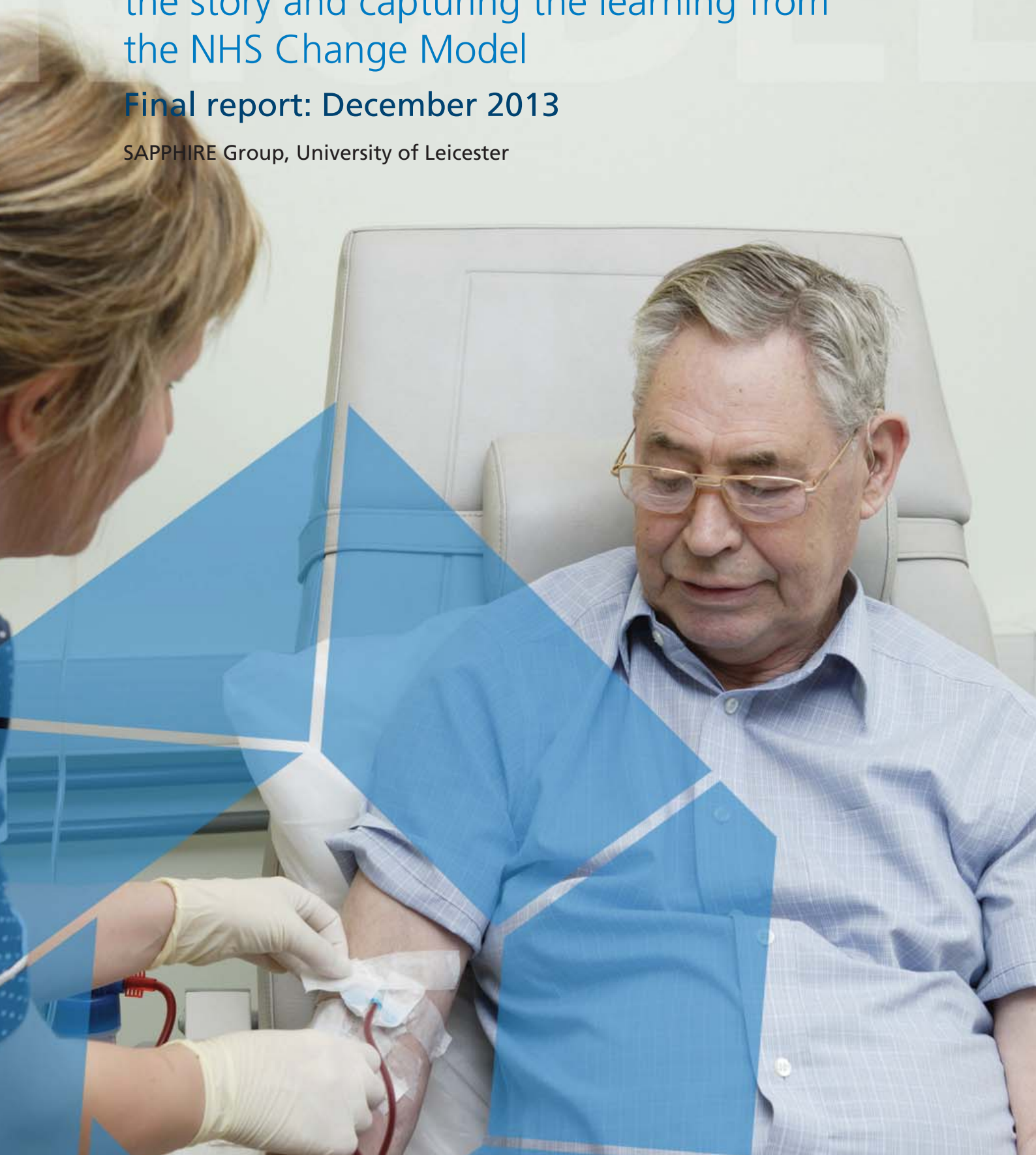# From shared purpose to joint action: telling the story and capturing the learning from the NHS Change Model

Final report: December 2013

SAPPHIRE Group, University of Leicester

Contents

Foreword

In his recent report *A promise to learn, a commitment to act*, Professor Don Berwick stated that the most important change in the NHS would be for it to become 'a system devoted to continual learning and improvement of patient care, top to bottom and end to end.' This concept is at the heart of what we do at NHS Improving Quality – enabling healthcare staff to continuously develop and use their skills for improvement.

The NHS Change Model can help us to deliver this. This excellent tool has been developed with you, for you. Based on evidence and experience, it provides a single approach to change, whether small scale, large scale or transformational, enabling healthcare professionals to make consistent and continuous improvements to services and care provision. At NHS Improving Quality, we are rolling out the NHS Change Model across NHS England, CCGs, and primary care, and testing its application in care settings. Going forward, we will continue to work with you to improve and develop the NHS Change Model so it can support you when leading or implementing change, whatever your role and wherever you are in the health and care system.

This evaluation is timely, providing useful intelligence that helps us understand where we currently are with the NHS Change Model and what we can do next to improve it. The report highlights the value of the NHS Change Model, demonstrating how it is has helped people as they embark on challenging and complex service improvements. The tool is commended for its practicality, and it is encouraging that people are keen to recommend it to others.

As the whole of the NHS should be focused around 'continuous improvement', so too should the NHS Change Model. We will respond to the feedback highlighted in this report around applying and using the model, and gather more feedback from others who are working to implement change. We must strive to continually make the NHS Change Model as good as it possibly can be and ensure its adoption and uptake is widespread. It needs to be relevant and engaging at all levels, instantly recognised by anyone working in health care and beyond as the 'go to' tool for achieving successful change.

As we begin this next stage of the NHS Change Model journey, I hope you will share your views and thoughts, letting us know how it has helped you and how you think it could be made better. Send your comments and feedback to **info@nhsiq.nhs.uk**. By doing this, you can help to ensure the NHS Change Model is responsive to the changing world around you, and that it continues to be a powerful and relevant tool. Perhaps more importantly, it will ensure that the NHS Change Model continues to belong to you, supporting you to successfully drive improvement and make things better and safer for patients.

Professor Moira Livingston
Clinical Director for Improvement Capability, NHS Improving Quality
September 2013

Executive summary

The NHS Change Model (**www.changemodel.nhs.uk**) was developed to provide a single, integrated, evidence-based toolkit for achieving change in the National Health Service, in a way that attends to the full range of aspects of change: organisational, technical, psychological, social. Based on theory and empirical evidence from a range of disciplines, the NHS Change Model has been adopted by NHS England as its chosen framework for instigating and managing improvement in NHS care. This report details the findings of a formative, strengths-based evaluation of the NHS Change Model, commissioned from the SAPPHIRE Group at the University of Leicester to provide early learning from the development and uptake of the NHS Change Model, to inform further improvements to the Model itself and the way in which it is communicated to and used by NHS staff.

The evaluation, which took place from September 2012 to March 2013, comprised two phases. The first phase considered the design, development and objectives of the NHS Change Model to generate a programme theory of change, using interviews with those involved in the development, analysis of official documents on the NHS Change Model, and observation of webinars relating to the NHS Change Model. The second stage focused on the application of the NHS Change Model in practice, using in-depth interviews with NHS clinicians and managers who were using it, including those from 'early mover' sites, and others who had taken up the NHS Change Model and sought to use it elsewhere. Interviewees included both commissioners and providers, and clinicians and managers.

Key findings from the study include:

- Testimony from those who had experience of using it in practice suggested that the NHS Change Model had a great deal to commend it. All said that they had found the NHS Change Model as a whole, or some of its constituent parts, useful in their change efforts, and all said that they would recommend it to others. The multifaceted nature of the NHS Change Model meant that participants were seeking to apply it to very challenging, complicated service improvement tasks (section 5.1).
- Much of the appeal of the NHS Change Model was to be found in its simplicity: it was not seen as novel by participants, but this was welcomed, since it was clearly grounded in existing evidence, and sought not to introduce a new, 'faddish', framework for change, but rather to bring together the best of what already exists (section 5.1). The practical orientation of the NHS Change Model was also valued, with its pointers to wider resources under each of its sections, and its guidance on what action is needed to support change.
- There was some suggestion in the data that participants had mixed experiences of applying the NHS Change Model in a way that was faithful to its design. In particular, participants struggled to use all eight of the components of the NHS Change Model alongside one another, and in a way that reconciled the tensions between them (section 5.3). The 'harder' aspects of change management posed a particular challenge. There were also signs in a few cases that participants saw the NHS Change Model as a solution in itself: a process to be applied (with guaranteed results) rather than a heuristic framework that needed to be drawn on more iteratively and creatively.
- Those using the NHS Change Model tended to do so in a relatively isolated, individualised way: rather than using it to explicitly frame change and mobilise those around them involved in the process, they tended to use it either individually or in small teams (section 5.2). They then would draw on the skills of others as and when they arose, without bringing these other stakeholders into the process of using the NHS Change Model as a whole. They also found that some of the language in the NHS Change Model risked alienating key stakeholders in change, and so worked actively to translate it for different audiences. While such an approach to using the NHS Change Model seemed appropriate in many cases, it also posed risks in terms of the resilience and sustainability of change led and managed by such small teams.

- Participants made a number of suggestions about technical improvements that might be made to the NHS Change Model, and modifications that might be made to its substance and presentation (section 5.5).
- Other challenges faced in using the Model were less readily remedied, most notably those relating to the organisational context in which the NHS Change Model is being applied (section 5.5). Participants identified difficulties in finding alignments with wider system drivers, and in ensuring that approaches to change achieved a balance between extrinsic and intrinsic motivators, in an NHS context characterised by rising demand, static or decreasing resources, and pressures to achieve changes rapidly.

In such an organisational context, a critical factor in the degree to which the NHS Change Model can be used to instigate sustainable improvement will be how far its use can be protected from these wider pressures: this suggests a particularly important role for senior leaders in organisations in mediating pressures and creating space for the steady, patient, thoroughgoing approach to change encouraged by the NHS Change Model. It also has important implications for the way in which NHS England seeks to encourage use of the NHS Change Model by commissioners and providers, discussed in section 6 of the report.

1. Introduction

This report provides detailed findings from a two-phase, strengths-based formative evaluation of the NHS Change Model. The evaluation, commissioned from the University of Leicester by the NHS Change Model team, sought in Phase 1 to provide an account of the origins and development of the model and associated tools in seeking to address the challenges faced by the NHS, and then in Phase 2 to offer an analysis of the NHS Change Model in action in selected areas across the NHS, based on the experience of those in 'early-adopter sites' selected and supported by the NHS Change Model team, and other individuals and groups who were making early use of the NHS Change Model.

The report presents findings from the two phases sequentially in two sections, with discussion and commentary following both. We draw judiciously from wider literature in order to highlight the dimensions of some of the challenges faced, and to illuminate some of the resources that the NHS Change Model can draw on in overcoming these.

2. Methods

Phase 1 of the evaluation took place from August to October 2012. It drew on three main sources of data:

- interviews with eight stakeholders involved in the initiation, development and spread of the NHS Change Model;
- documents describing the NHS Change Model available on its website or provided by the team; and
- a 'virtual ethnography' of NHS Change Model webinars, in which one or more researchers 'sat in' on webinars to observe both the presentations themselves and the responses of attendees (in the form of questions, chat-box comments and Twitter statuses).

Interviews were semi-structured and were conducted by telephone. The topic guide focused particularly on the background, need for and development of the NHS Change Model, and also on the content of the NHS Change Model, its strengths, anticipated uses and anticipated challenges for those adopting it. After being given information on the nature and purpose of the study, participants were given the opportunity to ask questions, and then asked to provide written consent to be interviewed. Interviews were audio-recorded, fully transcribed, imported into qualitative data analysis software (QSR NVivo), and then coded according to a mixture of predetermined and emergent categories, using an approach based on the Framework method.[1] Notes from seven webinars were also included in this analysis, along with the text of seven internal or public documents relating to the NHS Change Model.

For Phase 2, so far twenty-eight participants have been interviewed, of which analysis of 23 interviews was included in this report. Five interviews are awaiting transcribing, and subject to consent, two-to-three further interviews may be undertaken. These interviews are analysed and incorporated into the final version of this report. Participants in Phase 2 were purposively sampled via three approaches. These were:

- Early adopter sites using the NHS Change Model (15 interviewees from four sites)
- Individuals who had taken part in webinars highlighting the Model, and who consented to their details being shared with the research team with a view to an interview
- Individuals who agreed to participate in an interview following a 'Getting Started with the NHS Change Model' survey undertaken on behalf of the NHS Change Model team.

