

Driving improvement

Case studies from eight NHS trusts



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Our purpose

The Care Quality Commission is the independent regulator of health and adult social care in England.

We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can



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Foreword



Professor Sir Mike Richards
Chief Inspector of Hospitals

What enables trusts to improve? What do you need to do to turn round an organisation with thousands of staff, operating on a number of sites and with growing pressures on services?

Drawing on findings from inspection reports, CQC's 2016 State of Care report concluded that effective leadership and a positive, open culture are important drivers of change. In hospitals rated as good or outstanding, the trust boards had worked hard to create a culture where staff felt valued and empowered to suggest improvements and question poor practice.

In determining how well-led a trust is, CQC takes into account leadership capability and capacity, culture, vision and strategy, governance, staff and patient/public engagement, and the drive for continuous improvement.

We set out to explore what eight trusts had done to become 'well-led' trusts. We wanted to hear from people in those trusts about how they had achieved those improvements, specifically the steps leaders had taken and the effect of those actions on staff and patients. To do this, we interviewed a range of people from each trust, including chief executives, medical and nursing directors, non-executives, heads of communications, front line staff, patient representatives and external stakeholders.

We found that when trusts went into special measures or received a rating of requires improvement, some staff were unaware of the extent of the issues. They hadn't realised that things in the trust were not as they should be. Or, they were so focused on their own service that they could not see the bigger picture of care across the trust.

But this was not a common view. In most of the trusts we visited, staff knew things weren't right and were taking steps to make improvements.

Those driving improvement in the trust felt supported when leaders accepted the need for change.

Some trusts changed the leadership team to help drive improvement. For others, it was about empowering existing staff to take leading roles in effecting organisational change. Trusts that unleashed the potential of their staff now see improved patient outcomes and higher staff morale.

One of the first steps on an improvement journey starts with changing the culture of the organisation. Typically, trusts rated as inadequate are disjointed organisations. That may be a disconnect between clinicians and managers, between medical and nursing teams, between specialist and general services, or between different hospitals in the same trust. The priority for leaders is to bring all the elements of the trust together. This is best done by engaging and empowering staff – underpinned by shared values.

Leaders need to lead and be seen to lead. Our improving trusts placed emphasis on the visibility of leaders: chief executives and senior staff spending time on the ‘shop floor’, meeting staff and setting up regular channels of communication.

An outward looking approach is another aspect that’s enabled improvement. We heard how trusts reached out to their communities and encouraged staff to use social media to share stories and interact with patients and the public. They also involve patients and the public in the work of the trust, shaping services and providing feedback. Some of our case studies show how collaboration with local people and patient groups such as local Healthwatch has helped to drive improvement in a trust.

The feedback we received suggests that inspection does help improvement. As well as identifying problems and helping trusts develop improvement plans, reports can give a rigour and discipline to improvement work as well as giving clinicians and managers the boost to make changes.

These case studies support the premise of ‘Developing People – Improving Care’, the national framework for action on improvement and leadership development in NHS-funded service – that improvement and leadership capability leads to improved care for patients and more value for money.

The trusts featured in this publication show the strong correlation between improvements in each of the characteristics of ‘well-led’ that CQC uses to inspect and rate trusts and overall improvements in quality and safety. We want to encourage others to look at and learn from these case studies to help them in their own improvement work.

I would like to thank everybody connected with the featured trusts for the time and help they have given us in producing this publication.



Professor Sir Mike Richards
Chief Inspector of Hospitals

“These trusts have all worked fantastically hard to improve the services they offer their communities. The leaders have taken the time to really listen to both their staff and patients and have reaped the benefits. There is a lot in this report that all providers can learn from as we strive to make the kind of change we all want to see in our NHS.”

Jim Mackey, Chief Executive, NHS Improvement



The trusts that we interviewed

We selected eight trusts on the basis that they had achieved a significant improvement on their rating. Five trusts have improved by two ratings, and three trusts have improved by one rating.

	Trust	From	To
+ 2 level ratings	University Hospitals of Morecambe Bay NHS Foundation Trust	Special measures	Good
	East Lancashire Hospitals NHS Trust	Special measures	Good
	Cambridge University Hospitals NHS Foundation Trust	Inadequate	Good
	Wexham Park Hospital	Inadequate	Good
	University Hospitals Bristol NHS Foundation Trust	Requires improvement	Outstanding
+ 1 level rating	Barking, Havering and Redbridge University Hospitals NHS Foundation Trust	Special measures	Requires improvement
	Leeds Teaching Hospital NHS Foundation Trust	Requires improvement	Good
	Mid Essex Hospital Services NHS Trust	Requires improvement	Good

Source: CQC inspection reports

CQC, through the Chief Inspector of Hospitals, will normally recommend that a trust is placed in special measures when an NHS trust or foundation trust is rated as inadequate in the well-led key question (for example, there are concerns that the organisation's leadership is unable to make sufficient improvements in a reasonable timeframe without extra support) and inadequate in one or more of the other key questions (safe, effective, caring, and responsive).

Some of the trusts went into special measures following a review in 2013 by NHS England's Medical Director, Sir Bruce Keogh, before CQC started its comprehensive inspections.

For each trust we interviewed a range of people including: Chief executives, directors of nursing, chief operating officers, medical and nursing directors, senior consultants, front line staff, non-executive directors, heads of communications, patient representatives, and external stakeholders – such as Overview and Scrutiny Committee members.

We asked each interviewee questions that were common across trusts:

- What was your reaction to going into special measures/getting a low rating?
- How did you view the hospital/trust prior to it going into special measures/getting a low rating?
- How did you approach improvement?
- What support did you receive?
- What were the obstacles to improvement? How did you overcome them?
- How did you involve staff/public and patient representative groups?
- How did you ensure a focus on equality and human rights in your improvement journey?
- Did your inspection report help you to improve?
- Examples of tangible improvements
- Examples of improved outcomes for patients
- What next on the improvement journey?

A number of common themes emerged from the interviews, but as not all were given the same weight by our interviewees, we have not covered them all equally in each trust's case study.

Acknowledgements

We would like to thank everyone involved in the production of this publication. This work would not have been possible without the support and time of the eight trusts who agreed to be case studies for improvement.

We are especially grateful to the staff, patients and members of the public who took the time to give their views on the improvement journey of their trust.

We would also like to thank all the local Healthwatch and Overview and Scrutiny Committees for their input into this publication.



University Hospitals Bristol NHS
Foundation Trust



NHS Staff Survey

“Improvement starts and ends with staff engagement”

Chief Executive of East Lancashire Hospitals

Each year NHS staff are invited to take part in the NHS Staff Survey. This gathers views on staff experience at work. The 2016 survey was carried out between September and December 2016 across 316 NHS organisations. The survey had 423,000 responses from staff.

The survey results show how staff attitudes towards the trusts featured in this publication have become more positive. Staff are increasingly happy to work in their organisation and are more willing to let their friends or relatives be cared for at the trust.



Barking, Havering and Redbridge University Hospitals NHS Trust

NHS Staff Survey 2016 trust scores

Trust name	I would recommend my organisation as a place to work		If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	
	Agree/strongly agree (%)	Change since 2014 (%)	Agree/strongly agree (%)	Change since 2014 (%)
	2016		2016	
Barking, Havering and Redbridge University Hospitals NHS Trust	59	10	64	9
Cambridge University Hospitals NHS Foundation Trust	65	7	83	6
East Lancashire Hospitals NHS Trust	65	5	70	10
Leeds Teaching Hospitals NHS Trust	64	11	74	11
Mid Essex Hospital Services NHS Trust	71	8	76	2
University Hospitals Bristol NHS Foundation Trust	67	11	81	10
University Hospitals of Morecambe Bay NHS Foundation Trust	60	11	65	9
Frimley Health NHS Foundation Trust*	67	-10	77	-12
England average for acute trusts**	61	4	70	5

* Between the 2014 and 2016 surveys, Frimley Park Hospital NHS Foundation Trust acquired Heatherwood and Wexham Park Hospitals NHS Foundation Trust (and was renamed Frimley Health)

** This is the mean average, so each trust's results are weighted equally rather than being weighted according to their size

Source: NHS Staff Survey 2016



Leeds Teaching Hospitals NHS Trust



Key themes

“Staff had phenomenal stories about their improvement, but I suppose when I arrived I found quite a fear of sharing improvement”

Director of Communications at Barking, Havering and Redbridge University Hospitals

Each case study in this publication shows key themes of improvement. We hope that these themes will help to inspire other trusts to start and maintain their own improvement journey to help patients, who are at the heart of everything we do.

Reaction to initial inspection report/rating

We saw that trusts were able to make rapid improvements when leaders viewed our inspection report as an opportunity to drive change. Trusts that had recognised issues in their organisation were able to have open and honest conversations with staff and patients on how they could make improvements, and then take action to put these in place. Leadership teams who were in denial about problems made little or no initial progress in improving their organisation.

Some trusts were initially reluctant to accept the findings in the inspection report. “Initially I felt demoralised...but when you step aside and look overall, you can accept what the report was saying as fair” said one Consultant at Leeds Teaching Hospital.

However, other trusts told us that the inspection report validated the concerns they already had. These trusts were confident in knowing that care could and should be better for their patients, and were determined to make this happen.

In most of the trusts we spoke with, a change in leadership was the catalyst for accepting the findings in a report and working to drive improvement.

Leadership

Our case studies point to leadership qualities that really help to drive improvement. Leaders knew they needed to be visible and approachable in order for staff to feel supported. For example, Mid Essex Hospital Services' 'Clinical Tuesday', where all the matrons and lead nurses come and work on the ward, bridging the gap between the management and the ward staff; the meetings where the Chief Executive of University Hospitals of Morecambe Bay (UHMB) takes questions from staff; and the accessible video briefings from the Chief Executive of University Hospitals Bristol.

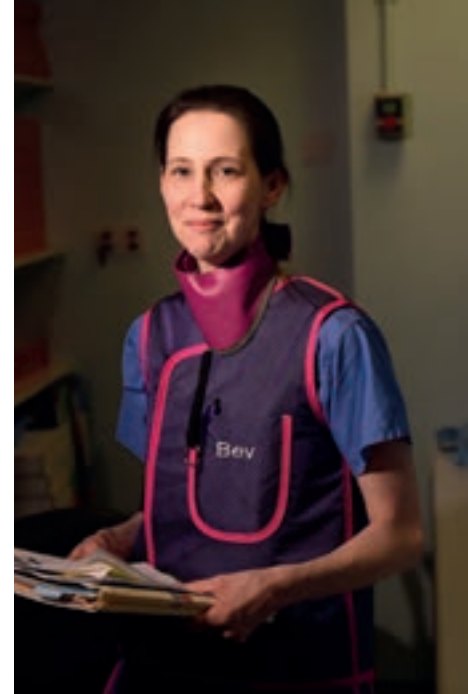
Good leadership is about building strong teams. Chief executives commented on the importance of having a strong executive team and we heard examples of how teamwork was fostered on wards and departments through rewards for achievements and by enabling better working between clinicians and managers. Visibility of leaders was also crucial to gauging cultural change in trusts.

But as Frimley Hospitals' Chief Executive put it, "You don't turn an organisation around just by appointing a new CEO or executive team". He emphasised the importance of clinical leadership, with clinicians having a vital role in setting the standard of what good looks like.

Cultural change

Trusts knew that it was not enough to create an improvement plan – they had to get the staff engaged and motivated to help drive it. "Improvement starts and ends with staff engagement", the Chief Executive of East Lancashire Hospitals told us, "getting staff to understand that they had the answers and the means to improve was critical". In Leeds, the Chief Executive wrote to more than 2,000 managers before he took up the post, setting the tone of his approach. In Bristol, 'Breaking the Cycle' events are held with staff to focus on operational problem-solving.

