Valued care in mental health: Improving for excellence

A national mental health improvement model
“Working on improvement with experts by experience in a co-productive way produces the best possible outcomes for people who use services, their families and carers. I am delighted that Valued care in mental health: Improving for excellence has quite rightly placed this as the opening chapter reinforcing the importance of working with people who use services, their families and carers and this is a theme throughout this resource.”

Paul Farmer, CBE, Chief Executive, Mind

“We all know the importance and positive impact of co-production and involving people who use services. However, sometimes it can be difficult for providers or commissioners to know exactly how to make changes to their practice; to be able to make decisions collaboratively, and use insight when shaping and improving services. This co-produced resource provides much of the detail related to ‘how’ providers can make changes and Rethink Mental Illness welcomes the focus on experts by experience throughout. We hope others will be inspired by these case studies, learning points and tips, and will continue embedding co-production consistently throughout their work.”

Danielle Hamm, Associate Director Campaigns and Policy, Rethink Mental Illness

“It is vital to do all we can to ensure that everyone, wherever they live and whatever support they need, gets the right help for their mental health at the right time to a high quality every time. Co-produced services that are built in an equal partnership, with staff who feel valued by the organisations that employ them, hold particular promise. Valued care in mental health: Improving for excellence provides invaluable insights, not just into some of the ways services are developing but also into the ways change happens, the challenges of achieving it and the experiences of those who are prepared to innovate and do things differently.”

Sarah Hughes, Chief Executive, Centre for Mental Health

“The experts by experience section is a triumph as it brings a revolutionary change to the fore and effectively bases it in a very practical and real-life context. It is both inspiring and, more importantly, humbling. This has been a fundamental cultural revolution and the insights from experts and professionals alike convey a truly effective transformation in thinking that has been far too long in coming. Clearly, the work that is being done across the country is delivering against one of the most fundamental weaknesses of our traditional system and that is empowerment. That is a clear and powerful message.”

John Brouder, Chief Executive, North East London mental health trust and chair of Cavendish Group

“The positive outcomes achieved by those organisations that have invested in a model for improvement speak for themselves. It is evident from those who have shared their learning that quality improvement can’t be an add-on or an initiative. It has to become the way you do things and whatever stage you are at the learning and improvement is continuous. This resource will help those interested in improvement to start or continue their journey.”

Samantha Allen, Chief Executive, Sussex Partnership NHS Foundation Trust

“Valued care in mental health: Improving for excellence provides the reader with the ‘how to’ for sustainable improvement from those who have made the journey. It demonstrates that it takes time and, most importantly, that working with those who use services is vital at the start and throughout.”

Chris Naylor, Senior Fellow in Health Policy, The King’s Fund
Our partners
Summary

A model for improving mental health services

Mental health trusts in England welcome the policy, media and public attention now being paid to mental health. Being in the spotlight offers an important opportunity to improve mental health services for the people who use them. It also raises local communities’ expectations of care from mental health services at a time of continuing funding constraints.

Many mental health service providers around England are facing this complex challenge with exceptional innovation, energy and creativity. In 2017, NHS Improvement committed to supporting the development of a national model to guide the continuous improvement of mental health services, drawing on the experience and skill within the mental health sector.

NHS Improvement asked Northumberland, Tyne and Wear NHS Foundation Trust (NTW) to be its strategic partner in this endeavour because of NTW’s outstanding record of care delivery. This stems from NTW’s eight-year, ongoing system-wide improvement programme, based on redesigning individual pathways to meet the needs of people who use services, their carers and their families.

Another eight mental health providers were invited to work with the two strategic partners on the basis of their distinctive experience of innovation and improvement. Representatives from these ten organisations have worked collectively over the past twelve months to develop the national model for improving mental health services presented in this resource.

The resource comes in two parts, this core document and a collection of interactive online elements, which will be supported and refreshed by NHS Improvement.

The model draws on the diverse experiences of all the trusts represented by the group. The trusts involved are at different stages of an improvement journey and each embarked on their particular journey for different reasons. The model reflects the challenges they have faced, and the lessons they have learned from setbacks as well as successful innovations and improvements. The aim is to benefit other mental health service providers making an improvement journey of their own.

The model does not suggest there is a single ‘right way’ to build capacity and capability in sustainable improvement. Rather, it reflects the group’s experience that continuous improvement results from the interaction of a number of different ingredients. This document describes the ingredients that have been most important to their improvement journeys so far. Other trusts may decide to use and add to these ingredients in different ways.

That said, the group has chosen the order of the ingredients in the model for specific reasons.

Experiences of experience come first because the primary ingredient in any work to improve services is the voice of the people who use those services. Trusts can make sure they hear that voice by integrating people whose use services, their carers and families as experts by experience in all improvement projects. Understanding the difference between these experts’ actual experience of care and what they hope to experience defines the distance an improvement journey aims to cover. By putting this ingredient first, the group is emphasising that the point of mental health services is to improve the lives of people who use them.

Next comes understanding the national picture – the national policy objectives and supporting initiatives comprising the strategic context in which trusts are trying to improve services – and understanding the local area. Understanding the local area involves knowing the social and economic characteristics of the local population – including population health inequalities – that inform current and future demand for mental health services. It also means understanding and working with local partners to improve supply.

Culture and leadership follow because these soft, ‘people’ ingredients of change need to be of a particular quality for improvements to be cumulative, sustainable and systemic. The culture must encourage staff to be open, to test new ideas and to learn from mistakes rather than to blame. The leadership has to strike the right balance between supporting staff, allowing autonomy within boundaries and excellent accountability.

Once these four ingredients are an integral part of an organisation, it will be better placed to gain a holistic understanding of its business and how to manage its resources – human, financial, intangible and physical. If resource constraints seem to have become a constant feature of the NHS environment, then the constant challenge for trusts is how to improve services within the resources available.

Trusts will be looking for a suitable improvement approach or methodology to drive continuous improvement in their business. Successful deployment of an improvement approach takes systematic quality planning and quality control.

Patient safety is a critical ingredient of care quality. So in the course of any improvement journey, patient safety must, as ever, remain a priority. Improvement approaches should complement systems of clinical audit and clinical governance structures in order to raise standards of patient safety.

The final two ingredients – digitilisation and innovation – are further critical drivers or sources of improvement. The slow pace of digital progress in the NHS compared to other sectors offers a significant opportunity. Digital and other kinds of innovation can bring step changes in service quality and value for money. They may also raise new risks, which trusts need to manage explicitly.

The combined learning that informs each ingredient in the model is complemented by a review of current thinking and theory provided at the start of each chapter by Henley Business School. 57 illustrative case studies appear throughout the document, as well as references to further resources.

The final chapter is a compendium of stories describing the improvement journeys of the trusts represented by the group.

An improvement journey never ends: all of the trusts involved in developing this model would say their journey continues. The model described here is a distillation of what they wish they had known before they started. If it gives encouragement and practical support to other mental health service providers committed to improving for the people they serve, it will be doing its job.
Table of contents:

Introduction 10

Chapter 1

Experts by experience 14

Chapter 2

The wider context: using policy, demand and supply data for improvement 40

Chapter 3

Culture 54

Chapter 4

Leadership 76

Chapter 5

Resources 106

Chapter 6

Improvement approaches 148

Chapter 7

Safety, clinical audit and clinical governance during major change 172

Chapter 8

Digitalisation 190

Chapter 9

Innovation 202

Chapter 10

Compendium of trust improvement stories 224

Conclusion 272

Appendix 274

Group improvement stories – thematic analysis
**Introduction**

**A model for improving mental health services**

Mental health trusts in England welcome the increased amount of policy, media and public attention which is now being focused on mental health. This development provides an important opportunity to improve services for the people who use them. This spotlight also raises expectations of the care that mental health services provide to their local communities which need to be delivered in the context of funding constraints. Many organisations around England are striving to meet this challenge with innovation, energy and creativity.

Drawing on the experience and skill within the mental health sector, NHS Improvement committed to developing a national model to support the continuous improvement of mental health services. (1) (2)

NHS Improvement asked Northumberland, Tyne and Wear NHS Foundation Trust (NTW) to be its strategic partner in this endeavour because of NTW’s outstanding record of care delivery. This stems from an ongoing eight-year system-wide improvement programme in NTW based on redesigning individual pathways to meet the needs of people who use services, carers and their families.

Eight mental health providers were invited to work together with the two strategic partners because of their record of innovation and improvement. This group has collectively developed this national model for continuously improving the services they provide.

The resource is in two parts, this core document and an interactive online resource that will be supported and refreshed by NHS Improvement. All the trusts involved are on an improvement journey. They embarked on these journeys for different reasons and are at different stages. The model draws on the diverse experiences of all the trusts represented by the group. This includes challenges and learning as well as successful innovations and improvements, to benefit others interested in an improvement journey of their own.

The model does not suggest there is a single ‘right way’ to build capacity and capability in sustainable improvement. Rather, the model reflects the group’s experience that this is the result of the interaction of a number of different ingredients. This document describes important ingredients which different practitioners may use and add to in different ways.

The combined learning that informs the model is further complemented by a review of current thinking and theory provided by Henley Business School. Throughout the document there are illustrative case studies, as well as references to further resources.

The improvement journey never ends, and all of the trusts involved in developing the model would say that their journey is ongoing. This model should provide a significant resource for organisations committed to improving services for the people they serve.

“By role modelling co-production, by working truly together, building trusting relationships with people who provide our care, we can enable change together.... I am living proof that co-production changes lives.”

Iris Benson MBE,
Mersey Care Foundation Trust
Chapter 1

**Experts by experience**

Nothing happens in healthcare without people who use services, their carers and families.

Involving them on your improvement journey pays dividends.

Feedback from experts by experience in whatever form (complaints, compliments, Healthwatch) gives an organisation the opportunity to evaluate what aspects of its services need to improve.

However if things have not been great, there is a need to gain their trust, as well as supporting staff to accept inclusion of experts by experience in improvement.

Embedding and sustaining this approach is simple, but not always easy.

**Current situation**

Involving people with lived experience in co-producing better mental healthcare gives everyone trying to improve services a far more informed base of knowledge and perception on which to draw. However, the take-up and practice of co-production in mental health improvement varies widely and the full potential of this approach is not yet being realised across the country.

Co-production with experts by experience is more demanding than ‘top-down’ improvement but its advantages clearly outweigh its demands and it is now a statutory requirement (Health and Social Care Act 2012). This group believes that involving people who use services in designing services offers an opportunity to improve service delivery, as well as other significant gains (Repper and Perkins 2003). For sustainable impact, co-production also calls for a radical and courageous rethink of deeply embedded attitudes of authority and deference.

Becoming an expert by experience needs self-confidence, belief and empowerment: co-producing professionals, for their part, need vulnerability, humility and self-awareness. The trusts belonging to this group have found that working in partnership with people who use mental health services advances service delivery in the widest sense to levels that could not be achieved without people who use services’ equal participation.

“Getting the right help at the right place as quickly as possible enables people to have access to information, support and services to improve their quality of life. It is crucial that the emphasis (where possible) is about working in partnership with them at the earliest point, to understand their difficulties and strengths in order to decide the way forward collaboratively. It is essential that people have early access to treatment and interventions after assessments, so that people are not left on long waiting lists which can be misleading and give false hope. Any standards and measurements around early access should be at the point of formulating, plans and goals, as it is these interventions at this stage of their journey that can/will have an impact and make a difference.”

Nicola Armstrong,
Patient and Carer Involvement Facilitator,
Northumberland, Tyne and Wear NHS Foundation Trust

“Our business is clinically and service-user led, and managerially enabled”

Sheena Cumiskey,
Cheshire and Wirral Partnership NHS Foundation Trust
What is an expert by experience and what does co-production mean?

An expert by experience is someone who has personal, lived experience of using health, mental health and/or social care services, or of caring for someone who uses those services.

Slay and Stephens define co-production as a “relationship where professionals and citizens share power to plan and deliver support together, recognising that both partners have vital contributions to make to improve quality of life for people and communities.”

(Slay and Stephens 2013, p3)

Co-production is therefore an approach to change based on dialogue. Working together, groups of experts by experience of mental health services, professionals and other stakeholders can co-produce every stage of efforts to improve services – from design and delivery to evaluation.

“My role (as Improvement lead) can support others to become more actively involved in speaking out; we have nothing to fear by people speaking out. If we don’t say what’s wrong, we can’t make it better. By role modelling co-production, by working truly together, building trusting relationships with people who provide our care, we can enable change together. Perceptions of mental health have changed in my lifetime but there is still a long way to go. My role in No Force First shows that it can be done. I am the living proof that co-production changes lives.”

Iris Benson MBE, expert by experience at Mersey Care NHS Foundation Trust

The six defining principles of co-production with experts by experience
(adapted from Slay and Stephens 2013)

- Recognising people as assets - transforming perceptions of people as passive recipients of care and ‘burdens’ on the system to equal partners in designing and delivering services.
- Building on people’s existing capabilities - actively supporting people to recognise and use their strengths.
- Reciprocity and mutuality - offering people who use services opportunities to develop reciprocal relationships with professionals (and with each other) and enter into mutual responsibilities and expectations.
- Peer support networks - enhancing the generation and transfer of knowledge by engaging personal and peer networks alongside those of professionals.
- Breaking down barriers - blurring the distinctions between professionals and producers and consumers of services, and reconfiguring power relations and the way services are developed and provided.
- Facilitating rather than delivering - enabling professional staff to become catalysts of change instead of sole providers of services.

Review of current thinking

The idea that people with personal experience of mental illness should be active partners in service development, support and provision for others reflects a shift from a discourse on mental illness with roots in beliefs, practices and language dating from the 19th century (Hutchinson 2016). This was a period when first-person accounts of mental illness were rare (Bateson 1974). Valuing the authority of personal accounts alongside the more traditional authority possessed by trained staff and professionals has many antecedents in the 20th century, including the adoption of gestalt, narrative and phenomenological methods in social science research from the 1960s onward, and later influences from critical theory, post-modernism and feminism (Noorani 2013).

Self-management in healthcare has been a component of government policy since 1999: the Expert Patient Programme (DoH 2001) required people who use services to be involved in developing mental health services (Tait and Lester 2005). The term ‘experts by experience’ has been in use in mental health improvement since around 2003 (McLaughlin 2009).

The ladder of participation

At the New Economics Foundation, Slay and Stephens (2013) have developed the ladder of citizen participation shown in Figure 1. The ladder distinguishes three levels of people who use services involvement in change and improvement.

Figure 1: The ladder of participation
The ladder is useful for NHS organisations wishing to reflect honestly on their progress and aspirations. It visualises a continuum from coercive levels of engagement, in which people who use services hand themselves over to the experts, through superficial involvement with people who use services, in which professionals still set the boundaries for the relationship, to transformative co-production, in which people are fully involved in all aspects of design, delivery and evaluation of services.

The characteristic defining each step on the ladder is power and its distribution between those with professional expertise and those with lived experience. It is tempting for organisations to overstate progress up the ladder, but to realise the true potential of co-production they should make an objective appraisal of where they are.

The ladder is equally helpful in reminding us what co-production is not. It is not consultation, volunteering or individual budgets (Boyle and Harris 2009); nor is it user-led services, user involvement or engagement; nor does it describe swapping one dominant power base for another. The full potential of co-production can only be realised when responsibility for both the design and delivery of services is shared between professionals and users.

In the national mental health improvement model, co-production can be seen both in hierarchical and holistic terms. As hierarchy, it emphasises and then challenges existing balances of power in relationships between the players in a mental healthcare system, but in holistic terms each individual player (and level) can only be understood in relation to the whole.

Why use co-production with experts by experience for improvement and what it’s like in practice

There are clear business reasons for co-producing improvement with experts by experience. Since they are customers of services, service designs that incorporate their insights are far better than those that rely on groups of professionals alone to plan and decide.

"Co-producing delivers better outcomes. This is a caring element but it also makes business sense, ie understanding what your customers want/need is key … at the individual through to the strategic level."

Expert by experience

Mental health trusts already engage with people who use services, families, carers and community members through consultations, surveys and the like. All types of participation have a role in organisational change. However, for trusts where the priority is continuously improving, people who use services are the value judges of the effectiveness of care, so wherever possible co-production with experts by experience is the most appropriate approach.
Supporting experts by experience and professionals in co-production

Co-production can expose vulnerabilities and conflicting perspectives. Experts by experience and professionals may need training or one-to-one support to make sure all their different perspectives are aired equally, for conflicts and challenges to surface openly and be heard, and for people to recognise that full consensus will not be possible on every aspect of a service. Co-produced projects that expect only unison and harmony can get stuck.

Paying attention to the potential needs of experts by experience and professionals under the headings below helps co-production teams form effective working relationships.

**Ability**

Do those involved have a clear understanding of the topic? Have any development needs been identified, and are they being addressed?

**Honesty**

Is everyone party to the same information? Do they have the same clear expectations about what can be realistically achieved and how power is shared? Who ultimately will take any decision that can’t be taken collectively?

**Time**

Is the time committed to the project realistic and fair for all? Co-production is a long game. The benefits will be sustainable but the approach does not always deliver quick wins. That said, as co-production skills become embedded in organisations, co-produced activities can run much more efficiently.

**Reciprocity**

What exactly can the experts by experience and professionals hope to gain in return for their involvement in the activity?

Things to keep in mind

As a co-production team starts working together, being alert to these three issues will help to keep its members working together effectively.

**Power imbalances**

Given the range of interests involved in co-productive working, people are bound to encounter power imbalances, whether consciously or unconsciously. Power dynamics that operate in clinical contexts tend to transfer to this new setting unless they are explicitly challenged. Team members need to understand and acknowledge equally what each can offer.

**Working together from the outset**

Co-production is often said to start from a blank page, meaning all partners in the piece of work are involved from the outset, before any major decisions have been taken, on the principle of ‘no treatment about me, without me’.

Experts by experience can easily see through tickbox co-production that kicks in after big decisions about a service have been taken. However, starting from scratch isn’t always possible. Where it isn’t, honesty requires that participants are given clear reasons.

**Acknowledging some resistance to the process or the outcome**

Co-production can be hard work if those involved are not familiar with or committed to this way of working. Teams may get ‘fed up’ if they feel their time is being wasted on meaningless activity and, of course, individual ideas of time well spent will differ.

Those who are new to co-producing a change may resist the new way of working. It takes time and care to see why it is worth adopting. The best case for it is made by the actual experience of co-production, supported by systematic debriefing.

**Summary**

This chapter has described a way of working on improvement that exemplifies the spirit of the national mental health improvement model. It has offered evidence from the literature for co-producing improvements with experts by experience as well as a practical approach, illuminated by experience from trusts in tips and case studies.
References


Case study 1 - Experts by experience

Involving experts by experience in recovery

Tees, Esk and Wear Valleys NHS Foundation Trust

What was the aim?

The trust’s recovery strategy, developed in 2013, aimed to ensure services gave people a sense of connectedness, hope and identity beyond mental illness. The trust sought to work in partnership with people who use services to ‘co-produce’ all aspects of care, from individual care plans to service design and delivery.

What was the solution?

A group of people who use services and survivors have formed TEWV Recovery Experts by Experience. Each member undergoes six days’ training. Initially, the training focused on their experience of distress and services; it explored what was helpful and unhelpful, and involved writing a short narrative. Now, training is broader: it encourages people to think about what recovery is and what it is not, what co-production means and the challenges it poses. The trust’s recovery lead and its experts-by-experience co-ordinator conduct the training. About 40 people have been trained so far and 27 are actively involved with the group, co-delivering staff training, sitting on steering groups and taking part in workshops.

What were the results?

Experts by experience were pivotal in setting up a recovery college and an online recovery college for people who use services in the trust. Both provide courses co-produced and co-delivered by staff and people who use services. The co-production group ensured that the trust considered cutting down on rapid tranquilisation as part of its force reduction project and that all inpatients are involved in formulation from the start of their admission; influenced the trust’s consent and medication policies; helped to write the trust’s harm minimisation policy; and helped to train staff in minimising harm on a course that almost all clinical staff have attended.

Want to know more?

Sally Smith, Experts by Experience Co-ordinator, sally.smith46@nhs.net
Case study 2 - Experts by experience

People with lived experience co-designing quality improvement

Lancashire Care NHS Foundation Trust

What was the problem?
People with lived experience of the learning disability service said that transition from the service and/or a change of service staff member were challenging events for them.

