

Learning from improvement: special measures for quality

A retrospective review

November 2017

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

Contents

Foreword.....	2
Summary	4
1. Introduction	7
2. Top tips for trusts entering special measures	11
3. Lessons from special measures	13
4. Conclusion	43
Annex A: Accessing support and further reading	44

Foreword

Giving patients consistently safe, high quality, compassionate care must always be at the heart of every trust's operations.

After the terrible failures unearthed as part of the Mid Staffordshire NHS Foundation Trust public inquiry, there were many recommendations and interventions designed to ensure such serious failings in patient care were not repeated. One measure introduced in July 2013 was a programme of inspection and support, known as 'special measures'.

The purpose of the special measures programme is to identify trusts with the greatest need to improve and provide them with an intensive package of support. The aim has always been to return the quality of care provided by these trusts to the standard that all patients are entitled to expect – as quickly as possible.

I have been involved in the special measures programme from the start, and have worked closely with the Care Quality Commission. During this time I have seen trusts make remarkable quality improvements, which are a tribute to the values, vision and tenacity of the leaders and staff working in these organisations.

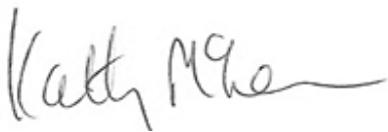
More than four years on from the programme's introduction, it feels like a good time to draw on the experience of those trusts that have been supported to improve and learn the lessons about what worked for them and the factors that were key to their improvement journeys. The purpose of this document is to share this experience, so that leaders and staff in other organisations, either currently in special measures or at risk, can benefit.

My own reflection is that we have at times been slow to accept some of the diagnoses and take more decisive action. A particular reflection, perhaps for NHS Improvement as well as for trust boards, is that this slow acceptance has in some cases delayed improvement. We also need to ensure that we learn from the experience of a very small number of trusts that have improved sufficiently to leave the programme but, unfortunately, now find themselves back in special measures.

All those who have supported trusts in special measures, including leaders and staff from 'buddy' trusts who have given their time and experience willingly, have

demonstrated the best of the NHS. So too have improvement directors, who often have to exercise great diplomacy and skill.

This document draws on interviews with senior leaders from trusts that have entered and exited special measures, and includes case studies developed by clinical fellows working with NHS Improvement. I would like to thank all the trusts who contributed to this review for their time and honesty.

A handwritten signature in black ink that reads "Kathy McLean". The signature is written in a cursive style with a long horizontal flourish at the end.

Kathy McLean
Executive Medical Director
NHS Improvement

Summary

The special measures quality regime for NHS trusts and NHS foundation trusts was introduced in July 2013. Trusts are usually placed in special measures by NHS Improvement following a recommendation by the Care Quality Commission (CQC).

This takes place where there have been serious failures in quality of care¹ and where there are concerns that existing management cannot make the necessary improvements without support. Special measures consist of specific interventions designed to improve care quality within a reasonable time.

Since 2013, 37 trusts have entered special measures for quality and 21 have exited (three subsequently re-entered). The average time spent in special measures is 23 months. Four years after the introduction of special measures, we have reviewed the experience of trusts that exited the process.

The purpose of this review was to identify the practical actions trusts and others took that improved the quality of care for patients and helped trusts reach a point where they could exit from special measures. We wanted these lessons to be available to help challenged trusts and boards that may be concerned about deterioration in quality of care.

Each trust that has exited special measures has been on its own quality improvement journey. Our review identified five themes that were essential for improvement: leadership, engagement (internal and external), culture, governance and the trust's approach to quality improvement. A common message across these themes was the need to communicate effectively.

Section 3 of this report describes the lessons learned under each theme, supported by case studies from trusts. Trusts have also shared their practical tips for those that enter special measures, included in Section 2. The report does not provide a comprehensive list of all actions taken by trusts that have exited special measures.

¹ There is a separate special measures programme for trusts with significant financial challenge. In this document, 'special measures' refers only to special measures for quality.

The most successful trusts, which have been able to make the greatest improvement in the shortest time, have:

- quickly built an effective leadership team and board
- ensured robust but lean governance, identifying problems locally and escalating those that cannot be resolved
- reviewed and developed their vision and values, engaging staff in this process
- given hope to the organisation that it could improve
- engaged staff in improvement, and aligned clinical and managerial priorities around patients' needs
- communicated effectively with all stakeholder groups
- used a quality improvement methodology to develop a quality improvement plan that is more than a list of actions, with short- and long-term goals
- identified some quick wins, and used their CQC report to identify 'must dos'.

The table below summarises the most important lessons by theme that trusts highlighted.

Key lessons from special measures trusts by theme

Leadership	Engagement	Culture	Governance	Quality improvement
<p>Rapidly assess leadership capability and capacity</p> <p>Make changes where necessary and put support in place</p> <p>Establish a stable and committed leadership team</p> <p>Build leadership at all levels, including medical leadership</p> <p>Collective board ownership of the issues</p> <p>Clear roles in relation to improvement</p> <p>Visibility and role modelling behaviours</p> <p>A clear strategy and priorities for staff to understand</p> <p>Focus on stakeholder management.</p>	<p>Build a comprehensive engagement plan</p> <p><u>Internal</u></p> <p>Structured programme of staff engagement</p> <p>Re-engage staff in the improvement journey</p> <p>Medical engagement can have the biggest impact, positive or negative</p> <p>Informal forums often work well to engage staff</p> <p>Embed staff at all levels in the improvement programme</p> <p>Engagement will take a significant part of the leadership team's time</p> <p><u>External</u></p> <p>Build trusted relationships</p> <p>Don't overpromise, push back on unrealistic expectations</p>	<p>Genuine visibility of whole board and moving beyond this to role-model expected behaviours</p> <p>Refresh vision, values behavioural standards and norms, and live them</p> <p>Link objectives to staff appraisals</p> <p>Check people's actions/responses are in line with culture – eg response when something goes wrong</p> <p>Learn from mistakes, avoid a blame culture</p> <p>Champion the maintenance of basic clinical standards and safe clinical environment</p> <p>Give the organisation hope and celebrate success along the way</p>	<p>Focus on getting organisational structures right early</p> <p>Clarity on roles, responsibilities and accountability</p> <p>Lean, transparent governance processes</p> <p>Decision-making must be agile</p> <p>Governance should enable consistent board oversight of the trust</p> <p>Unitary board challenging in a supportive way</p> <p>Strengthening processes for reporting and learning from incidents</p> <p>Collect and use data to explain the problem, design the solution and show the improvement</p> <p>Governance needs to be an enabler</p>	<p>There is no single best method for quality improvement</p> <p>Using a consistent, structured approach yields quicker results</p> <p>Improvement plans must be more than a series of actions</p> <p>It must be possible to assess the impact of the improvement plan</p> <p>There must be a clear understanding of the underlying issues and a vision for sustained improvement beyond special measures</p> <p>Buddying can be successful, enhancing capability and capacity, and sharing what good looks like. There must be clear terms of reference and monitoring</p>
Communication				

1. Introduction

NHS Improvement normally places trusts in special measures following a recommendation by the Care Quality Commission (CQC). This takes place where there are serious failures in quality of care and where there are concerns that existing management cannot make the necessary improvements without support. Special measures consist of specific interventions designed to improve care quality within a reasonable time.

