



Sustainable Improvement Team
and the Horizons Team

LEADING LARGE SCALE CHANGE:

A practical guide

#LargeScaleChange

A guide to leading large scale change through complex health and social care environments

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- Given regard to the need to reduce inequalities between patients in, access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.



Contents

1. Foreword	4		
2. Introduction to large scale change	6		
2.1 What the literature tells us about large scale change: theory and models	8		
2.1.1. Three ways to describe large scale change	8		
2.1.2. The evidence base for large scale change	11		
2.2. An organising framework for leading large scale change	13		
2.3. Principles of large scale change	14		
2.4. The model of large scale change	20		
2.5. The change model	25		
3. Creating the conditions for large scale change	27		
3.1. How the world is changing	28		
3.1.1 Change in an emerging world	28		
3.1.2 Old power and new power	30		
3.1.3 Commitment versus compliance	33		
3.1.4 From change programmes to change platforms	34		
3.1.5 Learning from social movements	38		
3.2 Energy for change	42		
3.3 Creating a shared purpose and a compelling narrative	46		
3.4 Framing and re-framing (transformational storytelling)	50		
3.5 Creating a climate for change where everyone can contribute	53		
3.6 Working within political and bureaucratic environments	58		
		3.7 Structure, process and patterns of behaviour	62
		3.8 Ambidextrous leadership styles	65
		3.9 Participation, co-production and diversity	67
		3.10 Spread and scale of change	71
		3.11 Governance and finance	76
		4. Tools and approaches for large scale change	78
		4.1 Planning questions for large scale change	79
		4.2 Theories of change, logic models and driver diagrams	81
		4.3 Managing complex dilemmas	89
		4.4 Measuring large scale change	93
		4.5 Continuum of commitment analysis	97
		4.6 Systems and stakeholders analysis	99
		4.7 30, 60, 90-day cycles of change	103
		4.8 Plan, do, study, act	105
		5. Moving forward: making sense of it all	107
		6. Acknowledgements	110
		7. References	113
		8. Appendices	121
		8.1. The model for leading large scale change – a narrative version	121



1. Foreword

// If we want things to stay as they are,
things will have to change. //

Giuseppe Tomasi di Lampedusa,
Italian writer, 1896-1957

Through the seven decades of the National Health Service, with the NHS preparing to celebrate its 70th anniversary in 2018, change leaders in health and care have always tended to respond to challenges with bravery, creativity and flexibility. Across generations, those who have cared passionately for the ideals of the NHS have taken action to meet the challenges of an environment that is ever changing.

Today is no different. In fact the stakes of change are higher than they have ever been. Large scale change (LSC) is the only real and sustainable bridge to get us from where we are now, to where we need to be, in a way that retains the principles of what the NHS stands for.

In health and social care today, we face an increasing demand and complexity of citizens' health needs; there are significant changes in treatments, technologies and the way care is delivered; and, of course, the ever-increasing financial pressures. Against this backdrop we must have due regard to reduce health inequalities and improve patient outcomes. The response to these health and care challenges also brings unrivalled opportunities. Care communities nationwide are beginning to organise themselves in new ways of working, breaking down organisational boundaries that have long impeded progress. Visionary leaders in all parts of the country are seeking to bring together all sections of their local community with a unifying shared purpose and clear process for delivery.

Transformational change such as this is often complex, requires radical thinking and strength of mind in decision-making. Those at the forefront of these large scale change programmes are attempting to overcome significant obstacles and objections while achieving democratic consent for their plans. The challenge is considerable.



Leading Large Scale Change: a practical guide has been produced by the NHS England Sustainable Improvement Team and the Horizons Team, NHS England, to help all those involved in seeking to achieve transformational change in complex health and care environments. This guide has been fully revised from the original 2011 publication to reflect latest policy and practice, in particular responding to the NHS Five Year Forward View¹ (October 2014), the Next Steps on the NHS Five Year Forward View² (March 2017), and the ensuing development of new care models and Sustainability and Transformation Partnerships (STPs) across the country.

This guide has a number of different resources which you can use according to your local needs and circumstances and has been designed to be interactive, offering many links to useful, external sources. As a starting point, it is recommended that you watch the [introduction to leading large scale change video](#), providing insights into why large scale change is so different to incremental change.

We hope you find this guide helpful and welcome your feedback – please email us at england.si-enquiries@nhs.net



2. Introduction to large scale change

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

- Key themes that can make a big difference
- A shift in power and a more distributed leadership
- Comprehensive and active engagement of stakeholders
- Mutually reinforcing changes in multiple systems and processes.

The approach to leading LSC is continuously evolving in the light of service quality, productivity and transformation challenges that are constantly facing us.

Using this guide

You should not expect to learn everything there is to know about LSC from this guide, but it will point you in the right direction for creating and sustaining large scale change and transformation.

Leaders should start from their local context and adapt these general principles to fit their situation. Every LSC will be its own unique journey. Done properly, this leads to such deep changes in attitudes, beliefs and behaviours that sustainability becomes largely inherent.

“ As leaders of health and care, we are steering change in a world where the power of hierarchy is diminishing and change is happening faster and becoming more disruptive... In the dominant approach, power to create change largely comes through positional authority. In the new world, power comes from connection and ability to influence through networks. ”

Bevan and Fairman³



Each section within the guide can be used as a standalone reference source for that particular element. Working through all the sections will provide a comprehensive toolkit for effectively leading LSC initiatives. Where tools and techniques being discussed link to specific aspects of the Change Model these are denoted by a number of useful icons.

The aim of this Leading Large Scale Change guide is to:

- Capture key ideas about change and transformation from leading practitioners, researchers, thought leaders and opinion formers
- Apply these ideas to a health and care context to determine actions that can be taken to create transformation strategy and develop change leaders who can accelerate change and achieve their goals
- Provide leaders of change, at all levels, with an 'action list' to support local and system-wide change
- Make available to colleagues in health and care a wealth of ideas, opinions, research and resources about the future direction of change.

What Leading Large Scale Change is about:

- The 'how' of change (mindsets, processes, relationships and methods to make it happen)
- Taking learning from multiple industries and perspectives and applying them to health and care
- A premise that by taking world class learning and themes about change in a generic sense, we can improve how we go about change in health and care, suitable for today's context
- Providing leaders with a clear agenda for action on change, based on evidence
- 'Evidence⁴' in its widest sense, incorporating tacit knowledge, the views of global opinion formers and consensus among thought leaders as well as formal research findings.

What Leading Large Scale Change is not about:

- The 'what' of change (explicit change interventions in a health and care context)
- An explanation of specific transformational themes, drivers and enablers within health and care
- A narrowly defined research paper or policy commentary
- Change as a goal in itself. Change is not the goal: 'the goal is the goal'⁵. This guide is about principles of change in a generic sense that can be applied to achieve specific health and care outcomes.



2.1 What the literature tells us about large scale change: theory & models

This section provides an overview of the key insights we can gain from the literature on large scale change (LSC). It is practical in tone. It provides the background to 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 will 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 health and care sector.

This leads us to identify 10 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.

2.1.1 Three ways to describe 'large scale change'

You will know about traditional service improvement methods and their application in health and social care. These methods support incremental improvement and they have an important place in large scale change, 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 service improvement approaches.

1. The village and river metaphor

Kurt Lewin⁶ described the difference between 'incremental' and 'transformational' (or large scale) change.

"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 health and care, requires integrated changes in structures, processes and patterns (of behaviour and outcome)⁷. You can learn more about structure, process and pattern (SPP) thinking in [section 3.7](#).

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

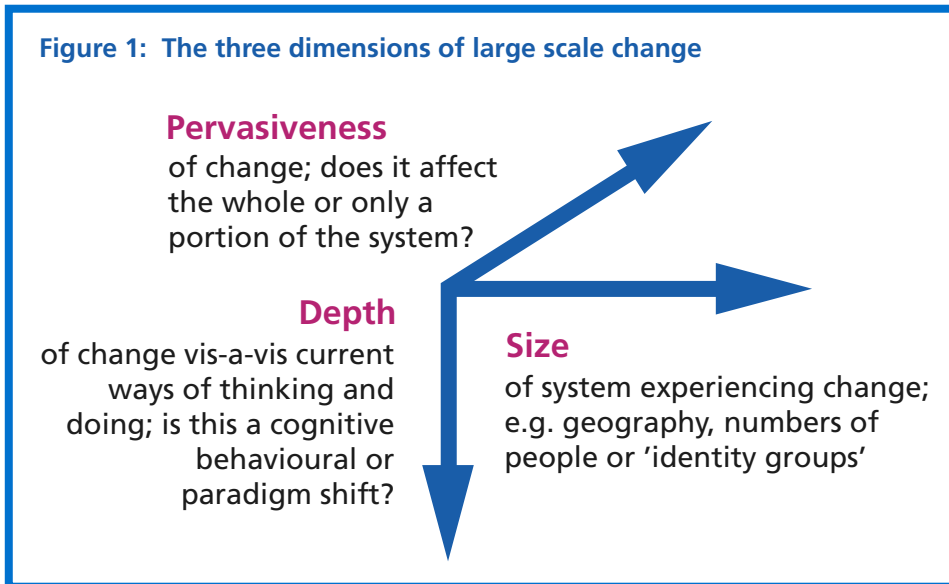
LSC is change that is:

- Widely spread across geographical boundaries, multiple organisations, or multiple distinctive groupings (for example, doctors, nurses, managers and 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 in time at work, and requiring co-ordinated change in multiple systems.



The further along these three axes you are, the more large-scale is the change⁸.

Figure 1: The three dimensions of large scale change



An example of something not so large scale is a change involving how a group of community nurses document medications when they visit their patients at home. It is not a very deep change in thinking, it is a single solution to a problem and it is something that can be focused upon by the nurses alone.

In contrast, efforts further along the continuum of LSC would include the strategies of system leaders to improve the physical health of people with mental health issues at both an individual and population level. There is not a high degree of certainty as to which interventions will deliver the best results in what circumstances. There is unlikely to be a single 'right' answer. These efforts impact a large number of people, require pervasive change, and challenge current mental models.

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?



2.1.2 The evidence base for large scale change

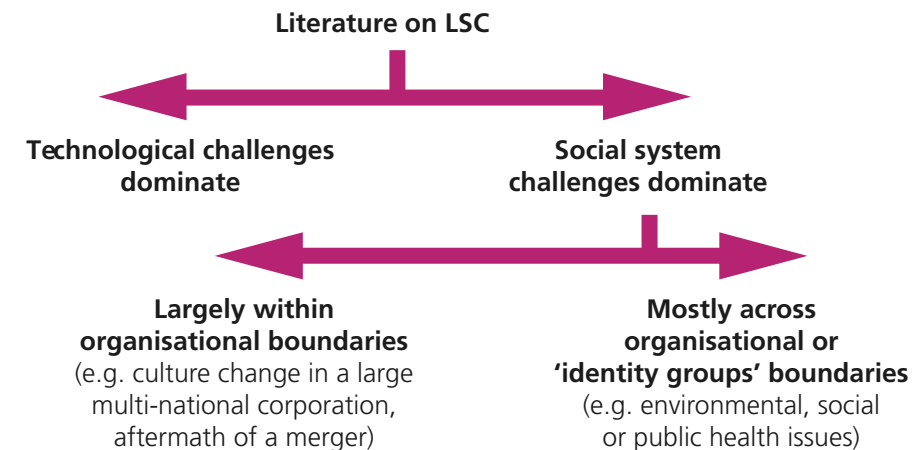
LSC has been studied in the fields of organisational change, engineering, management, leadership, and social science. We now know a great deal about how it comes about⁹. Furthermore, we can distinguish between major branches of thought in the literature about LSC (see figure 2 on the right). These are 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.

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, digital systems that transform functionality can be designed and tested by a small team of experts and then spread rapidly and on a vast

Figure 2: Large scale change literature/evidence



scale with the push of a button. Wouldn't it be nice if we had robot doctors, nurses, social workers, managers and so on in the health and care system, 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?



However, when you think of it, are not many change efforts designed with this mechanistic model of change in mind? They often involve 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 does not work very well.

Within the literature, there is a second continuum which has to do with the boundaries of the system that is undergoing LSC. Much of the evidence base on LSC comes from experience of organisational development, management, strategy and leadership of change in private sector corporations. In this context, LSC is often described as deep, strategic, operational and cultural change within a large, globalised firm. In a health and care context, the available evidence typically relates to LSC within 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, where you can draw a clear line around the boundaries of a system.

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.

Partnership¹⁰ 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 (for example, health and care providers, community groups, schools or government agencies).

As a result of our scan of the available evidence, we developed the following definition of 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
- Comprehensive 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.

We will develop these ideas further in the next section of the guide.



2.2 An organising framework for leading large scale change

There are many improvement and change methods in use across health, social care and other public sector settings. We have developed an 'organising framework' which brings together three critical elements for leading large scale change. The organising framework includes the large scale change model¹¹, the change model¹² for health and care and established improvement approaches, methods and tools. Utilising the framework and models may increase the likelihood of sustainable, large scale change.

Organisations working within complex health and care systems tend to use different improvement tools and techniques. This may appear to have the potential to cause conflict, but improvement and change methods share many characteristics in common and therefore a range of improvement tools can be and should be deployed to reflect the local context in order to gain maximum benefit.

Taken together, all the elements of the organising framework can enable the navigation of complex, system-wide change in a practical way.



Figure 3: An organising framework for change



2.3 Principles of large scale change

The literature highlights a fairly consistent picture of the key principles of large scale change, regardless of topic or social system setting. Review your current thinking against the concepts below as you consider how to approach your LSC effort.

The ten key principles of large scale change are:

01

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 public and staff that you are offering in your LSC effort? Can you articulate it powerfully and succinctly? (Framing and transformational storytelling are helpful methods that we discuss in [section 3.3](#) and in [section 3.4](#)).

02

Identification and communication of key themes that people can relate to and that will make a big difference.

Is your vision 'out there' and 'in the future'? Typically, if you are truly undertaking LSC, it will seem so distant and so in contrast with people's current reality that it may feel overwhelming or impossible. In order for people to get engaged they have to understand why they should be involved and 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 see themselves participating in? How will you ensure that all this effort fits together in the end? (Driver diagrams and 30/60/90 day cycles can help with this: [section 4.2](#) and [section 4.7](#)).



03

Multiples of things ('lots of lots').

Expect LSC to be complex with multiple stakeholders, agendas (both hidden and open), points of view, needs and wants, details, and systems that need change. Attempts to isolate or work around some groups, or to ring fence some parts of the system to be left alone while other areas must change, typically result in something less than LSC.

Do you plan to 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? (Structure, process and patterns, driver diagrams, 30/60/90 day cycles, and systems and stakeholders analysis, will help: [sections 3.7](#), [4.2](#), [4.6](#) and [4.7](#).)

04

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.

A small band of leaders cannot possibly make LSC happen alone. Tight, centralised planning and control actually works against LSC. Instead, multiple leaders from across the system, and at all levels, who are 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. 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. (Find out more about the differences between commitment and compliance, and framing: [sections 3.1.3](#) and [3.4](#).)



05

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 the processes and systems that need to change in an integrated way in order for you to achieve sustainable LSC? (See the driver diagram tool: [section 4.2](#))

06

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 lifeblood of LSC is the continual stream of new supporters who become attracted to the vision when they see it progressing. Without 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 do not 'get it'? (Reframing, storytelling, and measurement are tools that help leaders attract new interest: [sections 3.4](#) and [4.4](#)).



07

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

Due to the complexity and uncertainty involved, LSC outcomes are impossible to predict at a detailed level. Flexibility, adaptability and engagement of others are key. Detailed plans and milestones will be required but do not spend too much time on them before you start actually doing something and do not be surprised if every detail does not work out as planned.

How will you sufficiently plan and set milestones to demonstrate accountability 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: [section 4.7](#)).

08

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. It is reliant on 'distributed leadership' - a variety of different sources of leadership expertise moving into play and spreading around the system. Leaders pool their effort and expertise so that the collective result is significantly greater than the outcomes of individual leadership actions¹³.

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 mind-sets 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.



Introduction to large scale change

Creating the conditions for large scale change

Tools and approaches for large scale change

Moving forward: making sense of it all

Acknowledgements

References

Appendices

09

Transforming mind-sets, leading to inherently sustainable change.

According to the literature, when LSC is done well, sustainability is the natural by-product. If people have become engaged and believe that the vision is more desirable than the status quo (and you have addressed multiple structures, processes and patterns underpinning the change) they will be committed to, and will fight to keep, the new way. However if powerful leaders have simply demanded compliance and not brought others along in the thinking, those on the frontline, or the public affected by the change, will fight to keep or return to the old way.

How will you truly transform mind-sets as you go along in your LSC effort? (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.

Case studies on LSC make 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? (See energy for change: [section 3.2](#)).



Issues to overcome

Large scale change programmes may fail for many reasons. This could be that there was no initial mandate for the change, that leadership was lacking and there were not the resources available to achieve the changes required. Other reasons could be a lack of active engagement or even a lack of patience – transformational change takes time. Experience shows that in some cases the problem may be a lack of engagement among staff, that it is not seen as ‘the day job’. Achieving transformational change has to be fully embraced and become the day job if it is to succeed. The important thing is to do transformational change properly – it is hard work but it can work!

In this video **Paul Plsek**, a founder member of the Academy for Large Scale Change, talks us through these principles of large scale change.



Introducing large scale change - Paul Plsek



2.4 The model of large scale change

The model of large scale change¹⁴ can help support transformational change across complex environments. The model has emerged from the learning and lived experience of many system leaders who have strived for sustainable transformational change.

The model identifies several key stages in the leadership of large scale change:

Identifying the need for change: This is a good place to start as large scale change in health and care begins when there is a sufficiently well-defined remit and a vision of something that is better than the status quo.

Framing and re-framing the issues: The vision and need for change must be translated into key themes that people can understand and that they can feel passionate about. This coupled with a sufficient mix of drive, passion, need, incentives, shared purpose and burning ambition will capture the attention of others. The literature is clear that intellectual appeals, data and analysis alone are not sufficient. Change also requires emotional energy and the larger the change, the more energy is required. Furthermore, not everyone thinks alike. Getting the right appeal for change is critical to success.

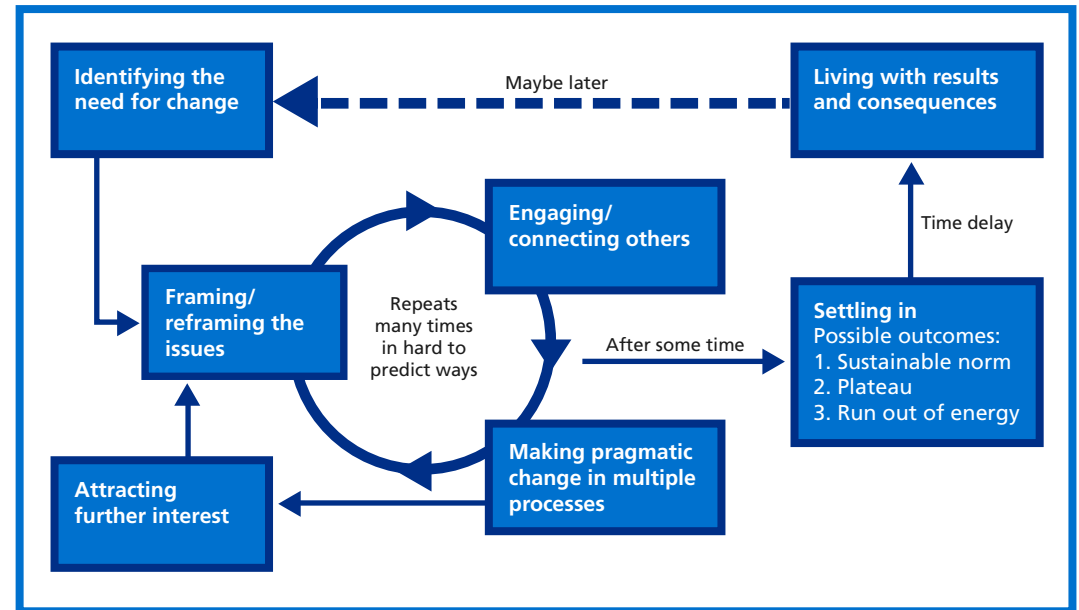


Figure 4: The model of large scale change



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 from the outset. We cannot identify a case study of true LSC where all stakeholders were completely 'bought-in' before anything was done. In reality, 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 momentum going.

These individuals might be at any level in the system and can be a coalition from across organisational, group or system boundaries. If successful, the initial momentum will enable others to come on board to support the change effort.

