Improving improvement in the public sector: the NHS Change Model

The "NHS Change Model" has been launched. In a nutshell, it is a framework for change to help NHS commissioners and providers improve how they go about improvement and deliver NHS goals for quality and value.

The impetus for the change model was a conclusion that whilst there have been significant improvements in the NHS over the past period, the rate at which the NHS will need to change in future is outpacing its current speed of change. The change model seeks to distil NHS learning about successful change over the past 15 years and offer a framework to get better, quicker change outcomes for patients and communities by:

- Creating shared ways of thinking about change and a common language for change
- Helping ignite the energy and brainpower of the NHS workforce, people who use NHS services and NHS partners in leading change
- Linking up change activities across the whole system

The development of the NHS Change Model has been led by a group of improvement leaders from across the NHS, with support from the NHS Commissioning Board. In order to build impact and legitimacy, more than 500 leaders, clinical and managerial, providers and commissioners were asked to contribute to its development. People got involved because they recognise that if we want the best outcomes for the people we serve at a time of severe economic challenge, we need to work in ways that give us the greatest potential for change.

The NHS Change Model is made up of eight components, based upon evidence and experience of change. The model and its component parts are shown in Fig. 1.

The framework is relevant to commissioners, providers and NHS partners. The underpinning principle is that the greatest potential to improve improvement efforts will be made if all eight components of the change model are considered together, through an integrated approach. Questions that leaders are asking include:

- Have we built all eight components into our plans, rather than just some of the components?
- Have we made the connections between and aligned the eight components?
- Have we considered the unintended consequences of an over dominance of one or more of the components on the other components (e.g. the negative impact that an overemphasis on rigorous delivery – a change approach that is driven by performance management – might have on our ability to create the conditions where innovation can flourish – spread of innovation?)

So, for instance, the change model includes the component improvement methodology because there is clear evidence that working with a systematic, evidence-based quality improvement methodology (such as Lean, Six Sigma or the EFQM Excellence Model) increases the chances of successful change. However, the change model framework doesn’t recommend or specify which methodology should be used. This is because many teams across the NHS have already adopted a methodology and will want to build on what they are already using. In addition, each methodology has particular strengths for different problems and they can be used in combination, particularly where we are seeking change at different scales simultaneously. Whilst all the methodologies can demonstrate impact, there isn’t a research evidence base to favour one over the others.

History suggests that in order to build and sustain large-scale change, connections should be made with the intrinsic motivation that people have to get involved in, and build energy for, change. We need to create hope and optimism and help people feel more ready and confident to build the future. The NHS Change Model seeks to do this through connection to shared purpose, engaging to mobilise and leadership for change.

At the same time, the experience of the NHS over the past 10 years has demonstrated the importance of drivers of extrinsic motivation including transparent measurement, incentivising payment systems, effective performance management systems and holding leaders to account to deliver change outcomes. If the NHS Change Model is to have impact, all of these features need to be part of its on-going approach.

The experience of NHS change efforts has also demonstrated what happens if these intrinsic and extrinsic factors for change aren’t aligned. Too often, an overemphasis on the extrinsic factors kills off the energy and creativity that is necessary for delivery of change at scale. There have also been many examples where change leaders have emphasised engagement and built commitment to change but haven’t hardwired this into the performance approach and the result is underachievement of change and the eventual fizzling out of the goodwill that was built. Most leaders of change tend to favour one side or the other (intrinsic/extrinsic) in their approach to change. The power of the NHS Change Model is that the strengths of both are necessary to improve the way the NHS improves itself.

More than 60 years ago, it was people taking collective responsibility for change and working differently that led to the establishment of the NHS. Since that time, many people who have cared deeply for the ideals of the NHS have seen the need to take action to ensure that the system continues to deliver for future generations. And today, there is a new cohort of clinicians, leaders and NHS partners who value the NHS and who are willing to free their minds to new possibilities. This is the generation of NHS leaders who will transform the relationship between quality and cost in the NHS and ensure the sustainability of NHS services. The NHS Change Model represents leading edge thinking about how to improve improvement. It has the potential to play a significant role in creating that future.

For more information about the NHS Change Model visit www.changemodel.nhs.uk

Helen Bevan, Chief of Service Transformation, NHS Institute for Innovation and Improvement