Eleven trusts entered special measures in July 2013 following the reviews by Sir Bruce Keogh of trusts with high mortality rates. Others have entered special measures on CQC's recommendation, almost always after a comprehensive inspection. Trusts deemed inadequate on two or more of five key attributes are rated as inadequate overall. In practice, trusts entering special measures are most frequently rated inadequate for 'safe' and 'well led', with some also being inadequate for 'responsive'.

Since 2013, 37 trusts have entered special measures, and 21 have exited (three subsequently re-entered). Every trust in special measures has its own individual challenges, but some characteristics are common to many. These were identified at the time of the Keogh review² and remain common factors in many CQC reports rating trusts as inadequate. They include:

- a failure to listen to, understand the importance of and act on the views of staff, patients and external stakeholders
- a lack of value and support for frontline staff
- a disconnect between staff and leadership
- transparency used for accountability and blame rather than support and improvement

² Department of Health (2013), [Review into the quality of care and treatment provided by 14 hospitals trusts in England: overview report.](#)

- geographical, professional or academic isolation
- poor use of data to drive quality improvement
- acceptance of reassurance rather than seeking assurance
- a failure to learn and share lessons.

Four years after the introduction of special measures, we reviewed the experience of trusts that exited the process so we can better understand why they entered special measures, their reactions to special measures status, the actions they took and how they changed over the course of special measures and beyond. We wanted to identify the practical changes that had the greatest impact on improving the quality of care for patients, and share this learning with other trusts in special measures, challenged trusts and partner organisations.

We approached 18 trusts and four improvement directors who have experienced and exited the special measures process.³ We obtained information and evidence of their experience through semi-structured interviews with each organisation, conducted with senior personnel who were present through some aspect of the special measures process.

We identified five key themes: leadership, engagement (internal and external), culture, governance and the trust's approach to quality improvement. Section 3 highlights lessons learned under each theme, and includes case studies showing how trusts applied these lessons. Section 2 includes practical tips from these trusts.

This document also builds on existing literature about quality improvement, referenced throughout, and includes a 'Further reading' section.

Each trust's journey through special measures is unique. This document does not provide a comprehensive list of every action taken by trusts that have exited special measures but focuses on recurring themes that we believe make the most impact.

This document draws on interviews conducted by clinical fellows working with NHS Improvement and was developed by PwC on behalf of NHS Improvement.

³ Some trusts we spoke to had exited and re-entered special measures.

NHS Improvement's expectations

Special measures should come as no surprise to a trust's leaders: they will have received early feedback from CQC following an inspection, and a draft report with ratings. They may have also received a Section 29A warning notice, and had discussions with us.

We expect trusts entering special measures to carry out several urgent actions:

Leadership: The chair should urgently consider whether the trust's senior leaders (executive and non-executive) are capable of driving the improvement needed. We will also consider this and whether a formal leadership review is needed.

External support: Senior leaders should consider what external support they may need both at trust and service level. They should consider possible options for buddying and/or for a more formal partnership.

Learning from others: Trusts entering special measures should be prepared to learn from other trusts or services that CQC has rated outstanding or good, and trusts that have exited special measures. The NHS has no place for insularity.

Medical engagement: All trusts entering special measures should commission a review of medical engagement using the Medical Engagement Scale, unless this has been done recently. They should also review in detail wider staff survey results from recent years to assess where engagement is poor, and develop a plan to improve this.

Staff engagement: Trust leaders should give high priority to new ways of engaging staff in improving patient care. Listening to staff has been a hallmark of trusts that have improved. Leaders must recognise the impact that special measures can have on staff morale. Staff must be empowered to identify ways to improve patient care, and to implement these.

Culture: The vision, values, culture and expected behaviours are often poor in special measures trusts and should be re-examined. Leaders must role-model these behaviours and hold to account staff whose behaviour does not meet expectations.

Governance: Governance structures must be fit for purpose. There must be a clear line connecting services with the board, and leaders must hold staff to account for delivering improvement. Leaders must have access to data that enables them to assess whether actions taken have had the expected impact on patient care.

2. Top tips for trusts entering special measures

We asked leaders to share their 'top tips' for trusts that may be currently in or entering special measures.

Top tips

- Be upfront and acknowledge the issues you face. You will have to deliver hard messages about performance, but remember the goal is to provide better service to patients.
- There is no magic bullet: every trust is unique and improvement will take time and investment.
- The trust may undergo a process of grieving before many can admit there are problems and accept change.
- Consider where your trust wants to be long term – it is not just about coming out of special measures. Aspire to become a centre of excellence in your own way.
- Get your top team right quickly.
- Leadership includes the board. It is not enough for board members to attend meetings: they must also be a visible and approachable part of the trust.
- Communicate clear and consistent values and your approach to tackling quality improvement.

- You cannot improve without your staff's support and engagement. Engagement can take many forms, but leaders need to develop and implement an overarching plan to meaningfully engage with staff and increase visibility.
- It is not the models and frameworks you choose to use. It is about staff believing you are committed to improving quality and getting them involved in making the changes.
- Persevere – even if only one or two people turn up to engagement events, you still need to be available.
- Nurture the relationship with your regulators. You stand a much better chance of managing expectations if you keep people informed, deliver what you say and spring no surprises.
- Look externally for support – there are many avenues and willing hands.
- It is essential to close the loop on any interventions and actions to ensure the outcomes are what you anticipated.
- Work within what is in your means to control – don't get distracted by things you can't fix now.
- Success breeds success. Celebrate your achievements along the way no matter how small they may seem. This can boost morale, encourage staff to drive change and give the organisation hope.
- Communicate, communicate, communicate.
- Don't take your foot off the pedal after you get out of special measures. Performance culture takes time to embed and can quickly slip backwards without consistent focus.
- Don't give up.

3. Lessons from special measures

This section describes the practical actions trusts took to exit special measures and the lessons they learned, under the five themes:

- leadership
- engagement (internal and external)
- culture
- governance
- approach to quality improvement.

All these themes can be aligned to NHS Improvement’s and CQC’s well-led framework.⁴ Experience shows trusts that focus on strengthening their performance against the well-led framework have the most success in sustainably improving quality.

Figure 1: The well-led framework

<p>1</p> <p>Is there the leadership capacity and capability to deliver high quality, sustainable care?</p>	<p>2</p> <p>Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?</p>	<p>3</p> <p>Is there a culture of high quality, sustainable care?</p>
<p>4</p> <p>Are there clear responsibilities, roles and systems of accountability to support good governance and management?</p>	<p>Are services well led?</p>	<p>5</p> <p>Are there clear and effective processes for managing risks, issues and performance?</p>
<p>6</p> <p>Is appropriate and accurate information being effectively processed, challenged and acted on?</p>	<p>7</p> <p>Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?</p>	<p>8</p> <p>Are there robust systems and processes for learning, continuous improvement and innovation?</p>

⁴ https://improvement.nhs.uk/uploads/documents/Well-led_guidance_June_2017.pdf

Leadership

Key lessons learned

Tackle leadership challenges early. Where rapid progress was made, trusts tackled leadership challenges early in the improvement journey. In many cases, this included changing individuals in key leadership roles.

