 1990s, there has been a steady growth of groups and organisations in which users of services have sought to represent themselves: organisations of (rather than for) disabled people, mental health service users, people with HIV/AIDS, etc., such as the campaign for access to medicines for HIV in South Africa, led by the Treatment Action Campaign (TAC) between 1998 and 2008.

In general, social movements aligned to issues of healthcare have traditionally formed, and developed, outside of the structures they seek to influence. The following section examines the journey of a particular movement within the NHS and records and updates the progress of the work championed by the NHS Institute in supporting social mobilising and organising approaches within the English NHS.

### 5.3 Social movements in the NHS: The story so far

This section reports on a number of change initiatives within the NHS which endeavoured to utilise a social mobilising and organising approach. Bate, Robert and Bevan (2004) asserted that

*"Healthcare systems around the world are engaged in striving to make radical and sustainable changes through various programmatic approaches to improvement".*

They cite examples from the UK, USA and Australia, all of whom are engaged in far-reaching transformations in order to address the needs of users in the future. They also suggest that most health care change programmes involve 'programmatic' approaches based on systems, tools and strategic perspectives. Whilst some of these approaches have had success, many seem unable to embed permanently as a sustainable new way of operation.

They suggest that a new paradigm, through the utilisation of social movement theory, has promise in delivering large scale change in the NHS. Based on the findings of a colloquium held in 2002 and comprising senior practitioners from healthcare, healthcare managers, clinicians, policy makers and academics; all of whom gathered to explore the potential for social movement theory as a new way to bring about improvement in healthcare, Bate and Robert (2010) report on practitioners reactions to the following questions:

How do these ideas resonate with your own experiences and views of leading improvement in the NHS?

What relevance does this approach to thinking about large-scale change have for the NHS?

What questions and issues would you want to pose to social movements academics?

What is the problem you would want to set for them?



## Appendix 4: Literature review

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Some initial scepticism was expressed, mainly based on the view that social movement approaches were seen to pose a threat to the organisation and its established structures; and therefore to those senior managers who sat within those structures. Participants' reactions seemed to suggest that the social movements approach challenged the current predominant NHS approach to improvement, offered something which felt new and different, and was perceived as potentially offering a way to address the unprecedented scale and pace of change with which the NHS was struggling (Bate & Robert, 2010).

Bate and Robert (2010) go into more detail about possible reasons for the positive response to these ideas. For example, since social movements are formed by groups on the basis of a desire to change the current situation, they are less likely to offer resistance to this perceived need for change. In addition, since they are effectively mobilised, there is no need to achieve 'buy-in' from the workforce since it is the people at 'grass roots' who are the instigators of the change.

The contrast between programmatic change and change instigated through social movements is that social movements harness energy and commitment to action, creating 'epidemics'. Bate, Robert and Bevan (2004) had previously made the observation that increasingly, organisations are moving away from tools and techniques of change and towards the formation of 'communities of practice', a concept more clearly aligned to the idea of social movements. Such a shift represents a move from 'top-down' prescriptive approaches to more 'bottom up' – from centrally devised policy to change managed at a local level by healthcare staff and/or service users and present another possible suggestion for the positive response to this change method.

The fundamental questions raised within this programme included questions of how the potential for a movement approach might be propagated within the current systems of the NHS and how participation in an improvement movement might be encouraged. Social movement theory suggests that the movement's aims must appeal to values, aspirations and identity in order for people to be committed to those goals and invest time and energy in supporting them. The congruence between the aims of the movement and the person's values and aspirations is contingent on the underlying message and how it is 'framed'. Framing needs to be 'empowering' so that people feel that there is something they can actually do.

Evidence from the colloquium discussed by Bate and Roberts (2010) also suggests that healthcare professionals are more likely to be engaged in a movement for change if they are actively involved in the process of planning and organising. Furthermore, the extent to which staff identities and values are aligned to those of the programme through initial framing was found to have a substantial effect on the adoption and sustainability of the programme.

A second key question when considering social movements within the NHS concerns how best to facilitate the process of mobilising people at a local level to take action. Bate and Roberts (2010) suggest that this movement is not based on prescriptive guidance, but on a common desire to undertake joint action to fulfil shared aspirations to facilitate change. However, it is only where the aims are consistent with grass roots aspirations and emotions that there is likely to be participation and concerted effort. In addition Bate and Roberts suggest that movements need advocates or champions to both generate and maintain momentum.

## Appendix 4: Literature review

Bate and Roberts (2010), go on to report on the development of further work in the area of social movements in the context of improvement in the NHS. They report how the initiative to develop social movement thinking in the NHS was given further impetus in 2006 by work with four NHS pilot sites. The aim of this work was to develop practical advice on implementing a social movement approach within the context of NHS organisations. Eschewing linear 'step models' of change, the authors worked with the pilot sites, enabling them the freedom to, as they put it "“find their own way up the mountain”" with the aim of developing some broad design principles" (2010:195) for large scale change. Teams from the four pilot sites worked on a range of projects over six months, with support provided in the form of training days given by the authors. Bate and Roberts (2010) report that this approach appeared to have 'struck a chord' with the teams and go on to suggest that change was likely to be more a function of commitment to change and enthusiasm, rather than project management. Teams reported a sense of new-found energy and optimism that things could be achieved.

Despite this enthusiasm, the authors report some disappointment in the extent of the achievement of the original goals, reporting that the projects had, in some cases, reverted to the old model of change in the NHS, rather than maintaining the impetus of a movement. Bate and Robert (2010) suggest the cause of this setback was the lack of personal identification amongst some staff groups with the presenting problem. An example of where the spirit of a social movement had been most apparent, was in a patient-led group, a group who displayed the greatest energy and momentum to tackle a number of heartfelt concerns including hospital acquired infection, transport problems, etc. Bate and Robert (2010) attribute this relative success, to users being much closer to the impact (ownership) of the problems they were striving to address. From this phase of the application of social movement thinking within the NHS, Bate and Robert (2010:196) concluded that the lessons for future interventions were:

**Frame to connect with hearts and minds:** in this context this relates to identifying an issue of concern and creating a persuasive message (hook) that would engage people's motives in such a way that groups of people would find it overwhelming and to 'turn an opportunity into action'.

