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Institute for Innovation and Improvement

Part 2

Leading large scale change: The postscript

Why do leaders of health and healthcare need these principles of large scale change right now?

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Introduction

Why do leaders of health and healthcare need these principles of large scale change *right now*?

Part 2 of *Leading Large Scale Change* complements Part 1, the main body of the publication. Its purpose is to reflect on the learning and messages about large scale change (LSC) explored in Part 1 and apply them to the current situation experienced by the NHS and its partner organisations to support health and healthcare improvement.

Part 2 highlights five of the most important messages from the NHS Academy for Large Scale Change (the Academy) that can help deliver the current NHS transformation agenda.

Five key leadership messages from the NHS Academy for Large Scale Change

1. Match our mindset and methods for change to the level of ambition for change
2. Manage our own energy and that of the people around us, for the long haul
3. Build leadership systems that are managerially loose but culturally tight
4. Redefine leadership boundaries within the 'NHS system'
5. Act to accelerate large scale change to a revolutionary pace

Summary

This is a summary of the five messages in Part 2 of *Leading Large Scale Change*

Message one
Match our mindset and methods for change to our level of ambition for change
Currently, many NHS provider organisations are facing unprecedented challenges to improve quality and reduce costs. The scale and pace of change they are seeking is large scale, in line with the definition used by the NHS Academy for Large Scale Change. We have to match these transformational ambitions for change with change methods and a mindset that is also transformational in nature. If we have transformational ambitions but we utilise our existing improvement methods, many of which are not designed to create transformational change, the outcome is likely to be underachievement of goals for large scale change. *Leading Large Scale Change: A Practical Guide* offers a set of transformational methods that match with transformational ambitions and increase the likelihood of achieving large scale change goals at pace.

Message two
Manage our own energy and that of the people around us, for the long haul
Energy, not resources or time, is the fuel of high performance (Loehr and Schwartz). Building and maintaining energy for change is one of the most critical tasks for a leader of large scale change. We need to unleash sources of energy for change at all levels, across the entire system, not just rely on those at the top of the organisation to generate the energy. In the current NHS context, we particularly need to build emotional energy (the energy of connectivity, collaboration and relationships) and spiritual energy (the energy that is created by building a sense of a hopeful future, shared purpose and connecting with core values) to complement and enhance the intellectual energy and physical energy that is often prevalent in NHS organisations and systems.

Message three
Build leadership systems that are managerially loose but culturally tight
As NHS leaders, if we want more control of change, paradoxically, we have to give up some control. Successful leaders of large scale change typically build strong cultures based on a

common purpose and shared values, thus reducing the need for micromanagement. They are likely to have built their efforts on a platform of commitment (collective action towards a different future and shared purpose) rather than through compliance with new policies, payment systems or operating rules. They are also likely to be working through a distributed leadership system focussing less on the behaviours and actions of individual leaders and more on the relationships, interventions and leadership practice across the whole system including connectivity with other leaders.

Message four
Redefine the boundaries of leadership within the 'NHS system'

As the task of delivering health and healthcare becomes more complex and the scale and scope of change increases, we need to think widely and innovatively about how we define the leadership role in a future distributed system. Leaders of the future are likely to include clinical leaders, community leaders, service users and local government, voluntary and independent sector leaders. We can call these leaders to action if we can create a sense of 'us', a shared purpose around a common cause. There is potentially a huge pool of leadership talent if we build the capability to organise and develop these leaders.

Message five
Take actions that will accelerate large scale change to a revolutionary pace

The NHS Academy for Large Scale Change identified a series of tools and strategies that leaders in the health and healthcare system can use to accelerate large scale change. We can connect NHS leadership tasks to a higher purpose and a deeper meaning, creating powerful narratives that frame the challenges that the NHS faces in ways that produce conviction, understanding and energy for action amongst key stakeholders. We shouldn't over-rely on reorganising structures and processes as catalysts for change. Successful transformation depends as much upon changing the patterns of relationships, organisational power, conflict, decision-making and learning that underpin behaviour in organisational systems. We can organise for action using a complex adaptive systems perspective as well as a traditional programme planning and management lens. We need to consider how we create mutually reinforcing changes across multiple areas if we want to achieve pervasive change at scale.

How can the tools and approaches from the NHS Academy for Large Scale Change help in our current situation?

There is much in Part 1 of *Leading Large Scale Change* that can help in current efforts to transform care including models of change, mindsets, leadership approaches and practical tools. In fact, the evidence base on large scale change suggests that the kinds of approaches set out in this publication could make a fundamental difference in achieving our current NHS change goals.