Moving from a culture of blame to one that celebrates success is another key theme of the trusts. "Staff had phenomenal stories about their improvement, but I suppose when I arrived I found quite a fear of sharing improvement...so we needed to do a lot of work with people to improve confidence and help them to understand that their journey of improvement is something that they should be proud of and that they should want to talk about", said the Director of Communications at Barking, Havering and Redbridge University Hospitals (BHRT).



East Lancashire Hospitals
NHS Trust

“We’re reporting more and more things. And that’s really letting people start to have conversations – we’re empowering staff to fix things.”

Associate Medical Director at Barking, Havering and Redbridge University Hospitals

The trusts recognised the need to tackle equality and diversity issues relating to staff and patients and in the wider community. “If you can’t be who you are at work, you are not going to give 100%,” according to UHMB’s Chief Executive, who took steps to engage doctors by working with the British Association of Physicians of Indian Origin. Cambridge University Hospitals has regular discussions with staff to highlight discrimination, and has a graphic to show the flags of the different home countries of staff as a visual representation of diversity. At Wexham Park Hospital, doctors made note of languages spoken during ward rounds.

Vision and values

Leaders placed an emphasis on getting to know how staff felt about working at the trust. They worked with staff to produce a set of shared values that would underpin positive cultural change. The trusts understood that staff needed to have ownership of the values if they were to be meaningful. Leeds used technology to ‘crowdsource’ staff views on how to make the trust a great place to work; Bristol billed 2015/16 as a ‘year of engagement’ that helped to establish a patient-focused culture and the Chief Executive at BHRT spoke of the values and behaviours that had been designed and developed by staff.

Governance

Addressing problems with governance was a priority for most of the trusts. The right connections needed to be in place from board to ward. There was a keen understanding of this at BHRT. “The processes and systems had been broken for some time,” the chair explains. “So the financial systems and systems for setting budgets had been broken, the governance systems for managing the board, and clinical governance... There was no consistent oversight of the organisation.”

Good governance meant looking at how the board worked and putting new systems in place throughout organisations – for example, Bristol’s focus on getting the governance structure and processes right around clinical incidents.

Getting finances in order often came alongside tackling governance. As we heard from the former Chief Executive of Mid Essex: “You might have to invest to save: you might have to put in an extra clinician to deliver a new service but, if that means patients get treated, and they don’t have to go into hospital and can go home, that’s saving the system money.”

Improving safety

Trusts knew that they needed to change their approach to quality improvement. Both Leeds and BHRT are two of five trusts that have been chosen to work with the Virginia Mason Institute as part of a programme led by NHS Improvement. Leeds adapted the approach to become ‘the Leeds improvement Method’, transforming the way patients move through the hospital. At Wexham Park, an independently chaired Quality and Improvement Committee oversaw improvement, while in Cambridge the Chief Nurse set up a Quality Improvement Programme to assure and challenge improvement plans.



Leeds Teaching Hospitals NHS Trust

As well as corporate initiatives, we also heard about localised quality initiatives such as BHRT's 'model ward', which gives ward staff the responsibility to define what a good ward looks like and then to take responsibility for improvement. At UHMB, quality improvement is driven by staff through Listening into Action projects, where front line staff propose projects that will make a difference to patient care. Quality improvement has become a front line activity in many trusts. For example, daily ward 'huddles' in Leeds, or Cambridge's '08.27' meetings.

Improving trusts are asking questions about the quality of their services. For example, in East Lancashire, each ward gets an unannounced visit from a panel of five staff members who carry out a 'CQC style' inspection to assess quality of care.

Strengthening processes for reporting and learning from incidents was also integral to improvement for most trusts. At BHRT, the Associate Medical Director commented that the rate of incident reporting is one area where the hospital's data highlights a tangible difference: "We're reporting more and more things. And that's really letting people start to have conversations – we're empowering staff to fix things."

“We followed up every action. I don’t believe we’d have got the rate of improvement and acceleration without the reports and action plans.”

Medical Director, University Hospitals of Morecambe Bay NHS Foundation Trust

Patient and public involvement

Taking the views and experiences of patients and the public into account is vital to making improvements. At Wexham Park, focus groups help to address cultural sensitivities, and Mid Essex emphasised that a fundamental part of its improvement journey has been listening to staff and patients, including through a series of ‘In Your Shoes’ listening events and through the ongoing work of the Patient Council.

Looking outwards

Some trusts pointed to the power of being open with staff and the public. For example, UHMB, Leeds and Cambridge all used social media as a tool to share stories of improvement. According to Cambridge’s Senior Communications Manager, “We used the #myCUH hashtag on Twitter to help show staff involvement in developing the improvement plan, but it was also used by staff themselves as a platform to share their own improvement stories.”

Better public engagement has also helped improvement. For example, the ‘Tell Ellie’ campaign at East Lancashire took the trust out to patients for the first time and the trust established a stakeholder listening event to take place every quarter.

CQC engagement

The feedback we received suggests that inspection does help improvement. As well as identifying problems and helping trusts develop improvement plans, reports can help to give structure to improvement work as well as giving clinicians and managers the vigour to effect change. A Medical Director at UHMB said, “They brought a rigour and discipline to improvement work and pointed to where you need to drill down... We followed up every action. I don’t believe we’d have got the rate of improvement and acceleration without the reports and action plans.”

CQC inspectors commented that the cultural change was notable as trusts improved, for example, in the way that trusts engaged more regularly and openly with inspectors.



Barking, Havering and Redbridge University Hospitals NHS Trust

Next on the improvement journey

All trusts have the ambition to keep improving. Trusts such as UHMB, Leeds and Cambridge are looking at their involvement in the wider health and care systems locally.

For Frimley Chief Executive Sir Andrew Morris, Wexham Park needs to maintain the improvements that have happened so far, as well as continue to enable staff to make further improvements. “Like a soufflé, which will flop if you aren’t careful, the challenge for the trust will be to maintain the improvements made and to continue to make further improvements.”



University Hospitals of Morecambe Bay NHS Foundation Trust

February 2017

Rated as good

December 2015

Came out of special measures

July 2015

Rated as requires improvement

June 2014

Went into special measures

University Hospitals of Morecambe Bay NHS Foundation Trust serves a population of around 365,000 covering South Cumbria, North Lancashire and surrounding areas. It is made up of three hospitals: Furness General, the Lancaster Royal Infirmary and Westmorland General, as well a range of community facilities.

The trust was placed into special measures in June 2014 following an inspection in February 2014. An inspection in July 2015 resulted in a rating of requires improvement, with the trust coming out of special measures in December 2015. In February 2017 the trust was rated as good following an inspection in October 2016.

Reaction to initial inspection report/rating

When the trust went into special measures there were mixed views from staff and patients. "We were disappointed in ourselves. We felt we had done a lot and moved on and made enough progress to have made a more positive mark," says Phil Woodford, Director of Communications. There was a general disappointment for staff who were working so hard under pressure, and for the community that supported the hospital.

Chief Executive Jackie Daniel joined in August 2012 at what she describes as the "low point" for the trust. "The board had gone, and there was an interim chair. The report findings were not unexpected and I came in with my eyes open. The report rang true." Jackie comments that staff morale

“was low when we were so busy. With staff shortages, training needs were not being met, which led to staff being disengaged”.

Consultant Andrew Higham – now Clinical Director for Medicine – was not at all surprised. “A good few years before the ‘big trouble’, the way the trust was being managed was increasingly a cause for concern.” Non-Executive Director Denis Lidstone also had concerns when he joined the board in 2012 to focus on governance. “I saw how bad things were. The board was disconnected from the organisation.”

Leadership

Jackie says, “The first thing was to get some sense of direction and support – and clear communications on how we were going to get through this. We needed to start to tell the story of what had gone wrong and why, so staff could make sense of it and then tell them what we needed them to do, in what order, to put things right.”

As Chief Executive, Jackie started by asking five questions: have we got a strategy? How are we approaching quality and safety? Are we building relationships with staff? What partnerships have we got to support what we do? How is our performance?

“For me, the first job was to scan these areas and understand what we had and hadn’t got. This framework guides me now, week by week, month by month.”

“People feel engaged because they’ve been listened to, not just told what to do.”

Andrew Higham, Clinical Director for Medicine

Jackie set about identifying gaps, setting priorities and putting a plan in place. “We needed to make sure we had good wiring from board to ward: for example, a good board assurance framework, a risk management framework, a performance management framework – the things any well-run organisation needs.”

When Andrew Higham became Clinical Director for Medicine, he appointed 11 clinical leads in the specialties. “Suddenly, I had 11 deputies to share the burden. We appointed clinical managers to support the clinical leads. It was like a breath of fresh air. We now have clinical teams much more engaged with that journey of constant improvement. People feel engaged because they’ve been listened to, not just told what to do.”

Cultural change

From Non-Executive Director Denis Lidstone’s perspective, getting the culture of the organisation right was crucial. “You had to get everyone on the same page and be clear about people’s roles. Culture is about how you get people to think and act differently.”

Jackie Daniel recognised that the best plans and strategies would fail if the people she relied on to make them work were not engaged and empowered. The staff needed a clear sense of direction.

Listening into Action to make a difference to patient care

Listening into Action (LiA) involves front line staff proposing projects that will make a difference to patient care. The project has to get patients and staff involved. Examples include:

- An intensive care unit project led by nurses to tackle the pain caused by nose tubes and pressure sores. Pressure sores can lead to infection, affect a patient’s length of stay and incur unnecessary costs. The project almost eliminated the incidence of pressure sores and has led to savings of tens of thousands of pounds.
- Specific education and training to spot signs of acute kidney infection. Following up an NHS England alert about mortality, an associate specialist doctor recognised that this could be easy, so she set up a LiA project and a training programme that is saving lives today.



Development and training with the British Association of Physicians of Indian Origin

Jackie Daniel saw that engaging with Black and minority ethnic (BME) groups of staff in the organisation was difficult.

She attended the British Association of Physicians of Indian Origin (BAPIO) national conference and presented the trust's work on equality and diversity. Phil Woodford thinks this was a turning point. "I think our Indian and Pakistani doctors who were there saw it as more than a token gesture." The trust then formed an agreement with BAPIO for development and training and established a BME network with BAPIO.

Regional local representatives from BAPIO worked with the trust on understanding the issues that are different for staff from BME groups.

Jackie says, "One of the ways I can help turn this issue around is by creating an environment where every member of staff can flourish in whatever way is important to them – but bring their best self to work. If you can't be who you are at work, you are not going to give 100%. And I think that equality and diversity work is a real cornerstone of that whole agenda."

"The Chief Executive gave up time to talk to staff," says Director of Communications Phil Woodford. "Jackie asked people, 'if you could change something, what would it be, why would that make a difference and what longstanding change do we need to make?' Jackie knew she would be held to account at the next staff survey or governors' meeting if she hadn't delivered promises."

The trust also focused on empowering clinicians to deliver best practice. As the Clinical Director for Medicine, Andrew Higham believes, this was about enabling clinicians to lead. "We had gone too far down the road of management control and clinicians being disenfranchised with no say. We had lost a lot of discretionary effort among clinicians; they just came, did the job and went home."

An early change was to establish five clinical divisions, each led by a clinician. "We asked a group of people to take responsibility who hadn't had to before," says Denis Lidstone. "We worked with them to get them to control their own areas. We provided training for managers and non-executives mentored people and divisions."

The trust tried to make sure that everyone was involved in improvement. The Listening into Action (LiA) project, which asked front line staff to identify improvements, is a good example as it led to all kinds of clinical leaders emerging to lead hundreds of projects.

"The temptation is to pull up the shutters, but actually the thing to do is keep up a dialogue."

Jackie Daniel, Chief Executive

Improving safety

"We are much better at reporting and learning," says Andrew. "Some things did happen before but they were not well-structured or embedded. The link between wards and boards is better."

The executive team now has weekly meetings to review incidents. Sister and Ward Manager Michelle McLaughlin says, "Every month I have a governance meeting with my staff where we look at learning from incidents, recalls and alerts. That results in better patient care and safety – that's a big change of culture."

