Minicourse M1: STUDY GUIDE
To read prior to the minicourse on 7th December 2015 as “flipped classroom” pre-work

‘I do not think you can really deal with change without a person asking real questions about who they are and how they belong in the world.’

David Whyte, *The Heart Aroused*

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Session 1: Being a healthcare radical: change starts with me

Introduction

‘Be the change you want to see in the world.’ MK Gandhi

Welcome to the one day School for Healthcare Radicals.

It’s tough being a change agent in healthcare, particularly when other people don’t always get it or want to change. Yet big change happens in healthcare only because of heretics and radicals: passionate people who are willing to take responsibility for change. We are people who support the goals of our healthcare systems, but also want to change existing thinking and practice and improve care for patients and people who use services.

Being a ‘radical’ isn’t related to hierarchy or position and you don’t have to work in the official system to qualify as a healthcare radical. People who have previously taken part in the School for Healthcare Radicals include patients and family members, students, senior leaders, improvement facilitators and clinical and care staff.

The School for Healthcare Radicals seeks to provide us with tools, ideas and connections with a community of radicals to help us thrive and survive as agents of positive change and improvement.

This study guide

‘Education is the kindling of a flame, not the filling of a vessel.’ Socrates

This study guide is intended to enhance and complement the minicourse and help deepen your thinking and reflection. It is not compulsory, but it may give you some ideas of things to think about, questions to ask and you may take some inspiration from some of the examples and quotations. If you would find it helpful, please feel free to use this guide as a place to keep track of your own thoughts and ideas so you will have a record of your work on the day of the minicourse.

Throughout the study guide there are shaded sections for you to reflect on your own experience or respond to key questions. Even if you don’t write anything down, do take a few minutes to think about your responses to the questions and prompts; again, these could form great discussion points on the day of the school.

What are YOUR goals as a healthcare radical?

In order to make the most of the one day School for Healthcare Radicals, you may find it helpful to give some thought to your own personal goals – what do you hope to achieve by engaging with the

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School for Healthcare Radicals? You may like to think of this as the beginning of the story you will tell about developing your skills, knowledge and confidence as an agent of change.

**REFLECTION: THE STORY BEGINS**

What do you hope to achieve from the School for Healthcare Radicals?

Here are some of the things other people have suggested:

‘Create a network of rebels!’

‘Reawaken interest in studying and applying knowledge. Connect with other participants who may understand what it feels like to be an extreme left field thinker in an ultra traditional organisation.’

‘I'd like to learn how NOT to get myself into trouble - or my ideas and the people I represent to be ignored - because I don't rock the boat in an appropriate way!’

**Setting the scene: the challenge of change**

Anyone who chooses to be a change agent, improvement or patient leader in healthcare doesn’t choose an easy life. There are so many forces opposing the changes we want to see; a system that rewards people for ‘keeping the trains running’ rather than radical change, those with the power and/or a vested interest in keeping things as they are, colleagues and leaders who are sceptical, apathetic or scared of change. Often in our role as radicals, we feel isolated, vulnerable and misunderstood. Yet the future of healthcare rests with the non-conformists, the radicals, the heretics and mavericks in our midst. We are the people who are passionate about change, who question existing ideas and methods and open up new fields for action. As Martin Luther King described it:

‘The saving of our world... will come, not through the complacent adjustment of the conforming majority, but through the creative maladjustment of a non-conforming minority.’

**REFLECTION: PASSION AND CHANGE**

What are you passionate about?

How do you ‘live’ your passion(s)?
What have you already done to bring about change?

How did that work for you?

How can radicals work with different kinds of power?

It is helpful to contrast what Timms and Heimans call “old power” and “new power”

Often in healthcare, the dominant form of power is “old power”; the people who can make things happen are the people with positional authority, who push commands through the system. Old power is like a currency, some people have a lot of money but most people don’t. Largely, old power is transactional; we hold people to account in a rational way for performance agreements and quality standards. By contrast, new power is like a current; it surges with energy when people come together with a shared purpose. It is relational; people engage in new power ways because they want to and it fits with their own priorities and values, not because they have to.

Healthcare radicals need to be able to operate in the zig-zaggy space between old and new power. We need to be able to operate with the levers and opportunities of both. New power brings us lots of opportunities even when we don’t have a lot of positional authority to make things happen. In our one day School for Healthcare Radicals, we will discuss how we can work with both kinds of power.
**Who are the radicals in healthcare?**

Research by Debra Meyerson suggests that the most effective radicals are those who have learnt to oppose and conform at the same time. Or, as she puts it, ‘they are able to rock the boat and yet stay in it.