The current NHS agenda, whether we focus on system reform, the challenge of delivering unprecedented improvements in quality, innovation, productivity and prevention (QIPP), transforming care delivery and/or new partnerships and relationships, is an agenda of significant change. If we use the yardstick of 'three ways to describe large scale change' set out in Section 2.1 of Part 1, we have to conclude that the interventions that NHS leaders need to be making now are large scale rather than incremental, small scale changes. We deduce this as a result of the depth, pervasiveness, scale and complexity of the changes required in our current context. As David Nicholson, Chief Executive of the NHS said when he described the combined challenge of system reform and QIPP goals, "it is the biggest [change] I have ever seen in my career in the NHS"[1].

The encouraging news is that the evidence base on LSC suggests that successful large scale change efforts tend to follow similar 'rules' or patterns. The picture of LSC is fairly consistent, regardless of topic or setting (Section 2.3). Furthermore, it also suggests that there are actions that leaders and advocates can take to orchestrate and accelerate large scale change to a revolutionary pace.

Nothing in the current NHS context suggests that our scenario is 'fundamentally different' to other large scale change efforts. 'Rules' that apply to other transformational change also apply to the NHS. The models, approaches and learning from the Academy provide valuable, thoughtful and evidence based guidance for successful large scale change in the NHS system. As NHS leaders, with ambitions for large scale change, we should consider building our strategies for LSC in line with the definition identified by the Academy as stated below.

Large Scale Change 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 (Section 2.3).

Message one

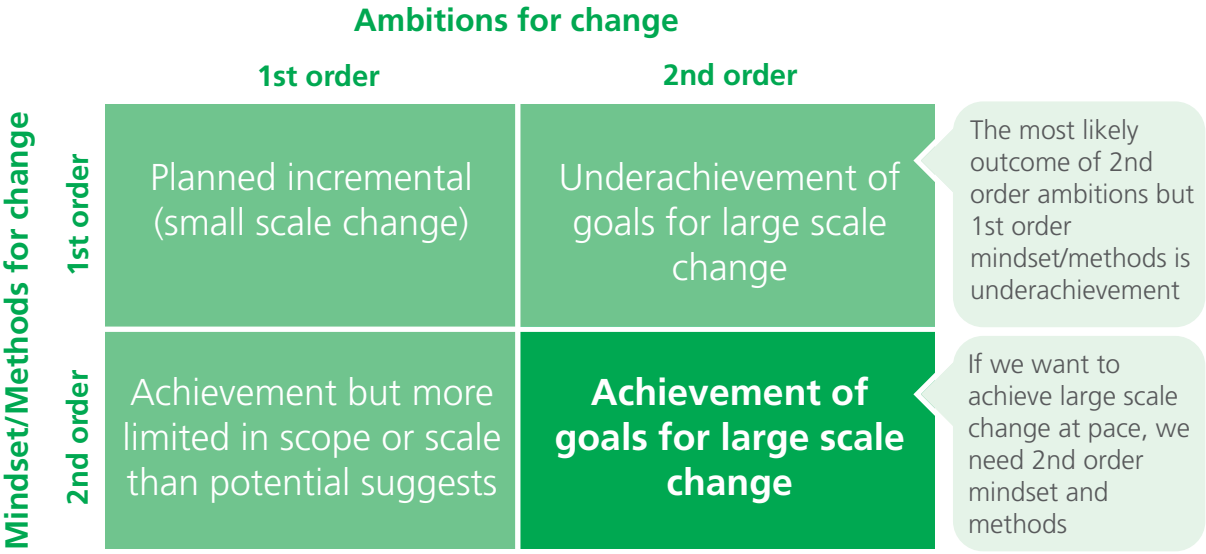
Match our mindset and methods for change to our level of ambition for change

An important motivation for establishing the Academy in 2008 was that the toolkit of change methods then available to NHS leaders was largely designed for small scale, incremental change and not for the radical, system level changes that leaders increasingly find themselves facing. The learning from the Academy concerning how to go about LSC, how to work with a theory of large scale change and how to maximise the likelihood of desired outcomes, is relevant to leaders at all levels in the NHS and in its partner organisations. However, it is particularly pertinent to senior leaders of provider organisations in the current context. Such leaders run mental health, hospital, ambulance, community and other health and social care services worth nearly £80 billion a year. This community of leaders finds itself facing unprecedented cost improvement programmes of 5% reductions or more, across the whole organisation[2]. This is not a short term, in-year challenge. Similar levels of cost reduction are projected for several years to come. This level of year on year compound cost reduction is unprecedented in the experience of any healthcare system, anywhere in the world[3].

The methods and underpinning mindset for change set out in this publication are '2nd order' in that they help us to fundamentally re-see, re-think and re-design current arrangements (Section 2.1). The Academy taught us about the relationship between mindset and methods. The change methods that we choose to utilise for LSC are determined by our own internal theory or mindset about what it will take to make change happen. One of the outcomes of the Academy experience was both an expansion of our mindset about LSC and a subsequent broadening of our toolkit of change methods[4]. The 2nd order methods promoted by the Academy can be contrasted with '1st order' change methods, which are about doing more or less of what we do already, in the same mindset as present.