**Energise and mobilise:** with the development of a persuasive, irresistible, frame comes the need to turn this into affirmative action; moving from 'engagement' to commitment to full blown participation, to inspire realisation of goals by unlocking energy within the organisation and leveraging 'discretionary effort'. Discretionary effort is important because it implies that groups need to work beyond the boundaries of their current roles to achieve change.

**Organise for impact:** drawing on the work of movement activist Saul Alinsky, this relates to the recognition that energy needs to be directed and channelled, that groups need the right constituents and organising structure and that the leadership function is 'distributed' (Gronn, 2002) within the group rather than the role of one individual. It also relates to choice of tactics and 'how' change can be realised.

**Making change a personal mission:** this relates to people identifying with the problems and the actions as change agents they employ to bring about that change. Bate and Robert use the term tempered radicals – in contrast to anarchists or managers. Among the characteristics of the tempered radical identified were authenticity, passion, stamina, and 'quiet courage'. This is not to say individuals put themselves at risk, since change can be seen as a threat to the established system and power structures, rather it is about also recognising where the risks are and working with rather than against the system.

## Appendix 4: Literature review

**Keep forward momentum:** much of the organisational change literature, within the NHS, suggests the need to create the conditions for 'spread and sustainability' however social movement thinking recognises that organisations are often not receptive to radical grass roots change and the task is likely to be impossible due to the scale of the organisation. Thus, rather than talk about sustainability and acceptance, Bate and Robert use the term 'momentum' to give a greater sense of the need to maintain impetus in the face of antipathy and to continue to harness the mass and energy of a movement.

This pilot led on to the development of a workshop in 2007 entitled *The Power of One, The Power of Many. Three Days in July*, where 3-4 volunteers from 12 NHS organisations were invited to work with the five principles and were given a 'crash course' in social movement thinking. The teams were asked to nominate a 'cause' that they felt very strongly about and were asked to do 'fieldwork' to observe the underlying issue and to ascertain a possible course of action. In particular, on the first day, participants worked on refining their causes (reframing).

Three weeks after the event, the authors re-engaged with the participants to discover how they viewed the experience and how they had used the lessons from the event in bringing about change in their organisations. What was interesting was that many of the participants felt that it tapped into some of the original core values on which the NHS was founded but which had become lost in the current 'top down' target driven climate. Also the ownership of the change process at the grassroots level and the skilfulness of framing the message for change to give it a striking impact on those involved, were cited as valuable lessons.

The dilemma of whether social movement approaches work 'with', or outside of, established structures was raised. It is worth recognising within this context that framing an irresistible message for change must also involve engaging senior management in the process and that some participants reported that the cases they had identified were in no way incongruent with the needs of the organisations or their management.

Importantly the authors identified a change in the mindset of participants – through thinking about change in a different way. This paradigm shift is an important step.

The project sponsor within the NHS was aware of a potential tension between some aspects of social movement theory and the NHS. A recognised tension was the possibility that issues framed too radically were likely to be rejected. Language, and the type of language used, is crucial. Much of the social movement rhetoric uses terms such as 'activist' or 'radical', terms which are probably not going to engage people. Language is identified as important in terms of changing people's mindset about their identity and actions and in enabling thinking in different ways.

Another question relates to the extent to which social movement approaches supplant other methods of change or are integrated within the range of approaches to change currently utilised within the NHS. The answer is that it appears to be dependent on the context, the problem and the people.

Bate and Robert (2010) report that they were suitably encouraged to take the process further by organising further events in 2008 in which the participants became champions for the social movement approach to change. In their recommendations, Bate and Robert suggest that in contrast to approaching senior managers to elect participants, the participants could be self selecting in order to engender a greater involvement of participants in choosing the issues (causes) they wanted to work on. There may, they suggest, be an argument for concentrating more on the 'how to' in terms of practical implications for implementation for practitioners in the future.

They conclude by reflecting on the sustainability of the social movement approach or whether it will end up as another good idea 'on the shelf'. Perhaps in the culture of 'evidence based medicine and practice' evidence needs to be generated and disseminated and it is clear that the sponsors within the NHS are actively doing that.

## Appendix 4: Literature review

Furthermore, pockets of improvement activity, which go against established top-down formulaic approaches to change, (activism) are occurring more frequently within the NHS. Bate and Robert refer to the study by Buchanan et al (2007) where in an acute cancer care hospital, as the research suggests 'nobody (was) in charge' of a successful quality improvement programme and as opposed to taking the project management route, the responsibility for undertaking the change was 'distributed' equally among members of a change team. The implication from this study was that anyone who wishes to assume responsibility has a chance to be involved. In addition, Bate and Robert (2010), at the time of writing their report state that there is increasing evidence that a movements approach has been taken up by groups of people within the NHS (Bibby, Bevan, Carter, Bate & Robert, 2009).

A complementary study by The Institute for Employment Studies (Cox & Garrow, 2010) involved a review of the material relating to social movement theory and its potential application to the context of the NHS, an exploration of intrinsic values important to NHS staff and the prospects of harnessing these into a social movement for change. Cox and Garrow (2010) also engaged a wide range of NHS staff in focus group discussions. Their research adopted an Appreciative Inquiry (Ai) approach to harnessing the deeply held values of staff and identifying their congruence with NHS Values; exploring personal fulfilment in their work; and identifying their views on the messages about the Quality Innovation, Productivity and Prevention (QIPP) agenda. Cox and Garrow (2010) present a process model of two scenarios – one leading to positive change through providing a persuasive framing – involving – empowering staff with a narrative which ensures congruence between the organisational vision and employees' deeply held values. The other path suggests a diminution of energy through a focus on managerial imperatives, lack of participation and the erosion of collective effort.

The key findings of this report include that staff reported that the opportunity to care for patients, teamwork, professionalism, opportunities for involvement and contribution to decision-making, use of skills and opportunities to specialise and progress were key sources of fulfilment in their roles which tapped into their personal values. In addition, the report identifies factors which support movement and factors which inhibit it. Cox and Garrow (2010) report that front line staff are needed to champion the message to avoid the perception of a managerial bias in the movement process.