What was the solution?
Co-designing an ‘always event’ with people who use the service. The always event enables each person who uses services to say that: “I will always be supported in moving on in care”. To ensure this support, the co-design team developed:

- a contact card to be given on discharge to people using the service
- notification of proposed staff changes or transfers by letter, with photographs of new staff
- a monthly ‘pop in and chat’ support session.

The team used plan-do-study-act (PDSA) methodology to develop and test these ideas.

What were the results?
Between July 2015 and January 2016, 26 people were discharged using the new procedure (letter, contact card, invitation to pop in and chat). A support worker made a follow-up contact call two weeks later, and cases were discussed at the team’s weekly discharge meetings.

Picker Europe (a not-for-profit organisation that makes people who use services’ views count in healthcare) evaluated the changes and found a positive difference to the experiences of care for people using the service and for staff. People using the service commented: “I keep the card on the fridge with a magnet – so I see it all the time”, and: “My idea was chosen ... I feel good”. Staff commented:

- “Co-design made the implementation feel real and right the way target-driven things aren’t.”
- “I was worried that it was going to be difficult to do but it’s not at all. It’s a small investment of time to have a big impact.”

Always events are now integrated into the trust’s organisational quality improvement approach, and other always events are being co-designed in many care environments.

Want to know more?
Anne Allison, Associate Director Quality and Experience, Anne.Allison@Lancashirecare.nhs.uk

Figure 2: Follow-up calls: summary findings

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Missing</th>
<th>Not sure / may attend another session</th>
<th>Not appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 Were you told in enough time that you were ready to move on?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q2 Were you involved in making choices about moving on?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3 Have you been told who to contact if you are worried about support with your health after you left the learning disability service at Bridge House?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q4 Did you receive a card with the contact details for Bridge House?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q5 Will you be coming to the Pop in and Chat Session?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Case study 3 - Experts by experience

Improving initial mental health assessments using experience-based design

Cheshire and Wirral Partnership NHS Foundation Trust

What was the problem?

Initial mental health assessments can be stressful for people who use services and their families: while feeling worried about their health, they must find the clinic and provide a lot of information, filling in forms in a busy reception area. The trust wanted to improve this experience.

What was the solution?

Chester Adult Community Mental Health Team used experience-based design (EBD) to improve initial mental health assessments. EBD is a methodology for working with people who use services, families, carers and staff to improve services that places equal emphasis on people who use services and staff perspectives. EBD gives teams an insight into the people who use services’ emotional response to experiencing a service, challenging assumptions and perceptions about what they think the person who use services or carer feels and needs.

The trust’s quality observatory trained the project team in EBD and provided support throughout. The team, which included representatives with lived experience, interviewed groups of people who use services and staff to capture their experience of receiving or delivering an initial mental health assessment. Consistent themes emerged from both groups’ responses, enabling the project team to recommend key improvements.

What were the challenges?

Getting people on board initially and then maintaining momentum; there were ‘political’ barriers and concerns about the ethical issues of involving people who use services in interviewing other people who use services.

What were the results?

The project began in February 2016 and is continuing. Improvements so far include:

- redesigned letters and leaflets – for example, a welcome information sheet for the outpatient department
- better seating and signage in the reception area
- a volunteer ‘welcomer’ working in the clinic on the two days a week when initial assessments take place, who is responsible for replenishing leaflets and signposting people who use services to further support. This volunteer identified and helped implement further improvements to the outpatient department, namely baby-changing facilities and a separate reception area for people using another service in the same building
- better signage across the hospital site
- an information screen in the outpatient department.

What were the learning points?

- Representatives with lived experience needed to be checked by the Disclosure and Barring Service before the project could begin.
- People who use services enjoyed being interviewed by another ‘peer patient’ and staff were comfortable being interviewed by the project team’s representatives with lived experience.
- The trust had a process for supporting people if they became distressed while being interviewed and volunteers had an emergency contact for any concerns raised.

Next steps

The project team is working through further improvements, such as training opportunities for staff, soundproofing clinic rooms and improving the hospital site map and directions to the clinic and car parks. Someone currently accessing services was involved in testing these improvements. The project team is exploring how to improve sending copies of GP letters to people who have used the service following clinics.

Want to know more?

Lesley Gledhill, Participation and Engagement Practitioner, Lesley.gledhill@cwp.nhs.uk

Carl O’Loughlin, Lived Experience representative, carloloughlin@gmail.com
Case study 4 - Experts by experience

Peer Experience Listening Service

Hertfordshire Partnership University NHS Foundation Trust (HPFT)

What was the aim?
The trust wanted to gather qualitative feedback on services and the experience of the people who used them and sought to do this in a way that elicited honest feedback and ‘customer’ insights.

What was the solution?
The trust established a service that provides the organisation with the ability to gain the desired insights through the use of a peer to peer approach via the use of semi-structured interviews.

The Peer Experience Listening Service (PELS) is both directed and delivered through co-productive approaches. Project requests are submitted from across the organisation and the decision about which are supported is made by a stakeholder panel that includes people who use services, carers and third-sector organisations. The stakeholder panel also holds PELS to account for delivery against the agreed timescales.

All the individual project materials (eg surveys) are co-designed and co-produced through the service and all the listening and elicitation of feedback is carried out by people with lived experience. Once all the data has been collected and collated, it is co-analysed and recommendations for service improvements are co-produced.

HPFT provides training and development to our peer listeners on actively listening and conducting semi-structured interviews. Peer listening is a paid activity that can be a route to getting experience towards gaining paid employment should they wish to.

What were the challenges?
HPFT found it challenging to manage people’s expectations about how, when or if they will be involved in a particular project or with the service at all.

HPFT works hard to balance our desire to make it easy for people to get involved against the need to have the right skills and mindset to ensure positive, subjective listening. Not everyone who would like to be a peer experience listener has the right skills, nor may they be the right person for a particular assignment.

Through their experiences HPFT has developed approaches to ensuring the most appropriate people are allocated to the work, reducing the risk that conscious or unconscious biases affect the information-gathering. HPFT sees this as part of the overall co-production ethos of the best utilisation of skills, knowledge and talent.

It has also devised sensitive approaches to managing people’s (unexpected) unavailability for work because of health and wellbeing issues through developing good understanding of peer experience listeners and having contingencies to account for unanticipated absences.

What were the results?
HPFT has gained a deeper understanding of its services from the experience of people who use them, beyond what would have been possible through standard approaches to testing experience.

One example of this is how safe people who use services felt in inpatient settings. The standard approach to asking “do you feel safe?” offered little insight into what may be driving those feelings. Following the Peer Experience Listening project in inpatient services, HPFT have gained insights into what makes, when and how people feel safe or unsafe and are able to now make improvements based on these insights.

HPFT is also pleased that a number of peer experience listeners have found paid employment (including within the trust) following their time with the Peer Experience Listening Service.

What were the learning points?
- It is important to engage with the service that is being assessed from the start of the work, helping it to understand and work in a positive and co-productive manner both during the assessment phase and in the improvement phase.
- This approach provides HPFT with a greater assurance and integrity about the results of our activity - even if similar conclusions could have been gained without using peer listeners.
- The benefit of the approach is not just about the outcomes, but also the positive experience for both the listener and the listened to.
- The approach can offers positive pathways to paid employment for people.

Next steps
- HPFT are continuing the work of the service and exploring ways of better integrating PELS with the rest of the work of the Inclusion and Engagement Team.
- The trust are seeking ways to progress this work into their learning disability services and with young people.

Want to know more?
Contact the Peer Experience Listening Service at inclusion.engagement@hptf.nhs.uk

There is no single, universal model of co-production – its practice takes many different forms (Needham and Carr 2009). But co-production is in general an exploratory, ‘real’ and often tough activity, which is also enormously rewarding. As a change approach, it may feel very messy compared to well-established ‘project management’ techniques. A necessary skill is learning to live with and embrace its uncertainty, ambiguity and occasional discomforts.

“We always think of service-user time as well as professional time when improving services”

Keith Loveman, Finance Director, Hertfordshire Partnership NHS Foundation Trust
Case study 5 - Experts by experience

Appointing an expert by experience as an improvement lead

Mersey Care NHS Foundation Trust

What was the aim?

The trust wanted to move beyond the important but limited aim of inviting people who use services to take part in presentations or interview panels, and make them central to planning and implementing solutions. In particular, it wanted to involve them in reducing restrictive interventions because success would depend on high levels of collaboration between people who use services and staff.

What was the solution?

Appointing an expert by experience as an improvement lead – someone who works alongside professionals with the same title and status – enabled ‘co-production’ to flourish. Staff and people who use services co-produced and co-delivered the trust’s programme to reduce restrictive interventions, known as ‘No Force First’. People who use services talked openly during engagement sessions about the traumatic effect of physical intervention and seclusion, making a critical emotional connection with staff that reinforced the need for change.

What were the learning points?

- Co-production must be sustained and prioritised if it is to thrive.
- Experts by experience need support to bring their abilities forward, but the benefits from this small investment are huge.
- Collaboration in developing strategies should start from a blank page. Anything less can appear tokenistic.
- Hearing people talk about their experiences of care in a constructive, balanced manner can win over hearts and minds and create the momentum for change in a way that traditional top-down directives cannot.

What were the challenges?

Some staff may have felt uncomfortable hearing people who use services speak out about difficult inpatient experiences, or may not have understood how critical it was for lived experience to have much more influence in the organisation. Outdated beliefs and stigma may still have remained. But with time, continuing board-level support and the prevailing national agenda, lived experience has become central to the trust’s plans.

What were the results?

No Force First gained national recognition for good practice and reduced the use of physical intervention by 37% between April 2016 and August 2017.

The trust’s expert by experience improvement lead, Iris Benson, comments:

“A co-produced approach to learning harnesses both sets of skills in a way that wins hearts and minds, bringing lived experience to life. It really helps to reduce the stigma I have experienced over many years and stops a ‘them and us’ culture, where people like me are not seen as equals and don’t feel valued or heard.”

Next steps

- Opening more posts traditionally filled by professionals to people with lived experience.
- Exploring ways to bring more people forward to share their experiences and supporting them in doing so.
- Continually pushing for lived experience to be part of decision-making and planning at all levels in the trust.

Want to know more?

Jennifer Kilcoyne, Clinical Director, jennifer.kilcoyne@merseycare.nhs.uk

Danny Angus, Senior Clinical Nurse, danny.angus@merseycare.nhs.uk
Case study 6 - Experts by experience

Meeting carers’ needs in a secure service

Mersey Care NHS Foundation Trust

What was the aim?
The trust wanted to meet CQUIN targets for involving carers in secure services and engaging them in helping people who use services recover. Carers told the trust they wanted:

- A carers’ support group.
- Information about services available at Ashworth Hospital.
- Tours of the hospital.
- Information about mental ill health and recovery.

What was the solution?
The trust seconded a staff member to the post of carers’ lead in 2015, and introduced:

- An expression-of-interest list of carers who want to receive updates about the hospital, research opportunities and forthcoming events, as well as copies of presentations to the forum.
- An information pack for carers, families and friends, based on carers’ feedback, which covers procedures for visits, recovery, services available in the hospital and links to carers’ support in the trust.
- Tours of the hospital for carers every weekday between noon and 1pm, visiting rehabilitation areas, the health centre and chapel.
- For staff, e-tutorials on carer awareness and face-to-face training to become a carer champion.

What were the results?
Carers say the forums have helped them promote their family member’s recovery and the trust believes the forums have helped break down barriers to engaging with carers. Guest speakers also report that listening to carers’ views has helped them.

More than 50 carers have registered on the expression-of-interest list. Those who have taken a hospital tour say they encouraged their family member afterwards to use the facilities explained on the tour, and that they feel reassured by knowing what is available for people who use services. One carer commented:

“Having a welcome centre is so very useful especially when travelling from the other end of the country. The staff are very welcoming and informative.”

A carer/professional said:

“Every secure service needs one! Very impressed and deeply touched by the thought that has gone in to the centre.”

What were the learning points?

- Sharing resources and information can benefit all services in their work with carers.
- Releasing staff for training and carers’ events benefits the organisation, its workforce and customers.

Want to know more?
Amanda McBride, Senior Forensic Social Worker/Carers’ Lead – Secure Division, amanda.mcbride@merseycare.nhs.uk
Case study 7 - Experts by experience

Peer-supported Open Dialogue

North East London NHS Foundation Trust (NELFT)

What was the aim?

Approximately 1.8 million people in the UK suffer from a mental health crisis such as a severe psychotic episode or suicide. The Care Quality Commission (CQC) stated in a 2014 report that 42% of people who use services were not getting the help they needed.

NELFT is part of a national pilot trialling Open Dialogue, which aims to offer a person-centred, more sustainable approach to supporting people in a mental health crisis.

What was the solution?

Open Dialogue is a model of mental health care pioneered in Finland that consistently involves a patient's family and social network. All healthcare staff receive training in family therapy and related psychological skills. All treatment is carried out via meetings of the person who uses services' whole system/network, which always include the person who uses services.

The key principles are:

• See people within 24 hours of them becoming unwell.
• Hold all meetings with the clinical team at home, or wherever the person using the service finds most helpful.
• From the word go, engage significant others in the patient’s life – family members or trained peer-support workers - in meetings.

What were the challenges?

Continuity of care is key to the Open Dialogue model: the clinicians who see the person who uses services in a crisis and help create the safe space of those first network meetings remain with the person throughout their journey. This is a challenge to put into practice. It has required a great deal of negotiation among NELFT’s different services. However, new services following the redesigned integrated care pathway will have continuity of care as a core element, in line with the new pathway.

What were the results?

Dr Razzaque explains: “In normal treatment, you explore what has led to the crisis, but then the response is usually to prescribe medication. With Open Dialogue, the person using the service takes the driving seat in understanding what are the factors that have led them to be the way they are. That’s a very healing thing.”

Suzanne, an expert by experience, adds: “If it wasn’t for Open Dialogue I wouldn’t be here now. This time last year, I was suicidal. I had totally lost faith in the mental-health services; I felt I’d been put in the ‘too difficult’ box.”

What were the learning points?

In Finland, where Open Dialogue started, 76% of all people who use services seen returned to work or study after two years in service, and never returned thereafter. This kind of outcome is pretty much unheard of anywhere else. As a result, people at NELFT were determined to trial it. Together with several partners around the country, it is now launching a multicentre randomised controlled trial - the biggest study of Open Dialogue in the world to date.

Next steps and sustainability

The trust runs an annual national conference to share the experiences of people who use services and staff using the service and to spread learning.

The trust now offers Dialogue First, a non-crisis community mental health service that follows the principles of Open Dialogue.

As the results from the pilot teams start to emerge, the trust intends to gradually roll out the Open Dialogue approach across its services and hopes to lead a national move in this direction too.

Want to know more?

Dr Russell Razzaque, Director of Research
Russell.razzaque@nelft.nhs.uk
“We will make sure that mental health gets the attention it deserves, in funding, research and technology investment; and we will be clear that when NHS leaders are redesigning services and developing new solutions, mental health should get its full weighting.”

Theresa May, Prime Minister (2017)
Chapter 2

The wider context: using policy, demand and supply data for improvement

Understanding how national imperatives apply to organisations helps those wishing to improve services.

Using the available national tools and resources will enable you to understand your local population needs to improve services that are bespoke for local need.

Understanding the range and quality of existing services throughout the country supports sharing of good practice throughout the NHS.

The mental health improvement model starts from the premise that services should be designed to meet the needs of the people they serve, as discussed in Chapter 1. Mental health services also have to comply with established and unfolding national policies directing NHS service providers. (In principle, these policies also represent people’s requirements of the NHS, manifested through the democratic process.)

Higher expectations have raised awareness and scrutiny of mental health in England, leading to a number of important recent policy initiatives. New initiatives tend to follow hot on each other’s heels, along with pressure to develop and implement them. The challenge for providers is to make sure they harmonise rather than conflict with each other on the ground.

To help service designers, this chapter highlights the factors that together form the wider context shaping mental health services today: current government policy, the implementation of policy promoting shared responsibility for population health, and variations by location in social characteristics and mental healthcare demand and supply.

Understanding policy

Having long considered mental and physical health in isolation from each other, governments increasingly see the two as interdependent, and are giving equal weight to both in their policies. It makes sense to consider, plan and provide mental health services for populations taking account of all the policy factors affecting healthcare provision, both statutory and non-statutory, including policy direction, current policy and unfolding policy.

Policy direction

In January 2017, the Prime Minister described the “burning injustice” faced by those who experience mental illness and outlined first steps in a plan “to transform the way we deal with mental health problems at every stage of a person’s life” (Theresa May, Prime Minister, 2017). She said the government “will make sure that mental health gets the attention it deserves, in funding, research and technology investment; and we will be clear that when NHS leaders are redesigning services and developing new solutions, mental health should get its full weighting.”

Mental health problems account for 28% of the burden of disease but only 13% of NHS spending

These commitments reflect increasing attention paid to mental health by policymakers over the past five years or so. This is bringing some welcome new investment. However, mental health services still have a long way to go before they achieve parity with physical health services in terms of funding or service provision. Mental health problems account for 28% of the burden of disease but only 13% of NHS spending. And only 25% of people needing mental health services have access to them (NAO 2016).

Local spending on mental health varies widely. The Five Year Forward View for Mental Health found that “years of low prioritisation have led to clinical commissioning groups (CCGs) underinvesting in mental health services relative to physical health services…Spending per capita across CCGs varies almost two-fold in relation to underlying need.”

There are also wide local variations in access, waiting times, quality and range of treatment. The degree of co-operative working between the agencies involved in providing care and support for people with mental health problems varies by location too.
Current policy

A number of government strategies, policies and laws concerning health have been introduced in recent years. Key documents include:

No health without mental health (2011)

This cross-government outcomes strategy, directed at the range of bodies involved in providing mental healthcare, has six key objectives:

- more people will have good mental health
- more people with mental health problems will recover
- more people with mental health problems will have good physical health
- more people will have a positive experience of care and support
- fewer people will suffer avoidable harm
- fewer people will experience stigma and discrimination.

Health and Social Care Act 2012

This Act of Parliament enshrines “parity of esteem” between mental and physical health in law. This means people with mental health problems should have the same access to care as people with physical health problems, and that the care should be of equal quality.

Closing the gap: priorities for essential change in mental health (2014)

This policy identifies four immediate priorities for organisations involved in providing mental healthcare:

- increasing access to mental health services
- integrating physical and mental healthcare
- starting early to promote mental wellbeing and prevent mental health problems
- improving the quality of life of people with mental health problems.

Five Year Forward View for mental health
(Mental Health Taskforce to the NHS in England, 2016)

The taskforce describes the state of mental health services in England, particularly from a person who uses services’ perspective. It recommends a programme of reforms to achieve parity of esteem between mental and physical health. One goal of the reforms is enabling access to high quality care for an additional one million people with mental health problems.


The plan envisages 21,000 new posts across mental health services. It sets out a model for improvement that will enable mental health providers to improve the quality and reach of the services they provide for local communities.

Unfolding policy: shared responsibility for population health

The NHS Five Year Forward View (2014) heralded new structures and approaches to the delivery of services, notably the principle of shared responsibility for population health. The move towards more collaborative planning and delivery of health and care services has a significant impact on the challenges and opportunities facing mental health providers. Initially through the development of sustainability and transformation partnerships (STPs) across the country, commissioners and providers (both trusts and primary care providers) have come together to agree more consistent and co-ordinated strategic plans for health and care services for their local populations. These include increasing collaboration with local government.

A number of emerging integrated care systems together with devolved areas, such as Greater Manchester, are taking this a step further by establishing much clearer shared responsibility for how they use their collective resources to improve quality of care and health outcomes for their populations. These systems are characterised by an increasingly clear common purpose across partner organisations, measurable system-wide goals for improving quality and health, a shared approach to the use of data and analysis, and new forms of clinical leadership, working with people who use services, staff, and public engagement that cross traditional sectoral boundaries.

In this context, it becomes increasingly important to develop approaches to quality improvement that span different care settings, enabling mental health providers to work collaboratively with general practice, community health teams, acute hospitals, local government and other community partners to design good, accessible care and support in the round. A number of organisations are also using the principles of integrated care to help improve collaboration between specialist mental health providers.

