KATE POUND:
Good afternoon, everybody. We will start Module 4, the School for Health and Care Radicals, in 5 minutes.

KATE POUND:
Good afternoon everybody. My name is Kate Pound, and I am your chair for today. Welcome to Module 4 for the School for Health and Care Radicals, Making Change Happen.

Just a reminder to everybody about how you can get involved today, you can contribute throughout the session by the chatbox.

Please don't use the Q&A box, because we won't be using that today. You can also join us by Twitter, and don't forget to use the hashtag, #SHCR. Thank you.

Send your request to Facebook to join the School for Health and Care Radicals Facebook. We will be putting a summary of the session on Stellar later.

So our team for today include myself, Kate Pound. And then Helen Bevan is our lead. We have also got Pip, our learning lead. And Olly will be monitoring Twitter and chat.

We have three storytellers today, Jas, Rebecca and Joyce, who we will be hearing from later.

You will be able to catch up with some of the sessions by the study guide, which are available on Slideshow, so make use of those tools to help you.

It is unbelievable, we only have one more module left, and that will be next week. I hope you can all join us, and that will be Moving beyond the Edge.

As we said before, the community is growing, find your flock. We have two new communities come to us at the moment, and that is The American College of Radiology and the Macmillan Nursing Team. We have a Twitter chat tonight with the School for Health and Care Radicals Mental Health group, and another one on Sunday. That is with the 6 Cs Team. And there is an after-school club in the North East in April.

We have an icebreaker today, so Making Change Happen. We have got the pens released. Which area are you most interested in? And what you want to find out about today?

Why change fails.

Large-scale change.

Motivating change.

NHS change model.

There are a mixture of things that people are interested in today, and I am sure we will learn lots throughout the session. Somebody is saying all of it. All of it there, Helen, so that is great.

I rather like the pen there! Thank you. If we want to take the pens off now, and I will hand over to Helen. I will pass the ball over to Helen.

HELEN BEVAN:
Yeah, thank you, Kate. Welcome to module number four, which is about Making Change Happen. And our agenda, what we are going to cover in the next 1.5 hours is, first of all, we will start with a

negative perspective around… We are going to look at why change efforts often fail to achieve their objectives. And we will look at lots of different evidence around that.

Then we are going to flip from that negative perspective to something much more positive, because the good news is, large-scale change, and in fact any change, you know, has got just as much likelihood of success. And there are lots of things that we can do, as change leaders and change activists, to make a difference.

One of the key issues at the heart of this is the issue around motivating people for change. And very often, we tend to over focus on extrinsic and under-focus on intrinsic. So we are going to talk about those two aspects, and look at using a change model that will help us to work with both kinds of motivators.

We are then going to move on and we are going to look at ways of building energy for change. And as we will see, energy for change is one of the most critical components, or helpful ways of thinking about delivering change.

And finally, we are going to focus on building shared purpose, which is one of the key components of making change happen. At the end, I will hand back over to Kate and Pip for our discussion and reflection. I look forward to a really interesting 1.5 hours.

Also, we have three really great storytellers today, which I think are going to enhance things.

So, this is a, kind of, mythical figure in the world of change, leading change, making change happen, and change programmes in organisations. So let's go into the chatbox, why is this figure, 70%, a mythical figure in our world of change and improvement?

Let's see, see if we can get some comments. OK, one from Nigel, "We think nothing fails, but 70% that you do does. We just cover it up."

Definitely in the right ballpark there. Anybody else want to add some comments in the chatbox? Why is 70% a mythical figure?

OK, we are definitely right there.

The reality is that 70% is a figure that is quoted time and time again in the literature as to the proportion of change programmes, or change aspects, or change initiatives, that actually achieve their objective.

This is some data here from McKinsey, and it was a big study, the McKinsey Performance Transformation Survey that was carried out with these three types of respondents.

And what it basically shows is about 35% of change initiatives get anywhere near to achieving their objective, and delivering the benefits. And the reality is that only about 5% of change initiatives get anywhere near achieving their goals, sustaining the change, and then moving on to the next change.

And this is backed up in many, many different ways. So 20 years ago, John Kotter was writing in the Harvard Business Review and he talked about this figure of 70%. I am going to show you some data shortly, from analysis that was done much more recently about what proportion of change programmes achieved their objective.

And again, it was about a 70% failure rate. There is lots of discussion about this, but the fact that 20 years on from when John Kotter was writing about this, we are still using a similar figure, which says that there are things here that we need to think about and learn from.

So the most recent literature that I have looked at is a study that was carried out by the Chartered

Institute of Management, a 2016 quality of working life study.

This is across multiple kinds of organisations, but I think if you look at our world, our world of health care, public service, I think the figures would actually be quite similar.

The headline says, across the UK, change programs are poorly managed, damaging morale and damaging performance. If you just look at some of this data. Why do we go about big change programs? We want to create decision-making, and we want to make it easier for our employees to participate, increase flexibility and productivity. And yet, if we look here, productivity has increased.

Less than 30%… These are managers responding, less than 30% said, "As a result, productivity has increased." OK? 32% said customer service has improved. 32% said employee participation has increased. Only 20% decision-making is faster.

And if you look at the other side of things, what we are seeing, if we look further down, key skills and experience has been lost. Only 23% of people disagree with that.

Employee turnover has increased, only 27% of people agree with that. What we are seeing is, the reality is for many change programmes that are going on in our world, we are not delivering the results that we are seeking. And why is that?

This is a very interesting paper that can be downloaded, and it is free. It comes from Peter Fuda, who pops up a lot in the School for Health and Care Radicals. He is one of the researchers and practitioners that we are very influenced by. And this is the paper that he wrote, which is called Why Change Efforts Fail. And he says, and he talks about this 70% figure. He says, "It is our contention that most change efforts are built upon the shaky foundation of five flawed assumptions." We have talked so much about mindset in the School for Health and Care Radicals. He talks about these five flawed assumptions.

The first one is that change is something that we can actually manage step-by-step in a rational way. The second one is that human beings are objectives, so that when we look at a change situation, people approach it in that way. The third is that there are recipes or programmatic approaches around the X steps to change. The fourth one is that when we are going about a change process, we have a neutral starting point. We see that so many times.

As leaders, we decide to have a change process, but what we often do is that we rush into action, and what has gone on before, what previous changes have taken place? What capabilities do people have?