Senior leaders became more visible around the trust. "We now know senior managers," says Michelle. "Before, staff would say 'who's that?' Now we see senior staff around a lot more, coming on to wards."

Denis Lidstone also emphasises quality. "Because we were missing a lot of targets, we started putting money into things. In some cases, money we didn't have – for example, to start recruitment. The money came later. We needed to focus on quality." Medical Director David Walker agrees with this. "It's about focusing on the basics of quality," he says. "You need the information to understand the business. We needed to provide clinicians with the information to do their job well."

Looking outwards

Jackie Daniel stresses how important it was to work with the local population. “The temptation is to pull up the shutters, but actually the thing to do is keep up a dialogue.” The trust held a listening event with a local GP practice in Barrow-in-Furness, modelled on CQC listening events. Commenting on the event, Phil Woodford added, “It was a revelation for our staff because you realise when you live in a bubble of failure you think everything is bad. People spoke about the good care they’d had too.”

CQC engagement

Part of Jackie’s mission as Chief Executive was to make sure that improvement did not become too bureaucratic. Action plans need to be “good enough to get the right level of improvement without sinking people in process,” she says. “We’ve looked to create as many ways as possible for staff to get involved in lighter, less formal, less bureaucratic and less hierarchical ways.”

There was general agreement that CQC’s inspection reports helped to drive improvement. “They brought a rigour and discipline to improvement work and pointed to where you needed to drill down,” says David Walker. Jackie agrees, “We followed up every action. I don’t believe we’d have got the rate of improvement and acceleration without the reports and action plans.” As a Clinical Director, Andrew views the inspection process as helpful as “it gives clinicians and managers some ammunition to effect change”.

Sandra Sutton, CQC’s Inspection Manager, praises the trust for the engagement with CQC between inspections. “They wanted to share progress with us and wanted to hear the feedback we were getting.” She thinks this open approach supported improvement and commented, “The improvement plan following the inspection in October 2016 was the best that I have seen.”

Next on the improvement journey

The trust is aiming for a rating of outstanding. As Phil Woodford puts it, “We have the staff and the talent. It’s about freeing them to do more.” Chief Executive Jackie says she is going to use the staff survey as her number one indicator over the next 12 months. “My mission is to get the most significant improvement in the staff survey next year.”

At the same time, the trust is central to the development of an accountable care system in the area, breaking down the traditional boundaries between hospital care, community-based services, primary medical services and adult social care services.

For more information about University Hospitals of Morecambe Bay NHS Foundation Trust, email communications.team@mbht.nhs.uk.

Involving local people in the new maternity unit

Lesley Bennett is one of the parents involved in helping to shape the design of the trust’s new maternity unit. She says that local people were fully involved in the development by meeting the architect and contractors, looking at the options and making suggestions. “We got everything we said we wanted. The new unit is better than we could have hoped for. We were not there to look good; they really listened to us and our opinions counted.”

The trust acted on the parents’ suggestion of using the bereavement room as a place to stay for families with a terminally ill child or a child receiving special care.

Lesley says, “The Head of Midwifery always said this maternity unit belongs to the community – the trust just staffs it, runs it, and provides the service. It was always about what the people wanted and how best it can be for them. It’s the start of a new beginning for families. If you get that experience right, you set up a family for life because you always think back to the birth.”

“We have the staff and the talent. It’s about freeing them to do more.”

Phil Woodford, Director of Communications

Safe
Personal
Effective



East Lancashire Hospitals NHS Trust

2015

Rated as good

May 2014

Rated as requires improvement and came out of special measures

July 2013

Went into special measures

East Lancashire Hospitals NHS Trust serves a population of 521,000. The trust has two acute sites: Royal Blackburn Hospital and Burnley General Hospital as well as three community sites.

East Lancashire Hospitals NHS Trust went into special measures in July 2013, following a review by Sir Bruce Keogh. In May 2014, a CQC inspection found that the trust had made enough progress to come out of special measures, and rated the trust as requires improvement. A focused inspection in 2015 led to the overall rating being upgraded to good.

Reaction to initial inspection report/rating

Many members of staff were shocked and disappointed when the trust entered special measures. At the time, the trust was working confidently towards gaining foundation trust status. Peter Rowe, who joined the trust as a Non-Executive Director in June 2013, recalls the “complete devastation” when it was announced that the trust would go into special measures. That same shock and disbelief was felt across the organisation. For Shirley Vicary, Ward Manager, “It was a real knock; it didn’t feel like we were that bad.”

Chris Pearson recognised the determination of staff to make positive changes when she joined the trust as Director of Nursing in January 2014, five months after the trust had entered special measures. “Some staff were sad and some disheartened, but many felt that going into special measures was the awakening that the organisation needed and they were determined to make things better.”

Leadership

Six months after the trust entered special measures, there were a number of changes to the trust's leadership team. "Jim Birrell came in as Interim Chief Executive and he had a way of unifying people," says Dr Ian Stanley, Deputy Medical Director.

Peter Rowe agrees. "Jim and the new leadership made it very plain at board level that quality was a priority and dropped any ambition for foundation trust status. We began to move away from being reactive reporters and started supporting staff to be proactive in identifying and tackling variations in quality. It was a real paradigm shift that involved a huge amount of staff engagement."

The executive team spent time being out and about, talking to staff on the front line and letting staff know they would be supported. "Previously there had been a profound divide between the board and the staff," says Peter Rowe. Dr Ian Stanley agrees. "It was only when the changes in the team led to a more open atmosphere that there was a change of mind-set – we just had to be honest and work together to tackle the issues at hand." Ward Manager Shirley Vicary feels that the trust is now a "far more open place to work" and that "if there is any issue that staff feel is not right, they will raise concerns, and it was never like that before."

Cultural change

Getting the culture right was also key for Dr Stanley. "At the start, there was a culture of not wanting to measure things, not wanting to monitor things and not wanting to report things because if you did you might get shot down, because you weren't reporting good stuff. One of the first things that we had to do was to change the approach to quality improvement and convey the idea to staff that we are measuring to improve, not to comply or tick a box."

For Foundation Trainee Doctor Rebecca Kuruvilla, "There's an unspoken camaraderie – almost like being in the trenches – a feeling of 'we're all in it together'". Rebecca feels there is a real emphasis on listening to what the staff want and what ideas they have. "The leadership style is very inspiring and it must have had a big effect on how things have been turned around – I can't see how it didn't."

For Kevin McGee, who took over as Chief Executive in 2014, improvement "starts and ends with staff engagement". He speaks from experience, having previously been Chief Executive at George Eliot Hospital NHS Trust where he took the trust out of special measures. "At both trusts, getting staff to understand that they had the answers and the means to improve was critical. After that it's about giving staff the practical tools to make and maintain those improvements."

When Chris Pearson joined in January 2014, one of her first actions was to set up regular meetings with all ward managers. "At the first meeting, I asked them all to tell me something good that had happened on their area and no-one said a word. They had never been asked about the positives before and at that moment I knew had a real job to do around changing the culture."

Tackling variation in quality on wards

Director of Nursing, Chris Pearson, introduced the Nursing Assessment Practice Framework in a bid to tackle the variation in quality between wards.

Chris says, "Each ward gets an unannounced visit from a panel of five staff members who carry out an inspection 'CQC style' to assess quality of care. On the panel there'll be a safeguarding lead, a matron from another area and other members of staff. Each ward is scored red, amber or green for how they are meeting each KLOE. We've not completed every ward yet, but we've done 89 assessments so far. A ward scored red (not meeting standards) gets another visit in two months. If they achieve more standards against the indicators they get amber. When a ward gets three consecutive greens, they get an accreditation." Chris is clear that this has really helped to highlight areas for improvement and drive changes in practice.



Establishing a pressure ulcer collaborative

Throughout 2014, the trust provided learning sessions and a summit to engage staff in a new quality improvement methodology aimed at reducing pressure ulcers.

“We haven’t had a Grade 4 pressure ulcer in this organisation across both acute and community services (we’ve got over 1,000 beds) since August 2014, which is a huge achievement,” says Chris Pearson. We can absolutely scrutinise every pressure ulcer, whether it’s acquired or inherited, consider what we’re going to do about it and prevent it happening again. We’re down to single figures of Grade 2 pressure ulcers now.

“We showed the staff the data and what they’d achieved. That gave them the boost to want to get involved in more improvement collaboratives.”



Vision and values

Embedding the trust’s vision of “Safe, Personal and Effective” was also crucial. Chris Hughes, Director of Communications, worked hard to promote this vision and the objectives that underpin it. “We had posters made and put them everywhere, we referenced the vision and values in every publication, and we flooded the organisation with the message that this is what we are about and stand for.”

Improving safety

The trust’s focus on quality improvement and harm reduction has led directly to improved outcomes for patients. “We have a systematic approach to dealing with harm now and a clear reporting mechanism,” says Dr Stanley. “Through the harm reduction programme we have reduced the number of pressure ulcers and falls and improved infection control practices. Mortality rates have also improved.”

“There’s an unspoken camaraderie – almost like being in the trenches – a feeling of ‘we’re all in it together’”

Rebecca Kuruvilla, Foundation Trainee Doctor

Looking outwards

The outside world seemed to perceive services as inadequate. This had an effect on staff morale and made it difficult to recruit new staff. According to Chris Hughes, it was about re-launching the organisation, re-establishing its reputation and taking some control. When she joined the trust in February 2014, one key task was to turn around what was a very hostile relationship with the local media and make a concerted effort to have a higher profile. “It was about working with the local media and not against them. We had to be brave and honest.”

The consensus is that entering special measures has benefited the trust, but the initial scrutiny from external regulators was at times testing. “Everybody wanted information and that was an added pressure,” says Chris Pearson. Dr Stanley acknowledges this. “It took an awful long time for the clinical commission group (CCG) and others to trust us and that is understandable. They asked questions about every decision we made and we had to re-build our relationship with them to get that trust back.”

Patient and public involvement

Public engagement has improved. The introduction of the ‘Tell Ellie’ campaign (East Lancashire Listens, Involves and Engages) marked a significant change as it took the trust out to patients for the first time. “Previously, the trust had waited for patients to come to them and in reaction they launched the Tell Ellie campaign and took staff out into the community to meet and engage with local people,” says Chris Hughes. “While it was limited in its reach, it served a purpose and was the start of a different approach to engaging with the public.”

After being appointed as Director of Communications, Chris Hughes established a stakeholder listening event every quarter to widen the public audience. “We invite people from a lot of interested organisations, including a number representing patient groups, to come and talk to the board. We get a lot of valuable ‘soft’ intelligence and it’s directly used to inform changes in how we deliver services.”

Individual local patient groups are more involved. Russ McLean is the Chair of Patient Voices in Lancashire and has worked closely with the trust to make sure that the views of the public feed into improvements to services. He says, “The trust is far more responsive to us now. We really work with them and they listen to what we’re telling them.”

Representatives from local Healthwatch have also been involved in the trust’s Patient Experience Committee, which meets regularly to discuss patient feedback.

Non-Executive Director Peter Rowe also notes how the trust has improved its process for handling complaints. “Previously it was meticulous in terms of following an auditable process, but it lacked any sense of humanity. The process has been completely overhauled. The moment something goes wrong a patient or carer can contact a matron by a bleep and we tackle the issue there and then. We get far fewer complaints now.”

CQC engagement

There is general agreement that CQC inspections have helped. For Chris Hughes, “The CQC requirements allowed us to get a real campaign going internally. We all knew we had to get through the re-inspection and get through it well. Everyone had a shared objective.”

Chief Executive Kevin McGee says, “The CQC process gives you a real focus for improvement. I was able to say to commissioners, ‘some of these areas for improvement are systems issues and I need your support,’ whether that is in terms of resources, changes to primary care services or whatever.”