Understanding the population

To provide effective and sustainable mental health services, providers need to understand the social context of the populations they serve, as well as variations in demand and supply. Variations in social context and demand for mental health services are captured in health, economic and social data collected and analysed by public health professionals across the country. This should be integral to healthcare planning and improvement. Variations in the adequacy of supply show up in Care Quality Commission (CQC) and other ratings. These are also useful for pointing those rethinking mental health services to places with good services from which to learn, as well as showing where services may be weak and possibly in need of assistance.

Social context

“Mental health issues are shaped to a great extent by the social, economic and physical environments in which people live”

(World Health Organization 2014)

General socioeconomic, cultural and environmental factors affect people’s access to community networks, their attitudes and lifestyle choices. Such factors exert a far greater influence on their mental health than biological determinants. Poverty and economic disadvantage, poor housing, reduced access to employment, social isolation, loss of family or friends, and stigma and discrimination all increase the prevalence of mental ill health and poorer outcomes for those with mental illness.
The requirement to satisfy rising demand with limited resources makes identifying and understanding trends in the particular needs of the local population critically important. With this detailed knowledge, providers can target resources more effectively to meet local needs.

“The mental health sector has been under-resourced and therefore has had to be innovative with the resources we have.”

Sheena Cumiskey, Chief Executive at Cheshire & Wirral Partnership NHS Trust

The incidence of different kinds of mental health disorder varies significantly across the country, as the diagrams below illustrate. (See Figures 3a, 3b, 4a and 4b). This in turn drives variation in local demand for mental healthcare.

Variation in demand for mental health services

Nationally, demand for mental health services is rising. NHS Providers reported in July 2017 that “demand for mental health services is rising at a rate that matches and in many cases exceeds that experienced by the acute sector. This is the case for services for adults, and children and older people. Bed occupancy rates for inpatient units at times exceed 100%-leading to out-of-area placements. Particularly concerning is the growth in children attending A&E departments for psychiatric reasons and the growth for referrals in child and adolescent mental health services (CAMHS), which have increased nationally by 44% over the past three years.” (NHS Providers, 2017). NHS Providers found that over 70% of mental health trusts’ leaders expected demand for health services to ‘increase’ or ‘substantially increase’ in 2017/18.
Variation in service supply

The adequacy of current local service provision will also influence the objectives and improvement plans of service providers. CQC ratings are one source of relevant information (see Figures 5a and 5b).

Figure 5a: Map of CQC ‘overall’ ratings of mental health providers across England

<table>
<thead>
<tr>
<th>Overall performance as rated by CQC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue</td>
</tr>
<tr>
<td>Outstanding</td>
</tr>
<tr>
<td>Green</td>
</tr>
<tr>
<td>Good</td>
</tr>
<tr>
<td>Yellow</td>
</tr>
<tr>
<td>Requires improvement</td>
</tr>
<tr>
<td>Red</td>
</tr>
<tr>
<td>Inadequate</td>
</tr>
</tbody>
</table>

Figure 5b: Map of CQC ‘overall’ ratings of mental health providers in London

Source: Adapted from CQC (2018)

Summary

This chapter outlines the national picture that will affect local health organisations when providing and improving mental health services.

It describes the population needs of the people served by providers, each of which has been reviewed by the CQC.

New national policies provide opportunities for further service development working alongside other national services.
## Appendix: Care Quality Commission ratings as of 26 October 2018

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Overall rating</th>
<th>Organisation</th>
<th>Overall rating</th>
<th>Organisation</th>
<th>Overall rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>2gether NHS Foundation Trust</td>
<td>Good</td>
<td>Lincolnshire Partnership NHS Foundation Trust</td>
<td>Good</td>
<td>Cumbria Partnership NHS Foundation Trust</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Avon and Wiltshire Mental Health Partnership NHS Trust</td>
<td>Requires improvement</td>
<td>Mersey Care NHS Foundation Trust</td>
<td>Good</td>
<td>Rotherham Doncaster and South Humber NHS Foundation Trust</td>
<td>Good</td>
</tr>
<tr>
<td>Barnet, Enfield and Haringey Mental Health NHS Trust</td>
<td>Requires improvement</td>
<td>Midland Partnership NHS Foundation Trust</td>
<td>Good</td>
<td>Derbyshire Healthcare NHS Foundation Trust</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Berkshire Healthcare NHS Foundation Trust</td>
<td>Good</td>
<td>Norfolk and Suffolk NHS Foundation Trust</td>
<td>Inadequate</td>
<td>Devon Partnership NHS Trust</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Birmingham and Solihull Mental Health NHS Foundation Trust</td>
<td>Requires improvement</td>
<td>North East London NHS Foundation Trust</td>
<td>Good</td>
<td>Dorset Healthcare University NHS Foundation Trust</td>
<td>Good</td>
</tr>
<tr>
<td>Black Country Partnership NHS Foundation Trust</td>
<td>Good</td>
<td>North Staffordshire Combined Healthcare NHS Trust</td>
<td>Good</td>
<td>Dudley and Walsall Mental Health Partnership NHS Trust</td>
<td>Good</td>
</tr>
<tr>
<td>Bradford District Care NHS Foundation Trust</td>
<td>Requires improvement</td>
<td>North West Boroughs Healthcare NHS Foundation Trust</td>
<td>Good</td>
<td>East London NHS Foundation Trust</td>
<td>Outstanding</td>
</tr>
<tr>
<td>Cambridgeshire and Peterborough NHS Foundation Trust</td>
<td>Good</td>
<td>Northamptonshire Healthcare NHS Foundation Trust</td>
<td>Outstanding</td>
<td>Greater Manchester Mental Health NHS Foundation Trust</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Camden and Islington NHS Foundation Trust</td>
<td>Good</td>
<td>Northumberland, Tyne and Wear NHS Foundation Trust</td>
<td>Outstanding</td>
<td>Hertfordshire Partnership University NHS Foundation Trust</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Central and North West London NHS Foundation Trust</td>
<td>Good</td>
<td>Nottinghamshire Healthcare NHS Foundation Trust</td>
<td>Good</td>
<td>Humber Teaching NHS Foundation Trust</td>
<td>Good</td>
</tr>
<tr>
<td>Cheshire and Wirral Partnership NHS Foundation Trust</td>
<td>Good</td>
<td>Oxford Health NHS Foundation Trust</td>
<td>Good</td>
<td>Isle of Wight NHS Trust</td>
<td>Inadequate</td>
</tr>
<tr>
<td>Cornwall Partnership NHS Foundation Trust</td>
<td>Requires improvement</td>
<td>Oxleas NHS Foundation Trust</td>
<td>Good</td>
<td>Kent and Medway NHS and Social Care Partnership Trust</td>
<td>Good</td>
</tr>
<tr>
<td>Coventry and Warwickshire Partnership NHS Trust</td>
<td>Requires improvement</td>
<td>Pennine Care NHS Foundation Trust</td>
<td>Requires improvement</td>
<td>Lancashire Care NHS Foundation Trust</td>
<td>Requires improvement</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Leeds and York Partnership NHS Foundation Trust</td>
<td>Requires improvement</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Leicestershire Partnership NHS Trust</td>
<td>Requires improvement</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Worcestershire Health and Care NHS Trust</td>
<td>Good</td>
</tr>
</tbody>
</table>
References


NHS Improvement (2017) Strategic finance team findings.


“Working as a whole organisation to build on a culture of improvement in order to deliver high quality and safe care for people who access mental health services is what we all strive for.”

Dr. Anushta Sivananthan, Consultant Psychiatrist/Medical Director, Cheshire and Wirral Partnership NHS Foundation Trust
Chapter 3

Culture

Understanding the characteristics of an organisation’s culture and how they can promote or impede improvement efforts is vital. This resource suggests an evaluative approach to understanding culture.

To bring about sustainable change, you must understand how to support the workforce to design and implement change.

The ‘how to’ implement and maintain culture, value and motivation for improvement requires constant efforts from all.

Current situation

‘Culture’ describes the rich pattern of social behaviour present in an organisation over time, including all spoken and unspoken rules, symbols, routines and stories. Culture binds together an organisation’s different parts, giving identity to the whole.

The NHS is multidisciplinary, multicultural and multi-level, involving all sorts of people, places, practices and procedures. Its diversity is one of the NHS’s greatest strengths. Binding all its people is the shared aim ensuring the safety, recovery and wellbeing of those who use the NHS. This forms the basis of a person-centred safety culture across the service.

Explicitly understanding and addressing culture plays a pivotal role in improvement. As staff strive to improve what they do in a dynamic and unpredictable world, they can find themselves held up by hidden or unacknowledged behaviour patterns and cultural conflicts. For improvement to flourish, NHS professionals need to understand the detailed cultural issues affecting every aspect of improvement.

Review of current thinking

Business scholars began studying corporate culture during the 1960s and 1970s, mainly developing typologies of structure (eg Handy 1993). Interest grew exponentially during the 1980s and 1990s with the rise of regional and global enterprises and the shift from vertically integrated manufacturing industries to horizontally networked knowledge and service-based ones. McKinsey consultants Deal and Kennedy (1982) borrowed the catchy phrase “the way we do things round here” (page 4) to begin their exploration of culture, but this is too general for those charged with change and improvement.

Johnson (1988) found that organisations will often try to define their own culture and distinctness in a vision or mission statement and express it in the form of their corporate structure. These are areas where many leaders begin to influence their organisation’s culture explicitly.

A comprehensive definition is provided by Edgar Schein, for whom culture is:

“a) pattern of basic assumptions, b) invented, discovered or developed by a particular group, c) as it learns to cope with problems of external adaptation and internal integration, d) that has worked well enough to be considered valid, and e) is to be taught to new members as the f) correct way to perceive, think and feel in relation to those problems.” (Schein 1990, page 111)

Schein said culture is evident on three levels:

- **Artefacts**: the physical attributes of an organisation, such as its physical location, uniforms and observable ways in which people interact with each other and with outsiders.
- **Espoused values**: what is said outwardly about the culture, including slogans and mission statements, procedures and rules, norms and shared beliefs.
- **Basic assumptions**: the organisation’s subconscious, which is tacit and not evident through observation of daily routine or analysis of surveys. Basic assumptions carry information about deeply held values and truths over time.

The espoused values of NHS culture focus on delivering a public good – namely the safe provision of care and treatment for people who use services, as noted above, in a publicly funded and fully accountable system.
Recent thinking and practice on organisational culture have identified several approaches to culture that naturally support improvement. These include:

**Learning culture**
A learning organisation fully embraces all the different interests in an organisation and continuously draws positive lessons from deviation, failure and error.

**Listening culture**
A listening culture has moved from transmission (a speaking culture) to engagement. The most important factors in developing a listening culture are the attitudes of those at the top and the examples they set.

**Open and transparent culture**
![](https://via.placeholder.com/150)

For cultural change and learning to be sustained, people need to be able to act authentically in accordance with their personal beliefs and values. The flow of permissions, accountabilities, responsibilities and power relations must be transparent, balanced and fair.

**Just culture**
A just culture seeks balanced accountability. Wilful, reckless behaviour or blatant disregard for procedure should be dealt with fairly but firmly. However, competent, careful people can still make mistakes: any culture that routinely punishes people for errors misses the point that many accidents have systemic causes. First developed and used in the aviation industry to investigate and eliminate potentially catastrophic error, a just culture is defined as:

> **“an atmosphere of trust in which people are encouraged for providing essential safety-related information, but in which they are also clear about where the line must be drawn between acceptable and unacceptable behaviour.”**

*(Reason 1997)*

Just and learning cultures are complementary. A virtuous learning process can only flourish where staff feel able to report what goes wrong without fearing the consequences. Staff need to trust that being open and transparent about mistakes is the right and safe thing to do for themselves as well as for people who use services, their carers and families. Organisations win that trust by responding to mistakes in an honest, compassionate and scrupulously fair manner. These cultural elements combine to reinforce the overall safety culture that explicitly binds everyone working in the NHS.

Just culture as a concept was introduced into healthcare in 2001. David Marx (2001) outlined four categories of risk to patient safety that can shape an organisation’s response to mistakes. These are human error, negligent conduct, reckless conduct (or conscious disregard) and knowing violations. This provided trusts with a framework for establishing fair procedures for investigating mistakes that gave staff a voice.

Sidney Dekker (2016) further clarified a just culture as requiring a choice between being retributive or restorative. In organisations choosing the former, questions following mistakes are designed to find out who or what to blame and correct: questions in organisations choosing the latter aim to find out who needs help and who needs to provide it in a way that uncovers all the possible systemic causes. *(See case study 11 ‘Developing a just and learning culture’)*.

England’s central NHS bodies see strengthening culture in NHS organisations as critical to the health system accomplishing its overriding task today: maximising clinical outcomes through innovation and improvement while minimising costs *(King’s Fund 2015)*. Many deliberate attempts to impose or strengthen a culture, especially in large or well-established organisations, fail to achieve their stated objectives. However, a planned strategic approach to culture change can improve the chances of success.

NHS Improvement offers a series of resources to help trusts plan strategic culture change. The resources concentrate on five elements found in high quality care cultures that are closely aligned with the values of the NHS Constitution.

**“Working on culture is essential, both strategically and operationally, for high quality sustainable care. The executive team at NHS Improvement recognises the importance of investing in work on culture and leadership, including a series of resources produced with provider organisations to support leaders to work on culture. We are also committed to applying the learning to our internal organisational development programme.”**

*Suzie Bailey, Director of Leadership and Quality Improvement, NHS Improvement*

Similarly, the national strategy for improvement and leadership development, Developing People – Improving Care (NILD 2016), published jointly by the main NHS arm’s length bodies, has as its highest objective developing cultures in NHS organisations that foster continuous improvement in population health, care for people who use service’s and value for money. The strategy draws particularly on the work of Michael West, an important contributor to thinking in this field.

> **“In compassionate and inclusive leadership culture in healthcare, all staff focus on continual learning and through this, on the improvement of patient care.”**

*West et al (2014)*

---

58 | Valued care in mental health: Improving for excellence > Culture

59 | Valued care in mental health: Improving for excellence > Culture
**Practical issues**

Many trusts have a thriving and positive culture that enhances and supports the organisation’s aims and objectives. The staff are motivated to deliver excellent care and are confident they will be supported to explore positive changes and developments (see case study 10 ‘Improving care quality by improving communication: the Albert Ward huddle’). They are also confident the organisation will take a non-punitive, just and supportive approach following a mistake, and a fair and systematic approach to understanding and learning from adverse incidents.

Staff in mental health trusts do their best for people who use services, their carers and families in highly complex and challenging circumstances. Everyone understands that high professional standards are essential in these circumstances because the consequences of deviating from them are so serious. (see case study 8 ‘Reducing use of physical restraint in inpatient units’).

Even trusts showing strong signs of a positive culture will want to test whether this extends across the whole organisation, including non-clinical services. Questions for a trust probing the strength of its culture are: Do our performance metrics tell a positive culture story? Does CQC feedback substantiate our own evidence? How successful are we in maintaining and augmenting our cultural strengths over time? Which areas need further attention? Where is there good practice that could be spread wider?

Such questions may reveal concerns about culture: the terms ‘toxic’, ‘punitive’, and ‘bullying’ have all been used to describe NHS organisational cultures in recent times. Serious cases may need external assessment and help. Statutory bodies such as the CQC and NHS Improvement may be involved, partly in exercising their regulatory responsibilities but also to give support: there may be very tough issues to address, especially in organisations that have struggled for some time.

In any organisation, one of the main cultural challenges is making sure the aspirations of individuals and teams align with the organisation’s ambitions. There are a number of ways for organisations to make sure all their activities reaffirm and strengthen their cultural values, including the following.

**Working with people who use services**

Many trusts have found working with people who use services, their carers and families invaluable in maintaining the motivation and vocational drive of their professionals. It helps professionals to emphasise and reaffirm ‘why we are doing this job.’

**Displaying thanks**

Clinicians frequently say how humbled they are by thanks from people they have served. Publicly displaying thanks from those who use services makes sure professionals and teams get the recognition they deserve, as well as inspiring other staff and encouraging other people who use services to do the same.

**Values-based recruiting**

Recruitment and interviewing practices that include motivational questioning make sure staff with congruent values join the organisation.

**Clear modelling of values from the top**

When all board members, including non-executives, visibly behave in line with a trust’s values, they send a powerful message that ‘this is how we do things around here’. Close links between board members and frontline services greatly strengthen this effect. Interview committees often include a mix of senior and frontline staff, but such links are less common in other areas of management, and worth extending.

**Celebrating benefits for people who use services**

Celebrating success is well known as a means of motivating staff. When success is measured in terms of benefits to the population a trust serves, celebrating a successful innovation or other improvement is always based on the measurable good effect it is having on that population. It shows that “how we do things around here” is the right way to do things because it gets the right results for people who use services. Celebrating success measured in this way is an important means of reaffirming values as well as recognising achievements.

**Working with public sector peers:**

Truly understanding and sharing ambitions across organisations can be a helpful experience for those working in the public sector. Sharing tasks with people in other public organisations – possibly taking secondment opportunities in them – can broaden and augment awareness of a shared public service culture (see case study 9 ‘Developing an integrated health and wellbeing service’).

**Working with the voluntary sector**

Exposure to and affiliation with people who choose to give their time and skills voluntarily can be both sobering and inspiring for those who do not. Trusts that have developed seasonal collaborations with initiatives such as Crisis at Christmas and other national charities find them immensely valuable.

**Summary**

This chapter and its case studies are about understanding organisational culture and how it can impede and support improvement, as well as some approaches to culture change.

There are many different approaches to supporting cultural change – for example, a just and learning culture.

Our case studies share learning and offer an opportunity to connect with others wishing to achieve a similar environment.
References


Marx D (2001) Patient safety and the ‘just culture’: a primer for health care executives. Funded by a grant from the National Heart, Lung, and Blood Institute, National Institutes of Health, Columbia University.


Useful resources

NHS Improvement has published a culture toolkit, designed to help organisations diagnose their culture:

www.improvement.nhs.uk/resources/culture-and-leadership/

It can help your organisation design its strategy for developing a culture to deliver high quality, safe, compassionate and inclusive care.

A second toolkit enables organisations to implement the findings from the diagnostic tool:

www.improvement.nhs.uk/resources/culture-and-leadership-programme-phase-2-design/
Case study 8 - Culture

Reducing use of physical restraint in inpatient units
Cheshire and Wirral Partnership NHS Foundation Trust

What was the problem?
National benchmarking data in 2014 suggested the trust was reporting more incidents of prone position restraint than the national average.

What was the solution?
A quality improvement project to accelerate a reduction in physical restraint, sponsored by the medical director, was set up in 2015. It quickly and significantly reduced use of prone position restraint. Further training and monitoring sustained the reduction.

What were the challenges?
Mobilising all parts of the trust at the same time was achieved through senior sponsorship and use of internal benchmarking data to demonstrate the extent of the problem. A factor in sustaining the improvement was a quarterly report showing changes in the use of prone position restraint by ward, as well as changes in the use of seclusion, rapid tranquilisation and training. This reiterated the wider context in which the trust was managing all aspects of people presenting with challenging behaviour.

What were the results?
Fewer reports of prone position and other incidents of physical restraint – and more use of de-escalation techniques – show staff are learning from incidents by reflecting on their practice and people who use services’ feedback.

What were the learning points?
The trust attributes its success to:
• trust-wide communication and a zero-harm campaign
• matrons undertaking a 72-hour reflective review of each restraint incident, including debriefs using human factors techniques and people who use services’ views
• routine reporting of prone position restraint at ward level through locality data packs
• matrons and ward managers’ representatives producing an enabling plan to sustain the improvements.

Next steps and sustainability
The trust undertook a 90-day rapid improvement project, testing what more it could do to reduce prone position restraint. This identified areas such as improving the completeness and accuracy of incident reporting and further improvements to training.

Want to know more?
Helen Fishwick, Healthcare Quality Improvement Manager, Helen.Fishwick@cwp.nhs.uk

Figure 6: Reduction in prone restraint
Case study 9 - Culture

Developing an integrated health and wellbeing service

Lancashire Care NHS Foundation Trust

What was the aim?

The trust and Chorley Council wanted to create an integrated health and wellbeing service by removing organisational barriers and restrictive referral criteria so staff put people who use services’ needs before those of their organisation.