There is also the need to create a collective identity through using peer champions and activists to inspire staff to get involved in QIPP activities – however just being told what to do without authentic participation in decision making may lead to the whole group lacking ownership. In addition, Cox and Garrow identify the need for senior management commitment or 'buy-in' – not just to the 'idea' of mobilised change but to action as a result of the group's suggestions – reporting that otherwise staff will see this as just another missed opportunity, creating disillusionment. They outline 4 key principles for framing messages:

1. Messages need to value and recognise staff – 'record and celebrate success' to avoid reinventing the wheel and stress the positive to counter a climate of messaging around 'what not to do'.
2. Involve staff in creating messages and include 'bottom up' examples of how to shape service.
3. Make messages simple and limit their number to make QIPP activities more memorable and easier to grasp.
4. Messages should be realistic and open the door for action, acknowledging organisational constraints and promoting small changes which can make a big difference, to enable QIPP to gain traction on the ground.

## Appendix 4: Literature review

Cox and Garrow lay emphasis on face-to-face engagement, since face-to-face communication with individuals whom staff trust is the most powerful means of engaging and mobilising staff through opportunities for emotional engagement and interaction and it is especially important to convince people at lower levels in organisations that their contribution is valued.

Cox and Garrow (2010) also cite the importance of tapping into Public Service motivation (PSM) embodied in ideas such as altruism and pro-social (discretionary) behaviour, indicating a willingness to go beyond contractual requirements of a job. Public service motivation is seen potentially, as a powerful source of energy within the NHS which could be tapped by a social movement frame (Brewer, 2008).

This also includes a commitment to the NHS as an institution. Akin to this is recognising the importance of the 'psychological contract' (Rousseau, 1995) and the wider concept of employee engagement. A positive psychological contract is one where employees and employers believe each party is fulfilling their obligations and is associated with a range of behaviours and attitudes that are beneficial to the organisation.

### Summary of section 5

There is currently limited evidence of social movements within organisations. Social movements in health care date back to the industrial revolution and traditionally originate outside of the organisation. A key question therefore is why do movements emerge?

Suggested answers include:-

- Response to event or grievance seen as part of the organisational identity.
- Entrance to the organisation of new members.
- Changes in organisational practices or policies.
- Hostility from the organisation to changes sought.
- Pre-existence of strong social ties.
- Pressure from external organisations.

There have been a number of recent initiatives relating to social movements in health care as a means for facilitating large scale change.

Key lessons from these include:-

- Frame to connect with hearts and minds
- Energise and mobilise
- Organise for impact
- Make change a personal mission
- Keep forward momentum
- Involve health care practitioners in planning and organising change
- Gain support from frontline staff, senior managers and clinicians as advocates and champions
- Frame in familiar and moderate language
- Obtain early, and ongoing, evidence of success.



# Appendix 4: Literature review

## 6 Leadership, yes but what sort of leadership?

The need for leadership within health care services is a given, so that the issue is not so much leadership, as what kind of leadership? (Grint; 2010). The work of Ganz puts leadership into central focus and Ganz (2010) states that there is a specific set of requirements in the leadership of social movements, in the form of the five leadership practices (p.21 of this review). Since leadership in the organisational theory literature, comprises so many different schools of thought and, is in a constant state of evolution, the review team considered that it would be most helpful to look at those specific aspects of leadership which have been identified as particularly relevant to the development of social movements in organisations and/or to leadership in public organisations.

### 6.1 Public leadership

Brookes and Grint (2010: 2) suggest that the recent crisis in public services, which they attribute to the 'audit culture' positioned against a background of apparent decline in trust and confidence' in public service leaders, calls for

*"A form of collective leadership in which public bodies and agencies collaborate in achieving a shared vision based on shared aims and values and distribute this through each organisation in a collegiate way which seeks to promote, influence and deliver improved public value as evidenced through sustained social, environmental and economic well-being within a complex and changing context"*

(Brookes and Grint, 2010:2)

Under this heading of collective, or public, leadership, Brookes and Grint include collective and distributed leadership.

### 6.1.1 Collective leadership

Collective leadership views leadership as the 'property and consequence of a community rather than the property and consequence of an individual leader' (Grint, 2005:38).

It is a leadership that extends across organisational boundaries (Ansari et al.,2001) and encompasses leadership both 'with' and 'without' authority (Heifetz, 1994). Allen (2004) distinguishes 'collectivity' from 'collectivism' and sees collectivism as denoting a movement. Despite this distinction, collective leadership shares features of social movements in its focus upon the public good, social justice and positive governance.

Grint (2005) suggests that where collective leadership might differ from collectivism is in the prominence given to individual agency within a collective response. Interestingly, the work of Ganz (2010) where it has been applied to the English NHS has responded to this particular context by providing room for individual agency within the collective response, perhaps recognising that what Gladwell (2008) refers to as the 'tipping point', when applied to successful leadership and organisation, may lie in recognizing the need for an alignment between distributed (vertical/formal) and shared/collective (horizontal/informal) leadership.

### 6.1.2 Distributed leadership

Perhaps the most salient of conceptions of leadership to the notion of organising and social movements, and one integral to public leadership (Brookes, 2011) is the notions of shared or 'distributed' leadership (Bate & Robert, 2010; Grint, 2010) in which leadership resides in the collective. It is not clear at what point notions of shared and distributed leadership attained prominence within the leadership literature, however Yukl (2006) cites the work of Peter Gronn (2002) and Pearce and Sims (2000) as two originators of these constructs.

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Indeed it is only recently that recognition among management writers has developed of the potential impact of the increasing complexity of current organisational structures and processes. Within distributed leadership model, leaders pool their expertise across the system to enable a collective result greater than the sum of individual leadership actions. Key to distributed leadership then is a recognition of the greater need to work across institutional boundaries, the emergence of new forms of governance such as multi-agency partnerships and self managed teams and the general move towards networked organisations with increasing interdependencies. Pearce and Sims (2000), elucidate shared leadership by making the simple assertion that:

*"...one is hard pressed to find any job that is not interdependent with other jobs. Almost all work that is done today is the function of teams."*

(p116).