![Image: disruption is the new normal!](http://www.theedge.nhsiq.nhs.uk/school/)

“Tomorrow’s management systems will need to value diversity, dissent and divergence as highly as conformance, consensus and cohesion.”

Gary Hamel

These are change agents who stand up to challenge the status quo when they see there could be a better way. They develop the ability to walk the fine line between difference and fit, inside and outside. These people are driven by their own convictions and values which makes them credible and authentic to others. Most importantly of all, they take action as individuals that ignite broader collective action that leads to big change. Radicals already exist in and around every health or care organisation, in many different roles and multiple levels. Often they are not at the most senior levels of the organisation yet the impact of their change activities are often just as significant as if they were.

**REFLECTION**

**What makes you a radical?**

**Radicals versus troublemakers**

Lois Kelly makes the distinction between ‘rebels’ and ‘troublemakers’. As radicals, we fit with her ‘rebel’ criteria (and we use the terms “rebel” and “radical” interchangeably). We continuously seek innovative new ways of delivering care. We are committed to the patient-centred mission and values of our organisations. We are driven by our passion for better care for patients. We are optimistic.
about the future, the potential for change and see many possibilities for doing things in different ways. We generate energy for change which attracts others to unite with us for a common cause.

‘Troublemakers’ also challenge the status quo but in a way that is very different to ‘rebels’. Troublemakers complain about the current state of affairs but their focus tends to be around their own personal position rather than achieving the goals of the organisation.

<table>
<thead>
<tr>
<th>Troublemaker</th>
<th>Rebel</th>
</tr>
</thead>
<tbody>
<tr>
<td>complain</td>
<td>create</td>
</tr>
<tr>
<td>me-focused</td>
<td>mission-focused</td>
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<tr>
<td>anger</td>
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<td>energy-sapping</td>
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<td>alienate</td>
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<td>problems</td>
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‘Troublemakers’ are often angry about how things are and don’t have much confidence that things will get better in the future. They alienate other people because if others link with them, troublemakers will sap their energy. This just confirms what troublemakers probably know already—they don’t belong.

There are risks here for healthcare radicals. Firstly, some organisational leaders view ANYONE who challenges the status quo as a troublemaker. Therefore, radicals get unfairly labelled as troublemakers. Secondly, lots of change activists in healthcare start out as radicals but when their voices don’t get heard, they begin to question the status quo stridently and often in a manner which is self-defeating; and they cross the line from rebel to troublemaker.

As rebels, we have a responsibility to look out for this and try to prevent it happening by building relationships and forming alliances with others who challenge the status quo (there will be more on this topic in Module 2).
REFLECTION: REBELS AND TROUBLEMAKERS

What is your experience of rebels and troublemakers?

How can you protect yourself against moving from rebel to troublemaker?

Rocking the boat and staying in it

Successful boat rockers tend to:

1. Be driven by conviction and values
2. Have a strong sense of ‘self-efficacy’, that is, the belief that they are personally able to create the change
3. Be able to join forces with others to create action
4. Be able to achieve small wins which create a sense of hope, self-efficacy and confidence
5. Be more likely to view obstacles as challenges to overcome

The issue of self-efficacy is a particularly important one for healthcare radicals. By self-efficacy, we mean the belief that a person has that she or he is capable of delivering the specific change required. There is a positive, significant relationship between the self-efficacy beliefs of a change agent and her/his ability to facilitate change and get good outcomes.

ACTIVITY: BUILDING SELF-EFFICACY

What are some of the ways that you can build self-efficacy into your practice as a healthcare radical?
Being an effective healthcare radical is about knowing, doing, living and being change that makes a difference

For healthcare radicals it is important, but not enough, to continue to build our knowledge of improvement methods and approaches. It’s also important, but not enough, to take responsibility for our own development as skilled leaders or facilitators of change.

What sets the most effective healthcare radicals apart is the extent to which they seek to live and be improvement in the way they operate in the world and in their interactions and relationships with others.

It’s only when we live the things we believe in (that is, we can align our sense of deeper life mission or calling, our values and the activities that we undertake every day) that we can make our full contribution as healthcare radicals and generate the kind of signals that lead others to transformational change.

ACTIVITY: MAKING A DIFFERENCE

What are the opportunities for you to build your perspectives and skills as an agent of change and improvement?

