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How can we build skills to transform the healthcare system?

Helen Bevan
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Abstract
Across the world, healthcare organisations are implementing radical change strategies in the face of unprecedented financial challenge. In this context, a focus on building capacity and capability for improvement is a key strategy. Global analysis shows that the most common characteristic of healthcare organisations that deliver outstanding performance in cost and quality is a systematic approach to capability building for improvement. The paper looks at where to start in order to build improvement skills at every level of the healthcare system and empower frontline staff to make changes that will deliver results. The current situation of the English NHS is used to illustrate the points made. What will it take to skill up and mobilise the entire healthcare workforce, to create a mass movement of change agents, to sustain the energy for change for the longer term and deliver the transformational results in cost and quality that are sought for patients and populations?

Keywords
healthcare improvement, capacity and capability, change management, quality improvement, mindset shift

The context
Across the globe, healthcare systems face unprecedented financial challenges. The National Health Service (NHS) in England is no exception. The English NHS is one of the largest health systems in the world, with 1.4 million staff, providing comprehensive care to a population of 54 million people. There is a gap of up to £20 billion between the current trajectory of NHS spending and what is likely to be available over the next three years (NHS Chief Executive, 2009). Significant efforts are being made to address this. However, the agenda is not just about working with fewer financial resources. Within the NHS, there is a strong national commitment to quality as the biggest strategic priority (Department of Health, 2008). It means that the strategy to reduce costs must also improve quality. The overall challenge is how to utilise improvement approaches to deliver higher quality, safer care at lower cost.

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Over the past 10 years, the English NHS has invested significantly in skills for change. Many impressive gains have been made, for instance, eradicating waiting times for many patients, the biggest reductions in infection rates of any healthcare system in the world and significant improvements in care for people with heart disease and cancer (Department of Health, 2009). However, the scale and pace of change that is now required is probably greater than that achieved previously by any other healthcare system globally. There is recognition that the thinking and leadership action that has got the system where it is today is probably insufficient for the future. There is a need for big picture, transformational approaches that can be translated into practical changes that deliver quality and productivity benefits for every patient and for the whole country.

The topic of this paper is how to build improvement skills at every level of the healthcare system and empower frontline staff to make changes that will deliver the required results. The current situation of the English NHS is used to illustrate the points made. Skill building is a critical component of any systematic approach to large-scale change. Global analysis of healthcare systems that deliver outstanding performance in cost and quality shows their most common characteristic is a systematic approach to capability building for improvement (Bevan et al., 2008; Staines, 2007). What does the evidence suggest that it will take to skill-up and mobilise the entire healthcare workforce, to create a mass movement of change agents, to sustain the energy for change for the longer term and deliver the transformational results in cost and quality that are sought for patients and populations?

The challenge

A significant investment of time, resources and leadership effort is required to create the capacity and capability for large-scale change needed to transform an entire healthcare system (Staines, 2007). By ‘capacity’ we mean having the right number and level of people who are actively engaged and able to take action. ‘Capability’ means that those people have the confidence and the knowledge and skills to lead the change.

Research on large-scale change shows that if cost and quality outcomes are to improve dramatically, it will be through the engaged improvement efforts of frontline clinical teams that do the work, effectively supported by their leaders (Bevan et al., 2008; Bibby et al., 2009; King and Peterson, 2007; Staines, 2007). The skills and capabilities that are required often already exist within the system, but in isolated areas. Evidence suggests that bringing ‘outside in’ change capability (consultancies and external experts) can add momentum, new perspective and discontinuous innovation in the short term. However, in the longer term it is ‘inside out’ change, the capability of the system to change itself, that will create the sustainable improvements in cost and quality that are sought (Parcell and Collison, 2009).

In addition, capability building needs to be ‘hard-wired’ into the day-to-day practice of healthcare staff. This principle is built into The Productive Ward: Releasing Time to Care, a national programme that has been adopted by the majority of hospitals in England. This programme seeks to free up more time for ward staff to spend on direct patient care by redesigning the way that care and work is organised (National Nursing Research Unit, 2009; NHS Institute for Innovation and Improvement, 2009a; NHS London, 2010). Rather than sending them on classroom-based courses, or giving them special projects, ward teams are taught key change skills by improving the actual processes they work on, in real time and on the job. More than 50,000 frontline staff, the majority of them nurses, have been given the skills, support and confidence to make changes through The Productive Ward (NHS Institute for
Innovation and Improvement, 2009a). The results are significant. In a pan-London research study, ward teams from across the city reported a median 13% improvement in direct patient care time, a 7% improvement in patient satisfaction and a 23% improvement in patient observation (NHS London, 2010). In another study of the programme, on a national level, staff from every level from healthcare assistants to executive nurses were asked to rate those areas where The Productive Ward had a ‘high’ impact. Eighty six per cent of respondents reported that the programme had such impact on team working, 82% on staff experience, 80% on efficiency and 75% on patient safety (National Nursing Research Unit, 2009). The results are being replicated in other ‘Productive’ programmes that are being rolled out across the NHS, such as The Productive Community Hospital, Productive Mental Health Ward, Productive Operating Theatre and Productive Community Services (NHS Institute for Innovation and Improvement, 2009a). These programmes demonstrate just how much energy can be unleashed by encouraging frontline teams to question how they work and providing simple tools and skills development to support them, on the job (National Nursing Research Unit, 2009). Finding ways to tap into, mobilise and skill-up the huge pool of latent individual and organisational energy for change is a key aspect of healthcare transformation (Bibby et al., 2009).