What was the solution?

Co-locating 120 trust staff with council staff in the council’s civic centre from April 2017. Both organisations developed a joint vision for the service. They communicated this to stakeholders and staff, helped by an animation, Dave’s story, about the negative effects of disjointed health and social care services. Before the co-location, a series of engagement events brought staff together to win their support for the vision, help them get to know each other and envisage working in a more integrated way. They overcame organisational and cultural boundaries to co-design and co-produce integrated services: for example, they were involved in designing the optimal building layout.

What were the results?

Three months after co-location, a staff survey found:

- 29% speak highly of working in the integrated community wellbeing service
- 37% are neutral or have not formed an opinion yet.
- 37% are neutral or have not formed an opinion yet.

One respondent noted “the positive culture and the way that staff from both organisations have so easily started working with each other and are making suggestions for working more closely”.

The survey achieved a 52% response rate (62% among trust staff). Focus groups are developing an action plan in response to the survey.

Next steps and sustainability

To foster an integrated culture, staff have suggested:

- introducing cross-team and cross-organisation work shadowing to improve understanding of team and individual roles
- rotas for attending the weekly integrated referral hub meeting and team meetings
- team photo boards
- social events and health walks.

Want to know more?

Phil Gooden, Community and Wellbeing Service Manager (Pennine & North Locality)
Philip.Gooden@lancashirecare.nhs.uk

Case study 10 - Culture

Improving care quality by improving communication: the Albert Ward huddle

Mersey Care NHS Foundation Trust

What was the problem?

Communication between the Albert Ward team and the multidisciplinary team (MDT) was poor. Staff, people who use services and carers noticed this led to inconsistent care planning. Staff reported low morale and were not always up to date on management plans for people using the service. Because of the ward’s high turnover of people who use the service, the trust felt staff should have a forum to discuss management plans and clinical changes, and devise care plans in a timely manner using a team approach.

What was the solution?

The daily huddle – a structured 30-minute session where staff use a fixed template to aid discussion, record actions and take minutes. All MDT members attend without prompting.

What were the results?

People who use service’s experience, teamwork and perceptions of communication across the MDT all improved. Two other wards have now implemented huddles and experienced similar results.

Next steps

The trust plans to implement the huddle across the division, to promote positive practice.

Want to know more?

Louise Gill, Ward Manager, Louise.gill@merseycare.nhs.uk
Case study 11 – Culture

Developing a just and learning culture

Mersey Care NHS Foundation Trust

What was the problem?

Staff saw disciplinary investigations as likely to shame, blame and possibly dismiss those who made mistakes rather than identify wider, systemic issues. This, and the time-consuming, technically demanding reporting procedure, made them reluctant to report mistakes. They were also deterred by lack of feedback, time taken to resolve issues and sometimes by a concern that they would not be taken seriously.

The high number and length of disciplinary investigations were causing ill feeling among staff. Many disciplinary hearings found ‘no case to answer’: 48% of those in the secure unit at the beginning of 2015/16.

What was the solution?

Developing a just and learning culture, informed by an 18-month programme of ‘structured listening’ to staff. The trust asked clinicians what they thought prevented it from operating more transparently and how to overcome this. It asked other staff what they wanted and needed from a just culture, what it meant to them and where executives should focus attention.

The trust implemented the new culture under four headings (see Figure 7 overleaf). It emphasises accountability and learning equally. The first response to a mistake is to ask what was responsible and why, not who was to blame. The trust aims to concentrate first on whether an investigation is necessary, and then to be compassionate, honest and fair if it is. Policies and procedures for dealing with errors no longer use punitive language. But staff are expected to act responsibly, following clearly understood lines of accountability to allow them and the organisation to learn from mistakes.

Tension between encouraging openness and recognising that not every action can be tolerated needs to be constantly managed.

Ambassadors across the organisation give credibility to the just and learning culture objectives, helping shape how the trust learns and demonstrating how it values staff.

What were the results?

- The number of disciplinary cases fell from almost 30 in early 2016 to just a couple by mid-2017, mitigating distress to staff from unnecessary investigation and saving the trust between £63,000 and £112,000.

Want to know more?

Clare Almond, Deputy Director of Workforce, clare.almond@mereycare.nhs.uk

Figure 7: Implementing a just and learning culture

- Culture change
  - Zero Blame Strategic Goal
  - Mega Conversations & Active Listening
  - Just and Learning Culture Ambassadors

- Governance
  - Surveillance moves to Quality Information learning and Support System
  - Impact Assessment of Key Policies
  - Review of Investigation Process

- Leadership
  - Board to Ward Compassionate Leadership
  - Engagement of Staff – Experts by Experience
  - Management Semantics - Positive Communication

- Objectives
  - Road Map of Principles and Deliverables
  - Implement Incident Decision Tree
  - Supportive Infrastructure for Staff

A just learning culture
Improving staff engagement through ‘Speak Easy’ events

Northumberland, Tyne and Wear NHS Foundation Trust

What was the aim?
The trust wanted to become a better employer and improve the care of people who use services by increasing staff engagement. Despite above-average engagement scores in the annual staff survey compared to other mental health trusts, its sickness rate was higher than average too, and at about 6% cost more than £8 million. Its workforce strategy stated: “We will embed our values, improve levels of staff engagement, create positive staff experiences and improve involvement in local decision-making.”

What was the solution?
Having previously held large-scale engagement events for up to 500 staff, the trust decided to devise smaller local events so that staff could raise more local issues and be better heard. These became known as ‘Speak Easy’ events; two executive directors and other senior management team members attend each. The first, in 2015, asked simply: “What’s on your mind?” and “How can we help and support you?”

What were the results?
Staff voiced frustrations with the trust’s e-learning systems, its ever increasing range of performance indicators, central recruitment processes and car parking. Later Speak Easy events focused on staff survey results, generating ideas for improvement and exploring the trust’s emerging service strategy for the next five years.

As a result of the Speak Easy events, the trust:
• made its e-learning platform and performance dashboard more user-friendly
• reviewed statutory and essential training standards
• altered its central recruitment processes to involve operational groups more.

The trust’s engagement score in the staff survey rose to 3.87 in 2016 (up from 3.75 in 2014). It scored above average for:
• managers and the organisation valuing staff
• support from immediate managers
• communication between managers and staff
• those reporting they were able to contribute towards improvement.

In the Friends and Family Test, 71% recommended the trust as a place to work in 2015 (2014: 66%) and 79% recommended it as a place to receive care or treatment (2014: 74%).

Next steps
The trust intends to develop the Speak Easy concept by supporting managers and staff to lead local engagement work. Momentum and support for Speak Easy events continue to grow as staff see this approach to engagement making a difference.

Want to know more?
Mark Spybe, Head of Team and People Development, mark.spybe@ntwnhs.uk
Talk 1st – preventing violence and aggression in inpatient services

Northumberland, Tyne and Wear NHS Foundation Trust

What was the aim?
Eradicating aggression and violence, both self-directed and towards others, from inpatient services by better understanding its causes and intervening to prevent it. Despite major progress in the last decade, some clinical settings continue to rely too much on seclusion, restraint and rapid tranquilisation. The trust’s aim was to minimise use of restrictive interventions, ensure safe care environments and focus on evidence-based therapeutic intervention.

What was the solution?
In 2016 the trust began its ‘Talk 1st’ programme to prevent violence and aggression. Three months before launch it provided 57 teams on inpatient wards with detailed data in a user-friendly format on numbers of incidents, times of day and day of the week they occurred, number of restraints and uses of seclusion, and whether prevention management of violence and aggression (PMVA) techniques were used. The data dashboards were available to all clinical staff and could be used in ward-based meetings such as Care Programme Approach reviews and care and treatment reviews. Each team used the data to help develop its own solutions to violence and aggression.

What were the results?
Work to date has helped produce downward trends in key areas (see Figure 8). In addition:

- The trust routinely provides models of debrief and post-incident support for people who use the service and staff in all wards.
- All staff are trained in how to de-escalate violence and aggression.
- Talk 1st data is used in multidisciplinary team meetings and to support tribunal reports and case conferences.
- The trust has used the data to discuss recruitment options across MDT disciplines.

Next steps
The trust is exploring with speech and language therapists the possibility of providing the Talk 1st data in a person who uses services-friendly format.

Want to know more?
Ron Weddle, Deputy Director, Positive & Safe Care, ron.weddle@ntw.nhs.uk
Case study 14 - Culture

A carer’s story

Paula, whose son Anthony (not his real name) is a person who uses services at Ashworth Hospital, describes the importance of the carers’ forum

When my son Anthony was admitted to Ashworth Hospital’s high dependency ward three years ago, my world fell apart. I felt deep distress, panic, shock and raw grief. I felt he was lost to me forever.

The very thought of a psychiatric hospital filled me with dread and foreboding. I was overwhelmed by fear of what was in store behind that wall for Anthony, who had never used mental health services in his life. Yes, I had preconceived negative ideas about Ashworth Hospital and the power and control it exerted. I thought I would have a lifetime of challenging abusive practice.

I was desperately worried about my son, and couldn’t make sense of the world anymore. His admission to a high secure hospital made me feel I didn’t belong anywhere.

During that first year, Ashworth Hospital had no carers group. Everyone else seemed to have a support group: I felt the world of psychiatry deemed me unworthy of one because my son was detained in a high secure hospital. I wondered if it wanted to keep carers apart so we couldn’t confer.

I don’t have any family and friends supporting me, so I desperately needed to connect with other carers going through a similar experience. I wanted to be part of group that understood my needs.

Then in 2015 Ashworth Hospital Carers, Families and Friends Forum was formed. Carers were consulted on what we wanted from a support group. We set the forum’s terms of reference – confidentiality, respect for each other, listening to others speak.

Having a space specifically for carers made me feel valued and worthy of support. It showed me I am considered an asset as carer to my son, and I don’t feel isolated from society any more. I am not the only one experiencing this journey through the high secure system.

Sharing and communicating via the forum helps me regroup, gather my strength and look after my own mental health, which ultimately enables me to continue to deal with my son’s situation.

At times I’ve felt traumatised because of my son’s physical and mental distress, so Ashworth’s psychosocial programme has helped me enormously as I’ve gained an understanding of the complexities of mental illness. By meeting staff and listening to them speak in a caring, compassionate, committed manner about their work with people who use their service, I’ve banished forever those preconceived negative thoughts about this hospital. Communicating, sharing knowledge, passing information to me reveals the organisation’s transparency. This has helped me develop trust and a positive relationship with all those who care for my son.

During the last three years, due to his illness I’ve only visited Anthony on a handful of occasions. The forum and the support extended to me have been a lifeline as it’s the only tangible facet that I have connecting me to Anthony.

I feel incredibly supported, I belong to a group specific to my needs, and I don’t feel isolated. I am therefore, able to remain strong, focused and hopeful for my son’s future.
“Empowering all staff to lead continuous improvement is a key leadership role as chief executive, as well as supporting staff when the going gets tough – this is exactly when, as chief executive, you need to hold your nerve and encourage staff to keep focused on being the very best they can be.”

John Lawlor, Chief Executive, Northumberland, Tyne and Wear NHS Foundation Trust
Chapter 4

Leadership

There should be leaders at all levels of an organisation. Organisations need to promote and develop leaders to make improvements a reality. Leaders will support, promote and champion improvement through their ability to inspire others.

“The leadership chapter is honest and the quotes feel as though they genuinely come from the heart and admit to vulnerability and fallibility. It somehow takes out the myth that macho is best… this section is a must read for all leaders in the NHS.”

John Brouder, Chief Executive, North East London Foundation Trust

Current situation

Leadership has a number of timeless, general characteristics. For instance, leadership implies authority, accountability and responsibility, so leaders need to be certain and decisive. Leadership means developing a clear vision and the means of achieving it. And leading other people is always a matter of relationships. However, improving services calls for particular kinds of leadership.

In today’s NHS, staff at all levels are asked to maximise clinical outcomes through innovation and improvement, while minimising NHS costs and meeting financial challenges (King’s Fund 2015). What kinds of leadership and initiative are called for in this context?

The national framework for improvement and leadership development, Developing People – Improving Care (NILD 2016) encourages leaders of NHS-funded services to adopt compassionate leadership skills by:

- “paying close attention to all the people you lead, understanding the situations they face, responding empathetically and taking thoughtful and appropriate action to help”

(NILD 2016)

King’s Fund research concludes that sustained improvement in the NHS needs a new kind of leadership (Ham et al 2016). In the current context of change and improvement in the NHS, today’s leaders need the abilities to:

1. Shake things up and create a sense of urgency in recognising the need for improvement.
2. Reach out to all parts of the system, communicating with partners inside and outside the trust, and championing their full engagement in improvement.
3. Employ sound judgement in selecting improvement methodologies, and remain present and involved in their implementation (see Chapter 6).
4. Support and embed a positive culture for improvement while also ensuring consistently high levels of compassionate care for those who use services.
5. Act as stewards for the next generation of leaders.

Review of current thinking and practice

As suggested above, definitions of leadership tend to change over time and in different contexts. Peter Drucker famously said that the only definition of a leader is someone who has followers. While defining leadership in detail has proved difficult, leadership generally answers two fundamental questions:

1. Who is in charge?

Organisations in which people’s roles are clear, and where hierarchy and lines of command and communication are transparent, tend to find a settled, balanced state relatively easily, even when there is change. All organisations can experience disruption, but if there is order in the relationships between people – in short, when it is clear who is in charge – there is often calm and reassurance. Knowing who is in charge is closely connected to responsibility in each context: at every level people just want to know who has the power to call the shots. Sometimes this is a question of rank, sometimes expertise, and sometimes protocol. For example, when a person suffering a cardiac arrest comes into hospital, the training of all staff involved makes it clear who is following whom at any given moment.

“A good leader is someone who will want you to do more in a positive way… someone you like coming in to work for.”

Barry Bryan, Facilities Co-ordinator, NHS Improvement

2. What could be?

This question is about the future and the drive to do new or better things. Leadership sometimes concerns the process of identifying and taking the actions needed to create a collective movement from ‘what is’ to ‘what could be’. A leader is a person who occupies a special position within that process.
Every organisational system has a purpose. Over time, as it meets new situations and demands from its environment, it must plan, adjust and prepare to keep going in its mission. This second leadership question is about survival and sustainability when business as usual will not be enough. The world is rapidly changing, presenting leadership paradoxes and dilemmas. Leaders need followers, but may encounter resistance to change because of fear of the unknown.

The NHS draws on many theories and traditions for its current thinking on leadership development in healthcare. West et al see the leader’s job as ensuring “direction, alignment and commitment”, primarily at team and organisational levels (West et al 2015, page 2). This is a well-established view, which draws on explanations of leadership that include:

- the traits and characteristics of the person
- a set of learnable competencies or skills
- a set of particular behaviours.

In brief, it says organisations should identify the right people, develop experts in the right skills, and then train them with the right knowledge to influence others. The result is an extending range of outcome-driven NHS leadership training and development courses designed, usually, for particular contexts or levels of experience.

There is certainly a need for this type of support and outcome-driven training for improvement (see Chapter 6). But improvement also demands that leaders develop high levels of emotional intelligence and self-awareness. These traits are much harder to develop and measure using traditional training methods. Developing self-awareness, or “knowing thyself”, is a sign that a leader is taking care of their own health and wellbeing to serve the health and wellbeing of their team, organisation and society.

“Leadership is like being the conductor of an orchestra; not the solo violinist… your job as the Chief Executive is to bring everyone back around the script”

Joe Rafferty, Mersey Care NHS Foundation Trust

“Leadership should be practised as a universal responsibility, as improvements can only be sustained through collaborative engagement and trust of each other.”

Ronke Akerele, Director of Innovation & Transformation, Hertfordshire Partnership NHS Foundation Trust
Foundations of good leadership for improvement

‘Authentic leadership’ and ‘appreciative inquiry’ are two reliable foundations for leading improvement in today’s NHS.

Authentic leadership

Self-aware leaders are authentic. Accepting ownership and responsibility for oneself and acting with no hidden intentions or agendas are the bases of authentic leadership (Gardner et al 2005).

Authentic leadership leads to effective collective leadership because when leaders are true to themselves, they naturally lay the foundation of trust required for others to be the same. Collective leadership (West et al 2015) is a good way of distributing and disseminating change, but it can also mask where individuals are struggling.

Leadership of others begins with a non-judgmental and reflective understanding of self. Below are six tips for leaders in developing their self-awareness (based on Dalton 2017):

1. Acknowledge things as they are, without judgement.

This stance is key to self-awareness because it brings to consciousness the leader’s own beliefs, strengths and weaknesses for re-examination.

2. Be driven by insatiable curiosity

Always seek further information. The art of leadership is not finding the right answer but looking for better questions.

3. Use authority in service of the health of the system

Leadership roles bring power, but this influence should flow through the person in that role, not from them.

4. Love the problem, just enough

Leaders are often conditioned to solve problems as quickly as possible, to close things down and to move on. This frequently leads to new problems popping up in other places because underlying issues are not addressed, or hidden assumptions are not seen.

5. Give everyone a voice

Leaders respect the expertise of others. They know that there are many blind spots in their experience and knowledge and that no one can know, see or do everything. They retain their humility, honouring the diversity of wisdom of others. Above all, they listen.

6. Trust the process and assume the possibility of positive change

If the leader doubts the competence of the people around them, they cannot possibly earn the trust of others to bring about change. Whatever the improvement approach to designing and shaping new models of care, the ability to understand and have confidence in the techniques and be involved in the process is crucial.

The last point on this list is in line with an approach to learning and change in organisations known as ‘appreciative inquiry’ (Cooperrider and Whitney 2005, Lewis and Passmore 2016).

“Getting the best from people is always possible if we take the right approach and adopt the right values and behaviours.”

John Brouder, Chief Executive, North East London Foundation Trust
Appreciative inquiry

Appreciative inquiry makes the connection between what is working well in a system and what needs to be done to maintain success in the future. It was originally developed from positive psychology as a means of exploring change and improvement. Appreciative inquiry starts by identifying and analysing what works, to develop a credible vision for the future. Taking this route, people often come up with ideas and goals they had not thought possible. Appreciative inquiry rests on the premise that an organisation will grow in whichever direction its attention is focused, whether on long-term strategy or short-term tactics.

The method has four stages:

1. Discovery

Asking positive questions engages people in discovering their organisation’s diverse range of achievements, values, strengths, best practices, financial assets. Appreciative inquiry invites leaders to ask people questions about their work to understand their organisation’s ‘positive core’. This makes appreciative listening to answers another vital leadership skill.

2. Dream

Reflecting on the organisation’s positive knowledge took place in ‘Discovery’; in the ‘Dream’ stage, leaders clarify the organisation’s higher purpose. The result is a clear and motivating vision for the organisation linked to past accomplishments, which people can connect to in a positive way.

3. Design

This stage develops ideas for making the dream real. For the vision to be truly shared and widely understood and realised, everyone should be involved in designing its detail, so that each person in the organisation knows what to aim for in their job. Leadership here is about starting initiatives and putting in place the support and processes to help improvement.

4. Destiny

This final stage is to keep everyone in the organisation interested in the future. Leaders’ visible and authentic commitment to an improving organisation’s values are vital to achieving its purpose: leaders must be seen to ‘walk the talk’ to build and maintain the momentum to improve. By the same token, any hypocrisy or double standards among leaders (‘do as I say, not as I do’) will undermine progress: the organisational grapevine will spread the news immediately. Acknowledging success is another key to building a culture of change and improvement. Celebrating local improvements keeps enthusiasm high. Leaders seen to ‘praise the good’ will have a far more positive impact on quality than those who rely on chastising the bad.

In general, to build the leadership foundations for improvement described above, leaders in healthcare organisations should expect to spend a lot of time and attention on both their personal and collective awareness. This also has to be consistent with and reflected in their people processes and structures – recruitment, supervision and leadership development.
Practising good leadership for improvement

Whatever the style or school of leadership that an organisation follows, from a practical viewpoint it must:

- enable the organisation to identify, analyse and accept the need for change
- meet the challenges that introducing a systematic improvement approach and methodology will raise
- provide the excellent leadership and management skills needed at every level to implement change successfully.