This mix provided a balance of those who had used the NHS Change Model and those who had expressed interest in using it but had yet to commence working with it. The sample, however, is thus inevitably comprised more-or-less exclusively of those who were open to using the NHS Change Model, and who had actively sought to investigate it or adopt it for their own purposes within the first six-to-nine months of its existence. The composition of the sample should be taken into account in interpreting the analysis of Phase 2 data. Table 1 gives an overview of the roles of the participants in Phase 2.

Table 1: Background and roles of participants in Phase 2

Interview number	Job role and background
001	Clinical and managerial background, head of transformation team
002	Managerial, service redesign
003	Managerial, directorate responsibility
004	Managerial, Strategic Health Authority level
005	Innovation manager for two trusts
006	Managerial, responsibility for a team within a directorate
007	Managerial, responsibility for a team within a directorate
008	Managerial, responsibility for a team providing non-clinical support across an organisation
009	Managerial (other)
010	Clinical training and education
011	Consultant doctor
012	Clinical and managerial background, public health
013	Managerial background, head of development
014	Public health background, head of commissioning
015	Clinical background, team leader
016	Managerial background, head of innovation
017	Private-sector background, managerial role
018	Managerial background, head of commissioning
019	Managerial background, contract management
020	Clinical and managerial background, public health
021	Managerial background, strategic programme lead
022	Programme director
023	Managerial background, clinical network manager
024	Private-sector background, transformation manager
025	Clinical background, project manager
026	Clinical background, change leadership role
027	Clinical background, change leadership role
028	Clinical background, managerial role

As in Phase 1, interviews were semi-structured and were conducted by telephone. In Phase 2, the topic guide for the interviews focused on use of the NHS Change Model in practice, strengths of the NHS Change Model, specific components, challenges in its use, and strategies used in spreading the Model. After being given information on the nature and purpose of the study, participants were given the opportunity to ask questions, and then asked to provide written consent to be interviewed. Interviews were audio-recorded, fully transcribed, imported into qualitative data analysis software (QSR NVivo), and then coded according to a mixture of predetermined and emergent categories, using an approach based on the Framework method.[1] The analysis to date (as at 20 March 2013) is based on 23 interviews. In the course of the analysis, the coding frame was also revised in the light of new themes that emerged from the data. These iterative and inductive approaches allowed for flexible and recursive consideration of key themes as and when they emerged.

3. Findings from Phase One

3.1. The background to the NHS Change Model

It was clear from the sources we analysed that the NHS Change Model is a product of its time. Unprecedented increases in demand produced by the demographic changes of an ageing society, the shifting burden of disease from acute to chronic conditions, new technologies and interventions, and the changing expectations of contemporary healthcare consumers require major changes in the way in which healthcare is organised and provided. At the same time, a real-terms freeze in national expenditure on healthcare for the foreseeable future, and institutional restructuring and turbulence, compound the challenge. Though the past couple of decades offer examples of how the NHS has successfully pursued change at various scales in response to such pressures, the pace and scale of change now required may be of a different order. The NHS Change Model seeks to offer a resource to help the NHS organise and mobilise its response to challenges of a nature that simply has not been seen before.

At the same time, however, the NHS Change Model also seeks to transcend the current fiscal, demographic and organisational context by appealing to core values that underpin the NHS. It is not intended as a snap response to the specific challenges posed by the economic scene of the 2010s, but as a durable resource that consolidates existing learning, can be applied in all sorts of situations, and above all is faithful to the ethic and core values that underpin the NHS.

"There's been some fantastic changes in the NHS so far which have improved care for so many people. As a national care system however we are not good at sharing those great improvements for all and shrinking finances make this even more important now. The NHS Change Model takes the best of what we know and gives us a checklist for the components of change necessary to deliver and share for the benefit of all."

Output report from NHS Change Model: The Big Event

"When we look forward at the unprecedented change agenda that we face, like when we think about the NHS and the system, between now and 2014/15 there is a four per cent per year compound reduction. In global terms it is unprecedented. There is no other healthcare system in the world that has taken that big a hit, and particularly seeking to make the changes through quality."

Interviewee 2

Thus while the model may have been spurred by the need to increase the pace and scale of change, it also responds to learning from perennial problems associated with change in the NHS: failures to learn from the existing evidence base; failures to link up and align change efforts so that they often result in piecemeal or unsustainable change; failures to spread learning so that others might benefit from both successes and mistakes.[2] In trying to provide a resource that will help to overcome these failings, the NHS Change Model also seeks to harness the NHS's strengths to address some of the problems that can plague change efforts in complex organisational contexts: 'top-down', coercive approaches to change that alienate frontline staff and result in a focus on compliance rather than commitment; 'internecine' strife between different stakeholders within the health service who, despite being united by a common set of values and motivators, are often in conflict, especially when it comes to change efforts; and tensions and apparent contradictions between extrinsic and intrinsic motivators of change. In this way, the NHS Change Model builds on an increasing body of evidence which emphasises the importance of a 'mixed economy' of change that uses various strategies for improvement, and also addresses the potential tensions between them.[3]

" The scale of transformation needed in the NHS in order to deliver improved quality from available resources is huge. It requires an evidence-based, systematic and skilled application of change management approaches in order to achieve it. "

Commissioning Board workshop on the NHS Change Model

These conditions gave rise to a perceived need for a framework that would:
- bring together a range of evidence-based approaches to change,
- provide resources to NHS staff to help them to achieve that change, particularly by maximising the benefit they gained from existing, underutilised strengths, and
- ensure that change efforts align with other pressures and priorities in the NHS, to maximise the chances of sustainable and replicable success.

3.2. The idea behind the NHS Change Model

The NHS Change Model seeks to achieve these aims through clear diagrammatic representation, connections to supporting strategies developed by the NHS Institute for Innovation and Improvement and others, and a range of tools—some already available, some in development—to ensure that components are used synergistically rather than antagonistically. It is intended to appeal to all sorts of NHS stakeholders, so that it becomes a common language for change and avoids creating tensions and conflicts between the NHS's 'tribes' of professionals and managers. By placing the uniting 'shared purpose' of the NHS at the centre—literally—of the diagrammatic representation of the model, it also seeks to centre that shared purpose in the change initiatives undertaken in the NHS. By appealing to the key resource of the common values of NHS stakeholders, the aim is to provide a model that attracts authentic commitment from staff who want to make changes that adhere to the underpinning ethos of the NHS, improve its appropriateness for patients, and ensure its survival as a mode of providing healthcare.

Alongside this emphasis on the values, content and structure of the NHS Change Model, great consideration has gone into ensuring that the way it is communicated to its potential user base does not undermine these good intentions. There has been recognition that, as a model vaunted by an NHS 'elite', developed by a national agency and adopted by the National Commissioning Board (now known as NHS England), the NHS Change Model risks being viewed as 'just another' managerial tool to be incorporated into routine work.

Adoption that is driven by 'compliance' rather than 'commitment' may mean a half-hearted approach that does not reap the full benefits of the intellectual work that has gone into the alignments between its components—or worse still, induces a 'box-ticking' approach that achieves no real change, encourages 'gaming' and contributes to cynicism.[4] Considerable effort has therefore gone into the planning the manner in which the model is publicised, with several interviewees describing a launch "by stealth" that eschewed grand pronouncements, central launches and implementation 'roll-out' in favour of low-key events, word of mouth, and work to plant the seeds for a 'social movement', reliant in particular on social media.

This combination of approaches to content, structure and marketing are intended to make available the set of tools needed to make the changes necessary for the NHS, ensure their fidelity to its underpinning values, and spread uptake by 'leaders' from all sorts of backgrounds and in all sorts of contexts:

" It's to help the NHS make change at scale and pace, and to involve as many people as possible, but to make sure that that change is done in a rigorous way so that the change is sustained and people are engaged in the process and buy into what we're trying to do."

Interviewee 3

The emphasis of the NHS Change Model on multifaceted approaches to change, on actively working to ensure alignment and reduce potential tensions between its eight components, and on ensuring that all change is underpinned and directed by the shared purpose that is seen to unite NHS staff, came through strongly from interviews and documentary sources; it was also clearly articulated by presenters and participants in webinars. Particularly evident is the work that has gone into making the language of change accessible and acceptable, in a context where resistance to managerial initiatives and change fatigue could easily generate major obstacles for a model that is essentially about change management.[5] Care has gone into aligning the model itself with the central ethos and spirit of the NHS, and viewing the NHS itself as a product of radical innovation and responsiveness to change rather than of conservatism:

" More than 60 years ago, it was people taking collective responsibility for change and working differently that led to the formation 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 our national health system continues to deliver for future generations. Today, we are the cohort of clinicians, leaders and improvement activists who value the NHS and who are willing to free our minds to new possibilities. We can deliver a health and healthcare system that is the envy of the world, even with constrained resources but it won't just happen without concerted action. The NHS Change Model can play a key role in achieving this but it depends on thousands of us joining up our change activities."

Output report from NHS Change Model: The Big Event

Participants were positive about the way in which the NHS Change Model as developed had managed to marry this array of differing concerns, resulting in a framework that was both useful and likely to be used by diverse stakeholder groups. At the same time, they stressed that an essential aspect of the theory of change of the model was that it be owned and adapted by NHS practitioners. As such it was still in development and would remain so for some time: to remain effective and relevant, it would need to continue to build on and learn from the experiences of its users and thus remain a 'live' resource undergoing constant improvement, adaptation and refinement.

" I think we all expect better convenience and better quality, and so as a nation I think our NHS is precious, but people are expecting more of it, and to be able to meet those needs, to be able to continue, so that the NHS continues to deliver the things it was set up to deliver in 1948, we have to do something, and that something means we have to improve the quality and cost of services that we provide."

Interviewee 5

3.3. Strengths, challenges, and overcoming the challenges

Key strengths of the NHS Change Model perceived by interview participants were the way its design and format sought to address the important concerns noted above. By bringing together essential sources of knowledge and tools for change, the NHS Change Model "gives us a fighting chance of delivering what we need to deliver" (Interviewee 2). Equally importantly, the asset-based approach of the model, and its attention to fostering commitment, were seen as qualities that might secure uptake:

"It starts from a very good place, and that's that it's asset-based, and that it's evidence based, and I think that gives it a real 'va-va-voom' if you like, because rigorous performance management cultures and target-driven cultures have made people think about the deficit that they have yet to sort out, i.e. you're only treating 80% of your people within 18 weeks, you've got 20% to sort out, how are you going to do it. The NHS Change Model doesn't start from that position, it starts from what's our shared purpose, what's the outcome we're looking to deliver, and what has worked very well before, and let's try and sort of look at that and say how did that work and start with that. I think the other thing about the NHS Change Model is, because of the hearts-and-minds starting point, it appeals to people's values."

Interviewee 5

The compatibility of the NHS Change Model with existing efforts at improvement and change management was seen as an important complement to this, helping to emphasise that the model was not a 'top-down' imposition designed to sweep away the 'bottom-up' work of frontline practitioners, but rather a helpful framework to be used pragmatically to enhance such efforts.

The alignment of extrinsic and intrinsic motivators, and the variety of rationales for change to which it draws attention, were seen as a powerful means of securing buy-in from a range of stakeholders and overcoming professional resistance:

" That is the ultimate strength of it, and I think the other thing is that it recognises that people react differently to change, so people who are rational, and respect rational arguments—like we've got to save some money so this has got to change—they might respond to that, whereas most doctors would just say no, forget it. Then there's the people who sort of have the sort of intrinsic, if you like, reasons for changing, so you would say to them, we must change because actually things could be a lot better for our patients and we're really not doing the best by them at the moment, and that's much more powerful argument for a doctor than we've got to save a bit of money so we need to change."

Interviewee 5

The combination of coherence and flexibility of the NHS Change Model was seen as a potentially crucial strength given some of the challenges in practice that it was likely to face. For example, one participant pointed out the importance of institutions and factors external to the NHS—for example, the way in which its fate is tied up with that of social care. A model that is solid in its evidence-based foundations, but whose appeal can be tailored to different audiences, may help in ensuring that it can be used profitably in informing system-wide change. Similarly, the ongoing development of the NHS Change Model, building on experiences of using it in practice, was seen as critical to making sure that appeal across stakeholder groups is maximised.