How can you move beyond skills and knowledge of change to live and be the change?

Who can help and support you as a change agent?

What are the implications for the way you work?
Beginning to be the change: RCTs (Randomised Coffee Trials)

It’s hard to ‘do’ change on your own and one of the best ways of being the change you want to see is to work with others who share your intentions and values.

During the School, we will be encouraging you to develop your networks and find other people with whom you can share ideas and explore opportunities. One great way of doing this is by an RCT, that is, a Randomised Coffee Trial. RCTs can help you connect with people over a cup of coffee (or tea). It is a particularly useful approach within organisations where people may have little time to get to know one another, exchange ideas and share stories but it is also a wonderful way for cross-pollination to occur across organisations.

Do take a few minutes to learn more about RCTs here:  
http://www.gurteen.com/gurteen/gurteen.nsf/id/randomised-coffee-trials

And here:  http://www.nesta.org.uk/blog/institutionalising-serendipity-productive-coffee-breaks#

Questions for reflection

1. What are the opportunities for me to build my perspectives and skills as an agent of change?

2. How can I build self efficacy as a change agent?

3. How do I move beyond skills and knowledge of change to live and be change?

4. Who can help and support me as a change agent?

5. What are the implications for the way I work?
Session 2: Building alliances: forming communities for change

Introduction

As human beings, we are inherently social animals. We form pairs, families, communities, societies and cultures. As the previous section reminded us, we are all interconnected. It is when the connections are broken that radicals may become trouble makers. Without those connections it is unlikely that we can bring about significant social change and improvement.

So how can we harness the power of our shared humanity to help us accomplish positive change?

As we settle into the 21st century, organisations are shifting away from hierarchical models of leadership that seek to shape the workforce to the goals and ethos of the organisation and towards the recognition of the need for shared purpose, shared values and a sense of community. So what can we learn from those leaders who had few economic resources and little power in a formal sense, yet were able to change the course of history? These people are the leaders of the great social movements, for example, the women’s suffrage movement, the Civil Rights movement, the Anti-Apartheid movement, the climate campaigners of the 1970s and leaders of the Arab Spring.

ACTIVITY: SOCIAL MOVEMENTS

What learning and inspiration can we take from social movement leaders to help us in our roles as agents of change in healthcare?

Effective framing

Framing is the process by which leaders and agents of change construct, articulate and convey their message in a powerful and compelling way in order to win people to their cause and call them to action. Effective framing is a critical first stage to creating the conditions that lead to mobilisation and large-scale change.
ACTIVITY: FRAMING

How can you frame your messages about change in a way that will win others to your cause and call them to action?

‘I have a dream’ – sharing the vision and telling the story

‘Storytelling is the mode of description best suited to transformation in new situations of action.’ Schōn, 1988

Most of us, if we are passionate about something, want to share our passion with others in the hope of drawing them into the future we want to create for our patients, service users, colleagues and communities. This requires more than just vision or passion. We need to give something of ourselves, to connect with others and let them know that we are authentic in our attempts to bring about change. A story that offers some insight into us as individuals will have a more powerful effect than a story that is based on statistics or targets. A vision of improving care that is based on an experience of care that was either wonderful or terrible is more likely to engage people than a vision that is based on the number of people affected by a particular condition.

The best stories also reveal the storyteller’s ability to meet and overcome challenges by making the most appropriate choice or choices to achieve the desired outcome.

‘No matter what form the dragon may take, it is of this mysterious passage past him, or into his jaws, that stories of any depth will always be concerned to tell....’

O’Connor 1969
Framing your story

If you want people to join you in your change attempts, you will need to engage them. Here are some guidelines:

1. Tell a story
2. Make it personal
3. Be authentic
4. Create a sense of ‘us’ (and be clear who ‘us’ is)
5. Build in a call for urgent action

ACTIVITY: CHALLENGES AND CHOICES

Give some thought to your story. How will you attract the attention of the people you want to call to action? What personal experience will enable them to connect their experiences with yours? How will you make your story authentic?

Imagine that you have to write the story that will convey your mission for change in four sentences.

In the first sentence, make a connection with your audience.

In the second sentence, give us the context of your story.

In the third sentence, tell us about the challenge or crisis in your story.

In the final sentence, provide closure to your story – tell us the outcome of your choices.

