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EDITORIAL

The Psychology of Change and the NHS

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How does a large and complex organisation achieve real change? Much has been written, with many lessons presented, about why major organisational change succeeds (Castiglione and Lavoie-Tremblay, 2021) and why, as is more often the case for the National Health Service (NHS), it fails (Vindrola-Padros et al, 2022).

But in the health service, those lessons rarely get heeded when major plans are launched, reorganisations are directed, or even when service-level or clinical pathway change gets considered.

The Importance of Psychological Factors in Understanding Change

Frequently, those leading change both nationally and locally demonstrate a clear failure to learn lessons. As Richard Thaler (2015) has remarked, those human factors cannot be underestimated when it comes to understanding how change really happens in complex systems. The overall human factors philosophy is that the system should be designed to support the work of people, rather than designing systems to which people must adapt. Frequently, however, this simple understanding is lacking in approaches taken by the health service, both nationally and locally.

How people think, react to change, resist change, engage in 'groupthink', and ignore what they don't want to hear are all crucial factors in the psychology of change. Groupthink occurs when a group prioritises harmony and consensus over critical evaluation, leading to irrational or suboptimal decisions (Esser, 1998).

It often arises in high-stress environments, where dissent is discouraged or where there's a strong desire to maintain group cohesion. They also get dismissed as 'soft' and unworthy of systematic, deep thinking. Yet these human factors are crucial in public policy and in creating sustainable change.

Julia Unwin writes of two lexicons in public policy (Unwin, 2018). On the one hand, she describes the rational language of metrics, value added, growth, resource allocation and impact. On the other hand, the relational language of kindness and emotion. The use of data, of metrics, of analysis, innovation and new digital tools are all crucial in driving improvement and change. But increasingly, there is a 'crowding out' of the relational in the pursuit of a rationalist ideal.

And there is significant change happening within the NHS right now—from the abolition of NHS England and the merger of some of its functions back into the Department of Health and Social Care, to the cutting of a large number of Integrated Care System (ICS) staff and corporate staff in provider trusts, and the launch of a new 10-year plan. With public satisfaction with the NHS at an all-time low (Taylor et al, 2025), implementing change in a way that works has never felt so important.

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The Levers of Change and the Role of the Relational

Several approaches are commonly utilised when approaching large-scale change in the NHS: workforce redesign, financial flows, structural change, plans to get the public to change their behaviour and, increasingly, the application of digital and Artificial Intelligence (AI) solutions (Nuffield Trust, 2018; Oliver, 2025). All require a careful consideration of human behaviour. Yet frequently, despite the health service being a 'people business', it often isn't at the heart of change. Let us explore two of those levers for change, where the relational is found to be lacking—financial levers for change and workforce redesign.

Financial Incentives

Financial policy levers are often seen as transactional interventions on a system where people are expected to behave rationally and predictably. Yet we know with financial incentives—perhaps the most transactional lever of all—that there are real psychological reasons why some work and why some fail. Evidence shows you cannot 'buy' the right behaviour with the wrong incentives: financial incentives do not produce rational or predictable behaviours (Marshall and Harrison, 2005). Little research exists on the interaction between financial incentives, professional identity and motivation, but research on values congruency indicates this is extremely important (Edwards and Cable, 2009).

Economists as far back as Adam Smith in the eighteenth century recognised 'human sentiment' as an important part of understanding economic behaviour. But it wasn't until the 1970s onwards that behavioural economics showed that people shape economic models rather than behaving according to them (Heukelom, 2007).

These models have had some impact on public policy (Halpern and Sanders, 2016), and have brought the human and the psychological into the centre of considerations of how change happens. But still, we see little substantial impact of an understanding of the psychological factors that influence change being systematically used in the approach to managing change in the NHS.

Workforce Redesign

Another intervention for change commonly applied to the NHS in England is adjusting the skill mix in the health service workforce in order to address the need for greater efficiency or productivity. There are more examples of this in England than anywhere in Europe (Palmer et al, 2025), but as yet, the impact of this on outcomes for patients is unclear: there are a high number of variables and as yet, very little detailed research (Walshe et al, 2024).

However, we do know that changing the NHS skill mix is often implemented with little consideration for the emotional challenge and impact on professionals already working. Introduced transactionally, it fails to take account of the significant human impact or the behavioural changes that are needed for successful implementation (Palmer et al, 2025). A recent example of this is the further roll-out of physician associates in the English health service, which is now being subjected to an independent review (Department of Health and Social Care, 2025).

Beyond healthcare, the idea of skill mix is partly based on the assumption that it is possible to break jobs up into their constituent parts and parcel them out. In some industries, this works effectively. But in others, it can lead to reduced worker autonomy, reduced job satisfaction, and what has been referred to as the 'McDonaldization' of society (Ritzer, 2013). There is little research on what this means for the health service. It is clear, however, that the psychological and relational factors that are so crucial to making large-scale workforce change work are rarely front and centre when the NHS workforce skill-mix lever is pulled.

A Failure to Learn

Time and again, the approach that the NHS takes to large-scale change is both unclear and psychologically illiterate. Despite this being well known, the same mistakes occur.

Pieter Degeling and colleagues (2001) highlight that different groups—doctors, nurses, patients and managers—already have different attitudes to key issues like autonomy versus accountability; responsibility for resource use versus clinical purists who are uncomfortable with the idea that clinical decisions have financial implications; attitudes to team working and power; and willingness to adopt systemised work processes. Most change processes fail to acknowledge this type of research and the need to work systematically with these differences, their complexity and their uncertainties.

Conclusion

In a 'people business' such as the NHS, psychological literacy and ensuring others' psychological safety are essential both for creating and sustaining change and supporting greater productivity. This is well known across the NHS. But this understanding, alongside wider literature about how good change should be led, does not consistently influence policy development or the implementation of change at local levels. For those holding power, at all levels from government to local leaders, there has perhaps never been a more important time to consider this literature and to think more carefully about how to put its learning at the heart of leading change work in the NHS.

Key Points

- Psychological literacy and ensuring others' psychological safety are essential for creating and sustaining change, and for supporting greater productivity.
- The people tasked with changing the NHS consistently fail to learn from past failures, and neglect the importance of human factors.
- Financial incentives and workforce redesign are key levers in the NHS to drive change, but even financial incentives fail in the health service because human behaviour is misunderstood.
- Workforce redesign is often implemented with far too little consideration for the emotional challenge and impact on staff already working.

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