Establish priorities. Leaders must be clear on the trust's priorities, communicate these consistently and, as a team, present a united front.

Lead by example. Leaders must go beyond visibility. They must lead by example, act as a role model and give hope to the organisation.

Recognise the importance of medical leadership. Leadership capacity and capability must be strengthened at all levels in the trust, but as service leaders, consultants in particular have the power to drive or halt change.

Tackle leadership challenges early

Strong, capable leadership is vital for trusts to improve quality. Studies show the importance of leadership at all levels in an organisation⁵ and in all staff groups, not just at board level.

In general, trusts able to improve most rapidly while in special measures addressed any leadership challenges early on.

As well as having the capability and capacity for the role, leaders must have the appetite and resilience to lead an organisation in special measures. Trusts told us the level of resilience required for this role should not be underestimated, and those that take on the role are making a significant commitment.

You may need to invest in developing your senior leadership team's resilience.

⁵ Bohmer RMJ (2016). *New England Journal of Medicine*.

Examples included individual coaching and mentoring support from leaders at other trusts and from external parties.

Leaders demonstrating their commitment to the trust's long-term improvement were key to driving change. Those who had been in an interim role told us such roles should be minimised, as staff and stakeholders often experienced a leadership carousel and were not always willing to engage with yet another interim leadership team. Such positions can make it more difficult to establish a high functioning team, for the same reasons.

Establish priorities

Successful leaders put their mark on the organisation early on and are clear about their priorities. Then they repeatedly communicate these priorities to the organisation and stakeholders.

Case study: Sherwood Forest Hospitals NHS Foundation Trust

The trust entered special measures following the Keogh review, which raised concerns about several areas of clinical quality.

With support from a buddy trust, the leadership team focused on three priorities for improvement: mortality, sepsis and *C. difficile*. There were detailed programmes of work behind each priority, but these three areas gave staff a clear focus and an understanding of steps they could take as individuals to improve quality in the trust.

The nature of the priorities meant improvement was measurable, and success could be celebrated, boosting morale and motivating staff.

Trusts took different approaches to this. Some had a few consistent key priorities. Others changed their approach over time – for example, having a focus area of the month. At other trusts, more general values or a vision for the trust guided actions. This set the tone with a new 'norm' in terms of how the organisation operates.

The CQC report should act as a guide to these priorities, but leaders must rapidly assess and understand the organisation themselves. This must include the trust's local and political context.

These priorities should be agreed with external stakeholders. Their buy-in, support and ongoing challenge will help rapid improvement. To do this, many trusts have an established external stakeholder board or similar (see the external engagement section for further examples).

Lead by example

A common theme among trusts in special measures is that the board and other leaders are not visible. Successful leaders go beyond merely improving visibility; they must lead by example and act as a role model for the behaviours they want to see from their staff.

Case study: Barking, Havering and Redbridge University Hospitals NHS Trust

When Barking, Havering and Redbridge was placed in special measures the CQC report said the trust leadership was not visible and needed more focus to resolve longstanding quality and patient safety issues.

In response, the executive and non-executive team implemented the 'improvement walk'. An executive director and a non-executive director would walk through an area and speak to staff about their job, their role and their objectives. The aim was to find out what issues prevented staff from doing their best and use executive power to overcome the obstructions there and then. This cycle was repeated three times a day for leaders to get an idea of how the organisation worked at all times and to be able to address cyclical problems.

A real change in the relationship between frontline staff and executives was noted in the 2017 CQC report, which praised senior leaders for being visible and involved in clinical activity, remarking that executive board members frequently visited departments, interacting with staff and patients.

Leaders play a pivotal role in helping staff see a way out of special measures – not only the chief executive, but every board member and leaders at all levels in the organisation.

Successful trusts highlighted important steps leaders should take early in their role:

- Active listening: taking time to listen to and understand the frustrations and concerns of staff, patients and stakeholders. This can be achieved using existing information such as external reviews and the staff survey, as well as formal engagement programmes and visiting wards and clinics.
- Working alongside staff: to give real insight into the challenges they face.
- Setting the tone for 'the new norm' and calling out unacceptable behaviours. Trusts told us leaders' actions early in their tenure were the most critical as they demonstrated to staff the type of culture the leadership team was trying to instil.
- Giving clarity on a small number of priorities. Leaders told us you cannot communicate too much.
- Identify and engage with pivotal staff members (formal and informal leaders) throughout the organisation – those who will be essential to improving quality and influencing change.
- Celebrate success: this drives motivation. Some trusts used social media to share good news. Others rewarded improvement with small gestures, such as vouchers for staff.

Case study: Cambridge University Hospitals NHS Foundation Trust

The current chief executive joined the trust shortly after it entered special measures. At the time, staff morale was low.

The team had already taken steps to understand the organisation and staff's concerns:

- spending time listening to and understanding the frustrations and concerns of staff, patients and stakeholders
- from this, establishing regular sessions where staff could raise their concerns and get information about the trust, including weekly, open-invitation, from the chief executive, to '8.27' meetings (held at 8.27am every Tuesday morning), which continued after special measures
- all executives held open-invitation drop-in sessions and free-for-all sessions where staff could speak directly to senior leaders
- working alongside staff – for example, doing night shifts on wards to understand the realities staff faced and engage better with them
- the chief executive established and chaired both the quality and finance committees, which enabled him to link the impact of quality and efficiency measures.

This gave the chief executive, and team, a far more in-depth understanding of the trust's issues, allowing him to develop a prioritised plan and identify the key individuals who could help deliver it. Staff saw the chief executive and team modelling the behaviours they were being asked to demonstrate, which also influenced culture change.

Recognise the importance of medical leadership

While leadership at all levels and across all staff groups is important, medical leaders have a key role in driving quality improvement, and can hinder progress if they are not engaged. Many trusts told us that when they entered special measures, medical leadership had been absent, or that medical and corporate leadership had been deeply divided.

Successful trusts took a range of approaches to engage with medics, which we consider further in the Engagement section below. These trusts worked to become clinically led organisations. This involved supporting, strengthening and sometimes challenging clinical leadership.

Case study: North Cumbria University Hospitals NHS Trust

When the trust entered special measures, there was a single clinician on the trust board and an executive operational management group with very little medical representation. The Keogh review identified as a key issue a disconnection between leadership and realities on the ward.

Over several years, informal and formal engagement approaches, combined with development support for clinicians, were used to identify clinical leaders and involve them in the trust's leadership. For example, the chief executive would have dinner with consultants at a local hotel to get to know them in a more informal setting. Leadership development programmes were introduced.

There are now five clinicians on the trust board, and the executive operational management group has been transformed into a clinical management group. This has greatly improved the connection between board and ward.

A consistent theme was increasing the level of medical representation in committees and in leadership and decision-making overall. Several successful trusts re-interviewed all medical leaders. In some cases trusts chose to support and develop less experienced staff members in these roles, benefiting from their insights and energy.

