SPEAKER:
Hello to you, welcome to your module for today. My name is Gary and I will be your presenter for today.

If you do need any help, press start on your telephone and someone will be help you. I will hand over to Helen Bevan.

SPEAKER:
Good morning. Welcome to module four of the School for Health and Care Radicals course. Our topic today is making change happen.

What are going to do is focus on lots of models and approaches that are helpful in taking action and making change happen.

It is great to see so many of you here today. The numbers have hardly dropped at all in the four weeks, so so many of you are stalwarts of the School for Health and Care Radicals. So for those of you who are joining us at a different time, watching the recording, at work as well. It is great to have you with us.

I hope we can keep up the quality and quantity of connectivity. The spirit of the School for Health and Care Radicals, this isn't just a lecture. This is an opportunity for health and care change activists across England, across Britain, across the globe to connect with each other.

Please use the chat box to keep contributing throughout the web seminar today, those who are joining us live.

Some of you can see two boxes, a chat box and a Q&A box. What we want to say is stay away from the Q&A box and use the chat box.

Please keep tweeting using #HSCR.

There has been such great and interesting conversation. And as usual we will be producing summaries of this module using Pinterest, and we will be giving you the details in our newsletter.

Finally, we hope you will join us next Wednesday for our tweet chat. Let's keep the conversation and connecting going.

In terms of our teams today, I'm Helen Bevan, and I'm leading the session. I'm joined by Dominic Cushman and he is going to lead us to an icebreaker shortly. He is also going to attempt to monitor all the chat.

Kate Pound is with us, and Kate is going to attempt to monitor Twitter.

As usual, we have our fantastic learning lead, Pip Harvey. Pip will be reflecting with us on learning at the end of the web seminar today.

We are also delighted to welcome Jenny Clark with us today. She has got the most fantastic story to tell in her role as a midwife change activist.

So let's get going!

Our agenda for today is about making change happen. The nuts and bolts of change, the whole step of approaches and tools to help us to do that.

We're going to start off a conversation on why so often change effort doesn't achieve what we set out to achieve. We're going to talk about lifestyle change and what we know about leading successful lifestyle change.

The first model we will look at is the change model. I think it's really helpful and powerful for thinking about the intrinsic and extrinsic aspect of change. Actually, we need both and we will have some discussion on that.

We will look at the topic of energy for change, and the reason we are doing that is if you go right the way back to the top of the agenda, what the evidence tells us is that the main reason that change doesn't happen, and we fail to achieve our objective, is because the energy goes away. So how we create energy for change for the long haul is a very important topic for us as health and care radicals.

Our final topic is about creating the foundations for the magic to happen that we want to see.

Jenny is going to share her case study with us. Then we will have some study and reflection. A pretty content-rich and hopefully action packed hour and a half.

Let's go on to our next topic. We've got a different kind of icebreaker this morning. I want to introduce this and I'm going to hand over to Dominic.

What this is about and what we'll look at is a really interesting experiment that researchers at Harvard University did.

They put a gorilla image on this scan of a lung. Then they gave the scan to radiologists to look at.

Can you see the gorilla on the scan? Can you see the gorilla?

OK. I'll give you a clue. There it is. Holding its arms up in the air.

Now I will hand over to Dominic and he is going to get us to do some reflecting on this. So, Dominic?

SPEAKER:
Thanks, Helen. Can you move the next slide by any chance?

SPEAKER:
I've done it. Can you see that?

SPEAKER:
Brilliant. As you can see from the last slide, the X-ray for where the gorilla was, it will be interesting to know if you can use the tools in the top right corner for annotations. There is a little arrow in the top left to see how many of you think what is the proportion of radiologists who reviewed this scan actually saw the gorilla.

Looking forward to see your comments. Not looking very positive!

Oh, David Souter seems to be 90%, very positive.

OK, lots of pessimistic people here. Let's get a few more and then we will get to the answer.

OK, I would take a picture of that.

Let's see what the percentage was. The percentage was 17%.

I'm going to hand back over to Helen who will explain why that was the case.

SPEAKER:
I do think it's really interesting. The idea of this, what basically happens, was when any of us look at a situation, we see what we expect to see.

We don't think more broadly. Even though there was a gorilla on the scan, the radiologists weren't expecting to see a gorilla. So they didn't see it.

We are like that with change. When we look at a scenario of health and care delivery or a situation, we see what we expect to see.

I guess one of the things is to say in terms of seeing the big picture, what do we need to do to actually be able to stand back and see the gorilla?

I think this is what we talked about last week in terms of diversity. We need to have fresh eyes and different perspectives and different voices with us, as they help us to see the picture when we might not be seeing the things in it because we have got so used to it or we expect certain things.

Dominic, back to you for the second icebreaker.

SPEAKER:
Can you pass the presenter rights, Helen, please?

SPEAKER:
Yes.

SPEAKER:
Thank you.

SPEAKER:
You need to click on "next slide".

SPEAKER:
The next question we want to ask you all is all about making things happen. We want to figure out what you are most interested in finding out about today. We've got our change wheel here and we are asking you to do the same again using the annotation tools in the top left-hand corner with the arrows.

Let us know what you are thinking.

SPEAKER:
A bit of everything, here. That is good.

SPEAKER:
Wide-change fields. Shared purpose. Motivators of change. Large-scale change. Someone is being a rebel today.

SPEAKER:
Excellent.

SPEAKER:
I think everyone wants to see a little bit of everything. Let's pass presenter rights back to you, Helen.

SPEAKER:
Thank you, Dominic. Hopefully you can see me again now.

This figure here, 70%, is a mythical figure in the field of change and transformation.

Does anyone want to say in the chat box why that is? Why is it such a mythical figure in our world of change?

Yes, that's right. The next person that got that right was Alan Jony. Well done, Alan.