Of course, in the current NHS context, an effective cost improvement programme will be a mix of 1st and 2nd order methods: seeking to deliver basic systems effectively and efficiently (1st order) whilst at the same time, radically redesigning processes and structures of care (2nd order). The point is that we maximise our potential to deliver our cost improvement goals if we align our (2nd order) ambition for large scale change with a delivery strategy that is built on a 2nd order mindset and methods. This is demonstrated in the figure below.

Figure 1: Matching our change mindset/methods to our level of ambition for achieving large scale change



Source: Adapted by Helen Bevan from Brooks and Bate (1994)

If we combine 2nd order ambitions for change (say, a goal of 6% reduction in costs, for three consecutive years, with no reductions in quality or patient safety) with 1st order change methods (say, reducing the budget allocation of every department and expecting staff to deliver current models of care with less resources), the outcome is likely to be 'underachievement' of goals for large scale change[5]. If, however, we utilise the kind of 2nd order methods and approaches set out in this publication to match our 2nd order ambitions for quality and cost improvement, we are more likely to achieve the transformational outcomes that we seek.

Message two

Manage our own energy and that of the people around us, for the long haul

We hold ourselves accountable for the ways that we manage our time and ...our money. We must learn to hold ourselves at least equally accountable for how we manage our energy: physically, emotionally, mentally and spiritually.

Loehr and Schwartz[6]

The current financial challenges of the NHS and the wider public sector are not short term and the quality and cost challenge is likely to be a key feature of NHS life for many years ahead. As leaders of the NHS and its partner organisations, we need to build energy for the long haul in ourselves and the people around us (Sections 2.3 and 4.9).

The themes of 'energy', 'momentum' and 'drive' appear throughout Part 1 of this publication as a critical source of fuel for LSC. With so much effort required on so many fronts in a complex change process, it can take a long time for LSC to be embedded. So a key role for a leader of LSC is to build and maintain energy for change over a long period of time (Section 4.9). The LSC literature suggests that the most likely outcome from a large scale change effort is that it runs out of energy for some reason...and simply fades away (Section 2.4). The least likely result from an LSC initiative is the one we seek, whereby 'the momentum and multiple cycles of change continue for some time until the change becomes a reasonably well established norm across a social system' (Section 2.4). So, in our current NHS context, what do we need to do to overcome the change fatigue, loss of energy and organisational burnout that is such a common feature of most LSC efforts?

Let's start with a definition of the 'organisational energy' that we need to sustain for the years ahead. It can be described as the extent to which the leaders of an organisation or system are able to put things in motion (change, core initiatives, innovations etc) that mobilise the intellectual, emotional and behavioural potential of the people in the system to pursue its goals. It represents the 'activation' of the organisation's human forces[7]. The evidence base that we amassed for the Academy suggests that our current goals for quality and cost improvement and health and healthcare reform won't be delivered without deliberate and far reaching leadership efforts to build and sustain organisational energy for change.

Radcliffe[8] helpfully differentiates between four different kinds of organisational energy, all of which we need to cultivate, in combination, to achieve our NHS goals. The first kind is *intellectual energy*. This is the prevalent form of leadership energy in the NHS at present and is being used to drive efforts to reduce costs and improve quality. It is the energy of planning, logic and analysis, and, unquestionably, it is important for helping us to get organised for change at scale. Across the NHS, many QIPP and cost improvement programmes are based on detailed planning, milestone goal and programme management processes. Intellectual energy feeds off the scientific basis of our healthcare mission and pursuit of clinical knowledge. It makes us investigate, study and plan more thoroughly.

However, there are drawbacks when intellectual energy dominates over other forms of organisational energy in the context of large scale change. It makes us over-rational and over-objective and can act as a barrier between the change process and emotional engagement. An excess of intellectual energy contains us within our current (1st order) mindset and prohibits the transformation perspective that we need to deliver LSC[8]. We won't deliver our goals for healthcare and healthcare reform on a platform of organisational energy dominated by intellectual energy. The literature from the LSC is unequivocal in its conclusion: *"intellectual appeals alone are not sufficient. Change requires emotional energy as well; the larger the change, the more emotional energy is required"* (Section 2.4).

The most dangerous combination of energies which we see sometimes in NHS change programmes, is where a predominance of intellectual energy is mixed with high levels of *physical energy*. Physical energy is the energy of action, motion, implementation and getting things done[7]. It is a critical energy for delivering our quality and productivity goals. However, without emotional engagement and a sense of higher purpose, this combination frequently leads to a frenetic 'acceleration trap'[7] in which too many activities are initiated, localised projects are not sufficiently connected to corporate goals, people don't feel conviction about, or meaning in, the change process and consequently they are left feeling exhausted and highly stressed by change. And the likely result? Underachievement of goals and difficulty in sustaining any changes made in the longer term.