In the final one that he mentions, the idea that change itself is the goal. And I see this time and time again. Here is a quote from Peter Fuda, he says, "Change is not the goal; the goal is the goal." Often we get into change processes and we want to build a lean organisation, or we want to create integrated care processes. But actually, the change itself isn't the goal. The goal is the goal.

Unless we connect with the goal, constantly through the change process, unless we can keep linking back to shared purpose, I think it is very hard to sustain things. I think there is a lot of wisdom in that paper from Peter Fuda.

I also want to show you another source of great wisdom, and this is a piece of analysis that my team was engaged in, together with The Health Service Journal and Nursing Times. And what we did was set up a platform, and we asked all sorts of people in the health and care system, many, many front-line people, and senior leaders as well. And we said, "What are the biggest barriers to making change happen?"

And I think this is an incredible piece of wisdom. So I used these 10 barriers to change that were identified, 14,000 contributions were made to create these 10 barriers to change, so this is real,

practical wisdom of people that live in this world of change, that are implementing change constantly.

So what I do is, whenever I am planning a new initiative, or a new change process, I come back to these 10 barriers, and ask if we are taking account for these. I don't think any of these are going to be a surprise to us, but let's just think about them.

The first one here, confusing strategies, what is interesting about that, confusing strategies, is that it really pays out. What people said to us is that sometimes we get a message coming down that a new thing is a priority, or something that we have to do. But nobody ever tells us, is this a bigger priority than the old priority? Do we still need to be carrying on with the old priority? How do they fit together? How do they make sense?

What is interesting to me is, in the same time that people in our system were feeding this back, a research study was being published by the Gallup organisation, and they mentioned is 70% mythical change figure. And they looked at why change efforts fail.

Lastly, what they found was that it was to do with this issue about confusing strategies. People that are at the top of the organisation, senior leaders, they have got a small number of priorities, typically, say about 10, that are very clear. But by the time that these messages get down to people at the front line, there are many, many different priorities, and it is incredibly confusing.

As the messages around the change priorities go through the organisation, it gets more complex and more difficult.

Gallup's research was multisector. It was about people in many different industries. But at the same time, research was being reported in Health Affairs. It was called the Dangers of Quality Improvement Overload, it insights from the field.

This was saying the same thing. If we want safe, high-quality care for patients, and getting buy in from front-line staff is critical. But what we keep doing, time and time again is overloading them.

There are lots of issues there. Caution and risk in change. But the title of this module is Making Change Happen. So I will flip off from what are the negative issues, the risks, and why does it keep going one, two when does it work?

The 14,000 contributors around how we make change happen in our world of health and care. They came up with 11 building blocks for change.

I think these are really important. What they do is help us understand what we need to be building in.

It is about leadership that is inspiring and supportive. That is the number one issue that came out. How can we work collaboratively? Flexibly? How can we use our resources in a really smart ways? Particularly in times of austerity, when resources are tight. How can we use them?

How can we be given autonomy and trust, and not be micromanaged? How can we give them the space to challenge the status quo? How can we foster an open culture for learning and sharing? If things go wrong, how do we ensure it happens early on and we learn from it?

It is about how do we nurture our people? How to we enable everyone to be a learner, a developer, and a change agent? Not just focusing on is really quick, short-term wins. But for the long-term.

The final thing here fits with our school as a place for diversity. Having change that is not just about a small number of people who think similarly, making decisions at the top of the organisation. But thought diversity is about how do we bring in many different voices, and different people with different experiences?

Again, it is worth taking this list, which is the wisdom of the people, and using it in our change efforts.

At the heart of this, I think, is an issue about motivation.

I think it is very helpful to think about the difference between intrinsic and extrinsic motivation when it comes to making change happen.

When we talk about intrinsic motivation, what we need is the kind of innovation or the kind of motivation that comes from within. It is about when I connect with the things that really matter to me, the things I am interested in, the things I enjoy, the things that make me feel satisfied.

Intrinsic is also about autonomy. It is the things that matter to me and have the space to do it. It is also connecting with meaning. Intrinsic motivation are the things I choose to do because I want to and because they connect with my values. They are things that are meaningful to me.

Let's contrast that with extrinsic motivation. Extrinsic motivation is the kind of motivation that comes from outside. It is about people commanding me to do things, or it is about financial motivation. It is about rewarding people. It is about pressure to perform. It can be about competition, or compliance.

Very often, extrinsic motivation, there is a lot of ego issues involved. It is about people trying to get other people to do things so they look great or so they will getting award.

Let's keep thinking about intrinsic and extrinsic motivation, these two kinds of motivation to get people to change. Let's compare and go right the way back to module one, where we talk about old power and new power.

What we say is many of our healthcare systems are built on the principles of old power. Very often, the people who have the authority and power are the people who have got senior positions in the hierarchy. This kind of power is to stand in organisations, and we are commanded to do things. It is transactional. We have to do this because it is a performance targets. We have to do this because it is a quality improvement standards. We have to do this because it is what is in the contract.

We contrasted that with new power. New power is the kind of power that is made by lots of people coming together. It is an energy that is like a comment.

And there is a shared purpose. It is where we come together and are mobilised because we want to create a different future, and it is not on trust and relationships.

Let's think about new power and old power in the context of intrinsic and extrinsic motivation. A lot of old power thinking is based on extrinsic. People at the top of the organisation putting systems into place that get us to move in certain ways.

What I say about new power, it relies much more on the intrinsic. In a world of new power, we are choosing to get involved and take action because we want to and because it is meaningful to us. It sits without motivation.

Where we need to be, as health and care radicals, we need to work with both. We need to think about the benefits and opportunities in both intrinsic and extrinsic motivation.

It is interesting. If we go back to this list about 11 building blocks for change, but we can see are the things that motivate us to engage in change, they are much more intrinsically focus than extrinsically focused. They enable us to connect the intrinsic motivation. Collaborative working, autonomy and trust. A collaborative culture, nurturing our people.

When you look at this list, it is far more about being able to connect with intrinsic rather than extrinsic motivation. The evidence around this is really clear.

If we look, what does the learning about large scale change tell us? What it basically says is that while both kinds of motivation have their place and are important, when it comes to implementing change, if we can identify the underlying intrinsic motivation, that time and time again, it remains the differentiating factor between long-term success and failure.