“The idea of ‘improvement’ sometimes felt overwhelming for people in my teams; there was so much we needed to change and the task seemed too big and impossible to achieve. By using quality improvement approaches I was able to help the team to break the task down into manageable chunks.

With a defined vision for where we wanted to get to, I supported the team to be more comfortable with the ambiguity of not always knowing how we would get there. I was able to show the team how taking incremental steps using plan-do-study-act testing cycles, we could ‘get going’ and start making small improvements towards our overall goal, learning as we went.

I would say that a key part of my leadership role around improvement has been to start to change how people think. In particular I help them to see that they are ‘allowed’ to take actions to improve and that if these don’t work out quite as they planned, this is OK – as long as they learn and take additional action.”

John Murray, Service Line Leader, Acute Services, Hertfordshire Partnership University NHS Foundation Trust

Leaders of improvement must recognise that different people accept the need for change at different speeds, so efforts to improve will bring discomfort and significant challenge. Leaders need to be resilient: things may get quite heated as worries and fears aroused by change come to the surface.

Improvement implies accepting that things may have gone wrong or that good practice could still improve. So it requires intelligent collection and analysis of data from all departments. This too can pose a considerable challenge to well-established departments and their leaders. Improvement leaders need to maintain a visible presence and ask appreciative questions at different stages of this process, as well as identifying and securing the resources to make it happen.

The greatest challenge in any improvement process is to implement change successfully. Excellent leadership is crucial to bringing in a new way of doing things, especially when the previous practice was strongly embedded. During implementation, leaders need continually to express their confidence in the vision and their unwavering intention to do what was promised. Excellent leadership at this time, as earlier in the process, takes courage, ability and determination.

“Well, we all did the design together. We were promised that the service would change to be like this. Now we are waiting to see if it happens”

Person who uses services

Summary

This chapter describes theories currently used in the NHS. It does not define what makes a good or bad leader. It shows that leaders’ relationships with colleagues, people who use services, carers and their families, who know its systems better than anyone, and – perhaps most importantly – their relationships with themselves, are all worthy of time and attention.

Understanding and managing these relationships is a leadership challenge facing every individual in an NHS trust today, wherever they sit in the organisation. Stepping up to this challenge brings the whole organisation into play to achieve the common goal: better care for people who use services for the resources available.
References


Case study 15 - Leadership

John Lawlor

Northumberland, Tyne and Wear NHS Foundation Trust

“Empowering all staff to lead continuous improvement is a key leadership role as chief executive, as well as supporting staff when the going gets tough – this is exactly when, as chief executive, you need to hold your nerve and encourage staff to keep focused on being the very best they can be.”

John Lawlor is Chief Executive of Northumberland, Tyne and Wear NHS Foundation Trust, a mental health trust employing 6,000 people.

He describes his role as setting the right tone from the top, developing a supportive, values-driven culture and creating a senior leadership team whose style is open, honest and enabling.

Self-awareness

He explains the dichotomy of wanting to know what is going on while empowering people to act without always having to seek permission. Aspects of the role demand that he is clear about the organisation’s few non-negotiable expectations (such as national targets and quality standards), and that he explain to staff why he must be so.

Organisational structure

The trust has structured its care group operational structure to be clinically led and professionally managed. The leadership teams are multidisciplinary, comprising those who manage the trust’s day-to-day and strategic business: a senior manager, doctor, psychologist, nurse and allied health professional. This ensures a collective leadership approach to running the trust’s services, working across professional boundaries and focusing on the whole person and their needs. Members share accountability for their team’s entire business.

Leadership development

The trust board’s support was instrumental in developing this devolved leadership model. The trust has developed professional and collective leadership programmes, as well as a general leadership development programme for all grades and roles. This is aimed at any staff looking to develop their leadership capacity. The trust is seeking to build, bottom up, its leadership capacity and capability in pursuit of continuous quality and organisational improvement.

Leadership style: John Lawlor’s top tips

Effective leadership requires always taking the time to explain why something needs to be changed. Engage, engage, and engage again.

As Senge says: “people don’t resist change they resist being changed.”

If there is a reason a leader feels it necessary to intervene, make clear what that reason is. Always explain why, and have an exit strategy already devised to step away again as soon as possible.

Always seek to provide the context, as everyone’s take on the world is not the same. The view from a ward manager’s chair is very different from that of a director of estates, for example.

Keep people up to date with what is going on around them. It is particularly important to communicate even when there is little to say. Otherwise, the rumour mill will do it for you.

Prioritise regular timeouts with the board, the executive team, the collective leadership teams, the wards and departments, and in support of all leaders at whatever level in the organisation.

And above all: be yourself, be honest and transparent, engage and be genuinely interested in others. Support people through the hard times, always say thank you, celebrate your staff’s successes and keep a clear focus on morale.
John Short

Birmingham and Solihull Mental Health NHS Foundation Trust

“Do you embody the compassion and commitment needed for the organisation? As the Chief Executive, you are the guardian of our values.”

John Short is Chief Executive of Birmingham and Solihull NHS Foundation Trust, a mental health trust in the Midlands employing more than 4,000 people.

He notes that in a leadership position having a good team in place is vital, and focusing on culture is key to success.

Self-awareness

He explains that you have to understand how people perceive you in this job, and be careful where you step. Patience and tolerance are important attributes for his role.

He trained and practised as a social worker. This clinical background has really helped with his self-understanding.

Leadership style: John Short’s top tips

It’s all about the people and the culture

As the Chief Executive, whatever I do reflects on the culture in our organisation.

“My experience as a leader is like running a really long race wearing a rucksack, and you’re not sure who’s putting stuff in.”
Case study 17 - Leadership

Sheena Cumiskey

Cheshire and Wirral Partnership NHS Foundation Trust

“We are a people organisation. ‘Getting people’ is our business.”

Sheena Cumiskey is Chief Executive of Cheshire and Wirral Partnership NHS Foundation Trust (CWP), a community and mental health trust in the North West of England employing approximately 3,500 staff.

She describes her role as “seeking to understand” the needs of the population that CWP serves and supporting staff who enable those needs to be met.

She reflects that mental health and community trust Chief Executives are particularly well-placed to lead and support the ‘new world’ of sustainability and transformation partnerships because of their strong history of partnership and collaboration, and because most mental health contacts occur in the community.

Self-awareness

She explains that understanding where people are coming from and what is going on in their lives is vital as a leader: you need good listening skills to ensure that you get the most from people.

She welcomes challenge from colleagues, recognising that no leader has all the solutions. Having an enabling approach facilitates quality improvement and change.

She describes how people only achieve good outcomes if they work in partnership. Relationships are key both within the organisation and the wider system.

Organisational structure

She describes the organisational structure at CWP as “clinically and service-user led, and managerially enabled” (see Figure 9). Operating within a flat structure, everyone works in partnership together and each person’s role is equally valued and important.

Challenges in the system

She notes the importance of regulation because it sets standards by which to operate. However, regulation is not yet done in a systematic way. “Our challenge is to look at systems, not just organisations.”

Some aspects of regulation are still about ‘hitting the target but missing the point’: this is the symptom of a bigger problem.

Leadership style:

Sheena Cumiskey’s top tips

Everyone is a leader: leadership is not confined to one person or group of people.

Have a person-centred philosophy: everyone needs to take a leading role in whatever position they hold.

Consistent messaging from the board is important.

Sheena suggests giving staff a “licence to operate”: so they feel enabled to try things, make mistakes, learn from them and make things better for the population.
Case study 18 - Leadership

Joe Rafferty

Mersey Care NHS Foundation Trust

“The leader is the catalyst for change, we believe everyone is a leader at Mersey Care and it is everyone’s responsibility and within our gift to improve our services and create an open, healthy and compassionate culture for people who use our services and staff alike. We know that providing care is all about relationships and that the best care and staff experience’s is delivered through high performing teams and leadership at its best. Our ability to create a Just and Learning Culture is highly dependent on people’s psychological safety, so our people feel safe in speaking out and when they do so, they feel supported. The key is the leader’s ability to engage and listen to staff, to create the environment in which learning, improvement and innovation is collaborative and forward looking and takes us into the space of prevention. We are not there yet, but we are well on our journey of improvement together”.

Joe Rafferty is the Chief Executive of Mersey Care NHS Foundation Trust (Mersey Care), a community and mental health trust in the North West of England employing more than 7,000 people.

He describes his role as articulating why collective and co-produced cultural change needs to happen. His principle assumption is that nobody comes to work to do a bad job. He describes Mersey Care as wanting to make sense of mistakes (or in their new language moving away from right and wrong to when things have not gone as planned or as expected) within the time and context they occurred. His wish is to move towards a restorative culture together.

**Self-awareness**

He sees authenticity as the key to fulfilling his role. The capacity for reflection is essential, especially on how compassionate leadership is seen in action. Leadership positions require you to understand your preferences and behaviours and to create checkpoints for reflecting on them along the way. Indeed, Joe reflects that no organisation or individual is immune from the unconscious bias that hinders judgement and stifles learning and creativity. Indeed, “learning can only flourish when we are self aware as leaders and are prepared to learn and lean into our own vulnerabilities, and that includes sharing our own lessons and learnings along the journey.” Clear, understood lines of accountability are equally critical to a just and learning culture to ensure that the lessons are not only learnt by front line care givers, but by the organisation and ultimately those that are accountable.

**Organisational structure**

People who use services, carers and professionals all co-design the services that Mersey Care provides. The organisation has a strong focus on ensuring there is alignment between the organisation’s strategic intentions, which everyone understands; the machinery to execute intended change; the values and behaviours which are needed by which Mersey Care is experienced and the wherewithal to adapt to an ever-changing external environment.

Senior leaders at Mersey Care talk about its organisational approach in terms of foresight (what we want to be like), insight (design thinking) and oversight (candour and openness, which promotes learning and innovation).

Figure 10: Improvements works across 5 domains, starting with outcome
Culture

At Mersey Care, people who use its services and its professionals stand side by side. They are constantly working to understand the power imbalance between them and what shifts and can shape it going forward.

When things do not go as planned or as expected, consideration is given to the first victim (people who use services and their families) and second victim’s (staff and colleagues) of those incidents. This includes understanding the systems, policies and procedures that supported or prevented the best possible practice and outcomes. This approach helps the trust to look at human behaviour differently, seeing human error as a symptom and not the cause. Simply speaking, understanding why people did what they did, and if it made sense to that member of staff in practice it will probably make sense to other staff in the same situation. So we have started to look at these events as a window of opportunity and as a marker to learn.

Challenges of embedding a Just Culture:

Embedding a Just Culture is challenging as it requires peoples to hold a mirror up to themselves, it requires continual questioning to help shape the way in which Mersey Care learns and demonstrates commitment to, and the value of their people (staff). Like any new way of looking at things, it is frustrating at times. It can expose people taking positions that others may not understand. It also risks conflict with regulators and other stakeholders who may question the approach of not holding people to account when there are failings in systems and processes. It was initially scary for staff at Mersey Care but now they articulate the approach when things do not go to plan or as expected by asking what? and how?, rather than who? Organisational learning and change will be limited without this sort of shift.

Believing in restorative relationships rather than retribution requires trust and partnership working on a new level. The goals and objectives of Mersey Care set year on year, will demonstrate how they are ‘walking the talk’. This defines compassionate leadership as a must. There is obviously much work to do, but overwhelming feedback from people has been positive, that they are at the beginning of a long journey, but their experience so far is that a Just and Learning Culture approach is the right approach for people who use services and staff alike.
Melanie Walker
Devon Partnership NHS Trust (DPT)

“It helps to hold a mirror up to people and provide them with clarity of purpose.”

Melanie Walker is Chief Executive of Devon Partnership NHS Trust, a mental health and learning disability trust in the South West of England employing around 2,600 people.

She describes her role as enabling and supporting people to do the right thing, ensuring that they can pay attention to delivery without being overwhelmed by the challenges. She stresses that the trust is clear that its work on values based recruitment is a key component in getting the right people.

Self-awareness

She observes that in her role it is important to be open and transparent, accessible and visible to staff. She attends staff induction and leads extensive engagement programmes to work with members on what really matters to the organisation.

People describe her as an inspiring patient focussed leader, saying she enables improvement to happen as well as trusting staff to do the right thing.

Leadership style:
Melanie Walker’s top tips

Be clear as a board about the purpose of your organisation:

“our job is improving services with the people who use them and everyone is clear on that”.

Empower people to work differently, as well as holding them to account.

Enjoy work and help others to as well.
Case study 20 - Leadership

Colin Martin

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)

“You need to find out what staff need by way of support to deliver high quality services; you need a light hand on the rudder.”

Colin Martin is the Chief Executive of Tees, Esk and Wear Valleys NHS Foundation Trust, a mental health and learning disabilities trust in the North East of England employing 6,500 people.

He describes his role as more enabling than directional – “do we all agree that the following is the best way forward?”. It involves reaching a collective view on what needs to happen and helping everyone to get there.

Self-awareness

He describes one of the most important elements of being a chief executive as remaining calm. If a leader comes across as being too anxious about a situation, anxiety can spread across the organisation and hinder progress.

Understanding how a leader comes across to others is also important to achieving the necessary impact.

Organisational approach to improvement

Quality improvement methodology is embedded in the organization, TEWV having been one of the early adopters of Lean methodology in healthcare in England.

Leadership style

Colin Martin’s top tips

Staff engagement is key to improving services and working with people who use services – improvement is not something that can be directed.

“Seek forgiveness rather than ask permission.”

This is a particularly important message to give people when they are trying something new.

My job is like “lifting rocks out of the road.”

Understand and work with people on the “shop floor” – having a ‘bottom up’ approach means you will get the best out of people.

Case study 21 - Leadership

Tom Cahill

Hertfordshire Partnership University NHS Foundation Trust (HPFT)

“I see myself as an advocate for people who use our services, and someone who enables staff to go the extra mile”

Tom Cahill is the Chief Executive of Hertfordshire Partnership University NHS Foundation Trust, a mental health, community and learning disabilities trust in England employing over 3,000 people. In 2017, too, he was awarded Chief Executive of the year for 2017, by the Health Service Journal.

A former mental health nurse, he is passionate about engaging effectively with service users and staff. He describes his role as ensuring that service users and their families are at the heart of decision-making. He is equally adamant that staff at all levels have the opportunity to shape the Trust’s strategy and are empowered to deliver the highest quality of care.

Self-awareness

Tom’s approach involves holding people to account for keeping service users safe but also trusting people to take risks and do the right thing. He believes that feedback is key to self-understanding. So he keeps an open door to feedback and creates the conversations and environment needed to receive it. He also sees self-reflection as a tool for supporting oneself in a leadership role.

Organisational approach to improvement

He describes people who work at HPFT as living the values of the organisation. By putting the people who use services at the heart of all of the improvement work, working with colleagues, adding value to everything that they do and by developing a mindset for improvement, people working at HPFT have also turned it into a learning and constantly improving organisation.

Leadership style:

Tom Cahill’s top tips

Put people first – remember everything we do connects to people’s lives

Be forthright and decisive when you need to be and maintain a level of grip alongside enabling improvement.

Remind people of how much scope they have to make improvements – sometimes they don’t realise just how far it extends.

Be approachable. People skills are vital – you need to be able to connect with people, to embrace the culture and not be too aloof in your approach and interaction.

Be brave. It is one thing to have the desire to do the right things – another to have the courage to do them.
Case study 22 - Leadership

Heather Tierney-Moore

Lancashire Care NHS Foundation Trust

“If you don’t know what good looks like you have nothing to compare it to – if you don’t look outward you don’t know what you don’t know… happy, engaged staff provide good care”

Heather Tierney-Moore is Chief Executive of Lancashire Care NHS Foundation Trust, a community and mental health trust in the North West of England employing 6,500 people.

She describes her role as not just about what you do, but how you do it, involving a congruence of leadership style and behaviour as well as an understanding the interplay between leadership philosophy and culture.

She notes that in some places there appears to be a disconnect between how clinicians and managers feel they should behave in demonstrating leadership.

Self-awareness

She contrasts servant leadership – “how do I help others be the best they can be” – with the ‘heroic’ state of mind, which can be distressing for all those involved and doesn’t work. She recognises the need to understand the nature of one’s leadership, how it’s experienced by others and how you might need to change your own behaviours. She notes that learning to lead is an ongoing, lifetime job. It needs practice until it becomes natural – organisations can spot a lack of authenticity a mile away.

Language – the words leaders choose – is vital. For instance describing a positive culture, exploring possibilities as opposed to a narrow problem solving approach. The things leaders pay attention to are equally important, although how individuals choose to attend to them may be different. The things that leaders pay attention to directly impacts on the culture.

It’s easy to assume that people in clinical roles will think and act the same as oneself and others in managerial/leadership roles. The “ask” of clinicians is that they approach leadership/managerial issues the same way as they would clinical opportunities and challenges.

Leadership style:
Heather Tierney-Moore’s top tips

Be aware of the high profile of your position. How does your leadership land? What is the impact of what you have said and done?

Take the initiative to meet clinical need with clinical innovation. How can leaders make that happen given today’s financial challenges?

System leadership is what you do day in and day out, not just what is discussed in STP meetings.

To create a culture, you have to act out the conversation.

Spend more time on people, less on processes and structures.

Have a really clear shared vision that everyone can connect with and work to.

Case study 23 - Leadership

Navina Evans

East London NHS Foundation Trust

“I am continuously reflecting on how I approach and deal with situations and thinking: Could I have done that differently?”

Navina Evans is Chief Executive of East London NHS Foundation Trust, a mental health and community trust employing almost 5,000 permanent staff.

She describes ELFT as a learning organisation, where people have permission to make mistakes. The trust has strongly embedded Quality Improvement methodology, with support from the Institute of Health Improvement. This has made a big difference to their improvement work.

Self-awareness

She observes that her clinical training as a psychiatrist and her own personal development have helped her to increase her self-awareness as a leader.

She uses a number of resources to increase her self-awareness, including 360° feedback, coaching, mentorship, a personal development plan and previously has had professional therapy. These help her to understand her blind spots and to develop as a leader.

She is also part of a group of new Chief Executives who work together and support each other in becoming authentic leaders, partly by being open to being vulnerable.

Leadership style:
Navina Evans’ top tips

Give people permission to make mistakes.

Ensure the culture and environment support improvement and learning.

Have hope when things are difficult.

Use your network – great things happen when good people come together.
“Improvement, finance and human resources have often been treated separately, however bringing them all together supports the best possible outcomes for improved care over the long term”

Sarah Brampton,
Deputy Chief Executive and Director of Finance,
Devon Partnership NHS Trust
Chapter 5

Resources

Organisations on an improvement journey need a clear understanding of what resources they have and how they function and support delivery of care for those who use services.

Resources are finite in nature and are constantly being reduced within the health and social care sector.

Any change (improvement) will entail a different use of resources.

Current situation

Recent health policy aims to improve health outcomes while minimising NHS costs (Alderwick et al 2015). Indeed, scarce resources are more or less a constant in decision-making about healthcare. This puts health service managers under continual pressure to find ways to improve productivity or ‘do more with less’.

Mental health trusts are large organisations, some with complex structures, often interacting with multiple CCGs commissioning for different populations. They face internal competition for scarce resources compounded by growing external demand. Trying to match the cost expectations of commissioners and the care expectations of people who use services, their carers and families is an extraordinary challenge (Bullas and Ariotti 2002, Bryan 2005). Within this resource, there is an opportunity to learn from others for a more realistic opportunity to do more with less.

“It is essential to truly and accurately ‘understand the business’ – ie you need a detailed analysis of who provides what services and how for the population, whose needs must also be well understood.”

Stewart Gee, Northumberland, Tyne and Wear

This chapter describes how mental health service providers can manage their resources – financial, human, tangible and intangible – in pursuit of continuous improvement. It includes an outline of the benefits trusts, people who use services, carers and staff can expect from following such a strategy over time, and closes with top tips from resource managers in trusts on an improvement journey.

Health services can deliver better care for people who use services, better population health and lower cost, the ‘triple aim’ for health services as described here by the Institute for Healthcare Improvement (IHI). (see Figure 13)

Figure 13: Making the ‘triple aim’ possible Berwick, Nolan and Whittington (2008)

Managing resources for improvement over time

The full and effective use of resources of all kinds is essential to the future of healthcare organisations. This difficult objective needs to be achieved in an open and transparent way.