This example illustrates how capacity and capability building should not be viewed as a discrete activity. It has to be regarded as a fundamental component of a strategy for large-scale change (Bevan et al., 2008). There has to be clear alignment between strategies to build change skills and activities to raise awareness and mobilise people to the challenge, develop leadership capabilities, generate ideas, utilise evidence-based practice and deliver results. Figure 1 shows nine ‘enablers’ for system-wide change, such as systems for workforce development and talent management and performance management and incentive systems. Of the nine elements identified, four are specifically related to capacity and capability building. This analysis highlights the important of skill building to underpin an integrated strategy for transformation.

Where are the gaps?

Over the past 10 years, the English NHS has made a significant commitment to building improvement skills, but even with the clear priority that has been given to this work, there is a mixed picture. There are many organisations on primary, secondary and tertiary care that invested significantly in improvement skills and can demonstrate outstanding outcomes (NHS, 2008). However, skills gaps exist across a range of change management and change leadership capabilities.

Researchers from the University of Warwick (2007) looked for evidence of the kind of improvement approaches that have been used in industry for more than 50 years to improve operational efficiency and effectiveness. The researchers found strong evidence of such capacity and capability amongst NHS organisations and also in some of those organisations with the greatest improvement challenges. However, they found more limited capability in evidence-based change management amongst the majority of NHS organisations that are in the middle of the performance curve.

Recently, the NHS Institute carried out the first national NHS Innovation and Improvement Survey (NHS Institute for Innovation and Improvement, 2009b), in which 4,300 NHS staff took part. Respondents typically reported limited knowledge or skills in basic improvement approaches, but a hunger to learn more. They frequently said that their Board or Senior Management Team lacked the skills required to provide leadership in improvement and innovation issues and they questioned whether their organisations
The outcome:
Higher quality, lower costs, better outcomes across the system

Support and guidance in implementing changes

Access to the skills, competencies and know-how to propel the system to future success

Systems for workforce development, talent management and leadership succession planning

Systems for learning and discovery which enable health systems, local organisations and teams to learn about, experiment with and adopt new practice rapidly

Access to global benchmarking data at patient, clinician, team, organisation and health system level

Governance and assurance systems that:
(a) integrate clinical quality and cost reduction
(b) enable improvement

Performance management, and incentive systems that support improvement in quality and cost

Access to sources of world-class good practice and generalisable evidence

A systematic, integrated, yet emergent, approach to planning, measuring, and realising benefits

KEY
Where capacity and capability building makes the greatest contribution to design for large scale change

Support and guidance in implementing changes

The outcome:
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Access to global benchmarking data at patient, clinician, team, organisation and health system level

Systems for workforce development, talent management and leadership succession planning

Systems that enable service users to drive and influence change

Support and guidance in implementing changes

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Figure 1. Examples of system 'enablers' for large-scale change
were able to evidence the return on investment that improvement initiatives and innovations had made. However, respondents reported progress, compared with 12 months ago, in the improvement outcomes that their organisations were achieving, improvements in their own (individual) ability to get involved in change activities and improvement in the overall approach that their organisations were taking to enable and drive change.

**Where do we want to be?**

The aspiration is for a future where change management, innovation and improvement skills are regarded as a critical component in individual and organisational performance and behaviour. In addition, leadership teams and frontline clinical teams are able to identify the gaps in performance and resources and have the skills and confidence to close them in a systematic way.

The perspective for the new era is not just about developing new strategies and processes for skills development, it is also about changing mindsets. Table 1 shows the outputs of a brainstorm on this topic at the NHS Institute.

**Who should we focus on?**

In order to be successful, capability building strategies need to be highly focused rather than diffuse. They cannot be about large-scale training programmes that train literally hundreds of thousands of people in change skills with a ‘sheep dip’ approach. The strategies need to take account of how change spreads in complex adaptive systems, how skills relate to daily work and how far systems, organisations, teams and individuals have already come in their own development journey. Therefore, careful consideration should be given to identify the core groups to focus on initially as part of a strategy that might eventually result in every member of staff becoming a change agent. The initial groups need to be the people who determine what is important and those who can spread the skills most widely.