Engagement

Key lessons learned

Develop a comprehensive engagement programme. A comprehensive and structured approach to engagement, to which the leadership team is committed, is essential.

Consider internal and external engagement. Engagement must encompass staff, patients, regulators, the local community and other stakeholders. Trusts often found it helpful to consider internal and external engagement. There is no 'one size fits all' approach: engagement must be tailored to suit the trust and those being engaged. The approach needed will evolve over time.

Develop a comprehensive engagement programme

Trusts that exited special measures placed stakeholder engagement at the centre of a sustained quality improvement programme. For this to succeed the leadership team, and in particular the chief executive, must be fully committed to it.

Formal approaches, such as Listening into Action, only work if the whole leadership team supports them and a realistic approach is taken. A structured approach is important and allows the trust to measure and act on feedback and impact.

Key stakeholder groups to consider as part of any engagement plan include:

- clinical leaders
- medical, nursing, allied health professionals, managerial and administrative staff
- patients and service users
- families and carers
- clinical commissioning groups and NHS England
- other local providers
- healthcare regulators
- Healthwatch
- local MPs.

Case study: University Hospitals of Morecambe Bay NHS Foundation Trust

The trust launched Listening into Action in September 2014. It was used to listen to staff and support them to make changes. It helped remove barriers so that staff could take the lead, contribute to the trust's success, and feel proud of what they can achieve. Listening into Action is owned by staff, but was supported by the board and became part of the trust's language.

Projects are taken forward in waves, giving staff a cohort of peers who can provide support as they progress. The trust is now implementing Wave 10 projects. Examples of improvements made through Listening into Action include:

- implementing more frequent ortho-geriatrician reviews for all patients who require their input, not just fractured neck of femur patients
- developing a recognised risk assessment tool related to caring for intensive care unit patients
- increasing the number of adult day-surgery ear, nose and throat patients.

Successful trusts identified that building transparent relationships based on trust with internal and external stakeholders was critical to embedding quality improvement. Trusts also recognised that, given the breadth these groups cover, they needed to use different models of engagement to address different interests.

The chosen engagement approach and messaging need to be grounded in reality. Engagement will fail early if leadership is seen to promise things it cannot deliver.

Internal engagement

Engagement with staff

All trusts identified that the leadership must make a clear, visible commitment to engagement with staff groups. This requires leaders to implement formal and informal engagement avenues that enable staff to hear how important quality improvement is and to contribute to what it should look like.

This change in approach to valuing the contribution of staff to quality improvement leads to long-term cultural change.

The staff survey is important for understanding where focused engagement is required, and can help assess progress. All trusts that exited special measures had improved their engagement scores.

Successful trusts described a wide range of engagement activities that increased staff engagement. Examples included:

- a formal communications strategy that includes staff engagement
- use of established models such as Listening into Action
- 'Frontline Fridays', where the nursing director works a shift with staff
- executive directors leading focus groups across all staff groups annually
- a broad set of communication channels such as newsletters and proactive use of social media, including blogs, Twitter and Facebook
- board members regularly walking the wards listening to staff
- formal approach to 'you said, we did', providing formal feedback
- executive team members' regular attendance at team briefings
- executive directors having 'open door' drop-in times available to all staff to attend.

Case studies: staff engagement

North Cumbria University Hospitals NHS Trust – Big Conversations

The trust board implemented a structured programme of staff engagement across different geographical sites called '*Big Conversations*'. The leadership team held formal focus sessions with staff groups.

Through this programme the trust board understood that staff in different geographical settings had different concerns about barriers to improvement. It developed formal action plans as a result, and the board tracked progress.

This process was repeated annually with a slightly different approach each time.

East Kent Hospitals University NHS Foundation Trust – quality improvement and innovation hubs

This trust is dispersed over three acute sites. Despite common features and a shared trust vision, each had distinct characteristics shaped by local priorities. To develop staff engagement that took account of these different cultures, the trust developed quality improvement and innovation hubs.

These hubs, led by multidisciplinary site-based teams, run for four hours per week on each acute site, and are a physical place where staff can discuss and learn about quality improvement. If they have a problem in their own service, they can ask for advice.

The hubs are also vehicles for staff to contribute their views on solving problems. The difference in each site is reflected in the solutions, and they are led locally.

Medical engagement

Engaging medical staff in quality improvement is vital. Engaging consultants is particularly important: as a senior group they can champion quality improvement but also hinder it if they do not buy into the changes.

Trusts used different approaches to medical engagement depending on the staff they wished to engage. Some established regular, informal opportunities for

engagement. Others increased the number of medical staff on key operational committees. The aim was to generate trust between leadership and senior clinicians. Once trust was established, consultants were more willing to engage with leadership.

It was important that the leadership team met staff in a variety of circumstances and contexts: for example, in both large staff meetings and small groups, and by going to wards to listen to concerns and empower staff to lead service changes. One trust engaged junior doctors by taking them to visit trusts rated highly in a specific area of practice. These junior doctors were then empowered to implement their learning – a powerful way to drive change.

Many trusts used the Medical Engagement Scale. This is a short, simple survey which measures medical engagement across three meta-scales: working in a collaborative culture, having purpose and direction, and feeling empowered and valued.

Each meta-scale is measured in two ways: the individual and organisational aspects of engagement and culture.

Trusts in special measures used the Medical Engagement Scale as a way of monitoring and gathering evidence of significant improvement in medical engagement.

External engagement

Patient engagement

Involving patients in their own care is a top priority for the NHS. Trusts are encouraged to develop relationships with patients that empower and engage them in their own care. Although such engagement is not without challenges, successful trusts were able to involve patients in service-focused quality improvement. This approach was part of organisations building patients' and carers' trust in services. It was important that any patient engagement was service- and ward-focused.

Trusts found that when they engaged patients in service developments and quality improvement, complaints were less serious and dissatisfied patients less likely to go straight to the press.

Trusts described the process they used to re-engage with patients and listen to the patient voice. Many began by putting the patient at the heart of every conversation, and embedding this culture – for example, including patient views and case studies in board and management conversations. Leadership ward visits included conversations with patients and their families, to understand their views on services. Trusts shifted their culture from aiming to hit targets in responding to complaints to using these as important sources of information to reflect and learn from.

Case study: Wye Valley NHS Trust

Wye Valley NHS Trust is a combined acute and community trust in a predominantly rural area. It struggles to recruit clinicians in all professional groups and at all levels of experience. The trust involved young patients in recruiting three consultant paediatricians. The prospective candidates were interviewed by young people individually and assessed on how they addressed young people and their families. Candidates were also assessed on how they involved young people in decisions about their own care. The candidates were then interviewed in the traditional way by an interview panel, and results from the two processes compared. Both sets of assessments identified the same candidates for appointment. Using this innovative strategy this geographically isolated trust was able to recruit three consultant paediatricians.

External stakeholders

Trusts that made rapid progress identified that it was important to build positive and supportive relationships with external stakeholders. They acknowledged that relationships with these groups, especially regulators, could be strained when trusts entered special measures. However, the benefits from putting energy and effort into building effective partnerships were felt to be central to improving quality.