Basically, the mythological figure is that around 70% of change efforts fail to achieve their objectives.

20 years ago, what was happening was that John Carter was writing in the Harvard Business Review, saying that 70% of change efforts failed to achieve their objective.

Much more recently, there was research by the Gallup organisation and I will show you that shortly. What it was showing was 70% of change initiatives failed to achieve their objective.

So let's have a look at some data from McKinsey. This is a study that McKinsey did with 3000 respondents, 3000 senior leaders across industries and sectors.

Whatever sector they looked at, the outcomes were the same. But only about 25% of change initiatives get anywhere near achieving their objectives.

The reality is that probably only ever about 5% of change initiatives get to a stage where they actually deliver the change, they sustain it, and they move onto the next change.

I guess the question for us as a community of change agents is what we need to do? So we are at least in the 25% and ideally in that golden 5%.

That is a topic today around making change happen. What are the ways of thinking and action that can help us to enable our change to succeed?

We have talked a lot in the previous modules about mindsets to change, and how important that is. One of the things I think about very often is we have an attitude to change whereby here is our change objective and I am on this journey for change and it is a very rational, logical, technical way of thinking about change.

The reality is it can often be very different, because we live in a world where change isn't an easily planned highly engineered process.

It is in a world of complexity and people.

Somebody who I think explain this really well is Peter Fuda. Peter Fuda is going to appear a couple of times in this presentation today. Peter is a researcher and transformational change practitioner in Sydney, Australia. We have lots of colleagues in Sydney today which is great.

He wrote this excellent white paper around why change efforts fail. He related it to this mythical or magical 80%. He talks about five flawed assumptions we build our change efforts on.

The first one is that change is a process can be managed through a highly disciplined rational process.

I agree with him on that. I find even the term change management quite difficult.

The second is that human beings are objective. When it comes to a change process, emotions go away and we just deal with this in a very objective, rational way.

Third is that they are expected to change. Many colleagues who work for software companies will have a model of recipe for change, the 11 steps to confirmation of change.

The fourth is we have a neutral starting point for change. Organisational leaders decide that we are going to go through this change process, and it's almost as if history hasn't happened and we all start from the same place.

The final one I think is really important, the goal is change itself. We give a focus on change efforts, it's almost as if change is a goal, just making a change becomes a goal.

But actually we have a big goal. The goal is the goal. I think these aspects are helpful and these are things we should be thinking about to create successful change.

So what is the reality of large-scale change efforts?

[Martin.Captioner is Live]

The thing that is least likely to happen is the thing we want to happen, which is this. The thing least likely to happen is that the change becomes at least reasonably well-established and that lots of different layers in the system change to accommodate or support the change in a sustainable way.

The most likely thing to happen is this. The effort, effectively, runs out of energy and fades away.

So I really like this quote here from Carol Pollock. Typically, around any change effort, there is an initial spike of energy that is very tangible. But often leaders will lose interest or they will move to other priorities, and then momentum for change slows down dramatically.

Another piece of research that for me makes this point is research published last year by the Gallup organisation. Again, why do 70% of change efforts fail to achieve their objective? What they show is that often, the leaders who are at the top end of the organisation, will be very clear about what the priorities are. As a group of senior leaders, we might set priorities. But the further we go down the organisation, towards the front line, the greater the number of priorities. Often, the people who are operating at the frontline and are in the delivery part of the organisation have got so many priorities that it is really confusing to us. What is the priority and what isn't?

Gallup were talking about this in a generic context because they were looking at lots of different industries. But I also found research which said the same thing in our specific health and care context. This was some research that appeared in health affairs in the USA.

This was an article called the Danger of Quality Improvement Overload: Insights from the Field. What this was saying is that if we want to make changes happen, then buy-in from frontline colleagues is absolutely critical, and what we mustn't do is overload people with different priorities.

As leaders, we have got to make clear what the priorities are.

In all my time in health and care improvement, one of the things I am proudest to be part of or help to contribute to is this document, this publication. It is called Leading Large-Scale Change: A Practical Guide. This is something that – it is free – you can download it and here is the reference.

One of the things this publication is helpful with is setting out what are the 10 key principles of large-scale change. If we look across multiple industries, multiple sectors, health and care, government, education, the corporate sector, the voluntary sector… What we see is that the reality of changes pretty similar, whatever the sector. What we have done in this publication is to identify the 10 key principles that we see time and time again when change works out.

I will go through the 10 now. I want you to think about the extent to which we are seeing these 10 factors.

The first thing we see is that the change is about moving towards a new vision or a new picture of the future that is better and fundamentally different from the status quo, because the reality is that if people do not think that this new vision or this new picture of care delivery is better and fundamentally different, then they won't engage with it.

The second thing we see is being really clear about what the key things are on the change and communicating them in a way that people can really, really connect with. We spoke about this in module two and we spoke about leaders needing to sense make. We always talk in about people needing to change, but what we don't do is make sense of the change. By sense making, we mean putting the change across in a way that makes an emotional connection for people.

This is about, how do we communicate these key things in a way that sense make?

Number three is that lots of different things need to be happening. This isn't about a rational, objective process. It is about multiple changes happening in lots of different places.

Number four relates to what we talked about in module two respoke about bringing in social movements thinking and framing of proposition in a way that mobilises people. So, framing the issues in ways that will engage and mobilise the imagination, energy and will of a lot of different people.

And then, again, number five ties in with the theme of lots of different changes are happening and they are happening across lots of different processes and lots of different subsystems.

Those are the first five. What is happening in your system? Are those five things happening?

Number six, we have to continually refresh the story so we can keep attracting new and active supporters. I have seen this so often in the NHS. When I think back, for instance, to a big initiative in the NHS called QUIP, over four years ago. It was a strategy around how can we save costs by improving quality? When it happened, there was a really clear narrative. In fact, I can remember there was a special narrative for the clinical community that really set out QUIP.