In their formulation, shared leadership is a process of shared influence between and among individuals that can emerge in a group context as an alternate social source of leadership. The notion of shared leadership thus moves away from most established conceptions of leadership such as individualised or dyadic theories as well as contingency approaches and the transactional-transformational distinction, all of which focus exclusively on the relationship between the solitary leader and their followers.

They make the distinction between 'vertical' leadership – to denote more traditional top down approaches within organisational hierarchies and shared leadership where all members of a group can contribute equally to the leadership process. Pearce (2004) goes on to provide an account of the contexts in which shared leadership represents an advance in terms of team effectiveness.

These include (a) when there is a high level of task interdependence; (b) where there is a higher need for creativity, which requires inputs from several individuals; and (c) in contexts that are characterised by high levels of complexity and turbulence. Pearce, however, also recognises rather than discounts the importance of vertical leadership, whilst suggesting it is there primarily to create the conditions for, and facilitate, effective shared leadership within their organisations. Bevan (2011) similarly highlights a key aspect of distributed leadership, which is that its ethos 'doesn't negate the critical role of the senior leader' but rather makes it even more important and places an emphasis upon acting in accordance with espoused values in order to generate signals that

*'reduce uncertainty and ambiguity about what is important and how to act'*

(Bevan, 2011:17).

Distributed leadership highlights leadership as an emergent property of a group or network of interacting individuals. This contrasts with leadership as a phenomenon which arises from the individual. Gronn's (2002) work is helpful in explicating and elaborating this. What is most distinctive about the notion of distributed leadership is summed up in the second of the meanings identified by Gronn, namely concertive action.

Contrasted with numerical or additive action (which is the aggregated effect of a number of individuals contributing their initiative and expertise in different ways to a group or organisation), concertive action is about the additional dynamic which is the product of conjoint activity. Where people work together in such a way that they pool their initiative and expertise, the outcome is a product or energy which is greater than the sum of their individual actions.



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Secondly, distributed leadership suggests openness of the boundaries of leadership. This means that it is predisposed to widen the conventional net of leaders, thus in turn raising the question of which individuals and groups are to be brought into leadership or seen as contributors to it. Of itself, the notion of distributed leadership does not suggest how wide that boundary should be set. However, equally, there are no limits built into the concept. This openness is not limited merely to the extent to which the conventional net is widened within a particular community.

Over and above the more general findings regarding the components which constitute high performing organisations, there have been numerous attempts to encompass the specific organisational and managerial capacities required of leaders and managers in public sector organisations. Although there is not the space to cover all these factors extensively, some represent consistent refrains within the literature.

Hartley and Allison (2000 p.38) note, leadership is 'no longer (if it ever was) solely about command and control from the "top" of the organisation'. Increasingly, the role of public sector leaders is the active engagement of others. They also describe this as 'distributed leadership' because it is spread across an organisation rather than simply located at its apex. Hartley (2002) further proposes that distributed leadership is exercised most often by those people who have constructed alliances, support, systems and collaborative cultures for inter-agency working.

They see this as dispersed across the organisation. They consider distributed leadership to be the result of alliances and team working and a natural consequence of new collaborative ways of working and flatter structures. These accounts clearly do not exactly chime with traditional conceptions of leadership; and rightly so. Maddock (2009) also supports this view:

*"What is emerging in Britain is an acceptance of the need for adaptive, agile and collaborative leaders who listen and motivate staff by a commitment to social or public purpose, rather than direct and threaten with command control methods."*

(Maddock, 2009: 145)

Another recent report for the King's Fund on the state of leadership, with reference to healthcare (Benington & Hartley 2011) also took the view that there was a need to reconceptualise leadership in the face of increasing demands on the health system in this country. They also eschew the relevance of traditional 'great man' conceptions of leadership and favour leadership as a process or 'leadership as a verb'.

They support the arguments made by the King's Fund Commission (2011) for greater appreciation of the significance of distributed leadership and of leadership constellations (Denis et al., 2010) in which the exercising of leadership is shared depending on the context and the task and the type of challenge facing the group.

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They conceive of leadership as being bound by context and view it as a dynamic interactive process at a number of potential levels: – within different groups; across networks of groups; or organisations and, in the context of mobilising, across a diverse set of stakeholders. For example, leadership is required to work across sectoral boundaries, services and levels, in particular in the context of increasing incidence of co-production of outputs between a diverse range of stakeholders (Brookes, 2011). Brookes and Grint (2010) make the observation that with the increasing requirement for public organisations to work in partnership, the notion of the ‘leadership community’ should be articulated. Thus the leadership challenge requires

*“harvesting ideas for service change and improvement from users of services and from local communities, not just from government, staff and other stakeholders.” (p.6).*

This involves a significant shift in thinking from a position in which public servants and the public sit in different spheres, to one in which citizens and communities as well as public servants sit within the same complex adaptive system. From this perspective leadership is applied at a whole system level wherein the challenge is not just to coordinate people and resources for common goals, but to lead networks and movements within the wider civil society.

Their view draws a number parallels with the challenge of leading social movements. Leadership as a verb; originally coined by Heifetz et al (2009), as opposed to leadership as position is also congruent with social movement theory and practice. In line with social movement theory, they emphasise the importance of leaders’ ‘framing’ of issues and ideas through a process of ‘sensemaking’ (Weick et al, 2005) in terms of a problem’s definition and how it can be resolved.

It also requires the capability to see how others (constituents) frame problems and in taking this into account with a view to helping groups to reframe that problem through marshalling collective emotional and intellectual resources. They also emphasise (after Heifetz, 1994) the view of leadership as ‘mobilising’ groups, communities and other stakeholders, to address difficult problems as opposed to purporting to have the answer and telling them what to do. More explicitly, they cite the work of Benington and Moore (2011:28), which codifies their conception as a strategic triangle comprising three elements:

- Clarifying the public value goals and outcomes that are aimed for (what is the value proposition in terms of adding value to the public sphere; and what does the public most value?)
- Mobilising commitment from the authorising environment (have all the stakeholders who are necessary to provide legitimacy and/or support of the public value proposition been mobilised?)
- Aligning operational resources to the desired public value outcomes (are the necessary resources of money, people, skills, technology and equipment harnessed behind achievement of the desired public value goals and outcomes?).