Resources available in healthcare organisations fall into four categories:

1. Financial: Providing health services is financially demanding, and improving NHS services means managing financial resources prudently. However, money isn’t always mentioned upfront in discussions about care quality (see Figure 14).

Figure 14: We need to talk about money

2. People: the staff, service users, carers and their families plus all the knowledge they possess, know-how as well as know-what.

3. Processes: the embedded practices and technological competence required to maintain and improve operations that deliver services.

4. Places: tangible or intangible fixed assets, such as estates, equipment, IT and logistical infrastructure.

All four kinds of resource are intrinsically interlinked. Managing them to support a strategy of continually improving care quality is both a leadership and a management task.
1. Financial resources

In England mental health provision is a publicly funded social good. However, society’s demand for mental health services generally outstrips public funds to provide them. Taking an improvement approach to whole care pathways shows resource managers where to allocate funding most productively, both internally and in the wider health system, so they ‘get the most for people who use services from every penny’. NHS Improvement worked with Healthcare Financial Management Association (HFMA) mental health faculty and finance directors of mental health trusts to support this chapter.

“the emphasis on quality of care and level of knowledge and engagement by senior finance leaders about the people they provide services for is really impressive”

Sinead Dwyer, Economist, NHS Improvement (on HFMA workshops that supported this chapter)

Trusts often respond to continued pressure on resources by ‘salami slicing’ – trying to cut the same percentage of costs from each team’s budget across an organisation regardless of actual need (see Figure 15).

This kind of exercise can take place without trusts having gathered the information to understand the effectiveness or efficiency of care pathways. As a result, resources may be withdrawn before changes to systems and processes can be made that could deliver the quality required within the funds available.

Applying fewer resources to the same ways of working leads to pathway or even system failure. The approach looks fair but will often reduce the quality of care more than it reduces costs, representing a fall in productivity.

Cost improvement programmes (CIPs) focus on reducing deficits in the short term. Like many targets, they take costs out at isolated points in a person’s service journey such as an outpatient clinic. But the effects on the rest of the person’s journey can make any gains short-term and unsustainable. Discrete cost-cutting measures also rarely take account of their combined impact on the quality of care for people who use services and on staff morale.

By contrast, reallocating financial resources to priorities identified by a structured improvement approach and programme, as described in Chapter 6, can enhance the care of people who use services and safety within existing budgets. In accounting terms, the goal of such improvement approaches is to maximise value to people who use services represented by the equation in Figure 16.

Put more simply, structured improvement gets the most for people who use services out of every penny. Improvement tools help people identify and remove waste of all kinds – especially wasted time for people who use services and staff. They improve the cost as well as the quality side of the patient value ratio at the same time (Ansell and Maughan 2014).
Measuring care outcomes is not an exact science. However, much progress is being made, and there are practical measures good enough both to encourage and record improvement (see Box 1: Targeting key performance indicators that make a difference to people who use services).

Box 1: Targeting key performance indicators that make a difference to people who use services

A trust trying to maximise value for people who use services needs to define simple, practical performance indicators based on outcome measures that matter to people who use services and that can guide teams at every level. The teams need to have direct traction on the measures, so they can see that what they do makes the measures go up or down. Available measures are not yet perfect. But there are good enough measures to drive rapid progress. Members of the group behind this resource recommend the work of the International Consortium for Health Outcome Measurement, although this is not yet specific to mental health (see www.ichom.org/). The US company Patients Like Me has developed innovative methods for learning how a person using services feels each day, including their feelings about the impact of medications, and what is most important to them (see www.patientslikeme.com/).

2. People

Nothing happens without people. In mental health trusts, people are by far the most important resource to invest in for improvement. More and faster improvement becomes possible when people have the skills and attitude they need and can co-operate openly and freely, guided by the right leadership.

Every leader in a trust committed to becoming a continuously improving organisation must truly believe that the people around them are capable of realising that goal. Professional human resource management offers ideas for understanding and developing a workforce that delivers sustainable change and improvement.

Workforce planning

The first step towards developing the workforce is to understand in detail the current organisational design and structure and the impact it has on people. Trusts can gain that understanding by asking people and teams across the organisation questions like:

- what matters around here?
- what gets in the way of delivering what matters?
- how do you see your contribution to what matters?
- what are your hopes and fears?
- how can we work together to do better?

The next step is to prepare the human resource base for the challenges of the future (Hamel and Prahalad 1996). This work needs to be done when improvement programmes reach the stage of redesigning processes and care pathways (see Chapter 6). It entails determining the skills and competencies required by redesigned pathways and preparing and recruiting people for new roles. A service-driven workforce plan needs to be flexible but will generally cover the following key elements:

- detailed designs for jobs in the redesigned pathways, using professional HR services where necessary and providing for flexible working
- forecast demand and supply of relevant labour in the locality
- a skills audit of the current workforce and gap analysis
- efficient processes for retaining and recruiting talent
- suitable training and development
- succession planning.

Retention and recruitment

Losing valued staff is a critical risk during a change process. Induction, training, development and internal communications that set realistic expectations of a more open, supportive, enterprising culture can go a long way to reducing resistance to change. They can encourage staff not just to stay but to enjoy participating in improvement activities.

“As Senge says: ‘people don’t resist change, they resist being changed’."

John Lawlor, Chief Executive, Northumberland, Tyne and Wear NHS Foundation Trust

Ongoing recruitment of staff should be for the long term too. This means selecting people not just for their know-how but with an eye to their cultural fit and adaptability to change. ‘Not fitting in’ may be a far more common reason for good staff moving on than rates of pay, or lack of expertise and training.
Motivation and reward

Enthusiasm for improvement may fade over time. When an improvement programme is underway, the inevitable uncertainty may have an impact on productivity and performance, which can damage a trust’s reputation. To maintain enthusiasm, trusts need to maintain clear and consistent communication with staff on the reasons for change, the improvement processes themselves and progress.

Recognising contributions to progress is critical. People are motivated and rewarded by receiving recognition and by seeing evidence of their achievements around them, both intangible and tangible. Seeing people who use services improve in particular helps people gain personal satisfaction and growth from their work.

Equality and diversity

Embarking on an improvement journey is an opportunity for trusts to become more equal and diverse. To that end, it makes sense to engage early with an equality and engagement expert and carry out an equality impact assessment. This will determine the impact of the workforce plan on any of the protected characteristic groups and beyond. Doing this assessment early is advisable so any of its recommendations can be considered and acted on appropriately.

Health and wellbeing of the workforce

A major change programme will have a range of effects on staff health and wellbeing, both positive and negative. Trusts need to consider the whole range and how to manage them. A particular issue to consider is the resilience of staff, including how best to encourage their confidence, purposefulness and adaptability, and how to meet their needs for social support.

Managing people thorough restructuring

An improvement journey may at some stage include restructuring services to improve the value to people who use services. However, strong the rationale for people who use services, restructuring means uncertainty for staff.

Everyone will worry about their jobs. It is a moment when transparent communication, fair processes and strong leadership are essential.

From the start of a major change, organisations need to ‘say it like it is’ openly and consistently. As plans for change mature, staff will need clarity. For instance, consulting them on firm proposals is better than consulting them on ideas with unclear implications for jobs. Similarly, staff need a clear timeline for processes related to jobs. Managers should communicate any updates immediately.

If there are to be redundancies, selection for redundancy should accord with organisational values: individual productivity and performance records should be the main selection criteria. Employers may need to give people specific support to manage the stress of the situation. Acknowledging the difficulties people face while applying the same transparent performance standard to everyone may be tough, but it is also fair.

Keeping the restructuring process as short as is fair and reasonable will help people get through it. So will keeping people focused on the long-term vision for people who use services and the organisation as a whole.

For senior leaders, restructuring may bring the biggest personal challenges of a career. Staying firm on the ‘givens’ – the need for change, the performance criteria, the overall goal – can help prevent their own emotion obstructing the process. Senior leaders are accountable for the upheaval. It makes things easier for staff if they stay positive and confident, and respond decisively to issues thrown up by events.

However, redundancies may not always be inevitable.

“When Northumberland, Tyne and Wear (NTW) Foundation Trust undertook transformation, it was clear some people’s jobs would be configured differently. It was equally clear that we had a skilled workforce and shouldn’t lose anyone. The outcome was that through significant transformation changes in services, no one was made redundant”.

Dr Carole Kaplan, Director Transformation Programme, Northumberland, Tyne and Wear NHS Foundation Trust
3. Processes

Processes are the ‘doing’ resource that supports improvement along the care pathway. They are embodied by the people working in the services, and made possible by funding for people and places, but they are more than the sum of these three. A trust’s processes and operations are its distinctive asset and the medium through which it implements a long-term quality improvement strategy.

Trusts and their finance teams can support improvement at a care pathway level by investing in quality management along the lines described in Chapter 6. This includes giving their clinicians, managers and frontline teams the training in improvement tools they need to ‘own’ improvement. To apply that training successfully, teams need to share clear care quality goals, to have a clear understanding of the resources at their disposal and to get real-time information to tell them how they are performing.

Teams may apply the tools just to the part of a pathway they work in: for example, to reduce a person who uses services’ overstays in long-term wards. However, teams risk being demoralised if the rest of the organisation is not yet ‘in tune’ with structured improvement approaches and ideas they come up with are blocked by ‘bureaucracy’ (including central finance). This is less likely to happen where trusts are consciously developing the improvement enablers described in this resource.

Taking an improvement lens to care pathways as a whole is likely to yield bigger gains in value for those who use services. Figure 17 shows a generalised map of the person who uses care pathway.

Figure 17: QI-aligning resource management around the care pathway

Working with people who use services and staff to understand the experiences of individuals along the pathways can help resource managers map current cost inputs and quality outputs for people at each stage. Applying improvement thinking along the pathway will show how resources could be better aligned to maximise value from the pathway as a whole.

Partnerships

Good working relationships with partners of all kinds are a significant asset for any organisation. A culture of collaborative work with people who use services, carers and families greatly enables continuous improvement. Similarly, close working with local authorities enables pathway flow.

“Police and mental health partnerships are talked about frequently, with much debate nationally on if this should be the case. However as Northumberland, Tyne and Wear NHS Foundation Trust and Northumbria Police forge ahead in improving the services and response offered to people who use our services and our communities, we are only able to do this due to working together. It is never one thing, it is everything we do, from working side by side in Street Triage and Criminal Justice Liaison teams, to our multi agency training (Respond) where we learn together alongside paramedics and those with lived experience. Essentially, at the basic level it’s about establishing and maintaining relationships, with a central point in each organisation. Through this relationship building comes understanding, trust and professional challenge. Each agency is able raise concerns with the view of reviewing and learning together with the overall aim of improving our services and the response to the communities we serve, ensuring resources are used effectively and appropriately.”

Claire Andre, Clinical Police Liaison Lead, Northumberland, Tyne and Wear NHS Foundation Trust

Inspector Steve Baker, Mental Health Lead, Northumbria Police.
4. Places
The environments where services are provided play an essential part in people’s outcomes and experience. The right environment will have an impact not only on the person using services, but on staff (stress, anxiety, fatigue, their ability to deliver high quality care), including recruitment and retention.

A vast amount of money is spent on the built environment and there is excellent practice in design and build solutions across the NHS. However, there are also poor facilities that do not lend themselves to high quality care. It is not sustainable to replace every building that is in poor condition or unsuitable. Different strategies are needed to improve the quality of buildings.

Therapeutic use of estates for people who use services to optimise recovery

It is important that healthcare environments continue to evolve in response to changing healthcare needs and technology advancement. Where possible, the need to build in generic solutions and flexibility to minimise changes in future is essential.

A simple example of this is using dementia-friendly signage across all buildings, as opposed to just those currently specialising in dementia care.

Understanding the human experience of the environment is essential to improving the care for people who use services. There is much published research on the ‘healing environment’. Providing the right environments will save money, increase staff effectiveness, reduce hospital stays and make the stay less stressful.

“|There has been a lot of thought and effort put into all the little elements that help someone along their recovery journey during this stressful period in someone’s life, even down to the accessibility for family and friends. I’m sure when I’m not well I may still not want to be in hospital but that would be the same for a general hospital for me. But hopefully I will be able to spend my time thinking about my recovery and the help and support I will receive rather than the fact that I feel like I’m being punished for being poorly.”|

Person who uses services on the new build at Hopewood Park, Sunderland

How to make estates work for you

Having a clear understanding of your estate – where it works well and where it needs improvements aligned to service strategies, the informatics strategy, financial model, etc – is essential to any improvement plan.

In most scenarios, organisations will need to prioritise areas requiring investment and improvement. However, areas not on the major improvement plan can benefit significantly from minor investment in the interim.

Simple improvements

Consider the importance and impact of simple things such as light, fresh air, noise, paintwork, artwork, views, cleanliness, external spaces, space adjacencies, personal space, having to cope in a strange environment, living with large numbers of strangers, and dealing with boredom. All may provide opportunities to make small-scale improvements.

Putting yourself in the shoes of the person using services, staff member or visitor may identify a small change that could make a significant improvement to someone’s perception of how they are valued. A lick of paint can improve morale significantly. Getting the basics right – painting, making internal and external repairs, ensuring an effective cleaning regime – sounds simple, yet it becomes more important when large-scale change is required but is potentially years away.

How your estate can support improvement

Understanding how the environment affects service provision is essential to supporting improvement. Combining technological advancement with new ways of working may provide opportunities to radically change how an environment needs to support clinical services. The estate should not be considered as a traditional place of work but as an enabler in maximising our resources.

A hot desk, if needed, and access to a private space to think may be a better use of resources than a desk and an office. Outpatients may prefer to wait in a canteen with a pager rather than sit in a waiting area.

The opportunities are there: we just need to look for them.

“It is so important that the people who have mental health problems can come to a place where they can very clearly see people care and mind about them when they walk through the doors.”

HRH Countess of Wessex, 2014

How resources support strategic change

Better understanding of the elements in an individual’s pathway leads to better informed ‘big picture’ strategic choices, involving major reallocation of resources. For instance, one rural trust in the group had over 60 ‘subscale’ community sites that were costly to run largely because of staff travel time. These sites were also inefficient for people who use services with multiple needs as they had to go to many different places to get care. The trust created an integrated pathway, based on three hubs covering the whole of its area, where people who use services can have a ‘one-stop’ service. Staff now see 60% to 70% of people in the hubs, rather than in their homes. This has improved care quality by increasing staff/people who use services’ contact time and patient access, and enabling the trust to offer better multidisciplinary care. At the same time, it has saved staff travel costs, and the trust has made one-off gains from disposing of unused community estate. Feedback from staff has been good, and people who use services’ feedback has been positive, partly because of the time saved.

Applying improvement thinking to discrete processes or pathways allows trusts to make year-on-year incremental improvements in the value for people who use services. Applying improvement thinking to multiple pathways and beyond the bounds of individual service providers enables the kind of strategic organisational innovations that make ‘step changes’ in healthcare quality and cost across a local area. Since people who use services’ journeys often take people to acute and community providers, and social services as well as mental health providers, this level of improvement thinking involves mental health trusts in wider health and care system improvement with their local physical health and social care partners. Members of the group of trusts that developed this model for mental health improvement are keen to work jointly with their local partners to improve the health and care systems in their local communities.
Benefits over time from a strategy of structured improvement

In this group’s experience, the nature and timing of the benefits will vary with a trust’s improvement progression. Of course, every trust’s improvement journey is different, but for the sake of argument, imagine a trust moving smoothly through three overlapping phases. In phase 1, the trust invests in a small number of prototype improvement projects; in the second phase, it will scale up the use of structured quality improvement across all areas of the organisation; by phase 3, the trust’s operations in their entirety will look like a system of linked improving processes. As this phase progresses, the trust becomes an organisation that learns and improves systematically.

Table 1 shows the kind of benefits trusts can expect to see and when, and which measures will capture them. None of the benefits are one-off. Once each kind of benefit starts to appear, it is likely to grow year after year. All the benefits are mutually reinforcing.

Table 1: Benefits from structured improvement

<table>
<thead>
<tr>
<th>Phase</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 1</strong> Years 1 to 2</td>
<td>Years 3 to 4</td>
<td>Year 5+</td>
</tr>
<tr>
<td>Improved outcomes and experience for people who use services and families</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved staff engagement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved productivity and efficiency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost avoidance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost reduction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Growth</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Benefits appearing in phase 1, from one to two years

**Improved outcomes and experience of care.** Teams working on individual improvement projects will see improvements in outcomes and experience for people who use services, carers and families touched by the project. Care quality returns from improvement projects are likely to be significant and measurable within a year of the project’s start, primarily at the team or microsystem level within a person’s pathway.

**Improved staff experience and engagement.** When teams are trained to use tools to improve care systematically and are given the power to decide – with people who use services, their carers and families – how to improve the system, their work becomes intrinsically more rewarding and people feel they have more control and autonomy over their work. Trusts are likely to find that teams working on improvement projects report higher levels of job satisfaction, better relationships with colleagues, lower turnover, fewer absences and a generally better experience at work. These benefits are likely to show up in two to three years in the annual NHS staff survey and any internal measures of staff engagement.

Benefits appearing in phase 2, from three to four years

**Improvements in efficiency.** As improvement projects proliferate in a trust, it will begin to work better as a whole system. Day-to-day operations will run more smoothly, allowing staff to allocate time and resources formerly spent on unplanned fire-fighting to improving their part of the system and its interface with other parts. In addition, many teams may choose to work on topics related to efficiency and productivity: for example, tackling non-attendance at appointments. Investment in ‘soft’ enabling factors, like culture change or working with experts by experience, will amplify gains in the system’s productivity. These gains will show up in a trust’s regular measures of efficiency and effectiveness.

**Cost avoidance.** By removing waste, inefficiency and duplication, teams will start to avoid additional costs, thereby reducing cost pressures. This could be because fewer staff are absent, requiring less bank or agency staff spend, or because staff are preventing harm and thereby avoiding the costs of managing and treating the avoided harm. At one trust fewer violent incidents meant fewer injuries to staff, so less sickness leave, reducing the need for bank or agency staff. It also reduced the costs of repairing damage, meaning lower spending on estate repairs.
Benefits appearing in phase 3, after five years and beyond

Cost removal. As it becomes increasingly effective and efficient as a system, a trust may start to target costs for removal, through quality improvement techniques. For instance, finding ways to support people who use services closer to home may sustainably reduce demand for beds over time, making it feasible for trusts to close whole wards or use them for different purposes. Closing a ward may represent a recurrent cost reduction of more than £1 million for a trust.

However, boards should remember that this scale of cost saving will be the long-term outcome of years of pursuing quality as the trust’s primary strategic goal. Such hard financial benefits cannot be achieved without doing the soft, human work to unlock all the other benefits available for people who use services and staff on an improvement journey. They are just one outcome of learning how to continually improve quality, year after year, across the organisation.

Growth. At this level of improvement maturity, a trust’s deserved reputation for improving care quality and cost-effectiveness will help it to grow in several dimensions:

- Revenues are likely to grow because its increasingly high quality care will attract people who use services and more contracts from commissioners.
- More efficient care may release resources to invest in growth or new service development.
- Being a great place to work will attract staff with values aligned to improvement, thereby accelerating the rate of quality improvement and potential growth.

They depend on developing a culture of openness and trust, where staff feel safe to point out what could be done better and know how to improve. Trusts that set cost savings as an explicit early objective of their quality improvement journey risk diminishing the soft benefits and failing to achieve cost savings as a result.

Tips on best practice for long-term improvement programmes and pitfalls to avoid

Top tips include:

- Understand the value for people who use services in every part of the pathway.
- Maximise clinical time on what adds most value for people who use services.
- Stop talking about wasting money and look for what wastes time for people who use services and for staff.
- Embrace failure and share learning and success.
- Allow staff to choose how they maximise the value to those who use services, rather than make them hit targets, and the targets will take care of themselves.
- Make changes across the whole resource base to improve and continue improving the value for those who use services, not just at the margins.

Main pitfalls to avoid include:

- Making short-term resource decisions for expediency without understanding their full impact on the care of those who use services and costs.
- Lack of incentives to do the right thing.
- Sticking with a decision when the evidence tells you it is wrong.
- Ignoring the cost of not changing.

Summary

This chapter describes how improvement depends on a clear understanding of all resources across an organisation. Different resources are interdependent.