Efforts to refine the language of the NHS Change Model and address early misinterpretations were evident in the webinars. One participant commented, for example, that "it would have been good if we'd managed to articulate in the model the importance of patients and the public" (Interviewee 4). We noted that clear effort had gone into foregrounding the place of patients and the public in the model in several of the webinars we observed. Feedback about the challenges of reconciling and aligning the divergent components of the model gave rise to work to produce a 'polarity toolkit' that is currently in development. All in all, the NHS Change Model's status as a work in progress, and the product of the collective wisdom and experience of so many NHS practitioners, offers great opportunities to enhance its appeal and utility for all sorts of situations.

A potentially more challenging risk to the NHS Change Model is that of 'corruption'. Notwithstanding the intentions of its creators, a tool such as the NHS Change Model may be subject to managerialisation. In particular, it may be deployed in coercive, heavy-handed ways that stifle bottom-up innovation and enthusiasm, and risk undermining the emphasis on commitment over compliance.[6] Even if not incorporated into top-down managerial techniques, there is also the risk that the NHS Change Model could become viewed as a 'checklist' to be ticked rather than a heuristic tool that provides challenge and inspiration: if viewed in this way, its potential would be severely impeded:

"The other weakness is that it can be seen as a checklist. And I don't know quite, I think we're doing something to get over that, but I think there will always be some people who like checklists who will see this as a checklist: you know, I've ticked all of those boxes, I'm all right."

Interviewee 4

The ongoing package of support, dialogue and development accompanying the NHS Change Model was seen as a crucial source of strength in countering this risk. The real experiences of those using the model in practice could offer a vital resource, both in evidencing the value of the NHS Change Model to convince more sceptical stakeholders of its worth, and also to offer rich examples of how best to draw on the model and use it intelligently to inform change efforts.

"I think getting back to a quick early action review with key champions and key shapers of the thing. I think there is a danger of using the great and the good too much and not people with their sleeves rolled up enough because the breadth of expertise around this is much bigger than the core theme."

Interviewee 1

Continuing, then, to build the 'infrastructure' around the NHS Change Model—including supplementary information and know-how, and the social infrastructure of like-minded, mutually supporting professionals—was seen as crucial in ensuring that it is used optimally.

3.4   In sum: the NHS Change Model's theory of change

Briefly, based upon our analysis, the theory of change that underlies the NHS Change Model might be summarised as follows.

The NHS Change Model provides a framework for guiding and organising change in the NHS by bringing together evidence-based guidance and resources in a way that is accessible and comprehensible to NHS staff, and which explicitly addresses the need for alignment between the diverse components of change. It posits that previous efforts at generating lasting, large-scale change in the NHS have been hampered by a number of problems: failure to take a multifaceted approach that involves achieving change through multiple mechanisms; failure to address sufficiently the tensions between these mechanisms, and to turn these into synergistic polarities; an overall approach to change that is managerialised and compliance-oriented, and which thus has failed to make the most of the 'shared purpose' that unites NHS stakeholders. It also posits that an underutilised resource in instigating change is the experience, expertise and peer support of NHS managers and professionals themselves—as well as their common shared purpose—and that this is also vital to the generation of a framework that is effective, user-friendly and credible.

It seeks to build on this learning by: (i) providing an integrative framework, comprising eight components, that summarises in an easily accessible format the 'ingredients' needed for successful change, addresses the need to align these and overcome the tensions between them, and which provides access to further evidence-based resources that offer assistance in putting these into practice; (ii) offering a programme of support to practitioners that provides further assistance from experts and peers on the NHS Change Model and applying it effectively, and which responds to the ideas and needs identified by the model's users; (iii) relying for uptake and spread not on a top-down process which is likely to generate compliance without, necessarily, sincere and enthusiastic use of the NHS Change Model, but on 'horizontal' spread among peers in the NHS which facilitates support and knowledge sharing, pragmatic and creative adaptation to particular circumstances, and ownership of the model among its users.

4. Reflections from Phase One

Our analysis suggests a few overarching challenges for maintaining the current momentum behind the NHS Change Model, and securing the role of the model in improvement.

1. **Reaching beyond the proselytes.** The attendance and enthusiasm of those participating in webinars and Twitter clubs is impressive, and interviewees commented upon how quickly interest in the NHS Change Model has spread. What is not yet clear, however, is how readily this enthusiasm will spread beyond these early adopters: is this the start of the 'S curve', or something which will only ever appeal to eager enthusiasts? Some participants noted that some of the language of the NHS Change Model, despite best efforts, continues to alienate those who are not 'tuned into' improvement and change; the 'social movement' approach to spreading the NHS Change Model, while avoiding managerialisation and compliance-oriented uptake, may risk reinforcing the perception that this is a model for a certain, change-oriented, social media-savvy cadre of NHS staff, and not for others. Consolidating the place of the NHS Change Model in mainstream NHS change efforts, and appealing to the more conservative sections of the NHS community, may require complementary approaches.

2. **Resisting (the perception of) managerialisation—but taking advantage of alignment opportunities.** Participants were clearly conscious of the narrow channel between relying solely on 'horizontal' spread through enthusiastic adopters on the one hand, and relying on top-down imposition on the other. As noted above, both strategies have their vulnerabilities. The adoption of the NHS Change Model by NHS England thus presents a double-edged sword. Those sponsoring it are clearly aware of this ("This is not a Stalinist 'we must use this'—but it will underpin the commissioning system. If we just seek compliance, we won't get the outcomes"—NHS Commissioning Board workshop on the NHS Change Model). While managerial imposition is unlikely to give rise to the kind of nuanced engagement with the NHS Change Model that is central to its theory of change, there is evidence that a 'mixed economy' of intrinsic and extrinsic incentives can be an effective influence on change if used with care—and of course, the model itself highlights this. What this perhaps calls for is a 'meta-alignment' exercise, with a view to identifying how best to take advantage of the promotion of the NHS Change Model by NHS bodies that enjoy managerial authority: how they can use this positional power to raise the profile of the model without distorting its purpose; how to inspire uptake of the model without compelling.

3. **Striking the right balance between creativity and fidelity.** Novel application of the NHS Change Model by creative professionals in different parts of the NHS is a central component of the theory of change. This is a strength that will ensure uptake, ownership, effectiveness and embedding. Avoiding dictatorial imposition is essential. But the NHS Change Model is also an evidence-based approach, and indeed the evidence underpinning it is important both to its appeal and to its potential effectiveness as a tool for change. How, then, to encourage ownership and creativity while also ensuring fidelity to the fundamental, evidence-based tenets of the model? Reliance on horizontal spread through the social ties of adopters poses a particular threat here, as descriptions of components can quickly change as they are disseminated, and there is a thin line between adaptation and distortion. Equally, however, the NHS Change Model itself recognises that inspired adaptations of the model to tailor it to contexts, scenarios and relationships that they know best is a vital resource that should be harnessed, not sidelined. In this light, continuing to draw on the powerful opportunities for feedback, dialogue and direction that are afforded by social media would seem to be an important way of 'anchoring' the model in evidence-based bedrock without unnecessarily impeding professionals' use of it, and also enhancing the model itself by building on the learning of users in various contexts.

4. Overcoming scepticism and cynicism. Several interviewees noted that although founded on evidence-based tools, the evidence base for the NHS Change Model as a whole is inevitably weak so far - a clear disadvantage in an environment that values evidence of efficacy so highly. Though it is unlikely to be possible to offer gold-standard, experimentally derived evidence for its value, it is expected that increasing adoption of the NHS Change Model will start a positive feedback loop, generating more evidence which prompts more adoption. Clearly maintaining momentum and gathering a repository of evidence of various kinds about how the NHS Change Model can be utilised will be important during this period. Perhaps a bigger challenge than this kind of healthy scepticism, however, is overcoming the cynicism of those who view the model as another managerial fad, to be paid lip service or treated with contempt until it goes away. A risk here is that rather than overcoming it, the work to spread the word about the model 'horizontally' works to entrench the division between 'proselytes' and 'non-believers'. The social media campaign might be seen less as a 'social movement' and more as evidence of irrelevance.

5. Articulating the difference made by commitment-driven adoption. Interviewees and documents were adamant that for the NHS Change Model to work in practice, engagement with it needs to be driven by commitment, rather than by compliance with external expectations. This is clearly important if the NHS Change Model is to gain traction in an NHS with so many competing top-down demands. What is perhaps not so clear so far—though may well become more evident as learning is gathered from its use in practice—is the difference that a commitment-based approach makes to the ability of the model to guide change. Put simply, how does a commitment-driven use of the NHS Change Model look different to a compliance-driven use of the NHS Change Model? Is commitment only important in helping users to see the worth of the model in the first place, or does it inform how they engage with it post-adoption?

6. Addressing the tensions in the 'shared purpose'. While the values-driven approach to change that the NHS Change Model embraces has much to commend it, it is inevitable that in times of resource constraint, there will be real conflict between well-meaning stakeholders acting in good faith about difficult decisions. Interviewees, and NHS Change Model-related documents, were optimistic about the potential of the commitment to 'shared purpose' to mediate in such disputes by providing common ground on which all can agree:

"It's fairly obvious in 'shared purpose', but say in 'engagement to mobilise', some of the people that we want to do things differently are actually patients. So if we need to make big change, reconfiguration of hospital services for instance, which might mean closure of wards, then ideally we need patients to be understanding why that change is happening and supporting it, rather than being on the street outside with placards saying how awful it is, given that mostly, most of the closures that have happened so far have actually been to do with improving safety, we clearly haven't been getting our conversation right with patients."

Interviewee 4

Yet this perhaps underestimates the degree to which even 'rational' decisions based on service quality and safety are political, and can become politicised: service rationalisation intended to improve safety and allocate resources optimally will almost always create losers as well as winners. The risk here is that 'shared purpose' becomes a motif that those in favour of a particular change deploy to seek to neutralise opposition, by characterising it as misguided or constituting vested interest. Used this way, the currency of 'shared purpose' could very quickly become devalued (and the NHS Change Model itself could begin to be seen as a political tool deployed to facilitate the imposition of controversial changes). A more challenging—but ultimately potentially much more profitable—way of harnessing the strength of 'shared purpose' may be to see it as a starting point to inform debates about how the change options ahead might be selected: an approach which recognises legitimate differences but provides a framework for reconciling them.

5. Findings from Phase Two

5.1   Appeal and application

The views on the NHS Change Model of the participants in Phase 2 of the study were, overall, very favourable. Their early experiences of using it in their change efforts had been largely positive, and it is worth noting that every participant, when asked, stated that they would recommend the NHS Change Model to others as a useful tool.

Participants identified a number of reasons why they found the NHS Change Model appealing. Many suggested that it was not a particularly novel way of approaching change, but saw this in positive terms: rather than 'reinventing the wheel', it was something that brought together a range of existing tools in a single, accessible place. As such, it provided an evidence-based resource that pooled otherwise dispersed knowledge about instigating and managing change, and helped to ensure that change efforts addressed the full range of dimensions needed for success:

"It's a methodology to follow isn't it, that gives us some concrete evidence of change using proven methods rather than random methods. So that's why I liked it, I liked the structure of it. And the simplicity of it."

(020)

"There is only so many ways you can change something, it's just trying to, for me it's—the real benefit is coming up with a quite easy to understand set of tools."

(017)

"I don't think the NHS Change Model is rocket science or something brand new but what it does do is bring together the components of how you make change into a very simple structure, even just the visual structure. It makes you think about the component parts of it. It is not enough just to have a shared vision. You also have to have the leadership and the engagement to mobilise and the system drivers or you at least have to question yourself about whether they are there."

(028)

"I think certainly they [colleagues] see it as not being something brand new that they have got to try and learn, and they do feel that because it has some degree of structure although it is not a cycle that you must do this before this, before this, it is a framework of reminding you what you need to be looking at

(023)

In bringing a complement of evidence-based resources together in this manner, the NHS Change Model was seen as having a very practical orientation that participants valued. The articulation of different aspects of change, and the links to specific tools, meant that it was seen as something that gave clear guidance on what to consider, and pointers on what to do. Rather than simply outlining areas for consideration, it was seen as offering clear direction on the need for action:

"Lots of these models don't—you have this theory and that theory and are often named after someone who invented them which is all very nice but the NHS Change Model says what it is. […] Things like the Leadership Framework and the Quality Framework and I suppose those things are all quite good but they are quite—what is the word? I want to say inactive but that is not quite the word I mean, but they are not very—I suppose the NHS Change Model is more proactive in terms of what it is trying to get people to do in a way that frameworks don't somehow. […]It is very much the language, leadership for change, for example, is one of the six or seven parts of the shared purpose. If you take leadership for change, it is just that language, for example, if you were using that heading within a framework, it would probably be something like strong leadership."