Next on the improvement journey

Chief Executive Kevin McGee is committed to continuing with the quality improvement work. “The emergency pathway work we have done has led to excellent quality services, but we need to improve on timeliness and meeting the four-hour target.”

Similarly, Kevin wants to continue the work to improve the trust’s reputation to help attract new staff. “There are still one or two areas where we struggle with recruitment – A&E consultants for example. I want to try to do more to show people that this is a great place to work.”

Kevin is aiming for an outstanding rating. “I’d like the work we have put in to improve clinical quality and staff engagement to be recognised with a rating of outstanding. We’ve got here, but we have to keep moving. We must continue to evolve.”

For more information about East Lancashire Hospitals NHS Trust, email communications@elht.nhs.uk.

Partnership in care

This project aims to improve the quality and experience of one-to-one care for vulnerable patients. In 2016, the trust successfully trialed a number of initiatives on three wards, including:

- communication aids for staff, designed to promote a ‘partnership in care’ with relatives and carers
- pocket cards for staff listing a set of standards to follow when providing one-to-one care
- a partnership in care leaflet for families and carers that recognises their rights as carers and experts in knowing what the patient’s personal preferences might be
- an activity log to help support engagement and stimulation with patients who receive one-to-one care
- the ‘Enhanced Care’ risk assessment tool, which helps provide a standard and assurance to determine which patients need one-to-one care so they receive the right care at the right time.

Shirley Vicary, a Ward Manager of a complex care ward, feels lucky she was able to be involved in the trial as “the immediate benefit to patients has been clear”. The project has now been rolled out to other wards and the learning is being shared with trusts across the country.



Cambridge University Hospitals NHS Foundation Trust

January 2017

Rated as good and came out of special measures

September 2015

Rated as inadequate and went into special measures

Cambridge University Hospitals NHS Foundation Trust is one of the largest in the UK with around 1,400 beds. The trust provides a major trauma centre for the east of England, a range of specialist services and district general hospital services to patients coming from Cambridgeshire, Essex, Suffolk and Hertfordshire.

Following a CQC inspection in April 2015, the trust was rated as inadequate and placed into special measures in September 2015. A focused re-inspection in February 2016 and a comprehensive re-inspection in September 2016 found the trust had made improvements in the quality and safety of services. The trust was taken out of special measures and rated as good in January 2017.

Reaction to initial inspection report/rating

Staff at the trust initially felt shocked at being rated as inadequate. Chief Pharmacist Sarah Pacey felt “surprise and disappointment” at the news, but recognised that “there was a large element of learning and improvement to be taken from the report and its findings”. Sarah was impressed with the trust’s “immediate and prompt” response.

Roland Sinker joined the trust as Chief Executive in November 2015 when the quality improvement plan was well under way. He comments that inspection reports “are a good reflection of the situation of things as found by CQC when they visit,” and he felt the report published in September 2015 was very fair.

After his initial shock at the rating, Chair Dr Mike More felt that the “issues were recognised for what they were”. Mike refers to the inspection period as a “perfect storm,” with issues in the new IT system, finance concerns and bed pressures, as well as a disconnect between the senior leadership team and frontline staff.

Sandie Smith, Chief Executive of Healthwatch Cambridgeshire and Peterborough, sympathised with the trust as it was in a “state of flux” at the time of the inspection. The trust was rated as outstanding for CQC’s caring key question, which for Rachel May, Division A Head of Nursing, was “nice for us to hold on to despite the overall rating”. Like many staff, Rachael drew strength from feedback from patients, who were “very supportive and happy with their care, which in turn helped us”.

Chief Nurse Ann-Marie Ingle stepped forward to lead the improvement work. She reflects on the difficulty of dealing with the rating on a personal level. “As a reasonably new executive at the trust, and as someone who was leading improvement, dealing with the shock of the report, and the scrutiny and challenge on the executive team was an additional pressure at a very difficult time. The trust and the Royal College of Nursing were both very supportive – but it shows that you have to be strong to lead in a trust that’s had a critical report.”

Leadership

One of Roland Sinker’s first priorities was to “calm people down, listen to them and go to see them physically – both patients and staff”. Roland felt it was “crucial to show that the senior leadership team was listening and visible”.

Mike More says, “As an organisation, we took ownership of the issues and challenges identified, and this was important, as being defensive is a negative action to take in this type of situation.” He explains that the board took it as an opportunity to “hold the mirror up to ourselves so we can recognise our weaknesses as an organisation as opposed to casting blame into the system”.

“As an organisation, we took ownership of the issues and challenges identified, and this was important, as being defensive is a negative action to take in this type of situation.”

Mike More, Chair

A lot of work went into improving the visibility of the executive team. New channels enabled and encouraged staff to ask questions and share ideas or concerns. Executive visits were a particular success, where each director was ‘assigned’ a clinical division and visited the departments in it, acting as a champion for staff engagement. This created rapport and the sense of a guaranteed voice at an executive level that was otherwise missing.

The Quality Improvement Programme

Work started at the time of the inspection in April 2015 as soon as CQC shared initial findings. After the report was published, Chief Nurse Ann-Marie set up and led a more formalised quality steering group and developed the project management process needed to deliver improvements. Ultimately the team identified 24 clear quality actions.

The first thing she did was to study themes in the inspection report, arriving at five priority themes for improvement: quality issues; leadership; culture; estates; and finance.

In each strand of the quality improvement programmes (for example, pain management), each one has had an assurance programme, linked to peer reviews that challenge the improvement plans. Ann-Marie says this has helped to “give more context and enables good dialogue with colleagues in other trusts”.



Improving communication from 'board to ward' at 8.27 meetings

"As a result of the initial findings in April 2015, we made a commitment to improve the communications from 'board to ward'. As a part of this, we introduced the 8.27 meeting," says Senior Communications Manager Dail Maudsley-Noble. "The meeting is held weekly at 8.27am every Tuesday morning and gives staff an opportunity to ask questions and hear about the trust's progress directly from the CEO and executive team."

The meetings usually last until 8.53am sharp – giving staff time to attend any 9am meetings they may have.

Although not a mandatory meeting, Dail explains that it is popular as it "really generates constructive discussion when managers from across the trust can raise issues and suggest solutions between them". Rachael May, Division A Head of Nursing, feels that these meetings are helpful as there is "no hierarchy and information is cascaded to staff afterwards".

Cultural change

In 2015, staff morale was low. Fiona Allinson, a Head of Hospital Inspection at CQC, reflects that at the time of the rating, nurses in particular felt "disempowered" working in the trust.

As Mike More explains, "We put a lot of effort into internal staff engagement to create a culture of listening and support – to make sure that our staff felt reassured and understood their importance to the organisation."

The communications team put together a full range of activities to keep staff, patients and stakeholders informed from day one. To find out the main issues for staff, Senior Communications Manager Dail Maudsley-Noble used surveys and staff focus groups. "We talked to all staff groups to get a better understanding of the challenges," says Dail. "Their feedback enabled us to highlight the major issues around the trust and specific areas where we could support improvement." The trust also encouraged departments to reach out to peers in other organisations to review processes and share knowledge.

As Roland puts it, "Our journey is about empowering staff in the clinical teams and frontline staff who work with patients to drive improvement. I wanted to help people feel empowered so they could feel able to do things themselves and see that our plans for improvement were achievable."

Initially, it was hard for the trust to communicate to staff why it went into special measures. "It was a huge challenge," says Chief Nurse Ann-Marie. "It took a long time – going out and explaining to staff what it was about."

Social media helped to get staff on board. "We used the #myCUH hashtag on Twitter to help show staff involvement in developing the improvement plan, but it was also used by staff themselves as a platform to share their own improvement stories and the work they were proud of," says Senior Communications Manager Dail Maudsley-Noble.

Before being placed into special measures, learning was not routinely shared across the organisation. "Even where someone's small team was working well, they didn't always understand what the whole team was doing," says Ann-Marie.

Roland explains that immediate action plans were started and proactively shared internally and externally to show "the energy that was being put into shaping where the organisation was going".

Using the inspection report, the trust developed a detailed tracking management document, which included CQC recommendations and other improvement actions. "We became determined to improve cohesiveness between ourselves," says Rachael May, Division A Head of Nursing. Sharing the improvement plan across the organisation enabled people to take responsibility for the concerns in the inspection report. "It was good to have the physical improvement plan and it was helpful as a guide to decide what to do next." Rachael added that it also helped staff to have "open conversations with senior leaders, which made a big difference".

Ann-Marie comments on the changes seen during the 2016 re-inspection, “By February, all staff knew what the improvement plan was and CQC inspectors saw a palpable difference in people’s views.”

Looking outwards

The trust has improved its links with external organisations. “We had talks with Healthwatch, patient representative groups, councils, MPs and the press so we could provide them with reassurance about the trust,” says Dr Mike More.

Before special measures, Healthwatch Cambridgeshire and Peterborough had only one point of contact for the trust. Its Chief Executive Sandie Smith felt that the trust tended to be a “corporate” organisation that was “not always that inclusive or willing to work in partnership”. Now she says, “the relationships we have with people across the trust are much more comprehensive...they put in place a direct line to all different areas of the trust – including a line to Roland Sinker.” The trust involves Healthwatch in discussions and specific work, as well as organising ‘Enter and View’ visits at Addenbrooke’s Hospital. “Addenbrooke’s were quite insular before, but are now more community focused and thinking more collaboratively,” says Sandie.

The trust also established quarterly liaison meetings with the Health Overview and Scrutiny Committee (HOSC). Departments were also encouraged to reach out to peers in other organisations to review processes and share knowledge.

CQC engagement

“It can feel like you are on the inside of a problem,” says Ann-Marie. “So I picked up the phone.” Ann-Marie researched CQC reports of trusts that had achieved good and outstanding to “build up a network of support.”

Next on the improvement journey

Roland feels that the move from inadequate to good has been a “powerful” one. However, “the fundamentals are still the same – to listen to patients and staff, get a grip on quality and waiting times, staffing and money.” Roland has set the agenda for making Cambridge University Hospitals NHS Foundation Trust the “best trust it can possibly be in terms of governance and staff empowerment”. For Roland, the question now is: “how do we build an organisation that is sustainable in the long run?”

The trust as a whole will now focus on improving patient experience, as well as building on academic and clinical research, and empowering staff to do the best job they can. Improving patient flow and capacity are also priority areas, both to ensure the best patient care and to relieve pressure on staff, giving them time to focus on long-term improvements for their patients. “We are building on our progress so far and making it business as usual,” says Senior Communications Manager Dail.

For more information about Cambridge University Hospitals NHS Foundation Trust, email communications@addenbrookes.nhs.uk.

Focusing on equality and diversity

Of the staff at Cambridge University Hospital NHS Foundation Trust, 27% are not from the UK (14% EU staff and 13% from the rest of the world). “There is an underpinning thread of equality and diversity in the work we do bringing everything together,” says Division A Head of Nursing Rachael May.

The trust has worked with groups of vulnerable people and regularly discusses inclusion with staff to highlight discrimination issues. Roland says, “The focus over the next 5 to 6 years will be on listening to people about what they need, combining that with where the hospital is going and tying it all together in alignment with each other.”

Following the EU referendum result, the senior team worked closely with its EU staff and as part of this, held a workshop with an MP to reassure staff and answer any questions.

The equality and diversity team provided talks, seminars and films around equality and diversity and mandatory training on unconscious bias was introduced, which Rachael says has made “a strong impact”. ‘Visual cues’ of inclusion and diversity made from the flags of the different home countries of staff are displayed all over the trust and online.



Wexham Park Hospital

February 2016

Rated as good

February 2014

Rated as inadequate and went into special measures

Wexham Park Hospital is a district general hospital serving a population of around 465,000 people with approximately 3,400 staff and around 700 beds. Since October 2014, it has formed part of Frimley Health NHS Foundation Trust, when Frimley Health NHS Foundation Trust acquired Heatherwood and Wexham Park Hospital.