What we haven't maybe done is keep refreshing the story. We haven't kept building a new narrative or taken a narrative to a new phase. Very often, what happens when we don't do that is other people will create a new narrative, which is one we might not like. I think one of the things that has happened around initiatives like QUIP is that people stop seeing it as about reducing costs through quality and just about reducing costs. If we don't keep refreshing the story, it's not going to happen.

Number seven, how we go about planning and designing a change. They need to be based on the reality of emergence. We cannot predict exactly what is happening from the beginning. We need to be costly testing things out and learning and adapting for our whole approach to planning and design. I think one of the things I see happening quite often, certainly in the English NHS, is that we produce program management approaches that are often very rigid and hard to change.

Number eight, again, you get a real sense here around the contribution of diversity, diversity of thought and engagement. Again, lots of different people contributing to the change beyond people in the kind of silos of the organisation.

Number nine comes back to mindset. We have got to think differently and we have got to see the bigger picture for sustainable change.

Finally, number 10, this issue of energy. We have got to really focus on energy and how we keep energy going for the long haul to stop it fizzling out.

So, think about those 10 principles.

At the heart of this is a key principle, which is about thinking about motivation. How are we going to motivate people to change? We need to think about the balance of the alignment between the intrinsic motivation and extrinsic. When we talk about intrinsic motivation, we talk about people engaging in change because they want to. I'm doing this because it makes a difference for me. It makes me feel fulfilled and gives me satisfaction.

The evidence says this invokes positive behaviours.

Extrinsic motivation means that people will engage in the activity or become involved in the change because if they don't, they might be punished, or they might be incentivised. So it does not come from within, the motivation, it comes from without.

Let's think about this in the context of our world of health and care. So, when we are thinking about large-scale change, we need to be thinking about the intrinsic motivators, how we work with intrinsic motivators to build energy and creativity to change. We are looking at things like… I can see this in the chat box. How do we connect to a bigger shared purpose? How do we engage many people and spur them into action?

So, for our change effort it is important that we are building these intrinsic motivators.

And if we are going to make change happen across our whole system or a whole organisation or even a whole team or unit, we also need to be thinking about the drivers and influencers of extrinsic motivation. These are the things that will give us momentum and help to drive change across the system. And here we are talking about factors like how we build in drivers and incentives. What are some of the mechanisms we can put in that will incentivise people to move in this way?

Often here we are talking about things like payment for quality, payment for results. If we do well, we get rewarded, and measurement that is about accountability. As a manager, I'm held to account for delivering these outcomes.

What we are basically saying is we are holding ourselves to both. If we go too far with one or the other, it can go wrong.

If we try to change a whole system or pathway of care across many different boundaries because we are trying to create a new program around the patient, if we only focus on intrinsic motivators, we would end up with 1000 flowers blooming. Lots of bits of change but it doesn't necessarily add up across the whole system. Again, if we go too far with extrinsic motivation, what can happen is people are doing the change because they have to, not because they want to, that is not a very good recipe for sustainable change.

When we look back at our world of health and care over the past 10-15 years, which

of these two do you think has been most dominant in the way we have gone about change? Do you want to put it in the chat box? Which one has been most dominant?

Yeah, I think we're pretty conclusive. I think what we have seen consistently in our health and care sectors, and in many different places, not just the NHS in England, is that drivers of extrinsic motivation, the way that we have created our change processes, and we have focused on this. What it tends to do is eat up all kill off our intrinsic motivation. So in a sense we need to find change processes that work with both.

[Rebecca.Uk.Captioner is Live]

Just to give you an example. A very big focus for all of us in different places around the world is how can we build really great systems of integrated care. Thinking about how healthcare and social care and different proponents of care can work together in a way that wraps around the personal location.

This is an article that Mick Goodwin produced about taking care forward. And he talked about a scenario where we say leaders and managers are wanting to apply this integrated care at scale and pace. We talk about this as well a lot, integrated care at scale and pace.

What we end up doing is driving forward organisational solutions or financial inducements, ie we lead with extrinsic motivation in the hope that it will be more effective than starting with a value-based shared purpose which is the intrinsic motivation.

He is basically saying it's the wrong way round. It's a mistake. If we're going to create integrated care at scale and pace, we must start with a value driven approach. We must start with the intrinsic motivation. That should be a prerequisite. And I agree with him.

What we're going to do at this point, I'm going to just pause for a moment so we can look at what we are seeing on the chat and on Twitter.

Dominic, what are we seeing on the chat?

SPEAKER:
Hi, Helen. Some really interesting conversations. Nice to see the camaraderie between everyone having conversations and the fun talking about Yoda and Santa Claus and how they go about delivering change in getting their jobs done.

There's a couple of points that sum up the conversations we are having today.

Christine Morgan completely agrees with everything you are saying and observes

that some NHS initiatives forget they are working with people and not just moving bits around. I think there was a lot of nodding of heads of people agree with that.

Stephen McBride made a good point offered through the conversation and I thought it was quite interesting, that not enough was being said about middle management and it needs to be challenged. We often focus our efforts on top leadership on the front line management. Very little is focused on the managers in the middle and it would be interesting to hear comments on that on whether it is true or not.

SPEAKER:
Our module next week, "Leading from the edge", we have got specific content in there about the really important role of middle managers. So watch this space on that one. I think it is a very important topic.

SPEAKER:
Thank you for bringing that up.

SPEAKER:
Thank you, David.

Kate? What do we see?

SPEAKER:
Again, this week, loads of activity on Twitter. There was quite a lot of amusement about the gorilla, so that was a great icebreaker. Again, more discussion around learning from change and looking at the 70%. We need to be moving that over.

There has also been discussion around how we can support each other with that, and making sense and communication being a key thing.

I'm just looking through.