(011)

"It's based in things that we've learned and it's based in a people reality rather than methodology reality. […] I've worked with NHS Change Models which try to cover all the bases but are quite simplified for the benefit of the teams that you are trying to engage with. So it doesn't come across as an onerous task, as a process it's quite straightforward to manage, you know it's quite linear. You know we're here, we need to get there. These are the stages we'll go through, these are the workshops we're going to have, these are the actions we're going to take. Whereas that hasn't worked very well I think and this feels a bit more complete."

(008)

"It's very holistic and rich in the way that it's designed, so it enables us to look back at a high level and ensure that we've really met the key parts of effective project management and large scale change. And I think before, we perhaps focused on you know the more traditional project planning approaches, but not necessarily on spread of innovation, or system drivers or leadership for change. So we've become very process led if you like. So the NHS Change Model has been very helpful with that."

(009)

In bringing together evidence founded in multiple theories of organisational change, and in articulating the connections, interactions and interdependencies between these, the NHS Change Model was seen to offer a clear manifesto that set out the active work required, along with links to detailed guidance on how to undertake that work.

Above all, participants tended to agree, the NHS Change Model had a face validity to it: a combination of strong foundation in evidence and clear applicability. As one participant (006) put it, the NHS Change Model did not make an especially striking first impression:

"It was more, 'Oh yeah, that makes sense', than necessarily something new, because I don't think there was anything particularly new in it—which is actually a good thing, because I'm not interested in novelty value, I'm interested in something that's useful and is going to help us."

This, it was agreed, meant that it was more likely to be acceptable to sceptical or change-fatigued managers and clinicians than something that looked unnecessarily novel or faddish. It also meant that the NHS Change Model could potentially be used to supplement, enhance or organise efforts that were already underway:

"We thought this would be a really good idea to [bring] all our history together, you know, not start afresh, really treat the model as an umbrella model, you know, we're not getting rid of things that we've done in the past, we're not throwing the baby out with the bath water, we're actually going to use the model to build on some of the change that we are making within the organisation."

(003)

This view of the NHS Change Model as a holistic, readily applicable approach that incorporated lessons from a wide range of existing approaches was reflected in the uses to which participants were seeking to put it. Though some acknowledged that they were in the very early stages of trying to put the NHS Change Model into practice, the applications that many described were typically ambitious and multifaceted, involving co-ordination and shifts across organisational and professional boundaries, and often in the context of pressing needs for cost savings.

"Because this is a sort of a multi-partnership project, so not just involving NHS ways of working, it involves a range of different providers and commissioners. But I think we all recognise that the tools [and] methodology within the NHS Change Model resonated across different sectors, even though it was about the NHS. Quite often you know we go straight to delivery rather than actually thinking about leadership, vision, what sort of methodology we want to use, how we are going to measure it, and we don't necessarily develop a project thinking about all the aspects that will make it work. We move quite often straight into implementation and then when we falter we don't recognise that it's because some of the things may not be in place. And so I think for us, it's about, 'Actually let's use a process where we are considering all aspects but also that we can actually measure where things have not been as successful as they could be'."

(014)

"What we are trying to do is over the coming year, and we have already started to work on it, is look at the whole of the urgent care pathway for [this area], [and] provider relationships across the health economy. We have got one-to-one relationships with mental health, community, acute etc., which is quite advantageous really for making shape changes to how we deliver services. I think that really lends itself to making some kind of large step changes and that's really what we are going to focus on."

(017)

"Generally these types of things always seem really useful... and it's one of those things where actually, sometimes you have got a problem and you are not, first of all you are not even sure sometimes how to define that problem. So I think I was hoping that the tool could help with that, but also in terms of suggesting some processes and techniques. […] We know we have got some issues, so for example we have got some issues around delayed transfers of care. We know that our unscheduled admission rate is increasing. We know that has a bit to do with demographic rise. But what we don't really understand as a system is how changes in one part of the system have a knock-on effect on the other. And also we don't really have a way of anticipating what those changes are going to be, so there is something about the system and the leadership within the system not working together, and it being such a complicated system that change and simultaneous change can be introduced without any knowledge of the consequences."

(018)

The NHS Change Model was seen as having potential—albeit as yet unproven—in addressing complex, systemic, 'wicked' problems which defy easy responses and require co-ordinated, multifaceted responses,[7] in a way that accounted for potential unintended consequences, engaged stakeholders and secured sustainable change.

"I think it is completely relevant to what we are trying to do and similar things where you are trying to make a transformational change: a project that is focused on trying to change hearts and minds and trying to change the way that staff work and really needing to engage a lot of different people, all who have something to do with this. And change will fail if you haven't got people behind it so I think that kind of big-scale change programme is probably where it is best used."

(002)

"The model helped [colleague] get an understanding that these were some of the areas that we need to be thinking about, because far too often we only think of one or two of those areas on that NHS Change Model, and not looking at the system drivers coming in to push the change and we just think of rigorous delivery and transparent measurement, you know, we don't always look at all the other areas. But the Model really helped."

(003)

Consequently there were high hopes for the way in which the NHS Change Model would guide change efforts. Failures of the past were attributed to insufficient attention to the breadth of considerations required in change efforts; correspondingly, the expectation was that in accounting for all the dimensions of change included in the Model's eight components, current work would have a greater chance of achieving a lasting impact for the better of the NHS:

"[The] NHS Change Model was really around helping us understand what we needed to do to be successful and recognise that we needed to look at our project from a number of different angles to make sure (a) it would be successful, but also that it was a sustainable way to manage patient care in the future."

(014)

Beyond its application to specific projects, several participants also described how they were seeking to use the NHS Change Model to inform their thinking in a more thoroughgoing way. It was seen as something that could inform ongoing efforts in an NHS that was facing changes on multiple fronts, to ensure that these were addressed as effectively as possible—and in a way that remained faithful to its core purpose.

"We have structured the papers using the NHS Change Model, so trying to embed it in the way we work, we've sort of used it as almost like a template, but we've made sure that the way in which we present things to the programme board is really within that NHS Change Model."

(007)

"Things like the risk register, for example, so we have an extra column on the risk register to say, 'What is the impact of this risk against the shared purpose?' […] So [to] hold a mirror up to the organisation and say, 'What's going on here then, and how do we feel we fit into this alignment grid?' And I guess that would be a longer term things around, 'OK, so what would we look to improve going forward?'"

(008)

Participants felt that the NHS Change Model was something that could help to facilitate the kind of cultural change that was ultimately seen as crucial in underpinning and sustaining specific changes in the way the NHS does its business needed to secure the future of the service.

"The NHS Change Model role is really a framework for me to think about how I could get that change in culture embedded. So making sure I do think about how I engage people with this. How do I spread it? How do I measure the effectiveness of it, because one of the bonus points of that is not just driving up the care but driving up morale which also drives up patient experience because cared-for nurses are able to be more compassionate [than] others."

(001)

"In a nutshell I want to change the culture of the current service offer in the community setting, and therefore change the service offer to meet the population need, rather than the individual organisation's needs."

(020)

Participants' use of the NHS Change Model to help them face daunting challenges was encouraging, and there was a sense across interviews that they saw in the NHS Change Model the potential to facilitate lasting change. It may not include much of great novelty, but it did bring things together in a way that could make change efforts more comprehensive, more sensitive, more impactful, in a way that evidence suggests is likely to be important.[3] At times, there was a sense from some participants that these were outcomes that would be achieved through adoption of the NHS Change Model in itself: that effective change would follow in a relatively straightforward manner from use of the NHS Change Model, fidelity to its eight components, and application of the tools included. This was the risk, as participant 010 put it, that "the nuance and the complexity of theory in these conceptual frameworks tends to get reduced to meaningless simplicity," or in participant 013's words, that "people make the Model more important than the work they are trying to do." Undoubtedly, experienced change leaders in the NHS would not be so naïve as to suppose that a framework, tool or model in itself represents anything more than the first step on a long path to change, but just occasionally, the sense was that change would be a direct and logical consequence of applying the NHS Change Model. In marketing the NHS Change Model to practitioners, it will be important to stress that while it may offer a promising recipe, it is the hard work and skill of the chefs that determine the quality of the pudding. It may even be that the title of the recipe itself needs changing. As we discuss in more detail shortly, many accounts suggested that the NHS Change Model was best understood as a framework that was useful in problem definition and directing attention towards the areas to be considered in solution formulation, rather than a model of change as more formally understood.

5.2   Mediating the Model

Interesting evidence of how participants used the model in practice emerged from our interviews. Its value seemed to lie in informing and guiding background thinking and structuring of activity, rather than taking the foreground as an explicit model of change held in common by all concerned parties. The normal pattern among interviewees was to use the NHS Change Model either as individuals or in a small team, such as a steering group, rather than presenting it to all stakeholders as a framework or model for the change task in hand. Typically, participants described a process whereby they used the Model to identify the dimensions of change that they needed to address and to form an idea about how to address them, and then sought to delegate particular tasks to other individuals in appropriate roles and positions. They would perhaps point these individuals in the direction of resources that could be of assistance, but rarely sought explicitly to introduce them to the NHS Change Model itself.

"What people use it for more is a reminder, so I'm leading, say I'm one of the programme managers, they're thinking, 'Well I'm working on the urology project, these are the elements, have I considered all these elements at the outset, did I help the clinical lead of this programme think through who their leads were in the organisations they were going to link with, and what it is we're trying to do and how we might make a difference?' [...] Whether it's a project manager or a programme manager, they're really key in helping clinicians to think through some of these elements, without saying, 'And here's a framework you must follow', because that would turn them off. Having a conversation about, 'Well have you thought about who the leads might be that you need, we could work with and have we got a primary care lead and acute lead, is that the type of leadership arrangement we need?' It's a trigger of the manager to work the clinician for change and collaboration."

(021)

Participants gave a number of reasons for taking this approach. Firstly, they felt that the notion of the NHS Change Model, and the language and tools it contained, risked alienating some stakeholder groups, especially clinicians. They therefore undertook an active process of mediation where they sought to 'translate' the domains of the NHS Change Model into language that they saw as being more 'clinician-friendly', making sure in the process that they did not overwhelm such groups by presenting the entire Model to them wholesale.

"To be honest we have not really got to the point of presenting the NHS Change Model to them in that format but more about sharing tools or sharing ways of working. I have not put the clinical leads in front of it and said this is the NHS Change Model and this is what you need to do because I don't think that would necessarily be a valuable exercise or necessarily help because of the sort of potential for management speak versus clinical speak and what does this actually mean we have to do."

(002)

Accordingly, participants tended to describe how they used the NHS Change Model to frame dialogue with others, ensuring appropriate inputs from various stakeholder groups, but with management of and responsibility for change remaining with the same core group. They might use the NHS Change Model more or less explicitly in facilitating these discussions, but they were clear that they did not adhere to it closely, raise all aspects, or use its language with all stakeholder groups. The aesthetics of the NHS Change Model were important here: its potential to be alienating rather than engaging was evident to participants, and they saw themselves as mediating between different cultures.

"We don't, we talked almost about the components actually and our shared purpose and improvement methodology, but even watering those terms down slightly because frontline clinicians you know, with all the best intentions probably don't understand, or some have trouble in understanding what a system driver is, or what engagement to mobilise means. So we help to translate that to people and then we listen to what they have to say and then use that information to help build our plans or our structures or our processes around that."

(009)

"I have seen it used by other people very mechanistically starting at the top and working round; that is not the way we use it. We work with the team who have got an issue. […] And we wouldn't say to them, 'We are going to use the NHS Change Model', in the same way we wouldn't say to them, 'We are going to bring some transactional analysis model into this piece'. We wouldn't tell them that, but we would have it with us and at an appropriate point now when they were trying to think about the change process, we would again get it out and say, 'Do you think this would help, shall we spend half an hour going round?' and we usually ask the question, 'Which bit interests you?'. […] [What] change leaders need to do is they have to be able to translate. If somebody reacts to any particular element of that Model, we wouldn't slavishly stick to the use of the language, we would say to them, 'Well how would you describe that?' and then we would in that session and in our work with them we would, you know we might even scribble out on the Model and put their words in there."

(013)

Second, participants often saw effective application of the NHS Change Model as resting on mobilising the specialist skills of different groups of colleagues. In engaging with those with expertise in measurement, for example, participants did not feel the need to refer to the entire NHS Change Model, but instead engaged with them on the specifics of the measurement challenge, having used the NHS Change Model to frame their own thinking about how this linked to the other components.