If we look back at the history of change efforts and we look at the 30% or the 5% in the McKinsey research, we achieved our goal and moved on. What we see is every long-term success story has tapped into intrinsic motivation at its core.

This is where we need to be. That is why module two for the School for Health and Care Radicals is about how we motivate people for change. Because every long-term success story has intrinsic motivation at its core.

Whilst we can see that intrinsic motivation just on its own can produce some initial successes, the problem with it is that if we keep just using extrinsic motivation, people will no longer find it challenging. They will move on to other things.

Unless, as system leaders, we want to continually increase giving more and more rewards to the same task, we have got to find a way to appeal to people's values and at the heart of that is intrinsic motivation.

When we look back to this work, the change challenge and what our 14,000 wise contributors told us, they absolutely understood this.

But what we are also saying is intrinsic motivation on its own is not enough. Let's talk about this. What we are basically saying is we need these intrinsic motivators because they build energy and creativity.

What we're talking about here is when it comes to change and making change happen, it is about our ability to connect to a bigger, said purpose. Whatever background people have, whether we are citizens, patients or families, or people that provide care, we are connecting to a shared purpose. We are engaging and mobilising people and calling them to action.

It is about the kind of leadership that is able to connect to that motivation. But if we are trying to change the whole system, intrinsic motivation on its own is not enough. What we end up with is 1000 flowers blooming and lots of great things happening all over the place, but they do not join up to change across the whole system.

We do need to think about how we can drive extrinsic motivation as well. And how we can use the drivers of extrinsic motivation, the goals and rewards, to create focus and momentum for delivery.

Some of the ways we can do that is through system drivers and incentive systems, payments for results, payment for quality, quality three strong performance measurement systems and management systems, and measuring for accountability and holding people to account.

In a sense, what we are saying is whilst intrinsic motivation is at the heart of this, we need to be working with and using both.

Let's just stop there for a minute. What has been the reality, in our world of health and care, over the past couple of decades? When you think about the relationship between both, what do we see happening time and time again?

Yes. Absolutely getting this. What we see that happens is that the extrinsic motivators, because they are so strong, they come along and eat up and very often they will destroy the energy and creativity of intrinsic motivation that is so important for creating sustainable, long-term change.

A really big focus for us as change agents and change activists and people who make change happen is to be able to work with both, to find ways to balance both the extrinsic and intrinsic.

What we need to be able to do is enable that to happen right from the beginning of the change process. So, there were lots of models and tools and frameworks that can help us with this. One of the ones that I like, and I really like very much, is the change model.

There is more information about this in the study guides for today's module, and I will really not do justice to this so please go back to the study guide and look at it more. But I find this particularly helpful at the beginning of a change process. If I am planning a new initiative, it could be anything from dementia-friendly hospitals or how we better support people with specific long-term conditions, or how we are going to increase health in our communities.

I think it is good to think about this change model. This is based on evidence. This is based on years and years of large scale teams' effort in the NHS and the wider health and care system. But it basically says is if we are going to create the seeds of success and foundations to enable great change to happen, then it is very helpful to think about eight different components of change.

Some of these are intrinsic, such as Our Shared Purpose. How do we build a really strong shared purpose from the start of our change process? Notice it says "our" change process. What is the purpose, why are we doing this change? And we will come back to this later.

It is also, when we think about intrinsic, how we motivate and mobilise people for change. And leadership by all, you know, thinking about who needs to be engaged in this, who is a leader, how do we build the kind of motivating leadership that will enable change to happen?

What we also focus on here are the extrinsic aspects. We think about the project and performance management system. We think about how we are going to measure. Measurement is interesting, because it can be intrinsic and extrinsic.

When I get to work with local teams that are really passionate about the changes and the improvements they are trying to make, what I see there very often if that measurement is an intrinsic issue, because we are so positive and we so want to make a difference that we are really motivated to measure what we are doing, because we want to see how we are doing.

Too often in our system, we often see it as an extrinsic thing, we are measuring for judgement, measuring for accountability, not necessarily measuring for improvement.

And these influencing factors, here, often what we are talking about here are the incentive systems, the reward systems, the compliance mechanisms that are part of change.

There are a couple of other aspects here, one is about using improvement methods and tools. The evidence on this is really clear. If, at the beginning of the change process, we work with an improvement method, so that we have a method to what we are doing, we tend to get better outcomes. And the other thing it says here is about spread and adoption, and thinking about how we are going to spread the change, right from the start of the change process, and not regarding it as an afterthought.

I think this change model is very helpful, because it gets us to think about what are all the different components, and not only thinking, "What does it do?" But also, what it may also do is make us think us think about how we got them aligned, are there stronger ones than others.

There are eight different components. One of these eight components that time and time again, people who work or are involved in change processes in the health and care system say to us, "I have been involved in this change, but if I had my time again, I would go back and put a lot more effort and emphasis on this particular component." Which of these eight do you think, retrospectively, people

say to us, "I wish I had put more effort and energy into that component"?

Have a go at putting those in the box. What do you think, which of the eight do you think?

It is shared purpose, if we don't build a platform of shared purpose, we are building on sand. And I think, very often, the kind of projects and programmes that people like us get engaged in, there is a lot of energy to get going with action.

And actually, if we start doing things and start making things happen, and we haven't built a strong shared purpose built on motivation, it is much less likely to happen.

I have a particular example about acute kidney injury. And this is one of the ways that we get teams to work with this model. We start off by saying, "If you were going to give a mark out of 10 to how strongly you are focused on that area, what would it be?" And it is really interesting to get different people to fill this in, because some people might give a seven to measurement, and somebody else would give a two to measurement. So why is there such a difference?

But what it helps us to do is to think about where we are strong and where we are less strong. In this particular example, here, we have built a really strong, shared purpose with a lot of our stakeholders, broadly, and we are doing pretty good. We have some clear measures, we have some strong program management systems, and we are really good on spread and adoption. But what we haven't done enough of is to think about how we are going to motivate and mobilise people to engage. And we haven't thought about how we can potentially align what we are doing here with some of the incentive systems, so we need to do that some more.

I think it is really good to come back and keep doing this, and maybe using this kind of change model analysis as we go along at various stages in our change initiative. Because one of the things that happens is that sometimes we start off with something like a shared purpose, but as we go on, we lose the focus on but why are we doing this, why does it matter, and focus on the what and the how.

