The new era of thinking and practice in change and transformation:

A CALL TO ACTION FOR LEADERS OF HEALTH AND CARE

Helen Bevan and Steve Fairman

JOIN THE DISCUSSION & DEBATE!
Please leave comments and suggestions at:
horizons@nhsiq.nhs.uk

NHS Improving Quality is the national improvement body for the NHS in England. We undertake work at a country-wide level to support actions at local and network level for large scale transformational improvement and change.

Our aim is to:
- Learn from leading edge practice in the NHS, other health and care systems and other industries and make that knowledge accessible to all
- Build the movement for improvement and safety across the country, making connections across the system, enthusing and exciting people to engage in change and transformation
- Stimulate new and disruptive approaches to transformation and improvement
- Provide easy access to the latest evidence base, knowledge and training programmes, so that improving and leading change remains part of the daily work of the NHS
- Help make the most of investment of money and effort across the system, so we are all pulling in the same direction
- Build commitment to change rather than compliance
- Develop large scale improvement programmes that support local action aligned to the delivery of the NHS Outcomes Framework: making better outcomes for everyone a reality, faster.

As part of this remit, we seek to develop our work in partnership and co-production with others in the health and care system. We hope you will be willing to join in the discussion about '*the new era of thinking and practice in change and transformation: a call to action for leaders of health and care*' and help develop ideas and practice further. Please leave comments and suggestions at horizons@nhsiq.nhs.uk

Disclaimer: This White Paper contains more than 100 references and resources, representing a wide view of ideas and experiences. Citing a reference does not mean endorsement.

Follow us on Twitter:
@HelenBevan
@SteveFairman1
@NHSIQ

contents

Foreword

A digital foreword by Steve Fairman, Interim Managing Director, NHS Improving Quality

Aims of this paper

The aim of this paper is to:
- capture key ideas about change and transformation from leading practitioners, researchers, thought leaders and opinion formers across the globe
- 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 this paper is about:
- The 'how' of change (mindsets, processes, relationships and methods to make it happen)
- Taking learning from multiple industries and perspectives
- 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 climate
- Providing leaders with a clear agenda for action on change, based on evidence
- 'Evidence' in its widest sense, incorporating tacit knowledge, the views of global opinion formers and consensus amongst thought leaders as well as formal research findings.

What this paper isn't 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 isn't the goal, 'the goal is the goal'. This paper is about principles of change in a generic sense that can be applied to achieve specific health and care outcomes.

The science of innovation shows us that breakthrough ideas rarely come through big cognitive leaps. Rather they are the result of many small incremental steps in thinking, building on and interpreting existing ideas and learning from others. That is reflected in this White Paper. The ideas it contains draw on learning from leading practitioners, researchers, thought leaders and opinion formers across the globe. We acknowledge these sources of ideas. The primary sources are hyperlinked throughout this document and contained in the reference list at the end.

[It is] the customary fate of new truths to begin as heresies.

THOMAS HUXLEY

A provocation

This is a time for radical change in health and care systems. This paper is written for the specific context of the English National Health Service (NHS) and the wider English health and care system but health and care leaders globally are making the same call for fundamental, transformative change. Small scale incremental change to existing models of care is no longer enough to deliver the scale of change that our patients and populations will need if we are to maintain and improve the quality of the services they currently receive moving forward.

The Chief Executive of NHS England has called for 'the unleashing of creative energy and the mobilising of collective action' for change. The Chief Executive of Monitor advocates 'turbo-charging' change in the NHS. The English public is being engaged in a 'call to action' to shape future services. Other commentators warn that the NHS must 'change or die'. The NHS Leadership Academy advocates 'collective' leadership styles, shifting power in the system to front line staff and patients and creating leaders everywhere. The King's Fund concludes that the greatest transformational force for change will come from within the NHS by engaging the clinical workforce in change. Looking across the health and care system, we see much aspiration for radical change but less capability and fewer bold ideas to actually make it happen. We see this situation replicated in other countries.

For instance, a recent survey of senior healthcare leaders in the USA identified innovative thinking, creativity, transformational change and change management as the '*skills that will be most critical in the next three years*' AND the '*skill sets that will be hardest to find within the broader health field*'.

When we look back in history at scenarios of fundamental change, we observe a common phenomenon. Such upheavals are frequently preceded by leaders starting to think in radically different ways, with a different logic, about how to achieve change. We should expect the same when it comes to our current agenda of transforming health and care systems. It is no longer enough to strategise for large scale change solely with the logic of the past, where change thinking is based on hierarchical power, executed through the mechanisms of incentive payments, compliance and quality assurance. To deliver change quickly enough and on a wide enough basis in our current era we need to supplement this with new thinking about how change happens. We need to reframe the role of diversity in the change process and get new and additional voices into change conversations for greater insight and innovation. Perhaps now, with the pressure for positive change so great, it is time for us as leaders of health and care to reflect deeply about our own mindset for change and consider whether we need to open our minds to additional possibilities?

Executive Summary

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. Small scale incremental change is no longer enough to deliver the scale of change that our patients and populations need moving forward. We need to supplement existing approaches with new thinking and practice in leading change.

In this paper, we contrast a 'dominant approach' to change that is prevalent in the NHS with an 'emerging direction' that is in line with some of the latest thinking about transformational change globally. 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. The dominant approach focusses change to achieve the mission and vision of the organisation. On the emergent 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.

Traditionally, change approaches in the NHS have been driven by rational planning logic, underpinned by data. Additionally in future, the emphasis will be on making emotional connections, linked to values as this is a pre-requisite for calling people to take action. We use a variety of planning, improvement and change methodologies that are well established and validated in practice. At the same time, in an increasingly open and connected world, opportunities are increasing to share ideas, compare data and co-create novel approaches to change.

Finally, many of the levers for change in our current world of health and care are transactional; performance agreements, contracts, compliance and inspection regimes and incentive systems. People are held to account through transactional performance agreements. In the emerging world, change is increasingly about commitment to a common cause, built on a foundation of relationships.

As leaders of change in health and care, we need to be able to operate at the interface of both worlds. Both have value. Both are essential. Success will come from effectively operating both in tandem.

The paper then sets out five enablers of the 'emerging direction' in change:

1. Activate disruptors, heretics, radicals and mavericks

In and around every health or care organisation, there are disruptive innovators, radicals and mavericks. These colleagues, often operating at the edge of current thinking and practice, espouse unorthodox views, question existing practice and open up new fields of inquiry and areas for action.

These are people who have learnt to 'rock the boat and stay in it'. They are capable of working with others to create success, NOT destructive troublemakers. Yet much of their work is not acknowledged organisationally and many health and care radicals report that they are creating improvement despite the change processes of their organisations, not because of them. These radicals may hold the key to the kinds of transformational change approaches that health and care organisations need for the future. Leaders should seek to identify them and engage them in the organisation's most significant challenges.

2. Lead transformation from 'the edge'

There is a global trend for creative processes, including organisational development and change management, to move to the edges of organisations. Futurists predict that the edges will be where almost all high-value work will be done in organisations in the near future.

Leading from the edge, building strong relationships both inside and outside the organisation, increases the potential for diversity in terms of thought, experience and background. Purposefully moving change processes to 'the edge' can result in more radical thinking, faster change and better outcomes.

3. Change your story

One of the most significant developments in the world of organisational development (OD) is the rise of 'dialogic' approaches to leading change as an alternative to, or to sit alongside, prevalent diagnostic approaches.

The diagnostic change approach is commonly used for change in the NHS. It typically involves a group of leaders diagnosing the problems or issues at hand through a systematic analytical process, creating a series of workstreams or change programmes to solve the problem through a series of planned change interventions and managing the change process from the top of the organisation or system.

Dialogic change is an alternative or additional approach. Creating change is about changing the conversations that shape everyday thinking and actions. It is about bringing new, different and diverse voices into the change conversation and creating new perspectives, stories, texts, narratives and other socially constructed realities that impact on how people think and make sense of things — which in turn, impacts on how they act and the results they achieve from the changes they make. Change your story and you can change your organisation.

4. Curate rather than create knowledge

In a digital era, we are overwhelmed with raw, unprocessed, context-free data.

A key role for future improvement leaders in health and care is to curate knowledge. We predict that improvement leaders will move from being 'bench scientists' (creating and testing novel local improvement solutions to the challenges faced) to curators of knowledge (collecting, filtering, evaluating, contextualising and sharing knowledge from multiple sources).

A further shift going forward in health and care improvement will be an increasing focus on tacit knowledge rather than explicit knowledge for change. It is tacit knowledge, or know-how, created by learning in action and experience that is the most valuable knowledge for improvement and is most likely to lead to breakthroughs in thinking and performance.

5. Build bridges to connect the disconnected

The kind of networks we operate in can make a big difference to the level of change we are able to achieve. 'Cohesive networks' made up of people with similar interests, professional backgrounds and interests are the best kind of networks for delivering small scale incremental change. However, if we are seeking large scale, transformational change, we should be building 'bridging' networks that connect disparate individuals and groups that were previously disconnected.

We can build bridging networks through our 'weak tie' relationships. When, as leaders, we organise in weak ties ways, we create the potential to mobilise all the resources in our community or system that can potentially contribute to our cause. History suggests that a weak ties strategy will probably give us the best chance to deliver the scale of improvements in quality and cost that health and care leaders seek in a challenging timescale.