Of course, telling a story in four sentences is a tall order, especially if you are trying to be specific and provide vivid detail. It is a good way of establishing the skeleton of your story though, and you can always go back later to fill in the details. It is also worth bearing in mind that the average attention span of 21st century humans is about two minutes, so if you can keep your story short and to the point, you will win the admiration and respect of your community!
You might be interested to watch an example of a very short story that was created with the intention of calling to action the air medical transport community to improve safety and reduce the number of helicopter crashes. You can see the story here:

http://www.patientvoices.org.uk/fly/0369pv384.htm

As you watch the story, notice how Cathy creates a connection with her audience, provides context for her story, leads us to the crisis, informing us of her choices, and finally, resolves the story.

Her story has successfully engaged not only the air medical transport community, but is now also used widely in training for other emergency services and throughout the healthcare community, particularly as a call to work inter-professionally, rather than uni-professionally.

**Bridging disconnected groups**

If we want to create large-scale change, we need to build bridges between groups that are currently disconnected or who have ‘weak ties’. Many of the great social movement leaders have succeeded by building connections between previously disparate groups and individuals, creating relationships based not on pre-existing similarities but on shared hop, purpose, possibilities and goals for change.

**ACTIVITY: BRIDGING DISCONNECTED GROUPS**

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?

**Your networks and communities**

You already belong to a number of networks and communities. Increasingly, there is an emphasis in healthcare on the need to work in and with communities, so it is a good idea to be aware of the communities of which you are a part.
REFLECTION: YOUR COMMUNITIES

1 What communities do you belong to as part of your role, through relationships and social networks?

2 What communities do you belong through social networks like Twitter and LinkedIn?

3 What communities of practice and learning groups do you belong to?

4 Draw a diagram or picture of your communities and illustrate the way they intersect and interconnect with one another and create opportunities for change.

Most of us belong to a number of communities: some may be virtual, such as Facebook and LinkedIn groups, while others will be actual, real time, perhaps even face-to-face groups. It is worthwhile to consider how each of these communities contributes to your efforts to bring about change – and whether they are the right communities for you.

Building your own community

As you develop your skills as a change agent, you should be growing more aware of the centrality of your own role in your informal networks. As you begin to build your own community that will support your vision of change, give some thought to the resources and the people you need to build capacity to effect the changes you want to see.
REFLECTION: BUILDING YOUR OWN COMMUNITY

Who is already part of your community?

What resources do they bring to the community?

Who else needs to be part of your community?

What resources will they bring?

Your membership in each of these groups is both an opportunity for you to contribute something of yourself and to benefit from the expertise or experience of others.

‘Each affects the other and the other affects the next and the world is full of stories and the stories are all one.’ Mitch Albom
Session 3: Rolling with resistance

Introduction

‘Learning is in the relationships between people.’ McDermott 1999

ACTIVITY: THE STORY CONTINUES

What do you hope to achieve from this module?

Have you ever given any thought to how you deal with resistance?

Have you considered the ways in which you may able to use resistance to help you achieve your goals?

What would you like to change as a result of engaging with this module?

What do we mean by resistance to change?

*Resistance* means any force that stops or slows movement.

*Resistance* is inevitable... learn to expect it, welcome it.

What is our mindset about resistance?

How we deal with ‘resistance to change’ depends on how we perceive the resistance. Is resistance something negative that will get in the way of the changes that we are seeking to implement, something that we need to overcome if we are to deliver the change? Or is it something to welcome that ensures a diversity of perspective and builds better change?
REFLECTION: YOUR APPROACH TO RESISTANCE

Think of a time when you were seeking to lead or make a change and other people were resistant.

What was the situation?

What was your response to the resistance?

How did your feelings manifest themselves?

Why did you react this way?

What was the outcome?

What might you do differently if faced with the same situation now?

It’s clear that we need to be thinking differently about change and resistance if we are going to be successful in our change efforts. Some of our work in Module 1 can help us here.

A dominant approach versus emerging direction view of change and resistance

You may remember this diagram from session 1, contrasting old and new power.

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Old power is often characterised by a *diagnostic* approach, that is, identifying problems and trying to find solutions. The future will be characterised more by solutions that arise from new power opportunities, improved and open communication, more creative dialogue and stronger connections.

We can also contrast these two ways of thinking about change when it comes to how we think about resistance.

The change isn’t going to happen all at once, but if we can create capability in these different approaches, approaches that rely more on connection, communication and dialogue than on diagnosis, then we can help create better conditions for positive outcomes from our change efforts.