The previous Heatherwood and Wexham Park NHS Foundation Trust was inspected by CQC in February 2014. The trust was rated as inadequate. CQC re-inspected the Wexham Park location in October 2015 and found remarkable progress, resulting in a rating of good in February 2016.

Reaction to initial inspection report/rating

Although staff at the trust were disappointed with being rated as inadequate and going into special measures, many felt the hospital had been trying to make improvements.

Reflecting with the benefit of hindsight, they felt that the decision to put the trust into special measures had been the right one. When staff came into Wexham Park after the acquisition, it was clear that being rated as inadequate had hit staff morale, and this was made worse by apprehension about the consequences of the acquisition and the lack of stable senior leadership.

Staff needed to believe that the hospital had a future and overcome the sense of being “rudderless” that CQC had found in 2014. The organisation had been under financial pressure for years, but started to receive support

from NHS Improvement once in special measures. It was widely felt that going into special measures and undergoing a takeover was a fantastic opportunity to turn things around.

Leadership

The leadership team set out to tackle issues identified in CQC's 2014 inspection report about the "dysfunctional working practices" of some consultants, and the "learned helplessness" of the trust. Many staff appeared to accept the falling standards as the norm, and in some cases, felt they were not part of the solution, or could make a difference. Heidi Smoult, Deputy Chief Inspector of Hospitals, was CQC's inspection lead at the time of the 2014 inspection. Heidi says that addressing the "learned helplessness" at the start enabled the culture to change "more quickly than might otherwise have been expected".

The hospital established Chiefs of Service to lead each major clinical area. The Chief of Service leaders, along with the executive team, started to make it clear what 'good' looked like through sheer commitment and determination. This element showed staff that senior clinical and managerial leaders were committed to staff and patients. Staff started to recognise that improvement was needed, and that they could make a real difference.

Dr Prem Premachandran, Chief of Service for emergency care, spent time at Wexham Park Hospital shortly before the acquisition. Prem feels that "if you tackle things in the right way you can get huge change quickly". Prem carried out interviews with 273 staff to understand the issues at the trust and implement plans to make improvements.

Clinical leadership was recognised and clinicians had a vital role in setting the standard of what good looks like. Frimley Chief Executive Sir Andrew Morris is clear that it goes beyond bringing in new leadership. "You don't turn an organisation around just by appointing a new CEO or executive team," he says.

Cultural change

Sir Andrew's first priority was to address the culture at the newly-acquired Wexham Park Hospital. "It's about trying to get everyone to treat people as though they are their own Mum and Dad."

Medical Director Dr Tim Ho echoed the need to address the culture at the hospital. He saw that people had forgotten what good looks like and needed to start believing in themselves again. For Sir Andrew, it was about "sparking the desire to do a fantastic job".

Dr Prem Premachandran agreed that the attitude of the workforce was key to making positive changes in the organisation. Prem likened the situation of the trust to the image of the clay-covered Golden Buddha – they needed to chip away at the clay that was hiding staff talent to expose the gold underneath.

Stable leadership at executive and board level, as well as clinical engagement and buy-in, has been vital in changing the culture of the trust. The senior team focused on tackling issues that had not been addressed. As Director of Operations Lisa Glynn says, "it was like a chef coming in to

Enabling patients to speak in their language

Recognising the importance of understanding the needs of the diverse local community, staff enabled patients to express themselves using their spoken language when entering the Emergency Department (ED).

At every ward round, doctors wrote down what language each patient spoke, and staff working in the ED recorded the languages they also spoke on a whiteboard. There was also a leaflet in a variety of languages explaining the availability of translators. Therefore, all staff knew of the languages spoken by staff working that shift as well as the languages individual patients spoke and were able to match patients to staff or translators with the relevant language skills so that patients and staff could communicate fully with each other.



The Ask Andrew page

The “Ask Andrew” page, which features on the Frimley Health website, enables all patients and members of the public to contact the Chief Executive with any queries, concerns or thoughts they have about the trust. Everyone who makes contact via this webpage receives a personal response from Sir Andrew Morris. Listening to concerns helps the trust to garner the views of the public, and helps to identify any issues early on.

The Ask Andrew page, alongside a range of other feedback mechanisms, are frequently used by patients and members of the public. Many people feel that it is proof they are being listened to, and their concerns are being taken seriously by the Chief Executive. Many feel it sets a different, more inclusive tone and shows hospital staff as approachable, even at the most senior level. This stands in stark contrast to the culture that had existed previously.

your kitchen at home, and throwing out the rubbish from the cupboards.” People commented that small changes can lead to big differences. After giving the staff ownership and the opportunity to show what they can do, they made “remarkable progress”. Putting patients at the heart of what they do, and looking after them as they would look after their own family, was fundamental to this shift.

Georgina McMasters, a patient with a long-term condition, felt like a “voice in the wilderness” when talking about the issues in the year before the acquisition. She feels that the organisation was blind to its own shortcomings. “You never notice your own dripping tap or curling wallpaper” she says. Her view is that “staff were fabulous, but were fighting in a culturally rotten environment”. Geoff Motley, another patient representative, felt that staff were not looking at patients’ overall experience, but only the immediate medical issue, treating patients as a number.

“staff were fabulous, but were fighting in a culturally rotten environment”

Georgina McMasters, patient

In the year following the takeover, patient care had improved dramatically. People were being diagnosed and treated more quickly, and by the right team, which had a positive effect on patient outcomes. Staff believed that the culture had fundamentally changed and they had started to recommend Wexham Park Hospital as a good place to work.

The trust knew it was important to acknowledge the hard work of staff and how this was improving care. It recognised outstanding work through staff awards and staff with many years of service. The Chief Executive used the language of staff working “for”, rather than “at” Frimley Health. One patient spoke highly of the “Ask Andrew” page on the Frimley Health website, where anyone who contacts the Chief Executive receives a personal response.

Vision and values

One way to get people on board was by sharing the organisation’s values. Rather than imposing the values from Frimley Park Hospital onto Wexham Park after the acquisition, the values were re-assessed and integrated across the whole trust, with workshops and input from staff. James Taylor, Director of Communications, commented that it was important to ensure that “the trust” meant the newly-created Frimley Health, and not to overlook the positive effect of celebrating success, both internally and externally.

Patient and public involvement

The trust took the different needs of patients into account. One example of this is when the trust ensured that a patient who could not hear their name being called was notified in an alternative way. Staff were aware that in some communities, patients were not registered with a local GP practice and work was being carried out to address this. Focus groups provided input into addressing cultural sensitivities, and faith and ablution rooms were made available. The two local Healthwatch groups, Slough and Bracknell Forest, also provided valuable information, and the Listening into Action (LiA) approach was renewed and extended across Frimley Health.

The trust kept staff and patients at the heart of discussions when shaping governance and processes. They kept the idea in mind: If this was your family member or friend, would the care be good enough? The trust also surveyed staff and patients to understand how people felt things were progressing. Georgina McMasters attended panel meetings and felt “vindicated on reading the findings from CQC’s inspection in 2014, having pointed out issues that CQC had also found”.

Looking outwards

As well as the Board being more aware of what was happening on the ground, an independently chaired Quality and Oversight Committee (QOC), was important in bringing about improvement. The QOC has consistent and appropriate senior attendance despite competing demands on people’s time. After discussions with each member, the committee’s Chair Dr Stephen Richards, was clear what its priorities would be and what would be delegated to other committees. There was early agreement on the areas of focus. As well as addressing challenges, Stephen says “celebrating success was a big part of what the Quality and Oversight Committee was about”. He wrote to each person who presented at the meeting, and progress was praised in hospital-wide newsletters.

Senior representatives from the five clinical commissioning groups attended meetings, as well as CQC, other partners and senior staff at the trust. Having a successful committee, holding people to account, tackling the issues and bringing together the right people to deliver improvements for patients, minimised the need for other additional meetings, which freed up time to get on with making improvements. One measure of success identified at the outset was that the Committee would be able to stand down with confidence. After an extended period of two years, the trust achieved this goal, and was rated as good.

Engagement with the trust’s diverse local communities was also crucial. Colleagues from the two previous trusts worked together to understand the best ways to communicate with local communities, and doctors noted down the languages spoken during ward rounds.

Next on the improvement journey

For Chief Executive Sir Andrew Morris, the trust needs to maintain the improvements that have happened so far, as well as continue to enable staff to make further improvements. “Like a soufflé, which will flop if you aren’t careful, the challenge for the trust will be to maintain the improvements made and to continue to make further improvements.”

The Chief Executive and Medical Director explain that this was part of a five year journey for the trust. Despite what CQC describes as “very significant” improvements, the trust acknowledges that there is still work to be done and a need to continuously improve, especially when changing the trust’s culture. The ambition is for people to think of Wexham Park Hospital as *the* place to go to – to work, to train, and to be treated.

For more information about Wexham Park Hospital, email communications@fhft.nhs.uk.



“It’s about trying to get everyone to treat people as though they are their own Mum and Dad.”

Sir Andrew Morris, Frimley
Chief Executive



University Hospitals Bristol NHS Foundation Trust

March 2017

Rated as outstanding

December 2014

Rated as requires
improvement

University Hospitals Bristol NHS Foundation Trust is made up of eight hospitals and is one of the largest NHS trusts in the country. It is an acute teaching trust and became a foundation trust in June 2008.

The trust was rated as requires improvement in December 2014 due to improvements needed in safety, responsiveness, and leadership of some services. After improvements in engagement with staff, patients and partners, the trust achieved an outstanding rating in March 2017.

Reaction to initial inspection report/rating

Staff were disappointed with being rated as requires improvement, but felt that the findings in CQC's report accurately reflected the reality of the pressures they faced. Staff morale in some places was low, and some staff felt they were not being listened to. This chimed with the 2014 staff survey results, which revealed below average scores in staff engagement. It made the leadership team think hard about why they were losing the goodwill of staff.

Chief Executive Robert Woolley believes that at that time, "the leadership team were not messaging internally strongly enough or inclusively enough in a way that connected with staff and the reason that staff come to work – which is not about making savings, or designing the future of the NHS, but is about delivering the best care they can possibly give themselves in the moment". Robert felt that there was a "disconnect between what the leadership team was expressing and what the staff was experiencing".

Reflecting back on 2014, some staff felt that it was a time of upheaval; multiple ward moves, consultations and operational changes made it hard

for them to get clarity on the trust's priorities for improving patient care. Robert explains how the trust had put in various programmes of work and support before the rating, which "clearly hadn't borne fruit in 2014" but have helped to achieve the outstanding rating this year.

Senior Sister Sarah Beech explains that the improvement work was "heading on an upwards trajectory – but it was all happening at the same time so it was difficult". Robert put a strong emphasis on the care that staff provided. "The senior leadership team was continuing to get the message across about compassion being equally as important as technical care."

Cultural change

Robert Woolley described 2015/16 as a "year of engagement", with leaders focusing on staff experience and patient involvement. He says this initiative "improved staff engagement... helping to establish a fully patient-focused culture and advancing the trust's strategy".

Breaking the Cycle Together events focused on operational problem-solving, and the trust introduced Schwartz rounds, a structured forum for staff to reflect on the emotional effects of caring for patients. The trust has used new posters and infographics in visual messages to staff, Chief Executive video briefings, safety bulletins, and the *We are Proud to Care* film, showcasing what Robert calls "the compassion and commitment of all trust staff".

"There is value in having an open conversation with staff and understanding what the staff feel. It's about making sure that we don't pay lip service to it, but we actually understand what challenges staff are facing and what we are doing to overcome them."

Fiona Jones, Divisional Director of Diagnostics and Therapies

Fiona Jones, Divisional Director of Diagnostics and Therapies, speaks of the value of staff engagement, calling it the "best gauge for the culture of the organisation". Fiona believes, "There is value in having an open conversation with staff and understanding what the staff feel. It's about making sure that we don't pay lip service to it, but we actually understand what challenges staff are facing and what we are doing to overcome them."

