School for Health and Care Radicals

MODULE 4 STUDY GUIDE

Making change happen

'The greatest danger in times of turbulence is not the turbulence – it is to act with yesterday's logic.'
Peter Drucker

http://www.theedge.nhsiq.nhs.uk/school/

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This Study Guide was prepared for the School for Health and Care Radicals by Pip Hardy.

Module 4

Making change happen

Introduction

> *'I can't change the direction of the wind, but I can adjust my sails to always reach my destination.'* Jimmy Dean

Welcome to Module 4 from The School for Health and Care Radicals.

In Module 1 we considered what it means to be a health and care radical; we looked at the differences between radicals and troublemakers and thought about some of the risks inherent in being a radical. We talked about the importance of living and being the change you want to see in the world and identified some useful ways of building your own self-efficacy in order to help you be an effective change agent. Finally, we put our work and learning into practice by making a change day pledge. We hope that you have continued to reflect on the content of Module 1 and on the various conversations that have continued via Twitter at #SHCR and our Facebook group at www.facebook.com/groups/1517022528586921/

In Module 2 we shifted the focus from ourselves as individual agents of change to the importance of community and the power of working together. We looked at lessons from great social movement leaders and community organisers and discussed techniques for connecting with our own and others' values and emotions to create a call for action through effective framing and storytelling.

In Module 3 we explored a phenomenon that is familiar to everyone who has tried to make changes: resistance. It is common to perceive resistance as a negative force, something to be battled with in order to win ground. It is more fruitful to explore different ways of approaching resistance and discover the tools that can help to harness the energy of resistance. Indeed, since resistance is inevitable, it is best to embrace it and make good use of that energy!

This module brings together some of the themes from earlier modules and examines ways of bringing your aspirations for change to fruition. We will look at the NHS Change Model and the energy model and consider the importance of balancing different types of energy while recognising the need for both extrinsic and intrinsic motivation.

This study guide

This study guide is intended to enhance and complement the web seminar and help deepen your thinking and reflection. It is not compulsory, but it will give you some ideas of things to think about, questions to ask, and some inspiring examples and quotations. Please feel free to use this guide as a place to keep track of your own thoughts and ideas so you will have a record of your work on the module and the overall programme.

Every week during the School, we will make a study guide available the day before the live web seminar. You can download the study guide from the website and use it to record your reflections during and after the seminar. You can also use the study guide in the discussions you have with your colleagues, coach, mentor or learning group after the web seminar.

Throughout this study guide there are shaded sections for you to reflect on your own experiences or respond to key questions related to the content of the module. We hope that you will free to use these questions as prompts to your own thinking, and the space provided to record your ideas.

The schedule for the release of the study guides is as follows:

Module	Date of study guide release	Date of web seminar
5 Moving beyond the edge	26th February 2014	27th February 2014

The overall goals [learning outcomes] for this module

By the time you have worked through this module, we hope that you will be able to:

- understand why many change efforts fail to deliver their intended benefits
- consider aspects of large scale change
- recognise the need to align components of change that connect with intrinsic and extrinsic motivators
- understand the NHS Change Model and to apply it to your change efforts
- understand the concept of energy for change and devise strategies for developing energy for change in the longer term, for yourself and in your change efforts
- consider appropriate ways to build shared purpose.

What are YOUR goals for this module?

In order to make the most of this module and of the overall programme, you may find it helpful to give some thought to your own personal goals – what do you hope to achieve by engaging with The School for Health and Care Radicals? What do you hope to take away from this module?

If you have engaged with the first three modules, please reflect briefly on what you have learned so far, and begin to connect where you are now in your thinking with your goals for this module, carrying forward what you have already learned to inform your future intentions.

In Module 1, you were encouraged to think about being the change you want to see and you will have begun to realise that you are unlikely to accomplish your goal single-handedly. In Module 2, our focus was on the importance of sharing both power and responsibility and working with others to accomplish your goals. In Module 3, we turned to the challenge of resistance and looked at different ways of approaching resistance in order to use its energy to serve our own purposes. Now, in Module 4, we will begin to bring together some of these themes to examine how we can bring about the change we want to see.

ACTIVITY: THE STORY CONTINUES

What do you hope to achieve from this module?

Do you consider multiple aspects of change before you take action?

How do you get organised for successful change?

Why do many change efforts fail to realise the benefits they were intended to deliver?