Making pragmatic changes in multiple processes: To enable LSC to happen, it is necessary to make practical changes at many points throughout the change effort. Changes could take place in areas such as service delivery, clinical decision-making, finance, human resources, policy, governance or workforce. Facilitating incremental changes will make your change effort visible across the system. This, in turn, can increase momentum by encouraging wider engagement and support for the change effort.

Attracting further interest: The aspects described above only bring about limited change; it is just the start. The key to success lies in building upon the successes of each change cycle, attracting the interest of other people who were previously neutral. These people join in and create yet another cycle of framing/re-framing, engaging and connecting others and initiating pragmatic changes in multiple processes and subsystems. In the early stages, this momentum can be created by just the appearance of success (for example, measurements, stories or celebrations) if this is communicated widely and effectively enough. Over time, more than just the appearance of success is required to sustain and build upon the change effort.

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 reasonably well established 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 occurring.



- b. The change plateaus 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 people 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 cycle of LSC and renewed interest might come later; perhaps with new players, which can further embitter the old players.
- c. The effort runs out of energy for some reason (possibly lack of engagement, lack of resources, attention diverted elsewhere, or political change) and simply fades away.

Living with results and consequences: The full, measured results and unintended consequences of true LSC are often not known until some time in the future. By that time, things have typically already sorted themselves into the three categories mentioned above. 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 address any unexpected outcomes but in most circumstances this cannot be predicted.

In this video Paul Plsek reflects upon his experience of leading, and supporting others to lead, and how the LSC model has stood the test of time.



The leading large scale change experience - Paul Plsek



Using the model in practice is further brought to life in this animation on LSC developed by a group of leaders in the north west of England who have successfully deployed large scale change approaches across, health, social care and the voluntary sector.



Source: Commissioned by Good Squared CIC and NHS North West



EXAMPLE

The NHS in the north west wanted to tackle the problem of excessive alcohol consumption in the local population. It is a prominent issue in the region with one person being admitted to hospital every four minutes because of alcohol. A team was established to develop a LSC programme and considerable effort was placed into 'framing' the message to ensure specific audiences, such as Trust chief executives, nursing directors and alcohol specialist nurses, were engaged. The programme developed a sense of momentum, launched a number of activities ('multiples of things') and brought in more and more interested people gaining 'distributed leadership'. The Drink Wise – reducing the risks together – LSC programme was launched. Yet six years after the LSC effort was initiated, a key theme around young people and alcohol had not been addressed despite it being a 'primary driver'. It was only when a message could be framed about the impact of passive drinking on children that Let's Look Again at Alcohol was created. The campaign aimed to engage communities to get them talking about how alcohol is priced and promoted to children. This is an example of going where the energy is – not every goal can be achieved straight away, sometimes it takes a little longer to find the 'frame' that will resonate with the audience and gain its own particular momentum.



For further information, ideas and support on this topic, see:

“Mobilising Leaders of Large Scale Change - More People, More Active, More Often” – an interview between Paul Plsek and Alison Wheeler: using learning gained from a LSC programme in South Wales:

<https://www.youtube.com/watch?v=PdFhHrt1gfM>

Enables and barriers to LSC: Atkinson J, Patel C, Wilson A, Mittman B, Dominello A, Brown B. Drivers of large-scale change in complex health systems: an Evidence Check rapid review brokered by the Sax Institute (www.saxinstitute.org.au) for the NSW Agency for Clinical Innovation – Executive Summary, 2013. https://www.aci.health.nsw.gov.au/data/assets/pdf_file/0004/202396/LgeSysTransf-exec.pdf

How ready is your health and care environment to change? See The Edge Readiness for Change: <http://theedge.nhs.uk/readiness-for-change>

Is change readiness the new change management? See <https://www.torbenrick.eu/blog/change-management/is-change-readiness-the-new-change-management/>



2.5 The Change Model

The change model is an integral, interconnected framework that works in harmony with the model for large scale change to support sustainable transformation.

A model for all sectors

The change model underpins the model of large scale change by providing a framework for any change programme which is seeking to achieve transformational, sustainable change. The model has eight elements that should be considered when leading change. These elements help organise an approach to create an environment where change programmes can make a real difference and deliver sustainable change.

The components are: our shared purpose, leadership by all, spread and adoption, improvement tools, project and performance management, measurement, system drivers, and motivate and mobilise.

The change model is a philosophy, not a methodology, and so is relevant to numerous change programme settings. The change model provides us with an approach which can be tailored to fit our unique situation.

Previous experience of change models in health, care and other sectors suggests that they are most helpful when teams take the essence of the approach and make it their own to fit with their context, their priorities and their patients or community.

Similarly to the LSC model, the change model does not recommend or specify which improvement tools should be used. This is because many teams have already adopted particular tools and will want to build on what they are already using. In addition, different tools are appropriate for different problems and they can be used in combination, particularly where we are seeking change at different scales simultaneously.



Figure 5: The Change Model



Introduction to large scale change

Creating the conditions for large scale change

Tools and approaches for large scale change

Moving forward: making sense of it all

Acknowledgements

References

Appendices

The change model does however provide examples of a number of improvement tools, resources and approaches that you might consider to support your change programme¹⁵.

The starting point for the model is understanding and articulating 'our shared purpose' which defines and connects people with what needs to be achieved. Putting time in at this stage will reap significant dividends throughout the rest of your efforts. This needs to be re-visited throughout the process as new people join the 'we' that makes up 'our' shared purpose. The components of the model can be applied in any order, but it is important to ensure they are all used in more or less equal measure and aligned to 'our shared purpose'.

While some components will appeal more than others, depending upon where you sit in the change effort, learning from LSC efforts and successes tells us that all components are interconnected and should be given equal weighting.



3. Creating the conditions for large scale change

There are many factors that can help to create the conditions for LSC. In this section, we highlight some areas that will assist and enhance the creation of the right conditions for LSC.

- 3.1 How the world is changing
 - 3.1.1 Change in an emerging world
 - 3.1.2 Old power and new power
 - 3.1.3 Commitment versus compliance
 - 3.1.4 From change programmes to change platforms
 - 3.1.5 Social movements
- 3.2 Energy for change
- 3.3 Creating a shared purpose and a compelling narrative
- 3.4 Framing and re-framing (transformational storytelling)
- 3.5 Creating a climate for change where everyone can contribute
- 3.6 Working within political and bureaucratic environments
- 3.7 Structure, process and patterns of behaviour
- 3.8 Ambidextrous leadership styles
- 3.9 Participation, co-production and diversity
- 3.10 Spread and scale of change
- 3.11 Governance and finance

Lynne Maher, director of innovation at Ko Awatea, health system innovation and improvement and honorary associate professor of nursing, The University of Auckland, and previous graduate from the Academy of Large Scale Change, says understanding and achieving success in leading LSC is important because:

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Health and care systems are special; they impact on people's lives, both those of the staff who work in them and those consumers and families who seek support from them. We constantly strive for excellence in these systems and so often achieve that; but not always. Leaders have a responsibility to enable staff and consumers to pool their expertise so that excellence in health and care provision becomes the norm but not in just one ward, one community clinic or one hospital but throughout our whole system. This is a large scale challenge and it requires large scale change. As I consider what this means to me I am reminded of a Maori proverb that is used very frequently in New Zealand. The proverb translates as: 'What is the most important thing? It is people, it is people, it is people'.

//



3.1 How the world is changing

3.1.1 Change in an emerging world

Description

The context for large scale change is changing. As leaders and change agents in health and care, we are operating in a world that is increasingly dynamic, fast moving and with many complex dilemmas where there is often no 'right' answer. Yet many of the strategic models and approaches we use in health and care were designed for a different era that was much more stable and predictable. Is there a risk that we will hijack the future by the constraints of our current ways of thinking and doing things?

Summary of the trends that will impact on our ability to deliver LSC

Across the world, change is happening at a faster rate and becoming more disruptive¹⁶. An increasing array of digital tools enable us to be in almost constant contact with almost everyone in the world, at very little cost or effort. Increased connectivity brings with it increasing complexity¹⁷. This increasingly complex work environment is eroding hierarchical management¹⁸ structures and styles. The most effective leaders of change are those who can build and use networks to create relationships. Research suggests that being an effective change agent is less to do with hierarchical power or positional authority and more to do with ability to influence through a network¹⁹.

“ Many times experts fail because they are experts in past versions of the world. ”

Vikram Khosia

The most influential thought leaders²⁰ globally are suggesting that hierarchy alone is not a sufficient mechanism to drive transformational change. On its own, hierarchically driven change is too slow and risk-averse. Organisational leaders have to learn to work effectively through both hierarchy and networks. This means that people in organisational life will no longer engage in change because they 'have to'. Increasingly it will be because they 'want to'.

In health and care, there is a move towards digital peer-to-peer healthcare²¹, where digital technologies are helping patients to work with each other and with care providers to navigate services and take more control of their own care²². The ePatient²³ movement of highly motivated, connected patient leaders continues to grow from strength to strength. As well as a focus on individual patients 'activated'²⁴ to self manage their own care, there is an increasing emphasis on the value of social networks and social relationships in helping people to manage their long-term conditions.



Much of the perceived wisdom about creating organisational advantage is being severely challenged²⁵. No longer is building (efficiency based) scale necessarily the best answer. In an increasingly disruptive era, organisations are finding that cost efficiencies can happen exponentially²⁶ and that technology cycles are quicker than corporate decision cycles, threatening existing business models²⁷. The nature of work is also changing: complex work is getting more complex²⁸. Trends in healthcare match those of other industries; compared to a decade ago, patients in inpatient beds are more unwell²⁹ and the work is more complex. Changing demographics and technological advances mean that the primary care workload is more complex³⁰. The upshot is that many previous ways of making improvement happen, such as through best practice databases and standardisation, do not work as well in this new world. In addition, in this globalised, hyper-connected world, the pace of creative work is accelerating³¹ - the cycle time for innovation has to speed up to keep pace with the changing demands of customers and service users.

Learning and education are also changing fundamentally³² with a move away from formal training to more person-centred approaches with real-time, constantly changing, collaborative support for learning in workplace situations³³. There is a mindset shift in the most forward-thinking organisations from seeing the organisational leadership task as building the organisation for scalable efficiency to building the organisation for scalable

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

Margaret Wheatley

learning³⁴. Around the world, levels of employee engagement are dropping³⁵ or remain stagnant³⁶. Organisational leaders are increasingly using open innovation³⁷ and digital social methods to directly connect with employees³⁸ and bridge the gap between leadership and workforce. This need to bridge the gap is hastening the demise of hierarchy³⁹. Digital skills⁴⁰ will become an increasingly important capability for leaders.

In future, work will be dominated by the emerging generation, the ‘millennials’⁴¹ who are digitally savvy, with their own culture, beliefs and expectations which are different to those of preceding generations. By 2025, those born in the 1980s and 1990s will comprise the majority of the workforce⁴². They relate to causes to help other people more than they do to institutions, and connect with issues rather than organisations. Millennials present even greater challenge to current ways of organising. Hierarchies are more effective in controlling employees when the workforce can be easily replaced. In future, it will take more than holding a job to motivate millennial employees. The millennial generation want to unleash their strengths, apply their passions and work alongside others who do the same.



Underpinning all of this are some emerging principles⁴⁴ for operating in a 'networked age' which include openness, sharing of intellectual property and resources with others, connecting with higher purpose and interdependence between teams, competing organisations and whole sectors; nationally and globally. Leaders will need to operate with greater transparency, including more public scrutiny and act as connectors⁴⁵ in this complex world. Large organisations that are slow moving and steeped in hierarchy were not designed to thrive in this rapidly changing world. This means that the disruption will continue⁴⁶ until organisational leaders adopt change thinking and practices that are better suited to the circumstances they find themselves in.

Questions for reflection

- What are the risks and negative consequences of the changing face of change for your change efforts?
- What are the implications for the new era of thinking and practice of change for your change efforts?
- What opportunities do the new directions in change present for you?



For further information, ideas and support on this topic, see:

Helen Bevan and Steve Fairman (2014) The new era of thinking and practice in change and transformation – a call to action for leaders of health and care http://aace.org.uk/wp-content/uploads/2014/08/nhsiq_white_paper.pdf

3.1.2 Old power and new power

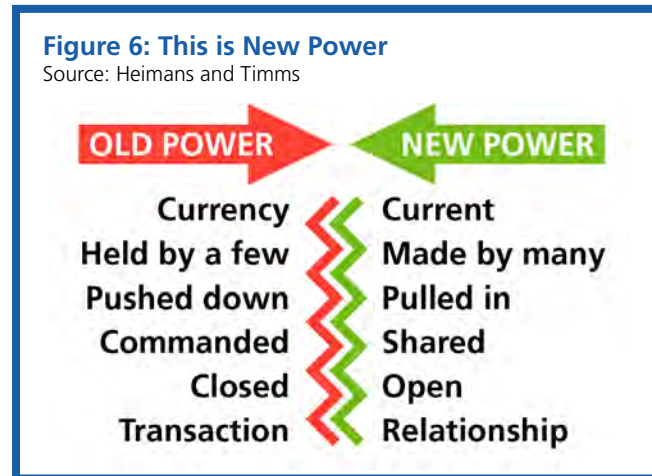
Description

We can characterise the current environment for large scale change as one where two kinds of power are in tension:

- Old power, based on positional authority and hierarchy
- New power, based on networks, social movements and communities.



This framework, developed by Jeremy Heimans and Henry Timms⁴⁶, provides great insight into our current predicament as LSC leaders:



These poles are not set out as a 'from/to' or with any value judgement of 'good versus bad'. While we think that new power will become more important, we also recognise that old power will remain⁴⁷ in years to come. Both old and new power have their value - those involved in LSC initiatives will need to find ways to take the best of both aspects and channel them where they are likely to get most benefit.

Old power creates change through positional authority. The most senior executives have the greatest clout. In a new power world, power comes from connection and ability to influence through networks and communities.

The old power approach focuses change to achieve the mission and vision of the organisation. This comes from a mindset that transformational change can be driven within the organisation or system where leaders seek to build the allegiance of the workforce to the goals, culture and ethos of the organisation. On the new power side, the emphasis is on shared purpose. The mindset is that transformational change is more likely to happen cross-organisationally than within a single organisation and that hierarchical levers cannot drive change across the wider system. From this perspective, LSC depends on many providers, partner organisations, patients, service users, families and communities uniting around a common cause for patient and population health.

Traditionally, change approaches in health and care have been driven by rational planning logic, underpinned by data. While data and logic will always have their place, in future the emphasis will also need to take into account emotional connection as this is a pre-requisite for calling people to take action, based on their convictions and values⁴⁸ as we move from 'have to' to 'want to' change⁴⁹.



Under old power, the energy and direction for innovation has often been leadership driven, as part of a corporate approach to change and improvement. Through new power, the drive for creativity is ignited by service users and the frontline workforce and is spread through virtual networks and social relationships. The human capabilities that matter most in a creative economy (passion, creativity, initiative) are those that are most difficult to manage⁵⁰ and control.

Many levers for change in the old power world of health and care are transactional - performance agreements, contracts, inspection regimes and incentive systems. In the new power world, change is increasingly about commitment to a common cause, built on a foundation of relationships. People hold each other to account through shared relational commitments⁵¹ - mutual commitments to work together.

It is common for LSC plans in the health and care system to favour the old power approach. This has been described as 'the analysis trap'⁵² whereby leaders focus on old power skills like process, measurement and execution.

Research⁵³ suggests that the failure of large scale transformational change initiatives is rarely due to the content or structure of the plans that are put into action. It is much more about the role of informal networks in the organisations and systems affected by change. To make LSC happen we should connect networks of people who 'want' to contribute.

History suggests that it will not be possible⁵⁴ to deliver the changes needed using the mindset and mechanisms of old power alone. While building on the strengths of the old power approach, we require a big investment in new power methods. Organisations and systems that embrace these new power skills - building shared purpose, diversity of thought and experience, connectivity, imagination, relationships and empathy tend to get better outcomes⁵⁵ when it comes to large scale transformational change⁵⁶.

As leaders of change in health and care, we need to be able to operate at the interface of old and new power. Even the great social movement leaders understood that both were necessary to achieve their goals for change. They did not just work in new power ways. They engaged 'the pillars of power'⁵⁷. Both have value and are essential. Success will come from effectively operating both in tandem and holding the tension between them.

Questions for reflection

- To what extent is your LSC initiative working with the positive aspects of both old and new power?
- What are the opportunities to avoid the dominance of old power and build new power?
- What are the implications for the forward direction of your change initiative?



3.1.3 Commitment versus compliance

Description

We can draw a distinction between ‘commitment’ and ‘compliance’ organisations⁵⁸. 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 mortality⁵⁹.

The table below demonstrates the transition from setting compliance to commitment goals.

Compliance goals	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 or shame creates momentum for delivery	Commitment to a common purpose creates energy for delivery
Based on organisational accountability ('If I don't deliver this, I fail to meet my performance objectives')	Based on relational commitment ('If I don't deliver this, I let the group and our purpose down')



EXAMPLE

An alliance of health and care 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, 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.

3.1.4 From change programmes to change platforms

Description

Leaders of large scale change globally are switching from closed innovation to open innovation⁵⁹. In the past, innovation was done within organisations, using internal expertise. In an era of open innovation, a much wider group of people from inside and outside of the organisation contributes to change.

In a world where knowledge is disseminated so widely, we have to look beyond the ideas and expertise of the people inside the organisation for new ideas for change. We want to make best use of our own internal experts but we also want to invite service users/patients, carers, partners in the wider community, leaders from other care organisations and other industries to take part in our innovation process to obtain the best possible results. The boundary between the organisation, its change processes and the wider environment becomes more permeable. Innovations are ‘open’ and can easily transfer inward and outward.

The table on the following page highlights some of the differences between ‘closed’ and ‘open’ innovation principles in a health and care context. While they are shown as polar opposites, in reality, most care organisations will choose a combination of both approaches.





Introduction to large scale change

Creating the conditions for large scale change

Tools and approaches for large scale change

Moving forward: making sense of it all

Acknowledgements

References

Appendices

Closed innovation	Open innovation
We have a highly skilled and experienced workforce which can work out most of the answers to the problems we face	By inviting others (with a common interest in solving key problems) to participate in our innovation process, we can take advantage of the wealth of knowledge that exists outside of our organisation
To get the most value from our innovation process, we must discover, develop and deliver it ourselves	Engaging others can add significant value to our innovation processes; we also need internal innovators to create a portion of that value
As a 'pilot' or 'demonstrator' test site for a new innovation, we want to be left alone for a period of time so we can work it out for ourselves	As a 'pilot' or 'demonstrator' test site, we seek to continuously receive ideas and guidance from others outside our local area over a period of time; as a result we sustain our energy for change and continue to implement changes over a longer timeframe
We will test our new ways of working internally 'to destruction'. When we are confident they will work, we will offer to share our 'best practice innovations' with others	A wider group has contributed to the innovation process, beyond our host organisation; when it comes to diffusing the learning from test sites, people from other localities already feel ownership. Spread is more likely to be 'done with' not 'done to' and to be 'pulled' not 'pushed'

A specific aspect of the growth of the open innovation mindset is the switch from change programmes to change platforms. The problem is not change programmes per se but the mindset that often underpins them when they are implemented in health and care settings. Too often 'change management' or a 'change programme' is based on the premise that a small number of people can envision the outcomes sought, that the change process can be controlled and that people have neutral starting points in the change. Yet history shows us that radical, transformational change cannot be pre-ordained in this way. As the model for large scale change shows, change is a deeply emergent process and we have to test, fail, learn and evolve as we go.

Source adapted by Helen Bevan from <http://www.specialchem.com/open-innovation/closed-innovation.aspx>





Shifting to a change platform means what Gary Hamel⁶⁰ calls 'socially constructing' change - creating the opportunity for everyone in the organisation or system (including service users) to help tackle the most challenging issues. It means valuing diversity - seeking out hundreds of ideas and potential solutions through a divergent process, rather than converging thinking prematurely around a single solution. We know that large, diverse groups of non-experts consistently outperform small groups of experts when it comes to decision making.

Of course, this whole approach is not 'anti' top down change – it is the opposite. It is about focusing leadership attention on creating an environment that is receptive to transformational change and harnessing the energy of the whole system on making it happen. It is what our patients, service users and families need and deserve.