I think the other thing that's really there today on Twitter is there has been a growing discussion about the school as a community and building a community to support each other, so we can challenge change and move it forward.

SPEAKER:
Excellent. Great.

So keep at it, Dom and Kate, and we will come back to you shortly. Brilliant chat, brilliant Twitter conversation. I love how this is going.

We are learning as well, at the school. Often we are putting across a model and practical ideas are coming from the community through the chat and Twitter, and I think that is really working well as an approach.

So what we are seeing here is we need to align the intrinsic and extrinsic aspect of change if it is going to work.

Here is our friend Peter Fuda again. His quote here.

Often we are working in systems where we have a transformational aspiration. What he said, and I agree with him, is that transformation is not a matter of intent. Just because we've got transformational ambition doesn't mean it's going to happen.

It is a matter of alignment, it is a matter of joining things up.

So we have a particular model that we really love to use, thinking about this. Again, bear in mind what we said on the module last week.

All models are wrong and some of them are useful, but when it comes to linking up extrinsic and intrinsic aspect of change, this is a model we like very much.

It is called the change model. The change model is built on about 15 years of experience in health and care, of seeking to make big change happen.

What the change model says is that at whatever level of change we are making, it is extremely helpful to think about the eight different components and to what extent they are a focus and we are really taking action against all eight of them.

Even more importantly, with the words of Peter Fuda ringing in my ears, to what extent are they aligned with each other?

Let's talk about his big components.

This first one here is about shared purpose. At the start of the change process and all the way through. When we look at what we looked at earlier, the 10 activities that we see in successful large-scale change, and so many of those components were about building shared purpose and keeping said purpose across a wide group of people.

Then some other aspects of this change model are about the intrinsic aspect. Particularly if we think about leadership in the context of motivational leadership and engaging to mobilise. Getting everybody on board.

These are our intrinsic aspects that need to be broken right from the start.

At the same time, we need to think about the extrinsic motivators of teams. We're talking about the drivers, the incentive, the mechanisms to reward or sanction people. Are they lined up with the intrinsic aspect?

When thinking about a rigorous delivery, do we have an effective approach to

perform management that enables us to deliver? And is there a link-up with the intrinsic aspect?

Measurement I think is an interesting one. Very often we think about measurement as being extrinsic. What we are doing is we are measuring and holding people to account for delivery of an outcome.

Very often we don't use the measures. They are part of a performance system. So often measurement. The extrinsic.

Yet when I look back over my history as a change activist and a leader of change, very often, in the best change and improvement projects, measurement is intrinsic. Teams are so focused on the changes they want to make sure their patients, they love measuring and are really motivated to measure.

Measurement can be extrinsic or intrinsic, but we need to make changes to ensure we are motivated to measure.

The next one is improvement of methodology. Do we have an evidence-based improvement of methodology underpinning our change? What is interesting to me is that the evidence showed me that explicit improvement methodology makes a difference.

Organisational teams that work with an explicit improvement methodology can to get better outcomes.

However, the evidence that is available to us at present says it doesn't seem to matter what the methodology is. It isn't really evidence that says it in terms of quality management, it's that methodology based on organisational development.

But what it does say is that as a team, if we identify the methodology we want to use and we stick with it for a period of time, we will get good outcomes.

The final one, the eighth one, is around studying innovation. Are we thinking about spreading our great new ideas right from the start of the change process rather than seeing the spread of innovation as an afterthought when we are making progress?

I think this is a really really helpful change model.

Yes, making sure all eight are present, but even more importantly, making sure they are all aligned with each other.

We use this model in lots of different ways. One of the ways we use to change models, is we get people to talk about which components they relate to. Again, we want a diverse team here in our change project.

Very often, for instance, when I work with groups of nurses who are involved in change projects, they nearly always prefer the intrinsic aspects. It's not surprising, is it?

But sometimes we don't have people who really appreciate methodology or people that are thinking about measurement.

In terms of our team, we want to understand what the components people connect with. We haven't got many people that are focusing on measurement of focusing on system drivers of focusing on methodology. Where can we get these people fund to help us?

Another way that we use it that I think is very helpful is to look at where we are. So what we have done here is created a spider diagram. What we said is that as a team, thinking about our project, where are we between one and 10 on this component of change?

It's really interesting to give everyone a blank spider diagram and say where do you think we're doing? And look at the difference between what everyone is saying. We also say where are we now in regard to this component and where do we want to get to in six or 10 months?

But if we look at this one, this is a real life one. This is from an action pathway project. But it is showing, you can see, that this is a team that is focused on leadership for change, it is b on that, and the b performance management.

But we haven't been thinking about how we are going to engage people to mobilise. We haven't thought about how we learn it up with our system drivers. We are not really thinking about transparent measurements.

It is very very helpful in terms of thinking about change.

Why a lot of our colleagues who work on the provider side, who are delivering services and primary community secondary care, is where they make it is it is the first time we are legitimising intrinsic motivation. In a sense, it gives us a language, a dialogue, a conversation that actually builds the intrinsic action in right from the start.

You know when you look back to what I showed you earlier? Around the 10 factors around large-scale change, seven out of the 10 are intrinsic. Yet often we underplay the intrinsic site.

You get the best motivation from others not by lighting a fire beneath them but by building the fire within. As change agents, we want to be building that fire within.

I think we need both extrinsic and intrinsic. We need what is seen in (unknown term),

take the passion and makes it happen. But let that passion be with the more intrinsic aspect.

What we'll do now, I thought we could pause and have a little discussion. We can do this on Twitter and chat. We can also maybe see if one or two people would like to make a comment.

So thinking about the change processes you are involved in now or that you have been involved in in the past, have you built intrinsic and extrinsic motivators into your organisations? How have you managed the tension?

I hope one to review would be able to make some comments of this advice through audio. I'm just going to ask Gary, our event manager.

