

Part 1

Leading large scale change: A practical guide

What the NHS Academy for Large Scale Change learnt
and how you can apply these principles within your own
health and healthcare setting

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On behalf of the
NHS Academy for Large Scale Change



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Foreword: having a map for change

I want to introduce you to the NHS Academy for Large Scale Change through a story that I learnt from Karl Weick¹. This story is a parable of some of the principles at the heart of the Academy. It concerns a Hungarian military detachment that was sent out on a reconnaissance mission in the Alps during World War Two. Unexpectedly, there was heavy snowfall on the mountain; the soldiers got lost and found themselves in a hopeless situation. They expected to die. Then suddenly despair turned to hope because one of the soldiers found a map of the mountains in his pocket. The map created a sense of calm amongst the group. The soldiers set up camp and withstood the snowstorm. They used the map to work out their bearings and walked down from the mountain. As a result of the map, they were all saved. On their return, a closer inspection was made of the map. The soldiers were astonished to find that it was not a map of the Alps but of the Pyrenees.

The publication you are reading now also tells a story, that of the NHS Academy for Large Scale Change (the Academy). The Academy ran for 18 months, providing learning for 80 leaders from the English National Health Service and its partner organisations on how to lead and accelerate change across a large, complex system. Like the Hungarian soldiers, those who took part in the Academy were trying to accomplish a mission (large scale change) in very challenging external circumstances, within which they appeared to have little control.

The hypothesis underpinning the Academy was that, in order to achieve strategic goals, leaders need a grounded theory (or 'map') of large scale change. However, we are not talking about a prescriptive blueprint or programme plan. Rather it is an overall model or framework that enables emergent planning and design, as the change process unfolds and the consequences of actions become clear. This premise is supported by evidence from the wider literature on change which suggests that leaders who want wide scale and rapid change are more likely to be successful in their efforts if they work with an explicit model or theory of large scale change². Recent research on endeavours to simultaneously create a culture of patient safety across hospital systems in several countries concluded that one of the reasons that some of the anticipated results were not achieved was because ambitions for organisation-wide change were not sufficiently underpinned by an organisation-wide theory of large scale change³.

In line with the theme of the Hungarian military detachment story, there appears to be little evidence that, on its own, one theory or model of change is more effective than another one in a

healthcare context². Having a model of change built on 'Lean' is no more guaranteed to deliver the outcomes we seek than say, a total quality management or improvement science approach. What seems to matter is that leaders identify or create a model, commit to it and stick with it, for long enough for the change to make a difference across the organisation or system⁴. Just 'having the map' makes a difference but it is the actions that we take to enable and execute change, following our roadmap, that matter most. So, if we can create a theory of change that is based on best evidence of how change REALLY happens in systems and can adapt it and deliver it within our own healthcare context, we enhance our potential for large scale results.

Up until now, we, as NHS change leaders, have tended to use two major sources of knowledge to inform our activities for improvement at scale:

The healthcare improvement literature
which shows us how to improve the quality and safety of front line clinical services



The organisational change literature
which provides evidence from large organisations and corporations that have undergone transformational change programmes.

Both of these sources provide important knowledge and inspiration. But, on their own, these sources are insufficient to support large scale change in healthcare. There is strong evidence for the methods and approaches that work at the level of care delivery (i.e. 'care bundles' for people with diabetes or ventilator care in critical care units). However, the bigger the arena of change and the more complex the system dynamics, the less clear the business case for large scale change utilising these methods⁵. A plethora of front line initiatives for change does not necessarily add up to a transformed system.

Many published examples of transformation programmes from the corporate world suggest impressive outcomes in terms of enhanced company performance through radical redesign of

services and workflow. However, most of the published case studies focus on changes achieved within 'bounded' systems – groups of companies or organisations where the boundaries of change are sharply drawn, for instance, discrete business units or divisions or geographically bounded entities. In contrast, the health and social care context that we operate in is much less bounded. Where, for instance, do we draw the boundaries around the care processes for people with dementia and other complex care needs? We won't achieve our system level goals for health and healthcare improvement solely by focusing inwardly on NHS organisations with clear demarcation of responsibilities. Our change efforts cannot be confined within single organisations but have to span multiple organisational settings.

This publication breaks new ground. It builds on and takes the best from, existing approaches to front line clinical improvement and transformational models from the corporate world. For the first time it brings together an eclectic set of sources to offer a comprehensive review of the evidence, a powerful holistic theory for large scale change that you can adapt to your specific context and a comprehensive toolkit for action.

Like the Hungarian soldiers, Academy participants found that having the 'map' (the theory of large scale change) and using it to guide their actions, made them more confident, competent and effective in their ability to achieve their goals for change⁶.

These principles for large scale change are more relevant than ever in the current context of reform of the English National Health Service. I recommend that you read the postscript (Part 2) for more ideas on how to utilise the model and principles of large scale change in the current change setting.

I hope that you will find inspiration and ideas from the Academy and the learning of the courageous leaders who participated in it.

Helen Bevan

Helen Bevan

NHS Institute for Innovation and Improvement



Footnotes

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PART 2: THE POSTSCRIPT

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Achieving this vision of quality requires a radical transformation across the entire system. Change on this scale, in a system as large and complex as the NHS, has not been achieved before. Strategies and processes alone are not sufficient to drive the degree of change we are seeking... the NHS should focus on tackling the behaviours and cultures in the system that stand in the way of moving quality forward.

David Nicholson, Chief Executive of the NHS

1. Introduction

There is no learning without action and no sober and deliberate action without learning.

Reg Revans

The more we cling to past practices, the more we deepen the crisis and prevent solutions.

Margaret Wheatley

1.1 Guide to this publication

If you picked up *Leading Large Scale Change*, it is probably because you feel that the title sounds like a description of your day job!

Perhaps you have been asked to lead on one of your organisation's or health economy's quality and productivity improvement programmes, a clinical pathway redesign, service transformation or some similar challenge that you would immediately describe as 'large scale'.

If so, you are just the sort of person we had in mind when preparing this publication. As you will see, you have a lot in common with colleagues who took part in the NHS Academy for Large Scale Change (ALSC) and the various sub-national groups it spawned.

We have designed this guide to initially be read through from beginning to end and then referred back to over time as you lead a large scale change effort.

In Part 1, we will explain large scale change (LSC), describe a literature based model for it and illustrate some practical concepts, tools and methods that participants have found most helpful in their journeys. We will also challenge you to think about yourself as a leader, just as the participants in the ALSC discovered they needed to do.

In Part 2, as you turn this document over and read from the back, you will find a postscript that applies the principles of LSC to the current context of health and healthcare leaders. It distils the learning from the ALSC into five powerful messages for tackling current challenges in large scale change.

The approach to LSC in the NHS is continuously evolving, in the light of the quality, productivity and reform challenges now facing us. You should not expect to learn everything there is to know about LSC from a concise guide such as this one, which only provides one snapshot in time based on the experiences of an initial group of leaders. There are additional knowledge resources available from the NHS Institute for Innovation and Improvement. You can learn more at <http://www.institute.nhs.uk/academy>.

1.2 The NHS Academy for Large Scale Change

The NHS Academy for Large Scale Change (referred to in this document as ALSC or the Academy) was established in response to the need to equip leaders at all levels with world-class improvement and change skills in order to make large scale change a reality.

The hypothesis behind this work is that in order to achieve strategic goals, leaders need a grounded theory of large scale change to make them more confident, competent and effective.

The national Academy was based around a formal structure of six two day events, an extended four day summer event and a final one day concluding event, supported by coaching during the six to eight weeks between events. Rather than having a rigid, pre-determined curriculum, the Academy was designed to be responsive to whatever participants needed when they needed it. Over the lifespan of the national Academy, the focus shifted from external inputs by outside experts to participant input ('wisdom in the room'), involving panel discussions, peer reviews of participants' LSC initiatives and breakout sessions. The several local academies that were formed as the concepts spread have followed a similar structure of events with active project work and coaching in between.

In a formal evaluation of the national programme, coaching was acknowledged as one of the most powerful parts of the programme. Coaches not only had national and international experience of practically implementing large scale change but they were also very experienced personal coaches, with the skills and abilities to interact with a wide range of delegates and their NHS stakeholders. Several participants in the national Academy have gone on to serve as coaches in local programmes, spreading the application of LSC thinking further.

This publication captures the learning from the Academy, which is now grounded in over two years of great work by change leaders from across NHS England and its partner organisations.

2. What the literature tells us about large scale change: theory and models

At present, prevailing strategies [in healthcare] rely largely on outmoded theories of control and standardisation of work. More modern and much more effective, theories seek to harness the imagination and participation of the workforce in reinventing the system.

Don Berwick, Former CEO, Institute for Healthcare Improvement (USA)

This chapter provides an overview of the key insights we can gain from the literature on large scale change. Yet, it is practical in tone. It focuses on a set of principles and a model that are potentially most useful for leaders of large scale change.

- ▶ We begin by asking you to think about whether or not the change for which you are accountable is truly large scale. To do this, we'll compare your understanding of what you need to do against three descriptions of LSC from the literature.
- ▶ We then describe the wide range of literature that is available and how we applied it to that which is most relevant to LSC in the NHS.
- ▶ This leads us to identify ten common themes or key principles in the literature which will challenge your mindset about what it takes to be successful in leading LSC. These are summarised in a working definition.
- ▶ Next, we present a high level model of the typical flow of events in an LSC effort and the likely outcomes that might result.
- ▶ We end this section with more practical thoughts about how you might use the model and how others have adapted it for various settings.

2.1 Three ways to describe 'large scale change'

You will know about traditional service improvement methods and their application in health and social services¹. These methods support incremental improvement and they have an important place in large scale change (LSC) as we shall see. But, LSC is something more.

Below are three ways of thinking about LSC. As you read these, think about what you are trying to do and determine if you have a challenge that requires LSC thinking in addition to what you already know about service improvement.

1. The village and river metaphor. Kurt Lewin² described the difference between 'incremental' and 'transformational' change (i.e. LSC).

Imagine a river flowing through the village where you were born. The river constantly changes in many small ways – higher or lower, muddier or clearer and so on. But while it changes a bit every day, it remains recognisable as the river that flows through your village.

Now, imagine that village leaders change the course of the river, re-routing it around the village and paving over its old course for a new shopping street. That would be transformational change. If you left the village at an early age and now return years later, everything would seem very different. Transformational, or large-scale, change changes everything. An NHS service user who had not had a need for care for many years but was accessing it after someone had led an LSC effort might say, "this is not like it was before at all!"

While someone returning years later to the village might experience the transformation suddenly, those living in the village would have experienced it as incremental on a daily basis – some digging here, concrete poured there, many workers doing seemingly unconnected tasks. But, there was a 'big picture' vision guiding it that remained fairly constant over time. The vision may be modified along the way as unexpected issues arise but in LSC a constancy of purpose ties the incremental effort together to create something wonderful in the end.

2. The complex systems lens. LSC in complex systems, such as the NHS, requires integrated changes in structures, processes and patterns (of behaviour and outcome)³. You can learn more about structure, process and pattern (SPP) thinking in section 3.3 later in this publication. LSC is not what we so often attempt to do in change efforts:

- we concentrate on changing structures without really changing processes or behaviour patterns
- we change care processes and pathways that are then not supported by changes in structures and behaviours
- we attempt to alter behaviours without really addressing structures and processes; for example, through targets, exhortations, or training alone.

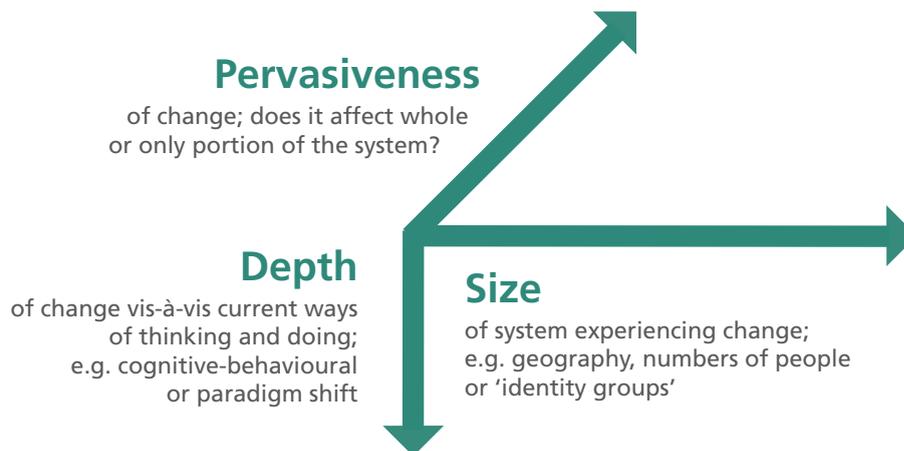
3. Three dimensions of LSC. Large scale change is change that is:

- widely spread across geographical boundaries, multiple organisations, or multiple distinctive groupings (e.g. doctors, nurses, managers, social care workers)
- deeply challenging to current mental models and ways of thinking (it feels uncomfortable and evokes some push-back from others because it is so different from the usual)
- broadly impacting on what people do in their lives or time at work and requiring co-ordinated change in multiple systems.

2.1 Three ways to describe 'large scale change'

The further along these three axes you are, the more large scale is the change.⁴

Figure 1: Dimensions of change



An example of something not so large scale is a change involving how nurses in one hospital document medications when they conduct rounds during the first half hour of their working shift. It is not a very deep change in thinking, it is happening in only one hospital and it is something that can be focused upon by the nurses alone for a small portion of their time on duty.

In contrast, efforts further along the continuum of LSC would include things like the projects of the NHS London Academy Team members to reconfigure major trauma services and transform the way that primary care is provided or the efforts of a participant on NHS East Midlands' Academy Team regarding the implementation of personalised care plans for people with long-term conditions across that region. Such efforts impact a large number of people, require pervasive change and challenge current mental models. The transformation of mental health services in the UK over the past few decades and the shift in attitudes towards smoking, both of which have led to profound behaviour changes, are further examples of LSCs.

So, is your challenge a large scale change effort...?

- Do you have a vision for change that would make someone who fell asleep today and woke up five years from now remark, "this is very different!"?
- Do you need to bring about co-ordinated changes in structures, processes and patterns of behaviour in order to make your LSC sustainable?
- Where does your effort fit on the three dimensions? What would be an even further stretch you could take in each of the three dimensions?

Footnotes

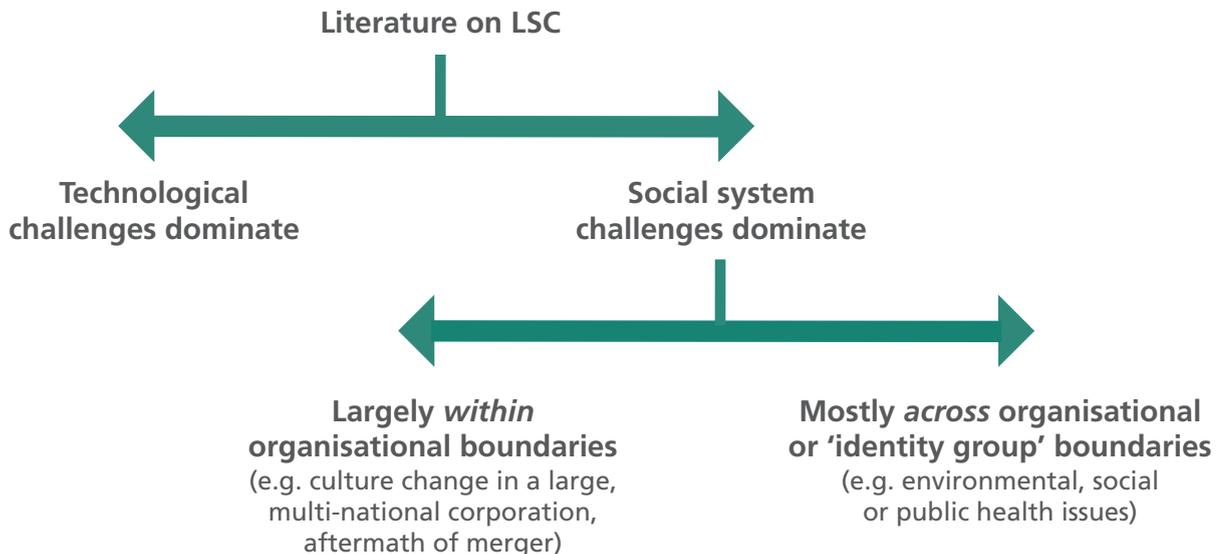
1. The NHS Institute provides an extensive array of educational materials on traditional service improvement efforts. See, for example, *The Improvement Leader's Guides* and other resources. Available at: www.institute.nhs.uk/building_capability.
2. Lewin K (1947). 'Frontiers in group dynamics'. *Human Relations*, 1:5-41.
3. Plsek PE, Greenhalgh T (2001). 'The challenge of complexity in healthcare'. *BMJ*, 323:625-8.
4. Mohrman A *et al* (1989). *Large-Scale Organizational Change*. Jossey-Bass.
Levy A (1986). 'Second-order planned change: definitions and conceptualizations'. *Org. Dynamics*, 15:5-20.

2.2 The evidence base for large scale change

Large scale change has been studied in the fields of organisational change, engineering, management, leadership and social science. We now know a great deal about how it comes about¹. Furthermore, we can distinguish between major branches of thought in the literature about LSC (Figure 2). These are continuums, not sharp distinctions.

The first continuum involves the degree of technological versus human, or social, challenge in the change process. At one end of the scale are studies from the field of engineering involving the technical challenges associated with large projects such as designing the IT systems used for currency exchange in international financial markets. At the other end are studies of LSC in social systems involving issues such as the women's movement or anti-smoking campaigns in which technology is hardly involved, other than for mass communications.

Figure 2: Continuums of change



A thinking trap to avoid in your LSC effort... When it is primarily a matter of implementing technological change, LSC is a somewhat simpler process than when the change requires high levels of engagement of people and social systems. In an IT or telecommunications system, software that transforms functionality can be designed and tested by a small team of experts and then spread rapidly, on a vast scale with the push of a button. Wouldn't it be nice if we had robot doctors, nurses, managers and so on in the health service, with cables connected to their heads through which the latest 'best practice' could be downloaded at night, so that transformation could occur at the start of the new day? It would be nice if you were the one pushing the button but none of us would want to be the one with the cables stuck into our heads! However, when you come to think of it, aren't many change efforts designed with this mechanistic model of change in mind? A small team of experts who work behind closed doors to design the 'right' way and then seek (often futilely) to get others to just do it. It doesn't work very well.

The focus of the research supporting the NHS Academy for Large Scale Change was on areas where social systems or people-related challenges dominate.

2.2 The evidence base for large scale change

Within this literature there is a second continuum which has to do with the boundaries of the system that is undergoing LSC. In organisational development, management, strategy and leadership literature from the private sector, LSC is often described as deep, strategic, operational and cultural change within a large, globalised firm. In a healthcare context, the evidence typically relates to a discrete healthcare system such as the US Veterans Administration, or a multi-site hospital system. In these organisations the change is large scale but it takes place within a system, around the boundaries of which you can draw a clear line.

In contrast, literature on LSC in public and voluntary sector organisations and in other fields such as education, political science, ecology and social movements, looks at LSC with a much more open systems view. Other institutions and organisations and society as a whole, are more explicitly considered to be in the system that is changing. We cannot draw a clear boundary around the system we are changing. Partnership² working across boundaries is essential and the actions and behaviours of all parties are considered to be just as much an integral part of the LSC process as those of any specific organisations that might be the instigators of the change (e.g. healthcare providers, schools or government agencies).

We have favoured literature describing LSC across organisational or group boundaries in our development of the models and tools. The need for cross-boundary, partnership working has never been more important.

Notes, queries and suggestions...

1. For a sample of the kinds of literature reviewed see:

- From the field of education policy: Wheatley MJ, Frieze D. (2007) How large scale change really happens: Working with emergence. *The School Administrator*, Spring 2007. Downloadable at www.margaretwheatley.com/articles/largescalechange The section entitled 'Working with emergence to foster change' describes an approach to large scale change.
- From the organisational development and leadership field: Keller S, Aiken C. (2008) The inconvenient truth about change management: Why it isn't working and what to do about it. *McKinsey Quarterly*. Describes both successful and failed large scale change efforts across a variety of settings.
- From environmental studies and the complexity and systems thinking literature: Gunderson LH, Holling CS (eds.) (2002) *Panarchy: Understanding Transformations in Human and Natural Systems*. Washington DC. Island Press. Features papers and case study examples from some of the leading names in the emerging study of 'panarchies'; the interaction and change process in systems embedded within larger systems.
- From healthcare: Oldham J. (2009) Achieving large scale change in healthcare. *JAMA* 301(9):965-966.
- From social movement thinking: Ganz M (2010) Leading Change: Leadership, Organisation and Social Movements in *Handbook of Leadership Theory and Practice*, Nohria N and Khurana R (eds), Chapter 19, HBS Press. Describes a model of organising leadership for change at scale.
- From the field of government policy: Best A, Saul J, Carroll S, Bitz J, Higgins C, Greenhalgh T, Lewis S, Bryan S, Mitton C. (2010) *A Systematic Realist Review and Evidence Synthesis of the Role of Government Policy in Coordinating Large System Transformation*. Vancouver Coastal Health Research Institute. Identifies how governments can put in place the contextual and enabling factors for large system transformation.

2. Partnership: A relationship in which we are jointly committed to the success of whatever endeavour, process or project we are engaged in. Barry Oshry.

2.3 Common themes in the literature on large scale change in social systems

The literature paints a fairly consistent picture of the key principles of large scale change, regardless of topic or social system setting.

Check your current thinking against the concepts below as you consider how you will approach your LSC effort.

The ten key principles of large scale change are -

1. Movement towards a new vision that is better and fundamentally different from the status quo. LSC is fuelled by the passion that comes from the fundamental belief that there is something very different and better that is worth striving for.

What is the attractive future for service users, members of the public and staff that you are offering in your LSC effort? Can you articulate it powerfully and succinctly? (Framing and transformational storytelling are two helpful methods that we will discuss later. Sections 3.7 and 3.8)

2. Identification and communication of key themes that people can relate to and that will make a big difference. The vision is 'out there' and 'in the future'. Typically, if it is truly LSC it will seem so distant and so in contrast with the current reality that it may feel overwhelming or impossible. In order for people to get engaged they have to see what they can do, now or soon, that would be a clear and meaningful step along the journey.

How will you explain the overall effort in more manageable 'chunks' that others can envision themselves participating in? How will you ensure that all this effort fits together in the end? (30/60/90 day cycles and driver diagrams help with this and we will tell you more about them. Sections 3.4 and 3.2)

3. Multiples of things ('lots of lots'). Expect LSC to be complex with many different stakeholders, agendas (both hidden and open), points of view, needs and wants, details, systems that need change and so on. The expression 'lots of lots' captures it. Attempts to isolate or work around some groups, or to ring fence some parts of the system to be left alone while others must change, typically result in something less than LSC.

Do you plan to embrace and navigate through the complexity of the systems you are trying to change or do you hope that you can 'just keep it simple' or 'divide and conquer'? Does complexity energise you or do you want to run from it? (Systems and stakeholders analysis, driver diagrams and 30/60/90 day cycles methods will help. Sections 3.5, 3.2 and 3.4.)

4. Framing the issues in ways that engage and mobilise the imagination, energy and will of a large number of diverse stakeholders in order to create a shift in the balance of power and distribute leadership. Because there are 'lots of lots', a small band of leaders cannot possibly make the LSC happen. Tight, centralised planning and control actually works against LSC. Instead, multiple leaders from across the system and at all levels, drawn to the vision, must engage and commit their will and energy to the effort of achieving LSC. As more distributed leadership emerges and is enabled across the system, cross boundary and partnership working increases and change happens at a massive scale and pace. But the key lies in gaining the commitment of others to act, not merely their compliance in doing what you tell them to do. Experience shows that change based on compliance without commitment is difficult to sustain over time.

How will you let go of some control, inspire commitment in others to lead, facilitate partnership working and create the supporting infrastructure that will enable change at the scale and pace required? (Concepts and tools from social movement thinking and emerging leadership sciences can help. We will say more about framing in the Tools chapter and describe the key differences between commitment and compliance in the chapter on Leadership for LSC. Sections 3.11, 3.7 and 4.4.)

5. Mutually reinforcing change across multiple processes/subsystems. If the vision is sufficiently clear and the collection of key themes comprehensive enough, what may seem at first like a chaotic lack of control actually comes together in the form of changes that connect with and build upon, one another.

What are all the processes and systems that need to change in some integrated way in order for you to achieve sustainable LSC? (The driver diagram tool we will share with you is one way to keep all this in mind. (Section 3.2))

6. Continually refreshing the story and attracting new, active supporters. While LSC efforts often start small, with just a few people who are switched on by the vision, the life blood of LSC is the continual stream of new supporters who become attracted to the vision when they see it progressing. Without a steady stream of new supporters becoming committed to the change, LSC efforts can plateau or run out of energy.