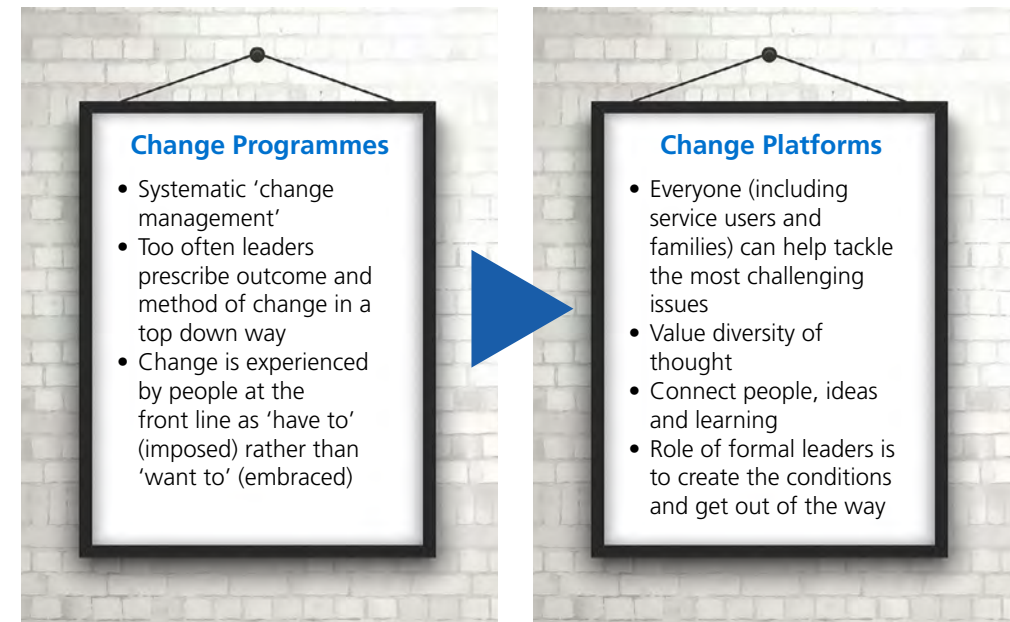


Figure 7: Source: Horizons Team



Questions for reflection

- What are the opportunities for you to use open innovation as part of your LSC process?
- What examples can you give of change platforms in health and care?
- How could a change platform help you to deliver better change?



For further information, ideas and support on this topic, see:

Bevan H (2015) From change programmes to platforms, <http://www.mckinsey.com/business-functions/organization/our-insights/build-a-change-platform-not-a-change-program>

Hagel J (2015) The power of platforms, <http://dupress.com/articles/platform-strategy-new-level-business-trends/>

Thompson M (2017) From pipes to platforms <http://www.computerweekly.com/opinion/lts-the-business-model-stupid-three-steps-to-transform-UK-public-services>

Placing a digital platform at the heart of organisational change with Oxfam: <https://www.codecomputerlove.com/blog/placing-a-digital-platform-at-the-heart-of-organisational-change-with-oxfam>

Leading digital business transformation: Forrester Consulting (2016): <http://sugarcrm-online.s3.amazonaws.com/analyst-reports/forrester-business-transformation-2016-04-21.pdf>
See in particular their key recommendations on p6.

The power of platforms: Deloitte University Press: <https://dupress.deloitte.com/dup-us-en/focus/business-trends/2015/platform-strategy-new-level-business-trends.html>



3.1.5 Learning from social movements

Description

Across health and care globally, there has been a significant growth in LSC programmes and projects, as leaders recognise that the way we deliver services at present is not going to achieve the results we need for the future. Many of these initiatives have delivered impressive results but on their own, projects and programmes are unlikely to deliver the far-reaching changes required to transform the health and care system. In addition to changing care delivery processes and structures, we need some new and additional thinking and practice. One of the biggest gaps is in our understanding of motivation for undertaking improvement activities - how do we move our focus from people who 'have to' change to people who 'want to' change? How can we create change efforts that surge with energy, that are an unstoppable force for positive change? How do we mobilise all the people who could and should contribute to our change efforts: people who use services, their families, partners in the wider community, our workforce, and the leadership community?

What can we, as leaders of large scale change, learn from leaders of the great social movements: the women's suffrage movement, the American civil rights movement, the environmental campaigners of the 1970s? These were

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When we talk of social change, we talk of movements, a word that suggests vast groups of people walking together, leaving behind one way and travelling towards another.

Rebecca Solnit

//



Figure 8: The Change Model: Motivate and mobilise

leaders who had no hierarchical power and few resources in a conventional sense but were able to build movements for change that literally changed the world.



A social movement perspective may help us to think about our transformation efforts in a new light, offering fresh but complementary approaches to existing improvement thinking and practice. Social movement thinking is about building activists: connecting with people's core values and motivations and mobilising their own internal energies and drivers for change.

Hahrie Han⁶¹ looked at the roles that the most effective civic activists play. She identified three different kinds of activists – see figure 9.

These three kinds of activists have different levels of success when it comes to building power and influence to make change happen. Lone wolves are the least effective because as individuals they do not create power through people. While mobilisers can engage people and create energy, mobilising involves people taking individual, discrete action with no sustainable infrastructure for change. It is only organisers who create leaders, encourage relationships and create the conditions for ongoing collective action. Han says that the most effective civic activists are a combination of mobilisers and organisers.

Figure 9: Which kind of activists are most successful at delivering change?



Lone wolves: Build power by expertise and information - through advocacy, oversight, contributing to committees, public comments and other forms of consultation.

Mobilisers: Build power by mobilising people - being able to call on large numbers of people to contribute, engage in change and take action.



Organisers: Build power by growing leaders - identifying, recruiting and training future leaders in a distributed network, building a community and protecting its strength.

Source: Hahrie Han: How Organisations Develop Activists - Civic Associations and Leadership in the 21st Century

The healthcare system creates lone wolves constantly. This applies to promising young clinicians who are plucked from clinical practice and given big management roles without a strong peer group or support system. Healthcare systems frequently treat patient leaders as lone wolves. This excerpt from a blog⁶² by Anette McKinnon, a patient activist, sums up the situation:



“What I am ranting about is the way in which patients are being streamed into advisory sub committees, the way we are being used as tokens and to help tick off the right box... Where is the attitude that patients are part of the team in healthcare, that we are partners? Why are we always asked to participate inside a pre-determined frame? When will we see co-design of new policies, and ultimately co-production?”

Applying social movement principles in health and care is about building agency. Agency is the capacity of individuals to make their own choices and to take action in a given environment. Most current health and care transformation efforts globally are built on a premise of increased agency for patients and families. We want patients to take more control of their own health and have more power over decisions about their care.

Much of current practice in healthcare improvement is agency at an individual level through approaches like patient activation, shared decision-making and self-care. These are critical for the future but insufficient on their own. They also have limitations because, in the absence of a wider mobilising and organising strategy, they can be about singular, isolated

patients taking action for their own health. Social movement principles tell us that we should also focus on collective agency.

Collective agency occurs when people act together, united by a common cause, harnessing the power and influence of the group and building mutual trust. It draws on the connective power of social media and online platforms to inspire and enable people to highlight problems and opportunities and find solutions. Collective agency increases the likelihood of bringing positive disruption into the system for faster change and bigger outcomes.

This means moving beyond the lone wolves strategies of many health and care organisations and helping develop a new generation of system leaders and patient leaders to be mobilisers and organisers.

Questions for reflection

- What learning and inspiration can you take from social movement leaders to help you in your role as a leader of large scale change?
- How can you help create mobilisers and organisers rather than lone wolves?
- Who are the people who are currently disconnected that you want to unite in order to achieve your goals for change? How can you build a sense of ‘us’ with them?



For further information, ideas and support on this topic, see:

A social movement reading list: <http://theedge.nhsiq.nhs.uk/wp-content/uploads/2014/11/Social-Movement-Reading-List-HB-Nov2014.pdf>

A Deloitte video on narratives, platforms and social movements: Hagel J (2015): <https://www2.deloitte.com/us/en/pages/center-for-the-edge/articles/john-hagel-at-sxsw.html>

A blog by Digital Tonto on 'To create real change, you need to do more than just protest: http://www.digitaltonto.com/2017/to-create-real-change-you-need-to-do-more-than-just-protest/?ct=t%28Women_s_March1_29_2017%29

Bate P, Roberts G and Bevan H (2003) Towards a million change agents: a review of the social movement's literature: implications for large scale change in the NHS

Bibby J et al (2015) The power of one, the power of many: bringing social movement thinking to health and healthcare

Boyd, A, Burnes, B, Clark, E & Nelson, A (2013) Mobilising and organising for large scale change in healthcare: 'The Right Prescription: A Call to Action on the use of antipsychotic drugs for people with dementia'. NHS Improving Quality

Nesta (2016) Health as a social movement: https://www.nesta.org.uk/sites/default/files/health_as_a_social_movement-sept.pdf
See in particular the empowering nature of a social movement on p7 and a timeline on the influence of social movements in healthcare p12.

Satell G (2017) How to create transformational change, according to the world's most successful social movements

What can health and care improvement learn from social movements? The Edge: <http://theedge.nhsiq.nhs.uk/what-can-health-and-care-improvement-learn-from-social-movements/>



3.2 Energy for change

// Energy, not time or resources, is the fuel of high performance. //

Loehr and Schwartz, 2003⁶³

Description

As we described in the [model of large scale change \(section 2.3\)](#), the most frequently occurring result is that the LSC effort runs out of energy and fades away. Therefore building energy for change for the long haul is one of the most important considerations for LSC leaders.

Organisations with high positive energy do better on every dimension of performance (Bruch and Vogel)⁶⁴. Change leaders who can tap into the positive energy for change that exists among the people involved and unleash it for the benefit of achieving LSC are more likely to achieve their goals.

Energy for change is a concept which enables different and sometimes difficult conversations about what can best support LSC. It involves exploring a diverse set of factors that influence the force and vigour with which change is pursued. A model of energy for change⁶⁵ has been developed by a partnership of improvement leaders in the NHS, York Health Economics Consortium and Landmark Consulting. It is the result of a literature review of energy for change, and collaboration and co-design with leaders from the health and care system.

Five domains of energy for change

Energy for change is defined as ‘the capacity and drive of a team, organisation or system to act and make the difference necessary to achieve its goals’.

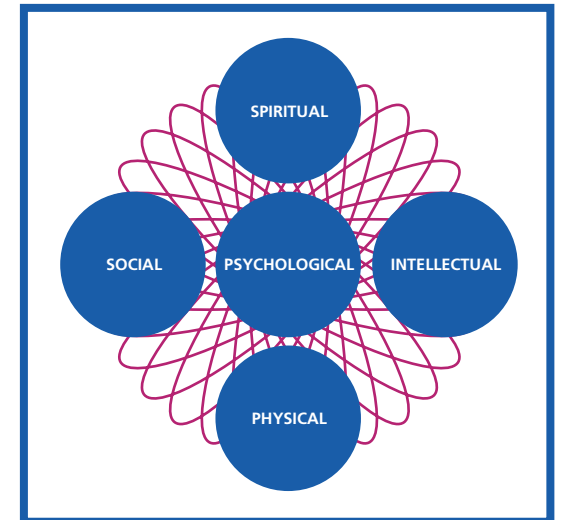


Figure 10: The five domains of energy for change

Source: NHS Improving Quality



The five domains of energy within the model are:

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

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



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

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

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

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

High and low ends of each energy domain

	LOW 	HIGH 
Social	Isolated	Solidarity
Spiritual	Uncommitted	Higher purpose
Psychological	Risky	Safe
Physical	Fatigue	Vitality
Intellectual	Illogical	Reason

Source: Horizons Team

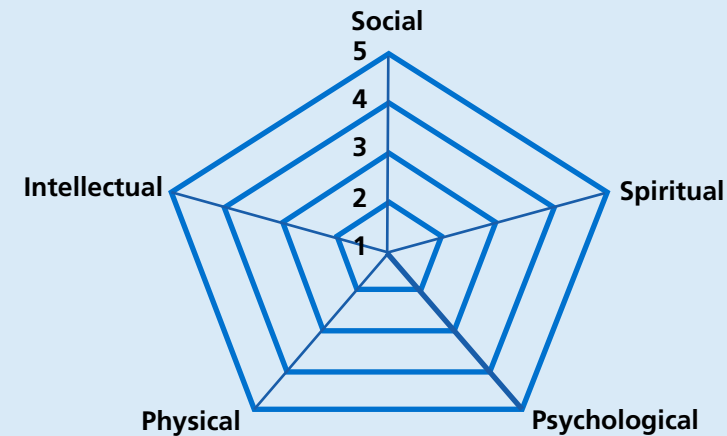


Teams can see whether any particular energies are dominant in their change efforts and can take action to build the energies that are low. Assessment with senior leaders in the health and care system shows that intellectual energy is often disproportionately high when compared to the other energies. This reflects change efforts that are often dominated by logical, rational planning efforts where the social and relational aspects of LSC are underplayed and where shared purpose may not be strong. An over-dominance of intellectual energy spells trouble for LSC. On its own, intellectual energy cannot be transformational. It keeps leaders in their comfort zone, intellect-to-intellect.

As an approach, energy for change deliberately seeks to tackle the social, spiritual and psychological domains, to complement the attention given to physical and intellectual aspects. There is a growing understanding of the importance of psychological energy at work⁶⁶. Without strong psychological energy, people do not feel safe to innovate and try new things that might fail. The most effective way to build psychological energy is by building social and spiritual energy.

Teams can rate their energy scores under each domain of energy, and the energy levels for a specific change initiative is calculated on a scale from one to five (see the framework below).

Figure 11: Energy for change score card





Reflections on energy for change

- How high are your own energies for change with regard to your current LSC initiative?
- How high do you think the energies are of other people in your change team?
- What can you do to build energies that are too low?
- How can you keep energies in balance as your LSC initiative progresses?



For further information, ideas and support on this topic, see:

Peter Fuda, Leadership transformation creating alignment from the inside-out http://www.tap.net.au/resources/TAP_WhitePaper_LeadershipTransformation.pdf

See in particular pp6-17 for the seven metaphors for transformational leadership

The Kings Fund (2015) The practice of system leadership: https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/System-leadership-Kings-Fund-May-2015.pdf

See in particular pp7-8 for summary of common themes from interviews with system leaders



3.3 Creating a shared purpose and a compelling narrative

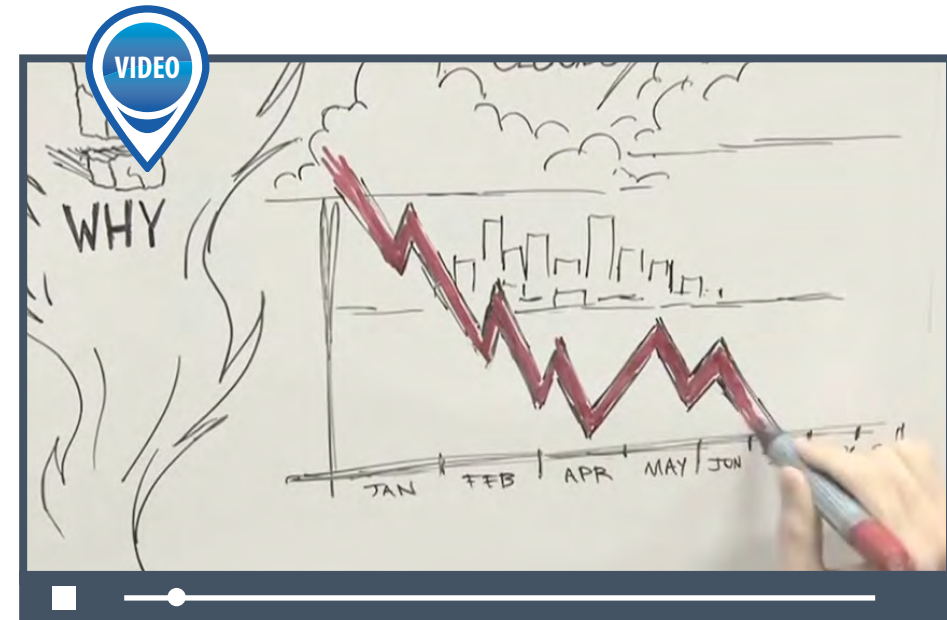
Our shared purpose – the big ‘why?’

The Model for LSC talks about a vision and a case for change. A shared purpose adds depth and breadth to your vision. Often we build a case for change based on a ‘burning platform’ or what really has to change. Focusing on our shared purpose starts us thinking about our shared ambition – not just what we want to achieve but why that is important.



Figure 12: The Change Model: Our shared purpose

Peter Fuda explains the ‘burning platform’ metaphor in this video:





Introduction to large scale change

Creating the conditions for large scale change

Tools and approaches for large scale change

Moving forward: making sense of it all

Acknowledgements

References

Appendices

Taking these ideas further to think about our individual and shared ambition, Simon Sinek has articulated how understanding 'why?' is important for success:



Source: Simon Sinek: How great leaders inspire action. Filmed September 2009 TEDxPuget Sound

A vision is the ideal picture in your mind, and in the minds of your people – it reinforces purpose. A sense of shared purpose should go beyond the vision or mission – it sets out our burning ambition:

- Why this change is personally important
- Why this solution rather than any other.

//

A clear vision helps to empower your purpose. It shows the desired end result and so provides the motivation to work toward that goal. //

Jeff Randelman



Compelling narrative

Building on your vision and shared purpose you need to engage others effectively in your change. This links back to transformational story telling in the LSC model: [see section 3.4](#) 'framing and re-framing (transformational storytelling)'.

For many colleagues, LSC initiatives can feel messy and at times they may be resentful, holding a sense of endured 'change fatigue'. Obtaining their buy-in into a better way of doing things and a desire for a brighter future is essential to developing a sense of shared ownership and building momentum.



Figure 13:
The Change Model:
Motivate and mobilise



EXAMPLE

The process of developing a sense of shared purpose is as important as the statement that results. In South Tyneside, partner organisations working on integrating services around the patient, focused on their shared purpose to engage staff and drive forward their efforts.





For further information, ideas and support on this topic, see:

Research into the effects of building shared purpose through transformational leadership: Belle (2013) http://sna.gov.it/fileadmin/files/ricerca_progetti/SNA_Bocconi/2/JPARTheory_2013_Belle_Leading.pdf

Motivating followers through transformational leadership: Grant (2012) Leading with meaning: Beneficiary contact, prosocial impact, and the performance effects of transformational leadership. https://faculty.wharton.upenn.edu/wp-content/uploads/2013/04/Grant_AMJ2012.pdf

A global perspective on systems leadership: Stanford Review, Leading Systems: https://ssir.org/articles/entry/leading_systems



3.4 Framing and re-framing (transformational storytelling)

Description – framing and re-framing

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^{67, 68}. Effective framing is a critical first stage to creating the conditions that lead to mass mobilisation and large scale change⁶⁹.

We need to develop ‘frame resonance’ with our target audience so that we can call them to action for LSC. This is more likely to occur if the messages connect with individual and collective values, world views, life experiences, beliefs, existing preoccupations and history of action of the audience. 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 many change leaders tend to do. Often we create a compelling case for change that appeals to us and try to convince others. When you are frustrated that others ‘don’t seem to get it’, ask instead what it might be that you do not ‘get’ about them.

Framing is a critical component of LSC. Framing is the process by which we create a compelling message that connects with values and motivates others to engage in change. Framing has its place in supporting health as a social movement⁷⁰.

Description – transformational storytelling

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. In contrast to the analytical approach to presenting a challenge to others, stories can spark deeper mind-set shifts through a three-step process of getting attention, stimulating desire, and reinforcing with reason.

Engagement in change in order to create commitment, distributed leadership and mass movement is key in LSC. Storytelling and narrative is an additional approach to framing that builds on the factual logical case for change and adds the emotional experience.

A powerful and effective transformational story will often tend to have many elements from the template shown on the next page.



Introduction to large scale change

Creating the conditions for large scale change

Tools and approaches for large scale change

Moving forward: making sense of it all

Acknowledgements

References

Appendices

Introduction	What is the problem?	Challenges	What are our challenges and how will we overcome them?
Current situation	Where we are and where have we come from?		Expectations 1
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’

**EXAMPLE**

In 2014, NHS worker Catriona Ogilvy began writing a blog called The Smallest Things⁷¹. Inspiration for the blog came three years after Cat and her husband Mike had first brought their baby Samuel home from hospital following an extended stay after his premature birth. Reflecting through the blog, Cat realised that while as a family they lived through the memories of neonatal intensive care and regular re-admissions to hospital, family and friends did not fully understand what they had been through. She decided to frame her story through the blog and use it to raise awareness.

The blog audience grew and soon she was getting enquiries from local media interested in provision for premature babies and their parents. Spurred to action by a national maternity experience campaign in 2016, Cat created a petition to extend maternity leave for mothers of premature babies. Framing a ‘story of us’ with other mums, she achieved local and national media coverage. Cat mapped her community and identified powerful allies such as a local MP. Cat and colleagues created a compelling call to action and achieved more than 100,000 petition signatures, a level which would lead to a Parliamentary debate on the issue of extended maternity leave. In February 2017, The Smallest Things became a registered charity to continue the fight for recognition and the need for change.