"We've been dealing with the NHS Change Model in two parts. In terms of our internal commissioning team it's been quite useful just to help people understand what they need to consider and how are tools that we started to develop actually fit within the model has been useful. […] We haven't been using it in the workshops or the clinicians, because what we thought that it may turn them off a little bit, if you see what I mean. […] I think there's probably subdivisions in how much you actually get the clinicians to understand it."

(019)

Third, and connectedly, this approach reflected an understanding of the NHS Change Model less as a 'model' per se—a highly specified methodology with a clear protocol that needed to be followed exactly—and more as a guiding framework to sensitise and inform. Several participants explicitly stated that they saw the Model not as a model at all, but as a framework or guide. This was mirrored in the way that many participants described their personal use of the Model in practice: as a heuristic set of reminders, prompts and checks that could ensure that they were undertaking change in a way that was as likely as possible to achieve the desired ends:

"Rather than a model I would describe it as more of a framework on which there are change tools that you can use, depending on I suppose the circumstance and the organisational structure as well."

(017)

"I call it a framework actually. That seems to go down well, that it is a framework. It's a reminder that if you're going to move forward in an initiative there are elements that you have to work on as a whole to achieve your ambition and that you have to work at the shared purpose. […] I would recommend it as a framework to ensure that at the outset of delivering across organisational change programme, you had refreshed and reminded yourself that you'd considered all components."

(021)

"The NHS Change Model is a framework into which you can put your own different models or your own way of thinking, and it's a way to think about them, so it seemed quite a broad church and open way of thinking about it. So it was an inclusive thing, so you weren't trying to force something different onto people, but you were going, 'Look, this framework might just help you think about it and break down a situation or an issue into a number of elements as to how you're addressing it'."

(005)

"I don't go methodically through and think I have got to have an action task for each one, but I just probably scan it and remind myself what I think is important in this or where the potential issues are, and certainly with CQUINs I think it's getting engaging and mobilising. A lot of them have to be delivered by clinical staff, the ones I am involved in at the moment and it's getting the message across. […] It's just been helping me with my thought processes, rather than sitting down with a pencil and paper and going I have now got 15 minutes to write a plan."

(005)

In many ways this might be considered encouraging. The NHS Change Model was being used by some at least to sensitise, to broaden thinking, to inform. The risk that the NHS Change Model might be conceived of as a solution in itself, whose effectiveness lay simply in its application—rather than as a set of considerations, tools and ideas that could assist change leaders—was recognised. However, such relatively individualised use of the NHS Change Model also meant that knowledge of the approach remained highly concentrated, and thus easily lost as individuals change roles and organisations. It also placed a heavy burden on the skills and efforts of the small teams applying the NHS Change Model. Use of the Model as a heuristic could result in an application that was not quite faithful to its theory of change, especially if by an individual rather than a multidisciplinary team. A key part of the NHS Change Model's programme theory is that it involves use of all of the components in a way that attends to their alignment and polarities—and, as we discuss next, the extent to which this aspect of the theory was being adhered to in practice seemed to vary.

5.3   Applying the full NHS Change Model and attending to alignments

Participants differed in the extent to which they said they were seeking to use all aspects of the NHS Change Model. Some were able to talk at considerable length about how they had used each component, how one component fed into another, and how they had managed the tensions between them.

"At that moment in time for the programme, those components were most significant but [colleague] has also fed back that it has been a great opportunity to look holistically as well, whereas she might have focused on two or three of those aspects and been quite myopic about it. But actually stepping back and looking at all eight components and [she] did a really good stop check to make sure she was on track with all of those eight components. […] I think that as you look at the Model, they look discrete, they look like eight components with very clear boundaries between them and that is the way the Model is drawn and the image that you look at. Actually what I am finding in application is that the interface and boundaries between those components are very blurred, and that is not to dilute any of the components, it is just the relationship between them."

(016)

"I've had a look and with the transparent measure, for example, we are starting to look at different things within that, but we've only just started looking at that, so I probably wouldn't be able to give you that much information but it's one area we're starting to look at. The system drivers, we've looked at that. […] And we've said about engagement. Then spread of innovation, we're starting to go to conferences in different areas to discuss what we're doing and how we're doing it and why we're doing it. Leadership for change, we've started going on courses to enable us to look at ways that we bring in change, so there's two that I'm booked on anyway at the moment and how you lead staff through change and what that means and how you do it, et cetera. So there's that. And then the rigorous delivery we're starting to look at a little bit as well. So again it's not down in definite way of talking about it, but it's definitely something we're starting to look at and how we deliver that service, how we're going to, the underlying systems and pathways that are going to be behind these teams and how we're going to deliver the care that we're talking about."

(026)

More often, participants acknowledged the importance of addressing all eight of the NHS Change Model's components, but reported that to date they had only used a small proportion of them because of the stage they were currently at in the change process.

"At the defined stage we wouldn't necessarily be talking about the spread of innovation. So we'd just use the components of the NHS Change Model or our tools in the components within the NHS Change Model at the most appropriate stage in the process. So for the spread of innovation we probably wouldn't be talking about until the innovation stage, which is further down the process, because our first stage is all about defining the problem, so it would use the other components. And then the measure would obviously be collecting data about what's going on so you may use another part of the NHS Change Model."

(019)

What was clear was that for most, the central component of 'shared purpose' was very useful as an underpinning principle of the NHS Change Model—both in providing an anchor for the rest of their work, and in helping them to engage and mobilise other parties, as discussed above. 'Shared purpose' was seen by participants as both a starting point and a theme to which they returned frequently as they progressed their change efforts.

"I think that particularly significant has been the our shared purpose component because I think it is something, and it was coming out of the review that we completed in [this area] as well, as much as we might like to think that we spend sufficient time and appropriate time reaching a consensus or at least a near consensus to what we are trying to achieve across multiple organisations or stakeholder groups, in fact the reality is that I don't think we often do spend enough time on that, and really cement that."

(016)

Some participants, however, were unsure as to whether they would ultimately be able to make sense of and use all of the components of the NHS Change Model. They had found value in some aspects, and could see the importance of a balanced approach to change in theory, but in practice could not always see the applicability of others to the particular challenge they were facing.

"I am struggling slightly with it. It all makes absolute sense and I think the concept of the different areas that all need to be addressed as part of a change is absolutely bang on, but in terms of the support tools within each area, it may just be that they seem like common sense and are the things that I would use anyway, but it is very difficult to navigate. […] We have an awareness that we need to concentrate on all of them, but I imagine that at the moment we are probably concentrating more on leadership for change and engagement to mobilise and I think some of them come at different stages in delivering change. It is very difficult to say. To be honest I have not really looked through the improvement methodology or got my head around the improvement methodology."

(002)

In practice, participants often therefore described a process whereby they used the NHS Change Model to help them to identify particular areas of concern, but did not necessarily embrace all its components. Some components were simply seen as more important, immediate and pressing than others, given the nature of the problem and the stage at which they found themselves in addressing it:

"My focus would not be on all parts of the NHS Change Model because you know as well as I do, organisations tend to have specific problems and specific issues and they will tend to focus on those so, for example again, the issue might be around engagement, 'My organisation is not working effectively because we are not engaging well enough', so I will want to focus probably on the engagement to mobilise aspect of the NHS Change Model—but not to say I would want to lose the rest of it, but I would certainly want to focus on that. As I say, I would want a NHS Change Model that would allow me to do that and to just maybe focus on that particular issue."

(011)

Similarly, there were mixed views on the extent to which the NHS Change Model was useful in facing and overcoming tensions between aspects of change, through an active process of alignment. Participants highlighted some clear confluences between domains of the NHS Change Model in interviews, and also talked in more general terms about potential tensions to manage, particularly between intrinsic and extrinsic motivators and 'softer' and 'harder' components of the Model.

"If you take improvement methodology and rigorous delivery, well they practically go hand in hand, if you have got a good improvement methodology underpinning what you are doing, then you are feeding your rigorous delivery. If you have got a good improvement methodology, you will be undertaking appropriate and transparent measurement and that will again give you a rigorous delivery so these things are self-reinforcing. […] I think that in terms of intrinsic and extrinsic motivators and how that plays out, I think we see how some of the things around the 'our shared purpose' sits very much in the intrinsic, values orientated, driver of change and that feeds naturally into the engagement to mobilise, the leadership for change where they are very interpersonal skills and very personal skills as well. They really touch us as human beings. I tend to think of the extrinsic factors as the more structural aspects of the model so thinking about the rigorous delivery, thinking about some of the measurement side of things that to me are quite structural. They are objective. They are the nuts and bolts of what makes this work but they won't work on their own."

(016)

However, in terms of addressing specific areas of potential dissonance between aspects of change, some participants found that although the NHS Change Model alerted them to these, it could not offer specific, actionable ways of dealing with them:

"I may have [aligned the elements of the NHS Change Model] without realising it. It would be interesting to go and read through my notes to see if I can identify that I have done it in other ways. I possibly have."

(001)

Interviewer: "How far has the model been useful in helpful in helping you to make sure that the different aspects of your work are aligned with each other and are complementary to each other?"

002: "I have not used it at all in that way yet."

Interviewer: "Is that something you are aware of? Because sometimes engagement to mobilise could be seen as conflicting to transparent measurement but actually but trying to work it so that they are both working towards a common outcome."

002: "No, I had not seen it like that. I know it is all about this shared purpose and so in theory all of those things add up to a shared purpose. I think I have struggled to see how you make every single one of those add up to your shared purpose."

Participants tended to find on the whole that the NHS Change Model was effective as a prompt to consider the full complement of considerations that needed to be addressed if change was to be achieved. But it did not in itself provide a means of translating these into a coherent, well aligned programme of action. Again, this is encouraging in that it suggests that the NHS Change Model is being applied in the spirit in which it was designed, rather than being seen as a 'magic wand' to be waved at a problem that will lead in a straightforward manner to the anticipated outcomes. On the other hand, some participants found it much more challenging than others to move from a set of principles to a programme of action that fully addresses those principles.

Because the NHS Change Model provides a framework and an approach rather than a fully formulated set of solutions, much rests on the capacity and judgement of leaders of change in making it successful. This means that it presents a flexible tool, open to the kinds of applications that are likely to make it work, but it also means that those aspects that are meant to be adhered to at all times—such as use of all eight components and active consideration of their alignment—may be neglected, especially if they are seen as too challenging or not relevant. While adherence to 'shared purpose' seemed an intuitively useful aspect of the NHS Change Model that many participants could account for in their work in practice, alignment and use of all components seemed more problematic.

5.4   Challenges of using the NHS Change Model in practice

Correspondingly, some of the biggest challenges identified by participants related to specific parts of the NHS Change Model. Four components of the Model in particular were picked out as being especially difficult to turn into practice. One related to the 'softer' side of change ('Engagement to mobilise'); the other three were about harder drivers ('System drivers', 'Spread of innovation', and 'Transparent measurement').

Interestingly, in the case of 'Engagement to mobilise' and 'Transparent measurement', a key challenge highlighted by participants was the way in which both of these tasks could throw into sharp relief the tensions of shared purpose. Both could reveal differences of opinion among different stakeholder groups about the essence of shared purpose, and how change that remained faithful to that purpose might be valued and measured:

"I suppose the one bit that worries me slightly is where it says transparent measurement. Because anything that talks about measurement is going to get complicated and it is going to get difficult and is going to get contentious because again, we have got lots and lots of NHS Change Models but we have also got lots and lots of different measurements as well within the NHS. So I think anything along those lines is going to be difficult and contentious."

(011)

"When you are talking about something that is about patient experience and value based, it is sometimes hard to talk about what are we going to measure, what does good look like. [For example] the Six Cs to measure patient experience— because if it is good feedback, what made it good so that we can start to think about transparent measurements because then we can start sharing that with each other."

(001)

"I think probably it's just yet another thing the NHS want us to try and implement, and for what purpose, and who gets what out of this by having this framework, who gets the glory if you like. I think there is always some element of suspicion when something comes from a national directive."

(023)

"I think that audiences are more used to stakeholder management or stakeholder engagement rather than engagement to mobilise but engagement to mobilise is very particular in that it is not just trying to engage people but it is engaging people to take action and it is about that proactiveness and that action orientated nature of it so that again takes some interpretation."

(016)

More generally, finding a way of measuring change transparently and effectively was something that several participants accepted would be a challenge, since it was an aspect of change with which they were less familiar:

"It's been hard to think about how we're going to measure things."