Gary, can you see if a couple of colleagues would like to make comments?

[Martin.Captioner is Live]

SPEAKER:
If you want to ask any audio comments, press star and one, say your name and press the hash key.

SPEAKER:
Dominic, in the meantime, in terms of what people are saying, can you pick anything from the chat?

SPEAKER:
Just a couple of things about being authentic, really. Although we can be positive, we need to be authentic. It doesn't matter where you work, make sure you work from every level and engage with every level, from middle managers to the top to the frontline.

SPEAKER:
Great advice. Gary, anybody that would like to make a comment?

SPEAKER:
Yes, we do have somebody in the queue now.

SPEAKER:
It is Helen. Great to hear your voice.

SPEAKER:
Great to hear yours, and thanks for the inspiration. I was just reflecting. I manage a program of peer reviews and challenges. What struck me about the slide you just showed was that we tend to focus on the practicalities and process of getting things

done, making sure we have ticked all the boxes. When I reflect on what we have been doing in the West Midlands recently, the intrinsic things are almost taken for granted and are not seen as part of the outcomes for the success of the program. Actually, if I was telling the story you have told this morning I would tell it in a different way. The motivations for people being involved, the benefits they gain from delivering or seeing all the places and meeting the people, it is all about the emotion, the fact they have got stories to tell, ideas to share. I found that slide really important.

SPEAKER:
Fantastic. I think you are making a very important point there as well. Like you say, what we do is we just assume the intrinsic stuff is happening and don't plan for that. So many other factors around successful change come from connecting with and harnessing the energy that intrinsic motivation. Really appreciate your comments.

Gary, anybody else?

SPEAKER:
The next comment is on the line.

SPEAKER:
Shay here, in Australia. I think we have made a really fundamental shift with hospitals to achieve a four hour target. The main conversation was about how to achieve that. The conversation really shifted to a shared purpose of providing quality care for all patients with no tolerance for waiting. There were key principles about how they would implement that in terms of trust. Again, there's no tolerance for waiting.

That really helped intrinsically motivated everyone. It certainly lead to more collaboration across the continuum of care.

SPEAKER:
Brilliant. Based on that experience, what advice would you give to other change agents?

SPEAKER:
It is not just achieving the goal for the goal's sake. Intrinsic motivation is from that shared purpose of what we want to deliver.

SPEAKER:
Fantastic advice. Thank you very much for sharing that. There's a lot of love for you in the chatterbox! That's great.

I'm just going to take those two comments now. Hopefully we will have some time later on.

What I would like to do is carry on now with this issue around energy. This was a slide we looked at earlier. What happens to large-scale change efforts in reality is the thing most likely to happen is they run out of energy and fade away. Going back to the 10 key points of large-scale change, it is critical that we build energy for the long haul.

So, thinking about energy relates to both extrinsic and intrinsic, but particularly to intrinsic. That is where the fuel comes from. What I would like us to do now is do a bit of thinking about energy for change. This is some research here from (unknown term), who are gurus of thinking about organisational energy and change.

Research shows that more than almost any other factor affecting an organisation, whether or not we have got this energy could be either a wellspring of corporate activity or the destruction of its core.

Energy is palpable. Again, just because we like data, if you look at some of the statistics, it is very compelling. Actually, organisations that have this hyperactive energy, they score better or more highly on every component performance. It is worth thinking about energy.

What I am going to take you through now is a framework that we developed in partnership with York Health Economics Consortium and Landmark around how can we build and align energy for change? Going back to the change model, actually, how can we align different components of energy? These are all freely available.

It is very helpful, and what this work identified was a specific model of energy. So, first of all, let's define energy for change. It is about the capacity and drive at whatever level to take action and make the difference necessary to achieve its goals and improvements. So it's a pretty fundamental thing.

What we identified through this work with York Health Economics Consortium and Landmark was a model for change that is built on understanding and aligning five different kinds of energy.

They are social energy, spiritual, psychological, physical and intellectual energy. What I would like to do now, just briefly, is to take you through the five kinds of energy. I think it's very helpful.

This is a bit busy, so don't worry about this slide. But I'm just going to talk you through it.

So the first kind of energy a social energy, and this is the kind of energy we get from b partnership and relationships. On these WebExs, we have fabulous social energy. When we have b social energy, we have (inaudible).

The second kind of energy is spiritual. This is energy that is b when you have got a group of people that have got a really b vision or picture of where we are trying to get to. We are moving towards that together.

Spiritual energy is really critical for change. Actually, where you have got b spiritual energy, people will move together towards that different future.

The third kind of energy is psychological energy. This is energy at an individual level. This is the kind of energy that enables me to have courage to innovate. Organisations or teams where people are able to innovate and take risks and do things differently tend to have very b psychological energy, and trust that their leaders and colleagues will support them in taking risks and failing and learning if necessary.

Physical energy is the energy for making things happen, implementation, action, getting things done.

And the final energy is intellectual energy. Intellectual energy is the energy of rational thought, planning, organising, thinking things through.

We have now got, in our team, over 2000 data points with colleagues in health and care. In health and care… The most data is in NHS England. What do you think, in the NHS in England, when it comes to change projects, which of these five energies is the most dominant? In change projects in the NHS in England, which of these is the most dominant?

Very good, yeah, you are getting it right. Most of you are getting it right. The most dominant energy is intellectual energy. So many of our change initiatives are focused on cost and quality. It is like, you know, "Here is our project that is going to take X million pounds out of the organisation and improve quality and safety, nd with a very b rational program management approach. Here are the people who are accountable, here are the other milestones. "

A lot of you are saying physical energy, and that is true as well.