The underpinning issue that links all five themes is increasing the diversity of contribution and thought. All five themes relate to the need to increase the scale of innovation and new insights, to increase the number and range of voices that are contributing to change, to connect people who otherwise might not be connected and enable them to learn from each other. Diversity of thought plays a key role in achieving these goals.

The paper makes a 'call to action' to join the many leaders globally who are already rewriting the rules of organisational and system change and leading change from the future. It sets out '15 actions for leaders to thrive and survive as agents of transformational change in the new era'. These range from 'understand that change starts with me' to 'view dissent, disruption and diversity as core operating principles for improvement and innovation'.

Finally, some of the key principles in the White Paper are reflected in four case studies of change in action. They include 'Living Well in Cornwall and the Isles of Scilly - Striving for a collective humility in finding a way to work together for the person's benefit' and 'The School for Health and Care Radicals – teaching change agents to rock the boat and stay in it'.

"I grew up in a physical world and I speak English. The next generation is growing up in a digital world, and they speak social."

ANGELA AHRENDTS, quoted by PAUL TAYLOR »

What is happening in the Wider World of change?

In the following paragraphs, we have sought to summarise major shifts in the logic of organisational and systems change that are being reported and promoted globally by opinion formers and thought leaders.

Across the world, change is happening at a faster rate and becoming more disruptive. 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 complexity. Change processes that are driven by connectivity and social interaction are allowing people to connect and interact with unprecedented speed and ease as social engagement proliferates deeper and blurs boundaries between our personal and professional lives. They are also exposing long standing organisational problems and challenging traditional approaches to conducting business. This increasing complexity of the work environment is eroding hierarchical management structures and styles. The most effective leaders of change are those who can build and use networks to create relationships. In fact, 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 network.

The role of organisations is becoming less to organise work than it is to focus passion and purpose. The most influential thought leaders globally, such as John Kotter and Gary Hamel are suggesting that hierarchy alone isn't a sufficient mechanism to drive transformational change any more. Organisational leaders have to learn to work effectively through both hierarchy AND network. 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'. Organisational leaders will need to increasingly work with the 'spirit of the volunteer' if they want to enable transformational change.

The way that organisations relate to their 'customers' is shifting. Rapid data and social sharing are heralding the change in focus from mass customer segments to person-centred, individualised approaches. Organisational leaders are seeking greater connectivity with customers, more opportunities for co-production and a more personalised relationship.

We see these trends permeating into health and care. There is a move towards digital peer to peer healthcare, where digital technologies are helping patients to work with each other and with care providers to navigate the health and care system, provide support and take more control of their own care to significantly improve their own outcomes. The ePatient movement of highly motivated, connected patient leaders continues to grow from strength to strength. As well as a focus on individual patients 'activated' to help self manage their own care, there is an increasing emphasis on the value of social networks and social relationships in managing long-term conditions.

Returning to the generic context, much of the perceived wisdom about creating organisational advantage is being severely challenged. No longer is building (efficiency based) scale necessarily the best answer. In an increasingly disruptive era, organisations are finding that cost efficiencies can happen exponentially and that technology cycles are quicker than corporate decision cycles, threatening existing business models. The nature of work is also changing: complex work is getting more complex. Trends in healthcare match those of other industries; compared to a decade ago, the acuity of people in inpatient beds is higher and the work is more complex. This is a global trend. Changing demographics and technological advances mean that the primary care workload is also growing in complexity.

The upshot of this is that many of the previous ways we thought about making improvement happen, based on best practice databases and standardisation through guidelines, pathways and instruction manuals, don't work as well in this new world. In addition, in this globalised, hyperconnected world, the pace of creative work is accelerating; the cycle time for innovation has to speed up to keep pace with the changing demands of customers.

Learning and education are also changing fundamentally with a move away from formal training to a more person-centred approach with real-time, constantly-changing, collaborative, support for learning in workplace situations. There is a shift in the mindset about the relationship between performance and learning 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 learning. Around the world, levels of employee engagement are dropping or remain stagnant at very low levels. Organisational leaders are increasingly using open collaboration and digital social methods to directly connect with employees and bridge the gap between leadership and workforce. In fact, this need to bridge the gap is hastening the demise of hierarchy. Digital skills will become an increasingly important capability for leaders.

In future, work will be dominated by the emerging generation, the 'millennials' 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 workforce. 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. Due to these changes, all leaders will need to act like millennials.

Underpinning all of the above are some emerging principles 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 connectors in this complex world. Large organisations that are slow moving and steeped in hierarchy weren't designed to thrive in this rapidly changing world. This means that the disruption will continue until organisational leaders adopt change thinking and practices that are better suited to the circumstances they find themselves in.

"The organisations that survive the future will be those that are capable of changing as fast as change itself."
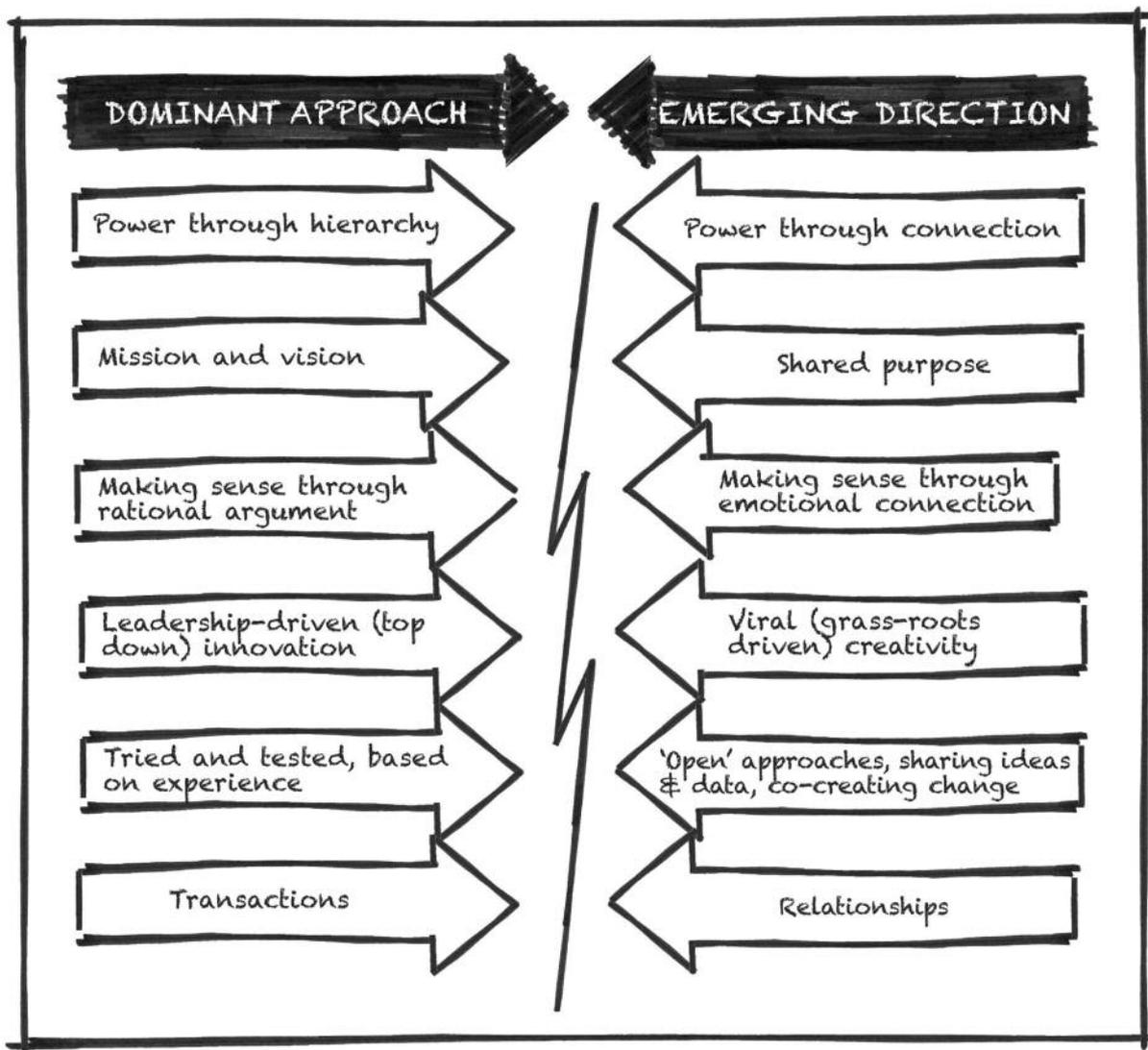
GARY HAMEL »

What does that mean for leaders of change in health and care?

Like other industries and sectors across the globe, our world of health and care is in transition. We have summarised some of the key themes in the table below.

On the left hand side is the 'dominant approach' to change. We use this label as it is the mindset and approach to change that we see dominating transformation efforts in the NHS and wider health and care system. We contrast this with the 'emerging direction' that is in line with the thinking in the 'wider world of change' that we described in the previous section. These poles are not set out as a 'from/to' or with any value judgement of 'good versus bad'. Whilst we think that the emerging direction will become more important, we also recognise that the dominant approach will remain strong, and that the leverage for change from hierarchical levers will remain in years to come.