The literature on leading and managing change is largely consistent. Many change initiatives, particularly those involving scale and complexity, struggle to achieve their objectives and realise their potential benefits

REFLECTION: RESPONDING TO CHANGE

Think about the last change initiative that you were engaged with.
1 What was the change?

2 On a scale of 1 to 10, to what extent did your initiative achieve its original objectives?

3 What factors helped your change initiative to be successful?

4 What factors hindered the success of your change initiative?

Leading large scale change

If we examine the experience and reality of large scale change across multiple sectors and industries, we can see some common patterns in successful initiatives (Bevan, Plsek and Winstanley, 2011). These are summarised as ten principles for making change happen below :

1. Movement towards a new vision that is better than, and fundamentally different from, the *status quo*
2. Identification and communication of key themes that people can relate to and that will make a big difference
3. Multiples of things ('lots of lots')
4. Framing the issues in ways that engage and mobilise the imagination, energy and will of a large number of diverse stakeholders in order to create a shift in the balance of power and distribute the leadership

5. Mutually reinforcing change across multiple processes/subsystems
6. Continually refreshing the story and attracting new, active supporters
7. Emergent planning and design, based on monitoring progress and adapting as you go
8. Many people contribute to the leadership of change, beyond organisational boundaries
9. Transforming mindsets, leading to inherently sustainable change
10. Maintaining and refreshing the leaders' energy over the long haul

A number of these relate to topics we have already covered in Modules 1 to 3 of The School for Health and Care Radicals. In Module 4 we will touch on those aspects we have not considered previously and consider how we align different aspects and components of change.

The NHS Change Model: aligning intrinsic and extrinsic motivators for change

'The role of a change agent is fundamentally about alignment, not judgement.'

Peter Fuda

The NHS Change Model is used widely by change agents in the English NHS to support their improvement efforts. It is helpful in our change efforts because it seeks to bring together multiple aspects of change. The model is comprised of eight components, based upon evidence and experience of change. The model and its component parts are shown on the next page.

The underpinning principle is that improvement efforts are more likely to be achieved if all eight components of the change model are considered together, through an integrated approach.

History suggests that in order to build and sustain large-scale change, connections should be made with the intrinsic motivation that people have to get involved in, and build energy for, change. We need to create hope and optimism and help people feel more ready and confident to build the future. The NHS Change Model represents this through connection to *Shared purpose*, *Engagement to mobilise* and *Leadership for change.*

At the same time, the experience of the NHS over the past ten years has demonstrated the importance of drivers of extrinsic motivation, including transparent measurement, incentivising payment systems, effective performance management systems and holding leaders to account to deliver change outcomes. If the NHS Change Model is to have an impact, all of these features need to be part of its on-going approach.

The experience of NHS change efforts has also demonstrated what happens if these intrinsic and extrinsic factors for change aren't aligned. Too often, an overemphasis on the extrinsic factors kills off the energy and creativity that is necessary for delivery of change at scale. There have also been many examples where change leaders have emphasised engagement and built commitment to change but haven't hardwired this into the performance approach and the result is underachievement of change and the eventual fizzling out of the good will that was built. Most leaders of change tend to favour one side or the other (intrinsic/extrinsic) in their approach to change. The premise of the NHS Change Model is that the strengths of BOTH are necessary to improve the way the NHS improves itself.

The NHS Change Model wasn't designed to be an alternative to the existing ways that NHS teams and organisations are going about change. Rather, its aim is to add components and emphasis that can help to make change faster and more sustainable. Previous experience of change models in the NHS suggests that they area most helpful when teams take the essence of the approach and make it their own, to fit their context, their priorities and their patients or community.

So, for instance, the change model includes the component *Improvement methodology* because there is evidence that working with a systematic, evidence based quality improvement methodology (such as Lean, Six Sigma or the EFQM Excellence Model) increases the chances of successful change (Boaden et al, 2008) However, the change model framework doesn't recommend or specify *which*

methodology should be used. This is because many teams across the NHS have already adopted a methodology and will want to build on what they are already using. In addition, each methodology has particular strengths for different problems and they can be used in combination, particularly where we are seeking change at different scales simultaneously. Whilst all the methodologies can demonstrate impact, there isn't a research evidence base to favour one over the others.

REFLECTION: COMPONENTS OF CHANGE

With regard to your current change efforts:

1. Have you built all eight components into your plans, rather than just some of the components?

Have you made the connections between and aligned the eight components?