Thus, the outcomes, Hartley and Benington (2011) suggest by which leadership may be best assessed, are not in terms of goals and targets but what outcomes actually represent value to the public (public value).

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### 6.1.3 Informal public leadership

West in t'Hart & Uhr (2008: 133) links social movements to public leadership with the term 'informal public leadership'. Interestingly, West claims that social movement leaders, in operating outside of formal structures and hierarchies, have to create authority through charisma and therefore rely on the use of 'moral capital' as a key resource of the movement and as a means of promoting social and cultural change.

West (2008) suggests that Social Movements within the public sphere should be 'recognised as active agents *'and that 'the movement itself exercises a kind of leadership role within the wider society'* (p 140).

### 6.2 Leaderful practice

The dethroning of the individualistic paradigm of leadership by Hartley and Benington (2011) is continued by Raelin (2011) in his call for 'leaderful practice'. This builds on the leadership-as-practice movement (Schatzi, 2005; Yanow and Tsoukas, 2009) which looks on leadership as a practice with an emotional and relational character (Chia and Holt, 2006; Raelin, 2011) and is concerned with how leadership emerges and unfolds through coping in day-to-day practice. Leaderful practice acknowledges both a locus of leadership in embedded practices and also asserts the value of democratic involvement across the practice realm. Leaderful practice has import for a consideration of social mobilising and organising in its emphasis both upon engagement and its implications for leadership development.

Engagement within the realm of practice becomes the preferred venue for learning, so that critical to this form of leadership is both public and private reflection. Raelin highlights the danger of normative pressures acting to restore a dominant hierarchically managed order and potentially undermining a more collective, distributed leadership style. Hence space gains prominence (Polletta, 1999; Grint, 2008, Brookes 2011), reminding us of Eyerman and Jamison's (1991)

definition of a social movement referred to on p5 of this document. Looking at leaderful practice, this space becomes a space for reflection, a neutral space in which people can begin to engage, can feel free to articulate their concerns and to question the legitimacy of institutional structures which deny them a means for resolving their problems (Bate, Bevan and Roberts; 2004; 34).

### 6.3 No more heroes - leadership in austerity

In 2010, the King's Fund set up a commission to investigate and report on the state of management and leadership in the NHS, with particular regard to the requirements of leaders in the NHS to maintain and improve quality in a climate of financial austerity. Their report (King's Fund, 2011), subtitled 'No More Heroes' paints a picture which supports both the theory and evidence from writers such as Gronn, Pearce and Sims and Ganz. This report encompasses a number of the themes referred to in this review so far and is seen worthy of inclusion in its own right due its relevance to the current context of leadership.

Within this report, the authors eschew conventional 'heroic' conceptions of leadership and instead define leadership as: *"...the art of motivating a group of people to achieve a common goal"* (p.12)

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They provide evidence from various sources which indicates that the performance of organisations can be directly related to the quality of leadership. The evidence links shareholder value with the level of investment in leadership development and talent management. At the operational level the increase in staff engagement through effective leadership can leverage staff performance by 57 percent. Giving staff a sense of their contribution to corporate objectives and providing fair and accurate feedback has been linked to increases in discretionary effort.

The Commission also assert that leadership matters because it is leaders who make improvements in service outcomes. They do this by promoting professional cultures that support teamwork, continuous improvement and patient engagement. The authors quote Sven Olof Karlson of Jönköping County Council Sweden (p.14) in stating that “every one has two jobs in healthcare in the region - improving care and providing care”. This reflects the distribution of leadership among all staff with the common goal of creating improvement across the system. At Jönköping doctors played key roles in the redesign of services and the integration of care across the continuum of paediatrics and later in seniors’ health services. A study of 13,000 hospitals in the USA and Europe by McKinsey and the Centre for Economic Performance indicates that higher performing hospitals gave managers a greater level of autonomy than lower performing hospitals with decision making and accountability devolved as close as possible to the clinical front line. In this model, “improvement is everyone’s business”.

In particular the King’s Fund Commission’s findings support a model of leadership which emphasises the permeation of leadership at all levels of the organisation, or as they put it ‘from board to ward’. In this vision of leadership for the NHS, people at all levels should be enabled to exercise leadership. This increases the capacity for change – through promoting change leadership through the system – essentially having more leaders working to change things.

The report cites Turnbull-James (2011):

*“Leadership must be exercised across shifts 27/7 and reach to every individual: good practice can be destroyed by one person who fails to see themselves as able to exercise leadership as required to promote organisational change, or who leaves something undone or unsaid because someone else is supposed to be in charge. The NSH needs people to think of themselves as leaders not because they are personally exceptional, senior or inspirational to others, but because they can see what needs doing and can work with others to do it” (p28)*

Turnbull James (2011) also emphasises the importance of leadership in harnessing a diversity of talents and building relationships, arguing that leadership requires social relationships to be forged between leaders and followers and to be aligned to the needs of the organisation as a whole. The report argues for the breaking down of traditional professional boundaries between managers and clinicians, with managers and clinicians in management, working in greater partnership.

The Commission asserted that old (heroic) models of leadership emphasising the individual’s personal capabilities require rethinking in the context of a modern NHS. They further suggest that models of shared/distributed leadership need to be adopted with their greater emphasis on the capability of teams and across systems; reflecting the complexity of the leadership challenge in the NHS to work with partners and other organisations to deliver care.

In this view, leadership is as much about leading systems as it is about leading one organisation. Leaders have to influence, and inspire, across boundaries rather than tell others what to do. With this emphasis upon cross-boundary working, inspiring discretionary effort and leading whole systems, the leadership advocated within this report has much in common with organising and social mobilising.

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### 6.4 Leadership as performance (Peck and Dickinson, 2009)

The view that leadership can be conceived of as a performing art is not new, dating back to Aristotle and more recently highlighted by Grint (2000).

Peck and Dickinson (2009) link performance to action and identify three key and interrelated components of a framework for leadership as performance: narrative (the story), audience and enactment (setting, context). In its focus upon the key role of the narrative and its link to action, Peck and Dickinson's (2009) framework for leadership also has parallels with social movement theory. Furthermore, this conceptualisation of leadership allows for an account of the relationship between leaders, followers and the institutional setting and therefore has the potential to add to a consideration of social movements and organising through a focus upon the organisational setting.