**Table 1. Mindset shifts for capacity and capability building at scale**

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being a change agent is a specialist role undertaken only by certain people.</td>
<td>Everyone is a change agent, improvement is everyone’s business.</td>
</tr>
<tr>
<td>I have not got time for innovation and change.</td>
<td>Improving quality and productivity is part of my day job.</td>
</tr>
<tr>
<td>I can only learn improvement skills through formal courses.</td>
<td>I learn about and achieve change through work based learning.</td>
</tr>
<tr>
<td>I have change skills but the system stops me.</td>
<td>I have a responsibility for changing the system.</td>
</tr>
<tr>
<td>We have improvement specialists in our organisation.</td>
<td>We are an organisation of improvers and change agents.</td>
</tr>
<tr>
<td>Clinicians are often reluctant to be change agents.</td>
<td>Clinicians are the most effective agents of change in mindset, behaviour and outcomes in a clinical setting.</td>
</tr>
<tr>
<td>Change is separate from patient care.</td>
<td>Change is the best way to improve patient care.</td>
</tr>
<tr>
<td>Improvement leaders are concerned with quality and patient safety.</td>
<td>Improvement leaders are financially astute and see cost as a core dimension of quality.</td>
</tr>
</tbody>
</table>

Source: NHS Institute.
Specific priority should be given to senior clinical and managerial leaders, defined as those who take executive authority and accountability for change across an organisation system. Evidence from high-performing health systems indicates the need to invest significantly in senior leadership-level skills for large-scale change; how to mobilise for improvement, strategically align goals, measures and implementation initiatives; how to work explicitly with models and theories of large-scale change; how to balance short-term operational results with longer-term transformation (Bevan et al., 2008).

Another priority for skills development is existing improvement leaders – those who are responsible for leading and enabling change, either on a full-time or substantive-time basis. The target should be those who ideally have significant existing change skills, but experience suggests that energy and enthusiasm is a more significant predictive factor in success at facilitating change than existing improvement skills. They must be at a variety of different levels in healthcare organisations, ranging from Directors and Heads of Improvement to change facilitators who support frontline teams. They need to have been identified (and potentially assessed) as capable of both facilitating change and coaching others in change skills.

Recent research from the roll-out of The Productive Ward across England demonstrates the importance of the role of improvement leader (change facilitator) in delivering quality and productivity benefits. External research reports from both NHS London and the National Nursing Research Unit highlight that having a full-time or substantive-time facilitator, with the skills and resources to support front-line clinical teams to make change, is a critical success factor (National Nursing Research Unit, 2009; NHS London, 2010).

It is necessary to define the skills that are needed by an improvement leader in the era of quality, innovation and productivity and ensure that these skills are acquired. Table 2 shows an emerging framework of skills. It sets out the four components of the skill-set for improvement leaders that have been built over the past decade in the NHS, based on the Discipline of Improvement for Health and Social Care (NHS Modernisation Agency, 2003). The components are:

- Process and systems thinking
- Personal and organisational development
- Involving patients, users, carers, staff and the public
- Making improvement a habit: initiating, sustaining and spreading change.

However, given the need to make stronger links between cost and quality improvement, to think differently and to become more self-sufficient in change, it also suggests three new skill categories that should be part of ‘core’ capability for improvement leaders in the new era:

- Delivering on cost and quality
- Problem solving/internal consultancy skills
- Innovation for improvement.

This framework has been labelled the ‘seven skill sets’ for quality and productivity improvement. The role of the improvement leader in this strategy is to both support/facilitate change AND lead the roll-out of improvement skills in their own organisations. Again, the evidence suggests that change skills are more likely to stick and to lead to actual
Table 2. What skills do change agents in healthcare need to deliver on quality, innovation and productivity?

<table>
<thead>
<tr>
<th>Process and systems thinking</th>
<th>Personal and organisational development</th>
<th>Involving patients, users, carers, staff and public</th>
<th>Making it a habit: initiating, sustaining and spreading change</th>
<th>Delivering on cost and quality</th>
<th>Problem solving/consultancy</th>
<th>Innovation for improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Quality measurement and improvement</td>
<td>• Leadership of quality improvement</td>
<td>• Involving patients, users, carers, staff and public</td>
<td>• Making it a habit: initiating, sustaining and spreading change</td>
<td>• Delivering on cost and quality</td>
<td>• Problem solving/consultancy</td>
<td>• Tools for thinking differently</td>
</tr>
<tr>
<td>• Statistical process control</td>
<td>• Clinically driven change</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Inductive and deductive reasoning</td>
</tr>
<tr>
<td>• Principles of lean (end-to-end value streams, flow, pull, scheduling, etc)</td>
<td>• Theory and practice of group facilitation</td>
<td>• Involving patients, users, carers, staff and public</td>
<td>• Making it a habit: initiating, sustaining and spreading change</td>
<td>• Delivering on cost and quality</td>
<td>• Problem solving/consultancy</td>
<td>• Assessing and evaluating potential innovations</td>
</tr>
<tr>
<td>• Model for improvement</td>
<td>• Basic coaching skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Building innovation into quality improvement approaches</td>
</tr>
<tr>
<td>• Demand and capacity analysis</td>
<td>• Managing conflict</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Metrics for innovation</td>
</tr>
<tr>
<td>• Pathway mapping</td>
<td>• Understanding and valuing difference</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Observational skills</td>
</tr>
<tr>
<td>• Complexity thinking for system redesign</td>
<td>• Stakeholder management and influencing skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Creating a culture of innovation</td>
</tr>
</tbody>
</table>