Often it is a toxic mix of physical and intellectual energies together. It is like, here is our change program, and here is our b management, and here is accountability and you are accountable for delivering this so off you go. Actually, it's pretty problematic because what evidence shows is that you cannot create transformational change via intellectual energy on its own. The thing about intellectual energy is that it keeps us in our comfort zone. It doesn't change the world. It needs to be aligned with the other energies.

Another little question. Again, based on our 2000+ data points, which group is likely to have higher scores around spiritual energy? Just go back. Spiritual energy is here, commitment to a common future driven by shared values. Do you think clinicians or

non-clinicians are likely to have high spiritual energy scores? And the closer you get to the chief exec, do spiritual energy scores get higher or lower?

Everyone is getting this right. Generally, commissions have higher spiritual energy scores. Let's do the second question. The nearer we are to the chief executive we have higher or lower spiritual energy scores?

This is a bit more mixed. Actually, the higher you are to the chief executive, you tend to have higher energy scores.

We have got a whole methodology that we have built around his energy profiles. Again, out of the change model, we use spider diagrams. So what we will do here is to say, for a team, and particularly around a particular change initiative, how high are our scores on the different components?

We want to align the energies, make them all high, but what is an optimal energy profile?

I will show you an example. This is a pretty acute hospital cost and quality improvement project. Again, what you can see here is what we talked about before, that the intellectual and physical energy are high and the social and spiritual energy is low.

Now, psychological energy is interesting because where psychological energy is often depends on where these two are.

So this one is very planning-driven. There is a lot of action going on. But we haven't kind of built spiritual energy around the kind of future we want. It goes back to module two about being meaningful, about sense making.

[Rebecca.Uk.Captioner is Live]

We are not sense making enough and connecting it to a different future. We also don't have enough sense making relationships, which makes the psychological energy with low.

I would just see you another one. This one comes from a group of community nurses.

I think this one is really interesting. What you see here, the social energy is really high.

That is because this team is a mature team and they have worked with each other for a long time, they have b, trusting relationships and a lot of support. Because the social energy is so high, the psychological energy is high because of those

relationships.

However, we asked a question, "What's going on in terms of how decisions get made?"

What's happening is that high social energy and connectivity is filling a vacuum that is created because we haven't got a direction to move toward together.

There's lots of things we can do to work with this team around building a ber spiritual energy. One thing to say to you, think about where you are and where the energy is.

The thing about this, it's like a lot of things. What it does is it gives us a language to be able to talk about some of the intrinsic things in different ways. It enables us to have very, very different kinds of discussions.

We have got a whole load of materials that are free and available around energy for change. Again, these resources are there for you to use if this is a helpful model framework for you.

I really like this quote from the network. It says what it leadership about? It's not about making clever decisions and doing bigger deals. It is actually about helping people, helping to release the positive energy that exist naturally in people.

I think this is where we have to go. Looking at the challenges that we have in health and care over the next period, we've really got to be that positive energy and we got to be that in our workforce, in our patients and communities that we work with and our other partners.

I think there's never been a time in the history of health and healthcare when this advice has been more pertinent.

How can we build that positive energy? And can we use this language? Particularly building in most of our health and care settings, taking that spiritual energy and social energy and aligning them with that b intellectual energy.

We are coming to the last bit of our presentation and we're going to talk about shared purpose. It's really bly in the chat, the idea of shared purpose at the heart of our change activities.

When we introduced our change model, we had eight components. And we talk to lots of things retrospectively about what would you have done differently? The big thing that so many teams are to us, "We would have spent more time at the beginning focusing on building said purpose".

Because very often we are very b on intellectual and spiritual energy and we start rushing in to make change happen. Where, actually, if we focused on shared

purpose at the beginning of a change process it would have brought spiritual and social committee much more bly which would have given us a great platform of psychological energy, which would have given us the ideal starting point for effective change.

Let's just think about this a little bit.

I think it's very helpful, and another way of thinking about this is to think about what is our pledge to change? Are we thinking about complaints or are we thinking about commitment?

When we think about complaints, we say that this is the minimum performance standards of performance target that we want everyone to achieve. And how we coordinate and control is through the hierarchies, the performance management system, and standardisation.

The thing about complaints is that if we don't comply, there are consequences.

The potential threat of penalty and of sanctions, financial or otherwise, or the shame of being non-compliants create a momentum for delivery.

Let's contrast that with commitment. When we say this is a collective goal everyone can aspire to, whether we are a patient leader or a finance director or a partner organisation, this is our collective goal. How we coordinate and control is because we got this shared goal, shared value, and shared sense of purpose. And how we create energy for delivery, there's that energy word again, is the commitment to a common purpose.

Now, if we look at the history of large-scale change, there is really very little evidence of any organisational system that has been able to create and sustain large-scale change through compliance. It just doesn't work that way.

Instead, if we look at the history of big change, what we see time and time again is that those leaders who have been able to deliver big change have done so starting with commitments.

If we can build really b commitment to change, then compliance happens.

History tells us you cannot drive compliance through compliance.

If we start with commitment and shared purpose, it makes sense. It creates meaning and people are much more likely to comply.

In the healthcare system we need both. And in the health care system we need both. We will never have a world without compliance because we need high-quality care. But we need to start with commitment. And that is about how we build shared

purpose.

What we know, and evidence tells us, when we think about successful change programmes and initiatives, it is a common thread. It is the one thing that is always there.

Also what we know is that organisations can change initiatives where there is a really clear and b shared purpose. It creates a spiritual energy. They create social energy that creates the conditions for the psychological energy to do things do fully. They consistently perform without shared purpose.

So when we think about said purpose, I think it's very helpful to think about three words. Our. Shared. Purpose.

Who needs to be part of our shared purpose? Who's going to add to the benefits we are trying to achieve? Who's going to be affected? Who's going to make it happen? All those people need to be part of ours and need to be there from the start.

The second part is shared. Every one of us comes at it from a different perspective. There are different power structures, but these are the things that bring us together.