A further risk sometimes witnessed in NHS contexts is one of 'corrosive energy' in which the underlying energy gets eaten away by negative competition between divisions or units or different parts of the system and by internal rivalries and corrosive relationships within senior leadership teams. This means that peoples' discretionary effort, emotions, intellectual capabilities and vast reserves of human potential, don't get directed to ignite and sustain the change effort[7].

So, as the Academy taught us, we need to build other kinds of energy to turbo-charge and sustain our change efforts. It is the connection with values and feelings that fuels the energy for change[9]. Specifically, we need *emotional energy*, the energy of connectivity, collaboration and relationships, as well as *spiritual energy*, the energy that is created by building a sense of hopeful future, shared purpose and connecting with core values[6, 8]. If we look at the history of large scale change, of those leaders who have orchestrated change at scale and pace, we can see that it has been achieved by building abundant amounts of spiritual and emotional energy and combining them with intellectual and physical energy (Sections 2.3, 2.4 and 4.9). An NHS leadership approach that is essentially 'pacesetting' (see messages three and four), without combining other styles, does not create the organisational climate in which all the energies can naturally flourish. Organisations and systems that are fuelled by spiritual and emotional energy can keep going for the long haul, experiencing much less change fatigue along the way.

This principle is also connected to the idea of distributed leadership (Section 2.3 and messages three and four), in terms of where the energy originates. It is helpful to think about 'batteries' as a metaphor for the sources of energy for change in the health and social care system[7]. Evidence tells us that it will be difficult to sustain LSC if the source of energy is one big battery at the top or centre of the system. We need to purposefully create lots of batteries, generating energy for change across the system. As NHS leaders, we can do this by building:

- a shared aspiration for a hopeful future and a deeper meaning for the change mission that we are calling people to take action in support of (spiritual energy)
- a sense of 'us' (rather than 'us and them') based on shared values, experiences and aspirations that is the basis of an appeal to others to join us in action[10] (emotional energy)
- emergent planning and design and a process for continually monitoring progress, learning and adapting as we go (intellectual energy)
- a 'plan of attack' and a sense of urgency to take action now (physical energy).

Part 1 is full of practical advice for developing these kinds of energies as part of a holistic approach to LSC. Concerning the building of spiritual and emotional energy, see the sections on framing (Section 3.7), transformational storytelling (Section 3.8), leadership mindset shifts required for LSC (Section 4.2 and 4.5), commitment versus compliance (Section 4.4) and leadership drive and energy (Section 4.9). For approaches to building intellectual and physical energy in a way that is complementary to the other organisational energies, see the sections on planning questions for LSC (Section 3.1), driver diagrams (Section 3.2), cycles of change (Section 3.4), systems and stakeholders analysis (Section 3.5), continuum and commitment analysis (Section 3.6), measurement frameworks (Section 3.10), Influence Model (Section 4.6), polarity mapping (Section 4.7) and four venues of leadership (Section 4.8).

As Henry Mintzberg, advises us[11], "leadership is not about making clever decisions and doing bigger deals. It is about helping release the positive energy that exists naturally within people." There has never been a time in the history of the NHS when this advice has been more pertinent.

Message three

Build leadership systems that are managerially loose but culturally tight

Mobilising people to tackle tough challenges ....is what defines the new job of the leader.

Ronald Heifetz[12]

The recent Commission on the Future of Leadership and Management in the NHS concluded that the NHS needs 'no more heroes'[13]. The recommendations of the Commission concur with the spirit of the Academy. In order to meet the leadership challenge of changing times, we need to broaden our leadership approach from one in which individuals are appreciated for their ability to drive organisations to success almost single-handedly to a leadership style and philosophy that also embraces engagement, collaboration, commitment to change and generates common purpose (Section 4).

The predominant senior leadership style in the English NHS is the 'pacesetter' style[14, 15]. Pacesetter leaders set high performance standards and live them out daily in everything that they do. The NHS leadership task, from the pacesetter perspective, is about doing things more effectively, efficiently and faster. Pacesetter leaders make high demands of people around them and may take swift action when people don't deliver the outcomes required[16].

As Paul Batalden says "every system is perfectly designed to achieve the results it gets"[17]. This 'pacesetter' style has evolved in response to an NHS leadership mission which has focussed on delivering nationally-set operational goals and performance standards and achieving financial balance. The pacesetter leader leads from the front and ensures that everyone in the organisation, whether clinical, managerial or support worker, is aligned around achievement of these goals.

However, as we learnt at the Academy, this style may not be effective in a world where goals and priorities are locally determined, where success depends on intra-organisational partnership and where the hierarchical mechanisms for co-ordination and control of performance that dominated the previous NHS system no longer exist. In fact, the mismatch between a locally determined NHS and a predominantly 'pacesetter' leadership style is a major potential risk factor in the reform process moving forward. The NHS Top Leaders Programme, an NHS-wide initiative to build a pool of talented, exceptional leaders who are ready to move into the most senior and enduringly challenging leadership posts in the NHS, is leading work to build a wider range of styles amongst the NHS leadership community[18].