(007)

Similarly, 'Spread of innovation' represented for several participants a fresh challenge which many of them felt relatively poorly equipped to address. It was also one which many participants, in the relatively early phases of their work, felt premature to consider in much detail, or which had been pushed down the list of priorities by more pressing concerns:

"The other thing is around spread of innovation. Because one of the things that we are quite keen to do is to capture lessons learnt as we go along, because it's quite difficult to remember what went wrong, because you have just got over that, but clearly important maybe if we want to expand this model say to children, or to the mental health side, and so actually really being rigorous around capturing those lessons learnt. […] I keep having to remind myself that actually, it is as much about other people learning from our learning and where we are at as about what they can bring to the stage we are at. And I suppose traditionally when you think of sharing your work you think it's got to be 100% really good, fantastic before you show anyone, when really this model says, 'Actually let's learn together as we go forward'."

(014)

"Obviously spreading innovation because we haven't actually got to that point yet, so I think there are some bits of it that we would pick up as time goes on as we start to look at the project and move it forward."

(023)

Participants identified what they saw as more fundamental problems with 'System drivers'. While in some cases, a great deal of work had been done to align change efforts with the priorities, strategic objectives and incentives that existed in the system, several participants struggled to make such connections. National priorities were seen as too fixed to be readily aligned with some of the change efforts being undertaken, while local levers were not always easily accessible, or sufficiently powerful to orient organisations and individuals towards the change desired:

"The system drivers one we find more challenging. I don't know, maybe because it's harder to influence and get very much—you can do it within your own team perhaps, but particularly when we start thinking about some of those system drivers potentially being technology driven, it's very hard to kind of influence that really, because it's so vast."

(006)

"I think some of the systems drivers around the contract leaders and how we use the systems levers to bring about change, I think have been a bit clunky for me. In just trying to—like contract levers like CQUIN. So CQUIN is payment for quality and I'm not sure that we've been able to match what we are trying to do with some of those contract incentives. And I think that's not helped me as much as I would have hoped it would."

(020)

"There are some areas of this where the context I am working in is either non-existent or needs to be grown in some way. […] There are people trying to grow those levers but the system drivers aren't there in terms of ones that I have no control over, so I guess for something like that it is difficult to use if there isn't a context to work within."

(012)

"The things like with the system drivers, you know, we'd put things into place but I think it's difficult for us because, at the end of the day, we're only the clinical leads, so we don't have that much clout, I suppose, in the realistically looking at things that, you know, incentives that you can offer."

(026)

While recognising the need to be cognisant of system drivers, participants found that the range of actions at their disposal to influence these, or even to align their own work with existing drivers, was limited. A related major challenge identified by several participants in using the NHS Change Model in practice was the organisational environment of the NHS. A hierarchical culture in general, and the specific financial and organisational challenges facing the service at the current time, resulted in difficulty in using the NHS Change Model faithfully to its full potential. While the major challenges facing the NHS meant for many participants that it was needed now more than ever, the urgency of resolving these challenges—and the ingrained way of dealing with change within the NHS—meant that now was probably also the hardest time to put it into practice, too:

"Often there's a lot of pressure to get work done immediately or quickly, and sometimes that's in direct conflict with doing things the right way."

(009)

"[Colleagues] might be willing to express leadership, motivated to change and understand the values, but they would hit a brick wall because of some of the practitioners around them and it was almost them saying to us, 'What are you going to do to help us? We are about to go out into this world and we know it is slightly dysfunctional in places but it is going to be tough'. So we have got to think about that."

(010)

"The health service at the moment, when people are losing jobs and the sickness level is so high and the demand for services is so high and there's so much change, it's not always the best [environment] to introduce these things because people just feel, they're too busy. […] Quite often, people look for quick answers within a model and they're not going to be there. As I say, you need to take this Model and work with it, facilitate, when you say the word facilitation, it means to make easy and I think that needs to be spelled out, that the NHS Change Model is a facilitation tool which is designed to make the change easier. And I think people might be looking at the NHS Change Model and saying, 'Come on then, give me some answers really, really quick so I can then move on and get onto something else', and that's not going to be the approach."

(003)

A particular challenge that resulted from such a context was keeping the extrinsic and intrinsic elements of the NHS Change Model in balance. As one participant vividly described, when the extrinsic motivators were so forceful and weighed so heavily on colleagues' minds, finding a space for mobilising for change through intrinsic motivators could prove difficult:

"The tension comes when we look at the system drivers when we look at the contracts that we're involved in. So you know things like we'll serve notice on the contract. Or if you don't up your game you'll be in the private sector and [an outside company] will take over. And I've had to protect the engagement bit from that. […] So the last thing I want is them to be thinking they've got this big axe hanging over them that unless they change the axe will change and the contract will go out for tender. Because that's distracting. […] I wouldn't want the system drivers to be involved in the engagement process, I've kept that away from it."

(020)

"One of the big things that us and a lot of people face is when times get tough, it's like, 'Show me the money', and that's the biggest challenge to a lot of improvement activity like ours, because we know that we are saving time, but then, you could say, 'Oh well we've saved this much time and these people are paid this much an hour, so that equates to that, if we rolled it out across all teams it would be that'. But of course you then say, 'But what are you going to do with the time that you've saved? Are you going to reduce staffing levels or are you going to increase workload?' and those kind of things are harder to deal with."

(006)

As one participant (018) put it, "introducing a NHS Change Model is a change in itself which requires thought and time and resources. How do you change to having a NHS Change Model?" We consider in the next section some of the prospects for creating a more receptive organisational environment in which a sincere utilisation of the NHS Change Model might be possible.

The complex organisational environment also gave rise to significant challenges of how to lead concerted, co-ordinated action using the NHS Change Model. As noted above, in the main participants sought to use the Model as an explicit framework for co-ordinating change only with, at most, a small team; with wider stakeholders, they preferred to simplify the Model's language, and to speak only to those specific elements of the Model that affected each audience. Nevertheless, they recognised the importance of securing the engagement of wider groups if change was to be achieved, and spoke of the difficulties of doing this in an NHS which remained dominated by organisational, sectoral and professional boundaries:

"If you are in a cancer registry looking at HES data for Public Health England on transparent measurement, you are in a different world to somebody who is looking at whether an acute trust has got their financial balance right for the Monitor review. There are some things we are just going to have to be realistic about but I think we can do a little better than we have done to align these different levels of leadership at different points of leadership and different responsibilities for leadership. "

(012)

"We've got clinicians leading change, so for instance I talked about our clinical lead on urgent care. She would understand it because she knows she's got to drive the change. However if we're talking to a frontline clinician or whatever, they're not really interested if you see what I mean? They're just thinking about how to make improvements to the patient pathway, delivering better quality of clinical care etc. Rather than thinking about, have I thought about the spread of innovation?"

(019)

Moreover, this preferred way of using the NHS Change Model, with only a small team actively using it to frame activity and to ensure thoroughness and balance of approaches to change, brought with it particular challenges of co-ordination that weighed heavily on those teams:

"We didn't necessarily have named leads in all the statutory organisations, so the organisation as a whole was going to contribute to delivery of a particular programme, but we didn't have a specific lead that was going to take that lead role that we could engage with. And I think the biggest lesson has been a belief that change will not happen without programme facilitation, if you are collaborating across organisational boundaries, it won't just happen on its own, you have to have some sort of programme facilitation behind the scenes. So you've got management and clinical leadership hand in hand."

(019)

"I think in the way that I described earlier which is that whole system co-ordination so we need to have the Director of Nursing talking the same language as the Organisational Development Manager et cetera et cetera. It is as simple and as complicated as that really."

(011)

In adhering to a relatively concentrated approach to putting the NHS Change Model into practice, participants thus had to work hard to ensure that particular tasks were delegated to the right stakeholders beyond their core group, and also to ensure that these dispersed efforts were all contributing to the common goal and aligned with the NHS Change Model. Such an approach mitigated the risks of misplaced effort and unco-ordinated change that a more distributed way of using the NHS Change Model might have brought, but did mean a heavy burden for those core teams—and attendant vulnerabilities in the potential greater impact of personnel changes or reorganisation.

5.5 Overcoming the challenges through the strengths of the Change Model

Participants were, on the whole, not overly concerned about the challenges of using the NHS Change Model itself. Indeed, some of the difficulties they identified were not as much problems with the Model, as challenges of change that the Model had highlighted for them. Consequently, they welcomed the way in which the NHS Change Model drew their attention to the full range of areas of work needed to maximise the chance of success, broadening their thinking. In this way it acted, as described above, as a heuristic that helped them to ensure that they were proceeding on all necessary fronts rather than becoming 'tunnel-visioned' and focusing only on the easier areas of change, or the aspects of change that they already knew well, to the neglect of more challenging components such as 'Transparent measurement'.

"The good point is the information that's there, it covers quite a bit and I do recognise that it's an early model so, you know, changes will be done to it according to the results of it. But sometimes that can be its downfall as well because it's sifting through all that information, isn't it, and trying to put it into an order that you can use, because the problem is it's good that you can move around the circle and you can jump in and out of bits as and when you need them, as things come up and as things occur. But sometimes it's going back and thinking well where does this fit in, where does that. But I think that's just the nature of anything."

(026)

"Part of it is about getting as many people as possible to think about everything at the same time and part of it is about having different people thinking about different things at the same time. Within the project group and underneath our steering group, we have a finance and performance group so they will focus on the transparent measurement. We have a communication and engagement group so obviously they will think about engagement to mobilise. We have clinical groups that will think more about the spread of innovation and delivery so we do have a number of different groups that think about each of these things."

(002)

Participants also suggested a number of ways in which the presentation and content of the NHS Change Model itself might be improved. These included:

• Materials that might be used to introduce the NHS Change Model, and individual elements of the NHS Change Model, to colleagues:

"I think there just needs to be some preamble to it to say look, here's a model, it's designed to help you ensure that each of the areas of your change project is given sufficient [for use with] yourself or within the project team." **(003)**

• In-depth examples of successful use of the NHS Change Model in co-ordinating a change project, and how this was done. There was a sense from some that although they had benefitted from the programme of support (webinars etc.) that had been provided by the Institute, this had remained largely 'theoretical', and the case studies to date had not been offered in sufficient detail to provide clear learning.

"We need some more examples of where it's being used and how are people using it really, because I think the danger is it feels quite theory based still. And if I had one kind of 'Oh I wish this had gone better', it would be that the seminars were really useful and I think they were really valuable. [But] I think it's been hard to get beneath the surface of those." **(008)**

• More support on the practicalities of generating alignments between components of the NHS Change Model. Some found the existing 'alignment grid' very helpful, but others suggested that examination of the specific potential tensions between components would help to concretise challenges and solutions.

"The only thing to say is provide some more information about the alignment of the process and almost the softer skill element to it. Such as how we can actually produce a plan or a particular set of processes that use all of the components." **(009)**

- There was a sense from some that the simplicity and visual appeal of the NHS Change Model was quickly lost once users 'dug below the surface': for example, on the website, the clean and minimalist depiction of the Model was not matched by the way individual components were presented, with much text and links to other sources.

"As you go deeper into the model, it sort of loses it a little bit and I wonder whether that could be maintained a little bit more. [It becomes too] wordy, technical, academic." **(011)**

"Possibly by putting in bullet points of the summaries of the different sections so like the key elements of each of the sections. I think it just feels like there's a lot of text to read and sift through and I know you need to do that to get a real idea of how the whole thing gels together, but perhaps having bullet points of what are the pertinent points of each section might be helpful." **(025)**

More broadly, the key challenge participants identified for the NHS Change Model was in making the transition from the 'next big thing' into an established way of approaching change in the NHS: a common framework that would overcome scepticism and provide a common language across groups for leading change. Here, participants saw the adoption of the Model by NHS England as a promising step. However, as we discuss below, there are also potential risks in this approach.