Tips for use

- Your mind-set as a leader is central to success with framing:
 - Speak with others in an appreciative way about what they think is important
 - Accept that people do what they do for a reason that makes sense to them
 - Avoid cynicism or assuming bad motives on the part of others
 - Frame your change proposition in a way that appeals to shared values and shared purpose
 - Be genuine and make sure you believe in the case you are making
- Ensure your framing covers the dimensions of diagnostic (explaining the cause of the problem you are tackling), prognostic (painting a picture of a different future) and motivational (creating an urgency for change and call to action)⁷². Frame the messages about the vision for the future rather than cost savings
- Show, don't tell; make the story vivid, authentic and memorable
- Use a story that is personal or where you have a unique perspective
- Practice telling your story to colleagues and seek feedback.
- Find ways to link your own story with that of your colleagues, partners and teams
- You will know that your story is effective when you hear others recounting it to you, or telling similar stories of their own



For further information, ideas and support on this topic, see:

Supporting materials on storytelling:

<http://www.institute.nhs.uk/storywriting>

Case study on transformational change in NHS North East:

<https://njl-admin.nihr.ac.uk/document/download/2003358>



3.5 Creating a climate for change where everyone can contribute

Description

For any change agent in health and care, 'readiness for change' is a key issue. It is the extent to which the environment we are working in is actually receptive to change and therefore, whether the change can be delivered, sustained and spread further.

In an environment that is ready for change, change agents might be 'boatrockers'⁷³, positively challenging the status quo and leading change. In a more challenging environment, the same people are regarded as 'troublemakers'⁷⁴, full of grievances and anger and not getting very far. The system and environment we operate within therefore has to support creativity and innovation if people are to have a hope of delivering it.

There are specific challenges in implementing LSC in clinical or professional environments. Previous efforts⁷⁵ to change entire clinical systems have led to uneven results and evolutionary/incremental change rather than the large scale transformation being sought. This is largely a consequence of the pronounced influence of the very organisational setting that the LSC programme sought to change. The issue of the power of clinical leaders (and their ability to promote or block change) is pivotal⁷⁶. The way the change process is implemented has to be sensitive to the nature of clinical work and the need to negotiate change with the clinical workforce. The fact that senior organisational leaders may support and actively lead the change programme is unlikely to be enough to ensure change across the

organisation or system. People who live and perform in 'formal organisation land' and people with the power to make or break change are two different lists (and both are needed):

Figure 14: Who makes change happen?

LIST A

- The Transformation Programme Board
- The programme sponsor
- The Programme Management Office
- The leads of the transformation workstreams
- The clinical director
- The team leader/unit manager
- The change facilitator

LIST B

- The mavericks and rebels
- The deviants (positive) who do things differently and succeed
- The non-conformists who see things through glasses no one else has
- The hyper-connected who spread behaviours, role model at a scale, set mountains on fire and multiply anything they get their hands on
- The hyper-trusted - multiple reasons, doesn't matter which ones



Source adapted by the Horizons Team from Leandro Herrera⁷⁷

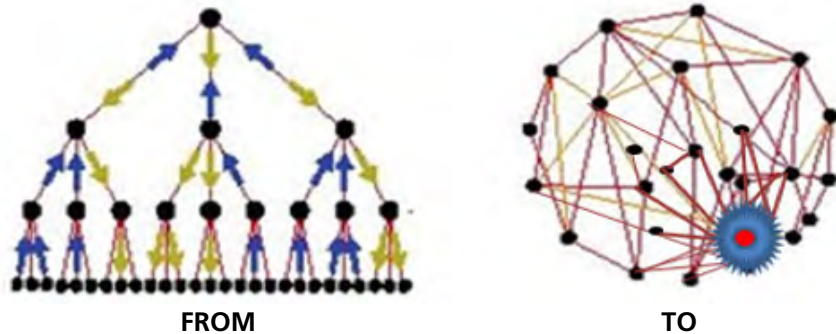


Research by Innovisor⁷⁸ across multiple organisations identified that typically 3% of employees are the ‘key influencers’ who drive conversations with 85% of the other employees. These influencers can be identified by asking a range of people in the organisation or the system who is most influential among their peers⁷⁹. When we draw an organisational chart based on key influencers and ability to influence change, it may look very different to the official structure. Key influencers who operate from the centre of a network often have significantly more power to lead change than those with formal authority⁸⁰.

These key influencers facilitate sense-making in the organisation or system and if corporate change initiatives are not meaningful to the influencers, they will not appeal to others. Key influencers are opinion leaders and should be treated and respected as leaders to enable LSC to happen. If leaders of LSC can find and make a direct link with key influencers, they can often enable change to happen more quickly as they do not have to wait for the change to progress through layers of hierarchy⁸¹.

How we view ‘readiness for change’ depends on how we define the reality of change. Many of the change readiness assessment tools that are currently available are based on the principle that there is an external ‘thing’ out there called the system or organisation that can be diagnosed and treated in the same way that a biological system can. Therefore the questions about readiness for change are often about having all the technical capabilities for change in place. An approach to readiness for change that complements the large scale change model (section 2.4) has to start from the position that the system that we are trying to change is multi-level and has complex inter-personal relationships. We have to take account of people with diverse needs, perspectives, priorities and power bases.

Figure 15: The communications paradigm is changing





More recent approaches⁸² see readiness for change as a collective reality in which people in the organisation or system:

- Feel a sense of shared purpose and a commitment to implementing the change
- Are confident in their collective abilities to make the change
- Engage diverse stakeholders very early on in the process of change
- Show persistence and energy for change for the long haul
- Demonstrate collaborative behaviour.

Actions to build readiness for change:

- Reflect on readiness for change and create the conditions where change and innovation can flourish, rather than rushing into action and/or designing programme interventions without the relational groundwork
- Understand the complex, interconnected web of individuals with different needs, interests, priorities, influences and previous experiences and start from there
- Use the change model ([section 2.5](#)) to consider readiness for change under each of the eight headings. Give your project a score out of ten in terms of how ready you are for change against this component. What action could you take to raise each of your scores?

- Create 'investors'⁸³ in change by engaging people as early as possible in the change process and ensuring the desired outcome is a shared outcome. Investors are different to 'buyers'. When we ask people to 'buy-in' to change, it is too late in the change process and resistance is more likely to be encountered
- Create the opportunities for people to talk. Social connection/discussion is 14 times more effective⁸⁴ as a way of influencing people for change than approaches such as written word, best practice databases or toolkits
- There may not be a time when conditions are absolutely perfect to launch a LSC programme. There are certain things you will always need such as resources, leadership, skills and a lot of patience. A general guide is to 'go with the willing', go where the energy is and the rest will follow. We do not live in a perfect world for carrying out major change programmes but putting as many things in place from the LSC and change models will help you in your task.

**For further information, ideas and support on this topic, see:**

Helen Bevan, *Leading Change in Healthcare in Patient Safety and Healthcare Improvement at a Glance*, Wiley 2014, <http://eu.wiley.com/WileyCDA/WileyTitle/productCd-EHEP003134,subjectCd-MDZ0.html>

Bryan Weiner *A theory of organizational readiness for change* (2009), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2770024/> Mary Dixon-Woods and colleagues *Explaining Matching Michigan: an ethnographic study of a patient safety program* 2013. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3704826/>

Bevan and Fairman: http://www.change-management-institute.com/sites/default/files/nhsiq_white_paper.pdf See in particular the call to action on p35.

Erskine et al (2013) *Leadership and transformational change in healthcare organisations: A qualitative analysis of the North East Transformation System*: <http://journals.sagepub.com/doi/abs/10.1177/0951484813481589> Article highlights a case study of the North East Transformation System. It concludes that without senior leader commitment to continuous improvement over the long term and serious efforts to distribute leadership

tasks to all levels, healthcare organisations are less likely to achieve positive changes in managerial-clinical relations and sustainable improvements in organisational culture.

Tate (2013) *Managing Leadership from a Systemic Perspective*: <http://www.systemicleadershipinstitute.org/wp-content/uploads/2014/01/CIPD-In-a-nutshell-edited-Jan-2014.pdf> See in particular p36 for the 'bare necessities of system leadership'.

Bevan (2015) *Scrap the Programme: Successful change starts with a change platform*, *Health Service Journal*: <https://www.hsj.co.uk/home/scrap-the-programme-successful-change-starts-with-a-change-platform/5078014.article> See in particular the discussion on systematic change.

Hagel (2014) *Platforms are not created equal: harnessing the full potential* http://edgeperspectives.typepad.com/edge_perspectives/2014/08/platforms-are-not-created-equal-harnessing-the-full-potential-of-platforms.html



For further information, ideas and support on this topic, see:

Hamel and Zanini (2014) Build a change platform not a change program <http://www.mckinsey.com/business-functions/organization/our-insights/build-a-change-platform-not-a-change-program>
See in particular the discussion on change platforms versus change programmes.

The Health Foundation (2012), Cross sector working to support large-scale change <http://www.health.org.uk/sites/health/files/CrossSectorWorkingToSupportLargeScaleChange.pdf>
See in particular p21 for the facilitators and barriers to help and hinder joint working and p26 for a driver diagram with key drivers for large scale change.

Transformational leadership behaviours: IMD Transformational Leadership Background Literature Review: https://www.imd.org/upload/IMD.WebSite/BoardCenter/Web/213/Literature%20Review_Transformational%20Leadership.pdf

Core capabilities of system leaders and global case studies: Senge et al (2012) The Dawn of System Leadership https://ssir.org/articles/entry/the_dawn_of_system_leadership

Developing systems leadership and the public service context: The Leadership Forum Systems Leadership: Exceptional leadership for exceptional times: Literature review http://www.cevi.org.uk/docs/Systems_Leadership_Synthesis_Paper.pdf

The revolution will be improvised – stories and insights in transforming systems: <http://leadershipforchange.org.uk/wp-content/uploads/Revolution-will-be-improvised-publication-v31.pdf>

The Art of Change Making <http://publicservicetransformation.org/resources/collaborative-leadership/909-the-art-of-change-making>
See in particular p2-12 for learning overview.



3.6 Working within political and bureaucratic environments

Description

If you are involved with leading large-scale change in public services, whether across geographical areas or diverse services, the chances are you will need to work in a political, large or small 'p', environment. You will also have to persuade people to see things from your point of view, and accept that other people have perspectives and priorities – and even language – that differ from yours. The change you are seeking is likely to be complex and multi-layered, with easy solutions thin on the ground.

In this scenario systems leadership is required. This means thinking not just of your organisational role (wherever you sit and whatever your job title) but beyond it, seeing yourself as part of a wider system. Leading in this context means seeing your role as connecting the broader system across health, social care, housing, emergency services and other sectors that might be able to help.

This way of working has a solid evidence base, encompassing leadership thinking, research and practice from around the world⁸⁵. In England, over the past five years, this evidence has been strengthened through a national systems leadership programme.

This programme, backed by the NHS, local and national government, social care, public health and other sectors, has included research⁸⁶, joint leadership development⁸⁷, and place-based support in an initiative called Systems Leadership-Local Vision⁸⁸, using specialist support to help people develop their systems leadership capacity. This support has since been extended to health and social care integration pioneers⁸⁹, Sustainability and Transformation Partnership (STP) teams, and accident and emergency services.

It has helped people make real progress in changing how they think, how they behave and what happens on the ground as a result, as evidenced in independent evaluation⁹⁰ and in reports from the places themselves, such as *The Revolution will be Improvised II*⁹¹, which illustrates how people have forged new, more inclusive ways of working within and across communities, and obtained better outcomes for citizens, patients and people using services.



Systems leadership: tips for use

1. Start by thinking about how you behave

The research⁹² identified six key dimensions of systems leadership:

- Ways of feeling: about having strong, personal values
- Ways of perceiving: about listening, observing and understanding
- Ways of thinking: about intellectual rigour in analysis and synthesis
- Ways of relating: the conditions that enable and support others
- Ways of doing: behaving in ways that lead to change - including narrative and re-framing skills
- Ways of being: personal qualities that support distributed leadership.

This is not about being a grand heroic leader. It is perfectly possible to be very good at systems leadership if you are a thoughtful listener and prepared to support others – if anything, it makes you especially suited for it.

When you are working in a political environment, ways of doing are especially important. It is worth spending time thinking about the kinds of frames, or narratives, that will resonate with (for example) local politicians, or people operating in different sectors. Do not imagine that people will automatically unite around your position.

//

The best systems leaders are not described in terms of charismatic heroes or divas, but as thoughtful, calm personalities who are as confident working in the background, supporting and enabling others, as they are in the limelight, leading from the front. //

**From 'Exceptional Leadership for exceptional times',
Virtual Staff College, 2013**

2. Do what works in practice

Some of the lessons from *The Revolution will be Improvised II* include:

- Start with the end in mind: start with the question 'what do we (all of the stakeholders) want services to be like for people in our place?'
- Think about how you use local or national initiatives to further this purpose, rather than seeing initiatives as ends in themselves
- Take your time - 'go slow to go fast' - in working with other people to come to a shared ambition
- Start with the work and what you want to achieve, then think about structures, frameworks and governance



- Include citizens, patients and people who use services from the start. Working with the voluntary and community sector is vital
- Focus on relationships and building trust - this is essential - and meet people offline
- Go where the energy is
- Work with a coalition of the willing to start with
- Be willing to cede (and not just trade) leadership
- Get political/high-level cover where you can
- Accept it is sometimes the wrong time, the wrong place or the wrong people - things will get in the way
- Keep going: it will take longer than you think and feel messy, but it really is possible to see change in your place.

3. Follow Myron's maxims

Myron Rogers⁹³ has developed ways of thinking based on seeing systems as living and adapting rather than as passive entities. These systems have their own identities that can change over time, as relationships and the stories about the system, change and develop. His maxims are:

- Real change happens in real work
- Those who do the work do the change
- People own what they create
- Start anywhere, follow it everywhere

- Connect the system to more of itself
- The process we use to get to the future determines the future we get.



For further information, ideas and support on this topic, see:

Systems leadership website: www.systemsleadership.org

The Revolution will be Improvised I & II:

Part 1: <http://leadershipforchange.org.uk/wp-content/uploads/Revolution-will-be-improvised-publication-v31.pdf>

Part 2: https://www.thinklocalactpersonal.org.uk/assets/News/The_Revolution_will_be_Improvised_Part_II.pdf

NHS Leadership Academy: www.leadershipacademy.nhs.uk

Systems leadership/virtual staff college research: <http://tinyurl.com/VSCSEC>

**For further information, ideas and support on this topic, see:**

Pioneers one year on report: <https://www.england.nhs.uk/wp-content/uploads/2015/03/integrtd-care-pionrs-1-yr-on.pdf>
and year two: <http://tiny.cc/89ns9x>

Transformational change through system leadership: <https://improvement.nhs.uk/resources/tcsl-programme/>

In It Together – developing local system strategy: <https://improvement.nhs.uk/resources/it-together-developing-local-system-strategy/>

Developing people, improving care: https://improvement.nhs.uk/uploads/documents/Developing_People-Improving_Care-010216.pdf

Leadership for change and future leaders: <http://www.leadershipforchange.org.uk>

The art of change-making: <http://tiny.cc/TheArt>

The King's Fund (2014) System leadership lessons and learning from AQuA's Integrated Care Discovery Communities: <https://www.aquanw.nhs.uk/resources/publications/system-leadership-october-2014.pdf>. See in particular the case study of Manchester's 'Living Longer Living Better' programme on pp24-30.

The Source4Networks platform provides a comprehensive resource to support system leaders who are required to come together, collaborate to shape services around local needs and lead across organisational boundaries operating in networks/partnerships across their local health economies: See <http://www.source4networks.org.uk/>



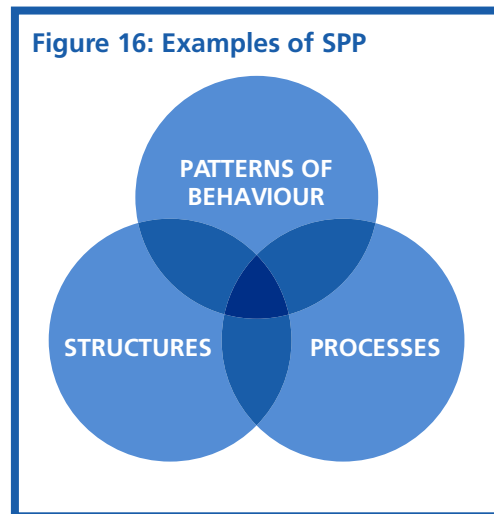
3.7 Structure, process and patterns of behaviour

Description

If we want change to be transformational, we need to consider structure, processes and patterns of behaviour (SPP)⁹⁴. Such aspects can make or break your change efforts.

Examples of SPP:

- **Structures** include organisations, policies, tariffs, regulations, guidance, recommendations, frameworks, roles, committees, physical space, equipment, resources, role reporting, decision making structures and accountability
- **Processes** include patient journeys, pathways, procedures, protocols, flows of people, sharing information, supplies, thinking, and resources
- **Patterns of behaviour** include the development of trust, honest relationships, power, conflict, learning, and how decisions are made.



Much of the past change effort in health and care has focused on structures. Service improvement work has been successful in focusing on processes to re-design the way care is delivered. But to bring about fundamental change in complex systems we also need to recognise the importance of patterns of positive mind-set and behaviour.

Often, the failure to achieve fundamental change through re-organisations, new programmes, and service re-design efforts lies in the fact that the underlying patterns of relationships, decision-making, power, conflict and learning in the system remain unchanged and unchallenged⁹⁵. In order to achieve sustainable transformational change, we must plan for, and actively address, changes in all three aspects of SPP.

SPP helps us understand transformational change by helping identify key themes that will make a big difference and mutually reinforcing change in multiple areas.



CASE STUDY

EXAMPLE

Ian Railton, as part of the NHS North East Academy Team, used the SPP framework in planning for LSC in regional mental health services. Through speaking to colleagues and stakeholders, they determined that in order to be successful the structures and processes of their approach needed to be implemented in a way that created the following patterns. They decided they must:

- Be the exemplar
- Lead the way
- Be free of controversy
- Be supportive
- Uphold the standard
- Live the organisation's values
- Shine light on the future
- 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.

CASE STUDY

EXAMPLE

The importance of fully considering patterns of behaviour as well as structures and processes can be seen in our hypothetical example of moving the deck chairs on Blackpool beach. For 25 years 'Mick' has been arranging the deck chairs the same way in rows facing south on the beach. One holiday-maker 'Lesley' has sat in the same position at the end of the third row every summer for a very long time. However, a new local director of tourism is appointed and works out that a different arrangement could fit in more chairs and make more money. His new Deck Chairs Forward View strategic directive is issued, and Mick is compelled, begrudgingly, to change the seating pattern. Lesley and her friends are angry and in complaining, they only receive negative feedback from Mick about the forced changes. Two outcomes are inevitable: either the director of tourism eventually leaves his job and the deck chairs go back to where they always were or Mick asks his customers how they would like to see the chairs arranged. As it happens, Lesley, friends and others respond that they would actually like to face the pier, and through co-creation, the mindset change leads to sustainable change. It is important therefore to consider all three aspects – structure, process and behaviour – in developing change programmes and not shy away from looking at the required mindset or cultural change for fear of resistance.



Tips for use

- Think of SPP as ‘whole-system thinking’ as this is a phrase that people naturally support and often use, but rarely define
- It is important that the desired patterns of behaviour 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 potentially dysfunctional working which could lead to conflict
 - You can create the dialogue in a single, large meeting of stakeholders, or through a series of interactions over time with smaller groups
 - Be sure to include all voices in the dialogue, especially groups who have been traditionally disadvantaged or overlooked
- SPP is not a rigid analytical or categorical framework. If you begin debating whether something is a structure or a process (for example, 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.



For further information, ideas and support on this topic, see:

Driving Culture Transformation During Large-Scale Change
http://c.ymcdn.com/sites/www.odnetwork.org/resource/resmgr/odp45_3/vol45no3-heckelman_et_al.pdf. See in particular using the ‘Bear model’ on page 27 on how to shape culture.



3.8 Ambidextrous leadership styles

Description

A challenge facing leaders is maintaining current operations while supporting innovation to make transformation happen. As well as being a challenge for leaders, this is also difficult for frontline teams. Having the time to think, develop and implement new ideas while also dealing with increasingly demanding day-to-day delivery is not easy.