If, following the example of the Academy, we look at the evidence about those leaders who have delivered rapid change at scale and sustained it over time (Section 4.4), we find they are much more likely to have built their efforts on a platform of commitment (collective action towards a different future and a shared purpose) rather than compliance with new policies or operating rules[19]. There is little evidence in the large scale change literature of any sustainable transformational change initiative built on a platform of compliance. Of course, compliance will always play a key role in the NHS, where adherence to standardised operating procedures increases safety and efficiency for people who use our services. However, it is actually much easier for leaders to build compliance when it starts from the foundations of ownership, meaning and understanding that come from a commitment-based strategy.

In the new NHS world that we are creating, the need to build commitment is even greater than before. As traditional management levers like hierarchy and structure diminish, within an environment that is complex and uncertain, commitment-building is an essential leadership skill[10]. This is pertinent to:

- clinical commissioners and leaders of local health systems who want to create shared purpose for their populations, providers and partners in care, delivering big changes quickly
- NHS providers who want to create effective partnerships with other providers to deliver integrated care and who want to build positive work climates that help the people at the frontline who deliver care to feel more ready and confident to face the future
- the NHS Commissioning Board and cluster leaders who are more likely to achieve a systematic response by calling others to action and by building a sense of shared direction through levers of commitment rather than compliance.

We should be reassured by the fact that clinical and managerial leaders in the NHS have consistently demonstrated their ability to adapt to changing circumstances and challenges. The question is, what does the leadership model and ethos moving forward need to be and how do we deliberately accelerate its practice?

If we look to the evidence base of successful system change, as described in Part 1 of this publication, we see that the most prevalent model of leadership that underpins successful large scale change is one of 'distributed leadership' (Section 2.3, point 8). Under a distributed model, step changes in performance are not dependent solely on a small number of key individuals in a hierarchy. Rather, leaders pool their effort and expertise across the system or health community so that the collective result is significantly greater than the outcomes of individual leadership actions[20]. Under a distributed leadership system therefore, the focus moves away from competencies or behaviours of individual leaders. The new emphasis is on relationships, interventions across the whole organisation or system and connectivity with other leaders and the wider system[21].

This 'distributed leadership' ethos doesn't negate the critical role of the senior leader in our current context. It makes it even more important. We need leaders who are visibly different, because positive role models really do make a difference when it comes to large scale change (Section 4.6). As senior leaders, we are 'signal generators' whose words and behaviours are constantly being scrutinised and interpreted, especially by those below us in the hierarchy[22]. There is an 'amplification effect' which means that the signals we send through our leadership actions resonate throughout the whole organisation. One of the major reasons why the workforce disengages with large scale change programmes is because it experiences a disconnect between the statements that leaders are making about organisational values and priorities and its own lived reality and experience of those leaders within the organisation[23]. If, as NHS leaders, we don't exhibit behaviour aligned with the values which are so pivotal to change, our workforce will have no respect for these values. Conversations and behaviours in the boardroom have a direct impact on the nature of the conversation between care giver and the person receiving the care.

Where we manage this effectively, we create the potential to make a significant difference to our large scale change efforts. Leaders of successful large scale change generate signals that 'reduce uncertainty and ambiguity about what is important and how to act'[22] which is a vital leadership skill in the current set of NHS circumstances.

What are the implications for our leadership practice? Clinicians and the health and social care workforce respond much more to their values and beliefs, to how they are socialised and the norms of their work group than they do to compliance and managerial controls[19]. A connection through values has significantly more bonding power than bottom line indicators such as financial and operational performance[23]. Within the kind of distributed leadership approach promoted by the NHS Academy for Large Scale Change, accountabilities are driven by collaboration around values and shared beliefs. We need to build on our 'pacesetter' style by visibly incorporating a wider range of styles and creating more partnership, trust and participation in our leadership processes. Delivery of our future goals will depend on our ability as leaders to:

- create a sense of urgency to act together around a shared higher order purpose
- build a combined and shared base of knowledge and expertise
- build relationships, trust and commitment to each other and hold each other to account through relational commitment rather than organisational hierarchy
- design the mechanics, levers and incentives at every level of the system so that they are aligned with a distributed leadership approach and help move things in the right direction, rather than act against it. As Section 2.3 describes it, if we seek transformational change, we need to find ways to orchestrate '*mutually reinforcing change across multiple processes and sub systems to create the momentum for large scale change*'.