What is your experience with initial success in a service improvement effort? Are you typically able to capitalise on it and draw others in who were previously neutral, or do you sometimes experience frustration when others don't 'get it'? (Reframing, measurement and storytelling are tools that help leaders attract new interest. (Sections 3.7, 3.10 and 3.8))

7. Emergent planning and design, based on monitoring progress and adapting as you go.

Because of the complexity and uncertainty involved, LSC outcomes are impossible to predict at a detailed level. Flexibility, adaptability and engagement of others are the keys. It is OK to have detailed plans and milestones — and, indeed, you may be required by others to have these — just don't spend too much time on them before you start actually doing something and don't be surprised if every detail does not work out as planned.

How will you do sufficient planning and milestone setting to satisfy your accountabilities yet remain flexible enough to adapt as you go along? (30/60/90 day cycles and the concept of going 'two steps down in your thinking' will help you achieve a good balance between planning and doing. (Section 3.4))

8. Many people contribute to the leadership of change, beyond organisational boundaries.

As LSC efforts spread and become increasingly complex, more and more leaders need to be recruited for the change effort. Leadership of the LSC effort is not dependent on a small number of key individuals in a hierarchy. This is 'distributed leadership'; a variety of different sources of leadership expertise move into play and are spread around the system. Leaders pool their effort and expertise so that the collective result is significantly greater than the outcomes of individual leadership actions¹.

What are your plans for distributed leadership for your LSC efforts? Think about how you will role model shared leadership for your LSC and the leadership mindsets and behaviours needed to work in this different way. The pool of leadership talent that you need for LSC may not be just the 'usual suspects'. Think widely and diversely about who these leaders might be.

9. Transforming mindsets, leading to inherently sustainable change. According to the literature, when LSC is done well, sustainability is the natural by product. If people have really become engaged and believe that the vision is more desirable than the status quo (and you have addressed multiple structures, processes and patterns) they will be committed to and will fight to keep the new way, showing little interest in going back to the old. However, if powerful leaders have simply demanded compliance and not brought others along in the thinking, those on the frontline will put things back to the old way. The way they still believe was 'right'.

How will you truly transform mindsets as you go along in your LSC effort? (The U-model in the leadership chapter and From-To tables will help you think more clearly about this. (Section 4.5))

10. Maintaining and refreshing the leaders' energy over the long haul. The case study literature on LSC makes it clear that large scale change can take some time to unfold completely. Too many leaders simply run out of steam.

How will you maintain your energy and drive for as long as it might take to achieve the vision for LSC? (We will talk more about this in the leadership chapter. Section 4.9.)

A working definition of large scale change.

Common themes from the LSC literature lead to a practical definition...

Large scale change (LSC) is the emergent process of mobilising a large collection of individuals, groups and organisations toward a vision of a fundamentally new future state, by means of:

- high-leverage key themes
- a shift in power and a more distributed leadership
- massive and active engagement of stakeholders
- mutually reinforcing changes in multiple systems and processes.

Done properly, this leads to such deep changes in attitudes, beliefs and behaviours that sustainability becomes largely inherent.

The common themes and working definition above describe large scale change overall and give leaders a list of things to check their thinking against as they proceed. Leaders must understand their context and adapt these general principles to fit their situation. Every LSC will be its own unique journey.

Personal reflection

Pause for a moment to reflect on the themes and definition above and relate them to your experience as a health or social care leader. Which of these do we seem to do naturally and which do we tend to do not so well? Which themes naturally fit your strengths as a leader and which do you think may be a struggle for you?

Let's look now at how the journey of large scale change tends to unfold over time...

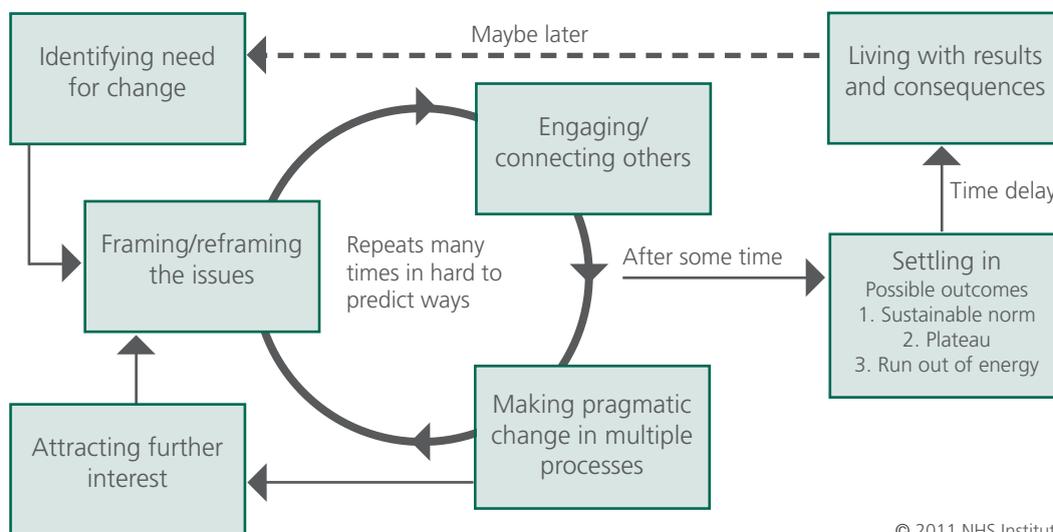
Footnotes

1. For detailed information on distributed leadership visit the website of the National College for Leadership of Schools and Children's Services. Available at: www.nationalcollege.org.uk/distributed-leadership.
Ancora D, Bresman H (2007). *X Teams: how to build teams that lead, innovate and succeed*, Harvard Business Review Press.

2.4 Emerging model of large scale change

Case study evidence from a variety of fields and settings describes a journey that, while unique in its detail, displays a remarkably similar pattern at a high level. This pattern is depicted in the graphic below and in the narrative description in the Appendix¹.

Figure 3: Emerging model of large scale change



As you read through this section, think about how your LSC journey might unfold and what you can do to lead and facilitate it.

Identifying the need for change. Large scale change in a social systems context like the NHS begins when there is a sufficiently well defined topic and a vision of something that is better than the status quo. LSC does not happen in general, it happens specifically, topic by topic. (Section 3.1)

2.4 Emerging model of large scale change

LSC topics that were addressed by members of the Academy included: personalised care plans for people with chronic diseases, implementation of a stroke pathway, dementia care, aligning services across primary and community care, patient safety, halting the rise in obesity and development and delivery of a clinical leadership strategy.

Framing and reframing the issues. The vision and need for change must be translated into key themes that people can make sense of and that they will feel passionate about. This, coupled with a sufficient mix of pressure, incentive, will, consequences, receptivity, connection to values and so on will get the attention of others. The literature is clear that intellectual appeals alone are not sufficient. Change requires emotional energy as well. The larger the change, the more energy is required. Furthermore, not everyone thinks alike. And so, even an intellectual appeal must be framed along a variety of lines if we need the commitment of multiple stakeholders. Getting the appeal for change right is critical to success. (Sections 3.7 and 3.8)

Engaging and connecting with others. The initial framing of the vision, key themes and need for change does not necessarily have to capture the imagination of everyone. Indeed, we cannot identify a case study of true LSC where all stakeholders were completely 'bought-in' before anything was done. Rather, the initial framing need only appeal to a small group of people, large enough to do something around one or more of the key themes to get the momentum going. These individuals might be at any level in the system and can be a coalition from across organisational, group or system boundaries. (Sections 3.5, 3.6, 3.8 and 4.6)

Making pragmatic changes in multiple processes. The key is that these people find some way to exert influence over some of the relevant and multiple processes and subsystems, e.g. service delivery, hand over processes, clinical decision making, finance flow, workforce planning, public opinion, policy, etc. to make pragmatic changes in a sufficiently effective and visible way. (Sections 3.3 and 3.4)

This pattern of framing/reframing, engaging and connecting others and making pragmatic changes in multiple processes and subsystems repeats many times and in hard to predict ways.

Contrast the description above of how true LSC tends to unfold with some far too common practices of change leadership in healthcare systems. The case for change is often made once and for all in a single document or PowerPoint slide set. We then attempt to get 'buy in' from all stakeholders to proceed, believing we can roll out a few focused changes and hope that everything else will adjust to make it work and keep it sustained.

Attracting further interest. The cycle described thus far only brings about limited change; it is just the start. The key to success lies in using the limited success of each such cycle to attract the interest of other people who were previously neutral. They then join actively in the change process and create yet another cycle of framing/reframing, engaging and connecting others and initiating pragmatic changes in multiple processes and subsystems. In the early stages of LSC, this momentum can be created by just the appearance of success (e.g. suggestive measurements, stories, celebrations) if this is communicated widely and effectively enough. Of course, as time goes by, more than just the appearance of success is needed. Healthcare staff quickly tire of propaganda that they know has no real substance behind it in terms of real patient care and process outcomes. (Section 3.10 and 4.6)

2.4 Emerging model of large scale change

Settling in. The momentum and multiple cycles of change continue for some time until (with the most frequently occurring result appearing last):

- a. the change becomes a reasonably well established norm across a social system and multiple processes and systems have changed or adapted to accommodate or support it in a sustainable way. This is, obviously, the hoped for outcome but the literature suggests that it is actually the least often occurring².
- b. the change hits a plateau at some level and is no longer attracting new supporters. At this point people tend to separate into those who believe they 'get it' and others who these people think 'simply do not get it'. The ones who think they 'get it' can become cynical and separated, thereby effectively preventing further attraction of others and sealing the change at the plateau. A new round of LSC and renewed interest might come later; perhaps with new players, which can further embitter the old players.
- c. the effort effectively 'runs out of energy' for some reason (e.g., lack of engagement, lack of resources, attention diverted elsewhere, political change etc.) and simply fades away. (Sections 5.1 and 5.2)

Living with results and consequences. The full, measured results and unintended consequences of true LSC are often not known until sometime in the future. By that time, things have typically already sorted themselves into the three categories previously mentioned. Therefore, while data is helpful and essential throughout most of the process of LSC, a certain amount of faith, courage, intuition, judgement and proceeding forward on incomplete evidence is inevitable. Hindsight is always 20/20, insight and foresight rarely are. (Section 4.9)

Future LSCs may be required to build further on what has been accomplished, or to undo the damage but there is no way to know in advance. Inordinate worry about change paralyzes action, sustains the status quo and is sometimes used to justify inaction.

If your learning style favours learning from examples you may want to skip ahead at this point to the case study (Section 6) for more insight into the model. But if you do skip ahead, return to this point for the personal reflection exercise below in order to embed your learning.

Personal reflection

Think back on your past experiences, both good and bad, of change that is large scale and compare these experiences to the high level model described here. What are the lessons you have learned about how to accomplish, or fail to accomplish, large scale change? How are these insights related to the theory and model of large scale change we have just reviewed?

Footnotes

1. A PowerPoint slide of the LSC model graphic, as well as the one-side narrative version of the model that is contained in the Appendix of this publication, is available on the NHS Institute's website www.institute.nhs.uk/academy. You will find these helpful aids in working with others on LSC.
2. For example, Professor John Kotter estimates from his experience that only about 15% of large scale change efforts actually achieve the goals that they set for themselves. See, for example: Kotter JP (1995). 'Leading change: why transformation efforts fail'. *Harvard Business Review*, 73(3):59-67.
Professor Chris Ham and his team at Birmingham University looked at the initial pilot schemes for the National Booked Admissions Programme (2002). They found that, after a year, only a third of the schemes had continued to make progress and spread. Another third had held the gains but had reached a plateau and a third had deteriorated or had been stopped.

2.5 Using the theory and model to think through your large scale change effort

The common themes, working definition and emerging model of LSC have served as useful thinking aids for the change leaders in the Academy and subsequent efforts. Key insights, drawn from 'wisdom in the room' interactive sessions at the Academy, that we can now offer to you as advice include -

- Learn to 'think backwards' in the cycle of change while you 'act going forward' in the model. That is, after you have your topic, vision and key themes, skip ahead in the model and imagine some pragmatic changes, which if successful, would attract attention. Work backwards and think next about who would need to be involved in doing these. Finally, think about how you will frame your case to get their attention and active engagement.
- You can start your thinking in the middle of the cycle as well. That is, you may have an already engaged group of people who want to do something. So, think about how you will frame the vision and need in such a way that what they end up deciding to do actually contributes positively to a key theme.
- Always be mindful of the potential to settle prematurely to an undesirable outcome (from among the three general outcomes presented in the model). For example, notice if you find yourself talking to the same people all the time and if the conversation is becoming one of 'us' and 'them'. You may no longer be framing things in ways that attract others and you may be heading for a plateau outcome. Also, be constantly aware of the need to nurture organisational interest and attract ongoing resources so you don't run out of energy even as the larger agenda of the NHS is changing. Reframing your topic in ways that keep it attached to the latest, larger agenda is not dishonest 'spin'. Rather, it is simply what a skilful leader of LSC must do in order to keep an effort going for long enough to be successful.
- Strive to identify and mitigate potential, unintended consequences. But, also strive to believe enough in the vision to steel yourself against others' fears of what might happen (e.g. bringing up worst case scenarios to block you). Inordinate fear of unintended consequences only results in maintaining the status quo.

The change leaders we have worked with have found the model to be a helpful guide for thinking. But it is not a substitute for thinking. Try something, reflect deeply on what happened and learn as you go.

2.6 Using the theory to develop your own model

Essentially, all models are wrong but some are useful.

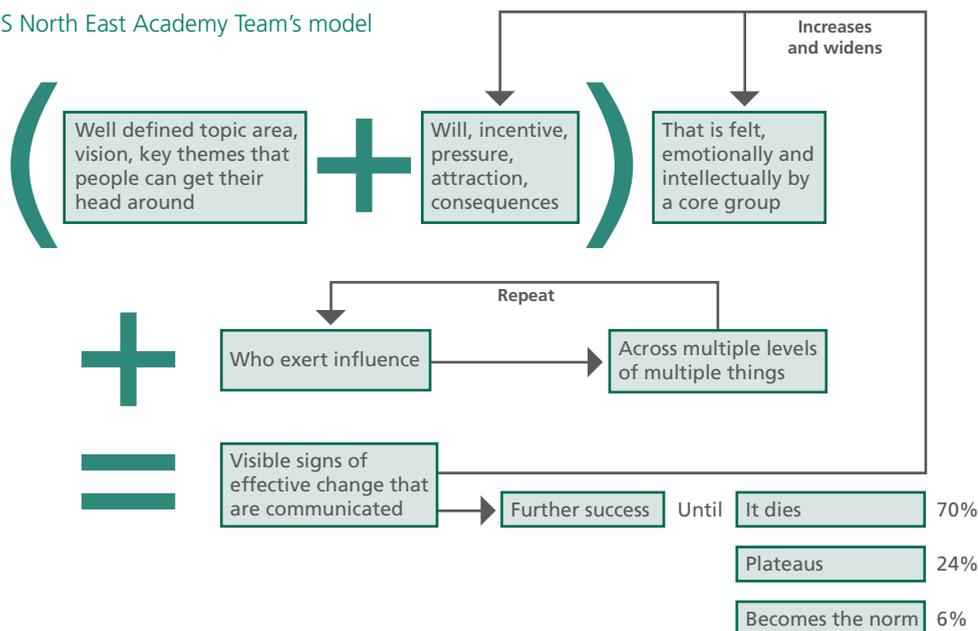
George E. P. Box

Statistician

The model presented in Section 2.4 is only one way of describing the very complex phenomenon that is LSC. Academy members adapted it and developed their own models for application at local, sub-national and national levels using terms, graphical depictions and emphases that were useful to them. We wholeheartedly support this.

Example at a local level: Ian Railton from the NHS North East Academy Team developed the model below to aid his thinking and planning for LSC in mental health services.

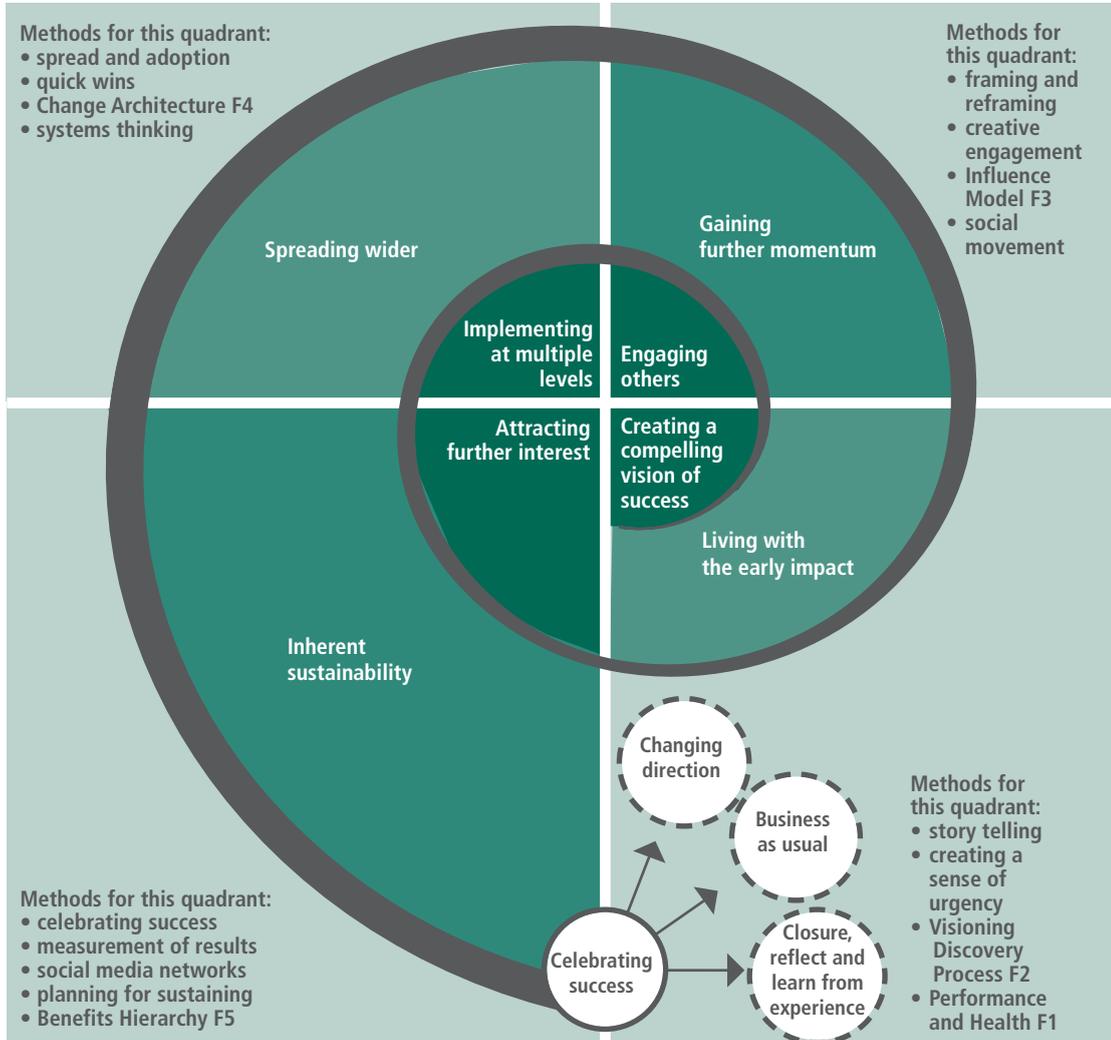
Figure 4: NHS North East Academy Team's model



2.6 Using the theory to develop your own model

Example at a sub-national level: The NHS West Midlands Academy Team and their coach Phil Davis developed this model (Figure 5). It has been used to guide a number of LSC projects across the West Midlands on a variety of topics.

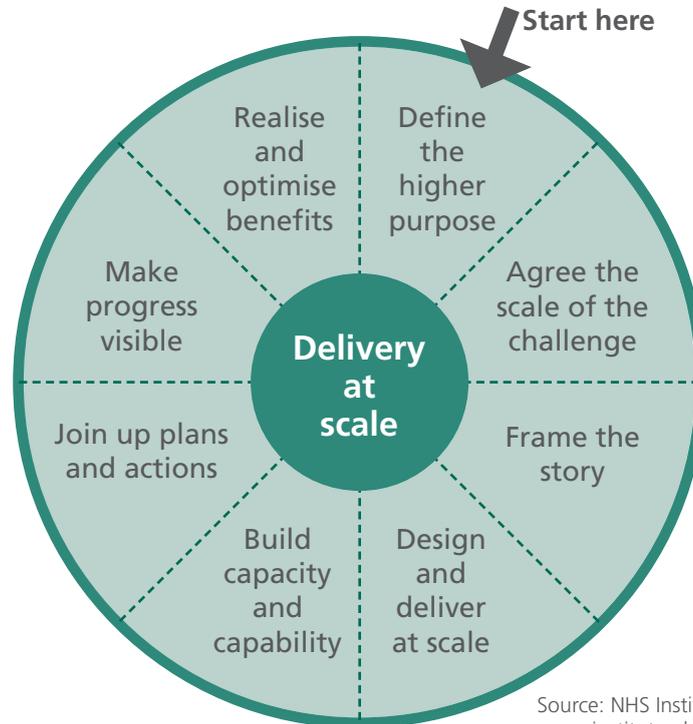
Figure 5: NHS West Midlands Academy Team's model



Example at a national level: The NHS Institute built on learning from the Academy to develop a model for delivering quality and cost improvement at scale (Figure 6).

Note how the theory of LSC is reflected in each of these models. In the end, it is the LSC mindset that is important, not any particular model.

Figure 6: A change model for delivering quality and cost improvement at scale



Source: NHS Institute 2011 available at: www.institute.nhs.uk/deliveringqualityandcostplans

We encourage you to develop your own understanding of LSC, your own way of describing it to others and your own model, consistent with the literature base and principles described previously.

For me, it starts with taking improvement methodology as the way we make change happen. What we should do is take all the discipline that we had in leading performance and in the best improvement work that we've done – clarity of outcome, relentless determination to finish, determination to create the capability and scale we need to make it happen – and link it to those things about engagement of people, raising of people's aspirations, passion and driving off the back of innovation. These are not incompatible opposites. They are the features of all the best change and improvement that you'll see in organisations around the world. They need to be built in at the heart of what we need to create together.

David Nicholson, Chief Executive of the NHS

3. Change management tools for large scale change

This chapter describes ten change management tools that Academy participants found helpful in supporting their LSC efforts. Each is linked to the literature and the model for LSC. We provide examples and tips for use. The tools presented here are:

- planning questions for LSC
- driver diagrams
- structure, process and pattern thinking
- 30/60/90 day cycles of change (“going two steps down in your thinking”)
- systems and stakeholders analysis
- continuum of commitment analysis
- framing and reframing
- transformational storytelling (use of narrative)
- World Café
- measurement.

Finally, we describe a host of additional resources, many of which are from the traditional toolkit of process and service improvement. These should also be in your skills set and in that of others you engage in your LSC effort.

Additional thinking tools are described in the chapter of this publication that relates to Leadership of LSC (Section 4).

3.1 Tool: Planning questions for large scale change

Description

A list of powerful questions to guide both initial and ongoing planning for LSC efforts.

Planning questions for large scale change

1. What is your goal for change?
2. What would it look like if that change had come about?
3. What are the key themes that make sense to people and that they will feel passionate about?
4. What might make 'a sufficient mix' of reasons to engage?
5. What are the multiple processes and systems that need to change?
6. Have you considered the diversity of your stakeholders and how the change will affect all the members of your system?
7. Who are the small number of key stakeholders who, if properly engaged, could lead the various change efforts in these multiple processes and systems?
8. How might we frame the issues in order to engage each of these?

Link to theory of large scale change

These planning questions follow directly from several of the common themes from the literature and track the flow depicted in the emerging model for LSC. Several phrases in the questions are taken from the earlier section on theory (refer back to Section 2 to refresh your understanding as required).

3.1 Tool: Planning questions for large scale change

Link to other change management tools

- Measurement frameworks (Section 3.10) might provide a helpful stimulus to your thinking about your goals and vision in questions one and two. (Also see the section on the distinction between compliance goals and commitment goals in Section 4.4).
- Driver diagrams (Section 3.2) can be used to capture the answer to question three.
- Systems and stakeholder analysis (Section 3.5) will help address questions five and seven.
- Continuum of commitment analysis (Section 3.6) is also useful for question seven.
- Concepts from framing and reframing (Section 3.7) can help with questions four and eight.
- 30/60/90 day cycles (Section 3.4) will help you avoid being weighed down by planning.

Examples from the NHS Academy for Large Scale Change

Nearly every team in the Academy used these planning questions in some form to guide their thinking. Some used them in a structured way, while most used them intuitively as they reflected on the model for LSC.