Table: Emerging themes in change and transformation

DOMINANT APPROACH	EMERGING DIRECTION
Power through hierarchy	Power through connection
Mission and vision	Shared purpose
Making sense through rational argument	Making sense through emotional connection
Leadership-driven (top down) innovation	Viral (grass-roots driven) creativity
Tried and tested, based on experience	'Open' approaches, sharing ideas & data, co-creating change
Transactions	Relationships

In the dominant (left hand) approach, power to create change comes through positional authority. The most senior executives have the greatest clout. In the new world, power comes from connection and ability to influence through networks. Right-sided thinking would suggest that the most important skill that leaders of change need to develop for the 21st century is the ability to build partnerships.

The dominant approach focusses change to achieve the mission and vision of the organisation. This comes from a mindset that transformational change can be driven within the organisation where leaders seek to build the allegiance of the workforce to the goals, culture and ethos of the organisation. On the emergent 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, large scale change depends on many partners; patients and families, communities, front line health and care providers and leaders of multiple organisations uniting around a common cause for patient and population health.

Traditionally, change approaches in the NHS have been driven by rational planning logic, underpinned by data. Additionally in future, the emphasis will be on emotional connection as this is a pre-requisite for calling people to take action, based on their convictions and values as we move from 'have to' to 'want to' change.

On the left side, the energy and direction for innovation has often been leadership driven, as part of a corporate approach to change and improvement. In the new world, the drive for creativity is ignited by service users and the frontline workforce and is spread virally 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 manage and control.

Many of the planning, improvement and change methodologies we use are well established and validated in practice. These include methods for improvement and patient safety such as Lean, Six Sigma and other quality management approaches. At the same time, in an increasingly open and connected world, there are many new opportunities to share ideas, compare data and co-create novel approaches to change. The sources of wisdom may no longer be the perceived 'experts' of the past. Often, the best mentors are just a few steps ahead, not experts.

Finally, many of the levers for change in our 'left hand' world of health and care are transactional; performance agreements, contracts, compliance and inspection regimes and incentive systems. People are held to account through transactional performance agreements. In the new 'right hand' 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 commitments; mutual commitments to work together, in a relationship, not just commitment to a programme plan or issue.

The left hand 'dominant approach' in healthcare matches the situation in other industries. Evidence of this is the 'top ten list of management tools' survey, conducted globally by the Bain management consultancy. Over the past twelve years, Bain has conducted regular surveys of the tools that managers across multiple industries and sectors use to enable change and improve performance. Eight out of the ten top tools are on the 'dominant approach' side and most of the tools mentioned by leaders in the most recent survey are the same ones that were cited ten years ago, despite seismic shifts in the circumstances of change. There is a risk that leadership practice, influenced heavily by hierarchy, tradition and risk aversion, lags behind the changes in the wider world around us. It is easy to see why, in the face of increasing risk and uncertainty, leaders might choose to stick with the practices that have worked for them in the past rather than operating more socially and adaptively.

Most of the corporate change plans we see in the NHS favour the left hand 'dominant approach'. This has been described as 'the analysis trap' whereby leaders focus on left-sided skills like process, measurement, and execution.

A recent global survey of corporate transformation efforts by Strategy& and The Katzenbach Center identified three major reasons why transformation efforts fail:

• They run out of energy (change fatigue)
• There are a lack of skills and capabilities in transformational change, particularly related to sustainability
• Transformation plans that were too 'top down' and which failed to fully engage the front line workforce.

All these issues are largely 'right hand', emerging direction issues, about connectivity, engagement, shared purpose and ongoing relationships. In terms of the transformational agenda that the NHS and wider health and care system faces, history suggests that it will not be possible to deliver the changes needed using the mindset and mechanisms of the 'dominant approach' alone. Whilst building on the strengths of the dominant approach, the NHS requires a very big investment in the 'emerging direction'. Organisations that also embrace these right-sided skills; building shared purpose, connectivity, imagination, relationships and empathy tend to get better outcomes when it comes to large scale transformational change.

As leaders of change in health and care, we need to be able to operate at the interface of both worlds. Both have value. Both are essential. Success will come from effectively operating both in tandem.

This film, a conversation between **Marshall Ganz** of the Harvard Kennedy School of Government and **Leith Jean Sharp** of the Harvard School of Public Health, illustrates some of these points well. At times of uncertainty, we need more leadership, not less. But more leadership does not have to mean more control. We have to be able to harness the tension between structure and emergence, achieving purpose through uncertainty rather than seeking to impose control on it. The real challenge is how to create collaborating structures; not 'collaboration' imposed from on high or the radical liberalism of 'do your own thing', but a shared commitment to work together to achieve a bigger purpose.

"Leadership is the art of mobilising others to want to struggle for shared aspiration"

JIM KOUZES

Five enablers of the 'emerging direction' in change

By drawing on our experience of leading large scale change in the NHS over the last twenty years and by examining global trends in transformational change, we have identified five enablers for transformational change in the future.

These are developments that have the potential to greatly accelerate radical change but that aren't yet happening at the scale that is needed, or they are happening underneath the radar. Whilst they are different to the kinds of change skills and thinking that leaders of health and care typically value today, they do build on current skills:

1 Activate disruptors, heretics, radicals and mavericks

2 Lead transformation from 'the edge'

3 Change your story

4 Curate rather than create knowledge

5 Build bridges to connect the disconnected

The theme that links the five enablers is diversity of thought; engaging with a wide range of people with different views and experiences in the ways we think about and go about change.

1. Activate disruptors, heretics, radicals and mavericks

Many of the ways we go about improving health and care were designed in a different mindset for a different set of circumstances. We face a challenging leap of change into the future. It is time for heresy.

Around the world, there is an emerging movement of change agents who are committed to their organisations and want them to succeed but also want them to go about change in different, more radical ways and are stepping up as corporate change activists. They are connecting with each other digitally, across the globe though growing movements such as Corporate Rebels United, Rebels at Work and Change Agents Worldwide.

These 'radicals', often operating at the edge of current thinking and practice, will espouse unorthodox views, question existing practice and open up new fields of inquiry and areas for action.

These people already exist in and around every health or care organisation, in many different roles and multiple levels. They are typically passionate people who support the people and patient-centred goals of their healthcare organisations, who are willing to take responsibility for change but who question and challenge many of the current ways of going about change. They aren't typically the chief executives or senior clinical leaders (many of them are patient leaders) yet the impact of their change activities may be just as significant.

> The new economy's equivalent of the industrial assembly line will likely be some system that celebrates rebels. This will be an epochal shift in management thinking.

CELINE SCHILLINGER

We have engaged with hundreds of such 'health and care radicals' (see the case study on page 40, The School for Health and Care Radicals); change agents who can rock the boat but are also able to stay in it. These are people who will stand up to challenge the status quo when they see there could be a better way. These leaders are driven by their own convictions and values which makes them credible and authentic to others in their organisations and networks. They are capable of working with others to create success, in line with the mission of the organisation, NOT destructive troublemakers. Yet much of their work is not acknowledged organisationally and many health and care radicals report that they are creating improvement despite the change processes of their organisations, not because of them.

Often these radicals face a tough time in organisational settings as they challenge existing thinking and practice. They may be forced to compromise their values, stay silent when they want to speak out or to leave the organisation as they cannot find a way to be true to their values and commitments and still survive. When surveyed, most senior organisational leaders say that to create more innovation, they need to activate the radicals and disruptive innovators in their organisations or systems yet only a minority of senior leaders are very satisfied that radicals/innovators are providing this value in their organisations or systems. Often we see a disconnect between the aspiration of senior leaders for radical change and the need of the system to preserve order and control/avoid risk.

As we move to an era that requires bold thinking and swift action, these disruptors, heretics, radicals and mavericks may hold the key to the kinds of transformational change approaches that health and care organisations need for the future.

> **How can you identify the disruptive innovators and radicals in your midst and engage them in the core transformation work of your organisation? How can you create the space, support and encouragement to make a difference, beyond hierarchy? How can you activate and engage them yet avoid overburdening them with programme management and accountability infrastructure?**

2 Lead transformation from 'the edge'

Global thought leaders in disruptive transformation such as Clayton Christensen, John Kenagy and Harold Jarche suggest that the most radical thinking about future possibilities is unlikely to come from the centre or top of organisations. There is a global trend for creative processes, including organisational development and change management, to move to the edges of organisations. Futurists predict that in the near future, the edges will be where almost all high-value work will be done in organisations.

Those at the centre of organisations are often stretched by and focussed on the delivery of the operational agenda. Organisational leaders often don't have the time and head space to engage in out-of-the-box thinking and testing innovative approaches. There is often an unconscious bias towards preservation of the status quo. It means that 'game changing' ideas or initiatives rarely come from the most senior leaders. We say this not as a value judgement but as an often observed consequence of the way that organisations are set up to operate.

> Go out to your edges. Explore the possibilities. Because you will find more opportunity in the edges, where you will be able to imagine, invent and thrive.
>
> **AYELET BARON** »

Leading from the edge, with a wider set of relationships, increases the potential for diversity in terms of thought, experience and background. Research shows that teams that are diverse consistently outperform teams that are of higher ability but homogenous. Diversity trumps talent. Purposefully moving change processes to 'the edge' can result in more radical thinking, faster change and better outcomes. 'The edge' can be interpreted in multiple ways:

I. The edge as a physical location; an increasing number of organisations with transformational aspirations are 'off shoring' innovation teams, so that they are unencumbered by the constraints of existing thinking. Such teams are typically positioned within, yet 'at the edge' of the system to promote the most innovative thinking, to incubate and test radical, future-focused ideas and bring them back into the mainstream organisation. The idea is that rather than the best ideas being identified at the top of the organisation and spread out through strategy execution, they can start at the edge of the organisation and be pulled in.