**ACTIVITY: DOMINANT APPROACH OR EMERGING DIRECTION**

Reflecting on my current activities in leading change:

Who are the ‘resisters’ and how do I manage them from a dominant approach viewpoint?

How might I work with the emerging direction approach in my own setting?

You have already begun to make connections and strengthen your weak and strong ties – we have seen this via the Twitter and Facebook groups, as well as the learning groups that have been established. We’ll go on to look at some of the different approaches to resistance and ways of harnessing its power.
The power of resistance

Resistance is powerful. If unharnessed, it can be harmful, much like lightning. But, when the power of electricity is harnessed, it is immensely useful.

Find ways of harnessing the power of resistance to help you achieve your goals. Go with the energy rather than against it.

Diversity

Research studies show that teams of people with diverse backgrounds, experiences and views of the world will consistently outperform groups of more talented but homogenous individuals.

Diverse teams have better insights, they are more effective as problem solvers and they make fewer mistakes.

The ‘best people’ for our change projects are not necessarily the people who are most like us. As healthcare radicals, we want to embrace diversity and bring people into our change teams who think differently to us or who have had different experiences of life. This may include patients and families, community leaders, people from other industries and organisations. By deliberately seeking diversity we create the risk of greater resistance, challenge and disagreement within the group, even though the outcome is likely to be better.

As change agents, we need to embrace and value the differences.
ACTIVITY: DIVERSITY - VALUING THE DIFFERENCE

In the context of ‘rolling with resistance’...

What are the implications of embracing diversity of thought, experience and background in my change initiative?

What skills and perspectives do I need to develop to work effectively with diverse groups of people for change?

Research conducted into interprofessional education (Anderson 2014) has found that, by bringing together people from different clinical professions to talk with and listen to patients, clinical outcomes are improved. Each profession looks for and sees something different and the sum of their perspectives provides a more holistic understanding of the issues facing the patient. This approach is a good example of the benefits of embracing diversity.

Understanding why people resist and what to do about it

There are a number of models and frameworks that can give us insight into why people are resisting change and suggest actions to take as a change agent to roll with resistance. Many healthcare radicals use the ‘Stages of Change’ or ‘Transtheoretical Model of Behaviour Change’ from Prochaska, DiClemente and Norcross to support their change effort. It is a model of health-related behaviour change that many clinicians are already familiar with through their clinical practice. It can be used for improving service quality and patient safety too.

Where am I in the change cycle and what will help me to progress to the next stage?

The basic model consists of five stages of change that individuals go through in changing their behaviours. By working out where on the cycle an individual is, we can plan some appropriate actions to help that person to embrace and contribute to the change. In healthcare, when people ‘resist’ change is it much more likely to be a result of their interpersonal interaction with the change process than their innate character traits. This means that people are more likely to be resisting because of a bad change process not because they are a difficult person. The Stages of Change model helps us to understand this and work out where the person is at.
The Stages of Change (or Transtheoretical Change) model

Prochaska, DiClemente and Norcross offer us framework that we can use to work out which stage of change a particular individual is at and plan actions to help the person get to the next stage. We unpack the model on the next couple of pages.

Prochaska, DiClemente & Norcross (1992)
### Stage | Where am I in the change cycle? | What will help me move to the next stage of change? | What’s a good outcome from efforts at this stage?
--- | --- | --- | ---
**PRECONTEMPLATION** | I am not thinking about changing my behaviours, actions or work processes. The problem or issue is outside my frame of awareness or my perceived need. Therefore, there is no problem because I am not awareness of the situation as it might affect me. Obviously, I have no intention to change at this stage and my defences may be raised if you push me to change. I often get labelled as ‘resistant’, ‘blocker’ or ‘in denial.’ | The focus should be on creating awareness for me of the need to change.  
- Use strategies to raise my awareness and lower my doubt  
- Increase my perception of risks and problems with current ways of working  
- Emphasise the consequences and costs associated with maintaining the existing system  
- Emphasise the benefits that I and others will get from the change.  
- Use basic skills such as reflective listening and open-ended questions  
- Function as my collaborator not my educator  
*Remember, the goal is not to make me (as a pre-contemplator) change immediately, but to help me move to contemplation.* | I begin to recognise that there might be a problem that I need to do something about.