Trusts described the importance of establishing external stakeholder forums, where they were able to meet regulators, commissioners, other local trusts and Healthwatch. These forums were two-way meetings, enabling the trust to give assurance on its progress by sharing updates in a single format. Additionally, forums allowed the trust to ask for support from its stakeholders, taking a system-wide approach to resolving some issues.

Successful trusts emphasised the importance of being robust in these meetings. When stakeholders requested unrealistic expectations or deadlines, these trusts were willing to push back. While this often resulted in more challenging conversations, the relationship became more trusting in time because trusts did not over-promise but kept to what was achievable.

External communication channels

An effective external communications strategy is crucial for an organisation's public image. Successful trusts built this into a continuous 'business as usual' approach:

- Explore all avenues: your communications strategy should embrace all possible avenues and cater for the population you serve.
- Establish a relationship: regular communication between you and the media means there are appropriate protocols and relationships so when news stories come up, both parties can benefit from fair and accurate reporting.
- Response time: after any incident or crisis a timely, preferably immediate, response is paramount. This has two effects: it allows you to understand the public perception of how the trust is handling the incident and prevents other parties exploiting the situation.
- Report bad news: it is always preferable for a trust to release any potentially negative news stories about itself as opposed to waiting for it to be released elsewhere. This not only allows direct control of the information but also full disclosure, preventing any escalation of the news story due to lack of information.
- Shift the narrative: one method for influencing media coverage is to shift the narrative away from negative reviews and incidents. During a crisis, this may simply involve shifting attention to how the trust is addressing concerns. Once the trust has moved to 'business as usual' it can publicise positive work, staff awards, milestones reached or patient quotes.

Case studies: external stakeholders

East Lancashire Hospitals NHS Trust

The trust's chair led the development of partnership working with local clinical commissioning groups and other stakeholders, such as regulators. This partnership working was based on gaining these groups' confidence through honest conversations, which managed expectations. The trust set achievable targets and regularly fed back to stakeholders about performance against these targets.

Barking, Havering and Redbridge University Hospitals NHS Trust

Barking, Havering and Redbridge was placed in special measures in 2013 and exited in March 2017. The trust had a poor relationship with its local population and media. There was an impression that only negative stories were published and that the local population had lost faith in local healthcare services' ability to deliver safe care.

The trust appointed a new director of communications and dedicated communications team. It undertook a wholesale change of the trust communications and public relations strategy. The trust focused on becoming more accessible externally by developing new avenues for contact, such as social media. The trust regularly published good news stories about its staff, patients and performance. Staff and patients were encouraged to post and spread news about their work and experiences.

Culture

Key lessons learned

Define or refine behavioural standards, norm, values or vision. These should then be embedded and role-modelled. These behavioural standards cannot be communicated and referenced too much.

Accountability is essential. Hold people to account for their behaviours and support the change required for improvement.

Learn from mistakes. Focus on learning from mistakes, moving away from a blame culture.

Celebrate success. Celebrate and reward success even if it is a small change. Culture change can take time, but changes can be made more quickly with the right focus.

Engagement and culture, though linked, are different concepts. Culture relates more specifically to the behaviours demonstrated, and includes:

- how staff feel about the organisation
- how managers behave towards staff
- how staff behave towards each other
- how managers and staff behave towards patients and relatives.

In trusts where engagement between managers and staff is poor, the culture of the organisation is nearly always poor too.

Define or redefine behavioural standards, vision, values, goals

One way leaders can influence culture is by defining expectations. They can do this by setting behavioural standards or refreshing vision, values and goals. Special measures provide an opportunity to redefine behaviours to focus on enhancing the care provided to patients.

Case study: Buckinghamshire Healthcare NHS Trust

The trust had been through a long period of change and challenge, including constant service change during the last decade to make a sustainable service, and acquiring community services. After being placed in special measures following the Keogh review, the trust sought to address the cultural challenges acknowledged in the review.

The trust recognised staff engagement and culture as the most important area on which to focus. The NHS Staff Survey had shown the trust in the bottom 25% for engagement for at least five years.

Key steps were to refresh and simplify the trust's strategy and values. It had previously had 54 strategic priorities. These were reduced to a mission, new values and three strategic priorities. Leaders were consistently clear about mission, vision, values. They used a variety of approaches to engage: for example, 'Feedback Friday', when leaders visited every service area engaging staff with the revised strategy and listening to any concerns.

While the trust's staff engagement scores have improved significantly, they are now only at the national average despite engagement and culture being a top priority – which demonstrates the focus and time that culture change requires.

Some trusts exiting special measures had refreshed their values using a bottom-up approach. They found this was critical to get staff buy-in, but was not enough on its own. These values also need to be embedded throughout existing processes and procedures such as recruitment, appraisals and performance management. Leaders at every level need to act as role models for the expected behaviour, communicating values and visions focused on high quality, patient-centric care.

Accountability is essential

By setting your standards you should give clear expectations for how staff conduct themselves and what they are accountable for. In many cases, this has led to re-engaging staff in the quality agenda.

There needs to be a 'line in the sand' with a robust approach to performance management. You need to tackle inappropriate behaviours rigorously to reinforce the commitment to the culture you are trying to build. In some cases you may need to take disciplinary action, but this tends to be only in a few cases.

Learn from mistakes

While it is important to recognise failures, setting standards and holding people accountable is not about blame – the focus should be on learning from mistakes. Key to this is how the leadership and trust react when things go wrong.

CQC found that an open culture, where staff can raise concerns about safety and feel listened to, is an important indicator of a trust's overall quality of care.⁶ This is often reflected in how incidents are reported and investigated and how learning is shared in a non-blaming way.

A safety culture needs staff who feel encouraged and supported to report incidents, errors and complaints. Trusts told us this information should be treated as an opportunity for learning. Discussion and feedback should be used to fuel a shared understanding of issues, improvements required and how reporting has a beneficial impact.

For example, as an immediate response to special measures one trust's executive team undertook weekly root cause analysis of all reported incidents. It has now implemented a formal incident reporting analysis process and a trust-wide safety summit to share learning. However, the leadership team emphasised the value of this interim solution, which encouraged visible role modelling and cultural change in the leadership team.

⁶ Care Quality Commission (2016) [The state of care in NHS acute hospitals: 2014 to 2016](#).

Case study: Tameside and Glossop Integrated Care NHS Foundation Trust

The Keogh review and subsequent CQC inspection identified issues related to safety reporting – for example, concerns about the reliability of systems to record and encourage safety, and some staff who did not know how to define patient safety.

As part of its corporate objectives in 2014/15, the trust agreed to implement a patient safety programme and took several initiatives to address shortfalls in quality. These included patient safety teams set up around specialties, with trust-wide workstreams. Clear metrics were defined for each programme, with results reported directly to the medical director. Improvements were seen across workstreams because of the defined goals, staff ownership and engagement.

During a reinspection in April 2015, the increased focus on quality of care, including patient safety, was noted as effective and resulted in several services receiving a higher rating. The trust was rated good by CQC in 2016.