II. The edge as a virtual place for building relationships and networks; this is about purposefully positioning change agents at the edge of the organisation, enabling them to interface more easily with others, both inside and outside of the organisation, simultaneously. From this perspective, we see change agents as hyperconnectors, building relationships with other change agents and innovators, utilising open innovation principles to make social connections, pulling knowledge into the organisation, making sense of it and sharing it to speed up change.

III. The edge as a way of being as a change agent; choosing as a leader of change to operate at 'the edge', leading through networks and social connection, looking outwards to the wider world of knowledge, relationships and networks as well as inwards, influencing though the processes of organisational life.

> **How can you move your change processes to 'the edge' so that the ideas are more radical and change processes more transformational? How will you enable 'the edge' to co-exist with and influence the mainstream organisation?**

3 change your story

A **watershed** is happening amongst leading practitioners in the world of organisational development (OD) based on practical application of interpretivist social sciences and complexity science.

One of the most significant developments is **'dialogic'** change as an alternative to or to sit alongside the prevalent 'diagnostic' approaches to leading change. *Diagnostic* and *dialogic* change processes are contrasted as follows:

Diagnostic change

The *diagnostic* change approach is a 'diagnosis and treatment' model for managing organisational or system change. It is a common approach to change in the NHS, amongst both commissioners and providers of care. It typically involves a group of leaders doing some of **the following**:

- Diagnosing the problems or issues at hand through a systematic analytical process
- Managing the change process from the top of the organisation or system
- Often the use of a management consultancy partner who is skilled in diagnosis
- Mapping the current state or value stream of the organisation or system (the 'as is' state) and the desired future state (the 'to be' state)

> change your story, change your organisation.
>
> **PEGGY HOLMAN**

- Creating a series of workstreams or change programmes to solve the problem and/or to transform the way care is delivered, through a series of planned change interventions (the prescription or treatment plan)
- Establishing programme management systems that hold people to account for the delivery of the planned change.

This diagnostic approach enables leaders to **plan out complex change interventions** in ways that make them feasible, to align different components (mission and vision, strategy, structure, people processes, culture, etc.) and to position the organisation for future success in its wider environment.

However, NHS experience over the last decade suggests that these diagnostic methods also have limitations. They are based on the principle that there is an external 'thing' out there called, for instance, the 'urgent care system' or 'the integrated care pathway' that can be diagnosed and treated in the same way that a biological system can, rather than as a series of complex interpersonal relationships involving people with very different views and needs. The diagnostic approach to change is typically based on a model of replication; we take the principles of what has worked well in one setting and try to replicate them in a different setting. However, such replication attempts in the NHS have often not delivered the results that were sought. In addition, diagnostic change processes, designed at an organisation-wide level, typically seek to get those in front line care roles to change what they do based on the innovative thinking of others higher up the system. The issue is that if people haven't co-created the change, they don't feel that they own it.

In a world where health and care delivery continues to grow in complexity and diversity and where change is unceasing and continuous, the episodic change processes that are represented by this diagnostic approach are likely to be less effective. We may have reached a point in time when leaders in the health and care system need more than incremental, controlled change processes.

Dialogic change

From a *dialogic* perspective, the focus of change is less on changing behaviour and what people do and more on changing mindsets and what people think. Creating change is about changing the conversations that shape everyday thinking and actions. Therefore instead of (or as well as) change driven by diagnosing how to objectively realign different components of the organisation or system, the dialogic approach invites us to consider how to induce new ways of thinking by altering the ongoing organisational conversations that lead to understanding and action. It is about bringing new, different and diverse voices into the change conversation. In the context of health and care, this creates the opportunity to include patients, families and community members in ways that we often haven't engaged them before.

The aim is to encourage new thinking and actions in the people who are the targets of change themselves It is about creating new perspectives, stories, texts, narratives and other socially constructed realities that impact on how people think and make sense of things — which in turn, impacts on how they act. From the dialogic point of view, the reason an innovation works differently in different organisational settings is because people create different meanings of the innovation in those different locations.

Leaders who utilise dialogic methods start from the premise that organisations or systems are socially co-constructed realities.

Because of this, there is nothing inherently 'real' about how we organise for health and care and no model of the 'right way' to organise independent of the people who make up the specific organisation or system.

Gervase R. Bushe, PhD
Professor of Leadership and Organization Development

As a result of exposure to dialogic ideas, an increasing number of system leaders with transformational aspirations are turning away from a dependence on diagnostic methods that treat organisations as if they were biological systems in their change methods. For instance, a group of commissioning nurse leaders in the NHS are starting to utilise dialogic methods to rethink their role as system leaders. They are seeking to increase their potential to influence at scale rather than to operate as hierarchical leaders as they recognise they increasingly don't have hierarchical levers for change.

The film above shows **Gervase Bushe**, one of the founders of Dialogic Organizational Development explaining the principles of the approach.

How might you induce new ways of thinking through transformational conversations, bringing more and different voices into the change process? How in your transformation efforts, might you combine the strengths of both diagnostic and dialogic change processes?

4 curate rather than create knowledge

Information is available everywhere, all the time, through multiple channels and sources. We are overwhelmed with raw, unprocessed, context-free data. As leaders of health and care, we often don't know whether the knowledge that we have identified is relevant, accurate or from a trustworthy source. There is a constant risk of trading quality for quantity and accuracy for timeliness. We probably don't need more content, we need less; but we need content that is high quality and right for our context.

A key role for future improvement leaders in health and care is to curate knowledge. Curators offer high value for others looking for high quality content because finding the right information and making sense of it is taking an increasing amount of time, attention and focus. The ability to filter and select appropriate information and shape it for a local context will become imperative in the future. We predict that improvement leaders will move from being 'bench scientists' (creating and testing novel local improvement solutions to the challenges faced) to curators of knowledge (collecting, filtering, evaluating, contextualising and sharing knowledge from multiple sources). In future, improvement leaders are likely to spend less time creating and more time curating.

> Curation is finding things out and determining what's valid from what's just noise. It's about identifying networks and communities and seeing where the nodes and amplifiers sit. It's about quality and coherence, not volume and mass.
>
> **JULIAN STODD** »

A further shift going forward in health and care improvement will be an increasing focus on tacit knowledge rather than explicit knowledge for change. It is tacit knowledge, or know-how, created by learning in action and experience that is the most valuable knowledge for improvement and is most likely to lead to breakthroughs in thinking and performance. The people holding the tacit knowledge, often in their heads, include front line staff, patient leaders and senior leaders. Tacit knowledge is critical for large scale change, but the only way tacit knowledge can be broadly shared is to turn it into explicit knowledge. Knowledge is explicit when it has been reviewed, codified and presented in a more formal way to meets the needs of a bigger audience. In health and care improvement, explicit knowledge includes best practice databases, guidelines, recommended models, methodologies and improvement toolkits.

Converting tacit knowledge into spreadable, effective explicit knowledge is a very challenging task and as a result, most organisations don't achieve their goals for performance improvement through knowledge spread. The reality is that what works in one context may not work in another. There are issues about people having access to the knowledge they need at the time they need it, the way the knowledge is stored and the extent to which it is reviewed, updated and ultimately discarded.

Whilst it might be easy to find an organisation's change methodology or policy on a specific topic, it's not so simple to work out how someone else put it into practice or overcame barriers to implementation. Sharing knowledge is a human process. Tacit knowledge is best developed and shared through dialogue, conversations and social relationships.

A model of curation for the digital era that is being used in health and care is Harold Jarche's 'Personal Knowledge Mastery' (PKM). This is about individuals making the best use of their networks and other sources of knowledge so that they can keep up to date with the most effective thinking in their area and practice new ways of doing things. Leaders who take responsibility for their own effectiveness through PKM create leverage and value for their organisations. The underpinning framework for curation within PKM is 'seek, sense, share'. 'Seeking' is about finding things out and keeping up to date; pulling' information, but also having it 'pushed' to us by trusted sources. 'Sensing' is about making sense and meaning of information, reflecting and putting into practice what we have learned and plugging information into our own mental models and turning it into knowledge. 'Sharing' is about connecting and collaborating; sharing complex knowledge with our own work teams, testing new ideas with our own networks and increasing connections through social networks.

This White Paper is a 'seek, sense, share' curation effort. We have sought ideas, evidence and opinions from across the globe on the future of change and transformation. More than 90% of the sources we have used are not health and care specific. We have tried to make sense of and frame this knowledge for our specialised health and care audience. We are sharing the explicit knowledge we have captured through this White Paper, through films and virtual lectures. We will also link it with the tacit knowledge of our core audience of change leaders through interactive means; web seminars, blogs, Twitter discussions and live video discussions. Our aspiration is that this community of improvement leaders will then 'seek, sense and share' this knowledge with their own networks and communities.

What are the opportunities to move the ratio of your improvement activities from creation to curation? How can you encourage more tacit knowledge sharing for better improvement outcomes? To what extent do you practice Personal Knowledge Mastery, staying connected and sharing with your networks and building your own capability as a change leader for a new era?