Tips for use

- ▶ Work through these items with a group of leaders who will become the guiding coalition for your LSC effort.
- ▶ Review the theory chapter of this publication (Section 2) to refresh your thinking before addressing these planning questions .
- ▶ If you are making an initial plan, consider working through these items as your initial 30 day cycle. Have several one to three hour meetings of your planning group over the period of a month, using the time between meetings to reflect and gather more input.
- ▶ Remember that the literature tells us to be flexible and adaptable in our approach to planning for LSC. You cannot know everything that will happen and you need to be open to the idea of evolving your plans as you go along. Taking action will change the dynamics of the system and that may open up new opportunities that you had not seen before whilst closing down others. With this in mind:
 - limit your initial planning cycle (in the tip above we suggest 30 days) and then start doing something concrete
 - if there are disagreements in your team, capture several options and launch 30 day exploratory cycles to test the effectiveness and value of each. There is nothing wrong with doing several things in parallel. This is almost always a better option than long arguments in planning meetings over selecting the one 'best' thing to do
 - revisit these questions at least every 90 days or so to modify and update your plans as things emerge.
- ▶ Consider using all the associated change management tools listed above in conjunction with these planning questions as well as the insights from the leadership chapter of this guide. This is a good way to integrate your LSC work into a coherent whole.

3.2 Tool: Driver diagrams

Description

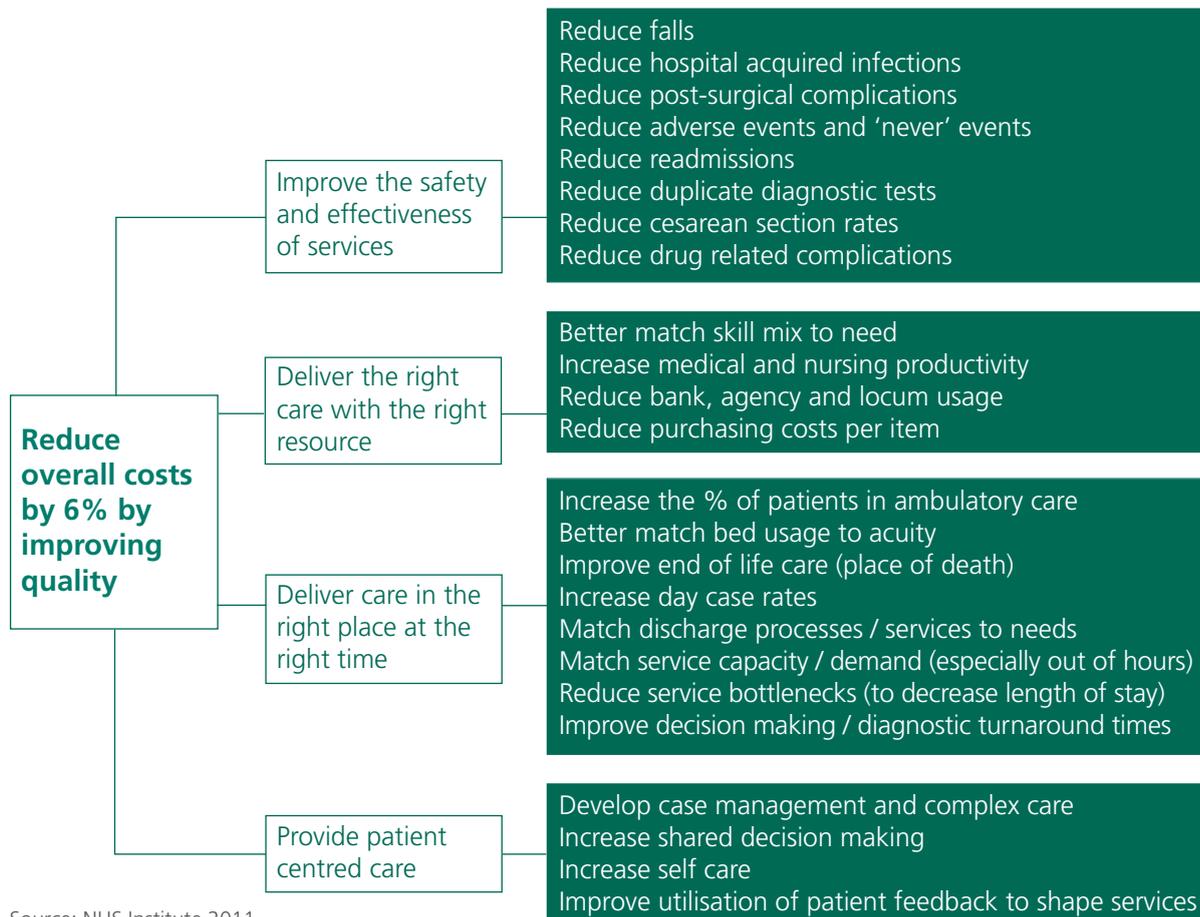
Driver diagrams are structured charts of three or more levels¹. A basic driver diagram would include:

1. a goal or vision
2. the high-level factors that you need to influence in order to achieve this goal (primary drivers)
3. specific projects and activities (typically done in 30/60/90 day cycles) that would act upon these factors.

For more complex goals the number of levels in a driver diagram can be expanded so that each primary driver has its own set of underpinning factors (i.e. secondary drivers). It is these secondary drivers that would then be linked to projects and activities.

Driver diagrams provide a 'theory of change' for our LSC efforts as they depict a logic model describing the link between a goal and the project activities that will be undertaken to deliver it. An example of a partial driver diagram is shown (Figure 7) for a hospital that has an LSC goal to 'reduce costs by 6% in the current year by improving quality'. The primary drivers set out our hypothesis of the factors that we should focus on in order to achieve our goals. In this case, they range from 'improve the safety and effectiveness of services' to 'provide patient centred care'. In each case these 'drivers' are stated as goals in their own right (using language like 'improve'). The secondary drivers then show the factors (or areas) that support the achievement of each primary driver, again expressed as goals (e.g. 'reduce falls'). The complete driver diagram would include the projects that underpin each of these secondary drivers (positioned on the far right of the diagram). For example, 'reduce falls' might be linked to a range of projects such as introducing a falls risk checklist or raising staff awareness about how to prevent falls. Using a driver diagram in this way creates a clear connection between LSC goals and specific actions to achieve them.

Figure 7: Example of a driver diagram



Source: NHS Institute 2011

Driver diagrams evolve over the life of a large scale change as leaders develop insight into the factors that contribute to their goal or vision. They can also support measurement of progress towards a vision or goal by expressing the drivers (where possible) in measurable terms (Section 3.10).

Link to theory of LSC

Driver diagrams explicitly describe the 'key themes that will make a big difference' and the 'mutually reinforcing changes in multiple areas' that the literature suggests are essential to LSC. They also help LSC leaders to see where 'commitment', 'distributed leadership' and 'mass movement' across diverse, multi-organisational efforts can contribute towards their overall goal.

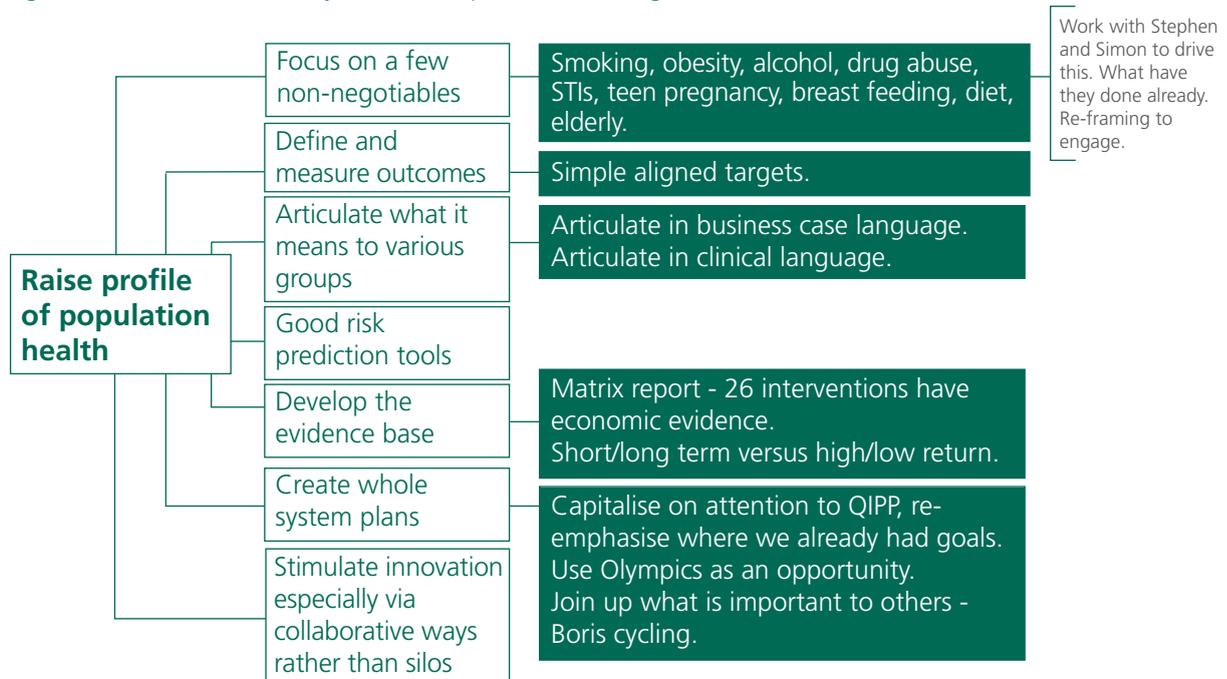
Link to other change management tools

- Use a driver diagram to capture discussion on question three in planning for LSC (Section 3.1).
- For sustainable LSC, a comprehensive driver diagram should capture the transformation required in structures, processes and patterns (Section 3.3).
- As driver diagrams are designed with measurable elements they also provide a mechanism for demonstrating progress and success (Section 3.10) which is part of a cycle of engagement (Section 3.4).

Examples from the NHS Academy for Large Scale Change

The NHS London Academy Team created this driver diagram (Figure 8) in its early planning for an LSC goal to 'raise the profile of population health'. The primary drivers were the result of a team brainstorm to identify the factors that would make a major contribution to this goal. The secondary drivers and beyond of the diagram captured early thoughts on activities and projects that could be initiated for several of these factors.

Figure 8: NHS London Academy Team's example of a driver diagram



The goal of one of the LSC projects undertaken by NHS Yorkshire and Humber Academy Team is a reduction in the rise in obesity. They captured their 'key themes that people can relate to' as a simple list that included: promoting five a day (fruit and vegetables), know what you are eating, access to weight management and surgery when indicated and so on.

You can find another example of a driver diagram in Section 6 in the case study section relating to the NHS North West Academy Team's alcohol reduction LSC effort.

Tips for use

- ▶ Driver diagrams are primarily for use by the small group of leaders overseeing an LSC effort. Their main uses are to maintain the 'big picture', stimulate discussion about what is significant and insignificant and enable co-ordination of diverse, small projects.
 - It is not necessary for everyone to be familiar with the driver diagram. Think carefully about how you use it in order to avoid overwhelming colleagues or appearing to be empire building.
- ▶ By deliberately using change orientated language (e.g. 'improve'), driver diagrams encourage groups to be explicit about what they intend to achieve. For each suggested driver ask the group:
 - are we clear what all the terms mean? (e.g. How do we define a 'fall'?)
 - do we know what level of performance we want to reach and by when?
- ▶ Review structure, process, pattern (SPP) thinking (Section 3.3) and keep these three aspects of a complex system in mind as you think about achieving your goal.
- ▶ Constructing a driver diagram provides an opportunity to check your plans with reference to equity. Make sure that you are thinking about, and engaging, the voices of everyone affected (public, people who use our services, carers and workforce). Driver diagrams allow you to succinctly describe your logic behind a programme of change and allow others to identify where they have a differing perspective.
- ▶ Use sticky notes, or other flexible means, to construct your diagram as part of a brainstorming effort. You can use drawing, flowcharting or spreadsheet software to capture the diagram. Keep it simple and constantly updateable.
- ▶ Keep in mind that people approach the process of creating driver diagrams in different ways. Some like to start from the overall goal and work their way methodically from the goal to the drivers and then to the projects (i.e. left to right). Others find it easier to think about the projects they believe are important and from there identify the drivers they support (i.e. work from right to left). In practice you will need to be flexible and accommodate both approaches.
- ▶ Review and update your driver diagram at least every 90 days.
- ▶ You can either keep completed activities on the diagram as a historical record of your LSC effort or continuously clear and update the secondary drivers and beyond so that the diagram is a snapshot of current and planned work only.

Footnotes

1. 'Driver diagrams' is another name for the classic 'tree diagrams' from operations research. For an overview of other such planning tools and how the Japanese introduced them into improvement science, see Plsek PE (1993). 'Management and planning tools of TQM'. *Quality Management in Healthcare*, 1(3):59-72.

The US-based Institute for Healthcare Improvement (IHI) has championed the use of driver diagrams in healthcare. Available at: www.ihl.org.

There is a section on driver diagrams on the NHS Institute's website in the Quality and Service Improvement Tools section, available at: www.institute.nhs.uk/qualitytools.

3.3 Tool: Structure, process and pattern (SPP) thinking

Description

Complex systems comprise structures, processes and patterns - SPP for short¹. If we want transformational change we must consider all three aspects.

- Much of the past change effort in the NHS has focused on structures.
- Service improvement work has been successful in focussing on processes to redesign the way care is delivered.
- But, to truly bring about fundamental change in complex systems, we also need to recognise the importance of patterns of mindset and behaviour.

Figure 9: Examples of structure, process and pattern (SSP)

Examples of SPP

- **Structures** include: organisations, policies, tariff schemes, regulations, guidance, recommendations, frameworks, roles, committees, physical space, equipment, resources, who reports to whom etc.
- **Processes** include: patient journeys, pathways, procedures, protocols, etc. any 'flow' of people, information, supplies, thought, resources etc. that can be captured on a process map.
- **Patterns** include: outcomes, behaviours, relationships, how decisions are made, power, conflict, learning etc.

Often the failure to achieve fundamental change through reorganisations, new programmes and service redesign efforts lies in the fact that the underlying patterns of relationships, decision-making, power, conflict and learning in the system remain unchanged and unchallenged². In order to achieve sustainable LSC we must plan for and actively address, changes in all three aspects of SPP³.

Link to theory of large scale change

SPP links directly with the second way to describe LSC - the complex systems lens. It also gives us insight into two of the common themes in the LSC literature; 'identify key themes that will make a big difference' and 'mutually reinforce change in multiple areas'.

Link to other change management tools

- Use the SPP viewpoint to inform your thinking when constructing a driver diagram (Section 3.2) and in conducting 30/60/90 day cycles of change (Section 3.4).

Examples

Ian Railton from the NHS North East Academy Team used the SPP framework in his planning for the Transformation Support Office that he was charged with leading (along with Dr. Suresh Joseph, another Academy member) as part of an LSC for mental health services. Through engagement and dialogue with colleagues and stakeholders they determined that in order to be successful the structures and processes of the office needed to be implemented and operated in a way that created the following patterns:

- they must be the exemplar
- they must lead the way
- they must be free of controversy
- they must be supportive
- they must uphold the standard
- they must live the organisation's values
- they must shine light on the future
- they must believe that the LSC is possible.

By making the desired patterns explicit, the NHS North East Mental Health LSC Team could address behaviours that might otherwise have derailed the transformational effort.

Tips for use

- ▶ Consider framing SPP as ‘whole-system thinking’ as this is a phrase that people naturally support and often use but rarely define. There is solid support for this view of ‘whole-systems’ in the literature on complexity.
- ▶ Patterns are linked to behaviours in a social system. So, it is important that the desired patterns are developed through dialogue and engagement with key stakeholders. The idea of a small group of people deciding what the desired patterns should be in a system is itself an example of a potentially dysfunctional power and decision making pattern that is likely to damage relationships and learning while creating conflict.
 - You can create the dialogue in a single large meeting of stakeholders or through a series of interactions with smaller groups over time. The examples in the mindset shift section of the Leadership chapter (Section 4.5) illustrate the outputs of several such sessions in the NHS.
 - Be sure to include all voices in the dialogue especially groups who have, traditionally, been disadvantaged or overlooked.
- ▶ SPP is not a rigid analytical or categorical framework. If you begin debating whether something is a structure or a process (e.g. commissioning) simply put it into both categories and instead spend your time discussing how it might need to change in order to support sustainable LSC.

Footnotes

1. Capra F (1996). *The Web of Life: The New Scientific Understanding of Living Systems*. New York. Anchor Books.
Plsek PE, Greenhalgh T (2001). ‘The challenge of complexity in health care’. *BMJ*, 323:625-8.
2. Plsek PE. (2003). ‘Complexity and the adoption of innovation in healthcare’. *Proceedings of Accelerating Quality Improvement in Health Care: Strategies to Speed the Diffusion of Evidence-Based Innovations*. National Institute for Health Care Management Foundation. Washington DC. 27-28 January.
3. For examples of how structure, process and pattern thinking links to the mindset shifts that are key to sustainable change see Section 4.5.

3.4 Tool: 30/60/90 day cycles of change (going two steps down in your thinking)

A Chinese proverb suggests, 'a journey of one hundred miles begins with one step'. Similarly, the long-term LSC journey needs small steps to gather momentum and make progress. 'Going two steps down in your thinking' (Figure 10) is a useful concept. For example, if you think it will take you five years to realise your vision, ask what concrete steps you can take in the next five weeks to begin movement in that direction.

The NHS Institute has followed the example of global companies like Proctor and Gamble in employing 90 day cycles in all its innovation processes¹ and the US based Institute for Healthcare Improvement (IHI) has popularised short cycle change thinking in healthcare². Academy Teams found a mix of 60 and 30 day cycles were better suited to the pace of change required in health and social care in the current environment.

Each cycle should involve:

- a clear, specific objective to be achieved (e.g. engage three thought leading finance directors in creating the business case to support our change)
- a specific timeframe (30, 60, or 90 days)
- anticipating a specific decision about next steps - What are the options? What will we do next if we are successful? What if we are not successful?

Link to theory of large scale change

30/60/90 day cycles set the pace for the circle of action in the LSC model - framing, engaging, changing, attracting. By breaking down an LSC effort into manageable pieces, leaders can:

- remain flexible, working on various key themes and multiple processes in parallel
- enable commitment, distributed leadership and mass movement
- create opportunities to pause for reframing and attracting new interest
- maintain their personal energy
- mitigate unintended consequences.

Figure 10: Establishing pace



3.4 Tool: 30/60/90 day cycles of change (going two steps down in your thinking)

Link to other change management tools

- Use cycles to create a balance between planning and doing when using the planning questions for LSC (Section 3.1).
- The projects and activities at level three and beyond on a driver diagram (Section 3.2) should be conducted as 30/60/90 day cycles of change.

Examples from the NHS Academy for Large Scale Change

The work of the NHS East of England (EoE) Academy Team illustrates the use of cycle thinking as well as several other concepts in LSC.

Large scale change is being sought in delivering the ambitious Towards The Best, Together (TTBT) programme. A robust programme architecture provides structure... while an implementation plan is periodically refined and updated e.g. to reflect external events. 'Cycles' have been used to develop and refine the progress reporting structure. Activity focusing on engagement with commissioners is also completed through 'cycles' of work, such as identifying a commissioner chief executive sponsor for each of the programme boards and enabling areas and establishing a new workforce planning process to tie workforce planning and development to TTBT and local commissioning strategies. Further 90 day challenges have been undertaken in two areas: (a) patient safety: establishing baseline data for all acute trusts in EoE to support adoption of a common programme and, thereby, reduce the number of avoidable deaths; and (b) long-term conditions: supporting commissioners in the active involvement of service users and carers, to shape care planning and local commissioning plans from the very outset. Among the key lessons we have learned are the usefulness of using cycles to develop and refine approaches, and the benefit of taking a flexible approach that responds to external events.

Adapted from NHS East of England Academy Team report

Tips for use

- ▶ There is not necessarily a one to one relationship between 30/60/90 day cycles of change and secondary drivers on a driver diagram or the three actions on the circle at the heart of the LSC model. That is:
 - a project on a driver diagram might require more than one cycle to complete. But the time period specified by the cycle allows for a purposeful pause to consider the next steps in the journey
 - a 30/60/90 day cycle need not result in a 'pragmatic change' as depicted on the LSC model. For example, a 30 day cycle might simply explore various framings of an issue or seek engagement of some key stakeholders in anticipation of a future cycle of action.
- ▶ While the objective of each cycle should be achievable in the timeframe specified, it should also result in a clear step beyond the place where you began.
 - In the example in the description section on page 56, the team begins the cycle without the support of finance directors to create a business case but they hope to gain that support from at least three individuals who are seen by their peers as thought leaders. That would be a step forward.
- ▶ Spend time purposefully thinking about and anticipating what you will do next. You are not bound by this thinking but if you have not given it any thought at all you risk wasting the momentum you have created.
- ▶ Readers familiar with service improvement tools will recognise plan, do, study, act (PDSA) cycles as a further model that could be used within a 30/60/90 day cycle. The point here is about pace not letting PDSA cycles of improvement drag on.

Footnotes

1. Huston L, Sakkab N (2006). 'Connect and develop'. *Harvard Business Review*, 84(3):58-66.
2. See examples of short cycle change thinking in healthcare on the IHI website. Available at: www.ihl.org

3.5 Tool: Systems and stakeholders analysis

Description

The circle of action in the middle of the LSC model guides us in framing and reframing our topic in order to engage others who then work on multiple processes and subsystems to make pragmatic changes. Essentially, systems and stakeholders analysis begins at the end by asking us to think about what processes and systems need to change and who might be the most influential in bringing that about. It is a two part process.

- In thinking about processes and systems, review the 'starter for ten' list in figure 11 and think about:
 - (a) those that need to change in order to have a direct, visible, positive impact on your goal
 - (b) those that could support needed change if better aligned with your goal
 - (c) those that need to be attended to so that they do not hinder change.
- For each such process and system identify the key stakeholders who could provide distributed leadership - the individuals or groups that you think could exert positive influence for change if sufficiently engaged and committed.

Figure 11: Processes and systems that might need to change

Processes and systems that might need to change in an LSC effort - a starter for ten...

- service delivery processes, hand-overs and care transitions
- clinical decision-making and professional practice
- reporting and management processes
- finance flows
- commissioning
- IT systems
- patient and public engagement and education processes
- communications processes (both internal and external)
- workforce development
- human resources processes

Link to theory of large scale change

This tool supports the circle of action in the LSC model. It guides our thinking about the many processes and systems that need to change in harmony. Stakeholders become the focus of our efforts to encourage the commitment, distributed leadership and mass movement required for LSC.

Link to other change management tools

- Systems and stakeholder analysis links directly to LSC planning questions five and six (Section 3.1).
- Identified processes and systems should be reflected in your driver diagram (Section 3.2) either as primary drivers or as the focus of 30/60/90 day cycle projects (Section 3.4).
- After identifying key stakeholders, consider moving onto continuum of commitment analysis (Section 3.6) and framing and reframing (Section 3.7).

Examples from the NHS Academy for Large Scale Change

The NHS West Midlands Academy Team working on LSC in mental health produced a systems and stakeholders 'map' and described it at an Academy event...

It [the 'map'] has clearly got the mental health policy part of the Department of Health, along with various other groups in the Department, working on payment by results (PbR), National Programme for IT (NPfIT) and the quality and productivity strategy. So, various pieces of the 'map' are thinking differently about how this might move forward. In our region we've got users and carers in the middle of the 'map'. We've got nine different providers who, of course, have different staff with different ideas and plans.

You've got clinicians engaging in one way, managers thinking, "Oh, that looks interesting... I wonder what that will do... I wonder what the commissioners will make of that". You've got the systems within those providers: the IT and data flow systems. And, around all of them, you've got 17 mental health commissioners. Then, we've also got our social care colleagues who, again, may come at things from a different angle.

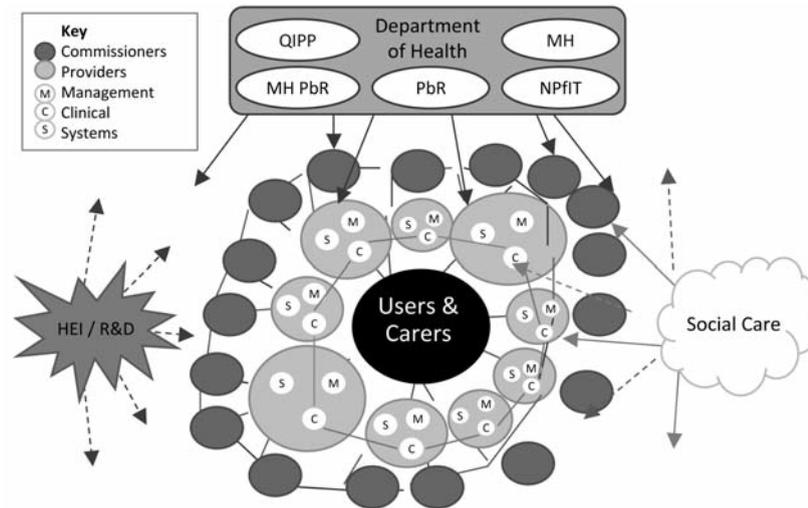
The thinking we were doing was around how you hold these pieces of the jigsaw together so you create coherent movement forwards, which is what I think we are doing quite successfully. Also, you have to think about how you will avoid something coming along to trip you up such as some organisation with a very different viewpoint.