As Sergiovanni challenges us[24], *"leadership of health and healthcare into the future should be 'more managerially loose and culturally tight'. If we want more control, we have to give up some control in a traditional management sense. We are talking about as much, or more, delivery discipline in the change process and holding to account for the outcomes of large scale change. However, we do so on the basis of commitment in relationship to one another, seeking a shared purpose, rather than solely relying on the performance management mechanisms of a compliance regime".*

Message four

Redefine the boundaries of leadership within the 'NHS system'

This old world was characterised by the need to manage things..... The new world is characterised by the need to manage complexity.

Stafford Beer[25]

As the distributed leadership task of health and social care becomes increasingly complex and grows in scale, we need many more leaders than ever before. The pool of leadership talent that we need to create for the future won't just include formal leaders from within the NHS hierarchy. We should think widely and diversely about who these leaders might be[20]. They include clinical leaders of primary care, community leaders, people who use services who want to help shape the future and our partners in local government and the voluntary and independent sectors. We need to think about the leadership mindsets and behaviours needed to work in this different way and how we create and promote the role models of distributed leadership needed for large scale change efforts (Section 4.2).

This raises a number of issues in the context of the learning from the ALSC and our current situation. The first relates to the leadership implications of the 'open systems' view we adopted within the ALSC (Section 2.2). We cannot draw a clear boundary around the 'NHS system' or the 'health and social care system' that we are seeking to transform and determine who and what is explicitly in or outside of the system. Multiple organisations, communities, indeed the whole population of England, are an integral part of the system. A distributed leadership approach is about widening the pool of leaders in the system. If we utilise this definition of the 'system', we are talking about a lot of potential leaders in a lot of different contexts. Some fundamental discussions are required about who is a leader, who contributes to leadership and who should be part of the focus for the development of leadership talent.

Secondly, in line with the distributed leadership perspective that '*varieties of expertise are distributed across the many, rather than the few*'[20], there is a vast, largely untapped resource for change in the leadership skills and wisdom of individuals spread across the system. If we can bring these together through commitment to a shared purpose (Section 2.2) we create an overall leadership capacity that is much greater than the sum of the individual parts. An example is the national 'call to action' on antipsychotic drugs for people with dementia[26]. This was launched under the banner of the Dementia Action Alliance, a coalition of more than 60 national organisations from voluntary, public and private sectors that share a joint goal of improving support for people with dementia and their carers[27]. The Dementia Action Alliance, supported by the Alzheimer's Society, the NHS Institute for Innovation and Improvement, and the Department of Health, has set an ambitious goal that 'all people with dementia who are receiving antipsychotic drugs will undergo a clinical review to ensure that if they are receiving these drugs they are doing so appropriately and that alternatives to their prescription will be considered and a shared decision has been agreed regarding their future care'. This is a huge undertaking involving a systematic clinical review for more than 100,000 people with dementia receiving antipsychotic drugs. There is an understanding that many groups of people and many individuals can play a part in helping to achieve this ambitious goal, including people with dementia and their carers, and the voluntary and advocacy groups that support them, leaders of care homes, the clinicians and clinical teams who prescribe, dispense and review the medications, as well as commissioners of health and social care.

Under the umbrella of the 'call to action', a leadership team has been built for each of these groups, each group has developed a compelling narrative to call others to action (Section 3.8) and identified specific actions that they are calling on their group to take. So, for instance, pharmacists have committed to 'review the people under my care to identify those who are prescribed antipsychotic medication and work in partnership with my prescribing and other healthcare colleagues to review each individual'. The leaders of the 'Pharmacy Commitment Group' are now working to call to action thousands of their colleagues to take action around these commitments. Each of the commitment groups aren't just mobilising, they are organising. They have created a leadership structure for change and set goals and milestones in terms of both numbers of people mobilised and outcomes achieved. They are working with an explicit model of change (Section 2.6), in line with the ten key principles of large scale change (Section 2.3). Change is being enacted through a leadership philosophy of commitment rather than compliance (Section 4.4).

The point is that the leadership of this countrywide initiative to improve health and healthcare isn't just connected to the hierarchical leadership arrangements of the NHS or the health and social care system. It is a distributed leadership model involving many leaders from many walks of life. It is demonstrating the reservoir of resources that is available for change if we step up to build the capability to organise and develop these leaders.

Consequently, we need to extend the reach of leadership development so that if many partners in the community have the potential to act as mobilising leaders in relation to specific health and healthcare goals, and they start having wide-ranging involvement in decisions throughout the system, then they should also have access to opportunities for leadership development.

Message five

Act to accelerate large scale change to a revolutionary pace

The leader's most basic role is to release the human spirit that makes initiative, creativity and entrepreneurship possible.

Bartlett and Ghoshal[28]

It is possible to look at the evidence in Part 1 of this publication and feel overwhelmed and discouraged about our potential as leaders to effect large scale change in the NHS system. After all, LSC is complex and uncertain, involving multiple stakeholders and 'lots and lots' of multiples of things (Section 2.3). It is an emergent process: the consequences of true LSC are often not known until some time in the future. Outcomes are impossible to predict at a detailed level (Section 2.3). Whilst data is essential, a level of faith, courage, intuition and proceeding forward on incomplete evidence is inevitable (Section 2.4). The most likely outcome of a large scale change effort is that it plateaus after a while or runs out of energy completely (Section 2.4).