Peck and Dickinson make reference to the work of Schechner (2003) and suggest that leadership as performance is an attempt 'to draw the routines of everyday life into the sphere of performance and, in so doing, (to) challenge the assumptions and activities of the society in which the performance is given'. Their work therefore has potential insights to add to Ganz's use of narrative as means of mobilisation and its application to organisational change within an NHS setting. This aspect of their work characterises the role of performance as "an act of resistance, in which prevailing social norms are challenged with a view to their transformation" (2009:101). Hence, leadership as performance places a strong focus upon the institutional context, arguing that it is central to the form of the story and nature of interactions which constitute 'performance'. Viewing social movements through a leadership as performance lens therefore locates a consideration of movements firmly within an organisational context and demands a consideration and analysis of the nature of the audience.

Peck and Dickinson's work reinforces the importance of framing, interpreting this term as the 'ability to shape received meaning of events/ subjects' and to privilege one interpretation over another. The concept of leadership of performance highlights the import of understanding the audience, of aligning the story with their own perceived values and priorities and of understanding the cultural and institutional pressures which may maintain a status quo and engender resistance to change.

Wilson (2010) also suggests that leaders too often 'fail to effectively motivate and engage their audiences. Or misunderstand the cultural forces that keep these behaviours in place (2010:21). Barker (2006:24) suggests that

*"there is no such thing as 'the audience'", rather that "there are a great variety of audiences that nonetheless display patterns and processes which bind them into researchable communities of response."*

The implication of this for social movement and organising approaches to organisational change lies in the apparent need for leaders to possess sensitivity to the potential patterns of response that may be demonstrated by distinct communities of interest within an audience that shapes, and is shaped by the reactions of individuals.

This also implies the need to understand and appreciate the different drivers, emotions and values of the various sub-cultures present within an organisational setting when framing messages and enacting stories for change.



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An often heard refrain in training events held by the NHS Institute on the social movement and organising approach, centres on the tension between crafting and using narrative to create action and the need to maintain authenticity and spontaneity. This concern with authenticity is echoed in a number of recent texts (George et al., 2007; Hames, 2007) which profess authenticity as the new 'answer' to leadership.

Goffee and Jones (2005) attempt to resolve this tension when they argue that 'authenticity has often been thought of as the opposite of artifice...managers who assume that their authenticity stems from an uncontrolled expression of their inner selves will never become authentic leaders. Great leaders understand that their reputation for authenticity needs to be painstakingly earned and carefully managed" (2005:94). Authentic leadership has a number of definitions but central to most is the idea that authentic leaders 'align their actions and behaviours with their core, internalised beliefs' (Harve et al., 2006:2). Through its emphasis upon crafting a 'story of self' which expresses personal values, Ganz's approach to narrative is therefore congruent with authenticity.

A number of organisational studies explore authenticity within the context of the organisation, (Ford, 2006; Alvesson & Sveningsson, 2003), reminding us that identities of individuals are shaped within the settings in which they are framed. Viewing Ganz's 'story of self' and 'story of us' through this lens, it could be argued that 'understanding the institutional setting is crucial in assessing the degree of authenticity which an individual may be perceived to hold' (Peck and Dickinson, 2009:183) and Avolio et al.'s 2004 definition of authentic leaders as "those who are deeply aware of how they think and behave and are perceived by others as being aware of their own and others' values/moral perspectives, knowledge and strengths and aware of the context in which they operate" (2004: 4), goes some way towards reconciling a purposively crafted story of us and self with authentic leadership.

### 6.5 Political leadership: applause and booing

It is perhaps natural, considering the involvement of Ganz in the 2008 Obama campaign, to look to the field of politics when seeking to understand the use of narrative in inspiring action. Within this review, our focus is upon politics as a means of engaging with an often disparate audience.

Heritage and Greatbach in their 1986 paper, analysed the response of audiences to almost 500 speeches at UK party and found that around 70% of applause was associated with seven rhetorical formats:-

Contrast List: typical three item list where the final item is preceded by 'and';

Puzzle and solution – pose problem and provide answer;

Headline and punch line – propose an announcement and then make it;

Combination – using any of the above together;

Position taking – adopting a clear stance on an issue;

Pursuit – repeating or recasting a point

Wells and Bull (2007) also highlighted the use of direct questions as a device for creating affiliation with an audience in their exploration of stand up comedy performance and a comparison with politics.

Whilst it may be rare for organisational/ movement leaders to speak in settings readily comparable to political or comedy audiences, there are clearly relevant messages in the findings that audiences respond strongly to rhetorical devices and both vocal, and non-vocal, features, in addition to the actual content of any 'story'. In crafting a story which seeks to engage with disparate interests, the use of these rhetorical devices may therefore have benefit to add when considering how to engage and motivate an audience.

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### The role of values in leadership

Implicit within the conception of the leadership of social movements expressed by Ganz (2010) is the importance of people in leadership positions conveying congruence in values between themselves and those they wish to influence and in turn to transmit these values into a vision for action.

Action, however, becomes more likely when the situation is experienced as intolerable but is also coupled with a sense of efficacy, solidarity, and hopefulness required to make a commitment to change. Social movement leaders mobilise the emotions that make agency possible. When we experience the “world as it is” in deep dissonance with values that define the “world as it should be,” we experience emotional dissonance, a tension only resolvable through action (p.517).

According to Ganz, the means by which social movement leaders share those values is through storytelling. Specifically, as previously outlined, through the story of self, a story of us and a story of now. A story of self communicates those values that call the group to action. A story of us communicates the values shared by those in action and a story of now communicates an urgent challenge to those values that demands action now.

A number of authors within the fields of management and behavioural sciences support the importance of values in the conduct of leadership. Heifetz, (1994) in the opening sections in his influential book, *Leadership Without Easy Answers* proposes that the exercise and even the study of leadership stirs feeling because leadership engages our values (p. 13). It was probably Kouzes and Posner (1993) who first postulated that the processes and practices of leadership are fundamentally amoral, but leaders are themselves moral or immoral. Consequently the personal values of leaders have very significant effects on leader-follower relationships.