Leaders may wish to spend some time contemplating and developing their leadership styles. To create an effective climate for transformation, leaders need to manage both exploration (the creative process) and exploitation (implementation and delivery) and switch between them. Rosing and colleagues⁹⁶ describe this as ambidextrous leadership. They stress the importance of context - there is not a simple relationship between transformational leadership and effective innovation that works in all settings. They conclude that success is more dependent on behaviours than roles - often effective leaders take on more than one role balancing their approach to guide progress of a programme.

The use of explorative and exploitative techniques will vary through the project lifecycle. Typically more explorative techniques that support developing the vision and creativity occur early on. Later in the process when there is a need to turn the idea into action both the vision and approach need to change.

However, it is important to recognise this is not an either-or decision and getting the balance right is crucial. In addition, leaders may benefit from taking time to consider the factors that motivate themselves, and others, to action.

Intrinsic and extrinsic motivating factors

Most people become involved in healthcare based on their values. These are strongly connected to intrinsic motivation – what makes people tick. Understanding and building on intrinsic motivation is a powerful source energy and commitment. Words associated with intrinsic motivation include: ‘mastery, belonging, knowing, love, fun, learning, caring’.



Figure 17:
The Change Model:
Our shared purpose;
Leadership by all; Motivate and mobilise; System drivers; Measurement; and Project and performance management



Extrinsic motivators are also important. These are often the ‘carrots and sticks’ of life. While people will often respond to extrinsic motivators they are not necessarily excited by them. If they do not align with intrinsic motivation and values they can create a cynical response that saps energy and reduces commitment.

The Health Foundation⁹⁷ has identified three groups of levers for change:

1. ‘Prod’ mechanisms (targets, performance management, price and payment incentives, regulation, competition).
2. Proactive support (relies on building ‘intrinsic motivation’ in staff to make the right changes to improve).
3. People focused (education and training, national contract, professional regulation, clinical quality standards).

Clare Allcock, the lead author, suggested that while leaders at the top of the system are most likely to use lever number one (‘prods’), these mechanisms, on their own, would produce less than 10% of the change needed at system level. Given that proactive support and people focused approaches take time to develop it is important to consider them early in programme design.

Key points

- Effective transformation depends on exploration and exploitation. Knowing when to use both approaches and when to switch is a crucial skill for transformation leaders. The evidence points to mind-set and behaviour being more important than role and this means there is scope to design solutions appropriate to the local context
- Establishing and maintaining a consistent culture at the organisational level is important. This allows individuals and teams to learn ‘how things are done around here’ and speeds up decision making
- Once an effective system is established it is a big decision to change. Boards should ensure sufficient time and attention are paid to organisational development to ensure long term clarity and consistency
- Prod mechanisms will not produce the scale of change needed. It is vital to work with intrinsic motivators. What is important will vary among key stakeholders so a one-size-fits-all approach is unlikely to be successful
- The change model (section 2.5) is very helpful in aligning multiple levers for change:
 - Think about the intrinsic factors (our shared purpose, leadership by all, motivate and mobilise)
 - Consider how to connect them with extrinsic drivers (system drivers, programme and performance management, measurement for accountability)
 - Create a compelling narrative for change that makes sense of the overall approach (sections 3.3 and 3.4).



3.9 Participation, co-production and diversity

Description

Participation, co-production and diversity should underpin all of our work. By bringing local people and voluntary, community and faith organisations together in enabling change, we build on the assets in our diverse local communities which can reduce loneliness and social isolation, increase community resilience and support people to manage their health. This approach helps make the shift away from ‘what’s the matter with you?’ to ‘what matters to you?’

Building community capacity requires this shared commitment so that the most effective approaches are recognised⁹⁸ and support coherent action that flies in formation rather than on separate flight paths⁹⁹.

According to the innovation foundation Nesta¹⁰⁰: “The most successful examples of person- and community-centred approaches in practice are those that are developed by people and communities, working with and alongside commissioners and policymakers to build on existing assets and co-produce solutions that work.”

Genuine participation is different because it also needs people’s actions. This can happen through one-to-one relationships with professionals where people play an active role in shaping and implementing their own support, or in wider peer or community support between people and professionals. It means that power is shared more equally between those who use services and those who provide them. Everyone’s skills and personal resources are put to use¹⁰¹.

Co-production and participation are enshrined in law – for example, the Health and Social Care Act 2012 places a duty on commissioners in relation to public involvement. When planning changes to services, it’s important to be aware of your duty to involve patients and the public and how this applies. Local authorities have scrutiny over the planning of health services and how these affect local populations. For more information on scrutiny and the duty to involve, please see the ‘useful links’ box at the end of this section.



Tips for use

Our top tips for participation, co-production and diversity are:

- Involve people from design to delivery rather than asking their opinion afterwards
- Involve people who have experience of the topic area
- Involve a range of people from the local community, for example, the black and minority ethnic community, older people, and people with a disability, to inform the work
- Ensure there is engagement at all levels of the change programme – local, regional and national
- Ask which parts of the programme it is most useful to contribute to – they do not need to be involved in everything
- Recognise their value in the same way as staff are acknowledged and pay their expenses in a timely fashion.



EXAMPLE

In 2016, NHS England established a key programme to drive a system-wide change to create the conditions for self care to be at the heart of health and care. Five individuals who were living with a long term condition, who were carers or who managed community social enterprises worked with the Sustainable Improvement Team to co-design the improvement component of programme. After looking at the key steps, it was agreed that language was the greatest barrier for moving the conversation from ‘what’s the matter with you?’ to ‘what matters to you?’ This was achieved via using a ‘language challenge’ tool during the sessions.

EXAMPLE

In the Heads of the Valleys area of south Wales a LSC initiative was set up to encourage more people to be more active, more often. The approach taken was to co-create the solution with a network of ‘community explorers’ – people who work in the voluntary, community and social enterprise sector, who could use their knowledge, skills and networks. The explorers took an asset-based approach focusing on the positive characteristics of the local area rather than any negative aspects. The explorers were recruited and trained in order to have two-way conversations with local people that bridged the gap between public health and public services and the community. Extensive engagement built up an understanding of the issues over time and led to the development of a LSC effort with distributed leadership.





//

Making progress on our priorities and addressing the challenges the NHS faces over the next two years cannot be done without genuine involvement of patients and communities. Nationally, we will continue to work with our partners, including patient groups and the voluntary sector, to make further progress on our key priorities.

Locally, we will work with patients and the public to identify innovative, effective and efficient ways of designing, delivering and joining up services. And by prioritising the needs of those who experience the poorest health outcomes, we will be better able to improve access to services, reduce health inequalities in our communities and make better use of resources. //

**NHS England: Next Steps on the NHS
Five Year Forward View (2017)**



For further information, ideas and support on this topic, see:

Involving people in their own health and care: statutory guidance for clinical commissioning groups and NHS England. <https://www.england.nhs.uk/publication/involving-people-in-their-own-health-and-care-statutory-guidance-for-clinical-commissioning-groups-and-nhs-england/>

Patient and public participation in commissioning health and care: statutory guidance for CCGs and NHS England. <https://www.england.nhs.uk/publication/patient-and-public-participation-in-commissioning-health-and-care-statutory-guidance-for-ccgs-and-nhs-england/>

Guidance for NHS commissioners on equality and health inequalities legal duties. <https://www.england.nhs.uk/about/equality/equality-hub/legal-duties/>



For further information, ideas and support on this topic, see:

NHS Act 2006 - <https://www.legislation.gov.uk/ukpga/2006/41/contents>

Health and Social Care Act 2012 - <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>

NHS Constitution - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf

NHS England - Patient and Public Participation in Commissioning Health and Care – <https://www.england.nhs.uk/publication/patient-and-public-participation-in-commissioning-health-and-care-statutory-guidance-for-ccgs-and-nhs-england>

NHS England – Engaging Local people – a guide for local areas developing Sustainability and Transformation Plans - <https://www.england.nhs.uk/publication/engaging-local-people-a-guide-for-local-areas-developing-sustainability-and-transformation-plans/>

Centre for Public Scrutiny, Smart Guide to Engagement: Working with Local Authority Scrutiny - <https://www.networks.nhs.uk/nhs-networks/smart-guides/documents/Working%20with%20local%20authority%20scrutiny.pdf>

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 - <http://www.legislation.gov.uk/uksi/2013/218/contents/made>



3.10 Spread and scale of change

Description

Evidence from health, care and other sectors shows that most large scale change initiatives fail to deliver their goals¹⁰² at the scale and in the time sought. This is particularly true of complex change initiatives that cross organisational boundaries¹⁰³ and involve multiple sectors. There is a correlation¹⁰⁴ between the complexity of the changes and the extent to which they spread.

Failure to spread is rarely due¹⁰⁵ to the content or structure of the plans that are put into action. Rather, it is much more likely to be that the changes do not connect and engage with people.

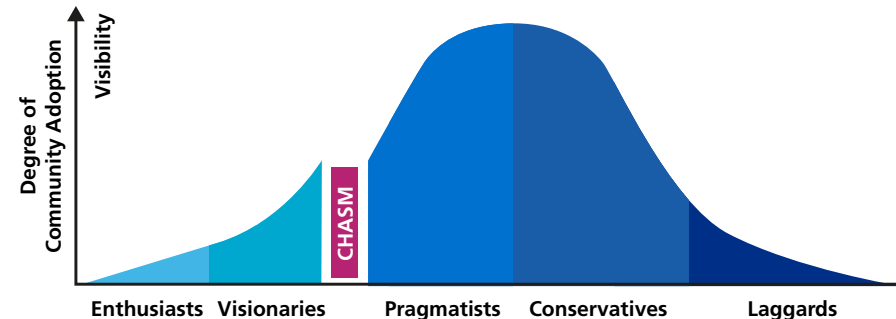
As a result, the change is often perceived as 'must do' (imposed¹⁰⁶) rather than "want to do" by stakeholders. They typically do not connect the changes with their own goals and values and the change becomes impossible to roll out at the scale required.



Figure 18: The Change Model: Spread and adoption

This plays itself out in many ways. One of the most significant is the 'chasm'¹⁰⁷ between the innovative people who create the new ways of working – shown in figure 19 as the enthusiasts and visionaries - and the rest of the system – pragmatists, conservatives and sceptics. Over the past 20 years in health and care we have seen multiple situations where policy makers have commissioned programmes to spread best practice from pilots to the rest of the country.

Figure 19: Beware the chasm



Source: Geoffrey Moore, building on the work of Everett Rodgers



The research of Grimshaw¹⁰⁸ and colleagues suggests that the typical effect sizes of spread activities are perhaps 10-20% at best. So why does this happen?

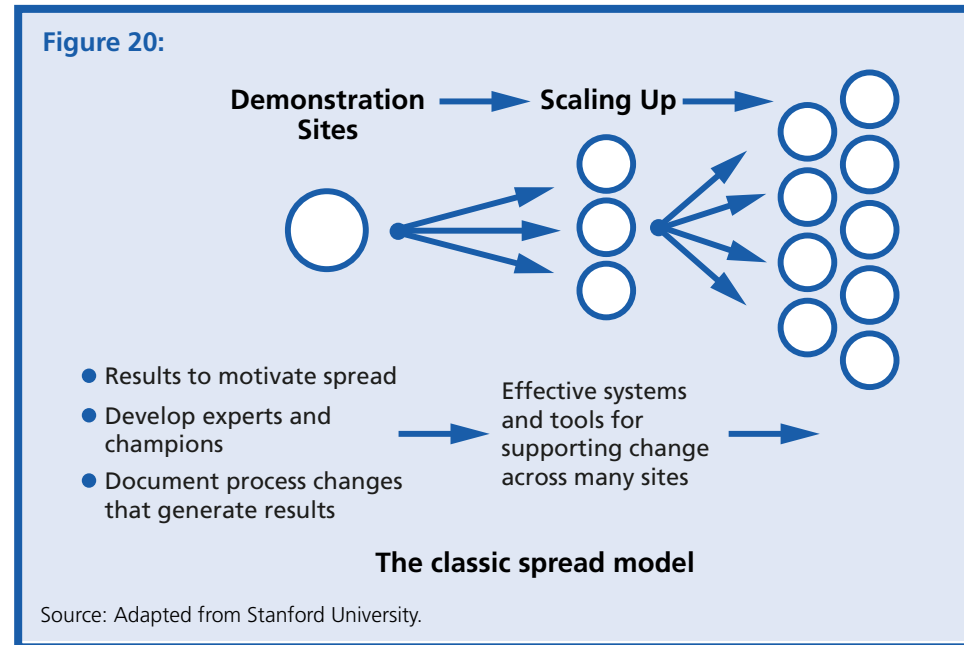
A pattern often seen is that the enthusiasts and visionaries are tasked with innovation strategy and implementation. Their focus is typically on invention, proof of concept and prototyping. These are critical activities but it means that the leadership effort and resources go into the early phases of the diffusion cycle and not into the challenge of crossing the chasm for large scale change. We cycle through the early (left hand) stages of the diffusion curve repeatedly and fail to achieve large scale traction.

Often in health and care, we see system leaders planning ambitious strategic change taking a big system view, while at the same time, innovators and inventors are seeking to scale up. Often the two processes are not connected. Across the globe, researchers and practitioners are concluding that the classic 'scale up' model (see diagram on the right) that underpins much health and care spread thinking and practice has limitations¹⁰⁹.

How to make change spread

There is a 50-year literature and evidence base on the spread and scale of change which suggests how leaders and change agents can create the conditions for spread. Some of the key ideas are set out on the next page:

Figure 20:





Ideas and new ways of working get spread when:

- The innovation demonstrates a clear advantage with current ways of working in a way that is meaningful to people
- The innovation addresses a significant problem or a major opportunity
- The innovation is seen to fit the local context
- People can see how the new way of working fits into the current system
- People can test it before making a full commitment to the new way of working
- People who are potential adopters get engaged in the design right from the start (principles of open innovation and co-production)
- People get the opportunity to have conversations about the innovation and learn together
- It is championed by senior or highly influential people in the system
- It is promoted by networks and communities, not just through the formal system
- It connects with people's emotions and values, not just rational decisions
- The spread efforts get devolved, involving lots of people.

Recently, David Albury from the Innovation Unit has re-examined the literature on spread and scale of change and identified the emerging direction of thinking and practice. His advice to leaders and change agents fits with many of the themes in Leading Large Scale Change:

1. Pay increasing attention to the demand side, to better understand the adopter's point of view
2. Build coalitions for change, using principles from social movement thinking and the spread of influence through social media
3. Pay increasing attention to system conditions
4. Acknowledge the uniqueness and sensitivity of each local context
5. Understand the importance of co-design for subsequent scaling.

How can we best learn from the evidence for successful spread of change?

1. Put as much momentum, energy and forethought into issues of spreading and scaling change as we do into new initiatives
2. Stand in the shoes of people that we are aiming our spread efforts at and consider how we can create a 'pull' for the new ways of working
3. Understand that change is most likely to spread through networks and communities of practice rather than just relying on compliance; create virtual and face-to-face opportunities for people to come together, learn and share



4. Find ways to involve the people who might be potential adopters in the early design of the change. That way, we will have to work less hard at 'buy-in'¹¹⁰ later on
5. Consider:
 - What are the systems for spread? How do we make our spread efforts as much like a social movement as a programme?
 - How do we utilise both traditional approaches to supporting improvement and new opportunities for connecting people, such as social media, crowdsourcing platforms, virtual learning communities?
 - How do we involve patients and families?
6. Create a narrative and a (social movement-style) call to action on spread
7. Use the change model to plan for the spread of change. Make sure that all eight elements of the change model are aligned to support your goals for spreading change (see section 2.5).



For further information, ideas & support on this topic, see:

Barker P, Reid A, Schall M (2016) [A framework for scaling up health interventions: Lessons from large-scale improvement initiatives in Africa](#) Implementation Science

Bevan H & Lord Z (2016) [How to create change that sticks and spreads](#), SlideShare

Bevan H, Plsek P, Winstanley L (2012) [Leading large scale change; a practical guide](#)

Bozarth J (2016) [Nuts and bolts; the cargo cult of training](#)

Buchanan D et al (2007) [The sustainability and spread of organizational change: modernizing healthcare](#)

Bunker B & Alban B (2012) [The handbook of large group methods: creating systemic change in organizations and communities](#)

Clay-Williams R et al (2014) [Do large-scale hospital- and system-wide interventions improve patient outcomes: a systematic review](#) BMC Health Services Research

Dinwoody D (2015) [Vertical leadership](#)



For further information, ideas and support on this topic, see:

De Silva D (2014) [Spreading improvement ideas: tips from empirical research](#) The Health Foundation

Fuda P (2013) [Why change efforts fail](#)

Gartner (2014) [The Gartner hype cycle](#)

Greenhalgh T et al (2004) [Diffusion of Innovations in Service Organizations: Systematic Review and Recommendations](#) Milbank Quarterly

Grimshaw J et al (2012), [Knowledge translation of research findings](#) Implementation Science

Jaben M (2016a) [The science behind resistance](#): Slide deck from British Columbia Patient Safety and Quality Council

Jaben M (2016b) [The science behind resistance II: now what?](#) Slide deck from British Columbia Patient Safety and Quality Council

Kastelle T (2016) [We've hit peak innovation \(hype\)](#)

McClure D & Gray I (2015a) [Scaling: Innovation's Missing Middle](#)

McCannon J (2011) [The spread problem](#)

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NHS Institute for Innovation and Improvement (2012) [The spread and adoption tool](#)

NHS Institute for Innovation and Improvement (2005) [NHS Sustainability Model and Guide](#)

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Randall S (2015) [Using communications approaches to spread improvement](#) The Health Foundation

Realising the value (2016) [Spreading change](#)

Everett M. Rogers (1962) [Diffusion of Innovations](#)

Schall M & Schilling L (2014) [An introduction to spreading effective practices and From sustainability to spread and scale up](#)



3.11 Governance and finance

Governance

It is unlikely that you will succeed in your LSC effort unless you create the right governance structure. The right structure will align key interests and enable the system to define, refine and pursue its vision. What is needed will depend on where you are and how you plan to proceed. Where you position your group will define the culture of your system and the supporting actions needed to make it work. Possible dimensions are set out below:

Fast decision making	<i>versus</i>	Careful consideration of risk
Holding the vision	<i>versus</i>	Introducing new ideas to refine the vision
Central control	<i>versus</i>	Dispersed leadership
Providing leadership	<i>versus</i>	Reporting and assurance

Fundamental to success is establishing, developing and maintaining trust between partners. This is much more likely to happen in the ‘doing’ rather than the ‘talking’. Results are likely to be achieved quicker by focusing on the vision and ways of working together rather than on the group’s terms of reference.

Experience suggests it is better to staff your co-ordinating group with people who want to use the position to get things done rather than to maintain the status quo of the position of their organisation. Be very cautious

about establishing a group that merely co-ordinates your existing infrastructure – you are unlikely to change existing ways of working sufficiently to enable transformation to happen.

There needs to be an effective secretariat in place to support the work of the group. This does not necessarily need to be the programme management office. The more entrepreneurial you can be, the more likely you are to effectively delegate responsibility to front line teams.

Finance

There is no doubt that there is significant financial pressure in the system. The art of finance in LSC is to use the available resource to accelerate transformation.

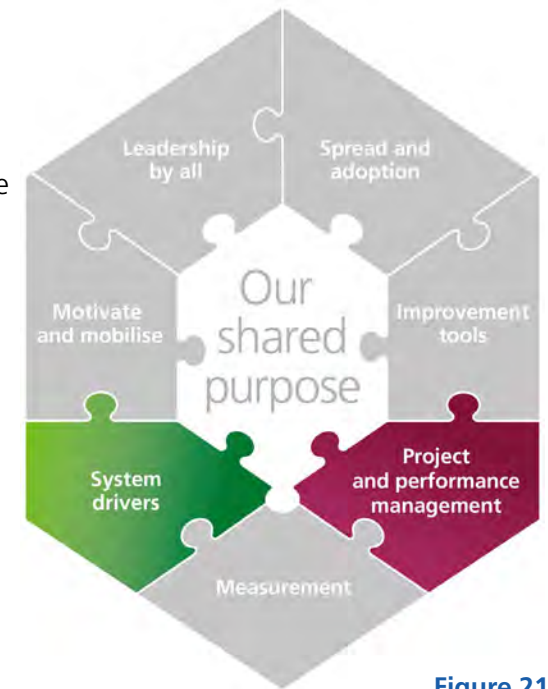


Figure 21:
The Change Model:
System drivers; and
Project and performance
management



There is limited evidence about what works so we offer some perspectives to challenge your thinking:

- Be aware of your relative financial allocation and how it is likely to change. Different populations, whether fast growing or static and ageing, will require different approaches
- Identify the major constraints in your system and ensure resources are directed to solving these. This may mean putting a disproportionate level of resource into one part of your system. If you shy away from this you are unlikely to make a transformational difference
- Seek to establish a few simple rules including prioritising investments that improve cash flow (or positive 'run rate') over those that do not
- Between 60 and 70% of NHS expenditure is on pay. Investing to improve productivity is a priority
- Support effective collaboration – this can share costs and accelerate learning and delivery.