The film above shows **Harold Jarche** describing Personal Knowledge Mastery and 'seek, sense, share'.

5 Build bridges to connect the disconnected

A recently published study based on 68 change initiatives in the NHS shows that the kind of network we operate in makes a big difference to the level of change we are able to achieve. 'Cohesive networks' made up of people with similar interests, experiences and interests are the best kind of networks for delivering small scale incremental change. However, if we are seeking large scale, transformational change, we should be building 'bridging' networks that connect disparate individuals and groups that were previously disconnected. Bridging networks are the most effective mechanisms for large scale change because they create the opportunity for fresh, radical thinking and learning about new and novel experiences. In the NHS, we often observe a mismatch between the network approach and aspirational goals; we see leaders with transformational change goals seeking to implement through cohesive networks. It is worth exploring wider social network theory to gain an insight on the situation.

> We build too many walls and not enough bridges.
>
> **SIR ISSAC NEWTON**

Much of the conventional wisdom of NHS improvement is based on a model of 'strong ties'. We have strong ties when we interact with 'people like us', people with the same life experiences, beliefs and values. Many leaders in health and care advocate 'strong tie' peer to peer influence (e.g. GP to GP, nurse to nurse, gynaecologist to gynaecologist) as the most effective method to spread change at scale in the NHS. Strong tie spread works because people are far more likely to be influenced to adopt new behaviours or ways of working from those with whom they are most strongly tied whom they like and trust. Trust is the most important factor when it comes to strong tie spread.

There are also drawbacks to spreading through strong ties. When we base improvement processes on peer to peer spread, we reinforce silos and 'groupthink' and restrict our ability to spread change or information beyond the professional group or organisational identity. As a result, the amount of knowledge that gets circulated round the system is severely restricted and the likelihood of innovation is limited.

When leaders of change build weak ties, they reach out to people 'not like us' and build bridges between previously disparate groups and individuals. Bridges bring in different perspectives and unfamiliar ideas. When, as leaders, we organise in weak ties ways, we create the potential to mobilise all the resources in our community or system that can potentially contribute to our cause. This is the basis on which many of the great social movements, the community organisers and the civic campaigns were able to deliver widespread changes. Weak ties have often been the basis for movement recruitment. For instance, the reason why Martin Luther King Jr was able to inspire such discipline among a multitude of followers was that he cultivated a large number of weak ties. As a result, people felt like they trusted him, even though they barely knew him.

History suggests that a weak ties strategy will probably give us the best chance to deliver the scale of improvements in quality and cost that health and care leaders seek in a challenging timescale. Weak ties are typically a more effective starting point for influence at scale because they build bridges between multiple networks and many more people, with fewer barriers than strong ties. In addition they give us the greatest insights to think differently about the future.

There is a particular risk for NHS leaders in this time of transition. In situations of uncertainty, we have a tendency to revert to our strong tie relationships, to stick to what and who we know and who we can trust. Research shows that the information flows of policy makers are often based on strong ties. Yet the evidence tells us that weak ties are much more important than strong ties when it comes to searching out resources and innovative thinking in times of scarcity.

The ideal network for a leader of change in health and care probably consists of a core of strong ties and a large periphery of weak ties. The mass adoption of social media and virtual social networking systems creates the potential for a greater number and much wider range of weak tie relationships. In future, leaders of improvement in the NHS will spend less time 'pushing' change through discrete improvement programmes and more time 'pulling' change by connecting people, experiences and ideas that were previously disconnected.

Does the nature of your network (cohesive/strong tie or bridging/weak tie) match your level of ambition for change? What is the potential to switch the focus of your change activities from running discrete change programmes to connecting those who are currently disconnected?

In this film, **Helen Bevan** imagines the health and care change agent of 2024, based on the five enablers

A call to action

There are already many leaders in the NHS, in other health and care systems and in other sectors that lead change with this 'new era' approach. Across the globe they are rewriting the rules of organisational and system change and leading change from the future. They pay attention to 'mission critical' performance requirements but also work for a higher purpose. They are positive about the energy, creativity and openness that these new approaches bring. So this call to action is about connecting people, embracing these principles and making sense of them in your own context. We ask you to consider the change ideas and change practice that are most likely to deliver the seismic shifts that are needed in the ways we deliver care to our patients and populations, building on your existing strengths.

Below we have summed up the key actions suggested in the White Paper as '15 actions for leaders to thrive and survive as agents as transformational change in the new era'.
We hope they will inspire you to take action.

15 actions for leaders to thrive and survive as agents of transformational change in the new era

1 Understand that 'change starts with me' and focus deeply on your own perspective and the ways you interact with and influence others

2 Frame 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 the leadership

3 Build shared purpose in an explicit way, focusing on the shared premise, (asking 'who needs to be part of the change?' and 'what unites us?') and the purpose (asking 'why are we making this change?')

4 Regard everyone as a leader and encourage many acts of leadership, beyond the formal leadership system

5 Lead outside the (formal) lines; identify the heretics, the disruptors and the gamechangers in your organisation or system and engage them in your most significant challenges

6 Rather than seeking to overcome 'resistance to change' view dissent, disruption and diversity as core operating principles for improvement and innovation

7 Consider what/where your equivalent of 'the edge' is, so that you incubate radical and disruptive ideas and lead health and care from the future

8 Treat everyone involved in the change as if they were a volunteer

9 Seek at least 50% buy-in for any change initiative at the start

10 Build your extended network of weak tie social relationships for new ideas and inspiration

11 Be more curator and less creator in building knowledge for leading improvement

12 Purposefully seek to build relational approaches to change as well as logic-based, rational leadership

13 Adopt emergent approaches to planning and design, based on monitoring progress and adapting as you go

14 Take steps to be a more social leader, investing in your digital skills and social connections and leading through networks as well as formal leadership systems

15 Take deliberate action to maintain and refresh energy for change over the long haul

JOIN THE DISCUSSION & DEBATE! Please leave comments and suggestions at: horizons@nhsiq.nhs.uk

CASE STUDY
Living Well in Cornwall and the Isles of Scilly - Striving for a collective humility in finding a way to work together for the person's benefit

It started with a conversation: over a thousand local older people came together in 2009 to tell public sector providers and commissioners in Cornwall and the Isles of Scilly about their 'Age and Ambition' – what mattered to them most and what support they needed to live well; their skills and talents; their desire to shape and control their own future. It was a wakeup call for these organisations – for too long they had focussed on fixing health and social care conditions, instead of helping people to live their lives. Together the commissioners and providers started to design a new approach - the Newquay Pathfinder.

The Pathfinder was led by Age UK Cornwall and the Isles of Scilly and voluntary sector partners in collaboration with local NHS and social care organisations. A small scale pilot started with 100 people in Newquay who had two or more long term conditions where there was an existing evidence base supporting the effectiveness of self-care and preventative measures. These were people at high risk of repeat hospital admission, many of whom had been housebound for years. The results were startling – reduced hospital admissions, people reducing their own packages of care and the emergence of new peer support and social groups.

As part of the pilot project, volunteers were trained in motivational interviewing and self-care techniques to have a 'guided conversation' with a person in their own home, listening to their story and understanding their motivation. The volunteers were part of a multi-agency team including the GP, community nurse, mental health worker, social worker, who proactively identify people using risk stratification. The team designed their own charter, shared care plans at regular team meetings and worked on the basis of respect and trust in each other's expertise.

For the team in Newquay, the ability to change really hinged upon developing personal relationships and having conversations. The team all knew each other on a first name basis across organisations and understood each other's personal stories. This was

driven by a few determined champions sharing real, individual stories of lives that had been transformed. The team developed a shared purpose to do things differently and lived that experience in the way that they behaved.

The wider community network was crucial to the success of their relational approach, and continues to remain crucial as the programme has now extended to a larger geographical area in west Cornwall. At an early stage the team mapped over 670 local groups and charities in west Cornwall and identified 48 'community makers.' They held regular workshops - 'Local People, Local Conversations' – involving the community makers – people who were already the conduits of social activity and connectivity – including lay pastors, charity leaders, the police, councillors and schools. This kept the focus on what was important locally and drew people in to co-produce the solutions, helping the team to avoid reverting to a default one-size-fits-all quick fix.

The ripple effect of all of this is bigger than the team ever thought it could be. The most surprising factor was the change in people, from the individuals whose lives have been transformed to the GP who says she has 'more magic to offer', and the volunteers who say "if the funding runs out, don't worry - we know what to do now". The team's quiet revolution is affecting everyone.

The Newquay Pathfinder evaluation reported:
- 5% decrease in social care packages
- 23% improvement in quality of life, compared with a local baseline of 8-11%
- 87% satisfaction rate among practitioners, in terms of feeling effective and making a difference
- 10% increase in social capital, from a 0% starting point
- 30% decrease in emergency hospital admissions

Living Well takes the learning from this pilot and, with voluntary sector funding and full support from Age UK national, NHS Kernow, Cornwall Council, HealthWatch Cornwall and all key providers, aims to support and measure the impact on 1,000 people living in West Cornwall.

To see how Living Well is changing lives view a video **HERE**.