Finally, we have the purpose. This is the why. The why has changed, not the what and the how. Time and time again we look at large scale change projects, we get focused on how we are going to do it and forget the why.

It goes right back to the beginning of this seminar where we talked about the 10 principles of large-scale change and talking about continually needing a consistent narrative. That is continually refreshing and reinforcing why we are doing this.

This is probably my favourite saying about shared purpose. This comes from Seth (unknown term). He says shared purpose goes beyond way deeper than vision and mission.

It is inherently intrinsic. It goes right into your gut and taps at part of your primal self. I believe if you can make this absolute intrinsic connection, if you can bring people with similar primal purposes together and get them marching in the same direction, then amazing things can be achieved.

I'm going to give you an example of this. One of the studies I've really enjoyed and learnt a lot from in the past couple of years has Matching Michigan. Matching Michigan was an initiative that happened in England, because what happened was the state of Michigan in the USA had achieved really outstanding results around producing central line blood infections.

The idea of Matching Michigan was how can we in England get at least as good or better results that have been achieved in hospitals in Michigan in the USA? This was

a study. I got the link there to go and read the study, because it's a great report.

This is an ethnographic study around what happened in the places, the site in Matching Michigan. Surprise, surprise, it fits almost exactly with what we looked at in the beginning. Most places did not achieve their objectives of improvement and only a tiny, tiny number actually achieved and sustained the change.

What this paper is to me is a beautiful study in shared purpose. This is just some of the wording from the paper.

Perhaps the single most important influence on the response by individual units at the different places that took part in this, either in promoting existing chains with the shared purpose, the extent of consensus and coalition between particularly senior nursing staff on intensive care units that are trying to reduce blood infections.

They said the transforming or boosting of effort was most likely to occur when those locally charged with implementation were sincere in their beliefs about the value of the programme and its authenticity. They were able to create alliances across disciplines. Shared purpose. Had credibility amongst their peers. Were prepared to tolerate debate, but intrinsic and extrinsic exercise firmness, and used multiple active including persuasion, reminders and constant feedback.

It's a really b shared purpose and a combination of intrinsic and extrinsic.

The very small number of places that succeeded in aligning with the McKinsey data right at the beginning, one of the consultants especially said I think it's been successful because the unified programme which shared purpose. It's one of the few things we have done that has been a doctor thing or a nurses thing, it involved doctors and nursing together. Shared purpose.

When I think about shared purpose, certainly in the NHS, one of the things I see constantly and I think one of the biggest risks is that we end up replacing shared purpose with de facto purpose. What we mean by de facto or purpose is that what we as leaders, particularly organisation leaders, what we pay attention to sends signals to our colleagues about what is really important.

We can end up focusing on certain things that say, even if we don't intend to, to our colleagues that those things are replacing the shared purpose. Particularly de facto purposes are, "You've got to hit this performance target, you've got to reduce cost, you've got to eliminate waste, you've got to reduce variation, you've got to produce these activities within the timescale."

De facto purpose is toxic. We will never achieve our shared goals and we focus on that purpose. If they are explicit and not said, something else will become the de facto purpose in the minds of our workforce.

What I've got here, does anyone know what this is?

This comes from one of my Twitter friends, @SimonJ.

He is a system thinking genius. He invented this thing called the person participation monitor. Give you a few examples. This one comes from the police.

What happens is what goes into the purpose of participation monitor is a shared purpose. We have got a concerned citizen who wants their house to be (inaudible). It goes through the purpose (unknown term) monitor and what comes out at the other end is a de facto process. "We can only afford 4.3 burglars for the rest of the day or we will miss the production target."

Let's look at the example of this from health. We've got a concerned citizen who is very poorly and goes into the emergency room and says "Help me get better".

That is a shared purpose. To help that person back to health.

Instead what do we hear?

We can laugh about this, but it's happening constantly and it's stopping us from building the shared social energy we need to achieve radical change.

[Martin.Captioner is Live]

The last year of management was about extracting the most performance from people. The next is about most humanity we can inspire.

Now I would like to introduce Jenny. Can you hear me?

SPEAKER:
I can.

SPEAKER:
Jenny, we are thrilled to have you here to give us your case study. I will not steal your thunder. I will let you explain yourself and tell us your story.

SPEAKER:
Basically, I'm a midwife in a hospital, and I was concerned by the fact that women having cesarean birth were not being allowed to hold the baby. They were thrilled to see the baby only to see it was separated from them. So I started to challenge people to say that mothers should have the opportunity for skin to skin.
It was first writing on the whiteboard in theatre. I started to write in the theatre. This went on for about two months. Every day it was wiped off.

SPEAKER:

Explain skin to skin.

SPEAKER:
That means that when a child is born, it is given to its mother to be held in the prone position, which means maximum exposure to the mother's skin. It colonises the baby's skin with bacteria from the mother. It prevents low blood sugar and low temperature. It starts off the brain activity for the baby. It is really important. The hands of the baby are initiating the baby's brain. When the baby is attached to the mother, it is sending signals to switch the brain on and to make it more into a human being. That transition from being a foetus to being a person.

It is also important for the mother. Blood pressure and things like that are stabilised more. There is somebody in Australia doing research to show that skin to skin contact for people having caesareans reduces postpartum bleeding. Oxytocin makes us all feel happier.

SPEAKER:
So tell us about how you made it happen.

SPEAKER:
I wrote on the whiteboard and it kept being wiped off. One day I just had this mad thought - "I am going to write on this theatre wall." I managed to get a porter to get some ladders. I climbed up and wrote, in huge letters, "Is the baby in skin to skin contact?" I wanted that women to feel confident to ask. I said, "Go in, see it on the wall, ask for it."