Alison Ryan, Non-Executive Director and Chair of the Quality and Outcomes Committee explains that they had to move away from the "we know best" attitude and move towards an organisation that was learning from mistakes and keeping patient safety at the heart of everything they do. Sarah Beech says, "Staff at the trust are now patient focused and quality focused". Patient Representative Jim Houlihan says, "Even in a resource-lean environment, the staff are never complacent."

Brenda Massey, Councillor for Southmead, believes that the trust has gone from having "a hands-off approach" to being a place where the staff are "willing to go in and look around and ask questions". The trust has a greater sense of "self-awareness" about the things they need to do to

Transformation of patient letters project

In response to complaints from patients, the trust introduced the Transformation of Patient letters project to improve the quality of its correspondence. Patients had missed their appointments because of shortcomings in the letters or because the content was confusing and unclear. The trust held a 'Letter Champions Week' when volunteers interviewed patients in outpatient clinics across the trust to find out how the letters could be improved. Patients' feedback informed a new set of Letter Quality Standards, which was applied to all existing letter templates in the trust's patient administration system.



Understanding staff satisfaction with The Happy App

The 'Happy App' is an interactive web-based tool to gather real-time feedback from staff. They can use the app to indicate how happy they are at work and record why. The app gives managers the opportunity to monitor and understand staff satisfaction and engagement, and enables them to act on issues. It has had a positive effect on local team culture and the trust is supporting it to continue, as well as helping other trusts to adopt the approach.



change, and that the environment is now a place where there is “so much more capacity to engage with one another”.

Vision and values

For Chief Executive Robert Wooley, “The values are embedded across the organisation” and “staff feel a greater sense of pride to work at the trust”. He refers to the “visible pride and confidence of staff that’s reflected in CQC’s report”. Fiona Reid, Head of Communications, thinks that staff sharing the values of *respecting everyone*, *embracing change*, *recognising success*, and *working together* helped the trust on its improvement journey. She says, “The values are the blueprint for how we want to work together, and are a massively unifying element that helps to reinforce what we are trying to achieve”.

“The values are the blueprint for how we want to work together, and are a massively unifying element that helps to reinforce what we are trying to achieve”

Fiona Reid, Head of Communications

Governance

Auditing played a key role in the trust’s improvement journey. An internal audit on the role of the ward sister found that many ward sisters and ward staff were not clear on the management role and responsibilities of the post. Alison Ryan, Non-Executive Director, describes a “perpetual tension” where “neither party felt empowered to work constructively in that relationship” despite it being one of the most important driving relationships. For Alison, the internal audit team is “magical” and “sometimes provides everything that you need to know”. Alison stresses the importance of getting the governance structure and processes right, particularly around clinical incidents, to ensure awareness and learning and how her accountability as a Non-Executive Director to the trust’s governors has helped with transparency.

Improving safety

Clinical processes needed to improve to benefit patient care and staff morale. Sarah Beech reflects, “I recognised there weren’t enough processes, and ways of doing things that were the same throughout the trust, so we all did slightly different things. Our ways of doing things were different so our processes and our clinical skills could be slightly different.” Senior Sister Alice Kershaw added, “You would strive to give the best care that you could, but unfortunately you would be up against different blocks that might stop you from doing that, whereas now there’s been a lot of work to remove those blocks.”

As part of the work to improve clinical processes, Senior Sister Alice Kershaw credits the new clinical lead for the tissue viability team who set up training and education for ward staff, which “empowered staff to engage more with the service”. The clinical lead worked on recognising

the tissue viability needs of patients on admission and improving incident forms, documentation and reviews of the service.

Planning has also improved the efficiency of some services. Staff now attend daily 10:30am flow meetings, which help to plan for admissions. Alice describes it as a “move from having a ‘shift by shift’ attitude, to having a proactive attitude towards finding the correct processes and constantly challenging ourselves to be more efficient”. Specialist teams such as the infection control team are “proactive and visible” and “genuinely prepared to come and help you”.

Next on the improvement journey

Staff are proud that the trust has been rated as outstanding, and they are seeing that success reflected back in its recent granting of NIHR Biomedical Research Centre status. There is a strong desire to continue to provide outstanding care. As Sarah Beech puts it, “You don’t want to plateau out – you want to be the best you can be.”

Robert Woolley believes that the next step in the trust’s improvement journey is to focus on patient flow in the emergency department, and the consequences of having demand in excess of what they can manage. The biggest immediate priority is to establish new models of emergency care that reduce the need to admit to hospital, or allow staff to discharge patients from hospital far earlier than they currently do.

You don’t want to plateau out – you want to be the best you can be.”

Sarah Beech, Senior Sister

As a patient at the trust and end of life care steering group lay representative, Jim Houlihan says a focus for the trust is to develop its relationship with social care. He believes there is work to do with other trusts. “There needs to be better collaboration between trusts and less of a competitive attitude.”

For Fiona Jones, it is about achieving consistency in patient care. “We need to make sure that patients are having the same experience, no matter what time of day, what day of the week, what time of year they are admitted.”

For more information about University Hospitals Bristol, email communications@uhbristol.nhs.uk.

Improving patient fitness using the prehabilitation programme

The prehabilitation programme aims to improve a patient’s fitness before major surgery. Patients on the programme are encouraged to stop smoking, manage their alcohol intake, eat healthily and manage their medicines effectively. The collaborative programme involves surgeons, anaesthetists and Macmillan nurses, academics at Bristol Research Unit and Elizabeth Blackwell Institute, digital start-up companies and the trust’s hospital charity Above & Beyond. Prehabilitation has been established as a pathway in thoracic, hepatobiliary and pancreatic, and obstetrics and gynaecology surgery. The trust has also worked with colleagues at North Bristol Trust to develop this in urology and vascular surgery.



Barking, Havering and Redbridge University Hospitals NHS Trust

March 2017

Came out of special measures

March 2015

Rated as requires improvement

December 2013

Went into special measures

Barking, Havering and Redbridge University Hospitals NHS Trust serves a population of over 750,000 in outer North East London. The trust operates from two sites: Queen’s Hospital, Romford, and King George Hospital, Ilford.

The trust was placed into special measures in December 2013, following an inspection in October 2013. In March 2015, a further inspection revealed encouraging signs, and the trust was rated as requires improvement. The trust came out of special measures in March 2017.

Reaction to initial inspection report/rating

“The way I would describe it is, you had professionally qualified staff coming to work – underpowered in terms of numbers, underpowered in terms of systems – and a demand from the top to sort it out.” This is how Dr Maureen Dalziel remembers the period before October 2013. Now Chair, Maureen had been on the board for a short time, and was one of a number of non-executive directors who had already expressed concerns.

“The processes and systems had been broken for some time,” she explains. “So the financial systems and systems for setting budgets had been broken, the governance systems for managing the board, and clinical governance. All the back-office systems had been stripped out so they were at a minimal level. The board oversight had gone through a revolving door for about 15 years. There was no consistent oversight of the organisation.”

Havering councillor Jason Frost sat on the borough’s Overview and Scrutiny Committee at the time of CQC’s inspection. He is clear about the

challenges the trust faced. “It serves three of the most populous boroughs in East London, that have the highest percentage of people with chronic illness,” he explains. “But we only have one major regional hospital. So it’s a question of capacity. When Queen’s Hospital was planned, the demographic dramatically shifted beyond the original projections. So the hospital was set up to deal with a smaller and healthier population.”

“There’d been a succession of crises, particularly around maternity, that preceded their inspection,” he remembers. “So there was this background noise about how the hospital may be falling down in several areas of its performance. It was in that context that the report was published.”

“All the senior players in the borough were worried about the hospital,” says Anne-Marie Dean, Chair of Healthwatch Havering. Concerns about the quality of care were made worse by poor relations with the trust’s senior management. “It was very difficult to create any sort of relationship with them. The very senior team were quite remote from everybody,” she recalls.

“The other thing that you got a strong sense of was that the consultant body was quite remote from the management team and, in lots of ways, quite remote from the staff,” she says. “So it didn’t feel like a unified organisation at all. And when patients used to give us feedback, they often used to say they felt sorry for the staff.”

Leadership

Matthew Hopkins was appointed Chief Executive in April 2014, a few months after CQC’s report was published. Early on, he formed the view that staff were strongly committed to providing good care, even if they hadn’t always been supported by clear direction, resourcing and prioritisation.

A priority Kathryn Halford, Chief Nurse, shares with other leaders across the trust is making sure that she is visible and accessible, and communicating well with staff. She has weekly meetings with senior ward managers, matrons and divisional nurses to keep her “in touch with the shop floor all of the time”. Taking part in plenty of walkabouts ensures she spends time with both staff and patients.

Cultural change

The approach of Director of Communications, Rachel Royall, hinged on four aspects of improvement. “How can communication and engagement help support operational performance and patient experience? How can we help improve employee engagement? How can we help improve stakeholder advocacy? And – if we got those three right – then the fourth priority, reputation management, would look after itself,” she says.

Improving employee engagement was crucial, particularly in an organisation where local reputation and the associations of special measures had had an inevitable effect on staff. When the trust went into special measures, only half of frontline staff said they were happy with the level of care they were providing for patients; the recent staff survey has shown a 30% increase.

“Staff had phenomenal stories about their improvement, but I suppose when I arrived I found quite a fear of sharing improvement,” Rachel

Partnership with the Virginia Mason Institute

The trust is one of five trusts chosen to work with the Virginia Mason Institute as part of a five-year partnership led by NHS Improvement.

Virginia Mason teaches healthcare organisations to use lean methods to support a patient-centred culture. As part of this, it helps them to develop their own ‘Kaizen Promotion Office’ (KPO): an in-house centre of excellence that helps to adopt continuous improvement methods across the whole organisation.

“Kaizen is a Japanese word for continuous improvement,” explains KPO Director Alf Theodorou, who leads the trust’s work with Virginia Mason. “We’re learning their quality improvement method, which is derived from Toyota. They adapted it for health care and now they’re coaching us to deliver it here.”

The trust has a particular focus on two elements of the approach: a lean-based improvement methodology – applied consistently across all improvement projects – and a cultural shift towards proactive improvement. “It doesn’t have to be broken for us to fix it,” he says.

The trust has focused on two areas, voted for by staff, patients and visitors: the first 24 hours in hospital for frail and older patients, and cancer diagnostic processes. Part of the KPO team’s work involves observing processes in action, making notes and timing stages to identify opportunities for improvement.

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It's an approach that can sometimes seem unfamiliar to hospital staff, and the team relies on good communication to win hearts and minds.

One of their successes on the diagnostics pathway was a large reduction in the time taken to prepare samples. "It was taking 22 hours and 14 minutes to prepare biopsy samples for analysis. It now takes four hours and 52 minutes, which means we can run more cycles of the analyser and it means patients are more likely to have their results on the same day," Alf explains. The two teams involved in processing the samples, who worked nearly 200 metres apart, have now been moved next to each other "so you're saving time by not having people walking backwards and forwards," he says. "And we've also seen that the error rate has come down – not in terms of sampling errors but in terms of all the documentation or repeat paperwork needing to be done – that's come down as well, just by that co-location."



says. "One of the divisional directors who had an excellent stroke service explained that he didn't want to tell anyone about it. It would be a bit like bragging about his kitchen when his house was falling down. So we needed to do a lot of work with people to improve confidence and help them to understand that their journey of improvement is something that they should be proud of and that they should want to talk about."

This reluctance to celebrate success is a theme that is also familiar to Kathryn Halford, who joined as Chief Nurse in early 2016. "I think they'd spent years being told they were rubbish," she says. "One of the things that was really evident when I came here was there was a lot of very good practice – clearly there were some things that needed to be improved – but actually, people didn't recognise themselves as delivering good services."