EXAMPLE

UK Sport is the body responsible for elite sport in the UK. It distributes funds to individual sports to achieve Olympic success. Sports need to establish what it will take to win and once the number is agreed the sport is held accountable for delivery. Rather than fund every sport at a sub-optimal level (with competitors just missing out on medals) sports are funded at the required level until the funds run out (leaving some sports with funding reductions). At first glance this is difficult to apply to transformation in healthcare. However, if you establish more programmes than you can resource it is increasingly likely that each programme will under-perform leaving you with a bigger problem to solve.



4. Tools and approaches for large scale change

There are numerous change management tools and approaches available to assist us with our change efforts, so selection of an approach can feel quite daunting. However, many of the most widely used, tried and tested tools and approaches are highlighted within the change model. This helps us to consider which approach might best support our change ambitions for our local context.

Some of the most useful tools and approaches that support large scale change are described in more detail in this section. The relevance of each tool or approach to the change model is indicated by an icon illustrating the change model dimension(s) that it is most applicable to.

The following tools and approaches within this section are:

- 4.1 Planning questions for large scale change
- 4.2 Theories of change, logic models and driver diagrams
- 4.3 Managing complex dilemmas
- 4.4 Measuring large scale change
- 4.5 Continuum of commitment analysis
- 4.6 Systems and stakeholders analysis
- 4.7 30, 60, 90-day cycles of change
- 4.8 Plan, do, study, act



4.1 Planning questions for large scale change

At the outset of your large scale change journey it may be helpful to consider this list of powerful questions to guide your initial and ongoing planning efforts for LSC:

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



Figure 22:
The Change Model: Our shared purpose; and project and performance management



Introduction to large scale change

Creating the conditions for large scale change

Tools and approaches for large scale change

Moving forward: making sense of it all

Acknowledgements

References

Appendices



Tips for use

- Work through these questions with a group of leaders who will become the guiding coalition for your LSC effort
- If you are making an initial plan, consider working through these items as your initial 30-day cycle. Have several 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, while closing down others. With this in mind:
 - Limit your initial planning cycle (we suggest 30 days) and then start doing something concrete
 - If there are disagreements in your team, launch 30-day exploratory cycles to test the options
 - Re-visit these questions at least every 90 days or so to modify and update your plans as things emerge.



4.2 Theories of change, logic models and driver diagrams

Theory of change

This guide has set out the importance of establishing a case for change, articulating a vision or goal (and ‘thinking backwards’ from that goal), identifying and communicating key themes that can make a difference, and continually refreshing the story to attract new supporters. The guide then encourages the planning and design of LSC activity based on what continual monitoring is telling us.

In essence this is about building and assessing a theory of change. A theory of change is an explicit hypothesis that links actions with goals: ‘if we do this, this and this, we will produce that result.’ We know that:

- Leaders¹¹² 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 change
- Research¹¹³ 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 underpinned by an explicit theory of change

“
In science, a good theory reveals compelling hypotheses that subsequent experiments will validate.”

Todd Zenger¹¹¹

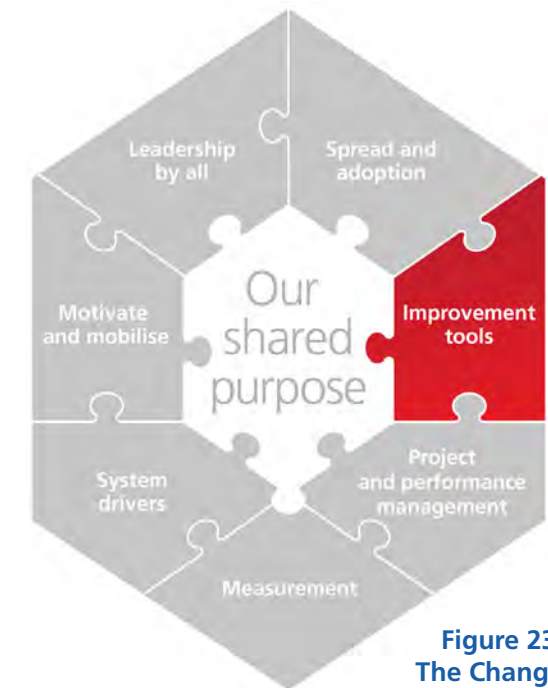


Figure 23:
The Change Model: Improvement tools



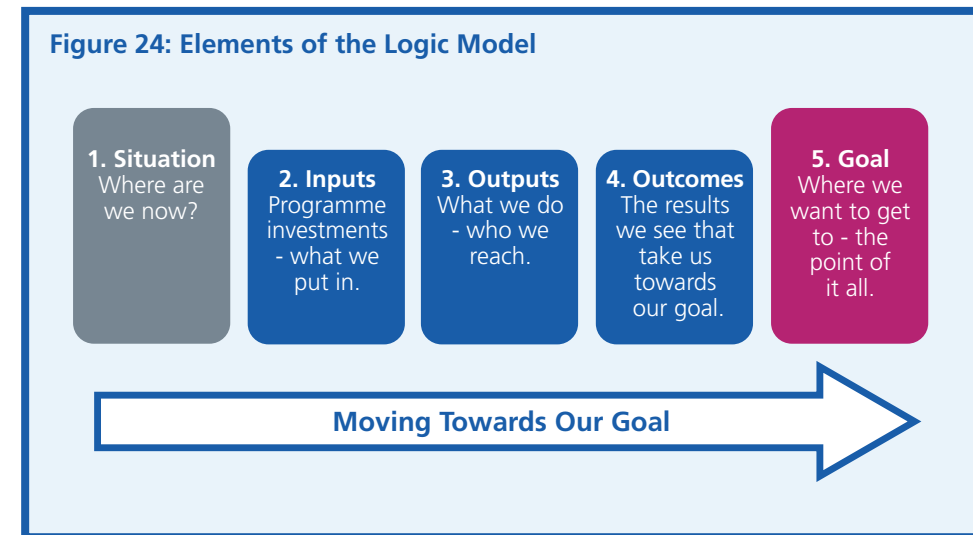
- Too much diversity of ‘mental models’ can impede forward progress. If members of a group, organisation or board have a ‘shared, organised understanding and mental representation’¹¹⁴ about the nature of the challenge and how to tackle it, it can enhance co-ordination and effectiveness when the task at hand is complex, unpredictable, urgent and novel (as in LSC).

The planning questions (in section 4.1) provide a practical means of thinking about all of this. Logic models and driver diagrams are specific forms of theories of change. They set out your plan for LSC and describe the link between the goal and the project activities that will be undertaken to deliver it. This is achieved by identifying the long-term goal and working back from it to identify all the conditions that must be in place (and how these relate to one another) for the goal to be reached¹¹⁵.

Logic model description

A logic model provides a full strategic depiction of a LSC programme. As well as setting out the links between activities, outcomes and overall goal, the model captures current issues, challenges and opportunities. It provides a good framework on which to base monitoring and evaluation as the key activities and outcomes of the LSC are very clear.

Your logic model will be a dynamic document and should be reviewed on a regular basis. The basic components of a logic model are shown in the figure below although you can arrange them in the most useful way to you (for example, linear or circular).





Introduction to large scale change

Creating the conditions for large scale change

Tools and approaches for large scale change

Moving forward: making sense of it all

Acknowledgements

References

Appendices

CASE STUDY

EXAMPLE

The NHS England Patient Safety Collaborative developed a logic model in November 2015 to support the NHS to deliver safe, effective and person-centred care that is consistently developed everywhere. It clearly sets out the key activities and short, medium and long term outcomes desired.

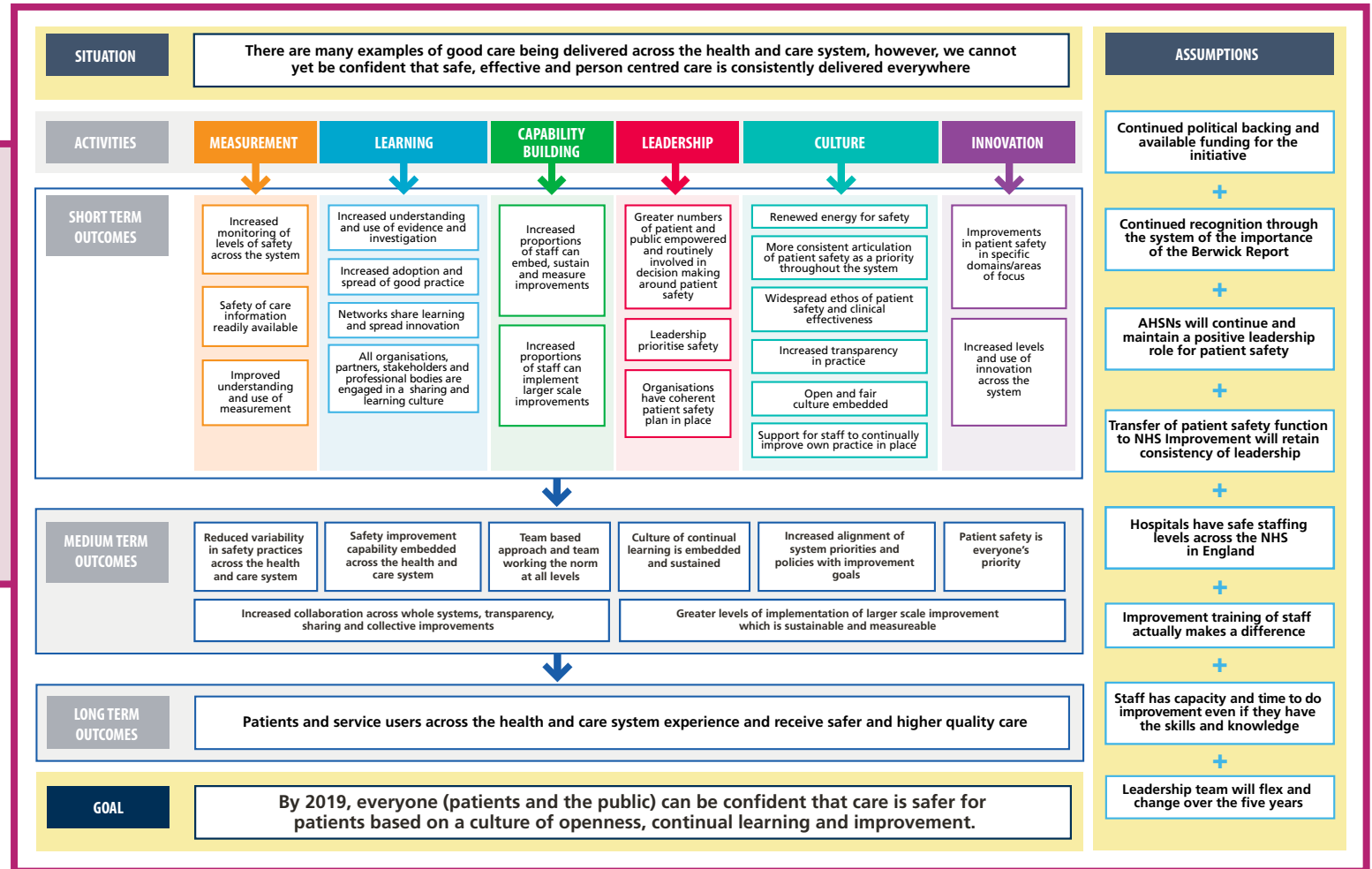


Figure 25: Patient Safety Collaborative Logic Model



Driver diagrams description

Driver diagrams focus on the links between activities, outcomes and goals. They are similar to logic models and are particularly helpful in focusing on discrete projects.

A driver diagram includes three levels:

1. A goal or vision
2. High-level factors 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.

The number of levels in a driver diagram can be expanded for more complicated goals. Each primary driver would then have its own set of underpinning factors (or secondary drivers). It is these secondary drivers that would be linked to projects and activities.

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



EXAMPLE

A partnership of national organisations involved in health and care have produced a national framework to guide local, regional and national action on developing NHS-funded staff. Those responsible for producing 'Developing People – Improving Care'¹¹⁶ used driver diagrams to help set out how they are going to achieve their shared ambition of large scale change. See figures 26, 27 and 28 on the following pages.



Figure 26: Developing People - Improving Care¹¹⁶ driver diagram. Setting out how to achieve their shared ambition of large scale change.

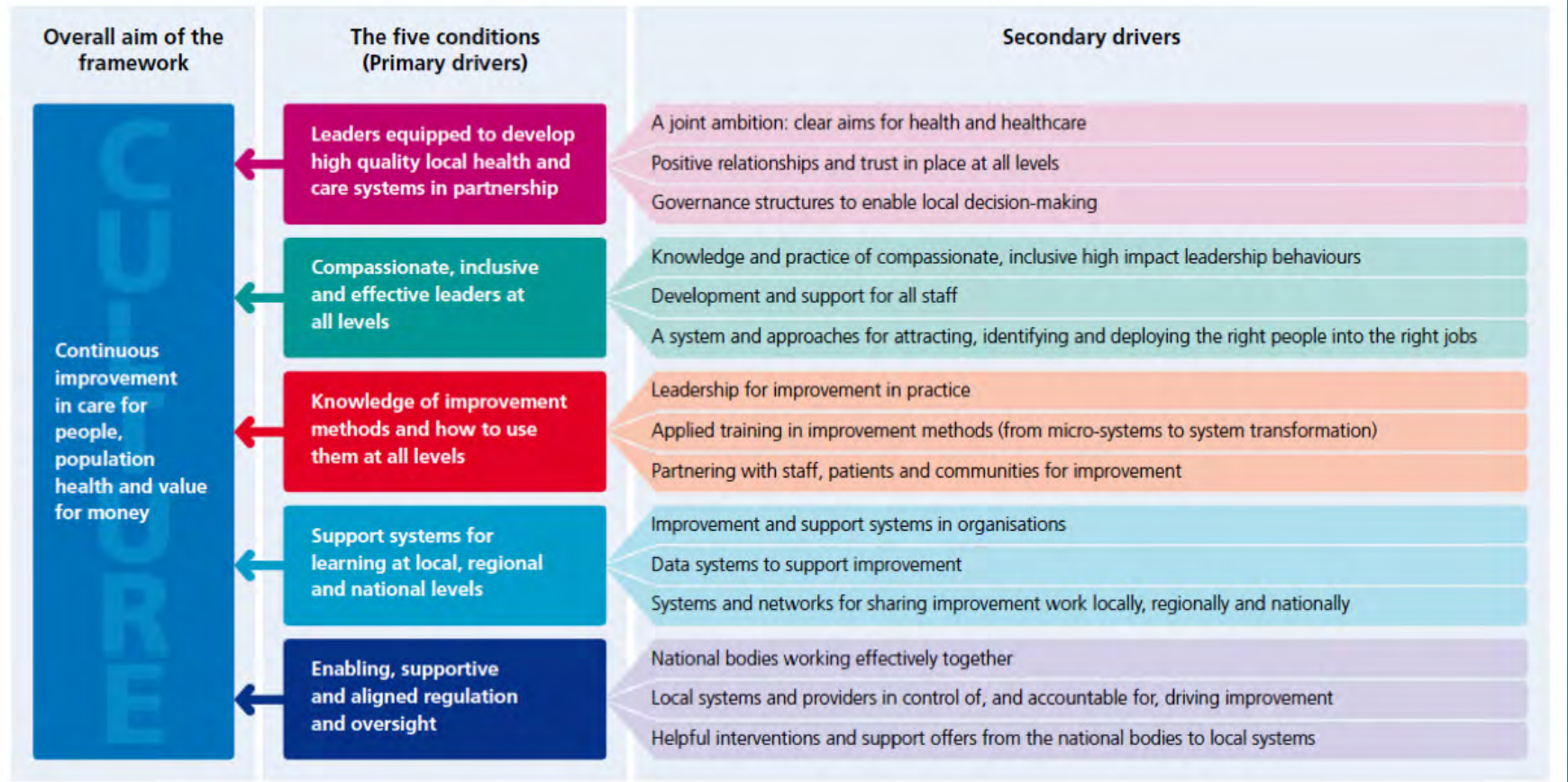




Figure 27: Developing People - Improving Care¹⁶ driver diagram. Proposed actions.

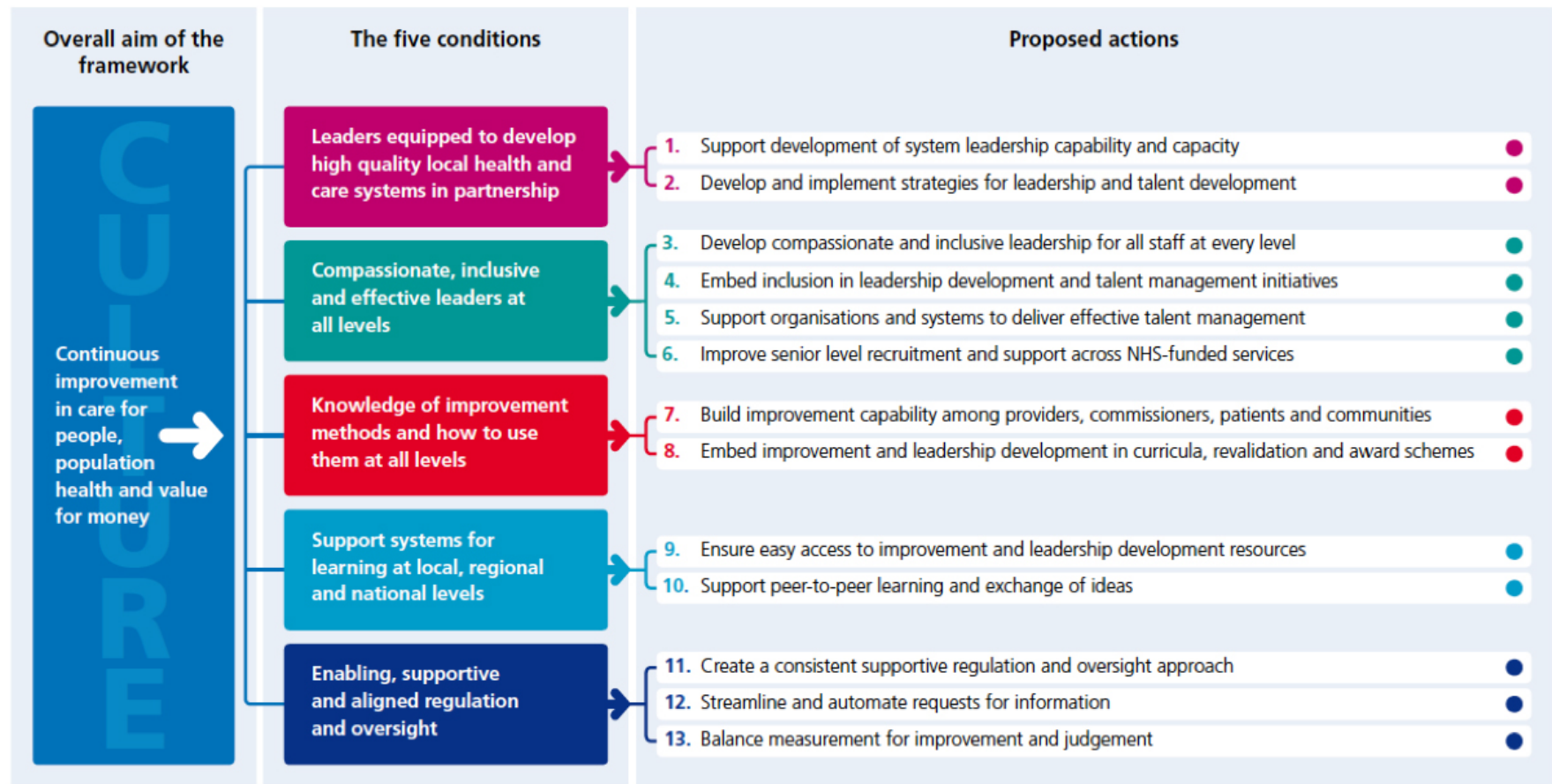
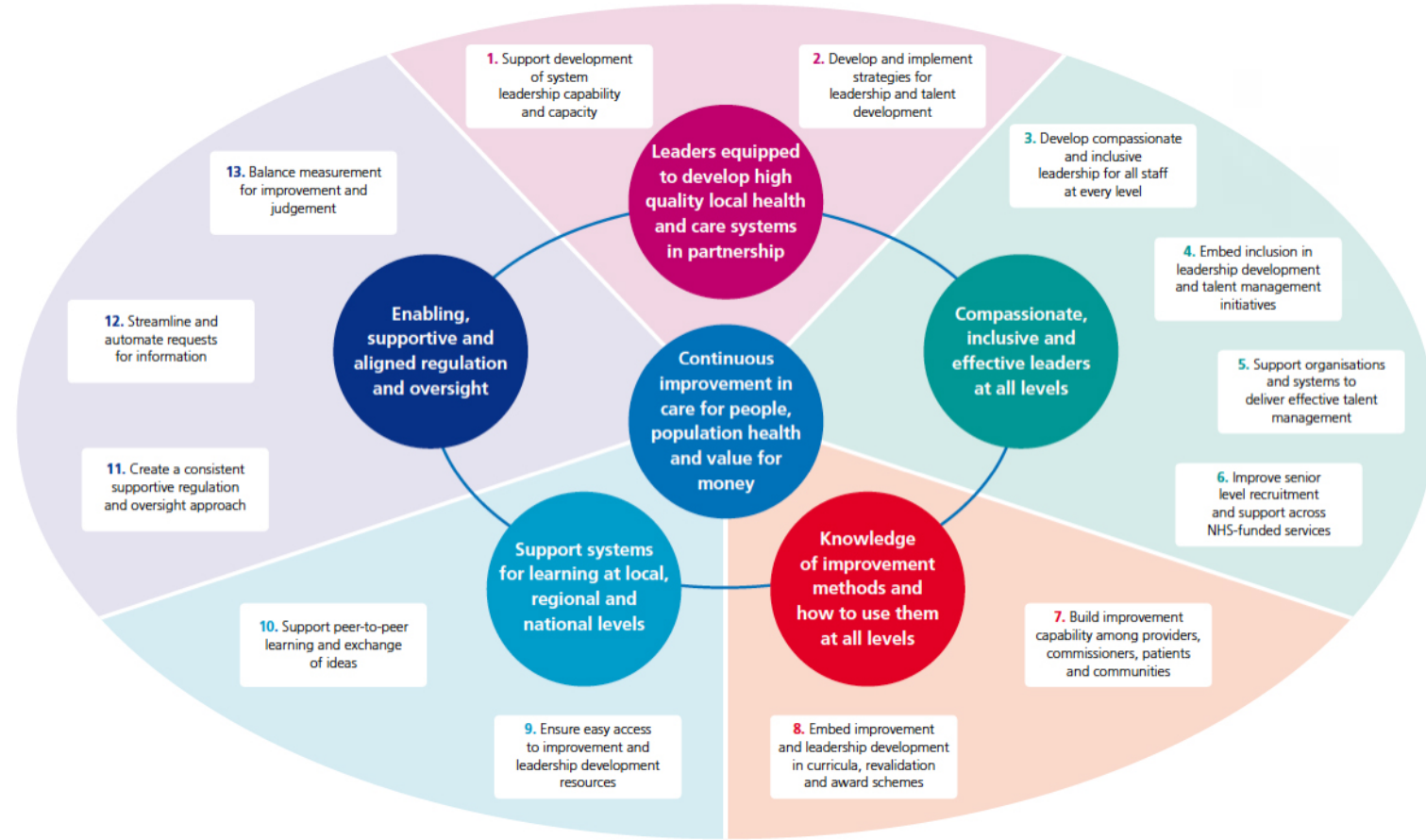