So, there's something about lining up those processes and systems, not only to move us through the implementation phase but also sustaining this over the next five to ten years.

Lawrence Moulin, Programme Consultant

Mental Health Modernisation, NHS West Midlands, adapted from their presentation at an Academy event

Figure 12: NHS West Midlands Academy Team's stakeholder map



Tips for use

- ▶ The output of your brainstorming about processes, systems and stakeholders can be captured as a diagram or in a simple table (one column for systems/processes and one for the associated key stakeholders).
- ▶ While you should try to identify all relevant processes and systems also discuss priorities for upcoming 30/60/90 day cycles. Resist the urge to say that everything is a priority and must change. It is impossible to get everything to change at once. Get it down to the eight to ten key processes and systems that are most important in creating momentum or keeping it going. If you attract attention other processes and systems may start aligning themselves naturally.
- ▶ Note that we are identifying stakeholders here primarily for the purpose of creating distributed leadership for change. We are NOT thinking about every group or individual who will, eventually, be impacted by the LSC effort. Rather, we are looking to target only those few key stakeholders who, if sufficiently engaged, could lead and influence others to drive change.
- ▶ Check your thinking about stakeholders to assure that you are offering the opportunity for distributed leadership to all groups in society. Giving voice to those who don't usually have it can lead to pleasantly unexpected new ideas and energy.

3.6 Tool: Continuum of commitment analysis

Description

Continuum of commitment analysis, a classic tool from the organisational development literature¹, is illustrated in figure 13. It is used to add a level of depth to stakeholder analysis and provide insight into how much and what sort of influence leaders might need to exert. While shown here as a table for illustrative purposes, it is most often used intuitively in discussing LSC strategy.

Figure 13: Continuum of commitment analysis table

Stakeholder	Obstructing	No commitment	Let it happen	Help it happen	Make it happen
A		X			O
B				X	O
C			O		X
D	X		O		

X = Currently O = Where we need them to be for successful change

- Stakeholder A is an example of an individual or group that is currently neutral to our LSC vision but who is key to get engaged in active, committed, distributed leadership. We might plan a 30 day cycle of framing the change in a way that will move them towards commitment.
- Stakeholder B is someone who is already where we need them to be in terms of commitment and we can move on to action.
- Stakeholder C is problematic but, unfortunately, not uncommon. This is an individual or group that wants to be seen in active leadership of the change but in reality it would be better if they were more hands off and behind the scenes. This can occur for a variety of reasons. The individual or group might not have the capability or capacity to lead effectively. Or, there may be patterns of power, conflict and damaged relationships that, unfortunately, create dysfunction and interference with the active engagement of other stakeholders. The required pace of change may not give us the luxury of time to build capabilities and capacity to lead or to address deep rooted patterns. Whatever the reason, someone will need to have a difficult conversation with Stakeholder C to explore the

situation, convince them that they need to rise above it for the sake of the vision or to redirect their energies into other places on the driver diagram where they can be more effective.

- Stakeholder D is the individual or group that we most often think of as the ‘difficult’ person who is blocking progress. It is important to understand whether we need to move this individual or group and, if so, how far down the commitment continuum. If we understand the patterns of relationships, power, decision making and conflict in the system we might be able to succeed despite their obstruction; but beware the potential impact on sustainability. On the other hand, perhaps all we need to do is address some serious objection they have and that may move them to ‘neutral’ or ‘let it happen’ status. If we need them to ‘help it happen’ or ‘make it happen’ we will need to spend serious time understanding them and finding a framing that engages them.

Link to theory of large scale change

Understanding stakeholders at this level of detail is essential to the distributed leadership and mass movement that we need for successful LSC. This analysis leads naturally to thinking about ways to frame the need for change and about how we can attract new, active supporters. Influencing stakeholders to move along the continuum requires mindset change and the literature tells us that this is essential for sustainable LSC. Finally, not recognising subtleties like those illustrated in figure 13 can drain LSC leaders of personal energy over time; either because they are expending too much effort getting everyone to the same level of commitment when this is not really required or because progress is blocked as the need for movement along the commitment continuum has been neglected.

Link to other change management tools

- Continuum of commitment analysis follows on naturally from LSC planning question six (Section 3.1) and from systems and stakeholder analysis (Section 3.5).
- Framing (Section 3.7) and transformational storytelling (Section 3.8) might help create the movement required across the continuum.

Examples from the NHS Academy for Large Scale Change

These concepts were used intuitively by many teams in the Academy.

Tips for use

- ▶ Tips are embedded in the extended description and examples above.

Footnotes

1. Beckhard R, Harris RT (1987). *Organisational Transitions: Managing Complex Change*. Second Edition. Reading, MA: Addison-Wesley.
For more information see Bibby J, Bevan H, Carter C, Bate P, Robert G (2009). *The Power of One, The Power of Many: Bringing Social Movement Thinking to Health and Healthcare Improvement*. NHS Institute. Available at: www.institute.nhs.uk/powerofonepowerofmany.

3.7 Tool: Framing and reframing

What the leader cares about – and typically bases at least 80% of his or her message to others on – does not tap into roughly 80% of the workforces' primary motivators for putting extra energy into the change programme.

Scott Keller and Carolyn Aiken (2009), The inconvenient truth about change management, *McKinsey Quarterly*

Description

Framing is the process by which leaders construct, articulate and put across their message in a powerful and compelling way in order to win people to their cause and call them to action^{1,2}. Framing refers to 'the conscious, strategic efforts by groups of people to fashion shared understandings of the world and themselves that legitimises and motivates collective action'³. Effective framing is a critical first stage to creating the conditions that lead to mass mobilisation and large scale change⁴.

In developing our frame we seek to create 'frame resonance' with our target audience so that we can call them to action for LSC. Frames are more likely to be resonant if the message connects with the individual and collective values, world views, life experiences, beliefs, existing preoccupations and history of action of the audience. The more important these are to the stakeholders and the wider the range the framing connects to, the greater the potential for frame resonance. The framing of the issue is not just about making a connection. It is an explicit call to action. The aim is to move people to 'step off the pavement' and change from bystander to committed participant.

The concept of framing is in marked contrast to what far too many change leaders do. Often we create a compelling case for change that appeals to us (in content, emphasis, language, logic flow, etc.) and we then try to convince others. Or, we continue to use the same case for change that might have worked with an initial group of stakeholders but are frustrated because others 'just don't seem to get it'. The skilful LSC leader has a different mindset. When you are frustrated with others because you have made your best case for change and they just don't seem to 'get' it, take a look in a mirror and instead ask what it might be that you do not 'get' about them.

Link to theory of large scale change

Framing is a critical component of LSC. It enables us to engage and connect with others and to attract further interest as we build change at scale.

In order to mobilise we need to motivate. That is the essence of framing. Each person who we want to engage has to be able to make a personal and deep connection with the message, enough to inspire that person to take decisive action. The key to motivation is understanding that values inspire action through emotion⁴. Emotions inform us of what we value in ourselves, in others and in the world and enable us to express the motivational content of our values to others. Because we experience values emotionally they are what actually move us to take determined action, not only to the idea that we ought to take action. So framing is the process by which we create a compelling message that connects with values and motivates others to engage in change.

Link to other change management tools

- Framing/reframing supports LSC planning questions four and eight (Section 3.1).
- Framing/reframing helps move stakeholders along the commitment continuum (Section 3.6) and should be considered in 30/60/90 day cycles of change (Section 3.4).
- Framing is a core component of transformational storytelling (Section 3.7).

Examples from the NHS Academy for Large Scale Change

Through progress reports at Academy events every team mentioned something about the importance of framing to engage others as being among the key lessons learned in their LSC effort.

Working to spread improvement thinking across the south west of England, LSC leaders in the NHS South West Academy Team, came to realise that, for years, improvers had been making the case for improvement science in presentations. They wanted presentations to be structured to present theory, process and deliverables/outcomes, in that order. This had naturally engaged some people, who had gone on to use this thinking to drive change. But, efforts to spread the thinking had reached a plateau (the second potential outcome in our model of LSC). Clearly, this order of presentation (framing) had not appealed to many others for whom concrete outcomes were the most important criteria. They would seem to switch off early in a presentation and conclude that improvement science was not for them. By reframing their appeals to spread improvement science that focuses directly on real, delivered outcomes and by only sharing more about the process of improvement or its underlying theory when asked, they are now attracting further interest especially in light of the current quality and productivity challenge facing the NHS.

Working on LSC in unplanned care in Doncaster, GP Lis Rogers (a member of the NHS Yorkshire and Humber Academy Team) needed to engage members of the public and various other stakeholders across organisational boundaries. Through several stakeholder consultations, a vision and 13 key objectives emerged. “The plan was extremely ambitious and relatively unheard of nationally” said Lis. “Other regions had implemented similar service changes but hadn’t gone as far as full integration of primary and secondary care clinicians”. A key insight was to map the 13 key objectives based on their appeal to patients, clinicians and managers. This information was then used to frame the vision and case for change differently for each group (and for subgroups within a group). When change is properly framed, different groups can contribute to a common high level vision, even though they do so for different reasons.

Tips for use

- ▶ Your mindset as a leader is central to success with framing.
 - speaking with others in an appreciative way about what they think is important and observing past occasions when they have been active in change provides insight into how you might frame things in ways that are naturally engaging.
 - Accept that people do what they do for a reason that makes sense to them even if it is not the way you think about it.
 - Avoid cynicism or assuming bad motives on the part of others. You would want them to do the same for you.
 - Engage in a genuine dialogue that enables you to understand the experiences and values of the person/people you want to engage in change. Frame your change proposition in a way that appeals to shared values and shared purpose.
 - Be genuine when using framing. Believe in the case you are making. If you are misleading people, or are just trying to manipulate people with 'spin', this will eventually show through and your effort will be discredited.
- ▶ Ensure that your framing covers all three framing dimensions.
 - Diagnostic (explaining why the problem which you are tackling arose)
 - Prognostic (painting a picture of the different future you are seeking to create)
 - Motivational (creating a sense of urgency for change and an explicit call to action)⁵
- ▶ Too often in our framing of quality and cost issues we over focus on the diagnostic element (emphasising the amount of money we need to save) rather than demonstrating the compelling future we are trying to create or asking the people we are trying to recruit to our cause to personally and collectively commit to change.

Footnotes

1. NHS Institute publications provide extensive background on framing and its origins in the social movement theory literature. They include many great examples from public health and marketing campaigns as well as from internal organisational settings. See Bibby J, Bevan H, Carter C, Bate P, Robert G (2009). *The Power of One, The Power of Many: Bringing Social Movement Thinking to Health and Healthcare Improvement*. NHS Institute. Available at: www.institute.nhs.uk/powerofonepowerofmany.
2. Snow D A, Benford R D (1992). 'Master frames and cycles of protest' in Morris A D and McClurg Mueller C eds. *Frontiers in Social Movement Theory*. Yale University Press.
3. McAdam D, McCarthy J D, Zald M N (1996). 'Introduction: Opportunities, mobilizing structures and framing processes - toward a synthetic, comparative perspective on social movements'. In *Comparative Perspectives on Social Movements: Political Opportunities, Mobilizing Structures and Cultural Framings*. Cambridge University Press.
4. Ganz M (2010). 'Leading change: Leadership, organization and social movements'. *Handbook of Leadership Theory and Practice*. Nohria N and Khurana R (eds). Chapter 19. Harvard Business School Press.
5. Benford R (2000). 'Framing processes and social movements: An overview and assessment'. *Annual Review of Sociology*, Vol 26, pp 611 – 639.

3.8 Tool: Transformational storytelling (use of narrative)

Description

While facts and analysis stimulate the mind, to really engage people in the hard work of change you have to go to the heart as well. By developing skills in storytelling (narrative) we build our ability as leaders to draw from our own experiences and values to inspire others to join us in action. Stories communicate our values through emotions. This is because it is what we feel – our hopes, the things we care passionately about, our commitments – not simply what we know that is most likely to inspire us with the bravery to act in the face of uncertainty¹. In contrast to the analytical approach to presenting a challenge to others (problem analysis solution), stories can spark deeper mindset shifts through a three step process of getting attention, stimulating desire and reinforcing with reason.

Transformational stories² are brief anecdotes, told from a personal perspective, using language that is recognisably the leader's own. These stories:

- capture the essence of a problem
- set out a compelling vision of something better
- describe some practical steps that show something different can be done
- answer the implicit questions in people's minds and are honest about uncertainties or difficulties ahead
- compel others to commit to make change because they connect to our values through the experiences we recount to them.

While not all stories need to have every element in order to be effective, Figure 14 provides a complete outline of a powerful story.

Figure 14: Transformational storytelling template

Introduction	What is the problem?	Challenges	What are our challenges and how will we overcome them?
Current situation inc springboard story	Where we are and where have we come from?	Expectations 1	What I expect from you (makes it personal)
Future vision	What will it look like when we get there?	Expectations 2	What can you expect from me (makes it personal)
Journey	How are we going to get there?	Conclusion	Personal and compelling closing - 'We are in this together' 'Remember the springboard story'

Source: Dr. Annette Neath, NHS Institute for Innovation and Improvement

Link to theory of large scale change

Engagement in change in order to create commitment, distributed leadership and mass movement is key in LSC. Storytelling and narrative³ is an additional approach to framing that builds on the factual logical case for change and adds the experiential emotional. Traditional change management literature tells us that the more substantial the change, the more emotional content is required.

Link to other change management tools

Storytelling/narrative is a way of framing and reframing the need for change (Section 3.7).

Examples from the NHS Academy for Large Scale Change

Storytelling (use of narrative) was the second most frequently mentioned tool when Academy participants reported on lessons learned from their LSC goals.

3.8 Tool: Transformational storytelling (use of narrative)

Commenting about her LSC project on maternity care for vulnerable women, Julie Grant, Project Director, NHS West Midlands, recounted the following...

“I engaged my clinical leads in storytelling and they went off and sourced a story for me that fitted the social model of care that we’re promoting in maternity and newborn. At a commissioners' workshop an obstetrician that I work with who is our clinical lead told this story of a substance misuse lady. One of our issues is trying to engage vulnerable women earlier in their pregnancy with maternity services. We know that once we get them engaged we can keep them coming, it’s going to improve the chances and outcome for that woman and the life chances for her baby. He told the story of a pregnant woman who had engaged with the service at an inner city Birmingham maternity unit. From her previous pregnancies, all her children had been taken away into care. She had a chaotic lifestyle and hadn’t changed her pattern of substance misuse during her previous pregnancies. By engaging early with the service, building a relationship with the substance misuse specialist midwife, she continued to improve her care. The midwife championed the social aspects of her care and she got her some stable housing. She actually got a job during the period of her pregnancy. She had a good outcome for the baby and kept that baby. We used that as an example and then we showed some of the MORI research about women not engaging with the service because they have feelings of guilt over the damage they were causing to their baby. There was a quote from a midwife about women almost feeling that the baby will 'have two heads or something wrong' because of the substance misuse. So, that is just one example of the stories that we’ve used.”

Tips for use

- ▶ Supporting materials and additional coaching on storytelling is available from the NHS Institute. See the website at www.institute.nhs.uk/storywriting.
- ▶ Show, don't tell. Make the story vivid and memorable.
- ▶ Your story has to be authentic. You are seeking to call others to action on the basis of shared values which you demonstrate through your own experiences. If they aren't genuine and sincere you will have the opposite effect.
- ▶ To be effective, the story needs to be either (a) one that you personally were involved in, even if it is only that you were in the organisation where it happened, or (b) have your unique perspective and interpretation regarding its potential meaning for your audience.
- ▶ Practice telling your story to colleagues and seek feedback. Hone it down to its essence and be able to deliver it succinctly.
- ▶ Find ways to link your own story with that of your colleagues, partners and teams. What are your shared values and experiences? What is your sense of common purpose? Sharing your stories is one of the most effective ways of building a collective call to action.
- ▶ You will know that your story is effective when you hear others recounting it to you, or telling similar stories of their own.

Consider how, as a leader, you are able to draw from your own story to inspire everyone in your community or organisation. Have you created a powerful narrative to unify everyone in the organisation and give them a collective identity and sense of direction? Does your own story inspire people to step up, to take action, to tackle the big challenges⁴?

3.8 Tool: Transformational storytelling (use of narrative)

Footnotes

1. Ganz M (2010). 'Leading change: Leadership, organization and social movements'. *Handbook of Leadership Theory and Practice*. Nohria N and Khurana R (eds). Chapter 19. Harvard Business School Press.
2. Aaker J, Smith A (2010). *The Dragonfly Effect*, Jossey-Bass.
Denning S (2004). 'Telling tales'. *Harvard Business Review*, 82(5):33-40.
Denning S (2005). *The leaders' guide to storytelling: Mastering the art and discipline of business narrative*. San Francisco. Jossey-Bass.
3. Section 3.8 draws heavily on the work of Dr. Annette Neath at the NHS Institute.
4. For a helpful list of questions to consider in constructing your narrative, see Denham C R (2009). 'Are you infected?' *Journal of Patient Safety*, 5(3): pp 188-196.

3.9 Tool: World Café

Description

World Café¹ is an interactive, large group dialogue process whereby a diverse mix of people come together to have conversations and record thoughts around questions that matter. Typically, a large room is set up to resemble a comfortable café with small tables seating four to five people and paper table cloths that can be used for note taking during discussions. A World Café event typically lasts two to three hours. Guidelines for conducting a World Café include -

- **Clarify the purpose** in order to know who to invite and to understand the parameters that are important to the event's success.
- **Create a hospitable, safe, inviting place** where people feel comfortable to be themselves and are encouraged to do their most creative thinking, speaking and listening.
- **Explore questions that matter to those who are invited.** Well crafted questions (see the example overleaf) attract energy, focus attention on the dialogue and invite enquiry and discovery rather than debate and point making.
- **Encourage everyone's contribution** but provide a variety of ways for people to contribute (e.g. through speaking, through just asking questions to hear more from others, through writing notes on paper left on the table).
- **Connect diverse perspectives** typically by requiring people to move from table to table, talking with different people each time in a series of three to five discussions lasting 20 minutes each. As participants carry ideas from table to table the possibilities for exciting new insights increase.
- **Listen for insights and share discoveries** by reserving the last 20-30 minutes or so of the event for whole group conversation where you can draw out key themes and discuss next steps (if appropriate).

Link to theory of large scale change

LSC depends on shared vision, distributed leadership, mass movement and change in diverse parts of the system. Large group dialogue methods create a venue for social interaction among stakeholders that often have no other parallel in the structures, processes and patterns of the system. It is difficult to imagine cross boundary, partnership working for LSC without some such forum. Open ended group dialogue methods also support the concept of emergent and flexible planning that is so often evidenced in successful LSC efforts.

Link to other change management tools

- The planning and conducting of a World Café event might be a 30/60/90 day cycle (Section 3.4) in your planning efforts to create shared vision, frame the change, engage multiple stakeholders or reflect on progress and next steps (Section 3.1).
- A systems and stakeholders analysis (Section 3.5) can help you identify individuals who should be invited to take part in a whole system World Café.

Examples from the NHS Academy for Large Scale Change

Following a demonstration of the World Café methodology led by coach Arlene Scott at an Academy event, several participants set up events of their own as part of their LSC efforts.

My LSC effort is around personalising care plans for people with long-term conditions. We set up the World Café and got people together in the room from across different work streams. We had workforce and information management and technology (IM&T) as well as long-term conditions leads, clinicians, providers and commissioners. We got them to do some innovative and creative thinking around what it means to improve the quality of care for people with long-term conditions using questions such as, What are the opportunities to improve quality, patient experience and innovation by using personalised care plans? How can we collaborate with others, to make personalised care plans a reality for people with long-term conditions? How will we create a culture that promotes expert to expert relationships between clinician and service users? It went down really well, stimulating lots of good ideas and with some people saying that this was the first time they had ever got together like this. They wanted more. It was important to keep that momentum going so we followed it up and kept sending reminder emails about things that were going on. Delegates took their learning back to organisations and local work was developed.

Lorraine Wright

Assistant Director Programme Planning, NHS East Midlands.

Tips for use

- ▶ Download the free resource *Café to Go* from The World Café website (www.theworldcafe.com/pdfs/cafetogo.pdf). This seven page practical guide contains a wealth of information.
- ▶ Organisational development and service improvement advisors in your organisation may also be able to help you and can advise on other large group methods involving open space technology.
- ▶ If your World Café dialogue includes patients and members of the public be sure to think carefully to ensure that you are inviting all members of society to participate.

Footnotes

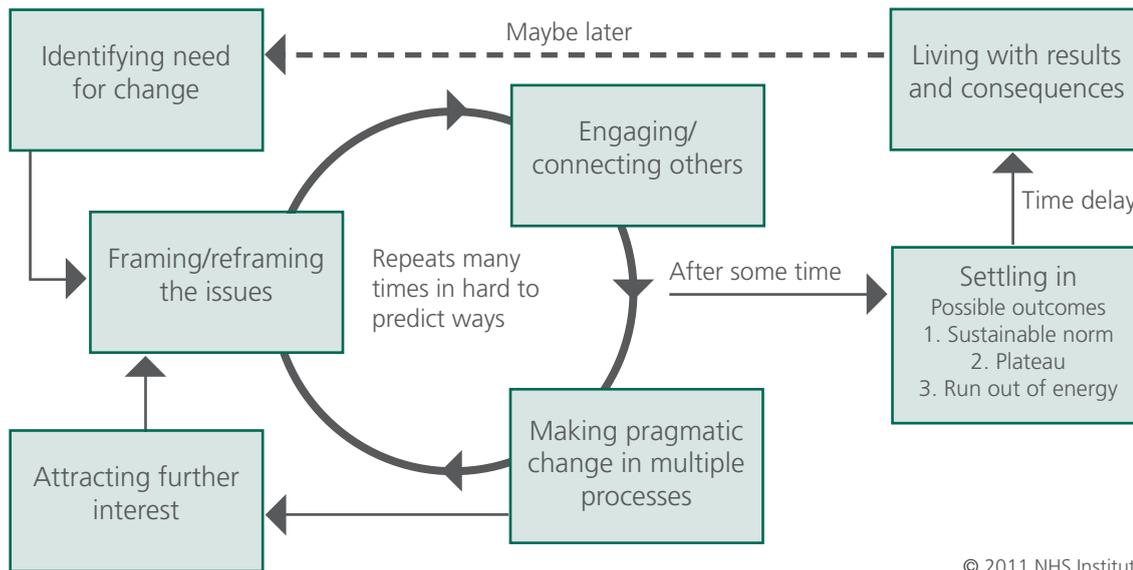
1. Brown J, Isaacs D (2005). *The World Café: Shaping our futures through conversations that matter*. New York. Barrett-Koehler. Helpful resources are available through the website: www.theworldcafe.com. The quick reference guide, *Café to Go*, from this website was used as the basis for the description section above. World Café is just one of several methods that use concepts from open-space technology to create understanding and dialogue among people in a large group.

3.10 Tool: Measurement frameworks for large scale change

Introduction

This section presents an overview of seven measurement frameworks that are useful to guide thinking in LSC. Our purpose is to provide broad guidance about what to measure, knowing that specific choices and the details of how to measure will vary greatly from one LSC effort to another. Large scale change leaders in the Academy and its successors adapted the advice here in a variety of ways to fit their unique contexts.

Figure 3: Emerging model of large scale change



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Purpose of measurement in LSC efforts

Our model tells us how LSC efforts tend to unfold over time. This leads to six potential uses of measurement.

1. Clarify the topic, vision and key themes when identifying the need for change.
2. Create a variety of cases for change that can be used for framing and engaging stakeholders.
3. Ensure that the pragmatic changes in multiple processes are effective in a way that can be visible to others.
4. Provide proof of success in order to attract further interest from previously neutral stakeholders.
5. Determine if efforts are on target for settling in to a sustainable norm.
6. Establish results and flag up any unintended consequences.

Key points:

- (a) measurement is important throughout LSC and
- (b) different measurements may be required for different purposes.

How to think about measurement

Leaders of change can sometimes over complicate discussions about measurement and get sidetracked by endless technical details that stall progress. The two key concepts to keep in mind when thinking about measurement are: observation and difference.