Celebrate success

Successful trusts stressed the importance of celebrating success along the way, no matter how small it might be. Special measures can have a significant impact on overall morale, with staff feeling they have no power to make changes that could lead to improvement. Trusts stated that positively rewarding people for good behaviour and improvement success is key to generating pride in the trust and moving the culture forward. For example, one trust gave gift vouchers to staff in services that identified and implemented quality improvement initiatives.

Some trusts used visible monitoring and public celebration of progress to communicate results to staff. These included ward-level dashboards, presentations at town hall meetings and updates in trust-wide newsletters. Social media can play a powerful role in celebrating success and shifting the tone of the culture.

For example, Cambridge University Hospitals NHS Foundation Trust used the #MyCUH hashtag on Twitter to show staff involvement in the improvement plan,

and staff used it to share their stories. North Cumbria University Hospitals NHS Trust had a weekly blog to celebrate success and share issues for improvement.

Successful trusts emphasised it can take two to five years to embed real changes in culture. Making changes sustainable takes continued effort. Yet significant changes can be made in months if cultural change is given sufficient priority.

Case study: Wexham Park Hospital

CQC inspected the former Heatherwood and Wexham Park Hospitals NHS Foundation Trust in February 2014 and found it inadequate. Since October 2014 it has been part of Frimley Health NHS Foundation Trust.

The CQC report described a culture of 'learned helplessness'. Changing this was a priority for the new leadership team. The stable leadership provided by Frimley Health helped, giving a clear direction and priorities that did not change. The focus was on putting patients at the heart of everything, asking staff to treat them as if they were their own family members.

Similarly, an external view of what good looks like helped to challenge some of the behaviours and issues to which staff had become blind.

These changes helped make a significant change to the culture in a relatively short time.

See <https://youtu.be/du6YRStftbM> for more details.

Governance

Key lessons learned

Lean governance arrangements. Governance arrangements must be lean, fit for purpose and transparent.

Board oversight. The board should have a clear view of its areas of concern, the actions taken, who is responsible, and whether those actions are having the expected impact.

The unitary board. A unitary board operating effectively is key to driving change and holding the organisation to account for delivery.

Agile decision-making. Decisions should be made by staff at ward and team level wherever appropriate. When decisions have to be escalated, there must be a clear, well-understood and responsive process.

Use data to assess change. To be reliable and meaningful, data must be owned by staff.

Lean governance arrangements

Robust governance processes should give the leaders of organisations, those who work in them and those who regulate them, confidence about their capability to maintain and continuously improve services.⁷

Weak or broken governance is an issue in all special measures trusts. In some, governance structures are absent. In others, they are too complex or not complied with, reducing their impact.

- Much guidance on good practice in governance is available. Most leaders focused early on getting governance working effectively to enable

⁷ NHS Improvement (2017) [Well-led framework](#).

improvement to begin. Effective arrangements prevented decision-making rising to the top of the organisation and distracting from key strategic decisions.

Case study: Cambridge University Hospitals NHS Foundation Trust

Before its CQC inspection, the trust had restructured its divisional governance to align more closely with the patient pathway. When combined with leadership capacity issues, some governance structures were not designed or embedded properly. In particular, it was not clear where decisions should be made. Many came to the board by default, slowing the pace of change.

In response, the trust introduced an investment committee, chaired by the chief financial officer, and a defined process for bringing decisions to this committee.

This freed the board to spend more time on strategic matters and overseeing special measures. It also prevented the finance and performance committee from being caught up in detail for small decisions. The defined process meant staff were clear on the process for approving investments, and the investment committee received the information it needed first time to make a decision, improving pace.

Board oversight

When entering special measures, trust boards may be tempted to review all areas of operation in detail. This is not possible and will reduce the board's effectiveness.

Instead, simple structures must be introduced to enable the board to know which services, wards or issues it should be concerned about and identify new problems as they arise. All trusts, even those rated outstanding, will have these concerns. The board must have clear information on areas of concern.

Having identified these areas, the board must be clear on the action taken, who is responsible for the action and how it will know if this action has been successful. Successful trusts 'closed the loop' on actions. This enabled them not only to track completed actions but regularly assess information from data and soft intelligence.

This ensures actions have had the impact desired. The focus must be on assurance, not reassurance.

Case study: North Cumbria University Hospitals NHS Trust

There were many quality concerns at the trust, many of which were highlighted during the Keogh review. In the initial months in special measures, the quality committee attempted to monitor all of these. This created a huge agenda but failed to gain real assurance of improvements. Meetings often lasted more than four hours.

In response, the committee was restructured to focus on trends and obtaining assurance. Its agenda was shaped using CQC's domains. Separate working groups undertook routine monitoring. For example, a weekly safety panel was established, systemising change across the trust and drawing on national guidance.

This approach reduced the quality committee's agenda so it could focus on assurance, while the working groups ensured the trust could be more responsive to issues as they arose.

The unitary board

As a result of early leadership changes after entering special measures, many successful trusts worked with a newly formed board.

Effective team-working and trust between board members are essential if the board is to oversee quality improvement. Many boards undertook board development work to improve trust and team-working while in special measures.

Effective oversight from a unitary board struck a balance between scrutiny and supportive challenge. An effective unitary board could link areas as part of the scrutiny and assurance discussions: for example, using data to make connections between changes in different metrics, or assess the impact of particular actions on patient feedback and staff satisfaction.

Agile decision-making

In special measures trusts, decision-making is often slow, and staff are not clear about the process to get a decision made. It is essential that roles and responsibilities are clear throughout the organisation, particularly responsibility for decision-making. This will help to shift away from decision-making rising to the top.

Case study: Hinchingsbrooke Health Care NHS Trust (now part of North West Anglia NHS Foundation Trust)

Decision-making at the trust had slowed, with decisions tending to be pushed upwards to the board. Staff were not empowered to make improvements at ward level.

The executive team used explicit communication to give staff permission to make changes. Conversations were focused on staff's biggest personal frustration and empowering them to find a solution. Leaders asked simple questions: will it cost anything? Will it have a negative impact on quality of care? Will it have a negative reputational impact? If the answers were no, staff were encouraged to make the change themselves, with support provided centrally if needed.

This made quality improvement less formal and more personal and improved buy-in at all levels.

Use data

Studies of governing for quality improvement show that more mature organisations use data for monitoring quality improvement. Their boards receive reports with clear, readable data where different sources are discussed together,⁸ meaning that boards can rapidly cross-check information.

⁸ Jones et al, 2017. [How do hospital boards govern for quality improvement? A mixed methods study of 15 organisations in England.](#) BMJ.

Many special measures trusts relied on anecdotes rather than information. Data was inaccurate, with no 'single version of the truth'. Reliable information on which decisions can be made is essential for quality improvement. Data accuracy will only be improved when staff own the data and address data quality issues. A structured programme of data improvement is often necessary to help this happen, and many of the most successful trusts have a strong information team.

Case study: Barking, Havering and Redbridge University Hospitals NHS Trust

The trust faced challenges with data accuracy, with fragmented information management, data quality and data assurance systems.