There was a culture change. We have now got it on the World Health Organisation's boards. It's amazing. I had a few arguments and got into trouble for writing on the wall. It's just amazing. People come up to me in the corridor and say, "Jenny, we did skin to skin today." It still brings tears to my eyes. I cannot believe that it was not happening and now it is.

Women send emails to work. We are spreading the word through other trusts. It is all positive things for women and for babies.

SPEAKER:
Wonderful, Jenny. There is so much love for you in the chat box.

In terms of your tactics as a change agent, you had to do the rebellious act of writing on the wall. What else did you do to make change happen?

SPEAKER:
I let the women convey how they felt when they held the baby. When I was with them, they spoke out loud how they felt about it. So, their emotions spread to the people in theatre and they started to understand it was a very positive thing for that

woman.

One of the anaesthetists noticed that raised blood pressure settled down when the woman held the child. They saw it as well on a machine. Sometimes you look at machines and not at the person. Then I found people a theatre nurse who was overwhelmed by this and started to say, "Jenny, I have started to do it when you are not there."

It is not about me. It became about skin to skin. I wanted to depersonalise it from being about Jenny to being about the actual act of skin to skin. I think that helped me a lot, seeing the goal of that.

SPEAKER:
I get a real sense that you are building social and spiritual energy and you are working with intrinsic motivation. In terms of what you have heard in the web seminar today, what are some of the connections you make in terms of your story with some of the things we have been talking about today?

SPEAKER:
The things to connect with are that the process you are doing for somebody… If you are having an operation and you go into theatre, it's a process. The processes sometimes are dehumanised. We dehumanise procedures in hospital. In a theatre situation, there are a lot of people and just one person having an operation. Do we truly think about the human side of what we are doing everyday?

I know a lot of us on here do because we are radicals, but does the NHS think for every person that it is one person?

I always like to think, one birth at a time will make the change. One woman having skin to skin will make the change. We have to start somewhere. We had to begin somewhere. It is beginning and it is actually being rebellious. It is getting like-minded people with you and shrugging off criticism. It is like the penguins of Madagascar when they say, "Smile and wave, boys". That is me. I smile and wave off criticism. If people criticise me, I go, great, and smile and wave. I like to think positive things all the time.

SPEAKER:
What you have done I think is a wonderful case study in being a mobilising leader. You have been able to mobilise lots of people in a way that intrinsically makes people want to be part of this change.

There's a bigger case study here because of how this is spreading. We are going to run out of time, but one last thing to say, Jenny. Do you want to say how this is going and what is going on around skin to skin?

SPEAKER:

It has taken so much that I have got involved with Florence from Kingston, a senior consultant on #MatExp on Twitter. It is going global. People from Australia, Canada, all over the place, getting in touch on Twitter for advice on skin to skin contact. I'm going to talk to midwives, chief executives about why it is an absolute must that women… It's a basic human right that a woman holds a child. If we look at the spiritual factor in that, we look at it in everything we do at work to do with patients. I think we will get there.

SPEAKER:
Wonderful. Jenny, can you put all the contact details… I think lots of people want to get in touch with you. The hashtags… I think lots of people will want to contact you. If you can put your contact details in the chatbox, that would be fantastic. What a great way to nearly end our module today. Our focus is on making things happen and you are making important things happen. So, congratulations.

SPEAKER:
Thank you.

SPEAKER:
Brilliant. We are nearly out of time. I just want to ask quickly Dominic and Kate to give us a really quick burst of what has happened on Twitter. Then we are going to hand over to Pip for our learning reflection.

SPEAKER:
Quickly, it's nice to see… I can go through the comments. It is nice to see the camaraderie and seeing people interact with each other today. Some of the jokes and the seriousness and inspirational Jenny telling her story and how fantastic it is and the emotional connection made. It is important to see there are people out there trying to deliver this change.

SPEAKER:
There has been a lot of love on Twitter today. People have really related to this subject and talks about the change model and how they can take that back to their own workplace. They have also talked about motivation and how we could involve patients more in our healthcare change. That's really important, to do that.

Jenny has been the star of the Twitter chat as well. Lots of people just love Jenny's stories and see her as a real rebel and the passion and emotion she put into the story has really come out.

SPEAKER:
Now I will give responsibility to Pip to take us through the final learning points.

SPEAKER:
Thank you, Helen and hello, everybody. It has been a great session this morning. We hope you will continue to use your energy to think about the model and reflect on

what you heard and what you have learned. Please do join us next Wednesday, 25 February, between 4-5, GMT. Next Friday will be module five.

Now you can start the process of becoming a change agent. If you want to get one of these lovely badges which you can see in the corner of the slide, it is not to onerous a process but by telling us about the changes you have made, you can get a certificate.

That is definitely something to think about.

This week's pause for action. We want you to use those intrinsic and extrinsic motivators in your own work. Think about how you can ignite energy for change in everybody involved in your project and how you are going to build commitment to shared purpose.

So, small but really important things to consider.

Finally a few questions for you to reflect on. How are you going to make the most of those intrinsic and extrinsic aspects of change?

How are you going to build energy for the long haul?

How are you going to ensure a shared purpose throughout the change process?

And what can you do tomorrow to accelerate change?

Think about even the smallest things you could do tomorrow.

So, thanks very much, everybody, I hope you have a good weekend back over to Helen now.

SPEAKER:
Thank you, Pip. Next week is our last module! Gosh, that has gone quickly. Next week we are going to think about leading from the edge and where we go from here.

Really appreciate the contribution and the real sense of community that we have. I think this is such a special experience for health and care radicals. I like to thank all the team for great input today and particularly to Jenny. What a great case study.

Wish you all a wonderful weekend and a great week of rebellion. Hopefully see you on the Twitter chat on Wednesday and virtually for our final module, "Leading on the edge", next Friday. So, goodbye, all.

SPEAKER:
Thank you very much, ladies and gentlemen. You may now disconnect. Thank you.