Figure 28: Developing People - Improving Care¹¹⁶ Proposed actions (circular view).





Tips for use

- Theories of change, driver diagrams and logic models are for use by a small group of leaders overseeing the LSC
- Use change-orientated language such as ‘improve’ to encourage people to be explicit about what they intend to achieve
- Make sure you are considering the views of everyone affected (public, patients, carers, workforce, others)
- The process of developing the theory is as important as the theory itself (people will own what they help to co-create)
- Use sticky notes or other flexible means to construct the driver diagram or logic model as part a brainstorming effort
- Be flexible about how the driver diagram or logic model is put together – people like to work in different ways
- Link your theory of change to your narrative for change (section 3.3)
- Review and update your work at least every 90 days.

<p>Theory of change</p> <ul style="list-style-type: none"> • Roadmap for change • Preconditions • Underpinning assumptions • Change process • Outcomes 	SHARED VALUES	<p>Story/narrative</p> <ul style="list-style-type: none"> • Connections to bigger purpose • Creating meaning • Commitment to change • Engagement/mobilising • Compelling people to act
--	----------------------	--

Figure 29¹¹⁷



For further information, ideas and support on this topic, see:

Plesk PE (1993). Management and planning tools in TQM. Quality Management in Healthcare, 1(3): 59-72

Using Logic Models in Evaluation: Briefing. Midlands and Lancashire Commissioning Support Unit. Prepared for NHS England, by the Strategy Unit, as part of a programme of training to support national and locally-based evaluation of the Vanguard programme and sites https://midlandsandlancashirecsu.nhs.uk/images/Logic_Model_Guide_AGA_2262_ARTWORK_FINAL_07.09.16_1.pdf

W.K. Kellogg Foundation Logic Model Development Guide <https://www.bttop.org/sites/default/files/public/W.K.%20Kellogg%20LogicModel.pdf>





4.3 Managing complex dilemmas

Description

The very nature of a large scale change effort is profoundly different to simple problem solving. LSC is riddled with complex dilemmas, dualities, and multiple 'right' answers that are polar opposites. The nature of the challenges can be described as:

An idea involving two opposing thoughts or propositions which, however contradictory, are equally necessary to convey a more imposing, illuminating, life-related or provocative insight into truths than either factor can muster in its own right.

Kim Cameron¹¹⁸

Between two poles of a duality lies a 'zone of constructive tension' i.e. a zone where a balance between extremes is possible.

Paul Evans¹¹⁹

There is a fundamental difference between a problem and a polarity (complex dilemma) – see figure on the right.

Figure 28: Problems vs. polarities (complex dilemmas)

PROBLEMS:

- Have one best or right answer that provides a solution
- The solution solves the problem and it goes away
- A definite end point where you can say that the problem is solved
- The solution to the problem usually contains no alternatives

POLARITIES:

- Are unsolved problems that need to be managed
- Often two positions that are in opposition
- Usually expressed as from one polarity to another
- A tension, not a choice with a best or right answer

As health and care leaders, we tend to seek one solution that we consider as being either the 'best' or the 'right' way to go. We might start with a 'top-down' directive approach, but when it does not deliver all the outcomes we are seeking, we lurch to a 'bottom-up' inspirational approach. This is because (like leaders in every sector) we have been taught that problems can only have one right answer.



But, paradoxes or polarities, as Barry Johnson¹²⁰ labels them, can never be solved, they have to be managed and require a 'both/and' solution. When we try to solve a polarity as we would a problem the results are usually worse. A few examples from the current scenario of large scale change in health and care can be seen in figure 30 below:

Figure 30: Source: Horizons Team

Authority of the 'centre'	AND	Authority of local leaders
Strong coherent leadership country wide	AND	Delegate to local leaders as much as possible
Taking the 'high performers' forward	AND	Getting the 'poor performers' to a minimum level
Transformational	AND	Transactional
Compliance to rules and an operating model	AND	Commitment to a common purpose
Driving consistency in standards	AND	Responsiveness to local needs
Ensuring/assuring quality of process ('tick the box')	AND	Making the system work for everyone

Complex dilemmas at the heart of current transformation efforts in health and care

The goal of managing polarities is to gain the advantages of the upsides and minimise the downsides. A well-managed polarity is one where you benefit from the tensions that exist between the two poles and get the advantages from the synergy between both the two poles and achieve the higher purpose. A badly managed polarity occurs when you over-focus on one pole, neglecting the other. When trying to manage a polarity, if you focus on one pole at the expense of the other, it results in the negative aspects of the one pole.

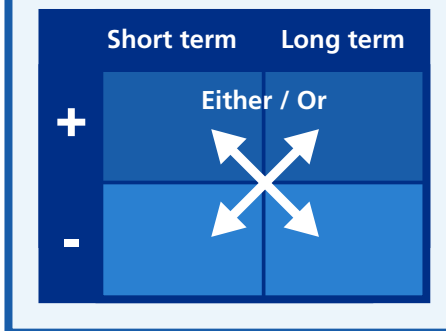
To effectively manage the polarity requires us to see the whole picture, to understand the whole map, to understand the dynamic that creates the tension, and to accept that the tension inherent within the polarity needs to be managed over time. Polarity maps look at such issues on a two-by-two matrix¹²¹.



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 are: short-term versus long-term focus, centralised versus decentralised, quality versus cost or productivity, or stability versus change.

We can introduce a third option that includes 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. This approach invites new thinking. It also, helpfully, suggests that both sides are right in arguing for their respective points of view, because there are advantages to each.

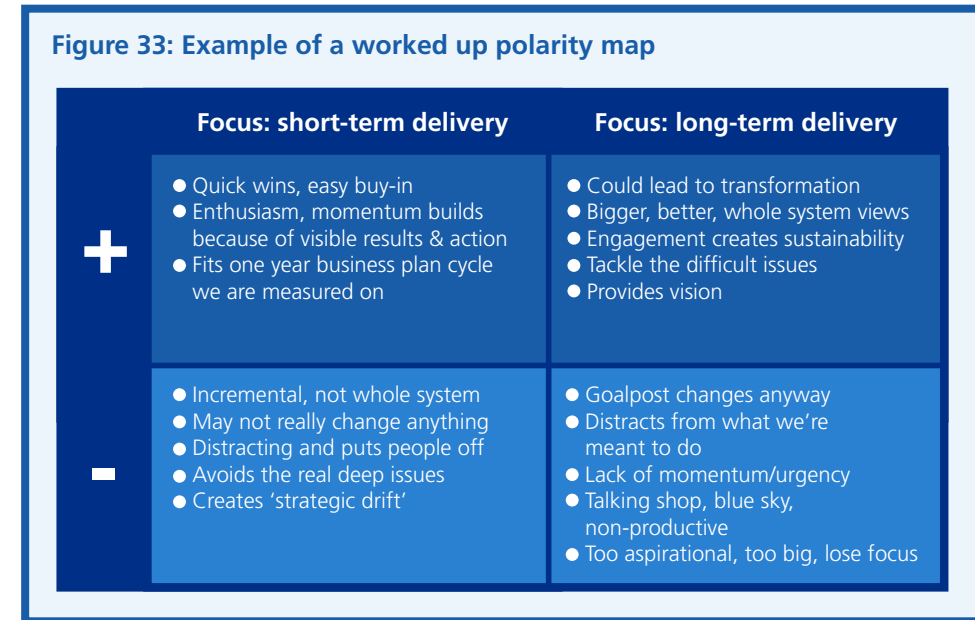
Figure 31:



However, it challenges each party to focus on the positives of both sides and build something new together.

As an example, a worked up polarity map is shown below.

Figure 33: Example of a worked up polarity map



[Introduction to large scale change](#)[Creating the conditions for large scale change](#)[Tools and approaches for large scale change](#)[Moving forward: making sense of it all](#)[Acknowledgements](#)[References](#)[Appendices](#)

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 via the process of creating a polarity map brings new insights and a willingness to, at least, discuss the potential of a third way that takes us beyond the usual argument. A number of characteristics have been identified for ideal leadership behaviours¹²² when working across systems and being faced by complex dilemmas.



For further information, ideas and support on this topic, see:

Johnson B. Polarity Management: Identifying and Managing Unsolvable Problems. HRD Press, 1996.

Blog: Levknecht L (2013) Using 'polarity thinking' to achieve sustainable positive outcomes <https://www.elsevier.com/connect/using-polarity-thinking-to-achieve-sustainable-positive-outcomes>

Polarity Management Associates website: <http://www.polaritymanagement.com>



4.4 Measuring large scale change

Description

This section introduces you to measurement for improvement so that you can capture and understand what difference your LSC programme is making. Our purpose is to provide broad guidance about how to measure in a way that is manageable, appropriate and proportionate, knowing that specific choices and the details of what to measure will vary greatly from one LSC effort to another.

Purpose of measurement in LSC efforts

Our [model for large scale change](#) tells us how LSC efforts tend to unfold over time. This leads to six potential stages where measurement can help us:

1. Clarify the topic, vision, and key themes when identifying the need for change



Figure 34:
The Change Model:
Measurement

2. Create and test a variety of cases for change that can be used for framing and engaging stakeholders
3. Assure 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 stakeholders
5. Determine if efforts are on target for settling in to a sustainable norm
6. Establish results and flag up any unintended consequences.

How to think about measurement in LSC

Leaders of change can sometimes overcomplicate discussions about measurement and get side tracked by endless technical details that delay progress. Douglas Hubbard¹²³ describes four useful assumptions about measurement that can help you stay focused and keep it simple:

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 adapt.
2. You already have more data than you think. Use your logic model or driver diagram (see section 4.2) to come up with a list of existing data and indicators. The advantage of using existing measures is that you will have a baseline of past data and will not have to invest time designing or capturing new data.



3. You need less data than you think to demonstrate change. Understand the stakeholders you are trying to engage or influence and think about what they want to know. 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 are not perfect, do not measure everything, or are not sufficiently pure for research.

Types of measurement

There are a number of different reasons why we would seek to measure what is happening and not all may be helpful within a LSC project:

Measurement for judgement/accountability

This form of measurement allows us to consider whether we have achieved a comparative level of performance and often takes the forms of monitoring against targets or benchmarking against similar competitors. This form is less useful for LSC as improvement is not about judgement, but you can use judgement to measure your own progress.

Measurement for research

This form of measurement is aimed at generating new knowledge, for example a random controlled drug trial to decide if we should invest in a new drug. The measure would be taken to assess whether or not an

anticipated change had or had not occurred and the value of that change, and is a less useful approach for LSC.

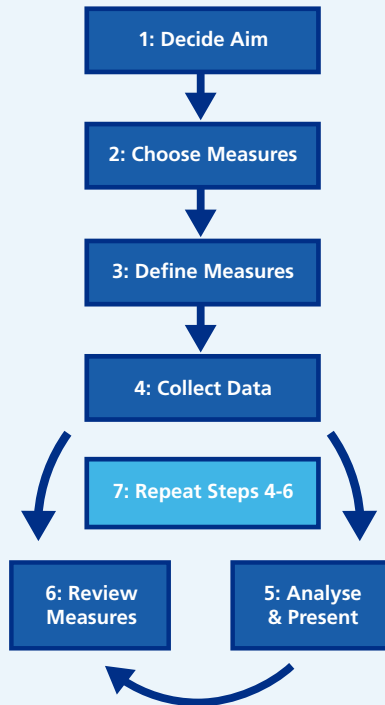
Measurement for diagnosis

This form of measurement is used to better understand what is happening within a system so that its performance can be optimised. This can be a useful technique, especially early in the LSC process, for example to investigate the demand and capacity at a bottleneck in the process.

Measurement for improvement

This form of measurement looks at the effects of an intervention and helps us to consider whether the improvement we are trying to accomplish has been achieved (see Figure 35). It can test whether change is happening in processes, if outcomes are changing or if key performance indicators are shifting. Measurement for improvement does not necessarily have to meet robust academic standards - it should be 'good enough' to give a good indication of what is happening.

One of the most effective ways to measure the impact of the changes being made in an improvement project is a technique called statistical process control (SPC)¹²⁴. Control charts are used to visualise and analyse the performance of a process over time and are very useful in telling us whether changes made to a process have resulted in improvement.

**Figure 35: Seven steps to measurement for improvement****PREPARE**

1. As part of developing your 'theory of change', you will be clear on what it is that you are trying to achieve, but try an 'elevator pitch' as a check. Can you explain the aims of your LSC work to someone in the time it takes to get to the top floor in a lift?
2. Look at your process map, driver diagram or logic model to help prioritise what indicators are needed and what data is already available to you. What do these tell you? Are there any gaps?
3. Be specific in your definition of measures. What do you need them to tell you? For example, if you are interested in measuring complaints, is it specifically the number of complaints, or the percentage of patients who complain, or something else?

COLLECT, ANALYSE, REVIEW CYCLE

4. Once you have established what data you need to collect, then work out the practicalities. Who will collect it? How and when? Are we interested in real-time or historical data?
5. Analyse and present your data to tell your LSC improvement story. This might work best in graphical charts, story form or film. Think about your stakeholders and what will work for them.
6. Make time to look at data regularly and decide what to do next. Are we getting the outcomes we expected? What is it telling us about our LSC effort? Do we need to make adjustments to our project?
7. Keep going back to step four and repeat. How often you do this will depend on your project and the type of data, for example you may stop collecting process measures once a certain standard has been routinely reached. However, outcome measures may need to be measured for as long as the project exists.



Introduction to
large scale change

Creating the conditions
for large scale change

Tools and approaches
for large scale change

Moving forward:
making sense of it all

Acknowledgements

References

Appendices



For further information, ideas and support on this topic, see:

View the Prezi presentation on how to become an improvement expert in 60 minutes:

http://prezi.com/3alg2jdmi5ea/?utm_campaign=share&utm_medium=copy&rc=ex0share

The Excellence Framework for Patient Experience - measures and metrics has articles focusing on the importance of capturing, measuring and reporting patient experience feedback as a quality outcome for patients; and the importance of patient experience feedback for accountability, transparency and quality improvement in the NHS:

<http://content.digital.nhs.uk/patientexperience>

NHS England Transforming Participation in Health and Care has sections on measuring participation and measuring patient experience:

<https://www.england.nhs.uk/ourwork/patients/participation/>

Measurement for improvement guide developed by NHS Elect: <http://linkis.com/www.nhselect.nhs.uk/Dy9CH>

NELA (Royal College Anaesthetists): Video on how to use data to drive improvement:

<https://www.youtube.com/watch?v=YqUlsuzJwx4&feature=youtu.be>



4.5 Continuum of commitment analysis

Figure 36: Continuum of commitment analysis table

Stakeholder	Obstructing	No commitment	Let it happen	Help it happen	Make it happen
A		X	→	→	○
B				X → ○	
C			○ ←	←	X
D	X	→	○		

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

Description

Continuum of commitment analysis, a classic tool used in organisational development¹²⁵, is illustrated in the table above. 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.

- **Stakeholder A** is an example of an individual or group that is currently neutral to the LSC vision, but 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 you might wish them to be in terms of commitment, 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, actually, it might be better if they were more hands-off. This individual or group might not have the capability or capacity to lead effectively or there may be issues over power, conflict or damaged relationships. The required pace of change may not provide enough time to address capacity, capability or behaviour. A difficult conversation will be required helping stakeholder C understand the bigger picture and that their actions could affect delivery of the vision



Figure 37: The Change Model: Leadership by all; Motivate and mobilise; and Project and performance management



- **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 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 substantial time understanding them and finding a framing that engages.

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 mind-set change, and the literature tells us that this is essential for sustainable LSC. Finally, not recognising the characteristics of the stakeholders illustrated above can drain LSC leaders of personal energy over time. This can be due to 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.

The continuum of commitment analysis is best used as a thinking tool, to aid analysis and discussion, rather than seen as a straightforward communications tool that might go into a communications plan for example. It is most effective when considered as the basis for discussion between a number of team members each bringing in their own different perspective.

The continuum of commitment analysis can be used alongside another tool – Think, Feel, See, Do – to help with the framing. In this tool, developed by Good Squared CIC, you need to state what the stakeholder thinks of you now, and then after positive engagement, what in the future you would like them to think, feel, see and do. Completing this preparation work will take time but is vital to getting the framing of the message right.

Person/Org	Think	Feel	See	Do		Think	Feel	See	Do
X									
X									
X									
X									

Figure 38: Source: Good Squared





4.6 Systems and stakeholders analysis

Description

When working in a system, it is likely that you will need to engage a wide variety of stakeholders – either to influence them to see issues in a new way, or to come together on the basis of a shared ambition in order to take action.

In this case, it helps to map who the stakeholders are and where they sit. This will help you understand the ways in which different people can and will exert their influence over what you want to achieve.

Not everyone will automatically see things from your perspective¹²⁶. The more you can understand where other people are coming from, the more likely you are to be able to collaborate effectively and exercise systems leadership.