CASE STUDY
A grass roots movement sparked by students coming together to prevent avoidable pressure ulcer prevent avoidable pressure ulcers

A single tweet ignited a passion in first-year University of Lincoln student nurse Charlotte Johnston to help prevent patients from suffering from painful and distressing pressure ulcers. Embracing an innovative idea to bring together her whole university cohort around this cause, Charlotte wanted a one-day conference to educate, motivate and inspire a generation to pledge and act to prevent avoidable pressure ulcers. Citing students as an essential (but often overlooked) part of the vital workforce, Charlotte pointed out that '... even if the message only reaches half of the student body on the day, that's 250 extra pairs of hands and eyes'. A partnership group backed Charlotte's idea, and, building on early work achieved locally, joined forces with The University of Lincoln, NHS England (Midlands & East) and NHS Improving Quality to hold a one day conference on campus for 500 student nurses in October 2013.

Each year nearly 700,000 people are affected by pressure ulcers and over 186,000 patients develop a pressure ulcer in hospital. Research suggests that between 80-95% of pressure ulcers are avoidable. The 'stop the pressure campaign' led by Chief Nurse Ruth May provided the impetus for the conference and sparked the initial tweet between Charlotte and Ruth. The students led on the design, input and fronted the conference which gathered interest and momentum with more partners wanting to join the cause.

Social and other media provided the key focus in helping to build the momentum and sharing the learning for this event and to actively publicise information. The hashtag #stopthepressurelincoln reached approximately 320,000 individuals on Twitter and secured around two million timeline deliveries. This in turn sparked the beginnings of a grass roots movement leading to the formation of other similar events to take place across England. Work on preventing and reducing the number of pressure ulcers continues and a number of spin-off projects like developing an app to support the evidence based pressure ulcer prevention care pathway, have arisen.

CASE STUDY
The NHS Change Day 'Hubbies'

Imagine frontline staff and young leaders from across the entire NHS coming together entirely voluntarily to take ownership and transform the organisation in which they work and the care they deliver for patients…

Roy Lilley, health write and commentator, describing the 'hubbies' of NHS Change Day in his blog, January 2014.

NHS Change Day, March 3rd 2014, was the single biggest day of collective action for improvement in the history of the NHS. Hundreds of thousands of pledges were made across the health and care system to take action to improve the outcomes and experience of patients, families, staff and the public. People were mobilised in more than 600 organisations. The commentator Jackie Ashley suggested that NHS Change Day represented a radical new way of organising and a demonstration that people power can change the NHS from within.

Change Day is a grass roots, frontline movement for improvement in health and care and 98% of the activity was undertaken by volunteers. The 'hubbies', a voluntary self-organising network of local leaders, were the beating heart of Change Day. They were an eclectic group; patient leaders, students and clinical trainees, healthcare assistants, NHS graduate management trainees, frontline nurses, hospital consultants, accountants and commissioners. There was no rule for who could be a hubbie; people had to believe in the mission of Change Day and be able to commit some time on a voluntary basis.

The hubbies put their purpose at the forefront of what they did every day. They focused on narrative and telling their story to spread the message. They coached and supported each other in a non-hierarchical way. Some hubbies sat on the core leadership team for NHS Change Day to help with the overallcoordination. All hubbies made plans themselves and shared their progress with the group. This enabled them to be accountable. The hubbies did not meet face to face. Rather, they worked through WhatsApp, teleconferences and Twitter. In the four months leading up to Change Day, the 15 hubbies exchanged 28,000 WhatsApp messages.

The hubbies were instrumental to the success of NHS Change Day. Their organising tactics resulted in many thousands of pledges. They also became the face of Change Day, demonstrating its grass roots nature which even the most sceptical commentators couldn't argue with. The hubbies represent the changing face of change leadership in many dimensions; focussing on a shared purpose; not waiting for permission to take action but getting on with what is required; organising powerfully through a network of volunteers but utilising the levers of hierarchy towards their goals; building exceptional relational skills; connecting with NHS values and unleashing a massive energy for change.

CASE STUDY
The School for Health and Care Radicals – teaching change agents to rock the boat and stay in it

A learning review of levels of activism for change and improvement in 2013 found that the biggest issue stopping front line NHS staff, trainees and students from taking action to improve their own services was a sense that they needed permission to make change. So as part of the run up to NHS Change Day 2014, a virtual "school" was established to build the capability of frontline staff to move beyond a sense of needing permission to confidently lead local change. The School aimed to provide participants with powerful ideas, tools and connections to survive and thrive as a change agent now and into the future. It was run as a five week virtual programme with weekly web seminars, backed up by learning materials, volunteer mentors, tweetchats and online discussions. The main channel of promotion was social media. It was free of charge and anyone could join from anywhere in the world. The view was taken that as soon as restrictions were put on it, it would exclude some of the people that were the target of the learning. Over 1,600 people registered to participate from 40 countries.

Each week, this community of change agents were united and really valued connecting and learning from other health and care radicals. This was captured in the feedback that was received on Twitter, during the WebEx in the 'chat' boxes and through the certification applications. The English participants that were the target of the School benefitted greatly from being part of a global community. Knowing that others had similar experiences, especially being able to rock the boat and stay in it or put another way those who have learnt to oppose and conform at the same time,

inspired the radicals to reflect upon their own practices. They drew inspiration from the diverse range of material and stories.

Lessons were learned which were then used to progress change back in their own organisations. This 'learn and share' philosophy is growing as some of the participants are replicating the experience by setting up their own regional schools.

The school had a significant impact:
- **materials were downloaded from the website more than 25,000 times**
- **the Twitter reach was 2.6 million each week**
- **there were over 5,000 tweets using the school's hashtag 'SHCRchat'**
- **there were 90 volunteer mentors**
- **over 100 people became 'certificated change agents'**
- **the weekly storify was viewed nearly 1,300 times**

So what did we learn about the change agent of the future? We learnt that there are change agents all around us. They are people who realise that change starts with them and that they are not alone. They are people that realise that there are many others that can share lessons and experiences and part of the role of the future change agent is to make those connections, build in time for reflection and tell their own stories of change.

References

Aguirre D, (2014),10 Strategic Principles Needed to Lead Change Management Efforts Blog,
http://switchandshift.com/10-strategic-principles-needed-to-lead-change-management-efforts

Aguirre D, Von Post R and Alpern M, (2013), Culture's role in enabling organizational change, Originally published by Booz & Company, Strategy&, http://www.strategyand.pwc.com/global/home/what-we-think/reports-white-papers/article-display/cultures-role-organizational-change

American Hospital Association, (2012), Are Medicare Patients Getting Sicker? Trendwatch
http://www.aha.org/research/reports/tw/12dec-tw-ptacuity.pdf

Ashley J, (2014), People power can change the National Health Service from within,
http://www.theguardian.com/commentisfree/2014/feb/26/people-power-nhs-change-day-empowers-liberates

Auchincloss E, (2012), 2012 Together on Diabetes Grantee Summit, Originally adapted from the works of Marshall Ganz of Harvard University, http://www.bms.com/documents/together_on_diabetes/2012-Summit-Atlanta/BMSF-TOD-Community-Organizing-Workshop-Guide.pdf

Bain & Co, (2012), Top 10 Management Tools,
http://www.bain.com/management_tools/BainTopTenTools/default.asp

Baron A, (2014), Preparing for a changing world SlideShare,
http://www.slideshare.net/fullscreen/ayeletb/preparing-for-the-future-the-power-of-relationships/1

Baron A, (2014), The most important marketing strategy you need for the 21st century, IT Business,
http://www.itbusiness.ca/blog/the-most-important-marketing-strategy-you-need-for-the-21st-century/49230

Barton D, Grant A and Horn M, (2012), Leading in the 21st century, McKinsey Quarterly,
http://www.mckinsey.com/insights/leading_in_the_21st_century/leading_in_the_21st_century

Bate P, Robert G, Bevan H, (2004), Towards a million change agents: a review of the social movements literature: implications for large scale change in the NHS, NHS Modernisation Agency,
http://discovery.ucl.ac.uk/1133/1/million.pdf

Bate P, Robert G, Bevan H, (2004), The next phase of healthcare improvement: what can we learn from social movements? Quality and Safety in Health Care. 2004 Feb;13(1):62-6,
http://www.ncbi.nlm.nih.gov/pubmed/14757802

Battilano J, Casciaro T, (2013), The network secrets of the great change agents Harvard Business Review, July-August, http://cci-catalyst.s3-us-west-1.amazonaws.com/uploads%2F1384364389642-ybp7cg76g1rzr529-33ce7d6c1677a906fea8a88cd3b37a0a%2FThe+Network+Secrets+of+Great+Change+Agents.pdf

Bevan H, (2013), Start by improving myself BMJ Blog, http://blogs.bmj.com/quality/2013/08/19/a-call-to-action-helen-bevans-blog-2/

Bevan H, (2014), Story: Biggest ever day of collective action to improve healthcare that started with a tweet,
http://www.mixprize.org/story/biggest-ever-day-collective-action-improve-healthcare-started-tweet-0

Bevan H, Plsek P, Winstanley L, (2011), Leading Large Scale Change - Part 1, A Practical Guide,
http://changeday.nhs.uk/files/Leading%20Large%20Scale%20Change%20Part%201.pdf

Bevan H, (2011), Part 2 Leading Large Scale Change: The postscript, Why do leaders of health and healthcare need these principles of large scale change right now?,
http://changeday.nhs.uk/files/Leading%20Large%20Scale%20Change%20Part%202.pdf