To identify what to measure in any situation, reflect on this simple question:
If we are successful what differences would we expect to observe?

3.10 Tool: Measurement frameworks for large scale change

Consider what it would take to convince a reasonable sceptic of your success and what such a person might be concerned about going wrong, e.g. you have reduced costs but has harm to patients increased - falls, infection rates etc.?

If something matters at all – and this should certainly be the case if you are investing your efforts in LSC – then it must be observable in some way. An observation can be the presence or absence of something. Both numbers and stories are useful because we know from the theory of LSC that change is both a logical and an emotional process.

Douglas Hubbard describes four useful assumptions about measurement that can help you stay focused and keep it simple¹.

- 1. Your problem is not as unique as you think.** Talk to knowledgeable others, search the Internet and review literature for existing approaches to measurement that you can replicate or adapt to your situation.
- 2. You have more data than you think.** Brainstorm a list of existing data, reports and indicators and ask if they may be sufficient (see also assumption four below). The advantage of using existing measures is that you will have a baseline of past data and will not have to consume valuable time just establishing your starting point.
- 3. You need less data than you think.** Understand the stakeholders you are trying to engage and think about what will move them to action. More data can sometimes obscure things; less may be clearer.
- 4. There is a useful measurement that is much simpler than you think.** Be pragmatic and look for simple, useful measures, even if they don't measure everything, or are not sufficiently pure for research.

Seven useful frameworks for measurement in large scale change efforts

We found seven frameworks useful for thinking comprehensively about what to measure in an LSC effort. You will not necessarily need to have indicators in all the categories presented (and some categories overlap) but it is useful to think about them all.

As you read each framework keep this simple question in mind: If we are successful in our LSC what specific differences in these various categories would we expect to observe?

1. Service delivery outcomes. Health service delivery is our ‘product’ and, therefore, most important LSC efforts will focus on service delivery processes. The NHS Institute’s seven dimensions of performance² suggest that successful innovations should transform performance on one or more indicators of:

- effectiveness
- safety
- timeliness
- efficiency
- co-ordination of care
- patient-centred
- equity.

2. Financial performance. Traditionally this has been a major focus of management work and there are many existing indicators. We recommend that change leaders work with finance colleagues to explore the ‘simple question’ above and avoid creating new indicators of their own.

Caution: Make sure that the set of indicators you select provides a picture of the performance of the whole system keeping in mind that public sector services are all, ultimately, financed from the same pool of tax revenues. Transforming services to improve financial performance in one area only to have new costs arise elsewhere is not helpful.

3. Health and wellbeing. This has been the focus of decades of work by academics, governments and agencies like the World Health Organisation. There are many existing indicators and survey instruments (e.g. SF-36, which is the short form (36) survey of patient health) that you can use. Work with others who are knowledgeable in this area (e.g. public health professionals), rather than trying to come up with your own indicators.

Two cautions. Firstly, while you should, of course, be rigorous, keep in mind that your main aim is to bring about pragmatic change, not to publish a research paper. Avoid long, distracting debates about measurement purity. Secondly, understand that indicators in this category will be slow to change. Consider these measurements to be primarily associated with the final stages of the LSC model (Living with results and consequences) and be sure to have a suite of other, more timely indicators of progress.

4. Satisfaction and experience of people who use services, their families and the workforce. It is important that the impact of LSC efforts is satisfying to all involved; otherwise there will be a constant pull to return to the old ways. While there are a variety of patient/user and staff satisfaction surveys that provide comprehensive assessments, the time lag for reports on these may be too long to fit the 30/60/90 day cycles of change needed to sustain momentum in LSC. Select just a few questions from these instruments (or create your own) and collect data in a more timely way to drive your change efforts. Keep it simple and be sure to also collect stories to put a human face on the numbers. Videotapes of patients/users, carers and staff talking about their experiences can be a powerful tool in engaging others in LSC³.

- 5. Mindset and behaviour change.** The theory of LSC tells us that one of the goals of an LSC effort must be to create a sufficient mindset shift in stakeholders to assure sustainability. We can measure mindset shifts via interviews and surveys by stating propositions and asking stakeholders to rate them on a scale from 'strongly disagree' to 'strongly agree'. For example, you might ask GPs to comment on the following statement: 'All things considered, we should be moving rapidly to offering extended hours in GP surgeries'. Behaviour changes can be described in a simple table indicating current and desired behaviours (you will see examples of these in Section 4 on Leadership). Data collection then involves looking for examples and tracking incidences over time that correspond to each of these behaviours.

Caution: Mindset and behaviour changes are difficult to measure rigorously but don't get caught up in debate here. Ultimately, the important indicators to track are shifts in performance in the categories above. It is enough to have an intuitive sense and some reasonable evidence to support shifts in this category.

- 6. Organisational capacity building.** Given the challenges facing the NHS, an important by product of any LSC effort should be the creation of capacity and capability for more LSC. Consider tracking and reporting on three categories:
1. Capability for continuously creating cycles of positive change, both in testing ideas initially and spreading those that work.
 - Potential indicators: Number of trained staff, number of successful projects, percent of target sites that have adopted new practice.
 2. Capability to sustain change.
 - Potential indicators: The NHS Institute for Innovation and Improvement's sustainability model⁴.
 3. Learning and mindset change among senior leaders.
 - Potential indicators: Table describing current and desired behaviours along with stories to illustrate these shifts.

7. Transformation structure and process indicators. Hacker and Washington⁵ reviewed the literature on large scale change in organisations and identified six structural and change process indications that were associated with successful LSC implementation. It is useful to consider how you will know that you have properly set up and are maintaining:

- well-defined result areas and goals
- well-defined objectives
- well-defined measurement processes
- well-established reviews
- well-defined responsibilities
- evidence of continuous improvement.

There is a massive need to teach staff more about measurement around benefits realisation as we think in terms of building capability and capacity for large scale change. Unless we can help people understand what to do and how to do it we're not going to know what we're achieving in terms of cost and quality.

Lynne Maher, Director of Design, NHS Institute for Innovation and Improvement.

Footnotes

1. Hubbard DW (2007). *How to measure anything: Finding the value of intangibles in business*. New York. Wiley & Sons.
2. Maher LM, Plsek PE (2009). *Making a bigger difference: A guide for assessing and stimulating service innovation*. London. NHS Institute. This framework combines concepts from the balanced scorecard, clinical value compass and the US Institute of Medicine's 'six aims'.
3. *Experience based design*. NHS Institute. Available at: www.institute.nhs.uk/ebdapproach.
4. Maher L, Gustafson D, Evans A (2007). *NHS Sustainability Model and Guide*. NHS Institute. Available at: www.institute.nhs.uk/sustainability.
5. Hacker M, Washington M (2004). 'How do we measure the implementation of large-scale change?' *Measuring Business Excellence*, 8(3):52-59.

3.11 Additional resources and service improvement tools available from the NHS Institute for Innovation and Improvement

While the LSC leaders that we have worked with found the ten tools described in Section 3 to be the most helpful - or the least familiar - they are only the beginnings of the kit that change leaders need in order to be successful. The NHS Institute has a host of other resources in improvement science with which you should become familiar.

Begin by viewing the NHS Institute's website and browsing the very useful web page *Fundamentals of Quality Improvement*. www.institute.nhs.uk/qualitytoolsintro. From this page you can access the online library of quality and service improvement tools. This resource provides an overview of over 70 tools covering project management, basic improvement skills, managing capacity and demand, creative thinking and dealing with the human dimension of change.

In addition to this overview page, you might find some of the more in-depth resources available from the NHS Institute helpful:

- **The handbook of quality and service improvement tools.** A paperback with similar content to the online library, that brings together a collection of proven tools, theories and techniques to help NHS staff design and implement quality and improvement projects www.institute.nhs.uk/handbookofqualitytools
- **Improvement leaders' guides.** This boxed set of booklets provides practical advice and examples on topics such as process mapping, data analysis and managing teams. www.institute.nhs.uk/leadersguides

- **Productive series.** These comprehensive kits are designed around lean thinking principles as well as other advanced methods from improvement science. These methods help leaders and frontline teams progress more rapidly in improving quality and reducing waste on hospital wards, mental health wards, community hospitals, community services, operating theatres, general practice and even in the day to day practice of organisational leadership. www.institute.nhs.uk/productivity
- **Sustainability guide.** This practical workbook and diagnostic tool guides leaders and teams in thinking about the potential sustainability of ongoing change efforts. Teams score their projects in the early stages, using evidence-based criteria and are guided to think about what they can do to enhance sustainability. www.institute.nhs.uk/sustainability

Personal reflection...

How will you learn more about and become skilled in, the application of the tools of change management as you embark on your LSC efforts?

Creating capacity and capability for large scale change in yourself and others is a critically important, ongoing challenge. It is never too soon to begin.

Leadership is about connectedness through shared vision, co-ownership, co-design and empowering partners in implementation.

Alimo-Metcalfe B, et. al. The impact of engaging leadership on performance, attitudes to work and wellbeing at work: A longitudinal study. *Journal of Health Organisation and Management*. 2008, 22(6):586-98.

4. Leadership for large scale change

The challenge is not starting but continuing after the initial enthusiasm has gone.

Ovretveit (2003) Making temporary quality improvement continuous:

A review of the research relevant to the sustainability of quality improvement in healthcare

This section looks at LSC from a leadership perspective.

We begin by asking you to reflect on your own leadership style, preferences and behaviours as we share key insights that participants in the NHS Academy for Large Scale Change uncovered in their efforts.

Next, we review seven powerful leadership concepts and models from the literature that underpins the shift in thinking often required by those who lead successful LSC efforts.

- Ambidextrous leadership styles (Section 4.3)
- Commitment versus compliance (Section 4.4)
- Mindset shifts (Section 4.5)
- Influence (Section 4.6)
- Managing polarities, dilemmas and tension (Section 4.7)
- Four venues of leadership (Section 4.8)
- Maintaining leadership drive and energy (Section 4.9)

We end by asking you to reflect, once again, on your style and preferences in the light of what the literature tells us about leadership and LSC.

4.1 Leadership and the theory of large scale change

Description

The emerging model for large scale change describes the phenomenon without regard to whether or how it is led. However, the literature suggests that the pace of change depends a great deal on leadership.

LSC that emerges over decades often does not have identifiable, highly visible leaders. For example, while it is clear that there has been LSC with regards to attitudes towards smoking, or shifts in the delivery of mental health services in the UK over the past few decades, the average person would be hard pressed to name the specific leaders of these efforts. Rather, leadership was widely distributed and lightly networked, although obviously aligned around a reasonably constant vision.

You need not worry too much about clear leadership for LSC if you have decades to wait for your vision to unfold. However, that is not a luxury we have in health and social care today. If we wish to create LSC at pace, leadership is crucial.

Leaders whose actions are grounded in literature based theory and who have a mental model for how the LSC journey typically unfolds, are needed in order to facilitate change at the scale and pace now required.

Personal reflection...

Take a moment to refresh your memory regarding the key themes in the literature for LSC by turning back to the theory set out in Section 2 to skim over the items in bold and take another look at the diagram of the LSC model. Now, think honestly about your own style, preferences and leadership behaviours as you read through the remaining sections of this chapter.

4.2 Wisdom in the room: Insights into leadership mindset shifts required for large scale change

After the first year of learning and work towards their LSC goals, Academy members reflected on their lessons learnt as leaders.

We asked: *What are the highest priority and/or highest leverage shifts in leadership thinking and development that you now feel are necessary for successful LSC across the NHS going forward?*

Responses were insightful. The table below indicates what Academy members thought they and other leaders, needed to do less of and more of.

Figure 15: From-To table

	From (Do less of this...)	To (Do more of this...)
Planning & executing	Rigid but lacking a coherent frame	Flexible, within agreed, thoughtful frame
	Concrete and closed	Enabling and open
	Performance management	Performance improvement
	Laissez faire – stumbling from crisis to crisis	Doing things more carefully with more preparation and thought
	Short term thinking	Long term thinking
	Bureaucracy in process	Focus on outcome rather than process
	Focus solely on executing process change	Attention to need for mindset change
	Fixed future	Dealing with emergence
	Expecting the solution to come from within	Exploring opportunities from without; eg, giving the public opportunities to influence
Risk Taking	Penalising risk taking	Encouraging risk taking/experimentation
	Asking permission in advance	Just do it and monitor
	Caution	Ambition, vision and risk taking
	Good is enough because it is comfortable	Being bold and accepting risk
	Demanding perfect solutions	Leading through complexity and contradictions
	Blaming, naming, shaming	Supportive risk taking, celebrate success, learn from failure, reward

	From (Do less of this...)	To (Do more of this...)
Bias to action	Inertia	Purposeful action
	Tolerating long debate	Securing action promptly
	Paralysed by challenges	Energised by opportunities
	Business as usual	Unusual business
	Unbridled change	Focused systematic innovation
	Repeating what we have always done and getting the same sub-optimal outcome	Issue is pace and scale of outcomes, so more attention to this
System Working	Organisational freedom and focus; autonomy beats quality	System accountability and focus; quality beats autonomy
	Single leader/organisation, competitive solutions	Leaders working together with joint accountabilities (win/win)
	Silo based, parochial vision	Matrix working, inclusive vision
	Talking only to NHS colleagues	Engaging with all public sector and people
	Foundation trusts planning for growth	Health community partnership working
	My organisation will be last one standing	Coalition building and maintenance
	I am a leader describing my organisation in £££ signs, power and stock	I am a leader playing my part in ensuring the health of the local population
Unaligned, perverse incentives	Aligned, integrated incentives	
Style Leadership	Telling people what to do and how to do it – autocratic, directive and micromanaging	Framing issues, engaging people, asking what they think, listening, enabling, coaching, co-creating - participative
	Controlling	Adapting levels of control to suit situation
	Hierarchical authority	Leading through influence
	One leadership style	A range of adaptive skills
	Organisations adjust to leaders' personal style	Connecting leadership style to organisational culture
	Singular focus on leadership per se	Leadership, management and administration – we value all three
	Strong personality/charisma	Humble leadership
	Moving others to action by stating the problem and the solution	Telling a story with passion to create inspirational engagement
	Not walking the talk; exposing unlived values	Modelling; doing and being the change you want in others
Reverting to transactional style when going gets tough	Courage to role model transformational style consistently	

What had Academy members learned and what does the literature say, about the leadership of large scale change? To follow are seven key leadership concepts and models.

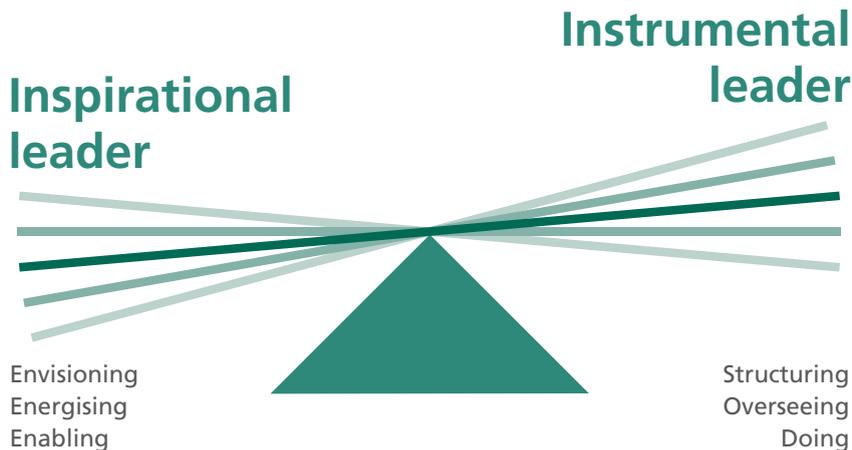
4.3 Leadership concept: Ambidextrous leadership styles

Description

Which is the 'right' style for LSC leaders? Should they be inspirational leaders who excel at articulating vision, energising and enabling others for commitment, or should they be instrumental leaders who excel at setting up structures, overseeing accountabilities and ensuring that things are getting done (Figure 16)?

The literature^{1,2} addresses this debate with a surprising answer: both! The skilful LSC leader, or team of leaders, balances them, as both are clearly needed on the journey. Vision and energy that do not lead to plans for action that others feel committed to and accountable for is just cheerleading. Over-reliance on structures and compliance with accountabilities handed down through a hierarchy can sap the individual commitment and energy required for change.

Figure 16: Ambidextrous leadership styles



Example

As the following example illustrates, Academy participants became comfortable with the balancing act required for success.

Setting up the dementia partnership network within the south east is a really good example of how I've had to work with others, or encourage others – to get things done. My challenge was when to step in, when to step out... We had a really good level of buy-in from very senior staff from both health and social care. I was almost surprised at the scale of their interest [in the vision] and their wish to get something done. You apply some of these principles and you're surprised to see the response. I think the role was for me to recognise that I had to be a catalyst and not to try to manage this and make it happen... I had to continually try to be willing to step out of it, give the leadership back to them and not try to do stuff myself. At one stage... they were saying, 'No, we want you to carry on convening this'... [but] then there came another stage when they said, 'Yes, we think one of the chief execs ought to be the leader of this'. That's now happened and I can step back from it... But the great thing is that it's their project, it's their plan, it's their programme.

Ian Bainbridge

Deputy Regional Director for Social Care in the South East Region, member of the NHS South East Coast Academy Team

Footnotes

1. Nadler DA, Tushman MC (1989). 'Leadership for organisational change', in Mohrman A *et al Large Scale Organisational Change*. Jossey-Bass.
2. Jansen JJP (2005). *Ambidextrous organisations*. Erasmus Research Institute of Management (ERIM). His resolution of an 'either-or' debate with the answer 'both' is an illustration of a more general principle, which we will address in Section 4.7 when we describe polarity maps.

4.4 Leadership concept: Commitment versus compliance

Description

A distinction is made in the literature between commitment and compliance organisations¹. Essentially, compliance organisations rely on rigid hierarchies, systems and standardised procedures for co-ordination and control. In commitment organisations, the co-ordination and control mechanisms are based on shared goals, values and sense of purpose.

There is no evidence in the large scale change literature that any healthcare system has ever delivered sustained transformational change through compliance, rather than commitment. Even in situations where challenging goals, standards and policies have to be adhered to or achieved in short timescales, better, quicker results are much more likely if the accountable leaders do so on the basis of commitment to the bigger purpose.

Commitment approaches build motivation, which is the best possible starting point for mobilisation. People who are highly motivated are more focused, persistent, willing to take risks and able to sustain high energy. In the context of clinical engagement, there is a strong correlation between clinicians who are engaged and motivated and high performance in almost every dimension, including patient outcomes and mortality².

Example

An alliance of NHS and voluntary sector leaders developed a strategy to enable people receiving end of life care to specify their choices regarding their deaths and for these choices to be supported. Rather than asking clinicians to comply with the best practice standard, they asked them to commit to having specific conversations with people receiving care at the end of life. The commitments were grounded in personal values and related to the kind of care and choices that we would want for ourselves and our own families. There was no less discipline or rigour in the change process (the clinicians agreed to be held to account for their commitments) but it started from a different premise connected to their personal values, which was much more likely to result in long term, sustainable change.

The table below compares compliance goals with commitment goals and was developed by Helen Bevan, a member of the Academy Faculty. Helen says “compliance goals have been prevalent in the NHS over the past ten years. As we move towards the new era where goals and aspirations will be more locally determined it may be a challenge to get consensus on local commitment goals if our clinical leaders think they are setting compliance goals and that they will be held to account for them in the old way. We will not be able to build the relationships we need to deliver large scale change goals if we don’t make the distinction between compliance and commitment goals.”

Figure 17: From... Compliance goals To... Commitment goals

From... Compliance goals	To... Commitment goals
States a minimum performance standard that everyone must achieve	States a collective improvement goal that everyone can aspire to
Uses hierarchy, systems and standard procedures for co-ordination and control	Based on shared goals, values and sense of purpose for co-ordination and control
Delivered through formal command and control structures	Delivered through voluntary connections and teams
Threat of penalties/sanctions/shame creates momentum for delivery	Commitment to a common purpose creates energy for delivery
Based on organisational accountability	Based on relational commitment (“If I don’t deliver this, I let the group and its purpose down”)

Footnotes

1. Bevan H (2010) *From compliance to commitment*. Available at: www.institute.nhs.uk/compliancetocommitment;
Ganz M (2010). ‘Leading change: Leadership, organization and social movements’. *Handbook of Leadership Theory and Practice*. Nohria N and Khurana R (eds). Chapter 19. Harvard Business School Press.
Ibarra H, Hansen M (2011). ‘Are you a collaborative leader?’ *Harvard Business Review*. July – August.
Walton R (2001). ‘From control to commitment in the workplace’. *Harvard Business Review*.
2. NHS Institute (2009). *The link between medical engagement and performance*. Available at: www.institute.nhs.uk/organisationalperformance.

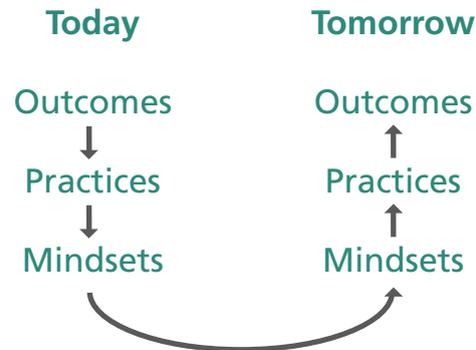
4.5 Leadership concept: Mindset shifts

Description

The Discovery Model¹ or U-model, developed by McKinsey & Company (Figure 18) captures a key point from the literature about the need to transform mindsets in order to create sustainable change. Today's outcomes are the by-products of today's practices. Change efforts typically seek to modify practices to get different outcomes. But, why were the practices that way to begin with? Practices are the product of our mindsets.

For example: if we believe that demand for services is infinite, we will design processes with lots of queues, leading to the outcome of unacceptable waits. If we try to implement a practice change alone without addressing the mindset (e.g. by showing that demand is finite and predictable, and that capacity can be matched to it), we will meet resistance or we will find that when we move on to the next thing, staff reinvent queues.

Figure 18: The Discovery Model



Raising awareness of current mindsets and creating new ones is a key leadership task. This can be accomplished via a process of honest dialogue among stakeholders, the output of which is often captured in a From-To table such as the ones shown in the examples on page 99. Leaders have a role in convening and facilitating this dialogue. But simply talking about mindset shifts is not enough. Leaders have a further role in seeking ideas and making concrete plans for changes in structures, processes and patterns of behaviour (SPP) that can support these shifts. The change management tools of SPP (Section 3.3), driver diagrams (Section 3.2), and 30/60/90 day cycles of change (Section 3.4) can aid this effort.

Examples

A group of NHS directors of finance (DoFs) used the Discovery Model to raise awareness of mindset shifts that they needed to address in themselves and their organisations regarding the role of finance today and in the future. The From-To table below is an excerpt from that dialogue. Now the challenge for these finance leaders is to consider what changes in structures, processes and patterns of behaviour might accelerate these shifts and, thereby, quicken the pace of LSC.

Figure 19: Mindset shifts - From-To

Example: Some outputs from finance directors' discovery process

Mindset Shifts - From...	Mindset Shifts - To...
Service is the COO's problem, finance is the FD's problem	Service is everyone's business/responsibility. Finance is everyone's...
DoFs say, 'no, because' (blocker)	DoFs say, 'yes, if' (enabler)
Focus on the cost of everything	Focus on the value of everything
Need to do extraordinary things	Need to do simple things extraordinarily well
Mutual mistrust between DoFs and others	Trust and respect and combined delivery
People don't think quality is part of DoF role	DoF is a key player in achieving quality goals
DoFs can come up with ideas and proposals to achieve financial balance on their own	The challenge is too big for DoFs to deliver on their own – we need to engage and lead colleagues to identify solutions
The main (only?) thing I am judged on (and therefore focus on) is the bottom line	My success is judged on a rounded view of my contribution to the organisation's progress and performance

4.5 Leadership concept: Mindset shifts

A group of communications specialists used the Discovery Model to stimulate dialogue about some of the mindset shifts required in the future in both members of the public and NHS staff to support quality, efficiency and reform goals². A sample of their output is captured in the From-To table below (Figure 20). These specialists can now use the structures and process of both existing and new communications channels to disseminate messages that can help change patterns of behaviour.

Example: Some outputs from communications specialists' discovery process

Figure 20: Communication specialists' discovery process

Mindset Shifts - From...	Mindset Shifts - To...
Public mindset: the NHS will cure me, no matter what I do to myself	I value my health and take responsibility for it
Staff: wait to be instructed	Take the initiative (within an open framework)
Staff: the system is working against me	My duty is to help make the system better
Staff: Individual vs being part of a public organisation with a duty. 'I'm proud of the work I do'.	I'm proud of the NHS

Multiple mindsets needed for change at scale

A mindset shift that has had particular resonance with LSC leaders in the Academy and its spin off efforts is the need to shift improvement thinking from a focus on purely clinical systems to more of a balance between this traditional focus and one of mobilisation of frontline staff. Both are pre-requisites for the scale and pace of change required in the current and future environment. The illustration below captures this key point and provides another facet of the ambidextrous leadership style needed for successful LSC that we described³.