The good news is that there are many actions that we can take in our current context as leaders of health and healthcare that will help to accelerate large scale change to a revolutionary pace. The same basic principles apply whether we are seeking to transform urgent care across a health community, integrate care for people with long term conditions or reduce operating costs by a double digit figure through quality improvement (Section 2.3).

Firstly, we have to connect our NHS leadership task at hand to a higher purpose and a deeper meaning for the people who we want to implement the changes: *'large scale change is fuelled by the passion that comes from the fundamental belief that there is something very different and better that is worth striving for'* (Section 2.3). We might consider how, as leaders, we create transformational stories (narratives) that draw from our own experiences and values and encourage others to join us in action towards that higher purpose (Section 3.8).

Central to this is the process of framing (Section 3.7), by which leaders construct the way they present themselves, in order to help others interpret what is going on, to draw support from others and call them to action. It isn't surprising that, of all the powerful principles of large scale change that the leaders who took part in the Academy worked with, 'framing' was cited as the most widely used[4].

Today, across the NHS, an increasing number of senior leaders are investing in the development of their own skills of narrative to transform the way that they frame the challenge of QIPP and by doing so, create conviction, understanding and energy for action amongst their key stakeholders. They are telling powerful stories that link their own motivation and leadership calling with what their organisation or community is seeking to accomplish. These leaders talk about transforming the relationship between quality and cost in the system. They outline the explicit choices that we face: either to let people who use our services pay the price of economic downturn and expect staff to work harder, with fewer resources OR to mobilise the entire workforce, NHS partners and local people to take action to improve quality and reduce costs[29]. They describe the higher purpose of transforming care, stewardship of NHS resources, creating sustainable care and protecting the NHS for the future[30].

The learning from the ALSC reinforces this kind of decisive leadership action. Amongst the 'ten key principles of large scale change' (Section 2.3) relevant points are:

- movement towards a new vision that is better and fundamentally different from the status quo
- identification and communication of key themes that people can relate to and will make a big difference
- framing the issues in ways that engage and mobilise the imagination, energy and will of a large number of diverse stakeholders
- continually refreshing the story and attracting new supporters
- transforming mindsets, leading to inherently sustainable change.

Half of the generic principles of leadership for LSC are connected to narrative, framing and communicating. This is highly pertinent to our current context where many of the biggest barriers to large scale change have an emotional underpinning: fear, anxiety, inertia, sense of isolation, self doubt. The LSC evidence base says that we need to make a leadership response that connects with emotions, generating and enhancing hopeful thinking, to engender widespread commitment to change and release and build the energy to mobilise action in the service of organisational or system goals[9].

The second point from the ALSC is that whilst building passion and energy for change is a critical component, it is an incomplete response to delivering change at scale. It isn't sufficient to be *mobilised* for change. We also need to be *organised* for action. I learnt the importance of this when my previous organisation, the NHS Modernisation Agency (the forerunner to the NHS Institute) commissioned a qualitative study of the factors that led to clinical and managerial leaders shifting their position from being sceptical to becoming champions of quality improvement[31]. In this work, a sub-population of leaders was identified. This was a group of clinical leaders who were originally sceptical about change but had become champions. However, because their expectations about the change process weren't met, some of them had become disillusioned and cynical. The danger here is that the sceptics who had previously been champions may become more sceptical than those who were just sceptical in the first place. As Benjamin Zander describes it, "*a cynic, after all, is a passionate person who does not want to be disappointed again*"[32]. The principles of mobilising (narrative, framing and calling to action) can be very powerful but they have to be followed up by a well-organised change process to keep people engaged in change and to follow through with all the change actions. The current phase of NHS transformation requires a holistic change approach that encompasses both the passion of mobilising and the delivery discipline of organising[27].

So what does the learning from the Academy tell us about what might be required to organise as well as mobilise for large scale change in our current NHS situation?
Firstly, that the complexity of the change that we are trying to create means that we need just as much (or more) discipline and accountability as characterise traditional NHS approaches to programme planning and management. However, we need to turn our focus towards 'emergent planning and design, based on monitoring progress and adapting as you go' (Section 2.2, point 8). We may need to ask different planning questions (Section 3.1), identifying the shared direction that we are seeking to create, the key themes that people can relate to and what might make a 'sufficient mix' of reasons for the people we want to engage to actually engage. We may need to break down the gargantuan change process into small 30, 60 or 90 day cycles of change (Section 3.4). We may also need to put a lot of effort into identifying the processes, systems and stakeholders that need to change at various levels of the organisation or system (Section 3.5) and we may need to think about metrics and measurements for LSC in fundamentally different ways (Section 3.10).