In the NHS, we must remember that our colleagues are our most precious resource, and require thoughtful and meaningful nurturing.
References


Using quality improvement techniques to reduce agency spend

Hertfordshire Partnership University NHS Foundation Trust

What was the aim?

To reduce spending on agency staff without affecting service quality.

What was the solution?

A project using quality improvement thinking and techniques, focusing on service delivery rather than just the financial perspective. The trust identified demand for initial assessment and lack of throughput as the main causes of its reliance on agency staff. The techniques it used included:

- use of data and information/data analysis
- ‘go see’ – understanding the problem where it occurs
- process mapping/analysis
- thinking about flow
- demand and capacity concepts
- managing variation.

Improvements were often small, such as changing process steps to eliminate waste or activity that added no value, and establishing better communication between the single point of access and community teams. The trust also conducted a full caseload review to challenge practice and identify delays to recovery of each person who use services. This generated capacity and provided a blueprint for flow management: teams’ fluctuating capacity was made visible, while processes for regular monitoring and management were standardised.

What were the challenges?

Finding time for staff managing and delivering the service to understand how to improve it. This took strong leadership, belief and commitment. As frontline teams saw a genuine desire to understand the problems and involve them in devising solutions, they found time to be involved.

What were the learning points?

- The trust was surprised by how little it knew about some of its processes and practices, and by frontline operational managers lacking important information.
- Understanding of a problem should be based on evidence, not intuition. Evidence is not always readily available information.
- Gaining understanding can take time and may require resources that are not immediately available.
- A deliberate approach focused on root causes can achieve results.

Next steps

The trust has begun quality improvement in its single point of access to address pressure around initial assessments. More widely, it is aware of staff discussing QI concepts and using improvement thinking.

Want to know more?

Eddie Short, Continuous Improvement Lead, eddie.short@hpft.nhs.uk

To see the other case studies in this series: visit the NHS Improvement website at: www.improvement.nhs.uk
Case study 25 - Managing resources

Improving the dementia pathway

Cheshire and Wirral Partnership NHS Foundation Trust

What was the problem?
Caseloads for older people’s teams have grown with increasing demand, lengthening waiting times. The trust therefore wanted to improve the rate of diagnosis and initiation of treatment, and increase support to people with dementia, by reducing inefficiency and duplication.

What was the solution?
Redesigning the pathway for people with dementia, to reduce duplication by eliminating reviews and appointments that were not clinically indicated. This included working with primary care colleagues as part of the National Association of Primary Care’s ‘primary care homes’ programme, which brings together health and social care professionals to provide enhanced personalised and preventive care. The consultant psychiatrist now holds clinics in GP practices, with full access to primary care clinical records. Nurses have access to hot-desking office space alongside health and social care colleagues.

What were the results?
Work began in June 2017. Early results show:
- Caseloads have started to reduce as primary care services manage more people’s care and treatment, releasing trust staff time to respond to other clinical needs.
- Waiting times for assessment and diagnosis have fallen from nine weeks to a maximum of five weeks, and involve fewer appointments, meaning less travel for older people across a large, semi-rural area.
- Communication between GPs and the trust’s older people’s team has significantly increased.
- Costs for the team have reduced as GP practices offer clinic rooms free of charge.

Benefits of the new pathway include improved patient safety and more equitable care: reviews by specialist mental health services are given to those with greatest clinical need. New assessments can take place within four weeks of referral; early diagnosis and treatment will reduce cost to the whole health and care economy, and have an impact in terms of fewer crisis presentations due to timelier responses from the team.

Next steps
- Meet commissioners to update the service specifications and formalise the revised clinical pathway.
- Extend current urgent response up to 8pm Monday to Friday.
- Extend input to other primary care homes in east Cheshire.

Want to know more?
Josephine Worthington, Community Team Manager, josephine.worthington@cwp.nhs.uk

Case study 26 - Managing resources

SMART: redesigning community services to improve quality, productivity and efficiency

Devon Partnership NHS Trust

What was the problem?
Inconsistent care pathways, variable triage, poor initial assessment and inequitable access to clinical services. Updating information systems and staff travelling time diminished direct contact with people who use services. Staff morale and people who use service’ satisfaction were low. Some buildings were in a poor state, with some sites less than 30% occupied.

What was the solution?
The trust’s SMART programme reviewed every aspect of its community care pathways, organising 14 three-day, clinically led workshops over 12 months and involving more than 240 clinical staff. The workshops compared the trust’s current pathways with National Institute for Health and Care Excellence (NICE) evidence-based pathways, and devised 14 new ones underpinned by:

- A 24/7 single point of access for routine and crisis response, including centralised consultant-led triage.
- Three multidisciplinary team (MDT) assessment centres, at which every person using the service is seen by a consultant and a psychologist, receives a brief physical health check and medicines reconciliation, and is assessed by a qualified senior mental health practitioner.
- Structured clinical pathways, which required a significant change to working practice, a cultural shift and more emphasis on senior clinical leadership.
- Clinical scheduling (job planning) that stipulates all senior mental health practitioners work from treatment clinics for up to two days a week.
- Redeveloped clinical space, investing more than £3 million in capital.
- Tablet-based mobile technology to reduce staff having to return to base to update records.

What were the challenges?
- It took time to articulate the vision and for clinical staff to understand it; sometimes the programme was seen purely as a cost-cutting exercise.
- Getting the right balance between quality improvement and gains in productivity and efficiency.
- Technology proved less advanced than expected, introducing an administration overhead and clinical risk rather than streamlining working processes.
- Getting services to work more collaboratively across directorates to support MDT reviews was difficult until a small cross-directorate group broke down barriers, one of the programme’s significant successes.
- Some senior clinical leaders disagreed with the planned changes.
What were the results?
The trust is still implementing key aspects of the programme, but benefits so far include:
• Best practice care pathways and guidance for clinical staff, including a complex personality disorder pathway and training programme.
• The booking system helps make better use of facilities.
• Disposal of low-occupancy facilities and others significantly improved.
• MDT assessment model implemented.
• Increased satisfaction from those who use services.
• Improved flow through assessment to treatment teams.
• Improved working across clinical directorates.
• Improved productivity in relation to contacts with people who use services.
• Development of a GP support service linked to the single point of access.
• Improved out-of-hours crisis support.

What were the learning points?
• Do not underestimate the time it takes to implement this level of change.
• Ensure you develop a transparent and clearly articulated vision.
• Resistance to change is normal.
• Keep the programme focused on the benefits.
• Document key decisions.
• Involve people who use services at all stages.

Want to know more?
Sarah Brampton, Director of Finance, s.brampton@nhs.net

Case study 27 - Managing resources

Using bed modelling to reduce out-of-area placements

Lancashire Care NHS Foundation Trust

What was the problem?
Escalating demand for mental health beds resulted in 94 people who use services being sent out of the area for treatment in 2016. This resulted in a less than ideal experience and was financially unsustainable for the trust.

What was the solution?
Enhancing community services to broaden alternatives to admission. The trust used bed modelling to identify the correct type and number of beds to meet the local population’s needs. It found many were admitted because of emotional regulation issues rather than psychosis or bipolar conditions. The trust developed:
• Assessment wards – admission to a specialist ward to establish whether needs can safely be met in the community.
• Crisis support units – community facilities linked to A&E departments, providing up to 23 hours of support and time for emotional regulation and community care planning.
• Acute therapy service – intensive five-day community programme, based on dialectical behaviour therapy, for those with suicidal or severe self-harming behaviour, to teach coping and self-management skills.
• Crisis house – six-bed house in the community run by a third sector partner for people with high levels of distress who would otherwise need a hospital admission.
What were the results?
Out-of-area placements have been reduced to about 16 for acute treatment and six for psychiatric intensive care. In the enhanced community services:

- 72.8% of people in assessment wards are discharged to community care.
- 74.9% of people in crisis support units are discharged to community care.
- 325 out of 326 people in the acute therapy service were discharged to community care.

Figure 19: Monthly adult mental health community demand

The enhanced community services absorbed a 9.8% increase in unscheduled demand in 2017/18, with a 1.9% reduction in acute admissions. People who use services now have a choice of treatment that offers an improved experience and better outcomes, while the new community support schemes are more cost-effective than inpatient admission. At a system level, commissioners have benefited from a related reduction in 12-hour breaches at acute trusts. Pathway flow has improved: if lengths of stay above 180 days were eliminated, out-of-area placements would fall to zero.

Want to know more?
Phil Horner, Deputy Head of Operations, Mental Health Network, Philip.Horner@lancashirecare.nhs.uk

Case study 28 - Managing resources
Appointing a senior nurse for clinical procurement

Lancashire Care NHS Foundation Trust

What was the problem?
It is essential to have access to the right clinical products, but with NHS Supply Chain providing more than 350,000 product lines, finding the right product at the right cost can be challenging.

What was the solution?
The trust created a nursing post to review clinical procurement practice, identifying opportunities to improve quality and make savings while working with clinical staff to streamline processes and enable more standardisation. Acute trusts had already created such posts and demonstrated they could improve safety, quality and use of resources; Lancashire Care was one of the first community and mental health trusts to do so. Its director of nursing has championed the role as lead for community and mental health trusts on the National Clinical Reference Board.

What were the results?
The senior nurse for clinical procurement has identified additional efficiency savings and helped the trust achieve challenging cost improvement programmes. Projects implemented during her first year have saved six times the investment in the post. These include:

- Reviewing the wound formulary.
- Introducing direct purchase for community dressings.
- Reviewing personal care interventions for mental health inpatient units.
- Standardising equipment.

Want to know more?
Nicky Morton, Procurement Nurse, Nicky.Morton@lancashirecare.nhs.uk
Case study 29 - Managing resources

Reducing travel time and expenditure

Lancashire Care NHS Foundation Trust

What was the problem?

The trust was spending significant sums on travel: £4.5 million in 2014/15. This affected staff wellbeing as well as productivity and finances.

What was the solution?

In 2015/16 a ‘task and finish’ group with representatives across corporate services found ways to decrease travel, especially for non-clinical purposes, by:

- using Skype more by promoting the technology and offering training, initially for management meetings, but extending it to include – for example – clinical supervision; this involved spending on headsets and desk microphones, and making private space available for confidential conversations
- reissuing the trust’s travel policy and guidance for completing claims; a review of claims found many were completed incorrectly
- circulating the top 100 claimants’ lists to senior managers, to target support about ways of reducing travel
- offering more online training and face-to-face training where staff are based.

What were the challenges?

The trust set up car-share schemes, but these were not successful due to the complexity of working patterns.

The changes released £500,000 in 2016/17. The outlay for Skype equipment was minimal and met largely from existing budgets. The biggest impact arose from communicating the project’s importance to staff by establishing meaningful baseline measures (see Figure 20). The trust challenged each staff member to reduce their own travel and act as a role model to others in their use of Skype. About 30% of meetings and supervision are now conducted via Skype from virtually none previously.

What were the results?

At LCFT 2013/14 we travelled 6,899,866 miles. That’s more than once around the world every working day! At a cost of £5,285,386.

Last year (2014/15 - cost £4,777,586).

At an average speed of 30MPH collectively we spent 26 years in our cars in 2013/14. It’s time, money, carbon and it doesn’t have to be this way...

Want to know more?

Bill Gregory, Chief Finance Officer, Bill.Gregory@lancashirecare.nhs.uk

Bill Gregory, Chief Finance Officer, Bill.Gregory@lancashirecare.nhs.uk
Case study 30 - Managing resources

Attracting, recruiting and retaining staff

Lincolnshire Partnership NHS Foundation Trust

What was the problem?
The trust’s nurse vacancy rate hit a peak of 16% in 2015/16, while staff turnover rose to 19% and sickness to 7%.

What was the solution?
The trust created a recruitment task and finish group, which appointed a recruitment and retention (R&R) lead who brought new ideas and experience from the private sector.

• Marketing materials were developed and used extensively across Facebook, LinkedIn and Twitter. These showcased staff, the estate and people who use services, emphasising Lincolnshire as a desirable place to live.
• The R&R lead developed relationships with universities in Lincoln, Sheffield, Hull, Nottingham, Derby and Leicester. The trust attended careers fairs for nursing and medical students, and gave talks to final year mental health students. It also held a careers open evening for all final year and return-to-practice students.
• A fast-track, values-based interview process was developed and labelled ‘career chats’, to relieve some of the pressure of interviews.
• The trust enhanced its staff benefits package to offer £1,000 relocation assistance when an employee moves between rented accommodation and £8,000 when selling and buying; it pays registration fees for the first year of employment, and Disclosure and Barring Service fees; it offers a £500 per person conference fund to be used in the first year of employment, and has a dedicated Band five development programme in addition to preceptorship.
• To help grow its own staff and talent, the trust is sponsoring 5 healthcare support workers to complete a nursing degree, trains nursing associates and recruits within the UK without seeking staff abroad.
• With Lincoln University, the trust supported 10 return-to-practice registered nurses with their initial placement and offered them posts; it is now supporting a further two.
• To shorten the recruitment process, the trust introduced key performance indicators at each stage.

What were the results?
• Job advertisements attracted 300% more views.
• The nurse vacancy rate fell to 1.7% within nine months. It remains around 2%, excluding vacancies in new services.
• The overall staff vacancy rate has fallen by 13% to 6%.
• Sickness absence has reduced by 2.2%.
• More than 50 people attended the careers open evening.
• The fast-track interview process attracted 50 applicants, and all were given conditional job offers.
• The recruitment process has been cut by 14 working days, and now takes 32 days on average.

What were the learning points?
• A clear brand is necessary to showcase the trust and its best attributes.
• Effective recruitment needs a dedicated lead who can target key areas and attend careers events.
• Do not undervalue the power of social media.

Next steps and sustainability
The trust is now focusing on a retention project. It is also examining talent management and how to address the needs of younger staff.

Want to know more?
Dr Ade Tams, Head of Workforce Planning and Recruitment, Ade.Tams@lpft.nhs.uk
Case study 31 - Managing resources

Using ‘radar’ meetings in discharge planning

Mersey Care NHS Foundation Trust

What was the problem?

Discharge planning meetings were disjointed and resulted in many delayed discharges. Trying to co-ordinate placements and packages of care resulted in poor capacity and flow. The trust wanted to improve people who use services’ experience and its own relationships with its partners.

What was the solution?

Weekly ‘radar’ meetings between local authority representatives, ward and community managers, to monitor delayed discharges and those that could become delayed. The meeting is chaired by a modern matron, and links to the local division meeting that includes clinical commissioning group and local authority members. Everyone attending brings updates on progress and information on any factors that may block discharge. They focus on inpatients whose stay exceeds 60 days. Initially meetings took two hours but now last one hour.

What were the results?

Delays fell by 12% to below the national average of 7%. Currently they are 5.4%.

Want to know more?

Derek Sharples, Modern Matron, derek.sharples@merseycare.nhs.uk

Case study 32 - Managing resources

Improving the effectiveness of pre-admission assessments

Cheshire and Wirral Partnership NHS Foundation Trust

What was the problem?

People in an acute mental health crisis are often admitted to acute psychiatric hospitals without a clear rationale for how the admission will help them. After analysing all admissions to two wards, the trust decided to improve the gatekeeping process by which the crisis resolution home treatment team assesses whether a person experiencing an acute episode of mental illness needs to be admitted or could be supported and treated at home. It hoped to highlight reasons for admissions and estimate their length so that people who use services would have a clearer idea about their proposed treatment. This would reduce confusion and delays in people returning home. The trust also wanted to improve the flow of people who use services through acute inpatient beds, which had been reduced by 60% in the last 10 years, by providing better community-based care.

What was the solution?

The crisis resolution home treatment team used the plan-do-study-act model to ensure that for all admissions to an acute mental health bed on the two wards, staff used the enhanced gatekeeping assessment tool on CAREnotes, part of the trust’s electronic record system.
What were the results?

Figure 21: Average length of admission

Increased use of the assessment tool has reduced length of stay (see Figure 21). Flow has improved, suggesting admissions are more focused and fewer discharges are delayed. The trust has now introduced the tool in two other localities; data from one shows a median length of stay of 16 days when the tool is used and 18 days when it is not.

Want to know more?

Sean Boyle, Lead Practitioner, sean.boyle@cwp.nhs.uk
Sarah Quinn, General Manager, sarah.quinn2@cwp.nhs.uk

Case study 33 - Managing resources
Creating a first response team

Bradford District Care NHS Foundation Trust

What was the problem?

Services responded poorly to people undergoing a mental health crisis. Presentations to accident and emergency were many, urgent assessments were delayed and only known service users could access urgent support from the intensive home treatment team. The police identified gaps in supporting people in crisis, placing them in cells until they could access services. This resulted in poor relationships with the police. After reviewing the clinical and financial implications of out-of-area acute placements, the trust recognised the need to give service users – and the many in crisis whose needs had been unmet – quick and efficient access to services via a single route.

What was the solution?

Using the telephone system to provide easy 24/7 access and encourage self-referrals to a team trained in mental health and risk assessment. Set up in 2015, the first response team has a varied skill mix and can offer rapid access to medication from advanced nurse practitioners, as well as social care from social workers who are part of the team but employed by the local authority. The police have a direct, dedicated emergency response line to the team.

What were the challenges?

Operating a telephone system as a first point of contact takes a lot of effort to perfect. Interpreting data also posed challenges.

What were the results?

No out-of-area placements have been made in three years; at their peak in 2014/15 out-of-area cost £1.8m a year. A&E attendances fell from 900 to 500 in a year. The number of service users detained in police cells has dropped by 90%. Increasing access has identified unmet mental health need among people the service would otherwise not have known about. Calls to the team have risen from under 1,000 at its launch to 6,000 a month.

What were the learning points?

In the short and medium term it is difficult to establish savings, so the evidence for this needs to be examined in the long term. Preventive work is scarcely resourced.

Want to know more?

Grainne Eloi, Interim Head of Service Acute and Community Mental Health Services, Grainne.Eloi@bdct.nhs.uk

To see the other case studies in this series: visit the NHS Improvement website at: www.improvement.nhs.uk
Case study 34 - Managing resources

Improving the Human Resource (HR) service

East London NHS Foundation Trust

What was the problem?

Improving the HR service was a project to improve HR recruitment and disciplinary processes to reduce the length of time that services were waiting for new hires to start and lessen the impact of disciplinary processes on day to day operations and reduce risk to the Trust. We used Quality Improvement methodology to introduce a series of change ideas which reduced the length of time to hire from 54 days to 38 days (30% reduction) and the length of time that a disciplinary process took from 113 days to 76 (33% reduction).

What were the challenges?

The time-lag between staff leaving a service and a new one starting was having an adverse impact on continuity of service, team functioning and service user experience. Similarly, suspensions and disciplinary processes were having an adverse impact on team morale, individual engagement and management capacity to deal with other service issues.

What was the solution?

A combined series of improvement projects were introduced to improve the HR processes at ELFT which lead to improved service delivery and patient experience. The work was undertaken across the whole trust of 5000 staff and 6 inpatient units.

Evidence from the Kings Fund demonstrates that improved people processes and higher levels of staff engagement correlate positively with patient experience and outcomes. Multidisciplinary teams were established including HR staff, service managers and staff side representatives to build dashboards of improvement metrics to measure the work and a number of change ideas were generated for each of the projects – recruitment and disciplinary.

The team used the quality improvement framework and support at ELFT to guide their work through not only the design and implementation phases of their project but also to ensure sustained levels of engagement from all those involved. The Driver Diagrams attached show clear identification of key drivers and change ideas to achieve the goals of the two projects and form part of a shared, overall strategy for the work.

With regard to the recruitment process, change ideas included stabilising the recruitment team itself to deliver a better service and reduce turnover of staff. Evidence from NHS streamlining demonstrated that less than 1% of references resulted in the withdrawal of an offer of employment so the team trialled new hires submitting a personal statement with one reference from the current employer, this focused the process to one core reference which reduced waste of chasing supplementary references. Likewise most NHS staff have DBS checks carried out at a cost of 48 pounds and up to 6 weeks for turnaround. If staff had had the right level of DBS check for the role for which they were applying, they were able to ‘port’ their DBS check to ELFT. The myriad of systems and process and workarounds in the recruitment process were reviewed to streamline and combine forms and processes wherever possible which resulted in a reduction of over 30% of form filling and duplication of data entry.