Overcoming the challenges they identified in the organisational environment in which the NHS Change Model was being put to work was something that, as might be expected, participants were less optimistic about. As noted above, participants saw the current volatile NHS organisational context as one that needed a coherent NHS Change Model more than ever—but one in which introducing it would be as hard as ever, if not more so. Faithful application of the NHS Change Model required an environment that renounced managerialist 'quick fixes' and offered the time and space to use the NHS Change Model fully and sincerely. While few participants saw any prospect of this at the level of the whole NHS system in the near future, they did identify an important role for senior managers and clinicians within NHS organisations in mediating the pressures from the outside, modelling a commitment-oriented approach to change, and creating time and space for sincere application of the NHS Change Model in a way that ensures that change is in accordance with shared purpose and the underlying mission of the NHS:

"It's talking about people working together across boundaries and that bigger picture thinking and I think perhaps that's a bit daunting and I understand that, it is daunting. I think because it takes a lot of time to operate in that manner and it's a lot simpler to crack down with authority sometimes. […] It's a challenging message, isn't it? Because we know when we manage change at the moment we don't do it very well and we know that because we don't get the return that we expect to. We don't get the outcome we expect to and we don't change the organisation in the way that we're supposed to change it. So we know that what we're doing doesn't work, but yet the alternative which sounds right just looks like it's going to take much more effort and time and organisation, and do we have the money to do those kinds of thing when the decision making around what projects are we going to do usually takes place still without this kind of ethos behind it. So there's a challenge there about if someone was, if an organisation was to adopt the NHS Change Model, at least the NHS Change Model way of approaching change, it would need to have this support from the very top of the shop in order for people to legitimately operate in that manner underneath it."

(008)

"Well I think that it's actually buy-in from the leadership. It's all very well individuals within an organisation understanding it, but actually it has to become a cultural— you talk about intrinsic change as well, intrinsically the organisations need to buy into this way of working, otherwise it actually won't have the benefits, the full benefits that people are trying to deliver. So it's all very well middle managers or lower managers using it but then if the chair and chief exec, directors et cetera don't get it, then it probably won't really deliver what it's supposed to."

(017)

"[Managers need to give] permission to see that actually it's not just OK, it's normal, it's proper to have all of these things which are not counterproductive, but that pull in different directions and the aim is to sort of work out which you need when and for what and that it's OK to have them at the same time and to have them self-reinforcing."

(014)

This would, participants argued, imply a major shift in the approach to managing change and dealing with the challenges faced by the NHS on the part of many senior managers in the service:

"I think for people who are facilitating that and senior leadership in organisations, it's cracking open a conversation that actually a lot of organisations in my experience would prefer to keep a lid on. Because a lot of organisations want to pretend to be the staff that the world is fine, challenging but fine. I work with organisations who don't encourage their staff to challenge policy decisions. […] The top of the NHS probably believes it's doing the right thing but turns a blind eye to the operational realities of delivering things, kids the public that everything can be done. Everything can't be done; we need a national debate on what the NHS should provide."

(013)

Yet participants did give some examples of how, on a local scale and in particular circumstances, they had managed to use the NHS Change Model with senior managers to adopt an approach to change that they felt did adhere to the Model's core principles. This required patience, access to and commitment from those senior managers, and a great deal of effort in managing the tensions between the NHS Change Model's components and ensuring attention to each of them in seeking to lead change. In overcoming such challenges, participants highlighted how the NHS Change Model in general—and in particular the 'shared purpose' at its centre—had helped them to make the right connections with both senior managers and frontline staff, and reframe the need for change in a way that was more acceptable for all:

"We have had quite a few different people inputting into us and at one point that was getting traumatic because different people were asking us to do different things and that has stopped now or virtually, so we have now got a more defined structure so whether other people are finding they are getting lots of input from other areas. Do you see what I am saying? Just different agendas, so different people from different areas of work. So for example, my original line managers and their general managers have obviously got an interest in the project and wanted the project to take us in one direction and get certain information and then my project manager would be saying, 'No, I don't want you to do that, I want you to go and get that', and then the chaos of that made it quite difficult to keep on track. I think it has come back on track since we have the new project manager and we all talk about what our shared purpose is and what our ultimate goal is which is the same sort of thing as a shared purpose and we regularly talk about that. It is always talked about whenever we communicate."

(015)

Participants described how they had used 'shared purpose' to try to reconcile apparently entrenched differences of views among stakeholder groups. Where senior managers saw challenges in terms of financial pressures and frontline clinicians saw them in terms of risks to jobs, 'shared purpose' could offer a common ground on which less polarised conversations could take place, reframing discussions instead in terms of how to deliver the best possible service to patients:

"There is system blockages and system changes that they can ultimately resolve by using some of these improvement tools, and actually that also helps them engage with the change process because they may think it's about job losses or changes to the way in which services are provided, but ultimately it's about improving the way in which we all work, in terms of the way we can maybe look at where wastage happens, and where we have got systems that aren't necessarily required but cause a step in a process which staff have to deal with."

(014)

"It's a good platform for developing common understanding. [...] The extrinsic ones I think are where we tend to get more resistance from the front line, but more, more demands from senior managers, the extrinsic stuff tends to be more standard project management approach, so that's what their natural expectation is. [...] What we're actually doing is we're working on quality, we're working on efficiency, we're working on the patient experience, and we're working on staff wellbeing. You can make measurements say anything you want to make them say, and so I think that, certainly at the, with frontline staff, we need to be able to tell the story as well, and for people to feel some of that emotion and impact."

(006)

Similarly, it could help to bridge gaps between different organisations (providers and commissioners, or different providers on a care pathway that was being reconfigured) and offer a starting point for conversations that moved beyond narrow organisational interests:

"Obviously there is the big bit in the middle of the NHS Change Model about our shared purpose and we are getting there but this project is more than just the local changes to staff within [local NHS trust] which is the organisation I work within. It is actually about more inter-agency shared working as well. We have a multi-agency steering group and people are still talking at cross purposes about the purpose of what we are trying to achieve and the vision and we have got a time out for that group in a couple of weeks' time so hopefully that is the opportunity to bring that together and get everybody back on the same page."

(002)

"I suppose the shared purpose is, yes it would be used, I suppose to give you an example on the unscheduled care side of things as well, obviously we talked about what was going on in the current stage, so everybody started to understand the problem. Then we got the different groups to actually say, 'OK what does the future look like?' And the surprising thing is that everybody near enough—there's like different tables set up—and surprisingly enough everybody came up with near enough the same kind of things, if you see what I mean? So that was really powerful in developing not necessarily completely coherent 'This is where we're going' sort of thing, but it did help us actually to bring together that largely all the clinicians are after the same thing."

(019)

To this extent, the NHS Change Model's users saw great potential in the ethos of shared purpose to make conversations that had previously been frustrated by polarised opinions more possible.[8] Engagement for change and the possibility of consensus flowed from this initial work. Agreeing on shared purpose could reframe problems, and bring stakeholders to the table to develop solutions that did the best job possible of generating solutions that were faithful to the underlying mission of the NHS.

What was also apparent from the way in which participants described their work, however, was that this was not always the way in which the task of achieving 'shared purpose' was put to use. Given the scale of some of the problems faced, and the need for haste in finding solutions, invoking shared purpose was often done more to overcome the opposition to change of groups seen as recalcitrant than to provide a shared basis for dialogue. Thus in practice it could be a discourse that was used to reframe stakeholder resistance,[9] rather than to reframe the challenge faced as a common one:

"A lot of organisations still talk about cost saving. [...] Actually if we forget that they are badged as a cost improvement programme and ask ourselves, 'Is it better for patients?', if the answer is yes, we can align it to the quality intent, which is one of the statements it says in the NHS Change Model, so you can actually achieve the same goal and get engagement with it by reframing the language that the trust is using. [...] Although the driver initially is about reducing this inefficiency and this waste and saving money, it is actually better for patients. You can align that to what the shared purpose is and the reason we are here is to create and deliver a good-quality service and care for people et cetera, so you can make that alignment."

(001)

"There's going to be some resistance to this change and pushing harder for the change isn't going to work. We need to take some of the resistance away. So within any of the areas that we're working in, identify where some of your resistance lies, and let's work to try and reduce that resistance and that's how we're going to bring successful change. And I think that's how I use it."

(003)

"It's tortuous. People are stuck where they are, aren't they? So it's trying to get them from where they are now and where we need them to be. It's such a behavioural change that they really find it hard to grasp. So just one example, our specialist nurses, we're asking them to be more generic, and they're saying, 'You can't take away the specialism'. No, no, no we won't take away your skill, you'll still have your specialist skills but your offer will be broader. So at the moment we can have a specialist nurse with a caseload of 90 patients, who is not able to pass stable patients back to the general team because they say they are not specialist, yet actually don't need a specialist nurse. It's a way of working that's been going on for years. […] Sometimes I think I've gone too far and it helped. I've said we've got to save millions of pounds in excess care, unless you change we're doomed! I'm not saying I would say it in exactly those words, but unless the community steps up to the mark and we reduce activity…"

(020)

Such uses of the NHS Change Model and the notion of common purpose do not necessarily represent a deviation from the approach. Undoubtedly the resistance of some groups to change is founded more in vested interests than in a sincere commitment to quality of patient care,[10] and 'shared purpose' may constitute a useful way of seeking to understand these concerns, and reframe them in a different light. However, it is perhaps useful to distinguish this from a model in which the need for change is approached more democratically. It also indicates how strong an influencing factor the pressures of finance and demand represent: in such an environment—where "unless you change, we're doomed"—one way of using the NHS Change Model seems more viable than the other.

In this context, and given the overwhelming nature of some of these pressures, the potential adoption of the NHS Change Model by NHS England was welcomed by participants, but they were circumspect about the degree to which this would augur a major shift in the approach to change. One risk, identified in our phase one work, is that such adoption might give rise to a perceived managerialisation, bureaucratisation or top-down imposition of the NHS Change Model, and an approach to its use that was founded on compliance rather than commitment. While care in the way NHS England seeks to incorporate the NHS Change Model into its operating framework may mitigate such risks, some cautionary reminders in our data show how easily such a shift can occur. One participant recounted how, in a recent reorganisation, staff had been required to reapply for their jobs—and told that, because the organisation was planning to adopt the NHS Change Model as an operating principle, they would be asked to describe how they would use it in the shortlisting and interview process. Such stories provide another reminder of how overbearing an influence the current financial and organisational environment of the NHS can be, not just on whether the NHS Change Model can be used, but also on how it is used. As another participant put it:

"People get excited about a model, people like me don't get excited about a model, because I have been working with models for 20 odd years, and I think the danger is the people make the model more important than the work they are trying to do. What I always say to people is you know if you are knitting a cardigan, you might have the picture and the pattern of what you are doing, but you don't describe to them every row that has got to be knitted, so I think there is a difference between special use of the model by a change agent, and using the model to help to get a cohesive approach to the things they want to achieve, but the Model shouldn't be, ticking the box on the Model, it's a means to an end, it shouldn't be the end itself: 'We have used the model, it should be a tick in the box'. […] I think if trusts introduce it as an initiative, if trusts say, 'This is the only model we use here', if they use it as a one-dimensional checklist of what you are doing on these things without actually having people embedded in the organisation that understand the evidence bases, or access to people who understand the evidence bases, that would stop it because it won't work."

(013)

5.6   Spreading the NHS Change Model

There were mixed views on the current approach to spreading knowledge about the NHS Change Model. Many participants had first encountered the NHS Change Model through webinars or via social media (Twitter), though this undoubtedly is primarily a consequence of our sampling approach—as well as of the fact that this had been the primary mode of introducing and spreading the Model deployed by the Institute (see section 3 above). The webinars were seen as a very valuable source of knowledge to accompany the NHS Change Model, offering 'how to' information that helped in applying the Model, though as noted above, some participants felt that more applied examples would be of great use. One participant described how she had made a social occasion of the webinars with colleagues, providing cake and watching together as a small team, then sharing their thoughts on the presentation and discussing the implications for their own practice.

Participants suggested that the language of the NHS Change Model, as well as the way it had been marketed and spread to date, risked creating a boundary—or perhaps entrenching an existing division—between those who 'bought in' to the NHS Change Model, and those who did not. As noted above, making components of the Model appealing to clinicians was seen to require a considerable translation process, but there was also a sense from some that the existing 'NHS Change Model community', as it manifested on Twitter and at webinars, could be somewhat excluding rather than including:

"I do feel like I have come into this a bit late and everybody else is further ahead because I was not around when we signed up to this model. I was [Clinical Commissioning Group-based] so I was trying more to capture what it was about and what our involvement meant so I think it would have been quite supportive or it felt quite supportive to everybody else but I felt a little out of my depth in the last webinar."

(002)

"The Twitter chats started for the first couple and I don't know if it's because of the media, you know the actual media of Twitter being very restrictive, but I have not really found those as useful. It's felt almost like there's a bit of a clique and there are people who join those who are from the Institute or that seem to be. There's like a little group of people that are NHS Change Modellers and they all know each other and it's been, you know they all kind of reinforce each other's view and it's been difficult to get to actually some practical, 'What have you done though, how have you used it to make a difference?' And it's just felt like it's quite a lot of rhetoric around you know, those Twitter chats. And it's great and it does need the enthusiasm around it, it does need people to be enthused by it, to take those messages back to base, but you know I feel like, after a few of the seminars I was really getting it on the WebExes and then I need something more tangible though and I think that's been lacking. And so I've stopped going to the Twitter chats because I'm not sure what I was gaining there. It was just the same people saying, 'That's the beauty of the NHS Change Model, blah, blah, blah.' It was like I know that's what it is but!"