A particular risk that we face as NHS leaders is that we talk the *lingua franca* of bottom up change but we get caught in a pattern of thinking about how to make it happen that is inherently top down. This creates a danger that, despite our radical intentions, we end up 'redesigning the cage'. One of the key tools that we used in the Academy to avoid this risk was structure, process and pattern (SPP) thinking (Sections 2.1 and 3.3). This helps us to understand and execute our NHS transformation agenda through a complex systems lens and avoid the risk of defaulting to existing mindsets and methods. Much of the NHS change effort historically has been over reliant on reorganising structures as a catalyst for change at scale. By structures we mean the tangible structures and artefacts of the system, the organisation chart, the payment mechanisms, the job role or the governance system. Too often, those of us in the middle of the system or at the frontline of care delivery wait for those at the top of the organisation or 'the centre' to change the policy or restructure the system. We lobby for changes in financial incentive mechanisms, payment systems, procedures and operating rules when these alone cannot deliver what we seek.

Over the past 15 years there has, in addition to this focus on structural reform, been a growing emphasis on pathway and process redesign to improve quality and patient access and reduce waste and unnecessary variation. Process redesign has delivered significant improvement in service responsiveness, patient access, effectiveness and efficiency of the system[33]. However we have to question whether redesigning structures and processes is a sufficiently all-encompassing response to the current challenge of change. The learning from the Academy is that changing structures and redesigning processes per say doesn't always deal with the critical underlying issues which have to be surfaced and challenged if transformational change is to be achieved: the patterns of relationships, organisational power, conflict, decision making and learning that underpin behaviour in organisations and systems[34].

In our current NHS context, we need to design strategies for delivery of large scale change that purposefully encompass all three levels: structures, processes and patterns. When we review systems for accountability, we tend to think about governance structures and processes yet a recent report on accountability in the reformed NHS[35], recognises the critical importance of patterns, alongside other system characteristics: *much of the reality of an accountability regime is determined by how relationships play out in practice, by the pre-existing culture and behaviour of organisations and by perceptions of the authority or power of actors.*

So, for instance, establishing and building new commissioning groups needs to focus as much on behaviours, relationships and decision making power as it does on accountability structures, operational policies and commissioning processes. In addition, if we want to accelerate the scale and pace of change, we should think in terms of the whole system: how we can create mutually reinforcing changes in structures, processes and patterns across multiple areas (Section 2.2). This applies to a wide range of activities, from how we create the dynamics for a high functioning Health and Wellbeing Board to how we move from a situation of 'power over' to 'power with'[10] service users and local communities in making decisions about health and healthcare priorities.

Some conclusions

At the heart of the current NHS transformation agenda is the issue of resources: how we resource the range of activities to deliver and support excellent health and healthcare for our population, how we offer comprehensive and effective care in situations of increasing pressure on scarce NHS resources and how, as a consequence, we fundamentally change the relationship between cost and quality in the NHS.

The NHS Academy for Large Scale Change challenged us to think about resources in a different way that is reflected in the five key messages in this postscript. Typically when we consider resources for the NHS, we think about finite, economic resources that diminish with use. The Academy showed us that there is another category of resources for the transformation of health and healthcare, resources that grow with use[36]. These are the resources of discretionary effort that people will make available when they can connect the change process with their own values in their work or community activities, when they feel part of a bigger movement for change and commit to take action in relationship to others. And the more effort and energy that we put into nurturing these resources for change, the more they will generate.

One of our fundamental roles as leaders of large scale change is to grow these resources. Via these resources we have the potential to achieve our transformational ambitions for change (message one), unleash energy for the long haul of change (message two), create leadership systems on the basis of commitment as well as compliance (message three), build effective, distributed leadership teams that deliver and sustain large scale change (message four) and accelerate change to a revolutionary pace (message five).

This is about building on the 'intellectual energy' of strategising and planning for large scale change and connecting with the emotional and spiritual energy that comes from providing deeper meaning in the actions that we ask people to take and truly engaging with the human forces in the organisation or community.

We are at an extraordinary inflection point in the history of the NHS, a time of uncertainty and transition but also a time of great possibility. An extraordinary leadership response is required to meet the challenges before us. We have the potential to rewrite the rules forever on how to galvanise an entire system for change. Our goal must be to identify how we can pull the collective motivation to move to a shared purpose from the core of our own system. As a result, we have the potential to transform the way we promote health and deliver care across the NHS system and create large scale change for an entire population.

I hope that you have found significant potential in *Leading Large Scale Change*. I also hope that many of the principles and ideas will inspire you to build on your current change strategy, offering you some new perspectives and tools for achieving your goals. Please join us in building the practice of large scale change so that we can all make our contribution to delivering the kind of health and healthcare system of the future that our people, our communities and workforce so richly deserve.

Helen Bevan

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