3 Have you considered the unintended consequences of an over-dominance of one or more of the components on the other components (e.g., the negative impact that an overemphasis on *rigorous delivery* - a change approach that is driven by performance management – might have on our ability to create the conditions where innovation can flourish – *spread of innovation)?*

It is likely that there are some discrepancies in your answers and almost inevitable that there will be tensions as you, as a radical, try to balance the inherent tensions between components of the NHS Change Model. However, the model gives us a language for conversations about including multiple aspects of change

It is also useful to consider the iterative nature of change. The NHS Change Model is not designed as a step-by-step process; there is not a recommended order in applying the components. Rather all of the elements work together, with no one element having greater 'weighting' than the other. Underpinning all of the components is the unifying factor of shared purpose. Whilst some elements will appeal more than others, depending upon where you sit in the change effort, the organisation, or indeed your professional allegiances, learning from large scale change efforts and successes tells us that they are all interconnected.

There are lots of resources for working with the NHS Change Model at www.nhsiq.nhs.uk/capacity-capability/nhs-change-model.aspx

Commitment and compliance

'You can't impose anything on anyone and expect them to be committed to it.'
Edgar Schein

What do we mean by commitment and compliance? Compliance is about following a process, within guidelines, rules and boundaries, usually established by other people. When we talk about commitment we are talking about what we do because we want to.

Mere compliance may not generate the best outcome as the following story illustrates.

Watch Ian's short story: *Measured Innovation* at http://www.patientvoices.org.uk/flv/0016pv384.htm

Ian has bipolar disease and HIV and compliance with his drug regime is not working. However, when Ian, his consultant and his pharmacist come together as a micro-community of radicals to look at how they can devise an apparently non-compliant but more effective approach to his care, their joint commitment results in positive change.

Some elements of the Change Model (rigorous delivery, system drivers, improvement methodology) are about compliance while others seek to build commitment to change. History shows us that building commitment on a big scale is very important when it comes to making changes in a complex environment. In the world of health and care, compliance will always be necessary; it is a pre-requisite for safe, high-quality care. However, when people have commitment to a bigger cause or they are personally committed to the goals for change, it typically creates a much easier environment for ensuring compliance.

REFLECTION: COMMITMENT AND COMPLIANCE

With regard to your current change efforts:

Who needs to be committed to the change for it to be sustained?

How are you building commitment to change?

How are you managing the tension between commitment and compliance?

Energy for change

'Energy, not time or resources, is the fuel of high performance.'
Loehr and Schwartz, 2003

When we look at the history of large scale change efforts, we find that the most common reason that leaders fail to achieve their goals for change is because the change effort runs out of energy; it simply 'fizzles out'. On the other hand, change agents who tap into the positive energy for change that exists amongst the people involved and unleash it for the benefit of achieving goals for change are more likely to achieve the benefits they are seeking. In an era of quality and cost improvement, the ability to build and maintain energy for change for the long haul is a key requirement for health and care radicals.

The model of energy that we are using in The School for Health and Care Radicals is called 'The Energy Index'. It was developed by The York Health Economics Consortium and Landmark following a development process which included an extensive literature review as well as interviews with NHS staff from a range of backgrounds. It draws on the work of Steve Radcliffe, Tony Schwartz, Stanton Marris, Heike Bruch and Bernd Vogel and Stephen Vogel as key contributors to the field of energy in the management literature. This body of work is included in the resources section of the study guide.

Five domains of energy

Energy for change is defined as 'The capacity and drive of a team, organisation or system to act and make the difference necessary to achieve its goals.' The five domains of energy within the model are:

Social energy: that is, *the energy of personal engagement, relationships and connections between people*. It's where people feel a sense of 'us and us' rather than 'us and them'

Spiritual energy: that is, *the energy of commitment to a common vision for the future, driven by shared values and a higher purpose*. It gives people the confidence to move towards a different future that is more compelling than the status quo.

Psychological energy: that is, the energy of courage, resilience and feeling safe to do things differently. It involves feeling supported to make a change and trust in leadership and direction.

Physical energy: that is, the energy of action, getting things done and making progress. It is the flexible, responsive drive to make things happen.

Intellectual energy: that is, the energy of analysis, thinking and planning. It involves gaining insight as well as planning and supporting processes, evaluation, and arguing a case on the basis of logic/evidence.