Figure 21: We need a clinical systems mindset AND a mobilisation mindset

The 'mobilisation'
mindset for improvement

Focus: energy for change

Imagination
engagement
moving
mobilising
calling to action
creating the future



The 'clinical system'
mindset for improvement

Focus: effectiveness and efficiency

Metrics and measurement
clinical systems improvement
reducing variation
pathway redesign
evidence based practice

Source: adapted from NHS Institute for Innovation and Improvement (2009) *The Power of One, The Power of Many*³

4.5 Leadership concept: Mindset shifts

- The NHS South Central Academy Team explained that the three levels of the U-model have enabled the region to think about how it will shape its future. Stakeholders can define shifts in outcomes via strategy, bring about changes in practices via process improvement and address underpinning mindset shift via cultural change.
- Jane Hazelgrave, Associate Director of Finance, NHS Yorkshire and the Humber, reported a mindset shift among finance directors in her region. “Following on from the work that we’ve done in the Academy, we’ve tried to engage the finance leaders across the whole region. The challenge we set ourselves was, “how do we improve quality and value for money within a finite financial resource?” ... We had four different presentations. The first three focussed on rules about systems and payment by results [and so on but] the final presentation was from a finance director who talked about, “Well, this is all about behaviours”. There was a realisation in the room that, actually, it is! We can talk about a few pounds for this or a few pounds for that but, at the end of the day, it’s how we relate to each other and how we behave and manage the system. We spent some more time talking about that. There is a paper that the finance director of the region has written, called The Cultural Paradigm which explains the output from this. It was just such a great event. We’re following it up with how we actually put some concrete outputs to this, so we go forward and deliver.
- John Bewick, Executive Director of Strategic Development, NHS South West discovered that, sometimes, leaders fail to tap into a mindset-shift that has already occurred. “We had an epiphany moment at a meeting of the clinicians where we asked them, ‘As we move away from goal setting by the Strategic Health Authority (SHA), what is your level of ambition?’ The response from the clinicians was that the SHA hadn’t been, in their view, ambitious enough. For example, concerning waiting for diagnostic results the SHA set what we thought was a stretch target of six weeks and the view of the clinicians was that, if we have in place the right processes, there should be no waiting whatsoever... So, to a large extent we are pushing at an open door with the clinical body.”

Footnotes

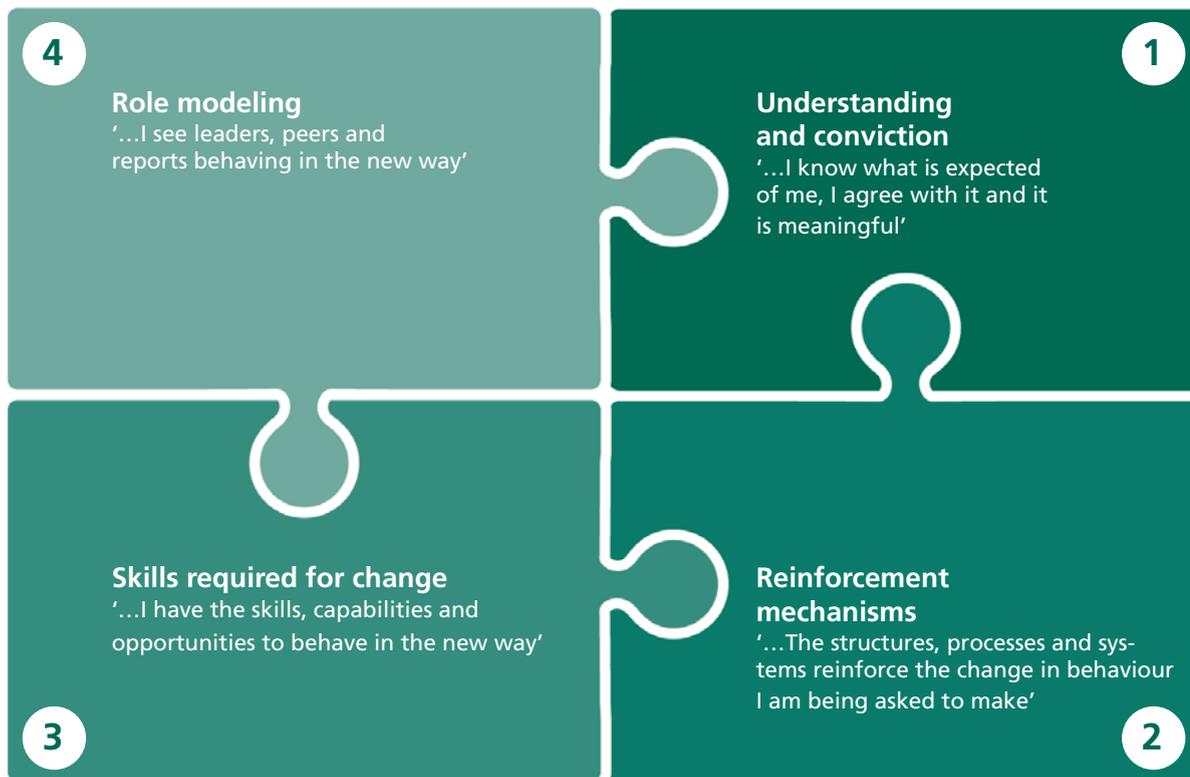
1. NHS Institute (2009). *Inspiring change in the NHS: Introducing the five frames*. Available at: www.nhsgraduates.co.uk/Pdfs/Inspiring_Change_in_the_NHS.pdf
Keller S, Price C (2011). *Beyond performance: How great organisations build ultimate competitive advantage*. Wiley.
2. We strongly recommend that any dialogue about mindset shifts required in members of the public actually includes members of the public. While this seems an obvious recommendation, in practice, these matters are often discussed in forums involving only healthcare professionals. When engaging with members of the public, be sure to include all segments of society; especially those who are disadvantaged or whose voices often go unheard.
3. Bibby J, Bevan H, Carter C, Bate P, Robert G (2009). *The Power of One, The Power of Many: Bringing Social Movement Thinking to Health and Healthcare Improvement*. NHS Institute. Available at: www.institute.nhs.uk/powerofonepowerofmany.

4.6 Leadership concept: Influence Model

Description

In an LSC effort, where leadership is distributed and so many changes need to be made across so many systems, organisations and stakeholder groups, insightful leaders soon learn that all they really have is influence. Positional power alone only goes so far.

Figure 22: Influence Model



For the most part, dictating, controlling and hierarchical management practices are neither realistic, nor effective. The Influence Model developed by McKinsey & Company (Figure 22), points leaders to four key aids for creating mindset shift¹. Leaders influence others by:

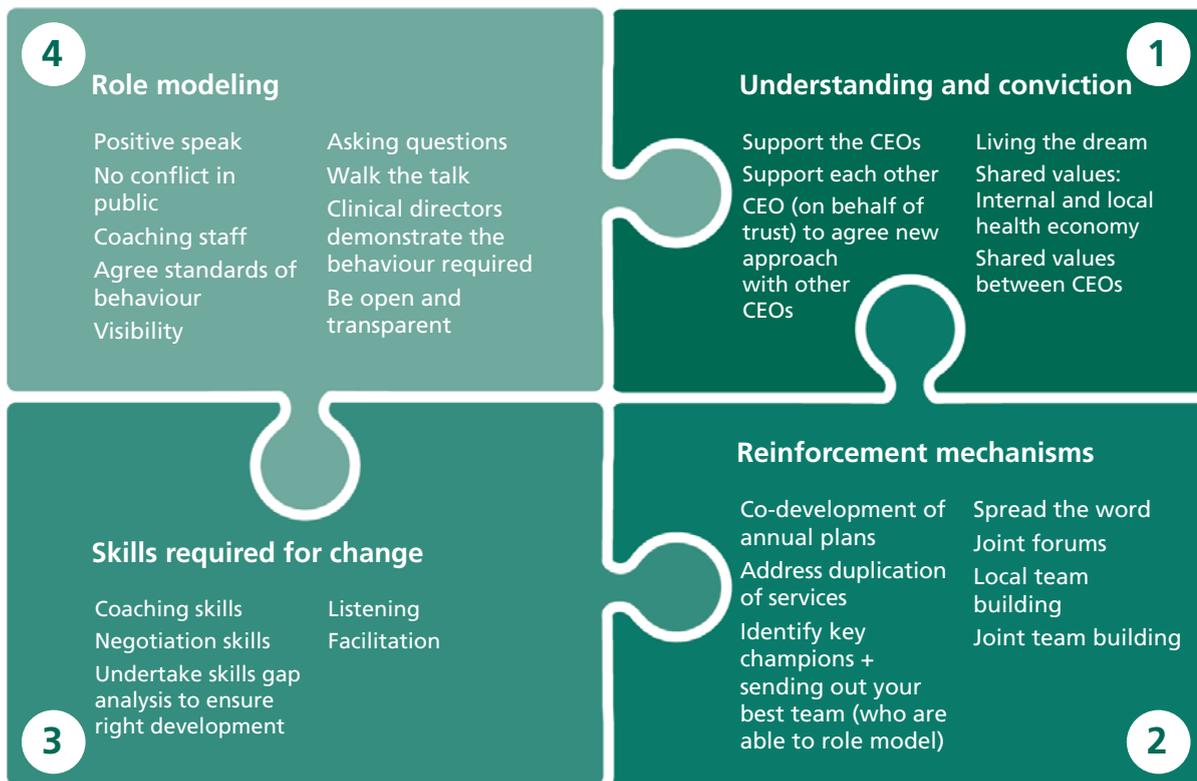
- creating understanding and conviction via framing and transformational storytelling (Section 3.7 and 3.8)
- providing reinforcing structures and processes that encourage desired behaviours and discourage undesirable ones
- attending to training and the development of the skills required in the workforce of the future
- role modelling the desired behaviours themselves.

Here, again, we see the balance of inspirational leadership (via items one and four) and instrumental leadership (via items two and three). Getting balance and alignment in these four things – rhetoric, system supports, skills development and leadership behaviours all sending the same message – is a crucial leadership task.

Example

After identifying the mindset shifts required to support partnership working between an acute care hospital and a primary care management organisation, the leaders of the two organisations selected a few mindsets and addressed the question, how might we influence the shift in mindset that we desire? The Influence Model was used to stimulate thinking and organise the results, as illustrated in figure 23.

Figure 23: Influence Model example



Footnotes

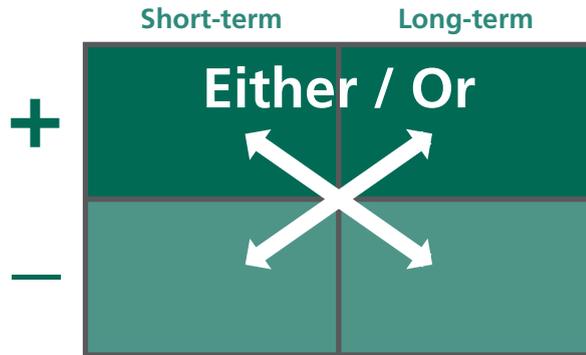
1. NHS Institute (2009). *Inspiring change in the NHS: Introducing the five frames*. Available at: www.nhsgraduates.co.uk/Pdfs/Inspiring_Change_in_the_NHS.pdf
Keller S, Price C (2011). *Beyond performance: How great organisations build ultimate competitive advantage*. Wiley.

4.7 Leadership concept: Polarity mapping for leading through dilemmas and tension

Description

In times of change, dilemmas create anxiety, spark seemingly endless debate and often paralyse action. "Should we focus on short-term delivery or long-term development?" is a classic example of such a polarising dilemma. The reason the debate goes on and on is because there are pros and cons to each side of the argument and, therefore, no obviously clear choice.

Figure 24: Polarity map - either/or

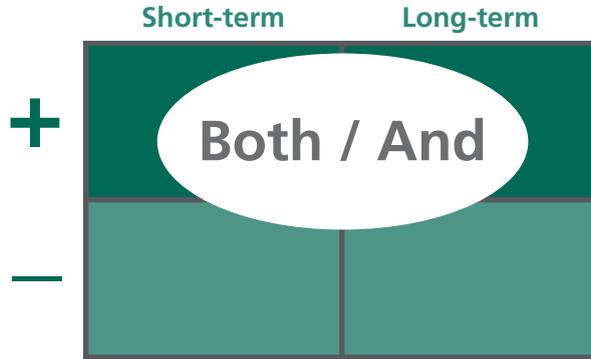


Polarity maps look at such issues on a two by two matrix^{1,2}. To construct a polarity map, we write a description of each 'pole' of the debate as a column heading and use the rows to capture pros (+) and cons (-) associated with each.

Issues typically debated as either/or choices

- Short-term focus versus long term focus
- Participative leadership versus directive leadership
- Competition versus cooperation/collaboration
- Standardisation versus customisation
- Centralised versus decentralised
- Quality versus cost/productivity
- Stability versus change

Figure 25: Polarity map - both/and



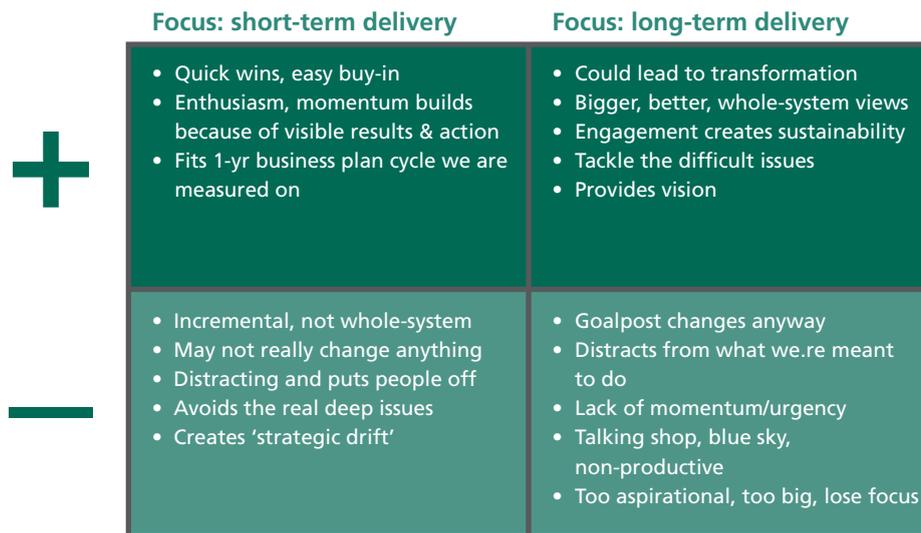
Another way to look at things... what we ought to seek, instead, is some third option that would encompass as many of the positive points of each pole, with as few negative points as possible. This can be depicted as an oval on the polarity map and can be described as seeking the both/and solution.

“We want to find a way forward that can give us the benefits of both short-term delivery focus and long-term development, with as few negative points of either as possible. What might that look like?” This invites new thinking. It also, helpfully, suggests that both sides are right in a way in arguing for their respective points of view, because there are advantages to each. However, it challenges each party to focus on the positives of both sides and build something new together.

An interesting simulation... using the polarity map below (Figure 26) stage a mock debate by imagining one person pointing out the plus points of a focus on short-term delivery and the minus points of long-term development – one diagonal of the cross – while another makes the points on the opposite diagonal of the cross. It comes out as remarkably realistic, doesn't it? We could actually just programme computers with polarity maps and they could carry on the debate without us! It would save us a lot of time and take us just about as far.

Obviously, we are being tongue in cheek here. But, the point is that surely we can be more creative than machines in our efforts to bring care to those who are counting on us to do so?

Figure 26: Polarity map example



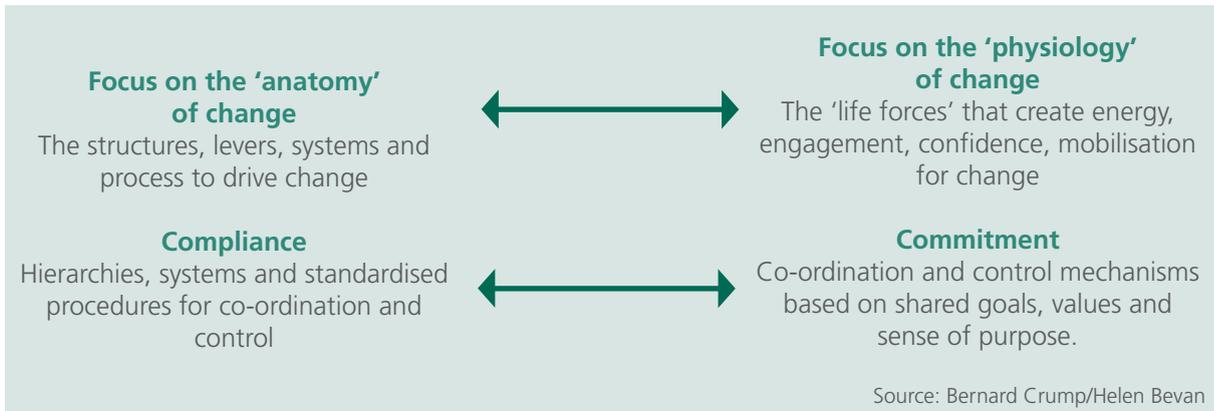
Adapted from an Academy team

Polarity mapping is not a silver bullet... Individuals can remain obstinate and entrenched in their positions, if they choose to do so. But, in the majority of cases, the reframing of the issue that the dialogue associated with constructing a polarity map creates brings new insights and a willingness to, at least, discuss the potential of a third way that takes us beyond the usual argument.

Examples

The diagram below (Figure 27) illustrates two polarities that several members of the Academy and its successors have identified as being key to bringing about LSC at the scale and pace required to meet the dual challenges of simultaneously improving quality and efficiency and implementing transformational system reforms.

Figure 27: Polarities to manage for change at scale



4.7 Leadership concept: Polarity mapping for leading through dilemmas and tension

The Academy Team from NHS North East found the concept of polarity mapping especially helpful in overcoming a frustration that was sapping their leadership energy.

We were stuck, going round and round in circles as a group, frustrated because we felt we hadn't got all the senior leaders bought into what we were doing. That was stopping us and we couldn't see how to get round it. The polarity model really helped. Framing the dilemma as 'change led from the middle' vs. 'change led from the top' enabled us to see that everybody is in the middle, really. Even those senior leaders are in the middle – they've got someone above them. What we mustn't do is use that as an excuse not to take action. Instead, you just need to ask how we do this in a different way – and that really helped us.

Lynda Cox

Head of Knowledge Sharing and Learning, NHS North East

Footnotes

1. Johnson B (1996). *Polarity management: Identifying and managing unsolvable problems*. Grand Rapids, MI. HRD Press.
2. There are several examples of polarity maps in Bibby J, Bevan H, Carter C, Bate P, Robert G (2009). *The Power of One, The Power of Many: Bringing Social Movement Thinking to Health and Healthcare Improvement*. NHS Institute. Available at: www.institute.nhs.uk/powerofonepowerofmany.

4.8 Leadership concept: Four venues of leadership

Description

Studies of LSC suggest that leaders must execute a skilful juggling act across what Frances Westley calls 'four venues'¹. Her research indicates that successful LSC leaders must:

- look UP hierarchically to the political process (both with an upper case 'P' and a lower case 'p') in which the change is embedded. Failure to understand the politics of a situation can undermine lots of hard work in a change effort
- manage IN to navigate bureaucratic processes that are essential for getting things done structurally. Many change efforts fall short and leaders get burned out, as a result of failure to work this venue effectively
- work THROUGH the adaptive process of action and reflection that is the nature of all large scale change efforts. This is, typically, the leader's main focus; but it cannot be the sole focus
- reach OUT in cultivating relationships and partnerships with others, in order to develop a sense of community and common purpose in the change effort. Failure to engage stakeholders effectively, including organisational partners and the public, can lead to strong reactions that sidetrack or derail the effort.

Figure 28: Four venues of leadership



Examples

At an Academy event participants studied and debated a Harvard Business School case study about the Washington Suburban Sanitary Commission (WSSC), a large, public water company outside Washington DC². The large scale change leader in that case, the firm's General Manager, made significant progress in transforming a failing organisation into one that significantly improved quality and efficiency, while reducing the workforce by 30%. The case clearly illustrated this leader's skill in navigating the adaptive action (THROUGH), bureaucratic (IN), and community (OUT) processes depicted in Figure 28. However, his efforts were ultimately undermined by his failure to deal effectively with the organisational and local government political (UP) processes.

Academy director Paul Plsek shared a leadership team discussion guide and set of tips for each of the four venues³ with participants. Several teams used this guide to identify gaps in their leadership skills and preferences across the four venues of leadership. This led them to recruit additional leadership team members in order to avoid the outcomes of the WSSC case.

Footnotes

1. Westley F. (2002). 'The devil in the dynamics: Adaptive management on the front lines', in Gunderson LH, Holling CS. *Panarchy: Understanding Transformations in Human and Natural Systems*. Island Press.
2. Edmondson AC, Hajim C (2003). *Large-scale change at the WSSC*. Harvard Business School Case, 9-603-056.
3. *Leadership team discussion guide* available at <http://www.institute.nhs.uk/academy>.

4.9 Leadership concept: Maintaining leadership drive and energy

Description

A final challenge for leaders of LSC that we will address here is that of sustaining oneself over what might be a long and emotional journey. There will be times and situations where you will feel tested, perhaps, sometimes, to the limit. The literature and the wisdom of others who have been at it a while, such as Academy coach Jayne Wilde, provides good food for reflective thought.

- Resilience is something that builds up through trying times. It is the ability to stand firm but without the brittleness that breaks; to take the knocks but then stand up again and be counted; to keep going, even when those around you appear to have no passion or stomach for the change. *Who comes to mind when you think about resilience and what can you learn from them?*
- Great leaders continue imagining what can be achieved, even when faced with the reality of what currently is. *Find ways to continuously cultivate your imagination and optimism through travel, reading, networking with others and further immersing yourself in your passions.*
- Richard Beckhard's¹ famous 'change equation' suggests that change can only occur when:
(Attractiveness of vision) X (Dissatisfaction with present) X (Sense of next steps) ≥ Pain of change
When you feel the 'pain of change' overwhelming you, reinforce yourself on one or more of the three factors. Also, note that if any of the three factors ever goes to zero, then the outcome is zero. *What will you do and who will you confide in, to help you bolster yourself in these three factors and guard against 'getting to zero'?*

4.9 Maintaining leadership drive and energy

- In contrast to traditional problem solving, which focuses on doing less of something we don't do well, appreciative inquiry² is a mindset that focuses on doing more of what works. It is optimistic and concentrates on the positives. By doing so, it breeds success, helping to fulfil the old proverb "we do not describe the world as we see it, we live in the world as we describe it". Positive thinking and optimism are essential mindsets for maintaining energy and drive, and they are often reflected in what we do and say; especially to those we consider to be in our 'inner circle'. *Check yourself and ask others to check you as well, on your language and approach to your situation as your LSC effort goes along. When you describe your work, your relationships, your colleagues, your clients or patients, other staff etc, – what language do you use? Are you building up or tearing down? Are you building confidence or undermining?*
- Energy can quickly be sapped by your reactions to events and people around you. Who hasn't felt drained after experiencing a 'knee jerk' reaction to something or someone who 'gets under your skin'? Anna Maravalas³ reminds us that we have a choice. We can have a reflexive, negative reaction, focusing on people and factors beyond our control (which drains energy), or a reflective, curious response that seeks reasons and learning (which gives energy). *How will you cultivate a reflective mindset that seeks, first, to understand, rather than blame?*
- Networking with others provides a critically important source of support in tough times. Reg Revans⁴ three questions can help you identify people you need to talk with when facing difficulties.
 - *Who knows?* Who might be able to help me with this situation, my next steps, or my learning?
 - *Who can?* Who are the people with the resources or power to get things done around here?
 - *Who cares?* Who shares my passion for this work? Who is concerned for me as a person and not just as a leader?*How will you build up your networks of support as you lead your LSC effort?*

- True LSC deeply challenges current ways of thinking and impacts widely on people's lives. Because of this, LSC is sometimes referred to as 'radical change' and those who lead are called 'organisational radicals'⁵. What we know about such leaders is that:
 - they know who they are and what is important to them; they have a profound sense of values and purpose
 - they have a strong sense of self-efficacy; they believe they can create change and that others will help them
 - they are action oriented and able to join forces with others
 - they use small wins to create more hope, self-efficacy and confidence
 - they are optimistic; seeing opportunities, while accounting for obstacles
 - they are able to rock the boat but stay in it; they walk the fine line between difference and fit, balancing conformity and rebellion, working within systems not against them
 - they are, often, not the senior leaders in organisations (although they can be); they are the essential, 'everyday' leaders who are often unrecognised.