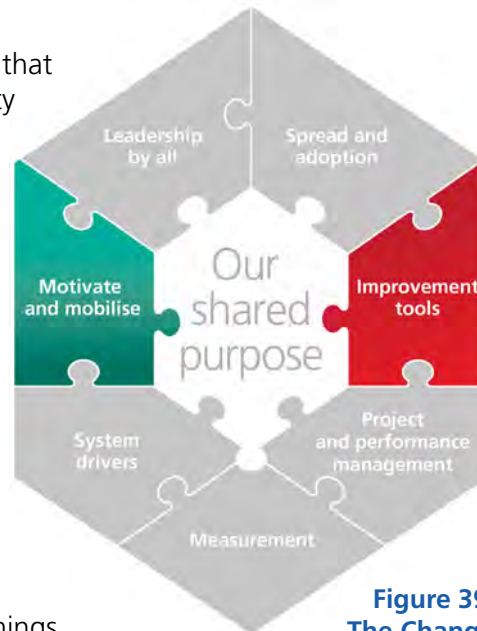


Figure 39:
The Change Model: Motivate and mobilise; and Improvement tools

In this scenario systems leadership is required. See [section 3.6](#) on ‘Working within political and bureaucratic environments’ for more information on systems leadership.

Stakeholder analysis - trust and agreement

Using systems leadership means understanding your stakeholders. Systems leadership research¹²⁷ identifies certain ‘ways of thinking’ – including having empathy and an ability to understand other people’s perspectives as being immensely helpful.

Stakeholder analysis can be a useful tool. It can help identify those who have influence in a system. It can provide frameworks to help understand the needs that they have and how to respond to them. This is important because by knowing the characteristics of your stakeholders, you can understand how you can frame your responses in terms that make sense to them.

For people coming from a health background, two key groups of stakeholders include officers and elected members in local authorities, and people working in the voluntary and community sectors. If you are a councillor, for example, you will most likely see yourself as having a community leadership role.



As the Local Government Association says: “Community leadership is at the heart of modern local government. Councils work in partnership with local communities and organisations – including the public, voluntary, community and private sectors – to develop a vision for their local area, working collaboratively to improve services and quality of life for citizens. Councillors have a lead role in this process¹²⁸.”

In addition to this leadership role, councillors need to be elected or re-elected, and will have a view as to what makes them electable (or not). Similarly, officers in local government - more than ever - need to juggle multiple and sometimes conflicting responsibilities and priorities. Meanwhile, the voluntary and community sector may feel that its voice often goes unheard, despite its close working relationships with citizens and service users.

Peter Block's stakeholder analysis tool

Leadership and management writer, Peter Block, has developed a tool¹²⁹ for stakeholder mapping that categorises people according to the amount of agreement they hold in the programme, and the amount of trust they have in the organisation to make success happen.

Each of the different categories has different characteristics, needs, demands and influences, and they need to be treated in different ways. The tool asks questions such as:

- What can they do?
- What are their needs?
- What are their interests?
- What are their concerns?

Once you have mapped your stakeholders, you can categorise them in a new way and think about what you might do to identify common ground, in order to work together (as modelled on the following page).

Bedfellows: high agreement, low trust

They agree with the idea but do not trust an organisation's way of doing things. On the plus side, they can be persuaded to see things differently. They tend to hear and say the things that suit their own needs. They are not entirely trustworthy or reliable: while they can be generally kept on side, they are also keen backstabbers.



Adversaries: low agreement, low trust

These stakeholders do not like what is being proposed and do not have trust in the organisation. They will typically resist all attempts at negotiation. Their oppositional behaviour needs keeping to a minimum. Ask ‘what can be done (if anything) to placate them?’

Opponents: high trust, low agreement

They trust in the organisation but think the idea is a bad one. This means that they question what has been done and said. This can lead to new ways of thinking as those opposing ideas are explored. Because they trust the organisation already, it is worth trying to persuade them that the idea is a good one.

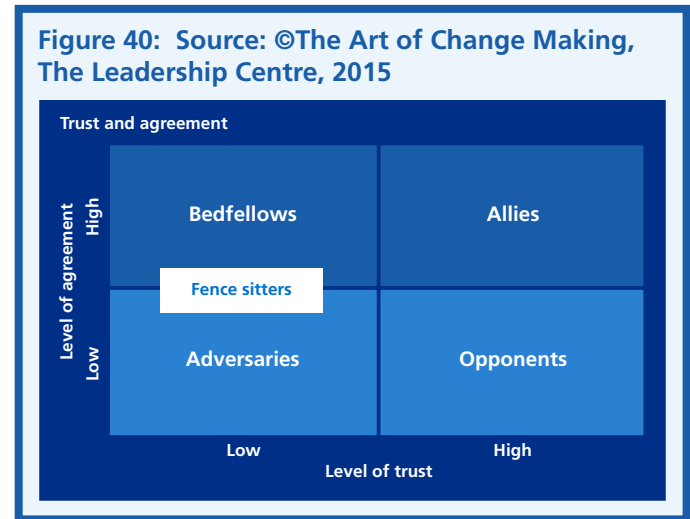
Allies: high trust, high agreement

These stakeholders are on side. They trust in the organisation and like where things are headed. They are good friends and because of that, a useful resource and good collaborators to make plans with. They have influence over other stakeholders. Their support needs maintaining but needs little input. It is a mutually good relationship.

Fence-sitters: low trust and cannot decide if they like the plans or not

Neither friend nor adversary, they are worth negotiating with by asking: ‘exactly what is stopping you?’ At the end of the day they usually make their own minds up.

You can use the model to think about how you might build trust with different groups, so that people can move from adversarial relationships to taking on more supportive positions.





Tips for use

- 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 do not usually have it can lead to pleasantly unexpected new ideas and energy
- You can capture your brainstorming in a simple table with one column for key stakeholders and one for systems and processes
- Resist the urge to say that everything is a priority and must change. Discuss priorities in upcoming 30/60/90 day cycles.



For further information, ideas and support on this topic, see:

There are many references to different mapping tools in The Art of Change-Making, a compendium of models and guidance for people looking to lead change initiatives. See <https://www.leadershipcentre.org.uk/wp-content/uploads/2016/02/The-Art-of-Change-Making.pdf>



4.7 30, 60, 90-day cycles of change

Description

The long-term LSC journey needs small steps to gather momentum and make progress. 'Going two steps down in your thinking' (see figure 42) 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.

Experience within health and social care¹³⁰ has found a mix of 30 and 60-day cycles are often better suited to the pace of change required than 90-day cycles which might be more effective in industry¹³¹.



Figure 41: The Change Model: Improvement tools; and Project and performance management

Figure 42: Establishing pace

Establishing pace

- Years
- Month
- Weeks
- Days
- Hours
- Minutes

However long you think it is going to take to fully accomplish something... move two steps down in your thinking.

Each cycle should involve:

- A clear, specific objective to be achieved (for example, engage three 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?).

[Introduction to large scale change](#)[Creating the conditions for large scale change](#)[Tools and approaches for large scale change](#)[Moving forward: making sense of it all](#)[Acknowledgements](#)[References](#)[Appendices](#)**CASE STUDY**

EXAMPLE

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 was 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, for example, 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 East of England 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

**TOP TIPS**

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
- 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
- Spend time purposefully anticipating what you will do next. You are not bound by this thinking, but if you have not given it any thought you risk wasting the momentum you have created
- The service improvement tool 'plan, do, study, act' (PDSA) ([see section 4.8](#)) is a further model that could be used within a 30/60/90 day cycle.



4.8 Plan, do, study, act

Description

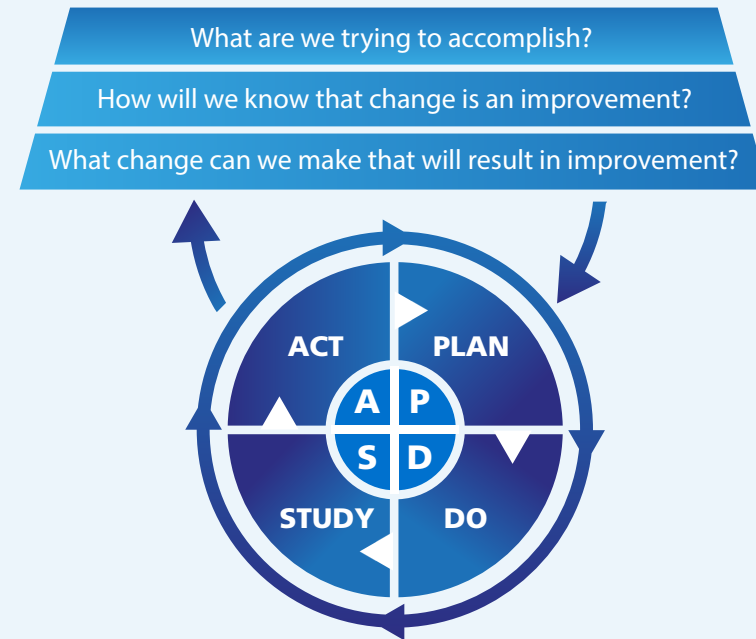
For any change to work, particularly service changes that directly affect patients, we want to be as sure as possible that the changes will be successful. We want to be assured that our changes will achieve better outcomes, be affordable and efficient, and understood by staff, patients and other stakeholders. The larger the change, the riskier this all seems.

One way to test your approach is by using 'prototyping' – testing changes on a smaller scale before spreading. This is not the same as 'piloting'. Prototyping is designed to test the failures and is built on the idea of plan, do, study, act (PDSA) cycles. Plan, do, study, act cycles come from evidence-based improvement science and are formalised in the model for improvement¹³².



Figure 43:
The Change Model: Improvement tools

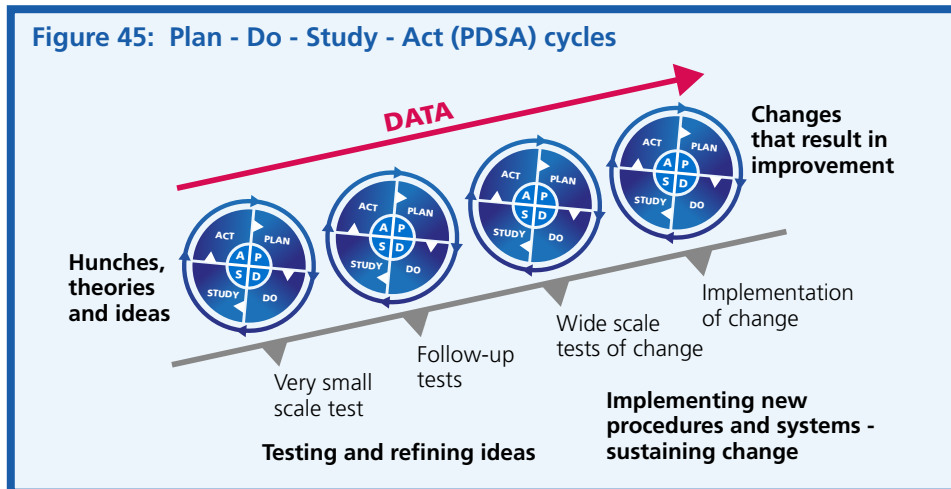
Figure 44: The Model for Improvement



Source: Langley, G. Nolan, K and Nolan, T (1994)
The Foundation of Improvement Quality Progress, 1994



Teams should be encouraged to test at speed multiple cycles of improvements. Starting small, some of these tests will fail but some will progress, achieve our aims and begin to achieve spread. These small tests of change will ideally be designed by the frontline, and enabled and supported by senior management to achieve the agreed shared purpose (the 'what are we trying to accomplish?' from the model for improvement). These activities will accumulate and build on each other to result in a sustained, measurable improvement, as illustrated in the model below.



For further information, ideas and support on this topic, see:

http://webarchive.nationalarchives.gov.uk/20121108074656/http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html

<http://www.qihub.scot.nhs.uk>

<http://www.ihl.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx>



5. Moving forward: making sense of it all

//

(There is a) discrepancy between, on the one hand, ideal methodologies and plans and, on the other, the realities of implementation, where chance, serendipity, trial and error, or even gross negligence seem to play a major role in shaping systems that will become of strategic importance and reference, but only after the fact. //

Claudio Ciborra¹³⁵

Large scale change can be one of the most exciting initiatives that we are ever part of. It is complicated, multi-faceted, requires engagement with many partners and individuals, involves many processes and may take many years to deliver. From our own experiences in either leading thought leadership or implementing change, the start of the process in creating a shared purpose has always been the most important aspect. Obtaining collective agreement on the end state needs to have dedicated time put into it; never under-estimate the importance of this part of the process.

#LargeScaleChange

Sustainability and Transformation Partnerships (STPs) and accountable care systems provide a unique opportunity for service re-design based on local population health profiles, for organisations to reduce bureaucracy, and to design care in cost-effective high quality models. Our knowledge and understanding of large scale change will help make sense of some of your local issues and provide tools and techniques to collectively make great change happen.

There is much in this guide that can help in your current efforts to transform care including models of change, mindsets, leadership approaches and practical tools. The evidence base on large scale change suggests that the kinds of approaches set out in this guide could make a fundamental difference in helping you to achieve your goals and aspirations for radical change.

The current health and care transformation agenda is one of significant change. The leaders and change agents who helped co-create this guide are tackling some very big challenges. These include new relationships with patients, service users, families and communities, novel and collaborative approaches to system leadership, STPs, new care models, re-design of urgent care and the complex dilemma of delivering unprecedented improvements in quality and productivity at a time when all these other changes are happening. If we use the yardstick of 'three ways to describe large scale change' set out in [section 2.1.1](#), we have to conclude that the interventions that health and care system 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.



Introduction to large scale change

Creating the conditions for large scale change

Tools and approaches for large scale change

Moving forward: making sense of it all

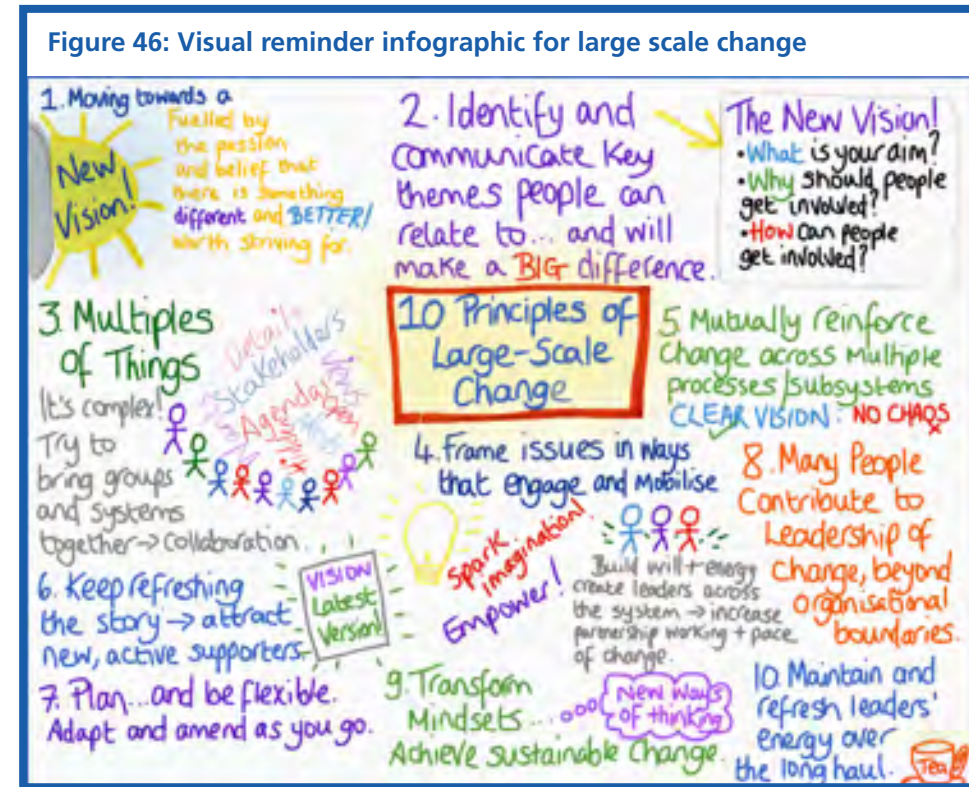
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Appendices

It is recognised that every local context for change is unique and that some aspects of this guide will be more relevant to you (and will appeal) more than others. To quote George Box¹³⁶: “All models are wrong, some of them are useful”. Please use as many of the materials and approaches in this guide as you wish. You may want to combine them with change methods that you are using already. We would suggest that you create your own approach for large scale change (using some of the approaches in this guide) or adapt an existing model or methodology. The literature¹³⁷ on improvement in the health sector suggests that organisations or teams that adopt a specific methodology tend to get better outcomes. However, there is no evidence that one methodology or approach gets better results than any other. Rather, it seems to be just the fact of having the methodology as a guiding approach. If there is one lesson we take from the evidence base on large scale change, it is the importance of context¹³⁸; a change methodology that delivers outstanding results in one health and care context may deliver little in another setting where the conditions for change are not so healthy.

On the right is an infographic to act as a visual reminder of the principles of large scale change:





You are welcome to share and print out this diagram. You might want to create your own version with your stakeholders or change team and/or display it to remind you of your key principles for large scale change.

Those of us leading large scale change in health and care face profound choices. In order to achieve our goals we can:

1. Seek to manage complexity by a rational and well-planned schedule of change activities in line with best practice in programme management
or
2. Accept that change is emergent and hard to predict so get people involved and just go with the flow
or
3. **Follow the principles in Leading Large Scale Change and seek to join up multiple aspects of change at multiple levels of the organisation and system, learning and adapting as we go.**

To really achieve sustainable change, choosing option three is preferable.

There is much that we can do to make a difference in any situation of large scale change. So many of the constraints we face are not imposed from outside but created by the dynamics and interactions¹³⁹ inside our organisations or systems. As leaders, we can orchestrate the changes in those. To quote David Bowie (Heroes¹⁴⁰) and Simon Stevens¹⁴¹ (the Chief Executive of NHS England): “[Tomorrow belongs to those who can hear it coming](#)”.

Leading Large Scale Change can help you to create a different tomorrow, one that builds on the strengths and proud history of the NHS and wider health and care system but that really meets the needs and desires of each individual and the whole population in a rapidly changing world.

Moving forwards, we do hope you find this guide useful. We would welcome your feedback on this guide and would encourage any systems that would like additional support to get in touch with us at: england.si-enquiries@nhs.net



6. Acknowledgements

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The Horizons team, based within NHS England, is a source of ideas, learning and connections to help large scale change in health and care.

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Introduction to
large scale change

Creating the conditions
for large scale change

Tools and approaches
for large scale change

Moving forward:
making sense of it all

Acknowledgements

References

Appendices

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Introduction to
large scale change

Creating the conditions
for large scale change

Tools and approaches
for large scale change

Moving forward:
making sense of it all

Acknowledgements

References

Appendices

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Introduction to large scale change

Creating the conditions for large scale change

Tools and approaches for large scale change

Moving forward: making sense of it all

Acknowledgements

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Appendices

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[Introduction to large scale change](#)[Creating the conditions for large scale change](#)[Tools and approaches for large scale change](#)[Moving forward: making sense of it all](#)[Acknowledgements](#)[References](#)[Appendices](#)

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[Introduction to large scale change](#)[Creating the conditions for large scale change](#)[Tools and approaches for large scale change](#)[Moving forward: making sense of it all](#)[Acknowledgements](#)[References](#)[Appendices](#)

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[Introduction to large scale change](#)[Creating the conditions for large scale change](#)[Tools and approaches for large scale change](#)[Moving forward: making sense of it all](#)[Acknowledgements](#)[References](#)[Appendices](#)

¹²⁵Beckhard R, Harris RT (1987) Organizational Transitions: Managing Complex Change, Second Edition. Reading, MA: Addison-Wesley. For more information, see the NHS Institute's social movement handbook The Power of One, the Power of Many.

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8. Appendices

8.1 Appendix one

The model for leading large scale change – a narrative version

Large scale change in a social systems context (such as the NHS and social care) comes about when:

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There is a sufficiently well-defined topic area that has been translated into a vision and key themes that people can relate to... on which there is a sufficient mix of pressure, will, incentive, consequences, receptivity and (re)connection to existing values that is 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 (such as service delivery, hand-over processes, clinical decision making, finances, public opinion and policy)... to make some pragmatic changes in a sufficiently effective and visible way. //

Leading Large Scale Change (2013)¹⁴

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 (through measurements, stories and celebrations) that is communicated widely and effectively enough to attract previously neutral others who then join actively in the change process, 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 (with the most frequently occurring result appearing last):

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, 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 and political change) and simply fades away.

The full, measured results and unintended consequences from a true LSC are often not known until sometime in the future. By that time, things have typically already sorted themselves into the three categories above. 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 accurate, 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, case study evidence about LSC shows remarkably similar patterns, regardless of context or organisational setting. While every LSC will be on 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 LSC.

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