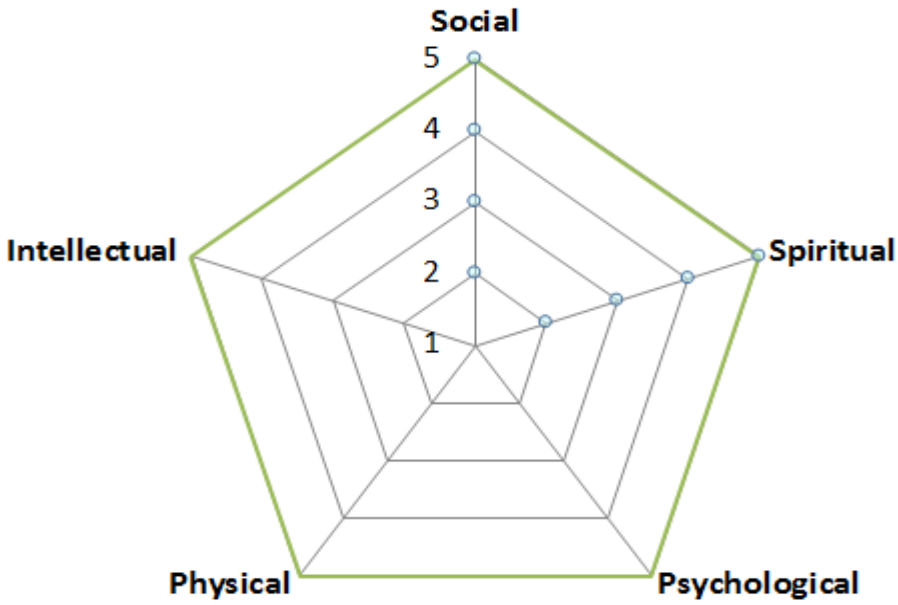
In a change initiative, we seek high levels of energy in all five domains. If one or more of the energies is low, it can have a negative impact on the change process as the table on the next page indicates.

	Low	High
Social	isolated	solidarity
Spiritual	uncommitted	higher purpose
Psychological	risky	safe
Physical	fatigue	vitality
Intellectual	Illogical	reason

Teams who are using the Energy Index rate their energy scores under each domain of energy and the energy levels for a specific change initiative is calculated on a scale from 1 to 5 (see the framework below).

Teams can see whether any particular energies are dominant in their change efforts and can take action to build the energies that are low. Assessment with thousands of people in health and care show that:

- intellectual and physical energies often dominate, particularly in organisations that deliver care
- clinicians are more likely to have high spiritual energy than those from other backgrounds
- the nearer that a person is in the hierarchy to the Chief Executive, the higher her/his energy scores are likely to be.



REFLECTION: ENERGY FOR CHANGE

1 How high are your own energies for change with regard to your current change initiative?

2 How high do you think the energies are of other people in your change team?

3 What can you do to build the energies that are low?

4 How can you help keep the energies in balance as your change initiative progresses?

Building shared purpose

> *'There's a sense in which final causes - purposes and goals - have this kind of attractive quality. They draw things toward them.... This is completely different from the model of things being pushed from behind in the mechanical universe.'*
>
> Rupert Sheldrake, Cause and Effect in Science

The notion of building shared purpose moves us on from work we have done in previous modules on the importance of building networks, connecting heads and hearts, listening, embracing diversity and using the energy of resistance. Clearly if we expect commitment from our fellow change agents, it is necessary to build shared purpose so that people are operating from intrinsic motivation as well as extrinsic motivation and so that they are committed rather than simply compliant.

In order to do this, we have to be able to see those we are working with as people and not just nurses or doctors or physiotherapists or radiographers or healthcare assistants. As people we are able to connect and share our passions and our values, especially through our stories. As representatives of one group or another, it is all too easy to create silos, build walls, become defensive and close our minds to others' ideas and perceptions.

Shared purpose isn't just important at the beginning of a change programme; it has to remain at the forefront of our efforts over time. As health and care radicals, we need to keep reinforcing WHY we are making the changes, not just focus on the WHAT and the HOW. If purpose isn't explicit and *shared*, then it is very easy for something else to become a *de facto* purpose in the minds of the workforce.

In the research underpinning the NHS Change Model, shared purpose was the component that respondents most commonly said that, in retrospect, they would have spent more time on. It is critical to achieving and sustaining change.