**CONTEMPLATION** | I am aware a problem exists and I am seriously considering action, but I have not yet made a commitment to an action. I have some level of awareness of the problem. I might not want to admit it but I also have a large degree of fear of the unknown and of the amount of effort I may need to make for the change. If you force me to change at this stage, there is a risk that my defences will remain in place. This means that I might be compliant with the change but not committed to it. As a result, the change may not be sustained. | The focus should shift to increasing the perceived benefits of the change and reducing the expected or perceived negative consequences of changing for me. You will want to create a ‘tipping point’ where the expected benefits outweigh the expected costs of the change. To get me to this point it may be necessary for you to help further clarify both the benefits (which may be unknown) and costs (which may be unrecognised). You need to try to step into my shoes, considering the pros and cons of change from my perspective. | I have made a tentative commitment to changing the way I currently do things but it is fragile.

**PREPARATION** | I have made a decision to take future action, but I am not yet prepared to actually take the action now. I need to do some more thinking about the individual steps that I need to take prior to attempting the new behaviour or new way of working. There is a strong likelihood that my peers will still be at the pre-contemplation and contemplation stages (80% of others in many research samples). As a result, I may be discouraged or question my decision to take action. | Help me to build my skills, knowledge and confidence in the new way of working:  
- build an action plan for change  
- include others in the plan  
- examine barriers to change and help me work through potential solutions (what will the first week be like?)  
- encourage me to take part in formal training sessions and workshops  
- give me interesting articles to read that show evidence  
- agree how the change will be evaluated | I’m making clear statements about the change and I have an action plan in place.
| ACTION | I am aware a problem exists and have actively modified my behaviour, work process and/or environment in order to overcome the problem. I’ve actually made the changes and I’m working in a new way. However, some of my old habits and tendencies toward the old behaviour are still in place and it is quite likely that I will revert to the old way of working. The good news is that my commitment is clear and I am making a big effort to change. | Reinforce the changes I have made by coaching and mentoring me:  
- Recognise and acknowledge the success of the change even if the success is only the attempt with results not yet evident  
- Reaffirm your own commitment to the change and engage in active problem solving with me and my colleagues | I’m working in the new way. The risk of relapse is diminishing as my new behaviours/ways of operating replace the old ones. |

| MAINTENANCE | I have made a sustained change. My new ways of working have become firmly established and the threat of relapse is become less intense. It’s no longer necessary for me to consciously think about and plan the new way of working as it has become more automatic. I (and my patients and colleagues) are realising the benefits of the change and my confidence that it was the right thing to do is growing. However, in times of stress there is still a risk that I might revert to the old ways of doing things. | Understand that even though I am well established in the ‘maintenance’ phase, I still need ongoing support and encouragement. Be there for me if I relapse. If this happens, help me to:  
- Reaffirm the original reasons for the change  
- Explore the factors that precipitated the crisis  
- Get back on track | Hopefully, I successfully exit the final stage of change cycle and move into a new cycle for a new change. If I relapse, I will re-enter the contemplation or preparation stage. |

Adapted from DiClemente, 1991; Prochaska and Norcross, 1994 and Wirth 2004 by Robert Ferris-Rogers and Helen Bevan
REFLECTION: STAGES OF CHANGE

At what stage of change are some of the key people that you need to influence for your change initiative?

What actions can you take to help them move to the next stage?

Building resilience

In Module 2 we explored the importance of building communities and forming alliances. We gain our strength from these alliances and this a way in which we can overcome feelings of isolation. Within these alliances and communities there are always critical friends, friends who can connect with us at an individual level. In Module 1 we looked at self-efficacy. Teachings on emotional intelligence show us how to develop our own support mechanisms from within. We can do this through building our self-efficacy and taking time to be kind to ourselves. Sometimes this is simply in sitting quietly and breathing, in practicing some mindfulness techniques, in sitting still to eat our lunch, in going for a walk. By taking time simply to be we are building our reservoirs of self-support.
REFLECTION: TAKING CARE

How do you take time to take care of your own physical and emotional well-being?

Please note down three things/activities that help to build your emotional reserves rather than deplete your energy.

How can you build activities like this into your daily routine?

One radical of our acquaintance has adopted a pragmatic approach to looking after herself. She says:

‘I only have three things on my “To do” list each day. And one of them is always ‘eat lunch’. ’ Cathy Jaynes

Caring for ourselves is particularly important if we want to care for others,

Reference list

Here are some of the references that we will refer to in the minicourse and in the study guide and/or which we have used to help shape the content. Click on the reference to get the link.

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