Indeed, definitions and terms associated with our conceptions of leadership are essentially based on beliefs, norms and values. Clawson (1999) maintains that honesty and integrity form the moral foundation of effective leadership through the four key values of: truth telling; promise keeping; fairness; and respect for the individual (pp. 46-9).

Similarly Alimo Metcalfe et al (2008) frame this conception of leadership as ‘engaging leadership’ which is characterised by integrity, openness and transparency and genuinely valuing others and their contributions, along with being able to resolve complex problems and to be decisive. This is coupled with as respect for others and concern for their development and well-being; in an ability to unite different groups and stakeholders in developing a joint vision; in supporting a developmental culture and in delegation of a kind that empowers and develops individual potential, coupled with the encouragement of questioning and of thinking which is constructively critical as well as strategic (p.587). The suggestion is that leaders help to create the culture of the group or the organisation. In effect therefore values underpin the way in which organisations are designed and 31 operated. As such, the orientation of structures and systems within an organisation is very much a function of the values embodied within them.

Shamir and Lapidot (2003) make the same assertion that shared identities and values are artefacts of the group’s or organisation’s culture. Kouzes and Posner (1993) also argue that the ‘value’ of establishing shared values is in maintaining an internal compass which enables them to act independently and interdependently. More recently Haslam Reicher and Platow (2011) also emphasise the role of leaders in expressing the norms and values of the group. The importance of the congruence between the leader’s values and the people within the organisation is summarised by Burnes and Jackson (2011).



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Much has been written over the years regarding the need to align organisational and individual values, usually from the culture perspective. The main argument is that effective organisations are ones where goals and values are congruent and shared by the leadership and staff of the organisation.

### 6.6 Leadership lessons from Public Health

The work of Gladwell (2000) integrates lessons from public health and systems thinking and whilst prior to the timeframe of this review, has more recently been developed by Shapiro (2004). In particular the work of Gladwell and Shapiro contains useful lessons on the subject of the spread of ideas and methods for overcoming resistance change.

Gladwell (2000) identifies three important and inter-related factors: content, carriers and context. A key statement iterated within Gladwell's work and stemming from the field of public health is that you cannot consider the spread of ideas (content) separate from the environment (context) or from the people (carriers) which are being affected by the ideas/change promoted.

Gladwell claims that the ability of the content to leverage change is dependent upon its 'stickiness', and that this stickiness, or ability to leverage change, is influenced by the extent to which content is designed to leverage the political, economic, social and technological constraints which are operating within the context. In addition, Gladwell claims that not all 'carriers' are equal and that leverage for change comes from identifying and recruiting those who have the respect of the audience being addressed.

Finally, Gladwell acknowledges the import of the support provided by management within the context of the change environment. Gladwell's work is developed further by Shapiro (2004) and of particular relevance to the context of social mobilising and organising is the attention paid by Shapiro to resistance. Shapiro (2004) suggests that resistance to change is inevitable and distinguishes between overt and covert resistance.

Whilst covert resistance is dangerous and can undermine change initiatives, open resistance can be healthy and has the potential to make a change effort more successful. Important to converting covert to overt resistance and to overcoming resistance is an understanding of the causes. Shapiro highlights three main sources of resistance; concern with change; exposure to unsupported change efforts in the past and fear of loss. Shapiro (2004) suggests that there are three key skills which are important to overcoming resistance to change: skilled conversation, fluency with the 'law of the few' and sensitivity to the variety of change styles operating within the context in question.

Shapiro highlights the importance of framing and reframing the content to enable feedback loops to be formed. For Gladwell (2000) and Shapiro (2004), the role of the leader is to foster change through utilising seven levers of change (Shapiro, 2004; 119):-

To foster contact between advocates of change and those apathetic to change.

- To create mass, and repeated, exposure to the change message
- To recruit' new advocates
- To identify leaders who walk the talk
- To provide rewards and recognition for every positive achievement
- To invest in the infrastructure for change
- To work at removing resistance

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Bevan et al, (2011:4) in their analysis of large scale change, highlight the need to create 'mutually reinforcing changes across multiple areas' in order to achieve 'pervasive change at scale'. Shapiro's work supports this claim in its identification of two forms of feedback loop; balancing (works to maintain equilibrium) and mutually reinforcing (works to create growth or decline).

A key role for a leader of large scale change lies in identifying the appropriate levers to utilise within the context of change in order to create effective feedback, spread the change and reduce resistance. In working in this way an effective leader of change utilises a variety of balancing and reinforcing feedback loops.

### 6.7 Removing resistance

The work of Gladwell (2000) integrates lessons from public health and systems thinking and whilst prior to the timeframe of this review, has more recently been developed by Shapiro (2004). In particular, although not located within the field of public health, the work of Gallop, Whitby, Buchanan and Ketley (2004) is worth mentioning here for its focus upon overcoming scepticism and resistance within the context of change efforts in the British NHS. Gallop et al's., work echoes some of the findings of Gladwell and Shapiro in identifying the key role of respected advocates (in this case clinicians), in the emphasis upon feedback and their discussion of the need to understand sources of resistance. Gallop et al (2004) identified that scepticism was widespread and difficult to manage but identified the following as important factors:

**Fragility of new support** – in early stages continuing evidence of improvement is vital (cf Shapiro, need for feedback loops). In early stages sceptics are most likely to become converted through practical involvement in the change process and positive talk is not sufficient without tangible evidence of improvement.

**Contextual factors** – a key factor in undermining efforts for change stemmed from competition with pre-existing targets, making it important to align to existing programmes of work, drivers, targets and a need to justify the perceived aims of any change effort.

**Promotional factors** – the initial promotion of the change effort played a significant role in influencing scepticism/support. There is a need for a respected champion to endorse the work stream in the early stages and similarly the need for early examples of practical benefit.

**Process of change** – importance of reducing uncertainty and therefore fear through providing practical examples of the need for change. Also important to use persistence and repetition and to build resources/time for this into any change effort. Similarly the authors identified that it is important to understand the reasons for resistance/scepticism and to draw on a number of narratives/methods to engage with the respective audiences.

# Appendix 4: Literature review

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## Summary of section 6

The terms public leadership, distributed leadership, collective leadership and leadership as performance, all share features with social mobilising and organising approaches to facilitating improvement in the public sector.