Sometimes, we can get very focused on the project and performance management side, and the measurement side, and we lose some of the intrinsic bits. So it is worthwhile doing this, not just at the beginning, but all the way to the programme.

We have an endorsement from Beverley Matthews, a national leader of this work. And she says, "Without using the change model to undertake a gap analysis, we would never have known many of our collective strength and our challenges, which would have had a direct impact on achieving our goal. This could think about systematically how we can build in the intrinsic and extrinsic."

No, we need both. To quote Flashdance, "We need to take our passion and make it happen," and start from a place of passion, and intrinsic place. Because the history is clear, even with successful change programs that have been built on strong extrinsic motivators, what the leaders have done is they work through extrinsic to make that happen.

I just want to show you one more thing before we hear from Olly with regard to Twitter and chat, and we will hear Jas, the first of our storytellers.

What happens is that the Gallup organisation do a study on people at work on engagement at work. A lot of analysis gets done as a result of that. And what this particular analysis does is identified two types of people at work, and it calls them the compliant, here, and the contributors.

Let's just think about this in our health and care context. What we know about compliant people? Actually, they are working in an organisation or system that wants them to behave in compliant ways. And because people are being compliant and sticking with the processes, following the rules, they feel disconnected from the bigger purpose, the shared purpose of the organisation.

And what we have here is that very often, in an environment where there are a lot of people that are this kind of person, they feel controlled and coordinated through performance management systems, standardised processes and so on. And very often, compliant people won't take a risk. So when people are asking to innovate and do things differently, they will hold back from coming forward, and resist change.

Very often, people work in context to a role specification. So we say, "Will you try out this extended role?" He or she might say, "You know, it is beyond my job description. It is too risky."

Let's talk about people that are contributing to work. The way these people are coordinated and controlled is because we have shared goals, shared values and a sense of shared purpose. And people that are contributors are collaborating with all kinds of other people, people within the organisation and people in other organisations, people in the wider community.

The thing about contribute is that they are embracing change. They are saying, "Bring it on." And they work not to a role specification, but to who they are with their values, the kind of people that they want to be in the world.

So let's take this a step further with the Gallup global research. What Gallup found was that only about 13% of the workforce overall are really engaged, these contributors. And what we know is that contributors create six times the value to an organisation come compared to the compliant. Yet many of us, we work in organisations that force us down the route of being compliant, you know, stick with the status quo, don't challenge, don't raise your head above the parapet, do the things that you are meant to do, don't start coming up with all sorts of ideas of doing things differently.

And yet we know that contributors will give six times the value to an organisation. And in a sense, that is one of the key reasons we run the School for Health and Care Radicals, because so many people in our system Thomas that they are forced to be compliant and they want to be contributors. And it is one of the things, one of the connections we make a through the School of health and care articles and our other networks, which enable us to be the people that we truly are, OK? And most of us are contributing to want to be.

I am just going to stop there. Let's just hear from Olly. Do you want to start with the chatbox, what are we hearing?

OLLY BENSON:
There is lots of chat today, some really interesting discussions. So going back to right at the beginning where you were talking about the goal being the goal, Carolyn Chambers says that often behaviour has to change and others.

Lesley Morgan says, "Lack of time comes under poor workforce planning."

And then, on motivation, Churchill said this… Sorry, I got a bit lost. Sorry, Carolyn Chambers said, "How can we redesign the plane whilst flying in it, to help move to newcomers?" Mark Outhwaite says that, "We beat up the pilot, or even change pilot in mid-air as it is going down fast."

It is a long and interesting discussion between Pip and Neil Churchill, and Frances MacGuire has posted an interesting question about being an experienced advocate, but finding it difficult to balance that passion and being taken to see. And there are some good responses to that.

On Twitter, Becky Haynes says, "Old power equals motivation. A stick is a frozen carrot," apparently.

Hannah Jarrett says, "Unless you build a platform of a strong purpose, you are building on sand."

HELEN BEVAN:
Thank you, Olly and everybody. I love the way that when somebody poses a question in chat, or an

issue, everybody else comes in and helps with it, and puts ideas forward. Please keep that coming.

We are going to hear now from the first of our storytellers this afternoon. That is Jas Atwal. Pip, why did we ask Jas to tell a story today?

PIP HARDY:
We asked her because, last year when she was in the 2015 School, I was really inspired by her creativity and her resilience, and her passion for social justice.

As I have got to know her better in the past few weeks, I have been so impressed by her ability to transform a difficult situation into something really, really positive, and particularly positive for the next generation. So I won't take up any more time, so I will hand over to Jas. Thank you for joining us.

HELEN BEVAN:
Jas, I will have to move your slide, if that is OK. Tell me when to.

JAS ATWAL:
That was a kind introduction. I am a mother of three, I am a GP on a career break, I was in the School for Health and Care Radicals last year, and I will talk about how my learning helped me to network, and along with others, start something really rather new and special in my local community.

Being part of the School for Radicals was hugely significant for me. I had always tried to bring about change for better, with an awareness for those voices that are often heard. But I was frustrated by my lack of impact. And my own personal sense for specificity was small. It was also a very low point in my life. I was reeling from having been compelled to leave my job as a GP. And in addition, my baby daughter had some serious health problems. In fact, this is the first time I have ventured back into the world of social and health care, and I am grateful for the opportunity.

There is something different about me now. If I can have the next slide, I have a hobby, an interest, computer programming. I am only really a beginner, but it is a family hobby. And my own studies are slightly on hold as I spend more time with my children, tinkering and having fun.

The site you can see now has a small but very powerful and fully functioning computer, and my boys and I have actually put it together, and you can see the resultant jubilation.

I realise that my children were only passive consumers of technology. I wanted them to be creator-makers. I wanted them to shape their future, and not being asked to do so is the type of thing that deepens inequality. This is very close to my heart as a mother and a Doctor.

What this call for radicals did for me is I was inspired by the things they had been tinkering with. That was to establish a local code club for children that would be free, inclusive and accessible for everybody. I had already come across an organisation called Code Club, which is dedicated to getting children coding. It is a wonderful organisation that provides an excellent educational resources. You just have to sort out if anyone volunteers.

This proved to be very easy for me.