(008)

In reaching other groups, a more mixed economy of spread was seen as being required. Adoption by NHS England—and the 'establishment' of the NHS Change Model as the NHS's preferred approach to change, rather than just another 'next big thing'—was seen as a crucial part of this (though as noted in the previous section, it also contained dangers). Also suggested by some was an approach to spreading the work about the NHS Change Model that took a more traditional track, alongside the 'stealthy spread' approach currently taken, to appeal to different audiences within the NHS:

"I'm trying to just get it on people's radar, but when I have talked to people about it a little bit, I think almost without exception they've been encouraged to know that there's something of value that is evidence based, and that's quite important for certainly the sorts of people I'm working with, that something is evidence based. And that can be of help to them and I've referred them to the website and so on, and that's any level of people that I'm talking with."

(004)

6. Discussion of Phase Two findings

Our analysis provides insight into the perceptions of 'early adopters' of the NHS Change Model, their approaches to and experiences of using the Model as a means of guiding change in the nine months since it was first introduced, and the implications of these for further work to spread, support and develop the NHS Change Model. We find much optimism about the potential of the NHS Change Model among those using it, tempered with caution and even pessimism associated with the scale of the challenges in hand and the pressures of the institutional context. In particular, participants expressed concern about the way in which wider, system-level pressures could militate against a faithful realisation of the NHS Change Model that responds flexibly to the tasks faced, but remains true to the principles and approach that it suggests. Box 1 (page 61) provides a summary of the strengths of the NHS Change Model, areas of the Model that need to be further strengthened, and wider issues that have an important bearing on how appropriately and effectively the NHS Change Model can be used.

Many participants were able to articulate a clear understanding of the purpose of the Model, and key directions about how it should be delivered, such as the need to ensure that 'shared purpose' underpins all activity, and the need to manage tensions between components. However, in the way they were using it in practice, participants often described approaches that deviated somewhat from these principles. While acknowledging the importance of alignment and of using all components, several stated that they were concentrating their efforts on some aspects more than others. Sometimes this seemed to have followed a careful use of the NHS Change Model to identify areas of current deficit that needed greater emphasis. At other times, it seemed more to be a matter of 'picking' those aspects of the Model that had the most resonance. Generally speaking, participants seemed more comfortable with the 'softer' sides of the NHS Change Model than the harder ones, and the 'Transparent measurement', 'System drivers' and 'Spread of innovation' components posed particular challenges—though some too struggled with 'Engagement to mobilise'.

This perhaps reflects the profile of participants, who, as leaders of change efforts and early adopters of the Model, tended to have backgrounds in organisational development, change management, human resources, and in some cases nursing. It highlights the importance of ensuring the right balance of disciplinary and skills-based inputs into change efforts—something which the NHS Change Model itself also emphasises—but it is interesting to note that for the most part, participants were using the NHS Change Model either on an individual basis, or in a small team. For various reasons, they tended to be reluctant to use the NHS Change Model explicitly as their basis for organising and articulating change activities with wider groups, particularly clinicians. Rather, they tended to use the NHS Change Model in a more-or-less heuristic way, ensuring that components were all being addressed and identifying groups that needed to be engaged, and then working with stakeholders from wider professional, clinical and organisational domains on a component-by-component basis. They acted as brokers and mediators of the Model,[11] translating it into clear and delimited instructions for others, but tending not to attempt to sell it to them wholesale. The NHS Change Model was thus something that provided a useful prospective planning tool and check on activities, broadening thinking, ensuring that all necessary routes to change were being followed, and managing the tensions between these routes.

The NHS Change Model was usually not used systematically and explicitly with the wider group of stakeholders involved in change. This had potential advantages and disadvantages. It could avoid dissipation of change efforts that might result from trying to involve too large a group in strategic work, and ensure that efforts remained focused and orchestrated.[12] However, it placed large demands on key individuals who had to mediate between the principles of the NHS Change Model and these wider groups, who had to ensure that efforts remained co-ordinated, and who were fundamental to the entire enterprise and thus difficult to replace. Some participants described an iterative process whereby a small team or steering group would periodically review progress against the eight domains of the NHS Change Model, and consider what further steps were needed under each of these, before returning to wider stakeholders to regroup and redouble efforts. Such an approach could ensure that the Model remained central to change efforts rather than constituting only an initial framework to guide change, and seemed a good compromise between the challenge of actively engaging a large group of stakeholders with conflicting languages and priorities on one hand, and the risk of using the Model as nothing more than an initial heuristic checklist on the other.

In describing their use of the NHS Change Model, there was also occasionally a sense from some participants that they saw it as a direct, unproblematic route to improvement that needed simply to be applied to get the right results. Some accounts downplayed or ignored the role that the interpretation, skill and tenacity of those leading change in the NHS had in using the NHS Change Model most effectively, fetishising the Model itself. Again, this emphasises the importance of communicating the limitations as well as the potentials of the NHS Change Model, and of using it in an iterative way that harnesses the expertise and skills of multiple stakeholders, rather than just as a one-off checklist or starting point.

Participants identified a number of ways in which the NHS Change Model might be improved, but on the whole saw the major difficulties with applying it properly as deriving from the wider organisational context rather than the content of the NHS Change Model itself. There was a degree of optimism about—and a few examples of—the way the NHS Change Model could be used to mediate this wider organisational context, and find space to address change in a more careful, comprehensive, appropriate and sustainable way. The Model's central foundation of 'shared purpose' was seen as something that could be used to find common ground in previously polarised debates, and initiate dialogue around challenging and contentious issues that had previously been characterised by entrenched positions aligned to particular interests. But in an NHS where financial pressures, levels of demand and organisational strain were so pressing, it could be difficult to sustain a truly balanced approach to using the NHS Change Model, in which the polarities between extrinsic and intrinsic motivators were balanced and both were drawn upon in constructing change. Rather, as several participants described, 'system drivers' could come to dominate discussions about change,[13] so that the discourse of 'shared purpose' became more a matter of convincing recalcitrant groups that change was necessary and inevitable, rather than engaging all in a discussion about how to craft a form of change that was true to the NHS mission. More broadly, the urgency and scale of change needed could mean that senior managerial patience for the measured, careful approach to change implied by the Model was limited, and resort to hierarchical imposition of change—that could provide quick fixes and avoid the complication of a more balanced approach— might be preferred.

In overcoming these challenges, there was some optimism that the adoption of the NHS Change Model by NHS England might portend an NHS environment in which senior managers felt legitimised in providing space for a sincere application of the NHS Change Model approach. However, those burning external pressures will remain constant, and much will depend on the detail of this adoption. We see in our findings the way in which, quite unintentionally, adherence to the NHS Change Model could become a matter of compliance rather than commitment,[6] and in building the Model into the NHS's operating framework, care will be needed to ensure that it is not reduced to a check-box model: in other words, that the ethos, as well as the content, of the NHS Change Model is endorsed, valued and communicated. As one participant put it, moving to a model of change informed by the NHS Change Model is a massive change in itself. A cultural and organisational context that facilitates faithful use of the NHS Change Model will not be achieved easily or quickly, but its endorsement and adoption by NHS England and others provide an important step in its establishment, and in making a normative mindset of the Model, rather than just a set of domains to tick off.

7. Concluding remarks

For almost all participants, the NHS Change Model provided an approach that was full of promise. They had found many of its elements useful, it had broadened their perspectives as they sought to undertake challenging change tasks, and all of them said they would recommend it as a framework to others. However, it was clear from the testimony of many of our interviewees that they faced formidable challenges in putting it into practice and realising its potential. In an environment that, more than ever, was characterised by overwhelming external pressures that required rapid change, and where resorting to traditional authoritarian approaches to change was a temptation that many managers found difficult to resist, using the NHS Change Model in a way that was faithful to its intent was very difficult. In our interviews we see some examples of how local organisational environments could be crafted that could provide protection from these external pressures, and give the time and space necessary for using the NHS Change Model in the manner intended.

The adoption of the NHS Change Model by NHS England was seen as a promising development, though for this to translate into environments that were more conducive to use of the NHS Change Model at a local level, participants perceived that a wider change in ethos and culture was needed. Perhaps just as importantly, though, was the need to provide tangible evidence of the NHS Change Model's potential. Participants were convinced that this was an approach that could produce more lasting change that was true to the shared values of the NHS. They were equally certain that the NHS's existing predominant approach produced changes that were quick, but often ill-thought through, with unintended consequences, and lacking in sustainability. For now, though, these remained only convictions. Clear examples of the value of the NHS Change Model in making this difference to change would give help to give legitimacy, spread the work, overcome scepticism of practitioners who saw this as 'just another' change tool, and advance the notion that taking more time now to do change properly would reap tangible rewards in the future.

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Box 1: Strengths, areas for strengthening and external challenges

Areas of strength
- The NHS Change Model was viewed as a very helpful tool by these early adopters, for whom it had strong face validity and intuitive appeal. It was seen as complementing and helping to organise existing change efforts, rather than displacing them.
- Its strong basis in evidence, and the way in which it offers practical directions on what to do and links to resources on how to do it, were seen as key selling points.
- Participants had found many individual components of the NHS Change Model, and the resources and tools to which they linked, helpful in structuring their efforts.
- For many participants, a particular strength of the NHS Change Model was in alerting them to aspects of change that, they said, they would not otherwise have considered—thereby ensuring a more comprehensive and holistic approach to change.
- Consequently the NHS Change Model was seen as particularly appropriate for addressing challenging problems that crossed boundaries of organisational, professional and sectoral responsibility.
- The notion of 'shared purpose' was identified as being particularly helpful for participants as they sought to transcend these boundaries and engage divergent stakeholder groups in change.

Areas for strengthening
- Participants identified a number of small but significant ways in which the presentation and content of the NHS Change Model could be improved.
- In some cases, there was a sense that participants saw applying the Model to a problem as constituting the major part of the solution. It will be important to continue to emphasise the need for thoughtful, skilled and tenacious application of the Model.
- Both the way in which the NHS Change Model has been spread to date, and the language it includes, divided stakeholders; clinicians were seen as being less enamoured of the vocabulary used by the Model, while spread via social media was seen as excluding some. It may be worth complementing existing approaches to spread and explanation of the Model with others.
- Participants' use of the NHS Change Model was as a heuristic framework rather than a detailed, stepwise model for change. While this seemed appropriate (encouraging flexibility rather than slavish adherence), it could also give rise to an approach that deviated from the Model's emphasis on using all its components, and attending to the polarities and tensions between them.
- More broadly, many participants struggled to put all of the components of the Model into practice, and to attend to the tensions between them by considering alignments.
- Some of these challenges related to the point in the change process at which participants found themselves, or a lack of specific knowledge on techniques to use, but other seemed more fundamental. Several participants struggled in particular to align system drivers with their change efforts.

External challenges to overcome
- The multi-professional nature of the NHS led participants to be cautious in the degree to which they enfranchised others in the use of the NHS Change Model, preferring to delegate specific tasks rather than explicitly use the NHS Change Model in collaborations with others. This seemed to work well for many, but does place a heavy burden of effort on the individuals or small teams who do this 'mediation' of the NHS Change Model.
- Those leading efforts using the NHS Change Model did not always have the power, influence or networks to tie their efforts into wider system drivers, such as organisational priorities and commissioning levers.
- The organisational environment of the NHS, and the tendency to resort to command-based approaches to change, militated against use of the NHS Change Model. This was compounded by the urgency of many changes given demand and financial pressures, which led managers to seek quick fixes rather than take the time to approach change in the way advocated by the Model.
- This environment could also give rise to 'imbalances' in the Model that were difficult to mitigate, with intrinsic motivation shadowed by overwhelming extrinsic factors such as budget cuts, competition for contracts, and risks to services.
- The adoption of the NHS Change Model by NHS England is a promising step in many regards, but there are risks of creating an approach to using the Model that is based more on compliance than commitment. The way in which the Model is advocated, and the broader tone set for dealing with the challenges facing the NHS, will be crucial in the prospects for commitment-based, sincere, and appropriate use of the NHS Change Model.
- Senior managers in organisations also have a key role to play in creating organisational environments in which this kind of approach to change is viable, mediating external pressures and creating time and space for change leaders.

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