In response, the trust's information team were identified as guardians of the data – to create a 'single version of the truth'. A divisional standardised scorecard was developed based on this information. With accurate measurement, the value of the metrics improved. Discussion centred on measuring what was important, including patient satisfaction data, rather than simply what was easy to measure.

To drive ongoing improvement, each division was asked to identify what a high quality clinical division looks like in their specialty nationally, and aim for those metrics in addition to the basic metrics assigned. This gave clinicians more ownership of the data.

Further details can be found in the trust's publication, *The only way is up*.

Approach to quality improvement

Lessons learned

Quality improvement frameworks. A structured approach to quality improvement is the best way to engage staff and achieve sustainable improvement. Being able to monitor the impact of actions is crucial to this. A framework, with patient safety at its core, is needed to change the way staff think and approach quality improvement.

Improvement plans. Improvement plans must be more than a series of actions; they are pivotal to enabling leaders to articulate what the trust intends to achieve in the medium to long term.

Buddying and learning from other trusts. Buddying and partnering with other trusts can work, but they require defined terms of reference and a practical contribution to capacity and capability.

Quality improvement requires sustained support and commitment from a trust and its leadership. Trusts that made the most improvement, exiting special measures in a short time, told us they took a systematic approach to quality improvement.

Quality improvement frameworks

For many trusts in special measures, sustainably improving quality required them to change the way they thought about improvement and involved introducing a framework for improvement.

Trusts have used different frameworks and methodologies for quality improvement: for example, the 'Model of Improvement' developed by the Institute for Healthcare Improvement, and the lean continuous improvement methodology applied by the Virginia Mason Institute (which is currently supporting five trusts to drive improvement using this method⁹).

No single approach to quality improvement has been shown to be superior to

⁹ <https://improvement.nhs.uk/resources/virginia-mason-institute/>

others. Establishing a framework with patient safety as the core is of central importance.¹⁰

Case study: Hinchingsbrooke Health Care NHS Trust (now part of North West Anglia NHS Foundation Trust)

The trust was placed in special measures following a CQC inspection in October 2014, which rated it as inadequate. A follow-up inspection in October 2015 found improvements, but CQC did not feel these were sufficiently embedded for the trust to exit special measures. This had a significant impact on staff morale.

The chief executive, who joined the trust just before the 2015 inspection, introduced an overarching strategy of 'good and beyond'. A central aim of this was not to get out of special measures but to sustainably improve quality.

There was significant pressure externally to work at a pace that increased the risk that the changes made would not be sustainable. Steps taken to deliver sustainable change beyond special measures were:

- an overall improvement plan rather than a list of actions
- communication and engagement – openness and honesty
- building internal and external relationships
- a transparent assurance process.

The trust exited special measures in 2016, and is rated good by CQC.

Trusts will need to invest in using this framework, dedicating both time and resources. Staff should be equipped with skills and supported within the framework to make the necessary changes. Developing quality improvement capability through internal training or external support is a key step to empowering staff to engage meaningfully and effectively in improvement.

¹⁰ Health Improvement Scotland (2009) [*A systematic narrative review of quality improvement models in health care.*](#)

Case study: Basildon and Thurrock University Hospitals NHS Foundation Trust

The trust used 'Stepping Up' as a banner under which quality improvement initiatives were communicated and managed. This was introduced shortly before the Keogh review was published. Examples of the Stepping Up programme include:

- morning meetings with leaders, held in the canteen and open to all staff to discuss the day's most pressing issues
- a monthly newsletter sharing good practice stories from around the trust and keeping staff up to date on important changes
- a Stepping Up board, overseeing the portfolio of quality improvement projects, each of which has its own 'project management office'-style workbook and milestones; this allowed the leadership to track the progress of quality improvement projects, celebrate success and address delays.

Stepping Up is a brand that staff recognise. It increased engagement across the trust and helped reduce 'initiative fatigue' that can occur when many improvement projects take place.

Quality improvement plans

All trusts developed quality improvement plans on their journey towards exiting special measures. They emphasised the importance of using them as a clear strategy and narrative to communicate with staff and other stakeholders.

There is a risk your plan can simply be a shopping list of CQC's observations for improvement. Trusts that rapidly exited special measures used CQC's observations to diagnose underlying themes and areas for improvement, focusing not only on exiting special measures, but on a longer-term view of what the trust wanted to achieve.

A quality improvement plan should prioritise and champion the maintenance of

basic clinical standards and safe clinical environments. Safety concerns in the CQC report should be addressed as a matter of urgency. Then it is essential to prioritise key issues within the trust's control.

The ability to review and assess whether outcomes or milestones (not just actions) have been achieved should be built into any quality improvement plan and quality improvement methodology selected. A project management office or service improvement team can help manage and monitor an improvement plan, but trusts that used this type of team told us their real value is in driving change.

Improvement plans can be used as the basis for communicating a positive vision of where the trust is going – giving a sense of direction to an organisation that may feel helpless about its situation. Involving staff in the improvement plan – and giving them ownership of discrete aspects of clinical practice that require improvement – can be an effective means of engagement while achieving the required improvement in performance.

Case study: Wye Valley NHS Trust

A CQC inspection in 2014, which rated the trust as inadequate, identified a long list of areas in need of urgent improvement.

The trust developed a quality improvement plan derived from the list of 'must dos' and 'should dos' highlighted by CQC. It developed with staff a list of projects to help implement the plan.

Each project stream had an executive lead, an operational lead, a senior manager and a clinician. 'Smart' aims were set for each project, and progress was monitored regularly through a status report but also a 'measures of improvement' report. Staff were given an opportunity to present their improvement projects to the chief executive, medical director, non-executive director and a programme manager, who were available to help overcome barriers to implementation. This led to improved ownership of projects by staff across the organisation.

The trust was reinspected in 2016 and awarded an overall rating of 'requires improvement', including requires improvement in 'safe' and 'well led', and was able to exit special measures for quality as a result.

Buddying and learning from other trusts

Some trusts in special measures suffer from insularity: they look inwards and fail to learn from good practice elsewhere in the health system. It is essential that trusts look outwards as they seek to improve quality.

Trusts can understand how other trusts approach their operations and quality improvement through various techniques, including buddying and more focused partnerships with other trusts.

Buddying with another trust has often proved valuable, but requires commitment from both parties. It helps to define the specific terms of reference for the buddying relationship: for example, a specific clinical area or specialty that needs more capacity or experience of what good looks like.

Trusts emphasised the need when choosing buddy organisation to take account of their circumstances. This may include type of trust as well as location and resources. It can help to choose trusts that have experienced CQC challenges and therefore can relate to special measures.

More formal partnerships were also successful in some cases. These include Guy's and St Thomas' NHS Foundation Trust and Medway NHS Foundation Trust; Frimley Park Hospital NHS Foundation Trust and Heatherwood and Wexham Park Hospitals NHS Foundation Trust (now joined together as Frimley Health NHS Foundation Trust); The Ipswich Hospital NHS Trust and Colchester Hospital University NHS Foundation Trust. In each of these cases senior leaders (managerial and clinical) from a high performing trust (outstanding or good, according to CQC) helped lead change.

Despite mixed success in buddying relationships, most trusts said buddying helped them think about best practice outside their organisation.