Initially, I faced barriers and a fair bit of resistance. I felt like an impostor. I was not a teacher or even a proper computer programmer, but I persisted. I put up my expertise over time. I network. It was not something that came naturally to me. I got up weak ties that turned into strong ties. I met other like-minded parents at my children's school.

I met Amanda Coffey and Ian Williams, two partners, and they are both community leaders in their own right. We formed a team. We decided we wanted the venue for our Code Club to be the venue of our children's school. We came up with a catchy name, Code for Firfield, and came up with a social media campaign for support. We got children excited about it, they drew their parents in and soon our

school playground was buzzing.

But we still met with resistance. Coding is not seen as a priority, but we rolled with it. We thought about the unmet need from the school's perspective. I became a school governor to better understand and align ourselves of our schools educational priorities. This culminated in Amanda developing and delivering teacher training in computer programming to three egrets, and we ended up with not just one Code Club, but two.

We achieve far more than we set out to. We know we have had a great impact, and benefited the entire community. Our change model was styled not on hierarchy and ego but camaraderie and inclusivity. I realise that we have been instilling this in the children. Not just by teaching them on traditional skills that should give them the confidence to participate in their own digital future, but we also involved in the campaign to get things established.

I hope to take away from this venture a better understanding of providing services from the perspective of the user. I do not think that is often apparent in health and social care. The growing awareness I now have of how digital computational making and design skills can help users and providers of health and social care code design really good services.

But I also want to be able to champion those people who have low self-advocacy and do not know what is hindering them. It is these very people we need to empower to make important change happen. The type of change that serves to reduce inequality.

The last slide that is my daughter. She is keen to get involved, as you can see. Thank you very much for listening to our story.

HELEN BEVAN:
Jas, I love your story. I think it is so wonderful. In terms of the themes, the ideas and principles in the School for Health and Care Radicals, the way you embrace them, and are seeking change. The connections are truly inspiring. I think that to hear your story is the reason why we won the School for Health and Care Radicals.

Personally, I thought massively, intrinsically motivated by your story. Thank you so much for that.

So, what we saw in Jas's story was a huge amount of energy for change. That is a topic we want to come up, so the story is a great transition into the next phase of this module.

Let's talk about energy for change. We know it is a very important topic when it comes to change. If you look at the evidence around large-scale change, what it tells us is that the thing that is least likely to happen, when we come about change, is the thing we most want to happen.

The least likely thing to happen is that the change will become well established over different levels of the system and lots of things changed to accommodate the change in a new way. That is the thing we most want to happen and that is the thing that is least likely to happen.

The reality is the thing that is most likely to happen is that the change effort will run out of energy. It will fizzle out and fade away.

So, actually talking about how we build energy for change and how we keep it for the long term is a very important topic. This is something else we see time and again when it comes to energy.

Around any change effort, particularly when it comes to change efforts inside organisations, it starts off with a spike of energy and interest from senior leaders, but then the leaders lose interest or their interest goes into other topics, and the momentum of change slows down drastically.

We see that in organisations and we also see it in community projects as well. People are really

positive to start with and really energised, but then another initiative comes along and the energy fizzles out and goes away.

So, actually focusing on how we build energy for change can make a real difference. This is about energy for change inside organisations. I just put this in for the people who like data.

This comes from Bruch and Vogel who are the most eminent researchers on productive energy for change in the world. Their study show across thousands of different localities that they've researched, in an organisation, where they have got high productive energy, they will score higher on almost every measure of performance.

Organisations or teams with high energy score better on every measure of performance. If we think about those of us who work inside health and care organisations, and we want to improve the performance of our organisations, actually focusing on how we build energy for change is a really good way of doing this.

What I will show you now comes from some joint work our team did with York Health Economics Consortium and Landmark. It is about how can we build energy and align for change.

What do we mean by energy for change? It can be at any level, a community, team system. But it is the capacity and drive to take action necessary to achieve our goal.

The work we did identified five different kinds of energy for change. The basic theory behind this is if we want to have really strong energy for change, so that if we want to have the kind of capacity and drive to take action and make a difference necessary to achieve our goal, it is helpful to think about five different energies.

So, we talk about social energy, spiritual energy, intellectual energy, physical energy and psychological energy. Now, I would take you on a whistle-stop tour through five kinds of energy.

The first one is social energy. Social energy is the kind of energy that is about relationships. It is about connections. It is about partnerships.

When social energy is high, we talk about us and us, rather than us and them.

The next kind of energy is spiritual energy. This is the kind of energy that comes from shared purpose. But a shared purpose moving towards a higher level goal, driven by shared values and a higher purpose. We know that when spiritual energy is high, people are more willing to move towards a different future, because it seems more compelling than the current system.

The third kind of energy is psychological energy. This is the energy that is about willingness to try new things. It is about courage, resilience and feeling safe to innovate. Psychological energy is high when people feel supported to make a change and they trust the leaders and the direction they are taking the organisation in.

The fourth energy is called physical energy. This is the energy of implementation, action, and getting things done.

The final energy is intellectual energy. This is the energy of analysing, planning, thinking through the big picture and what needs to be done. It is about gaining insight, planning processes, arguing things on the basis of logic and energy and evidence.

I will show you really quickly the highs and lows of each of these five domains of energy. What I want you to think about is that we have been doing energy analysis with many different teams across the health and care sector, mostly in England but also in many other places as well. We have about 3000 data points.

As I describe this, and maybe put this in the chat box, what we are seeing time and time and time again in the health and care sector, and particularly when it comes to senior leadership teams in organisations, which of these five do you think is most dominant?

Social energy? When social committee is low, I feel isolated and alone, but when it is high isolation sense of solidarity. When spiritual energy is low, I thought uncommitted to the goals and direction of the organisation, but when it is high, I feel a really strong sense of higher purpose. When psychological energy is low, it feels very risky to try new things and I do not want to innovate. But when psychological energy is high, it is safe to do new things. When physical energy is low, there is a sense of fatigue and weariness, but when physical energy is high, there is a sense of vitality. And when intellectual energy is low, there is a real sense of it is not logical, why on earth are we making stupid decisions? And when it is high there is a sense of reason.

So, which of these do you think, when it comes to senior teams in health and care organisation, one of these is very dominant.