Source: NHS Institute.
improvements if they are related to real-life work. So the strategy needs to encompass not just developing the skills, but the context in which to develop them.

What is needed?
The evidence base suggests that the following are important considerations in building a strategy for improvement skills at scale.

Plan for large-scale capability building based on the evidence base
The research stresses the importance of planning and resourcing capacity and capability building as a large-scale change implementation. Calculations need to be made upfront about how much extra time, effort, skills and systems will be required to execute the change and create the space and resources for it to happen. For instance, within the English NHS the recent Innovation and Improvement Survey identified that, for frontline staff, having insufficient time within their roles to dedicate to innovation and improvement activities was a major barrier to change (NHS Institute for Innovation and Improvement, 2009b). Assumptions should not be made that people will fit skill building projects on top of existing busy jobs. Sirkin et al. (2006) suggest that if anyone's workload increases by more than 10% as a result of an implementation initiative, it is likely to run into problems (NHS Modernisation Agency, 2003). This again emphasises why learning and implementing the changes as part of everyday work is so important to achieving improvement goals and why priority should be given to speeding up implementation of the programmes and initiatives that have already been identified as contributing to quality and productivity goals.

Raise the status and perception of change agents and service improvement programmes
There is a need to move away from the default position of ‘business as usual’ with improvement as a ‘nice to have’. The instigation, delivery and sustaining of change initiatives needs to be actively championed by senior clinical and managerial leaders so that it is seen as mainstream and mission critical. It needs to be built into existing operational and governance processes. Incentive and performance management systems need to underpin this.

Build on existing capability and talent
Moving from good to great in human service organisations like the NHS – to use the language of Jim Collins (2001) – involves understanding that many of the answers to the problems that exist lie within (Keller and Aiken, 2009). For instance, as a result of its reform process over the past 10 years, the NHS has tremendous organisational memory on how to implement radical change, probably more than any other national healthcare system globally. This existing talent will form the foundations of the strategy for large-scale change at local, regional and national levels.

Mobilise the workforce
The approach needs to speak to the hearts and minds of everyone who works for the health system. Everyone has the potential to be an agent for change and a champion for
quality and productivity. People can be mobilised for change, even in difficult economic circumstances. The aim should be to create a system-wide climate where change and challenge are encouraged and celebrated.

**Connect skill building to results**

The skill-building process needs to be linked to improvement aims and measures of success. Focusing on improvement methods or skills rather than relevant result areas is one of the quickest ways to alienate a clinical workforce from a change process (Collins, 2001). Leaders need to focus strongly on creating understanding and conviction for the workforce about how their new skills will contribute to better outcomes.

**Engage senior clinical and management leaders as role models**

Role modelling of new behaviours and mindsets by senior leaders and opinion formers is one of the most effective influencing strategies available (McNulty and Ferlie, 2004). Often senior clinical and managerial leaders have a gap in their knowledge and skills of improvement. Organise training and development (linked to strategic improvement goals) for this group first. Promote the fact this is happening and the impact it will have on outcomes to the wider workforce.

The evidence suggests that healthcare leaders potentially need to think very differently about how to create capacity and capability for change in order to realise ambitions for higher quality at lower cost. Skill building and development is not just the prerogative of the Training Department or the Human Resources Department. It has to be regarded as a fundamental component of a strategy for large-scale change. There has to be clear alignment between strategies to build change skills and activities to raise awareness and mobilise people to the challenge, develop leadership capabilities, generate ideas, utilise evidence-based practice and deliver results.

‘How’ the strategy is enacted is as important as ‘what’ is done. Leaders should look at the potential to develop mass mobilisation and engagement in a ‘champions of change and quality approach’ so that the workforce feel that they can challenge issues of poor productivity, quality and safety. Finally, it is important to identify and build on the outstanding work that will already be going on to systematically build change capability. The potential is very significant. In fact, given the scale and pace of change required, it will not happen without this kind of mindset change and engagement.

**References**


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