Vision and values

"I talked about three things, regularly and consistently, over the first year or two," Matthew Hopkins says. "The first one is improvements for patients. We didn't have a single method of improving things – as we do now. But the roll-out had come out of a set of values and behaviours that had been designed and developed by the staff, and the words were the staff's words, so they resonated with them. We used the values and behaviours to underpin our improvement work."

"One of the divisional directors who had an excellent stroke service explained that he didn't want to tell anyone about it. It would be a bit like bragging about his kitchen when his house was falling down. So we needed to do a lot of work with people to improve confidence and help them to understand that their journey of improvement is something that they should be proud of and that they should want to talk about."

Rachel Royall, Director of Communications

Governance

"Priority two was that we needed to get a much better grip on the money. Quality and money are two sides of the same coin – you can't do one without the other. The third priority was being much better organised – so things like getting our governance right, getting the structure of the organisation right. We restructured the executive team, restructured the board, got our information capability right, and got our meetings properly organised."

For Kathryn Halford, one of the keys to improvement is being able to clearly articulate the standards staff should strive for. "I feel very strongly that one of my key objectives was to describe what good needed to look like and then support people to be able to achieve it," she explains. "So I think if you went and spoke to people now, they would be much clearer about what good looks like, what they need to do to improve and how that's measured."

Improving safety

Senior Sister Nicola Osborn has seen improvements in patient safety – an area where she believes the organisation has made some of its most important gains. “I think we’re very good now at learning from incidents,” she says. “When things go wrong, we look at it and we ask: were we working to the PRIDE Way?” PRIDE spells out the trust’s values of passion, responsibility, innovation, drive and empowerment. It draws together the trust’s shared vision, values and operational plan. “I think the PRIDE Way makes people re-evaluate things and think about what we’re meant to be doing and why we’re doing it. It’s helped with communication and I think it’s helped bring departments together – we’re all working together as a team,” says Nicola.

The rate of incident reporting is one area where the hospital’s data highlights a tangible difference. “Our incident reporting is going up exponentially,” says Associate Medical Director Dr Andy Heeps. “We’re reporting more and more things. And that’s really letting people start to have conversations – we’re empowering staff to fix things. When this started, we saw Serious Incident (SI) rates start to go up. I think that was really powerful because that meant people were actually reporting and learning from harm. And as incident reporting has continued to rise, the SI rate has now started to come down.”

Next on the improvement journey

“We’ve made massive progress on standards, particularly around referral to treatment and cancer waiting times,” says Chief Executive Matthew Hopkins. “We want to continue to strengthen our emergency access as well. So that’s our number one priority. Number two is the way we continue to reach out to community settings. And the third area is continuing patient input into improvement work.”

The trust’s progressive shift away from addressing ‘CQC must-dos’ towards a more proactive and self-sufficient improvement culture is a theme that comes up more than once. For Andy Heeps, how this evolves is central to what comes next.

“I think we need to stay patient-focused and keep building our own assurance systems,” he says. “How do we assure ourselves that we’re doing what we say we’re doing – and not relying on CQC to come in and find out when it’s too late? My own area of interest in improvement is how it can be completely decentralised. How do you skill people to come in one day and say: this isn’t working, let’s try this. It’s the incremental wins. If you can say today we’re a little bit better than we were yesterday, then I think that’s not a bad philosophy for someone working on an NHS ward.”

For more information about Barking, Havering and Redbridge University Hospitals NHS Trust, email communications@bhrhospitals.nhs.uk.

Giving staff autonomy with the model ward

Director of Productivity Scott Fitzgerald has seen a major shift in attitudes since he introduced improvement walks at the trust in 2015. “The idea of turning up on a ward and rolling your sleeves up to support the staff and assure the senior teams was alien to the organisation,” he explains. But the walks have become an opportunity for staff to raise issues or ask for help.

“The improvement walks tell us what we need to focus on and ensure we don’t slip back,” says Lead Quality Improvement Nurse Tracey Thorne. Tracey is leading the development of a ward accreditation programme, which was prompted by the success of the improvement walks. It was an idea first suggested by an inspection report on Salford Royal Hospital, rated as outstanding in 2015. The team learned about the Salford programme as well as similar schemes at other trusts but opted to design their own.

Dubbed ‘the model ward’, the BHRUT programme is designed around four pillars: patient experience, staff experience, safety and efficiency. “We’re looking at how we can measure whether a patient feels comfortable on a ward,” Scott explains. “Were they welcomed? Were their fears allayed?”

Involving staff has highlighted the shift towards self-reliance over external scrutiny. “We asked staff what reward they wanted for being a good ward,” he explains. “And what they want is autonomy. They want to get to a level where they can continuously improve, delivering their own service.”



Leeds Teaching Hospitals NHS Trust

September 2016

Rated as good

July 2014

Rated as requires improvement

Leeds Teaching Hospitals NHS Trust serves a population of around 780,000 in Leeds and up to 5.4 million in surrounding areas, treating around 2 million patients a year. The trust employs around 15,000 staff and provides 1,785 inpatient beds across Leeds General Infirmary, St James's University Hospital, Leeds Children's Hospital and Chapel Allerton Hospital.

The trust had its first CQC comprehensive inspection in March 2014, which resulted in being rated as requires improvement in July 2014. Following a comprehensive inspection in May 2016, the trust was rated as good in September 2016.

Receiving the rating

There was no great surprise or shock at being rated as requires improvement. Chief Executive Julian Hartley had been in post for just six months when the inspection took place. Julian had come into the trust fully aware that there were issues that needed to be addressed. "The report was as expected," he says. "I had already got a strong sense of where the trust was." Most of his executive and non-executive teams were also relatively new to the organisation.

From his first day as Chief Executive, Julian began a programme of engaging staff and getting them involved in setting the values of the organisation. However, staff were disappointed that the work they had been doing up to that point did not seem to be reflected in CQC's report.

Consultant Alison Cracknell had been championing improvement in her area and says, “Initially I felt demoralised. Were we not doing a good job? We were trying hard and improvements were happening. But when you step aside and look overall, you can accept what the report was saying as fair.”

Chief Medical Officer Dr Yvette Oade also admits to some disappointment, but recognises the value of the rating. “If we had got a good rating, perhaps that would not have been helpful. If we had been good, we may not have been able to engender the same degree of momentum and energy to take us on the improvement journey.”

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Yvette Oade, Chief Medical Officer

Leadership

Julian Hartley and his executive team set about improving communications and becoming more visible to staff. On his first day as new Chief Executive, he sent out a bulletin to all staff – *Start the Week*. It continues to go out every Monday, with staff keen to have their achievements included.

“I spent my first 100 days largely visiting all clinical areas to cement the idea of collective commitment and that we are here to support staff,” he says. Associate Director of Communications, Jane Westmoreland points out that “this wasn’t just a 100-day project – he’s still doing it”.

The importance of visibility is echoed by Deputy Chief Executive, Chief Nurse and Chief Operating Officer Suzanne Hinchliffe. “I still do clinical shifts and every six weeks I will visit every ward and department in this trust.” She also goes on regular walkabouts with Chief Medical Officer Dr Yvette Oade to show that medicine and nursing are aligned.

Cultural change

Before he started at the trust, Julian Hartley personally wrote to more than 2,000 staff. “I introduced myself and asked for their three top challenges. There was a tremendous response and the main messages were clear: there was a real problem with engagement, the leadership was detached and invisible, and it was all about money and targets.”

The new leadership team encouraged people to say how they felt about the trust. Staff were encouraged to talk about their roles, what they felt was positive and what stopped them delivering great care. An online tool called Wayfinder was used to get staff involved and engaged in developing the trust’s values, called the ‘Leeds Way’.

The development of the Leeds Way helped to drive improvement in the trust. Summed up by Julian Hartley as “the way we do things around

Shaping the trust’s direction with the Leeds Way

After writing to the managers before he joined the trust, Julian Hartley was determined to use their feedback to look for solutions through employee engagement. To meet the challenge of reaching 17,000 staff, the trust ‘crowdsourced’ to find answers, using an online system called Wayfinder.

Every member of staff could log in and respond to a series of questions that asked what they thought were the most important values and behaviours, and how they could make the hospital a great place to work and a great place for patients. There were more than 45,000 responses. Submissions were anonymous, and people could comment on others’ suggestions and vote on them. The output was developed further at two large scale engagement events.

Responses were distilled to five things, which became the hallmarks of the ‘Leeds Way’ – the organisation’s values: patient centred; collaborative; fair; accountable; and empowered. “These were clear and powerful in the way they influence the culture of the organisation,” says Julian Hartley.

Clinical service units have used Wayfinder to develop their own plans, strategies and stakeholder involvement. An annual programme of corporate campaigns now uses Wayfinder to engage staff in shaping the direction of the trust. Campaigns include gathering ideas on how to learn more from incidents and how to improve the intranet and website.

Measuring progress and celebrating success with safety huddles

Safety huddles involve ward teams discussing one or more patient harms such as falls, pressure ulcers and avoidable deterioration in a daily focused safety meeting. “The ward team meets for a five to 10 minute focus around an area they are worried about. They review data and learning, for example, to understand how the last patient fell,” says Alison Cracknell.

The huddles include regularly measuring progress and celebrating success, helping teams to continually learn and improve. Ward staff report that the huddles encourage healthy competition between wards, for example on the number of days passed without a patient falling. Posters show a record of the number of days since the last harm event, and improvement charts track progress. Good safety performance in clinical teams is recognised and teams receive certificates when they achieve milestones.

In October 2016, 65% of the wards that had huddles on falls saw a steep reduction in falls. Nine of the 20 wards focusing on pressure ulcers achieved their longest stretch between a pressure ulcer occurring since before huddles were introduced.

here”, it became the engine room of improvement because it allowed the trust to move forward together. Staff were empowered to make changes. Consultant Alison Cracknell explains, “We’ve gone from a few individuals who might do improvement in their own patch, to an organisation that wants to empower everyone to do it.”

“We’ve gone from a few individuals who might do improvement in their own patch, to an organisation that wants to empower everyone to do it.”

Alison Cracknell, Consultant

Engagement and visibility set the tone and the trust received a boost in 2015 when it was selected to be one of five trusts in a national programme led by NHS Improvement on embedding the Virginia Mason system, a quality improvement method to help improve patient pathways.

The trust has adapted the Virginia Mason system to become the Leeds Improvement Method. “It is transforming the way our patients move through the hospital and the way individual services redesign pathways – to take out waste and inefficiency, reduce waiting times and make the experience better for staff and patients,” says Julian Hartley.

According to Non-Executive Director Mark Chamberlain, the Leeds Improvement Method team is enthused about the difference it is making. “By sharing experiences and improvement stories, other areas want to get involved. We need people to be thinking about improvement, what they can do to support it and what that means for patients.”

Promoting equality and human rights is integral to the Leeds Way. Even though policies and strategies had been in place, Chris Carvey, Deputy Director of HR, says, “There is now a greater commitment and visibility, with an equality and diversity strategic group that gives high-level ownership and commitment to equalities objectives.”

Governance

The new senior team recognised that governance needed to improve – to make sure that good reporting and learning became second nature, and that the board could be assured that actions were being taken when needed.

Professor Suzanne Hinchliffe, Deputy Chief Executive and Chief Operating Officer felt that many things needed to be put right from the last inspection. “We looked at governance and made it more fluent. We needed to make sure the organisation was clinically led and management supported – a complete turnaround from the previous way it had been managed. We wanted to get the new clinical management structure to work through a process of earned autonomy and also devolve decisions to teams.”

Senior Sister Kate Varley recognises the changes in the trust and says, “Working here is different now. On face value it may not look that way. However, it is when you see how departments work together. We are working better as departments to be more cohesive with delivering our care. Things are working faster and patient care is improving.”

Improving safety

At the time of the first inspection in March 2014, staff felt that the trust had a blame culture that could sometimes deter people from reporting incidents. For Senior Sister Sally Rollinson-White, the previous leadership team had had a “dictatorial approach”.