Bhargava R, (2013), ePatient 2015 - Introduction To A Book About The Future Of Healthcare (And How YOU Can Get Ready For It) SlideShare, http://www.slideshare.net/rohitbhargava/epatient2015-introducing-a-book-about-the-future-of-healthcare-and-how-you-can-get-ready-for-it

Biro M, (2014), Talent Analytics: A Crystal Ball For Your Workforce? Forbes,
http://www.forbes.com/sites/meghanbiro/2014/06/29/talent-analytics-a-crystal-ball-for-your-workforce/

Brown J, Duguid P (2001) Knowledge and organization: A social-practice perspective. Organization Science 12: 198–213, https://faculty.fuqua.duke.edu/~charlesw/s591/Bocconi-Duke/Bocconi/S4_DemandSide/SeelyBrownDuguidOS2001.pdf

Bushe G and Marshak R, (2014), The dialogic mindset in organization development. Research in Organizational Change and Development, 22, 55-97, http://www.gervasebushe.ca/mindset.pdf

Bushe G and Marshak R, (2013), Advances in Dialogic OD, OD Practitioner, http://c.ymcdn.com/sites/odnetwork.site-ym.com/resource/resmgr/ODP2/ODP-V45,No1-All_Pages.pdf

Bushe G, (2009), Dialogic OD Turning Away from Diagnosis, http://bit.ly/1cpBk8S

Bushe G and Marshak R, (2009), Revisioning organization development: Diagnostic and dialogic premises and patterns of practice. Journal of Applied Behavioral Science. 45(3), 348-368, http://www.gervasebushe.ca/revisioning.pdf

Change Agents Worldwide, (2013), Moving forward with social collaboration SlideShare, http://www.slideshare.net/chagww/moving-forward-with-social-collaboration

Christensen C, Bohmer R and Kenagy J, (2010), Will Disruptive Innovations Cure Health Care? Harvard Business Review, http://hbr.org/web/extras/insight-center/health-care/will-disruptive-innovations-cure-health-care

Clendenin B, (2013), The conundrum of leadership and open collaboration in the social era, IT Business, http://www.itbusiness.ca/blog/the-conundrum-of-leadership-and-open-collaboration-in-the-social-era/44506

Confab, (2014), Flatter Organizational Structures Nurture Engagement And Empowerment Blog, http://blog.confab.co/2014/06/17/flatter-structures-engagement-empowerment/

Cornwall and Isles of Scilly Pathfinder Pioneer, (2014), Living Well Video, https://www.youtube.com/watch?v=XnIMr7UAqgA

Crabtree S, (2013), Worldwide, 13% of Employees Are Engaged at Work, GallupWorld, http://www.gallup.com/poll/165269/worldwide-employees-engaged-work.aspx

Denning S, (2012), Gary Hamel: What Matters Now: Passion! Forbes, http://www.forbes.com/sites/stevedenning/2012/04/03/gary-hamel-what-matters-now-the-centrality-of-passion

Denning S, (2014), The New Yorker: Battle Of The Strategy Titans, Forbes, http://www.forbes.com/sites/stevedenning/2014/06/19/the-new-yorker-battle-of-the-strategy-titans/

Diaz_Uda N, Medina C, Schill B, (2013), Diversity's new frontier: Diversity of thought and the future of the workplace Deloitte http://dupress.com/articles/diversitys-new-frontier/

Ennis M, (2014), How online patient communities are changing the face of cancer care, BMJ Blog, http://blogs.bmj.com/ebn/2014/03/03/how-online-patient-communities-are-changing-the-face-of-cancer-care/?utm_content=bufferbaac3&utm_medium=social&utm_source=twitter.com&utm_campaign=buffer

Farquhar K, (2010), NTL's "Conference on the New OD": Turning Thought into Action, https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0CCAQFjAA&url=http%3A%2F%2Fwww.member.cbodn.org%2FResources%2FDocuments%2FKatherine_Farquhar.ppt&ei=Hz6yU-bUAsWsPeeogUA&usg=AFQjCNFYy_nhtVsJfVn5LNyF9yCcMJ1vbg

Fowler J, (2012), Does this improvement meet our shared NHS purpose?, http://www.changemodel.nhs.uk/pg/groups/12171/Our+shared+purpose/?community=Our+shared+purpose

Fox S, (2011), Peer-to-peer healthcare, http://www.pewinternet.org/files/oldmedia/Files/Reports/2011/Pew_P2PHealthcare_2011.pdf

Fuda P (2012) 15 qualities of a transformational change agent http://www.peterfuda.com/category/the-transformational-change-agent/

Ganz M, (2009), Why Stories Matter, SOJO, http://sojo.net/magazine/2009/03/why-stories-matter

Goudreau J, (2013), IBM predicts three ways technology will transform the future of business, Forbes, http://www.forbes.com/sites/jennagoudreau/2013/03/08/ibm-ceo-predicts-three-ways-technology-will-transform-the-future-of-business/

Gov. UK, (2014), Monitor: change in the NHS has to be 'turbo-charged', https://www.gov.uk/government/news/monitor-change-in-the-nhs-has-to-be-turbo-charged

Graban M, (2014), Some of Dr Covey's last written words, from introduction to "Turn the Ship Around", https://twitter.com/MarkGraban/status/476201384644075520/photo/1

Ham C, (2014), Reforming the NHS from within: Beyond hierarchy, inspection and markets, The King's Fund, http://www.kingsfund.org.uk/time-to-think-differently/publications/reforming-nhs-within

Hamel G (2012) What Matters Now: How to win in a world of relentless change, ferocious competition, and unstoppable innovation, http://www.managementexchange.com/feature/what-matters-now

Hamel G, (2014), Why bureaucracy must die Blog, http://management.fortune.cnn.com/2014/03/26/bureaucracy/

Harvey G, (2013), The Many Meanings of Evidence: Implications for the Translational Science Agenda in Healthcare International Journal of Health Policy and Management 1(3), 187–188, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2352368

Hawkes N, (2012), The NHS must change or die BMJ 2012;345;e4478, http://www.bmj.com/content/345/bmj.e4478?rss=1&utm_source=feedburner&utm_medium=feed&utm_campaign= Feed%25253A+bmj%25252Frecent+%252528Latest+from+BMJ%252529

Health Research & Educational Trust, (2014), Building a leadership team for the health care organization of the future, http://linkis.com/lnkd.in/Y6RtU

Heick T, (2014), Eight ideas that will break education as we know it te@chthought, http://www.teachthought.com/trends/disrupting-education-8-ideas-will-break/

Hibbard J. and Gilburt H, (2014), Supporting people to manage their health: An introduction to patient activation, King's Fund, http://www.kingsfund.org.uk/publications/supporting-people-manage-their-health

Holman P, (2013), A Call to Engage: Realizing the Potential of Dialogic Organization Development, http://bit.ly/IfwdP7

Holman P, (2014), Change Your Story, Change Your Organization Blog, http://seapointcenter.com/change-your-story/?utm_source=hootsuite&utm_campaign=hootsuite

Hoque F, (2014), How To Create A Culture of Innovation, Fast Company, http://www.fastcompany.com/3031092/how-to-create-a-culture-of-innovation-in-the-workplace

Hunt T, (2013), 11 Rules for the Social Era - book by Nilofer Merchant SlideShare, http://www.slideshare.net/missrogue/11-rules-for-the-social-era-book-by-nilofer-merchant

Huxley T, (1893) The Coming of Age of the Origin of Species (1880). In Collected Essays, Vol. 2, 229. http://www.amazon.co.uk/Collected-Essays-Volume-T-Huxley-ebook/dp/B004E3XBOQ

IBM Corporation, (2012), Leading Through Connections: Case studies from the Global Chief Executive Officer Study, http://www-01.ibm.com/common/ssi/cgi-bin/ssialias?subtype=XB&infotype=PM&appname=GBSE_GB_TI_USEN&htmlfid=GBE03535USEN&attachment=GBE03535USEN.PDF

Isern J, Pung C, (2007), Driving radical change, McKinsey Quarterly November, http://www.mckinsey.com/insights/organization/driving_radical_change

Jarche H, (2010), A framework for social learning for the enterprise, Inside learning technologies and skills, http://www.jarche.com/wp-content/uploads/2007/05/framework-social-learning-jarche.pdf

Jarche H, (2014), Move the hierarchy to the rear Blog, http://t.co/5m8cQOdYFh

Jarche H, (2014), Moving to the edges Blog, http://www.jarche.com/2014/01/moving-to-the-edges/

Jarche H, (2014), Rewiring for the complex workplace Blog, http://www.jarche.com/2014/05/re-wiring-for-the-complex-workplace/

Jarche H, (2013), Rebels on the edges Blog, http://www.jarche.com/2013/11/rebels-on-the-edges/

Kaplan S, (2012), The business model innovation factory: how to stay relevant when the world is changing, http://www.amazon.com/gp/product/1118149564/ref=as_li_ss_tl?ie=UTF8&tag=digitont-20&linkCode=as2&camp=1789&creative=390957&creativeASIN=1118149564

Kelly L (2014) In a world without rebels Blog www.rebelsatwork.com/blog
Llopis G (2014) Every Leader Must Be A Change Agent Or Face Extinction SlideShare, http://www.forbes.com/sites/glennllopis/2014/03/24/every-leader-must-be-a-change-agent-or-face-extinction