It is intellectual energy. What we also see time and time again is a very toxic mix between intellectual energy and physical energy. So if we go and look, for instance, at the transformation plans of many organisations, or health and care systems, they are so strong on intellectual energy. It is like, "Here are the plans, here are the 27 work streams, these are the people that are accountable, here are the deliverables, here is the critical change analysis…"

So we are planning a really big change from a very intellectual energy perspective. And the problem with intellectual energy on its own, where it is dominant over the other energies is that intellectual energy on its own isn't transformational. It keeps us in our comfort zone.

What we often see is this very toxic heady mix between intellectual and physical. It is, like, "Here is the plan, here is the transformation plan or the cost improvement and quality plan. We have got to take £27 million out of the organisation by the end of November. Here is the plan, this is the accountability, these are the timescales. Right, off you go, get on with it, make it happen, boom…"

What we are saying is, we need to think, as change agents, of how we can work with all of these energies, and particularly how we can build social energies, a sense of us and us, and spiritual energy, a sense of a shared purpose for a different direction. And what we also know, what the evidence shows us is that there is a very strong mix. When social and spiritual energy are low, psychological energy tends to be low, because it doesn't feel like a safe environment for making change happen.

Very often, the picture that we are seeing in our health and care organisations is that the change planning that is coming from the top is very driven by intellectual energy, but not a sense of social energy, not a sense of shared purpose and spiritual energy, so it isn't an environment where people feel very safe to innovate. So in a sense, what we want to be doing is building strength in all five.

A couple of other things, which group is most likely to have a higher spiritual energy score? Have a go in the chatbox. We are getting it right, clinicians.

Clinicians have a statistically significant spiritual energy score, compared to non-clinicians. The higher people are to a chief executive and organisation, the higher they are in the hierarchy, do they have higher or lower spiritual energy scores?

This was contentious, everybody got it wrong last time, but actually it is higher. Generally, the higher somebody is in the hierarchy, the higher the energy level they have.

What we are doing is we have got the five kinds of energy here. We have got a process, an online questionnaire, where we get people to assess the energy for change connected to their particular

change initiative, if their energies are low, it will be down here somewhere. If that particular energy is high, it will be up here. Bear that in mind. If an energy is high, it is up there. And if it is low, it is towards the middle of the spider.

This is a team profile that we see quite often when it comes to senior teams in organisations like hospital systems, or provide organisations. What we see here is very high on intellectual and physical, but low on social and spiritual. That means, as we said, that psychological energy seems to be quite low, because of social and spiritual energy being low.

Actually, doing this kind of analysis is very helpful, because it helps leadership teams to have different types of conversation. It is very hard to deliver a transformation plan if intellectual and physical energy are out of kilter with spiritual. But there are lots of steps we can take to build social energy and build spiritual energy.

Let's look at another example, this is a community nursing team. We can see social energy is very high, because this team is a very mature team, and they work together for a very long time. The social energy is so high, psychological energy is higher, because people trust each other. But there is not a strong sense of rigour and rational thinking and what they are doing. In a sense, that very high social energy compensates for spiritual energy, and not a strong sense of direction.

What we can do here are lots of things we can do to support this team, to build a sense of direction, and bring more processes in offering intellectual energy. So you get a sense of it.

Do you know what I would say, I really like this quote from Henry Mintzberg. He says, "Leadership is not about making the decisions and doing bigger deals. It is about helping release the positive energy that exist naturally within people."

The world that we live in, the world of health and care, there is so much latent spiritual and social energy that we need to be building.

I am going to stop there and we are going to hear our next speaker, who is our next storyteller, who is Rebecca. Pip, will you tell us about why we asked Rebecca to come and tell a story with the School for Health and Care Radicals.

PIP HARDY:
Thanks, Helen. We asked Rebecca to come along, because taking part in the 2015 school, Rebecca has just gone from strength to strength, making all sorts of changes in the hospital where she works. Recently, I was pleased to hear that she has won a very well-deserved Florence Nightingale Scholarship.

Rather than me talking about the changes that she has made, I would like to hand over to Rebecca. They do so much for joining us today, Rebecca.

REBECCA LACEY:
Thank you for inviting me today and for that kind introduction. I have to say, right now, I do feel out of my comfort zone, and if this was a pantomime, I am sure you would all be saying, "That is where the magic happens." Little did I know, when I received an email in my inbox a year ago, which had the word "radical" in it, I would be spending a lot of time out of my comfort zone.

I am a nurse. 18 months ago I took on a new challenge when my respiratory ward moved cross campus and I decided to stay where I was and help set up a new ward.

I am an ideas person, but I had always, in the past, had trouble getting people to engage with my ideas, to sell my ideas, and that was more about me than other people, really. And I found it was quite hard work. So much so, that I had conversations with myself, "Don't have any more ideas, go to work and come home again." But you don't, the ideas keep coming.

The School for Health and Radicals came at a difficult time for me. I had no idea what impact it would have on me. I am not a model student, I spent a lot of time at school uninspired and daydreaming. But the School for Health and Care Radicals really grabbed my attention. I was really inspired by the content and the concept, and the energetic and passionate, enthusiastic way that it was delivered.

And after the school had finished, I talked about it to everyone, not just colleagues at work, but to friends who work in other sectors for education, for example. And I tried to encourage other people to do the school this year.

I have to say, I was so happy that a friend of mine from many, many years ago, I nursed with her in Leicester, who had gone back home, lives in Australia and I haven't seen them for many years, took me up on it, and she is thinking about doing the school, and we are connecting, which is great.

Following on from the school last year, I was at work and one of the directors of our trust came up to the ward, and I was talking about some small projects I was doing as a result of doing the school, and I was really, really enthusiastic about the school. And luckily for me, he knew Kate Pound. And he put me in touch with Kate Pound.

Initially, I was going to ask Kate to do a couple of hours at some band six sessions that I helped to facilitate, some time out sessions, and that just grew and grew, and six months later I had been working with Kate and members of the Horizons Team, and that small couple of hours grew from a study day to a Hackathon event.

That took a lot of time, my own time, energy, learning new skills, it was a new concept to me. I took a leap of faith, I wasn't asking people to come to a study day, I was asking them to come along and interact, work and collaborative working all day long.

I really had to sell it. I had to put value on it, so people were given the time to come away from work, but we got there. People with different roles came along and it was a really great day.