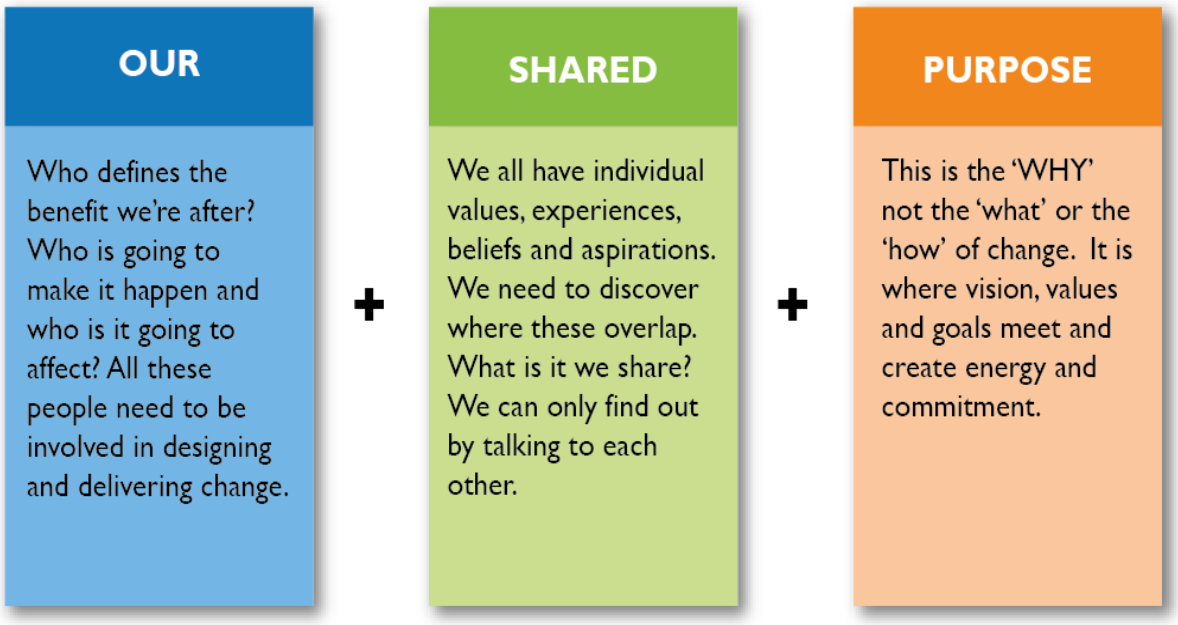
REFLECTION: EXPERIENCE OF SHARED PURPOSE

1 Have you successfully created shared purpose for a change initiative? How did you do that?

2 Have you been part of a team where purpose was shared? What did that feel like? How was it accomplished?

3 Thinking about your experiences, what might you do differently in the future to build shared purpose?

In building our shared purpose, it is important to consider each of the three words separately:



So, how will you build shared purpose?

Calls to action

During the course of this next week, we would encourage you to:

- reflect on how you can use both intrinsic and extrinsic motivators in your practice as a leader or agent of change
- seek to ignite energy for change in everyone involved in your project
- build commitment to shared purpose in all your change efforts.

Questions for reflection

Each web seminar ends with some questions for you to reflect on during the week. Here are the questions for this week.

QUESTIONS FOR REFLECTION

1 How can I make the most of both intrinsic and extrinsic aspects of change?

1 How can I build energy for the long haul?

3 How do we ensure shared purpose throughout the change process?

4 What can I do tomorrow to accelerate change?

Bringing it all together

Make a note of the things that stand out for you from this module and then give some thought to how you will use your new learning to make a difference.

REFLECTION: MAKING IT REAL

What have you learned?

How do you know you've learned it?

How will you take your learning forward? What will you do differently?

Reference list for Module 4

Bevan, H, Plsek, P and Winstanley, L (2011) *Leading large scale change*. NHS Institute for Innovation and Improvement

Boaden R, Harvey G, Moxham C, Proudlove N (2008) *Quality improvement: theory and practice in healthcare* NHS Institute for Innovation and Improvement and Manchester Business School

Leonard D and Coltea C (2013) Most change initiatives fail but they don't have to *Gallup Business Journal*

NHS Institute for Innovation and Improvement (2013) *Building energy for change*. http://www.institute.nhs.uk/tools/energy_for_change/energy_for_change_.html

Paluck T (2014) Why your employees aren't helping you to change

Additional resources

Heath, C and Heath, D (2011) *Switch – how to change things when change is hard*. Random House Business