Kenagy J, (2012), Choosing to Thrive in 21st Century Healthcare: The Adaptive M2S2, http://kenagyassociates.com/wp-content/uploads/_writing_pdf/268-d60cc5f2.pdf

King's Fund, (2014), Developing collective leadership for healthcare, http://www.kingsfund.org.uk/publications/developing-collective-leadership-health-care

Kotter J, (2014), Accelerate! Harvard Business Review Press, http://www.amazon.co.uk/Accelerate-John-P-Kotter/dp/1625271743

Kuppler T, (2014), 10 Clear Principles for the 96% that Need Culture Change Blog, http://www.cultureuniversity.com/10-clear-principles-for-the-96-that-need-culture-change/

Lew D, (2013), Disagreement is not disloyalty; dissent as an operating principle for business Blog, https://medium.com/on-management/disagreement-is-not-disloyalty-e9a21b574599?utm_source=buffer&utm_campaign=Buffer&utm_content=buffer76a51&utm_medium=twitter

Merchant N, (2013), eleven rules for creating value in the social era SlideShare, http://www.slideshare.net/missrogue/11-rules-for-the-social-era-book-by-nilofer-merchant

Meyerson D, (2008), Rocking the Boat: How to effect change without making trouble, Harvard Business Press Books, http://hbr.org/product/rocking-the-boat-how-to-inspire-change-from-within/an/2138-PBK-ENG

Meyerson D, (2001), Tempered Radicals: how people use differences to inspire change at work Harvard Business Press Books http://hbr.org/2001/10/radical-change-the-quiet-way/ar/1

Miller K (2014) Innovation Hub: Stop Listening to the Same People Xconomy, http://www.xconomy.com/national/2014/06/20/innovation-hub-stop-listening-to-the-same-people

Mikkelsen K, (2014), Future of Work, Blog, Scoop-It, http://www.scoop.it/t/futureofwork

Monitor (2014), Change in the NHS has to be 'turbo-charged', https://www.gov.uk/government/news/monitor-change-in-the-nhs-has-to-be-turbo-charged

Murphy S, (2013), The Death of Workplace Hierarchy Blog, http://switchandshift.com/the-death-of-workplace-hierarchy

Newquay Pathfinder Evaluation, (2014), http://www.ageuk.org.uk/cornwall/news--campaigns/newquay-pathfinder-evaluation/

NHS England, (2013), The NHS belongs to the people: a call to action, http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf

NHS England, (2014), Improving General Practice: A Call to Action Phase 1 Report, http://www.england.nhs.uk/wp-content/uploads/2014/04/emerging-findings-report.pdf

NHS Improving Quality, (2014), Stop the Pressure Campaign, http://nhs.stopthepressure.co.uk/docs/StopThePressureLaunchSlidesv8.pdf

NHS Improving Quality, (2014), The School for Health and Care Radicals, https://changeday.nhs.uk/healthcareradicals

NHS Institute, York Health Economics Consortium, (2013), Building and aligning energy for change: A review of published and grey literature, initial concept testing and development, http://www.institute.nhs.uk/images//Energy_for_change/Building%20and%20aligning%20energy%20for%20change%20v2%20Feb%2013[1].pdf

NHS Institute for Innovation and Improvement, The University of Manchester Business School, (2008), Quality Improvement: Theory and practice in healthcare, http://www.slideshare.net/NHSIQ/quality-improvement-theory-and-practice-in-healthcare

Page S (2003) Making the Difference: Applying a Logic of Diversity Academy of Management Perspectives http://www.virginia.edu/vpfrr/Making%20the%20Difference-Logic%20of%20Diversity_Page_Perspectives.pdf

Pell C, (ed)(2012), Delivering Public Services That Work: The Vanguard Method in the Public Sector, http://www.triarchypress.net/delivering-pub-ser-vol-2.html

Perkins N (2014) Bats and pizzas (agility and organisational change) SlideShare, http://www.slideshare.net/neilperkin/google-squared-online-0114

Ray K and Goppelt J, (2013), Dialogic OD in Day to Day Complexity, http://c.ymcdn.com/sites/odnetwork.site-ym.com/resource/resmgr/ODP2/ODP-V45,No1-All_Pages.pdf

Rogers A, (2014), Out with self-management support and in with social network involvement? Blog, http://minimallydisruptivemedicine.org/author/kerunit/

Royal College of Nursing, (2013), Labour Market Review, Safe staffing levels – a national Imperative: The UK nursing labour market review 2013, http://www.rcn.org.uk/__data/assets/pdf_file/0018/541224/004504.pdf

Satell G, (2014), To create real change, leadership is more important than authority Blog, http://www.digitaltonto.com/2014/to-create-real-change-leadership-is-more-important-than-authority

Satell G, (2014), Strategy Is No Longer a Game of Chess, Harvard Business Review Blog, http://blogs.hbr.org/2014/05/strategy-is-no-longer-a-game-of-chess/

Schillinger C (2014) Top-Down is a Serious Disease. But It Can Be Treated in Changing the world of work, Change Agents Worldwide, http://www.changeagentsworldwide.com/assets/doc/caww_ebook_11.pdf

Scrivens J, (2014), How managers build an authentic team and ecosystem with social Blog, http://ht.ly/tUTQy

Sernack J, (2014), Leading for Innovation in Extreme Uncertainty Blog,
http://www.innovationexcellence.com/blog/2014/06/14/leading-for-innovation-in-extreme-uncertainty/

Shinners C, (2014), New Mindsets for the Workplace Web,
http://www.changeagentsworldwide.com/assets/doc/caww_ebook_11.pdf

Steinberg R, (2014), Do You Have Game-Changers on Your Team? Blog, http://switchandshift.com/do-you-have-game-changers-on-your-team

Stevens S, (2014), Speech to the Kings Fund Annual Leadership Summit,
http://www.england.nhs.uk/2014/05/21/simonstevens-kf-speech/

Stodd J (2014)The future of leadership SlideShare, http://www.slideshare.net/JulianStodd/the-future-of-leadership-by-julian-stodd

Struab R,(2014), The Great Transformation - Lead Article for 2014 Drucker Forum SlideShare,
http://de.slideshare.net/straub46/the-great-transformation-richard-straub-gf-reduced

Tapscott D and Williams A, (2010), Macrowikinomics: Rebooting Business and the World Portfolio Hardcover,
http://www.kurzweilai.net/macrowikinomics-rebooting-business-and-the-world

Taylor P, (2014), Does your business need an innovation lab? SlideShare,
http://www.slideshare.net/mobile/Paulbromford/does-your-business-need-an-innovation-lab

Terry S, (2012), Management Practice Lags Culture Blog, http://linkis.com/tmblr.co/ThtQG

Terry S, (2014), The Future of Work is The Future of Leadership Blog,
http://simonterry.tumblr.com/post/78639010016/the-future-of-work-is-the-future-of-leadership

The Case Foundation (2014), Inspiring the Next Generation Workforce: The 2014 Millennial Impact Report,
http://cdn.trustedpartner.com/docs/library/AchieveMCON2013/MIR_2014.pdf

The Health Foundation (2013), Lining Up: How do improvement programmes work?,
http://www.health.org.uk/public/cms/75/76/313/4372/Lining%20Up_How%20do%20improvement%20programmes%20work.pdf?realName=7DOS97.pdf

USB Executive Development Ltd (2013), What Matters Now by Gary Hamel SlideShare,
http://www.slideshare.net/usbed/what-matters-now-by-gary-amel

Verjans S,(2013), How social media changes the way we work together SlideShare,
http://www.slideshare.net/sverjans/how-social-media-changes-the-way-we-work-together

Weber Shandwick, (2014), Employees rising: seizing the opportunity in employee activism,
http://www.webershandwick.com/uploads/news/files/employees-rising-seizing-the-opportunity-in-employee-activism.pdf

West M, (2014), Collective and inclusive NHS leadership is the only way forward, Blog
http://www.leadershipacademy.nhs.uk/blog/about/blog/collective-and-inclusive-nhs-leadership-is-the-only-way-forward/ NHS Leadership Academy

Williams B (2014) Working Out Loud: When You Do That… I Do This in Changing the world of work, Change Agents Worldwide, http://www.changeagentsworldwide.com/assets/doc/caww_ebook_11.pdf

Zimmerman E, (2014), Nir Halevy: How Do You Motivate Your Employees? Stanford Business,
http://linkis.com/www.gsb.stanford.edu/ROw1M

Zinger D, (2010), Avoiding Employee Engagement Pitfalls, Go2HR with permission from HRReporter
©Copyright Thomson Reuters Canada Ltd, https://www.go2hr.ca/articles/avoiding-employee-engagement-pitfalls

Acknowledgements

The Horizons Group

This White Paper was brought to you by the Horizons Group of NHS Improving Quality. The Horizons Group is a small team operating at the edge of current thinking and practice of change and transformation in health and care. Its remit is about sharing the disruptive power of connecting to influence change, leading edge knowledge, transformation and innovation. The aim is to support colleagues in health and care to think differently about the 'rules of change' and make sense of it in their own context, leading to effective change practice and better outcomes for patients. For more details of the specific activities of the Horizons Group contact: rachel.timms@nhsiq.nhs.uk

NHS
Improving Quality