Joint ownership and sharing problems and solutions has been crucial in combating this blame culture. Jane Westmoreland cites the example of motivating staff around hitting emergency care standard targets. “The message was that this is not just an A&E problem. We asked everyone in the trust to think of one thing they could do that could affect the pathway and enable us to deliver better care.”

Chief Medical Officer Dr Yvette Oade highlights the improving reporting culture and reduction in never events. “We have not had a retained swab in the last 18 months and no retained items.” Mark Chamberlain agrees. “Our accuracy and reliability of reporting and triangulation has improved as a board and as an organisation.”

Patient and public involvement

Non-Executive Director Mark Chamberlain thought that the patient focus needed to change. “The perception was that the hospital had areas of excellence, but the way patients experienced some elective encounters was not where it should be.”

Local resident Pat Newdall, who has been involved in ‘Enter and View’ visits on behalf of Healthwatch Leeds, says that tackling long waits in outpatients was a main focus for the trust. She believes there are now shorter waits in outpatients, and as a result, patient experience has greatly improved. Pat also says that the trust now involves patients in planning services and has an active Patient Experience Group.

CQC engagement

CQC Inspection Manager Sarah Dronsfield commented that in the trust’s second inspection it was evident how much staff had embraced the culture change and now felt engaged. “We could see that they were more prepared to put themselves forward and raise concerns. The new leadership structure had really helped to embed the organisation’s values and beliefs.”

Next on the improvement journey

Alison Cracknell sums up the trust’s ambition, “Before, I would have thought ‘chip away, just keep doing improvement...’ but now we can be really ambitious about what we can achieve throughout the organisation. Building on what we have already done, working with Virginia Mason and knowing we have got support to take this further, we are in a really good place.”

For more information about Leeds Teaching Hospital NHS Trust, email communications.lth@nhs.net

Addressing inequalities in the wider community

The trust has worked hard to raise awareness of equality and diversity among staff, local people and the wider community. Suzanne Hinchliffe says the trust has replaced lengthy “dry” equality reports “that people didn’t read” with four eye-catching charts that highlight equality and diversity issues and how the trust performs for staff and patients.

In particular, work has focused on addressing the most pressing inequalities, such as exploring how staff can support transsexual patients to have the best possible experience.

There is also work with the voluntary sector to reach out to groups of people known locally and nationally as least likely to access hospital services and raise any concerns, including Gypsies and travelling communities, asylum seekers and refugees, people with mental health needs and lesbian, gay and bisexual people.

Suzanne Hinchliffe says, “Using the support of Healthwatch, the voluntary sector and our wider patient engagement groups, we are trying to make sure that the community we serve is represented in health care and that we are meeting their needs as patients.”

All this work is supported by training and development for staff and wider cultural activity, such as involvement in activities to support the Leeds Pride festival.



Mid Essex Hospital Services NHS Trust

December 2016

Rated as good

April 2015

Rated as requires improvement

Mid Essex Hospital Services NHS Trust provides local elective and emergency services to 380,000 people. The trust, based in the city of Chelmsford in Essex, employs around 4,000 staff, and provides services from five sites.

A CQC inspection in November 2014 resulted in a rating of requires improvement in April 2015. Inspections in June 2016 found notable improvements and resulted in a rating of good in December 2016.

Reaction to initial inspection report/rating

Staff at the trust described their reaction to being rated as requires improvement in April 2015 as “disappointing” and “terrible”. Cathy Geddes, Chief Nurse at the time, says, “I felt devastated; I felt personally responsible,” but adds that the organisation’s senior leaders were “not surprised.”

Although Peter Davis, Consultant Histopathologist, was not surprised by the rating, he says the effect of the report on frontline staff was different. “Staff morale suffered a dip after the report came out. People were doing their best. There were certain things about governance and processes that people didn’t feel they had the time to do because they were firefighting. So being told ‘you are inadequate’ felt like a kick in the teeth.”

Sister and Ward Manager Prabha Guske felt the report revealed the inconsistency of quality between different hospital departments – her own ward had come out well in CQC’s inspection report, but she didn’t feel there had been much opportunity to share learning with other areas. “I was

thinking 'I wish everybody could work the way we work. I wish everybody could take this as an example, and share learning experiences.'"

But Prabha felt that some aspects of the report – how it highlighted problems with communication and patient flow “were not a surprise”.

Leadership

To support the culture work, the trust needed to reinstate a supportive management structure. Consultant Peter Davis remarks, “It was for the trust’s leaders to say: ‘how are we going to turn this around?’”.

Cathy explains, “Clinicians were trying to do it all with no infrastructure. The organisation should be clinically led, but clinicians need managers to help them.

“We had to try to bring back a managerial structure without worsening the financial position. Addressing that problem wasn’t cost-neutral, but there was recognition from the board that the lack of structure wasn’t sustainable.”

Sister Prabha said she could see that this change was about more than just putting people into posts, “It was a dramatic change. For example, Cathy introduced a new ‘Clinical Tuesday’, where all the matrons and lead nurses – including Cathy herself – had to come and work on the ward. She bridged that gap between the management and the ward staff.

“I’ve been here 15 years. I’ve seen so many changes, but up until this point I hadn’t seen management who proved that, if we want, we can get things done the right way.”

This extended to empowering staff to take responsibility for quality improvement. Peter Davis explains, “We wanted wards to feel that they had responsibility, that they had power, and that they were being listened to.”

This certainly reflected Prabha’s experience, “I feel comfortable speaking to management. If something is needed to improve the ward, they help. We have to make a financial assessment and provide a rationale, but if it is needed they would say ‘go ahead’.” One example is when Prabha asked for partitions to separate the observation beds to help preserve the dignity and privacy of patients. The trust immediately set to work achieving this.

“I feel comfortable speaking to management. If something is needed to improve the ward, they help. We have to make a financial assessment and provide a rationale, but if it is needed they would say ‘go ahead’.”

Prabha Guske, Sister and Ward Manager

Dan Spooner, Deputy Director of Nursing, is studying for a degree in NHS leadership. He stresses the importance of investing in people so that the whole team becomes engaged with the improvement journey. “It means that people are starting to understand what quality looks like and how to get it.

“For example, we provided our healthcare assistants with dementia training and they have since come up with innovations to improve dementia care. It’s important to give staff the context and help them understand why.”

Recognising excellence with the ‘Time to shine’ programme

The ‘Time to Shine’ programme was launched around the time of the trust’s CQC re-inspection, and gave staff the opportunity to highlight areas of excellence around the trust, providing every clinical area with a chance to celebrate the good work they were doing.

Examples of excellent clinical practice were shared internally with all staff by email and through the internal staff newsletter Staff Focus, and externally in press releases. The initial idea for the programme came after a previous CQC visit highlighted areas of excellence that the trust thought were not being emphasised.

The 'terrific tickets' scheme

The 'terrific tickets' scheme allows staff to nominate a person or department for an award, in recognition of care and service that is above and beyond their normal daily work. The tickets allow a member of staff to share a coffee with a friend, and the employee or department of the month receive vouchers presented by the Managing Director. Plus, the employee receives a certificate to display on the ward.

"This didn't feel like rocket science. It just felt like these were the right things to do"

Cathy Geddes, Chief Nurse

Cultural change

Addressing the culture of the organisation was a top priority for the trust. Cathy Geddes explains, "There was a disconnect between some members of the executive team and the rest of the organisation. Our staff were loyal – many had worked there for years – but they didn't feel listened to, recognised or rewarded. Not everyone on the executive team was conscious of that being a risk."

Dan Spooner describes how that 'disconnect' had felt from the front line, "If you had a problem in A&E, you had to fix it on your own. This wasn't feasible, because A&E is a barometer of the whole hospital."

Dan says that the culture is different now. "A&E is everyone's problem now. Now we have an emergency floor, which is responsible for that flow through the hospital and out of the hospital. Now we have a team approach to solving the daily challenges."

Prabha says the change is visible to her teams. "Our management team are seen on the ward much more now. Before, some staff didn't know who the chief nurse was – they knew the name, but had hardly spoken to them. Now you see the management team on the floor, actually walking through your door and saying, 'well done team – thanks for all your hard work.' Two or three little words make a massive difference for staff."

"Underlying all of the improvement that we made, I do think it was about the culture, about the leadership, about staff feeling valued and empowered, and feeling that they were listened to – and that safety and quality of care was our top priority as an organisation," says Cathy Geddes.

Cathy goes on to say, "This didn't feel like rocket science. It just felt like these were the right things to do. It just was about trying to be open, honest, approachable, visible and listening. There was an improvement plan to respond to the CQC report but that wasn't what made the difference. It was changing the culture."

Governance

Cathy Geddes explains how the trust managed to improve its financial position alongside making quality improvements. "You have to focus on the money obviously, but if you get quality right and you get efficiency right then the money does – to a degree – look after itself."

"You might have to invest to save: you might have to put in an extra clinician to deliver a new service but, if that means patients get treated, and they don't have to go into hospital and can go home, that's saving the system money."

Improving the quality of care has had a positive effect on the trust's finances. One example of this is the trust working to reduce the use of agency staff. For example, Dan Spooner explains that the Acute Medical Unit had been "a department nobody wanted to work for". But since improving the ward as a place to work, they have been able to bring a number of agency workers into substantive posts, reducing its agency staffing costs by half within a year.

Patient and public involvement

A fundamental part of the improvement journey has been listening to staff and patients, including through a series of 'In Your Shoes' listening events and through the ongoing work of the Patient Council. Robert Lee Bird explains, "The patient council has a genuine influence on the trust. We're not governors; we've got no legal powers. But we are like the trust's conscience."

Looking outwards

Victoria Parker, Interim Director of Communications and Engagement, would recommend speaking to colleagues at other organisations who have been through a similar experience and improvement journey: "There is an enormous amount of goodwill out there. You're not on your own; there are people that have been through it. There are lots of people that have gone before you who can help you – and you can only improve."

Above all, keep your focus in the right place, advises Non-Executive Director Nick Alston. "There are financial challenges in the local health system; local authorities are struggling to find social care places. So you're fighting challenges on a number of fronts. And what CQC does is come back to remind you that what matters most is the quality of care."

Having stepped into the role of interim Chief Executive in summer 2015, Cathy Geddes has since moved on to work for NHS Improvement as an Improvement Director. "Try to take a positive view," would be her advice for other trusts receiving a disappointing report from CQC. "Even if you don't agree with everything in the findings, see beyond your initial reaction."

CQC engagement

CQC's report made the organisation realise what really needed to change. "We were all working very hard but often there wasn't the right focus," said Cathy, who was appointed as the trust's interim Chief Executive in summer 2015. It was important to get the message across that this wasn't about responding to CQC, "It was about how to make things better for patients and staff."

The trust used the CQC inspection as a lever for clinical improvement. As Consultant Peter Davis, puts it, "we needed to get people into a room to talk together, to develop a solution."

"Our workforce was very reactive, and always firefighting. The organisation was going through lots of change, trying to manage financial challenges, but we had no clear plan or sense of direction."

This sense of effort was echoed by Non-Executive Director Nick Alston, "We already knew there were challenges. Everybody was already trying hard – so rather than being a great shift, it was about focusing, and making a renewed commitment to do better."

For more information about Mid Essex Hospital Services NHS Trust, email communications@meht.nhs.uk.

'In Your Shoes' listening events

The 'In Your Shoes' listening events were initially held in autumn 2015 as the first step in looking at the culture of the organisation, and examining how the trust wanted patients and staff to see it, and what levels of service and care were being provided.

The events involved separate focus groups with patients and staff, as well as joint meetings where feedback included shared experiences.

These events resulted in the trust's values and behaviours, which were agreed with patients and staff, and were adopted as part of the 'Creating Our Culture' project.

The trust is now running the next series of events to find out whether people think they got the values right last time, and whether they think the values and behaviours are being demonstrated across the trust.



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