It was fantastic to see the outcomes of that day, for the patients, there were four really great outcomes. I note we are short on time… I worked on one that was a hub. And I have had great meetings, over in our children's department, which was a great opportunity. And another one was a discharge app that has gone from strength to strength, and is really a large project now. It started its life at our Hackathon.

The most interesting thing to see was how fantastic it was to see people networking, sharing ideas, collaborative working, the amount of energy, passion and enthusiasm that there was in the room that day was really good.

I can talk a lot about Hackathon, and it really was a great event, and a good opportunity to work with Kate and the Horizons Team, so I thank them for that. But I would quickly like to say that I do feel that it is important to talk about how change starts with me, and what the school did for me.

I did a frontline leadership course last year, and because I did the school, I felt a much more productive and proactive student. I have enjoyed the talks, and the talks that Pip did. I connected with Pip, and in a couple of weeks I am doing her workshop, which I am proud about. This time last year, I would have run a mile from networking, and now I take a much more active approach in that Twitter was a mystery to me last year. Now, I am on Twitter and I check my tweets every night. I do not Twitter every day, but I encourage people to tweet and get on Twitter.

I Skyped for the first time this week in my Randomised Coffee Trial, which is another fantastic concept. Last year, I thought it was a really great idea. And this time I took it on board, and I met with my partner this week, and it was really, really good.

I wonder if you are thinking what kind of person I was before the school, but actually, I have a really great exciting life. I am quite creative, the school has not changed the person who I am, it has given me the tools and the skills, and confidence and permission to bring that side of my personality to work, and to help me make the dreams that I have got for my patients and my workplace become a reality.

So thank you very much. It was a really good thing that I did it. I am so pleased that I did it. Pip is right, I have applied for a scholarship. It is a scholarship with the Foundation of Nursing Studies, the Richard Tomkins Scholarship, and they awarded three this year, and I was happily awarded to receive one of those scholarships. So I think the school, because I am sure, without you, I wouldn't be said here saying that now. I also blame you when I am out of my comfort zone and feeling really awkward, but thanks very much.

HELEN BEVAN:
Rebecca, that was fantastic. And I think, again, I love your energy. As I said with Jas, I think you are the kind of person, and the response you had to the school, you make us very happy.

You are a really good example, resources are out there everywhere for us, and in a sense, the world is abundant. We just don't know they are there. And by taking a few steps, making connections, there are so many opportunities and possibilities for us. So thank you very, very much the doing that. Really, really great.

We are talking about building social and spiritual energy, and I think it is important to connect it back to the issue of our shared purpose. If there is one thing that we take away from today, it is the issue of our shared purpose. We need to think about all three words. The 'our'. He was part of our? Who are we building this with? We are trying to define the people who are benefiting from the change, the people who will be impacted by it. All these people need to be involved in designing and delivering change.

Then we have the 'shared'. Two modules ago, when we looked at building communities and social movement principles, what we talked about was how can we come together and create a sense of 'us'?

So many things keep us apart. So many things divide us. But what are the things that unite us?

And finally, what is our sense of purpose? That is the "why are we doing this?" Far too often in our world of health and care, we rush into the how and the what, and we need to stay focused at the why. If we stay focused at the 'why', we stay connected into the reasons why people are giving their time voluntarily and doing the things they are doing. Listen to Jas and Rebecca today. What a profound sense of intrinsic motivation, and for both of them it is connected to that 'why'.

The final slide I want to show you today is How to Make Change Happen? I took this from something called How to Motivate People, because it seems to sum up a lot of our learning around how to make change happen from the School for Health and Care Radicals.

Number one, stop bribing. Intrinsic motivators on their own are insufficient for making change happen.

Number two, make people feel something. So much of change is about that emotional connection. It is about connecting with emotions and values that will most effectively mobilise people for a change. Make that emotional connection.

It is interesting, looking in the chat box, some of you were saying you were in environments where you were told you have to be less emotional and more rational. That is a intellectual energy environment. But as change leaders, we have got to be connecting in with people's emotions and values.

Number three, emphasised progress. We talked about this a little bit in module number one, where we said "What we know about successful boat rockers?" They are able to connect with other people to make change happen and show progress.

Number four. I love this. Let's start a cult. What do we mean by a cult? May be a group of very many differences, but a group that has a shared purpose. We have many different ideas, but we can mobilise that for a shared purpose.

How can we make change happen?

That is the end of this section for today. Now I will hand over to Olly to hear from the chat and the twitter. Then we have a fantastic story from Joyce Lee. Olly, can you hear me?

OLLY BENSON:
I can. Can you hear me?

HELEN BEVAN:
Yes. Tell us what is in the chat and on Twitter.

OLLY BENSON:
In the chat and Twitter this afternoon, since we got it up last. There were a lot of interesting different discussions. Francis McGuire said, "We need people inside and outside the tent. I love the great outdoors."

Lisa said, "Change and fatigue is inevitable when we are constantly in flux and every new thing is the best thing."

Tony Longbourne said, "I am not qualified, hence I have no intellectual understanding, apparently." We say in the school everyone is qualified.

Frances Maguire also said, "What you said is great. You explained my Ph.D. in two sentences."

Louise asked a good question. She asked whether this discussion of energy is often gendered. Physical and intellectual energy is seen as manly and spiritual is seen as female.

This is why you need more women in the leadership team, so there will be more spiritual energy.

Then Caroline Chambers said, "Rebecca, you sound so enthusiastic, it is infectious." And those sentiments are also reflected on twitter.

HELEN BEVAN:
And we have had another poem from Nigel.

OLLY BENSON:
We have had several poems from Nigel throughout the afternoon. So I read the last?

The School for Health and Care Radicals create momentum sabbaticals.
No longer in their comfort zone, they were not alone.
The power was with the radicals.

HELEN BEVAN:
I love the spirit of it. We should publish these.

OLLY BENSON:
It will be a bestseller.

HELEN BEVAN:
A lot of people are enjoying Nigel's poems. That is great.

What I would do now is I will hand over to Pip to introduce Joyce, our final speaker. I will give Joyce speakers right so she can move the slide. So Pip, why did we ask Joyce to speak?

PIP HARDY:
Thank you, Helen. We asked her to speak because when I looked at her website, I discovered she was a physician, a researcher, a designer, and she also blogs, tweets, speaks at events, gives TED Talks, and I cannot imagine when she ever sleeps, but I think we need to hear from her about how she turns all that energy into making amazing changes.