How will you cultivate the personality of an 'organisational radical'?

Footnotes

1. Beckhard R, Harris RT (1987). *Organisational Transitions: Managing Complex Change*. Second Edition. Reading, MA. Addison-Wesley.
2. Cooperrider DL, Whitney D (2005). *Appreciative Inquiry: A Positive Revolution in Change*. San Francisco. Barrett-Koehler.
3. Maravalas A (2005). *How To Reduce Workplace Conflict And Stress – How Leaders And Their Employees Can Protect Their Sanity And Productivity From Tension And Turf Wars*. New York. Career Press.
4. Revans RW (1998). *ABC of Action Learning*. London. Lemos and Crane.
5. Scully M, Meyerson D (1995). 'Tempered radicalism and the politics of ambivalence and change'. *Organisation Science*, 6(5):585-600.

4.10 The changing face of leadership

Perhaps, now, you can see the basis for the shift in thinking that resulted in Academy participants creating the From-To tables at the beginning of this chapter.

The literature based leadership concepts in this section have had a powerful, transformative effect on many members of the Academy.

After their first year of effort, we asked Academy Teams to report on progress and specifically respond to this question: What will you, as leaders of change, now do differently compared to what you might have done before?

The NHS South East Coast Academy Team illustrated its leadership learning with the From-To table shown in figure 29.

Figure 29: NHS South East Coast Academy Team's From-To table

Pre ALSC thinking	Post ALSC thinking
Telling	Storytelling
Production	Co-production
Small	Big
Reactive	Pro-active
Frustration with blockers	Engaging them to test and challenge
Everything has to go to plan or I've failed	Use change and challenge to enhance delivery
If things go wrong it's my fault	Confidence in appreciating the levels of complexity

Dr. Phil Koczan, NHS London, referred to his work on introducing summary care records and stated "I don't believe I would have had the courage to take this on before."

The NHS North East team said it would now give much more thought to the framing of things, even when thinking through a problem or issue alone.

Anthony Kealy, NHS East Midlands, responded, “I have learned how not to over plan a change from the outset but to be comfortable with outcomes emerging through the framing, engaging and pragmatic changes cycle, looking for opportunities to unleash change rather than impose or micromanage it. The evolution of our regional Academy programme has particularly benefited from this approach.”

Judy Hall, NHS West Midlands, “My personal experience of large scale change is that recruiting the right people and getting buy-in from potential champions or potential adversaries is critical if we are to make the large scale change we need and to maximise development opportunities. On top of that, even really committed individuals and teams require coaching and support in order to maintain their energy and to move past the set-up stage to implementation and sustainability.”

Personal reflections...

How will you...

- develop and balance your inspirational and instrumental styles?
- create commitment to change, not merely compliance?
- create mindset shifts?
- influence others?
- manage polarities, dilemmas and tensions?
- succeed in the four venues of leadership?
- maintain your energy and resilience?

How will you now approach the leadership challenges of large scale change? Yes, it is a big job! But who else will do it? More importantly, how do you expect to succeed without doing it?

5. Spreading and sustaining large scale change

Having explored details of the concepts and tools for change management and leadership that lie at the heart of the LSC model, we return to a higher level view in this chapter to explore both the spreading and sustaining of a particular LSC and LSC thinking in general.

We begin with a look back at the underlying concepts from the literature and our tools and model, to note how you need to think about spread and sustainability throughout the LSC journey. We will draw special attention to the final stages of the model and suggest ways for leaders to keep an eye on the destination before them.

Next, we look at insights from the literature on the psychology of change and the spread of change in social systems. These can be translated into practical aids in planning for spread.

Finally, we look at how Academy Teams have begun the process of spreading LSC thinking more generally at national, sub-national and local levels across the NHS.

5.1 What does the model tell us about the spread and sustainability of large scale change?

In essence, the concepts and models of LSC are all about the sustainable spread of change, which might start small, across a wide context.

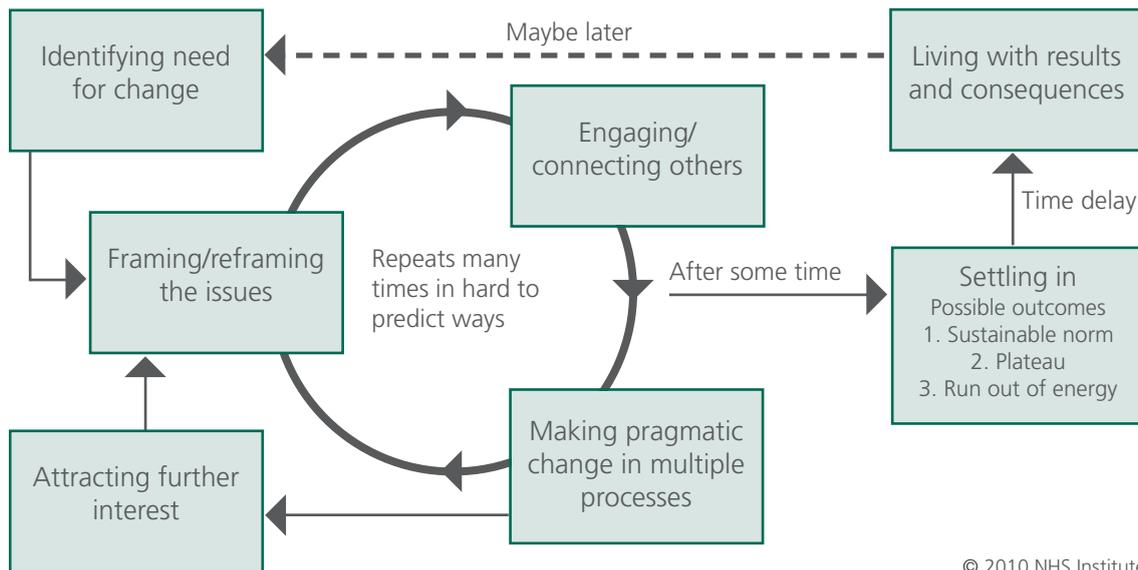
Recall, for example, these key themes from the LSC literature.

- **Framing and engaging in order to attract new supporters, develop distributed leadership and create mass movement.** In a positive sense, ideas for change spread like a virus across a system. 'Framing' or 'attraction' is the means by which the idea spreads and 'engagement' is what we call it when someone gets it. Many of those who get it pass it on, and that is what we call 'distributed leadership'. Viewed on a whole system scale, the spread effort looks like a 'mass movement' that builds momentum over time. As we learnt in the previous section, leadership is a key factor in the pace of this spread. Concepts such as the Influence Model give us insights into approaches to these issues. Change management tools, such as driver diagrams, stakeholder analysis and 30/60/90 day cycles support the thoughtful planning and execution of this spread effort.
- **Mutually reinforcing change across multiple systems.** Because complex systems like health and social care comprise structures, processes and patterns, engagement in change must spread across many stakeholders, who may not, initially, realise that they have a role to play. Although they may never come into contact with patients needing services, staff in finance, workforce development, communications and other diverse functions impact on care. Changes in clinical practice are difficult to sustain without harmonious changes in some of these other areas. Driver diagrams, systems analysis and the structure process pattern model help us to think through these issues.
- **Transforming mindsets, leading to inherently sustainable change.** The vast majority of people try to do what they think is right. Thinking that a current practice is 'right', in some sense, is what leads to the ultimate example of sustainability that we see every day in organisations of all types: resistance to change. When mindsets shift, change becomes easier and new practices become the norm. The Discovery Model (U-model) addresses this point directly, while framing and transformational storytelling are useful tools.

Spread and sustainability are also directly reflected in our model for LSC.

Large scale change will only be successful if as much thought is put into its sustainability as everything else. Sustainability is the result of great engagement, reinforcement activities and a belief in the new way of doing things which results in a mindset shift. In order to maximise the potential for sustainability start considering it from the start of your work¹.

Figure 3: Emerging model of large scale change



5.1 What does the model tell us about the spread and sustainability of large scale change?

- **The cycle.** The repeated activities at the heart of the model describe the way in which LSC tends to spread. This cycle plays out many times, somewhat unpredictably, over the life of a change effort. If it is done well (true mindset shift occurs as people become engaged and do things), sustainability is more likely to be assured. All of the concepts and tools we have presented here find application in various places in this cycle.
- **Settling in.** This phenomenon reflects the length and comprehensiveness of the spread effort and its ultimate sustainability. Every 90 days or so it is worthwhile considering where your effort might be heading with regards to these three potential outcomes, (see box below). Measurement and monitoring of both process and outcome indicators is essential to fuel this reflective effort.

Signs that your LSC effort may be running out of energy:

- You and your LSC leadership colleagues are personally growing weary.
- Partners and senior leaders are withdrawing resources, time and attention from the effort in a way that you feel slows or blocks your progress.
- You have tried repeatedly and creatively to attract new interest but have failed. Perhaps even those who were once active in the effort are starting to pull away.

Signs that your LSC effort may be heading for a plateau:

- You are neither attracting new supporters (or only a few), nor losing current supporters.
- Measurable results are being achieved but only in pockets here and there.
- You find yourself spending most of your time only with those who are already active supporters and you take great comfort in the fact that they are carrying on.
- When your conversations with active supporters turn to those who are not active, you disparage them and agree that they simply 'do not get it'.

Signs that your LSC effort may be heading for a sustainable new norm:

- You are attracting a significant number of new supporters on a regular basis.
- You hear about the work of others with whom you have not directly interacted but who seem to be getting on with achieving the vision anyway.
- Measurable results are being achieved (or at least suggested) on a large scale.

- **Living with results and consequences.** Regardless of where you settle in, your LSC efforts will have consequences. Poorly-led efforts can poison the path for future spread, or result in sustainable bad practices and mindsets. Even well led efforts might suffer unintended consequences. Remember that hindsight is typically 20/20, while insight and foresight rarely are. Be watchful for the consequences but don't let inordinate fear paralyse you into inaction.

Large system change is an exercise in identifying opinion leaders and seeking either to suspend their opposition, or gain their support. As change progresses across organisations, able enthusiasts are recognised and used as examples to others, thereby becoming the opinion leaders. They are tutored to ensure a consistency of message and vision. Leaders should seek to achieve an unstoppable momentum, requiring a subtle combination of psychology, marketing and campaigning using a delivery infrastructure. The enthusiasm and energy created by a well-constructed and well delivered large scale change programme is difficult to describe but it is the fuel that drives the scale of change.

Sir John Oldham, Academy coach

writing in the Journal of the American Medical Association, 2009. 301(9):965-6.

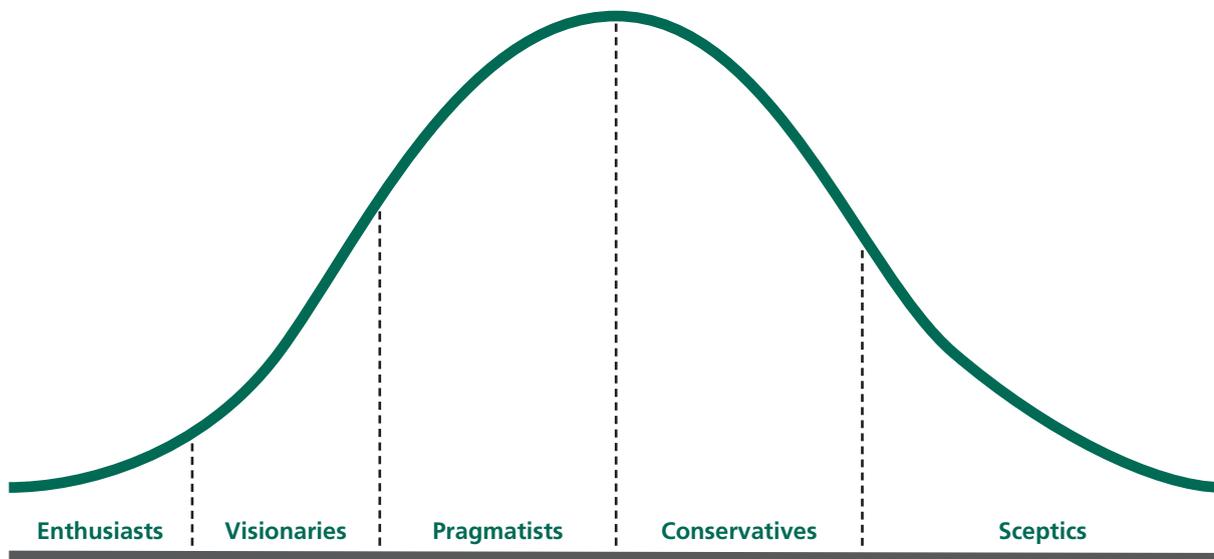
Footnotes

1. Maher L, Gustafson D, Evans A (2007). *NHS Sustainability Model and Guide*. NHS Institute. Available at: www.institute.nhs.uk/sustainability.

5.2 Understanding individuals' pre-disposition to ideas

Academy coach, Dr. Sarah Fraser, provided participants with insights into the phenomenon of spread and sustainability¹.

Figure 30: Spread and sustainability curve



Adapted from the work of Rogers (1995) and Moore (1999)

- One study of the spread of medical innovation noted that it takes about 17 years to turn 14% of original research into care that benefits patients. Further studies also show that healthcare has trouble stopping practices that have proven to be of little or no benefit.
- Individuals react differently to different ideas (Figure 30). This influences where they come out on the timeline of a spread effort and how we should approach them^{2,3}.
 - **Enthusiasts** are highly focused and committed to the cause. They like to be among the first to have a go at making an idea concrete. We need their endorsement, interest and enthusiasm.
 - **Visionaries** are forward thinkers who are willing to use their influence to break with the past but they are likely to want changes to what the enthusiasts have done.
 - **Pragmatists** 'protect' the system by asking for evidence and generalised proof of benefit before they will go along with any changes. They, typically, need to see the idea in place, as a whole, operating and functioning well.
 - **Conservatives** are a bit more pessimistic, more averse to risk and as a result, tend to be later adopters. In contrast to the pragmatists, they often want simple changes that work rather than seemingly complex, whole solutions.
 - **Sceptics** are the last to change (and may never) and are actually best left alone. They may have other priorities and we should respect that (unless it is a matter of safety). Sarah Fraser notes that "the trick is not to confuse the questioning visionary with a sceptic!"
- It is important to note that an individual can be a sceptic on one thing, a pragmatist on another and a visionary on a third. These are not durable personality traits but rather depend on an individual's judgement regarding a given idea.

These insights give leaders of LSC something to work with in planning for the spread of ideas.

Understanding these various pre-dispositions among your key stakeholders suggests a potential path of spread across a system. This can help leaders plan along an event timeline and avoid being blocked due to premature efforts.

Using the model to plan for spread of change

- Early on, find enthusiasts who will simply dive in and try something but allow them to work it out for themselves and give them space and organisational cover to do so. Be cautious about sharing too much information about this and, instead, consider operating 'under the radar screen'. The risk is that if you speak too enthusiastically about it all to a pragmatist stakeholder, you may switch them off as they label the idea 'half baked'.
- As you then look to move on to attract the visionaries, who are likely to be the more visible, longer term, distributed leaders, understand that they will probably want to modify what the enthusiasts have done. Being too insistent on 'one way' risks switching them off and stalling your spread efforts. Understand that this re-invention of the idea by the visionaries, who need to make it their own, will take some time. While you will need to maintain some sense of pace (30/60/90 day cycles can help), don't let your frustration explode into a "look, would you please just do this!" moment that switches them off or you will lose all pace.
- Looking ahead to the next group you will want to attract, the pragmatists, realise that you will need to put in good, whole systems data and story collection systems to capture it all for them to see. Engage them in some way during the time of the visionaries' efforts but avoid forcing them to 'buy in' before they are ready. Instead, allow them to observe and comment. Listen to what they ask about the idea and its implementation and then collect the data and stories they seek as proof of benefit. You will need to allow the time it takes for benefits to become apparent and seek to understand the minimum they need to be convinced. Help them think through the whole system of the idea as you move them into doing it for themselves.
- But, then realise that, at some point, you will need to begin to attract the conservatives. For them, simple, focused, not too risky bits of change are perhaps key to engagement. They are different from the pragmatists and the others you may have had success with. Be prepared to reframe your approach and 'sales pitch'.
- In the end, you'll have to decide what to do with the sceptics. If it is a matter of safety, you may have to employ somewhat negative consequences to get their conformity. But, note that you will have the weight of the vast majority of the rest of the stakeholders already in a mindset shift that might create enough isolation for the sceptics that they come along on their own. Regardless, the point is not to waste too much early effort on this group (subject to Sarah Fraser's 'trick', noted overleaf).

Footnotes

1. Dr. Sarah Fraser has written several engaging and practical books on a variety of topics in improvement and change. Two excellent books on the topic of spread of change are *Accelerating the Adoption of Better Practice*. Second Edition and *Undressing the Elephant: Why Good Practice Doesn't Spread in Healthcare*. Available at: www.sfassociates.biz. Material in this section is adapted from her September 2009 presentation to the NHS Academy
2. Rogers EM (1995). *Diffusion of Innovations*. Fourth Edition. Free Press. New York. NY.
3. Moore GA (1999). *Crossing the Chasm, Marketing and Selling High-Tech Products to Mainstream Customers*. Revised Edition. New York. HarperCollins.

5.3 Building capacity and capability for large scale change across the NHS

Participants in the NHS Academy for Large Scale Change have been enthusiastic about their personal learning and anxious to share insights with colleagues.

95% of participants in the final Academy event said that they had shared learning with colleagues.

While it is still early days, below is a sample of some of the plans and initial efforts for spreading LSC thinking more broadly. Note that they cut across the spectrum of formal, multi event educational efforts; master classes; coaching and informal education; and action learning. Think about what you might do in the part of the country that you can influence.

- NHS East Midlands built the model and tools of LSC into the curriculum of its Clinical Leaders Programme: Leading Large Scale Change which is delivered in association with the NHS Institute. This is a group of 80+ clinicians who play key roles in achieving the goals of *From Evidence to Excellence* (the region's transformation plan) and meet every eight weeks or so, for action learning. These leaders are applying the tools and models to their various efforts.
- NHS West Midlands has further developed their LSC model into a software tool and it is being used to support the development of Pathfinder Clinical Commissioning Groups in the West Midlands
- NHS South Central is taking LSC thinking out into its health communities, via master classes taught by Academy Team members.
- NHS North East has held master classes for colleagues, with Academy Team members offering their services as coaches for on-going efforts.
- NHS South East Coast has set up its own academy to support LSC associated with quality and cost improvement and other transformational goals across its three counties.
- NHS North West has held master classes for various groups, most notably leaders in public health from across the NHS and local government and is looking to build the thinking into its Health and Wellbeing Alliance.

Personal reflection...

What is your experience of the spread and sustainability of ideas in the NHS? Do you think we tend to do it well, or not so well? What have you seen that works? What do you know, from experience, does not work?

How will you plan for the spread and sustainability of your LSC vision?

What role will you play in spreading LSC thinking more widely among your colleagues?

As one participant said, ‘the programme is one where you live the principles that you are being taught’ and the evaluation findings suggest that it is the opportunity to apply new knowledge, tools and techniques to real LSC through intentional working relationships that are the key to building capability.

Dr. Valerie Garrow. Evaluation of the NHS Academy for Large Scale Change.
Institute for Employment Studies, January 2010

6. Case study application of large scale change: The North West Alcohol Harm Reduction Effort

It is a terrible thing to look over your shoulder when you are trying to lead and find no one there.

Franklin Roosevelt, American President

We now take a look at the concepts, methods and leadership challenges of LSC through the lens of a case study from one of the teams in the NHS Academy for Large Scale Change.

The NHS North West team has taken on the LSC challenge associated with the current prevalence and usage trends of alcohol in our society. We will follow the first 18 months of this team's effort in a chronological story format, with margin notes linking back to the various concepts, tools and models that we have described in other sections. Also note that the story tracks with the model for LSC (Section 2.4)

While this is still a work in progress, you will see how LSC thinking is leading this team's ongoing effort.

A short video about this project is also available on the NHS Institute's website at www.institute.nhs.uk/academy.

DRINK TWO GLASSES OF WINE PER WEEK? THAT ADDS UP TO THE SAME CALORIES AS AN EXTRA 34 ROAST DINNERS A YEAR?

DRINK WISE
NORTH WEST
REDUCING THE RISKS TOGETHER

SOMEONE IN THE NORTH WEST IS ADMITTED TO HOSPITAL EVERY 4 MINUTES BECAUSE OF ALCOHOL

DRINK WISE
NORTH WEST
REDUCING THE RISKS TOGETHER

Reducing alcohol harm in the North West

Identifying the need for change

The NHS North West (NW) Academy Team is a group of senior leaders (see box below), each working on individual LSC goals. However, they agreed it would also be good for their learning to select an important, common issue that they could all work on together in a mutually supportive way. Ruth Hussey and David Dalton convinced the group to focus on alcohol (which led to the addition of Hazel Parsons and Alison Wheeler, who joined the team in April 2009).

The NHS North West Academy Team

Jane Cummings	Executive Director of Nursing, Performance and Quality, NHS North West
David Dalton	CEO of Salford Royal NHS Foundation Trust
Dr. Ruth Hussey	Director of Public Health, NHSNW
Chris Jeffries	Associate Director of Commissioning and Professional Education, NHSNW
Hazel Parsons	Head of Communications and Advocacy for Alcohol, DHNW
Dean Royles	Executive Director of Workforce and Education, NHSNW
Mandy Wearne	Director of Service Experience, NHSNW
Alison Wheeler	Regional Alcohol Programme Manager, DHNW

Alcohol harm is a prominent issue in the North West, in terms of people drinking above sensible limits and at higher levels than in the rest of the country. It is one of the four biggest drivers of demand for services with the highest number of alcohol related admissions in England and has a negative impact, both on people's lives and on the healthcare delivery system. The region had just started a social marketing campaign – 'The Big Drink Debate' – to challenge current mental models about alcohol. This provided a platform to build on. The team also noted that the issue would be personally challenging because they all drink alcohol and would need to be prepared to role model the change they were talking about.

Theory: three dimensions of LSC

Leadership: Influence Model

Model: *unintended consequences*

Principle: *new vision beyond status quo*

Tool: *driver diagram*

Principle: *key themes*

Principle: *distributed leadership*

Tool: *measurement*

Principle: *distributed leadership*

Tools: *30/60/90-day cycles of change*

Leadership: *Influence Model*

A result of past LSC efforts? It is interesting to note that at least part of the environment that supports excessive alcohol consumption might, actually, be a consequence of a past successful LSC effort. Decades ago, city centres in the NW were renewed by efforts to create vibrant nightlife. While this obviously had many positive benefits, did it also increase alcohol consumption and create a greater social acceptance of it?

Despite general recognition of the problem in the region, the team wondered if a more aspirational vision was needed in order to engage others in a truly large scale effort. Dean Royles explained, “we found that 17 of our 24 local commissioners had reduction in alcohol related admissions in their strategic plans. However, at best, all of them were simply trying to reduce the rate of increase. Not one plan was aiming for fewer admissions.”

Initial 60 day cycle: Framing to engage acute sector chief executives

In January 2009, the team created an initial driver diagram, capturing their thoughts about what would be needed to really reduce alcohol harm. Not wanting to duplicate or appear to undermine efforts by commissioning organisations, the team initially decided to focus on acute trusts; knowing that efforts on other key drivers would proceed naturally on their own. They chose to work with acute hospitals to reduce alcohol harm in the North West, as measured by alcohol-related admissions, by a materially higher percentage than current strategic commissioning plans, as their initial aim. This open-endedness left room for refinement and ownership by those who might become engaged in the effort later.

Planning a cycle. Under this broad aim, the team designed its first 60 day cycle around the goal of actively engaging several of the acute trust chief executives in the region. They secured a place on the agenda of the region’s regular monthly chief executives’ forum in May 2009 - an experience they reported as being, “quite nerve wracking for us as we do not generally talk about this sort of personally emotive issue at that

meeting". To role model ownership of the issue, David Dalton volunteered to give the presentation in front of his peers. Team members divided up the list of chief executives and spoke to several of them beforehand about how they might present the challenge and achieve some support on the day. They also involved a communications team in putting the presentation together and reviewed plans with frontline alcohol specialist nurses, all with the goal of framing things carefully in order to create the greatest possible impact.

Tool: planning questions for LSC

Framing to engage. The presentation framed the issue of alcohol use from a variety of perspectives. To make it interactive and personally engaging, the team provided electronic voting buttons linked to the projector to instantly display the results. For example, they began by asking the chief executives how many would be likely to have a drink that night and then fed the results back to the group.