Critical success factors identified within these fields include: The use of intelligent networks engaging in problem-solving activities and focussed on building capability and capacity of public leaders. The production of multiple coalitions pursuing shared vision. Flexibility is needed in seeking to understand when best to deploy distributed or shared leadership depending upon the presenting context. Trust and legitimacy are key concepts involved here and are concepts which require a sensitivity to the organisational context.

This enforces the need for a blended approach when utilising social mobilising and organising within an organisational context. Leadership as performance is a framework which emphasises the importance of understanding the audience and the cultural and institutional pressures which can engender resistance to change. Leadership as performance also emphasises the need for 'authenticity' through alignment of actions with personal and organisational values. Lessons from public health and systems thinking have been explored by Gladwell (2000) and Shapiro (2004), amongst others and are useful to a consideration of social mobilising and organising within organisations through their insights around the reduction of resistance to change.

Central to the work of Gladwell and Shapiro is framing and re-framing to enable feedback loops to be formed. Leadership plays a key role for Gladwell and Shapiro in fostering change through seven levers of change and in working to combine reinforcing and balancing feedback loops. Gallop et al., identify a number of factors with a key role to play in reducing scepticism. These include the need for practical examples of successful initiatives, the need to align with existing targets/drivers, the need to understand reasons for scepticism and an important role for promotion.

# Conclusions

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This review has sought to identify some shared themes and narratives between social mobilising and organising and recent leadership literature. It may well be that as Helen Bevan suggests the time has come for social movement thinking to be embraced as a means of large scale change within the public sector. The leadership literature suggests that this time may come more readily if lessons from the leadership literature can be digested and used to enhance this process.

What do these lessons tell us? They tell us that social mobilising and organising approaches need to be sensitive to the context, that 'leaders' within the public sector need to invest resources in identifying the processes, systems and stakeholders across the system; and to work with, and through, them to identify their hopes and fears and to free resources which will enable improvement across the system.

We are in an extra-ordinary time and this time, whilst presenting 'risk, uncertainty and confusion' (Revas; 1982) also presents us with the opportunity to learn from practice and theory and to use this learning to transform our services. We hope that this review will contribute to this learning.

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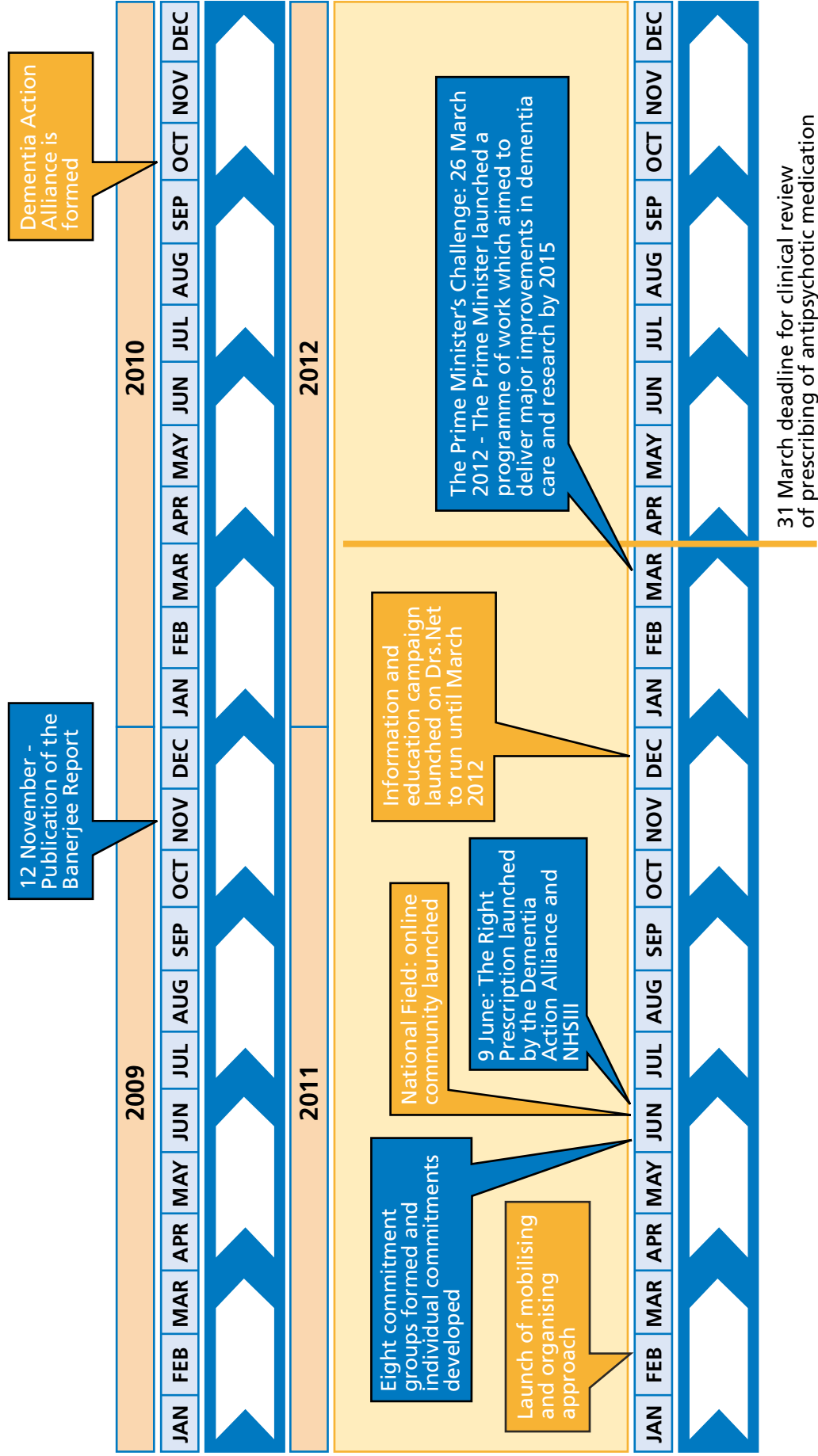
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# Appendix 5

## 'The Right Prescription- call to action': timeline of key events: 2009-2012











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