In some cases, buddying at a service level has been helpful where there are more local leadership challenges. For example, there was a successful buddying relationship in the maternity service at University Hospitals of Morecambe Bay NHS Foundation Trust. This allows for more direct support than some trust-wide buddying relationships, and still provides insight into what good looks like.

4. Conclusion

We are now four years into the special measures programme that has provided trusts with dedicated support to address their specific challenges. It has included embedding improvement directors, funding for improvement programmes, monitoring improvement plans, building leadership capacity, facilitating change and providing intensive support on patient experience and staff engagement.

There is now significant learning to be gained from trusts that benefited from this dedicated support, and from understanding what helped them most in making the sustainable quality improvements that enabled them to exit special measures and continue to improve.

We have reflected on this combined learning and on the challenges trusts face to sustain good practice and high quality patient care. We must continue to learn and hone our understanding of which interventions and support have the most effective and long-lasting impact, to ensure a continuous cycle of learning and improvement.

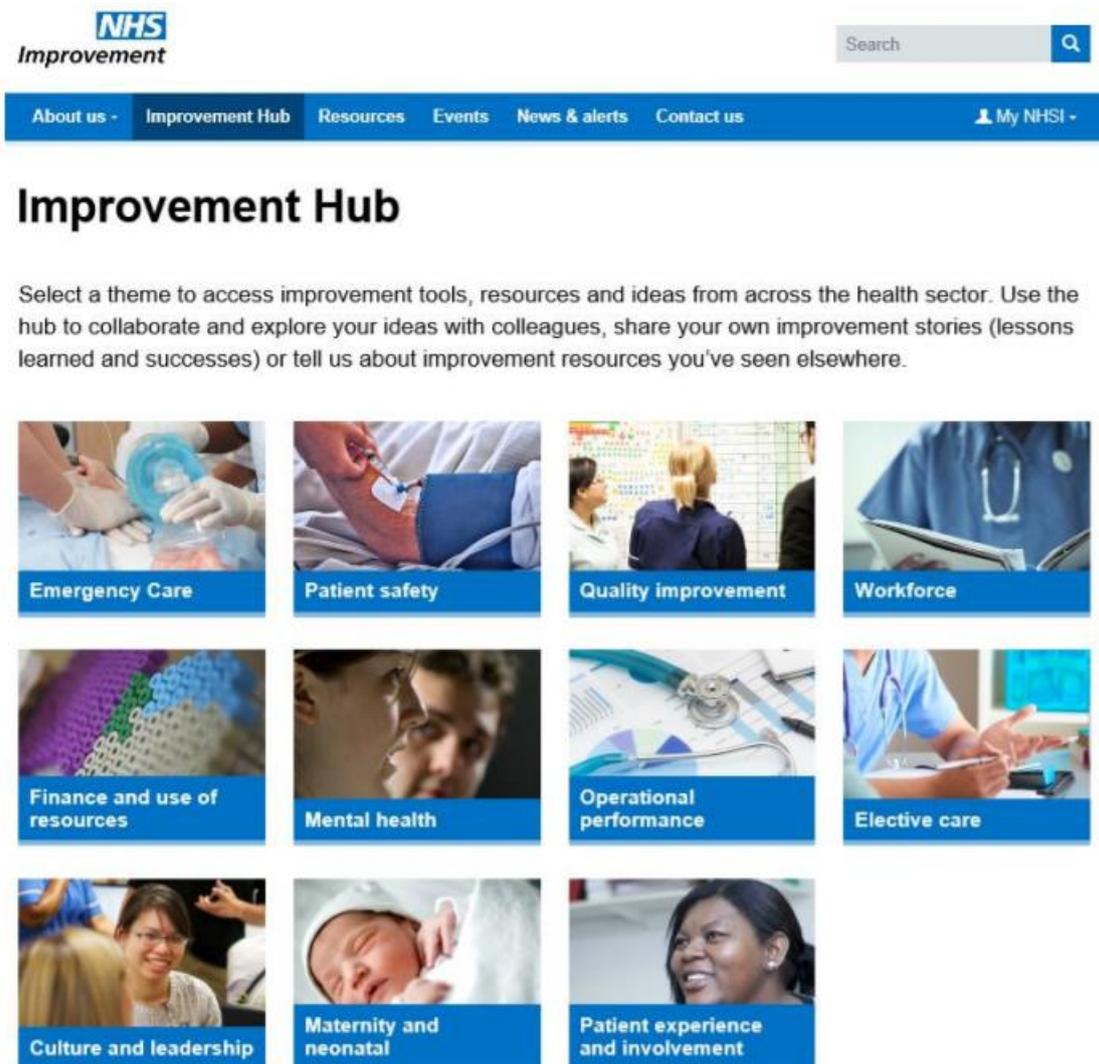
Our key advice to a challenged trust is:

- acceptance: recognise when things are not as good as they should be and ask for support – this is the start of the improvement process
- be courageous about getting strong leadership on behalf of patients and staff
- place great importance on engaging and developing staff and supporting clinical leadership
- expect the work to be hard but stay with it, and seek and accept help
- it will be a long and difficult journey, but you will be successful; and this is ultimately what matters to patients.

Annex A: Accessing support and further reading

New support offers are available all the time. The easiest way to find out about them is to visit the Improvement Hub: <https://improvement.nhs.uk/improvement-hub/>

This includes resources from across the NHS, as well as discussion forums and case studies.



Further reading

Quality improvement

NHS Improvement (2016) [Developing people, improving care](#)

NHS Improvement (2017) [Towards sustainable improvement](#)

NHS Improvement (2017) [Building capacity and capability for improvement: embedding quality improvement skills in NHS trusts](#)

NHS Improvement (2017) [Well-led framework](#)

The Health Foundation (2015) [What's getting in the way? Barriers to improvement in the NHS](#)

The Health Foundation (2015) [Building the foundations for improvement](#)

Institute of Healthcare Improvement (2016) [Sustaining improvement](#)

NHS Leadership Academy (2013) [The healthy board: principles for good governance](#)

NHS Wales (2014), [1000 lives plus: quality improvement guide](#)

Care Quality Commission (2017) [Driving improvement: case studies from eight NHS trusts](#)

The King's Fund (2013) [Patient centred leadership: rediscovering our purpose](#)

The King's Fund (2014) [Medical engagement: a journey not an event](#)

Healthcare Improvement Scotland (2009) [Making the case for quality improvement: lessons for NHS boards and leaders](#)

Reviews and investigations

NHS Improvement (2015) [Special measures: a guide for NHS trusts and foundation trusts](#)

Department of Health (2013) [Review into the quality of care and treatment provided by 14 hospitals trusts in England: overview report](#) (Professor Sir Bruce Keogh KBE)

Department of Health (2013) [Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry](#) (Robert Francis QC)

Department of Health (2013) [A promise to learn – a commitment to act: improving the safety of patients in England](#) (National Advisory Group on the Safety of Patients in England)

Care Quality Commission, Monitor and the Trust Development Authority (2014) [Special measures: one year on](#)

Care Quality Commission (2017) [The state of care in NHS acute hospitals](#)

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