Thank you very much, Joyce, for joining us today.

JOYCE LEE:
Think if I had money. Can you hear me?

PIP HARDY:
Great.

JOYCE LEE:
I am a paediatrician who is fortunate enough to work at the University of Michigan with the diabetes clinic. I work primarily with patients and families of children with diabetes.

I have the formal academic causes a physician, researcher, but what has made me most passionate about the job I do is my identity as a designer. I want to share a little bit of the story that lets me to design, because I do not have formal training in design.

I am a mum of two kids with life-threatening food allergies. Two years ago, when I went on sabbatical, I had to teach would-be day-care providers and teachers how to give the EpiPen in case of life-threatening practices. I had a really hard time with the healthcare provider, because they did not thought they understood the gravity of the situation and I wanted to help them create tools to save my daughter's life, in case they needed to use them.

Unfortunately, what you get from the healthcare system is this two-page, black and white allergy healthcare plan. It is just not sufficient. Around that time, it ended up delving into social media and doing a video with my son. You can find it at Ihavefoodallergies.tumblr.com.

I scripted it and created the educational pieces for it, but he actually did or the illustration and all the narration, which you can watch at a later time.

For us, it was an amazing experience. The video went a little bit by firework and got picked up on some blogs, but it was the talk we used every time we went to a new school or provider. We can give them this video and it communicates to our words how to save their lives. What I love this experience is one, patients are experts. I tried to find materials online that would suit us, but I cannot find any that we needed. They had to come up with the solution.

Secondly, patients are treated. Now we have access to social media, and access to PowerPoint tools, you can make live video, even if it is low production quality.

Finally, the collaborative piece was really important. This was a collaboration between me and my son and that was really important for me, but also important for him. He became an active participant in his care and understood much more fully when and how to give the medications. I think it prepared and protected him triply, because I was providing information. Teachers were receiving it, but he was learning it for himself.

When I came back from sabbatical, I started spending time with friends and I suppose starting our own cult. It is a collaboration of health care givers and providers, designers and artists, and members from the School of Information who do technology development and entrepreneurship.

We started doing a ton of collaboration, but really trying to integrate design into healthcare. Starting doing design workshops will be have patience of clients and we called our experts and they help guide us with the problems that need to be solved and they co-designed with us to create the solutions.

We were preparing students with patient partners to create educational materials. The cartoon in the middle called Insu-Man, that is a diabetes, it created by a patient with type I in partnership with the School of Information and Design. It is an incredible tool that could not be created by a health care delivery system, because what you need is the patient perspective in creating these types of tools.

On the right-hand side is the idea of these diabetes emoticons. There was a teenager with diabetes who wanted to communicate with her mother, but there was a lot of anxiety and frustration around taxing back and forth about blood sugars. The concept was wouldn't it be great to have some emoticons to talk with mum about some of these issues. We are now working with the Michigan Hackers to create an actual app they will be able to download from the App Store.

As we were doing all this design work, we found some makers in the local Ann Arbor community. We realise the parallels between the participatory and design communities. Peer-to-peer learning, something that is really important and key. We have helped a couple of Make Health Fest over the years, bring together the designers, the makers, and the tinkerers. Knowing that there are real problems that need to be solved that the healthcare stakeholders know about. There are great opportunities in technology and design the tinkerers need to know about, so how can we bring these together?

I would say we are low-budget, because we are a community that is really passionate about this. But I am trying to integrate this more into the clinical delivery workflow. If you can insert innovation into the meat of the system, I think the potential for scale is much greater.

I do not want to go too much over, but I guess one of the things I have been trying to do is take advantage of the fact that we, as healthcare stakeholders, our designers. Every time we see a patient, that is a design opportunity. It has helped me do with the fact that health care is pessimistic, but design is optimistic.

We have been doing all sorts of things. We are trying to integrate design into the daily workflow. User testing is an opportunity for experiences between me and my patients. We are making the dream clinic, because what we are doing is a group peer-to-peer clinic session. We are having kids create a gaming platform that would teach the points of type I diabetes.

So it is for people who have the design stick within them, but don't have the capacity of resources to unleash that. We are trying to bring them together to create innovation, quality and improvement inside the clinical delivery system. We are still a prototype, we are still moving along to get to production and scale, but I am very interested in connecting with this community to integrate healthcare, design and innovation, because encountering you guys has been incredible for helping me think about leadership and the work we are doing.

HELEN BEVAN:
Thank you, Joyce, for doing that so quickly. I am sure we do you a terrible injustice by making you do such a short version of that.

What I would say to people who have taken part in this module is to look at some of the links Joyce has given us. This work is phenomenal. The reason we wanted Joyce to be our speaker today is our

team around making change happen, and Joyce, I think that was a great example of that. Also, to be a transition into module five.

What we would do in our final module is leading from the edge. Where is the world going? I think this world of design thinking and practice is such a strong theme in our future and we will be touching on some of those design topics for next week. I think that truly is inspiring.

We are running out of time now. Seriously, I will hand back over to Kate and Pip. I hope to see you all there.

KATE POUND:
Thank you, Helen. I am just getting the ball and moving onto the next light. A quick reminder for everyone that our Twitter chat for the school is next Tuesday. We have our final module next Thursday.

People can also still take part in the randomised coffee trial. There has been lots of tweets about this. Join the randomised coffee trial and tweet about it.

I will quickly handover to Pip.

PIP HARDY:
A few things for you to be thinking about until we meet again next week, some questions for you to reflect on. How can I make the most of those intrinsic and extrinsic aspects of change?

How can I build energy for change for the long haul?

And how can I ensure shared purpose throughout my change process?

And then a call to action for you, something to get you out of your comfort zone, perhaps.

Identify three ways in which I can ignite energy for change within my own groups and communities.

Consider how I will build the commitment to shared purpose in all my change efforts.

And think about what action you can take tomorrow to celebrate change.

And finally, to hopefully inspire you over the next few days, "There is a thread to follow. It goes among things that change. But it doesn't change… While you hold it, you cannot get lost."

So, goodbye and good luck with your change efforts. We look forward to seeing you next week.

KATE POUND:
Goodbye all.

HELEN BEVAN:
Goodbye.