Tool: framing and reframing

David challenged his peers to think about their legacy as leaders in the community and cited a variety of rather dark health and wellbeing statistics. For example: every seven minutes in the NW someone is admitted to hospital for an alcohol-related issue, 50% of all violent assaults are alcohol related, a pint of lager has as many calories as a sausage roll and alcohol is one of the key factors in child and elder abuse.

When we were doing some of the framing around this with chief executives ahead of time, some were saying things like, "This is different to smoking; there is no such thing as passive alcohol". Try telling that to the child who is being beaten up by his father. There is an emotional tie in, then, in terms of some of the framing that we are doing with people.

Excerpt from NHS NW Team report to the Academy, July 2009.

David also pointed out that, while we tend to associate the alcohol issue with extreme anti-social behaviour, there is really a broader, cultural acceptance of drinking – a shared mindset – that we all take part in but that could be changed. To illustrate this, a team member lit a cigarette in the room as a way of stimulating reflection on the radical shift in cultural

Principle: mindset shift for sustainability

acceptance of smoking and the impact this has had on health and wellbeing. The team's question was whether some of the ways we now joke about alcohol consumption might, one day, become as culturally offensive as seeing someone smoking in a meeting room.

Tool: framing and reframing

Having made emotional and personal appeals, the presentation turned to the business case for action, noting that:

- on average, there are 3,000 alcohol related admissions every year at the average district hospital in the NW which is the equivalent to one ward being occupied at any one time
- alcohol related incidents make up 30% of all accident and emergency attendances and 70% of weekend night attendances
- they are the single greatest cause of aggression and violence towards our staff
- they are one of the principal reasons for staff absence, not only because of the alcohol that they consume but because they may be at home dealing with the effects of domestic violence or abuse of an elder or child.

Leadership: Influence Model; ambidextrous leadership

The presentation ended with a 'clear ask' – a personal call to action for the acute trust chief executives. The team challenged them to:

- find out how alcohol impacts their staff, talk to their patients about the issues of alcohol and think about their personal relationship with alcohol
- spend some time with the alcohol specialist nurse and find out what they do in their hospitals
- explore advice on what high impact changes they could make in their organisation
- run a communications campaign in their hospital about some of the consequences of alcohol.

Principles: attracting new supporters; emergent planning, monitoring, adapting

Tool: continuum of commitment

Attracting further interest. Following the session, the team made phone calls to each chief executive. Reactions were wide ranging and included: disinterest, anger at feeling preached at, supportive but too busy, supportive with initial actions taken and willingness to be even further engaged in leading or working on some aspect. The team created a commitment analysis tool to track the level of engagement in this key stakeholder group.

Impact of a well framed message. At an Academy event, the NW team presented a version of the chief executives' presentation. Participants complimented them on a good example of engaging others by providing multiple perspectives and including both emotional and analytical input. At a subsequent event, one of the participants shared the impact the presentation had on her personally. "I was so moved when Dean [Royles] asked us, 'Who is going to have a drink when they get home?' I would have had half a bottle of wine on a Friday night, probably one on the train. But, I actually didn't have anything. And I haven't had any alcohol since then. Now I've probably gone to the extreme. But, actually, I feel so much better and I'd just like to thank you for being so inspirational as a team."

Next cycles with hospital chief executives: developing the business case

The chief executives wanted more detail on the business case for investing in efforts to reduce alcohol harm at a hospital level. The team had anticipated this request and immediately asked for volunteers to form a working group.

David Dalton chaired the first meeting in July 2009, with representatives from finance, nursing and public health teams in eight organisations. Attendees came with their organisation's information, creating an engaged and active atmosphere. Several had already discovered that when they look at the top twenty reasons for attending accident and emergency, alcohol was a major factor. It was noted that there was evidence for the effectiveness of some hospital interventions and that NICE guidance was soon to be issued. This, essentially, reframed the issue for some from a nearly-impossible challenge to a hopeful one. The group created an aim and planned a series of working sessions to develop a framework business case that organisations could plug their own numbers into. The plan was to present this at the January chief executives' forum. They felt it was important for each chief executive to be able to look at her or his own numbers.

Leadership:
ambidextrous leadership

Tool: *framing and reframing*

Tools: *30/60/90-day cycles of change*

Attracting further interest. In order to maintain interest in the issue during the long period of development of the business case framework, the Academy Team created two podcasts. These featured Professor Ian Gilmore (President, Royal College of Physicians) and John Saxby (acute trust chief executive in the NW), talking about how alcohol harm has affected the public and staff working in a health environment. These were widely distributed and helped maintain the 'social buzz' critical to success of LSC.

The group's rich exploration of the topic identified both quick wins and interesting patterns about how people access and in some cases, abuse the service. Analysis indicated that there are about 10,000 potentially avoidable admissions and over £20 million savings possible over two years. An important finding was that a trust or commissioning organisation cannot do this in isolation; they have to work together and share the costs and benefits to achieve the business case changes.

Commenting on the group's work, Alison Wheeler, Regional Alcohol Programme Manager, said, "it was a real Pandora's box when we started looking at it but in the end, the result is understandable and there is a good business case for doing something about it."

The January 2010 presentation to the chief executives went well. Several trusts are currently populating the business case tool with their own data and working with commissioners as part of the region's planning efforts for quality and cost improvement. Issues that will determine if this effort hits a plateau, runs out of energy or goes on to future cycles of sustainable change include: how to work out the gain sharing from savings between the commissioners and the trust, whether the commissioners will supply pump priming money and whether trusts will actually close beds to liberate the costs as a result.

Model: *settling in*

Principle: *distributed leadership*

However for now, the programme appears to be continuing to attract attention and gain momentum. Another chief executive has volunteered

to take over the chair role from David Dalton and several chief executives are serving as role models, by doing such things as keeping a personal drink diary during Alcohol Awareness Week. At an April 2010 meeting attended by representatives from 20 organisations (hospitals and commissioners), participants agreed an action item for each locality to kick start the new approach outlined in the case for change i.e. sharing the risks/benefits between hospitals and commissioners and feedback progress. The group also feels that it should be able to capture early wins and signs of progress as something to hold up to attract further interest.

Leadership: *Influence Model*

Tools: *30/60/90-day cycles of change*

Our Board has evening sessions with the local system – local government and the local NHS. We invited them to tell us something that they wanted to tell us and they chose alcohol. What was absolutely fascinating was one of the chief execs basically gave the business case and presented that back to us. She never mentioned the words Large Scale Change but was totally owning it from the top of her organisation. It was everything we'd talked about in terms of how we want chief execs to take it. She had just gone on the whole journey and was now telling other people. It was great.

Dr. Ruth Hussey, commenting at the November 2009 Academy event

Principles: *attracting new supporters; distributed leadership*

Cycles with alcohol specialist nurses: another key acute sector stakeholder group

In the preparation for the initial chief executives' presentation, the North West Academy Team interacted with several of the alcohol specialist nurses who are based in acute trusts. There is good evidence for interventions by these professionals and, so, the team created several 60 and 30 day cycles aimed at this group.

Tools: *30/60/90-day cycles of change*

One such cycle was to encourage both chief executives and alcohol specialist nurses to seek out one another to raise awareness of issues and potential interventions. This created several good, local connections that can serve as the foundation for further work.

I emailed my chief executive, initially, to request a short meeting to discuss our role and the impact of alcohol on hospital admissions. He replied quickly and we met within a week. He praised us for being proactive and requesting to meet with him about our service... [due to him being fairly new in post]. He was very surprised at the figures we presented and shocked to hear that at any one time, one ward at the hospital could be full of patients with alcohol related admissions. We requested more senior management input to help champion and prioritise alcohol within the hospital. He agreed that this was a good idea. He asked us to produce a wish list for him as to what the ideal service would be and asked us to meet with him again.

Joanne Hough, Trafford Commissioners

Principle: mobilising mass movement

Principle: distributed leadership

Leadership: patterns in complex systems

Principle: multiples of things

Tool: systems and stakeholder analysis

Another cycle involved an event for alcohol specialist nurses and directors of nursing in November 2009. The goals were to: (1) create a coalition among these professionals and senior leaders for the changes identified in the business case and (2) build a supporting network for workforce development for alcohol nurses. The event was attended by more than 60 alcohol nurses and directors of nursing and the feedback was very positive. Work and sharing regarding the case for change and workforce development is now continuing, with good momentum in local groups who are integrating this work into existing leadership structures.

A third cycle involves creating a mini workforce plan for alcohol specialist nurses to inform professional development commissioning plans for 2010-11. If the business case for change were to be fully implemented across the region, there would be a significant shortage of these key professionals to serve both in the acute and community setting. This stream of work is designed proactively to address this need.

Cycles with other stakeholder groups

Over the summer of 2009, the team constructed system maps of alcohol harm improvement groups in the NW and created a stakeholder analysis table for the acute sector work. The group took the analysis further by rating each of the 31 stakeholders with regards to their power and

interest in creating change. Team discussion then centred on how to raise the interest in change in those who had power and how to increase the power of those who already had interest in change. This led to the creation of a number of parallel 30 and 60-day cycles.

- The team reframed the chief executives' presentation and took it out to various stakeholder groups e.g. nursing directors, medical directors, HR directors, commissioners to begin engaging them in the case for change. This creates high levels of awareness and a supportive environment for localities when they are ready to engage in meaningful change. The next cycles being planned will channel this awareness into concrete action; for example, building on strategic commissioning plans.
- Work is underway on a hospital based communications campaign to raise awareness among staff about alcohol harm. The team is also working with a university to conduct a survey into staff experiences and attitudes around alcohol. This will lead to future cycles with HR leads to include alcohol in staff wellbeing efforts.
- Team members are also working with others to create support materials and a network for local NHS alcohol champions who will aim to mobilise a social movement within NHS staff around alcohol harm and what they can do about it.
- Initial efforts are also underway to create a local authorities' working group to network those who are already taking action and potentially to join up efforts across sectors.

Principle: multiples of things

Tool: Framing and reframing

Principle: mobilising mass movement

How will we know we are having an impact?

The North West Academy Team has been continually aware of the need to measure the impact of its efforts on three levels: outcomes, process and individual cycles.

- Clear outcome measures for the hospital setting work are reducing hospital admissions related to alcohol and achieving cost savings. However, as the effort spreads out to cover more of the system, the team will want to track health and wellbeing outcomes for both the public and staff.

Tool: measurement

Tool: driver diagram

Principle: attracting new supporters

Tool: 30/60/90 day cycles of change

Tool: driver diagram

Principle: key themes

Principle: mindset shift for sustainability

Tool: measurement

- Understanding that LSC is about mobilising others to action, the team is tracking the process of actively engaging key stakeholder groups. Aspirational goals include: 80% of acute trust chief executives have publicly shown their support; and 90% of directors of nursing, and 100% of alcohol nurses are aware of and support, this work. Furthermore, since there is evidence for several interventions by alcohol nurses, the team plans to track indicators of the spread and utilisation of these practices as another type of process measure.
- Finally, the team maintains an LSC action plan that lists all 30/60/90 day cycles, along with a measurable outcome for each.

Looking to the future

In late February 2010, the NHS North West Academy Team met to reflect on efforts and to plan for the future. The team updated its driver diagram (Figure 32) and noted how much more effort is needed to truly bring about LSC. However, this driver diagram provides a way to track all the effort and maintain an awareness of the 'big picture'.

Knowing that mindset shift is the true long-term goal of any LSC effort, the team also created a model for the journey that it is hoping to see organisations and professional groups in the region take over the next five to 10 years. This provides yet another way to track progress over time.

Figure 31: NHS North West Academy Team's model to track the journey



Note: Back-flowing arrows in the journey indicate that as organisations /groups start doing concrete things, there will naturally be increased awareness, revisions of strategies and so on.

The work on reducing alcohol harm is undergoing a rapid transition, from a programme being overseen by a somewhat ad-hoc team of senior leaders in the region to one where leadership is more widely distributed and where achievement of goals is more integrated into people's day job. As alcohol is one of the region's four key drivers of demand, this work is easily integrating with strategic goals and plans for quality and cost improvement.

Principles: *distributed leadership; emergent planning, monitoring, adapting; refreshing leadership energy*

In late 2010, NHS North West launched its own, local version of the Academy, training dozens more individuals in LSC thinking and methods and initiating new strands of work. The effort is also now being funded from the Regional Improvement and Efficiency Fund (RIEF) to extend the application of large scale change in alcohol to work with local authorities in the North West.

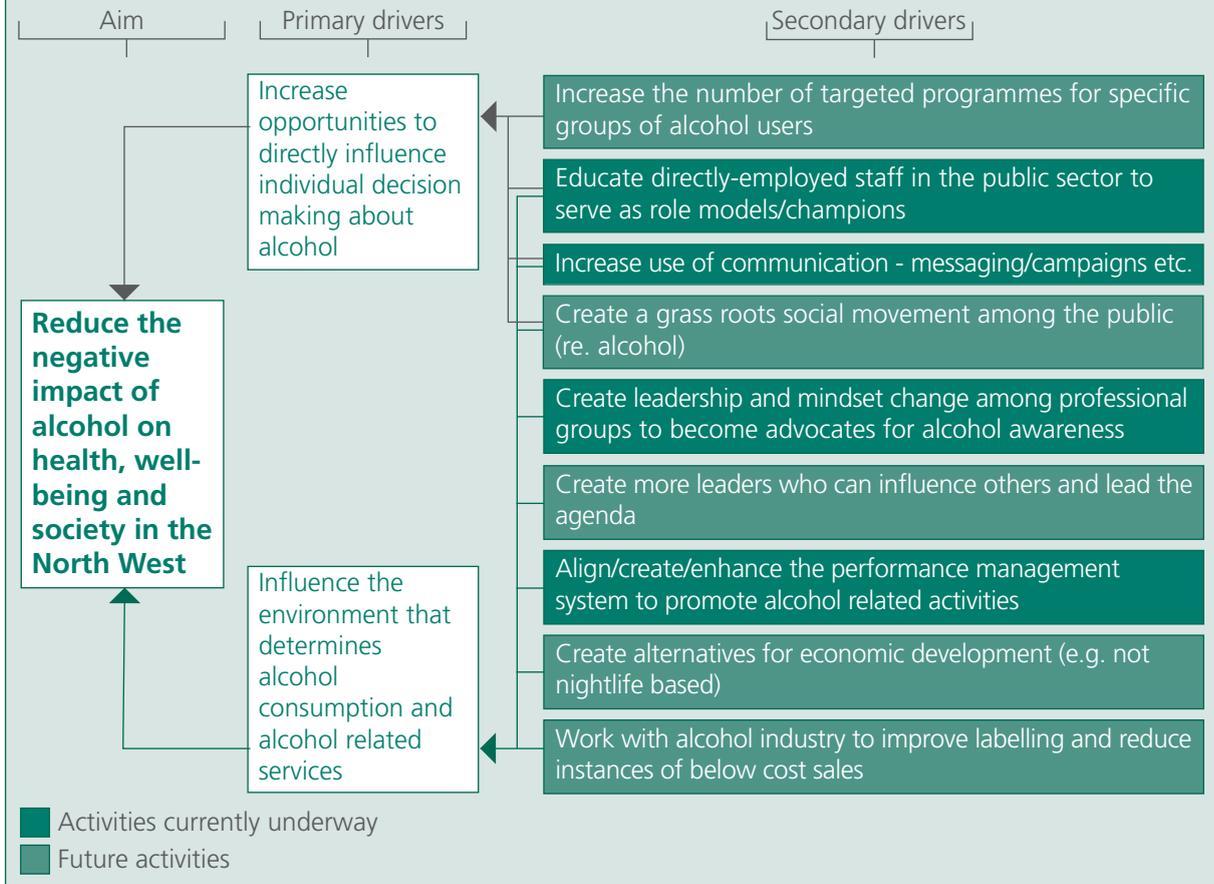
Lessons learned: Reflections by the NHS North West Academy Team

The NW team reported on its key lessons learned about LSC.

- There are a surprisingly large number of stakeholders.
- Continually frame and reframe the message and provide multiple framing to the same audience, in order to maximise target impact and enable others to look at the issue in ways that appeal to them.
- Take advantage of the existing infrastructure, e.g. using the monthly chief executives' forum to launch the effort.
- Have multiple, short action cycles and approaches to various groups going simultaneously.
- The main challenge is the change in mindset required; for example, the perception that it is funny to drink or that there is no such thing as 'passive alcohol effects'.
- Experience with LSC is transferable to other streams of work (each member of the team has continued to apply LSC thinking to their individual LSC goals).

While this remains a work in progress that is only in its early days, the NW alcohol project illustrates the emerging nature of LSC efforts and shows how the principles, models and tools can be adapted to suit the context.

Figure 32: NHS North West Academy Team's driver diagram



7. Conclusion

How wonderful it is that nobody need wait a single moment before starting to improve the world.

Anne Frank, Diary of a Young Girl, 1945

So, I'm incredibly optimistic. Firstly, because it has to be done, it's not an option. It's a war on waste, error, duplication, cultural mediocrity and a culture of self interest. And the NHS is fantastic in a war. When we're involved in a major incident of some sort, the NHS is fantastic.

The second reason for my optimism is the willing response I'm seeing. Imagine this... I've been going around the country, talking about the biggest financial challenge we've ever had and I've had fantastic receptions from groups of clinicians and leaders. People understand this is an external problem and because we care about the NHS and because we are its current stewards, we should deal with it. When we convert that into action, it will be tough and that's when leadership is important.

There is a willingness now. We've made a great start on the engagement and it will get tough. We need a war on that culture of backing away from difficult issues and to have a determination to follow through. But, because we are the organisation we are, I think we have a fantastic opportunity to make this happen. Your work on this is not just a nice add on. It's essential.

Jim Easton

National Director for Improvement and Efficiency

7.1 Your leadership challenge: Transforming care

Leading LSC is a big challenge. But, you can take heart in knowing that your colleagues in the NHS Academy for Large Scale Change and other similar sub-nationals and local groups are rising to it, while the environment in the public sector is increasingly demanding it.

We have introduced you to the essential elements of change management and leadership thinking from the literature on LSC and the experience of others. Some of it may be challenging to you and your personal leadership style. You may feel a bit of discomfort. But, here again, you will find yourself in good company...

Dr. Nikki Oatham, Professional and Strategic Lead for Psychological Practice, Kent and Medway NHS and Social Care Partnership Trust, member of the NHS South East Coast team, commenting on her personal journey from her work as a frontline clinician to a position of leadership in the transformation of services said... "It was a journey from the doing to the leading and enabling others to be able to step up into those positions of leadership as well. I remember at the very first session of the Academy, it is very distinct in my mind. We talked about having to 'be the change you want to see out there'. I was sat there feeling quite overwhelmed and thinking 'I should just be back doing clinical practice'. But, actually through this whole process, it's really about me recognising I was trying to over compensate for difficulties in the system. In doing that, I actually stopped other people getting on and progressing the large scale change. It's been a very difficult lesson but a very important one."

7.1 Your leadership challenge: Transforming care

The Institute for Employment Studies (IES) provided an independent evaluation of the Academy that included interviews, event feedback and reviews of team reports. In the January 2010 final report¹, Dr. Valerie Garrow concluded...

The Academy evaluation overall supports the initial hypothesis that leaders need a grounded theory of LSC in order to be confident and competent... the theory behind the design of the Academy was sound... It has been a brave and innovative initiative to develop capacity and capability for LSC within the NHS.

Evidence from the IES evaluation also suggests that some of the most likely predictors of success in large scale change are when:

- there is a clear, strategic priority that can be described as LSC; that involves multiple organisations; and has a diverse and well placed team, with senior level sponsors who see delivering the change as part of their day job.
- the senior sponsor is fully engaged with the LSC and works actively with the team to ensure success through agreed measures, as well as alignment with strategy and context.
- teams and individuals are of sufficient status to influence and engage the wider system.
- there is a strong structure for coaching in place, as coaches provide challenge and support to keep the focus on the LSC goal.
- teams and individuals are exposed to high level strategic thinking and direction, in response to the changing social and economic context. They have access to a national network of peers to share learning; and are provided with the latest theory, tools and techniques to refresh their approach and enable them to bring flexibility and innovation to LSC.
- teams and individuals have space and time away from their daily routine to reflect and learn.

Participants identified the value gained from the combination of knowledge, practical tools and a framework for working with the complexities of LSC. The concepts, tools and models in this publication can now be a 'starter kit' for your journey of LSC.

Welcome to the challenges ahead.

Footnotes

1. Garrow V (2010). *Evaluation of the Academy for Large Scale Change*. Institute for Employment Studies. Material in this section is excerpted from this report, the full version is available at: www.institute.nhs.uk/academy.

7.2 Acknowledgements

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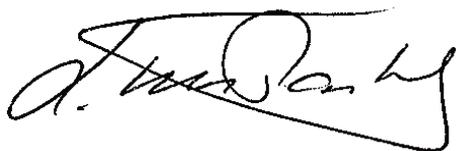
7.3 Thanks

As the managerial lead for the Academy I would like to personally thank all the participants, the support team, the Academy faculty and the NHS Institute board for 18 months of complete support and interest in this work. Leading the Academy has been one of the greatest highlights of my career. To have had the personal opportunity to be coached by and learn from Helen Bevan and Paul Plsek in transformational change has been a unique opportunity and experience. I hope this publication is now used and valued by leaders of the NHS, other healthcare systems and other sectors as providing a central resource for tools, techniques and case studies when considering delivering change across multiple organisations.

For those who were actively part of the Academy, our joint challenge is to maintain and develop momentum, to recognise that a focus on large scale change - supporting organisations to consider the cost agenda as a whole system quality and safety agenda, is the way forward as we take the NHS into the future.

Our partnership working and focus on personal, organisational and system priorities and actions is our new mission and our collective call to action.

I would like to give my very personal thanks to Jacqui Fowler who has relentlessly supported the editing of this wonderful guide. You have ensured we kept pace and have motivated Helen, Paul and me throughout the whole process.

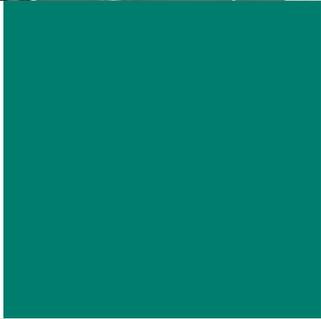


Lynne Winstanley

NHS Institute for Innovation and Improvement







Appendix: Narrative version of the model for large-scale change

Large scale change in a social systems context (e.g. the NHS) comes about...

...when there is a sufficiently well-defined topic area...

... that has been translated into a vision and key themes that people can understand...

...on which there is a sufficient mix of pressure, will, incentive, consequences, receptivity, (re)connection to existing values, etc...

...that is felt (i.e., experienced on an emotional as well as an intellectual level)...

...by a small but large-enough, group of people...

...who then find some means to exert some influences...

...over multiple processes and subsystems (e.g. service delivery, handover processes, clinical decision making, finance flow, public opinion, policy, etc.)...

...to make some pragmatic changes in a sufficiently effective and visible way.

This pattern of framing/reframing, engaging and connecting others, and making pragmatic changes in multiple processes and subsystems repeats many times, in hard-to-predict ways.

Momentum is further created by...

...the appearance of success (e.g. measurements, stories, celebrations)...

...that is communicated widely and effectively enough...

...to attract previously neutral others, who then join actively in the change process, ...

...thereby creating another cycle of framing/reframing, engaging and connecting others, and initiating pragmatic changes in multiple processes and subsystems.

This momentum continues for some time until (in reverse order of frequency of occurrence):

1. The change becomes a reasonably well-established norm across a social system, and multiple processes and systems have changed or adapted to accommodate or support it in a sustainable way. This is, obviously, the hoped-for outcome.
2. The change hits a plateau at some level and is no longer attracting new supporters. (At this point, people tend to separate into those who believe they 'get it', and others who these people think 'simply do not get it'. The ones who think they 'get it' can become cynical and separated unto themselves; thereby effectively preventing further attraction of others and sealing the change at the plateau. A new round of LSC and renewed interest might come later; perhaps with new players, which can further embitter the old players.)
3. The effort effectively 'runs out of energy' for some reason (lack of engagement, lack of resources, attention diverted elsewhere, political change, etc.) and simply fades away.

The full, measured results and unintended consequences from a true LSC are often not known until some time into the future. By that time, things have typically already sorted themselves into the three categories above. Therefore, while data is helpful and essential, throughout most of the process of LSC a certain amount of faith, courage, intuition, judgement and proceeding forward on incomplete evidence is inevitable. Hindsight is always 20/20, insight and foresight rarely are.

Future LSCs may be required to build further on what has been accomplished, or to undo the damage; but there is no way to know in advance. Inordinate worry about change paralyses action, sustains the status quo and is sometimes used as a 'trump card' by resisters to justify inaction.

At a high level, the case study evidence about large scale change shows remarkably similar patterns, regardless of context or organisational setting. Whilst every LSC will be its own unique journey, there are specific actions that we can take as leaders and advocates of change to orchestrate and accelerate the pace and scale of large scale change.