Significant numbers of applicants apply indiscriminately for posts which was resulting in low turnout at interview stage, to reduce this ‘3 reasons to hire me’ was introduced as part of the application process to focus candidates to those who really wanted to work for ELFT and had taken the time to target their application appropriately. This led to increased conversion of shortlisted to interview candidates.

A range of flexible practices were introduced to make the recruitment process far more candidate-focused which included interviews at weekends, phone calls to candidates to build the relationship and ensure they had what they needed to attend the values based selection process and regular phone calls through the process to keep candidates engaged and ensure that their experience of ELFT was in line with the values of the organisation (we care, we respect, we are inclusive).

With regard to the disciplinary process, the specific aim of the project was to reduce the length of time taken to conclude 80% of disciplinary processes to 115 days or less. To achieve this a number of change ideas were tested including reducing the preliminary report to a one page document, introducing a meeting between the commissioning manager, line manager and HR, pairing experienced investigation officers with non-experienced investigation officers, changing the disciplinary policy and streamlining all guidance and documentation available to support the process.

The combination of a number of change ideas including offering a hearing date at the outset of the process culminated in a reduction of time it takes to conclude a case from 113 days to 76 days. A review of all employee relations cases in the past 3 years was undertaken alongside the project with the aim of reducing the number of BME staff over-represented in Disciplinary processes. The increased focus on recruitment, disciplinary cases and processes has led to a higher awareness and interest in how the trust deals with hiring staff, performance and conduct and paved the way for the implementation of a performance framework which aims to improve the quality of the recruitment, on-boarding process for new staff and develop on-going feedback between managers and staff.
What were the results?

There has been a 33% reduction in time taken to complete disciplinary investigations, with the average reducing from 113 days (baseline period) to 76 days following a series of interventions.

There has been a 30% reduction in time to hire, with the average reducing from 54 days during the baseline period to a sustained average of 39 days following a range of interventions.

In 2014-15, the average number of days that staff members were suspended during a disciplinary investigation was 104 days, with an average cost of £296 per day. By reducing the length of time to reach a disciplinary hearing, our finance team have estimated a saving of £429,200 over a financial year (assuming the same number of cases are brought each year).

Although not quantified, recruiting to vacant posts in a timely way reduces burden and burnout on existing teams, and also reduces spend on agency and bank staff.

Next steps and sustainability

This project has now moved into quality control, with the team maintaining oversight of process performance within the routine operational forum, and making small tweaks to the process where appropriate. The team is now moving on to think about other areas of work, including thinking about the disparity between different ethnic groups entering the disciplinary process.

Want to know more?

Contact Dr Amar Shah
amarshah@nhs.net
Case study 35 - Managing resources

Taking CAMHS into schools

North Staffordshire Combined Healthcare NHS Trust

What was the problem?

In an average classroom, three children suffer from a diagnosable mental health condition. Schools therefore have an important role as a source of support and information for pupils, parents and carers.

What was the solution?

The CAMHS (child and adolescent mental health services) in Schools Team develops and implements practical support and guidance to promote safe and stable environments for pupils affected directly and indirectly by mental ill health. It provides clinical evidence-based programmes for whole class and year groups. The team also promotes staff training and support sessions to improve mental health and wellbeing, build resilience and encourage early interventions directly within schools.

The team offers individual children and families care co-ordination and interventions such as cognitive behavioural therapy, referring children who need more help to the most appropriate service. It also offers consultation, teaching, training, staff support and group work such as mindfulness programmes to the wider school population.

CAMHS in Schools also provided training for the Stoke Special School Learning Trust, covering positive psychology and mindfulness, attachment and autism. Clinicians from the trust’s CAMHS referral hub have shared their practice and advice on how to make referrals.

What were the results?

CAMHS in Schools has had a positive impact on pupil behaviour and staff wellbeing: the referral rate from participating schools to the specialist CAMHS team fell 92% in two years. Staff training in emotional wellbeing has had a positive impact on classroom values, beliefs and routines: teachers now see themselves as part of the solution rather than relying on specialist services. Partnership working across health and education has improved relationships and is achieving better outcomes for children.

The Care Quality Commission commented on the service offered being outstanding in February 2017. It is also cited in the Positive Practice in Mental Health Collaborative’s directory.

Head teachers commented:
• “CAMHS in our school is a seamless service that meets the needs of pupils, families and staff.”
• “Consistency allows confidence in the systems that are in place.”
• “The CAMHS input into school has had a very positive impact on pupil behaviour and staff wellbeing; this is documented in the CAMHS annual report to the school.”

What were the learning points?

Stronger links are needed between schools and Tier 3 CAMHS clinicians, who are recommended to share care plans and risk assessments with school staff, and provide training to school staff.

Next steps and sustainability

A mental health and wellbeing strategy was recently launched across the schools that the team is involved with; the intention is that it will cover all schools in North Staffordshire.

The trust was recently awarded Lorenzo Digital Exemplar status as part of a project that will create a self-help portal accessible in schools, through which support and advice for children and young people can be enhanced through digital enablement.

Want to know more?

Julia Ford, CAMHS in Schools Lead, Julia.D.Ford@combined.nhs.uk

To see the other case studies in this series: visit the NHS Improvement website at: www.improvement.nhs.uk
“Mental health services have been at the vanguard of challenging traditional models of delivery based upon people who use services’ need, the learning from which should be seen as a valuable resource for other parts of NHS care provision”.

Adam Sewell-Jones, Executive Director of Improvement, NHS Improvement
Chapter 6

Improvement approaches

Experience of piecemeal, unstructured change has not built sustainable improvement capacity within the NHS. Many structured approaches or methodologies are available for those seeking to improve services and build an organisation’s improvement capacity for the long term. However, there is no one ‘right way’.

Choosing and applying an improvement approach is only one element in a strategy to continuously improve quality.

Reliance on a sound understanding of organisational resources and demands in the widest sense is a required baseline.

Current situation

Money and time are being widely invested in healthcare improvement methodologies. These are formal, structured means of co-ordinating improvement efforts to best effect. Batalden and Davidoff (2007) define improvement as:

“The combined and unceasing efforts of everyone — healthcare professionals, people who use services and their families, researchers, payers, planners and educators — to make the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development.”

(Batalden and Davidoff 2007, page 2)

Embracing improvement methodologies is currently central to NHS strategy, most notably in NHS England and NHS Improvement’s 2016 guidance to ‘local footprints’ on delivering the NHS Five Year Forward View for mental health. This includes encouragement to “embed improvement methodologies to drive achievement of better outcomes” (NHS 2016).

Urged to improve quality but with limited funds, many trusts are looking to improvement methodologies to balance these two pressures. Yet not everyone in healthcare is familiar with improvement methodologies and their background, why they are so relevant to healthcare or what methodologies there are to choose from. This chapter aims to shed light on those questions, building on the guidance in the national framework for improvement and leadership development, Developing People – Improving Care (NILD 2016).

This national framework provides guidance on how the central bodies will engage with and promote improvement. The model for mental health improvement complements the framework with practical examples from those at the start or further down the line on their journey of continuous improvement, such as the case studies at the end of this chapter.

In creating this resource, we have found we have a great deal of common experience. In particular, our experience shows that implementing an improvement methodology is not enough on its own to achieve the large-scale, sustainable change that ensures high quality care for people who use services and carers. Stepping back to see the wider picture has shown that improvement methodologies are just one ingredient in a recipe for continuous improvement aimed at achieving sustainable change; other ingredients or enablers are required to fulfil a trust’s improvement potential, many of them described in other chapters of this resource.

Lastly, individuals and teams in many trusts across the NHS may already be using some improvement tools but often in isolated pockets. Only a few trust boards have chosen and implemented a particular improvement methodology rigorously and systematically throughout their organisation, as part of a trust-wide programme of sustainable improvement. This chapter includes advice to trusts on how to choose and implement an improvement methodology, including how to develop a trust-wide improvement programme.
Current perspectives on improvement methodologies

What are improvement methodologies and how have they been used in mental health trusts?

Formal improvement methodologies in healthcare are structured, systematic and well-established tools and techniques for continually improving service quality. They are based on principles applied successfully in other industries, first manufacturing and then services, for almost 100 years and in healthcare for the past 25. They are distinct from other service-improving approaches in:

- Their engagement and ongoing involvement of people who use services, carers, staff at all levels and other key stakeholders, in identifying what needs to improve, proposing solutions, testing those solution and adapting them in the light of evidence of their impact.

- Their intelligent analysis of constantly monitored quality metrics, presented in formats that allow staff, people who use services, carers and other stakeholders to take practical improvement action.

Several providers, along with a number of high performing healthcare organisations worldwide, now use formal improvement methodologies across their organisations. High performing healthcare organisations have attributed their success to the continual use of a formal improvement methodology (as opposed to one being a ‘nice to have’ addition to ‘business as usual!’).

Adapting improvement methodologies to healthcare

Many may question the appropriateness of making links between manufacturing industry and healthcare. However, both aspire to reach the highest quality and to reduce cost. And, like other industries, healthcare involves many ‘process steps’ to reach an outcome, although these steps do not all directly add ‘value’ for the person using services. This means healthcare can learn much from manufacturing’s approach.

In 2002, Virginia Mason (a healthcare facility in Seattle, USA) developed the Virginia Mason Production System (VMPS) from the ‘Lean’ Toyota Production System (Kenney 2010). Following Lean principles, Virginia Mason was able to greatly improve the quality and safety of its services. This led to the creation of the Virginia Mason Institute, which helps healthcare organisations elsewhere to understand and apply Lean methods (VMI 2017).

The NHS Modernisation Agency’s approaches to service improvement in the later 1990s and beyond also incorporated key elements from Lean, added to Six Sigma, theory of constraints and other improvement approaches, with a focus on small-scale innovations and measurement to show evidence of impact (Rogers et al, BMJ 2004).

In England in 2006, the North East Strategic Health Authority created a programme bringing together healthcare organisations from the north east to learn about Lean from Virginia Mason. As in Seattle, this programme significantly improved services across the region.

Many of the organisations involved now support other organisations within the NHS, with those that have ‘walked the walk’ themselves guiding others in doing the same. Such sharing of experience and expertise developed within the NHS reduces the need to use external management consultancy, with its associated costs.

The Boston-based Institute for Healthcare Improvement (IHI) and its founder Don Berwick have also adapted quality management principles used in other industries to improve quality and safety in healthcare. Many in England have adopted IHI’s approach, which focuses on ‘projects with time-bound goals’ (Scoville and Little, IHI White Paper 2014).

Improvement methodologies adapted for UK mental health settings

Some of the approaches successfully adapted for UK mental health settings, both inpatient and community, are listed below. All these draw on one another, and no single one has necessarily proved superior to the rest. However, adopting a single approach to improvement and applying it consistently across an organisation is key. This in turn promotes consistency in leadership, especially the devolution of leadership throughout the organisation, which is critical to ensuring the best outcome. Improvement approaches used successfully in UK mental health settings include:

- Total quality management (TQM).
- The Model for Improvement (IHI-QI).
- Lean.
- Experience-based co-design (EBCD).
- Six Sigma.
- Theory of constraints (TOC).

‘The joy of quality improvement is the coming together, as equal partners, of people who use services and people who provide services. When quality improvement brings people together to make services better for people who use them, and work easier for staff, an energy and delight seems to happen that is almost magical to me.’

Ruth Briel, Senior Clinical Director, Tees, Esk and Wear Valleys NHS Foundation Trust
Components of quality-focused healthcare organisational Strategies

Quality is the focus of all these improvement approaches, as one would expect it to be in all healthcare organisational strategies. Juran’s well-known quality trilogy breaks down quality management into three management processes (see Figure 22).

Figure 22: The quality trilogy - adapted from Juran (1986)

**Quality Planning**

Quality planning will include:

i. Understanding local population needs for mental health services

There can be no single strategic model for the operation of mental health trusts that want to provide excellent services to every local population in England, because each local community’s mental health needs are different. Local needs are shaped by the population’s size, geography, social, cultural and age profiles, economics, history and recent changes, among other factors. The position of other local institutions also affects needs, in particular bodies involved in the care and protection of mentally ill people, such as local authorities, CCGs, housing and education services, the police and prison services and, of course, other health services.

To ensure success, mental health trusts must base their improvement programmes on a close and continuously updated understanding of their local community’s mental health needs, as well as the impact of physical health conditions on this. Public Health England (PHE) National Mental Health Intelligence Network (NMHN) has published a series of mental health data-profiling tools that make the essential yet complex task of understanding an area’s mental health needs quicker and easier. An excellent video demonstrating how to use the tools is also available.

These tools give access to relevant metrics collected across the country by national and local institutions for their particular areas, with a focus primarily on data from local authorities and CCGs, but also mental health trusts, acute trusts, and sustainability and transformation partnerships (STPs). As well as showing the nature of current and likely future needs for mental health services, they indicate how current service provision is meeting current need and can help understanding of where the gaps are. PHE also publishes a mental health and wellbeing knowledge guide that helps those planning mental health services to consider factors that affect mental health and wellbeing in their local area, and to identify some of the key data, information and knowledge they should acquire to build a picture of need.

ii. Understanding current level of performance

All trusts have performance reporting requirements, contractual and otherwise. However, quality improvement approaches cannot always gain traction on trusts’ existing performance metrics and ways they are expressed. Relying on historical data, which omits people who use services’ experience and clinical outcome measures in many areas, leaves large gaps in board members’ understanding of how well the ‘business’ of the trust is really operating. The huge volumes of quantitative information, often readily available in trusts yet difficult to interpret, can obscure the real quality issues.

In contrast, glimpses of these critical issues can be gained from information given in complaints and following Serious Incidents, surveys, and discussions with clinical staff and stakeholders of all kinds.

**Step 2: Develop an outline**

Based on the quantitative and qualitative information that senior leaders gather, they can develop an outline view on the quality priorities for the organisation for the coming three years, incorporating national direction and local obligations.

**Step 3: ‘Catch ball’**

In this step, senior leaders take the draft priorities back to the people in the organisation and its stakeholders and governors, offering them the opportunity to comment on the priorities and say how they believe the priorities can be delivered. This ‘listening’ promotes further engagement.

**Step 4: Finalising priorities**

The next step is to finalise the priorities and for the board to sign them off. By this stage, it is important that not just the ‘what’ but also the ‘how’ is agreed, with key milestones and metrics aligned to evidence progress. An improvement plan can then be developed to deliver these priorities.
Step 5: Check and review process

Once the board has set the priorities, related objectives and measures can be put in place across the organisation. For example, medical and other professional job plans should reflect these objectives, as should job plans for those in corporate functions.

A regular check and review mechanism should also be put in place. The purpose of check and review meetings are not to ‘blame’ or ‘scold’ people, but to hold them to account for what they have agreed to deliver and, crucially, to direct top-level help and support at removing barriers that cannot be dismantled at a lower level in the organisation.

Step 6: Repeat for next year…

Quality improvement

The eight steps in this process cover choosing and implementing an improvement methodology and a trust-wide improvement programme.

Improvement methodologies are invaluable tools for trusts whose primary strategic goal, shared by all the people working in them, is to ensure the provision of high quality services to the communities they serve. As noted previously, using a specific improvement methodology is not a strategy in itself: a chosen methodology is just one of the enablers of a planned quality improvement strategy, and needs to be aligned with other elements in that strategy. Many trusts start on their improvement journey with standalone projects based on an improvement methodology. However, as their journey gains momentum, they will generally need to link their various projects in a planned improvement programme, which is tied to the trust board’s priorities, developed through the process of quality planning described above.

“We are playing for high stakes. A good strategy should be the most natural thing in the world – it ought not to be a struggle to set a course of action and – as long as you are standing honestly in the right place, with the right attitude, with no baggage, and with the right skills to lead with vision and humility – there is a lot that can be done”  
(Dalton 2016 pages 249-250)

Step 1: Choosing a methodology

We outlined above some of the improvement methodologies used successfully in mental health services. Each trust will want to choose the methodology most appropriate to local mental health needs and its improvement priorities. In addition to the comparative review by Andrea (2011), Slack and Lewis (2015) offer a helpful framework for distinguishing between some of the methodologies previously described, according to whether radical or incremental change is appropriate, and whether the approach emphasises what changes are needed or how changes should be made (see Figure 23).

Figure 23: Framework for choosing a methodology (adapted from Slack and Lewis 2015:112)

Engaging the whole organisation and people who use services and carers in deciding on an improvement methodology is likely to increase its chances of success. Trust leaders can ask all stakeholders the following questions to help choose their improvement approach (adapted from Slack and Lewis 2015):

• Does it align with the strategy of the organisation?
• How urgent and large-scale is the need for change?
• Of the alternatives, which approach do people who use services, families and carers see as adding most value to them?
• What has been the experience of similar organisations that have adopted the methodology?
• What resources are required to communicate the methodology and train and develop people to carry it out?
• Are all the necessary resources available?
• Does it fit with local partners’ approaches to improvement?

Step 2: Demonstrating trust board leadership

For an improvement culture to take hold in an organisation, people need to see their leaders’ commitment to it. Having executive leadership as vocal and visible champions of continuous improvement, whatever the methodology chosen, is important. The chief executive must cultivate and support an environment where it is permissible to fail, and encourage the kind of managed risk-taking that achieves optimal quality and safe services for people who use services, families and carers. Trust board members should:

• choose an improvement methodology supported by the organisation’s staff, people who use services and carers.
• understand how the methodology works, i.e. non-executive directors should see it in action in other organisations and understand its principles
• fund the chosen methodology and the improvement programme, and show commitment alongside a willingness to adapt
• explicitly choose ways to show board support for the improvement programme and the methodology, eg non-executives’ visits to see improvement in action within their own trust, with visible celebrations of success
• learn how to do better from failures.

“Empowering all staff to lead continuous improvement is a key leadership role as chief executive as I see it, as well as supporting staff when the going gets tough; this is exactly when as chief executive you need to hold your nerve and encourage staff to keep focused on being the very best they can be”

John Lawlor, Northumberland, Tyne and Wear NHS Foundation Trust
Step 3: Attracting clinical leaders

Clinical leadership is key to embedding improvement practices across a trust. When clinical leaders commit serious time and effort to the improvement programme, they show how much they believe in its importance, giving it further credibility. Clinical leadership is also needed to align the work of improvement to people who use services’ needs, while ensuring it reflects clinical best practice.

Step 4: Managing improvement programmes and projects

Jones and Woodhead (2015) suggest having a central improvement team to support improvement across the organisation, with the skills to build capacity in the chosen methodology organisation-wide. An improvement team can be created from an existing clinical audit team or a programme management office (PMO). However, the central improvement team is not the only team involved at the outset: improvement is for everyone at all levels of the organisation. It is vital that people who use services, families and carers are part of the improvement journey too (see Chapter 1).

Indeed, most trusts in this group have introduced a formal improvement methodology on a particular, strategically important and measurable piece of work across their organisation and involving people who use services and carers. While staff in all teams, not just the dedicated improvement team, should be empowered to identify issues at work that they feel need improvement, staff, people who use services and carers will need support in learning and using appropriate improvement tools and metrics, which a central improvement team can organise. Over time, at a trust on an improvement journey, a number of improvement activities will be taking place simultaneously and crossing service lines, lending themselves to more centralised programme management approaches. These ‘hold everything together’ by making sure all the activities are complementary and aligned with the organisation’s strategy.

Improvement and programme management skills are not necessarily something to expect from every individual: if the scale of improvement is large, it may be better to establish improvement and programme management teams as separate but collaborating functions.

Step 5: Training people in improvement methodologies

When choosing an improvement methodology, trusts need to consider how expertise, capacity and capability in the chosen methodology will be built across the organisation. They should prioritise developing and carrying out appropriate training in that methodology, offering different levels of training appropriate to the organisation’s goals and to each individual. This needs to be done quickly and on a large scale, involving clinicians of all disciplines, experts by experience and corporate staff. Senior executives and clinical leaders will also undertake training so they can sponsor and lead improvement activity, and also provide challenge, on the basis of sound knowledge.

Sources of training in improvement methodology available to trusts are being expanded in line with the NHS national strategy for leadership and development improvement (NHS Improvement 2016). Many business schools familiar with improvement methodologies are located on the same campus as medical and nursing schools in universities, yet they are rarely expected to collaborate. Don Berwick (former President and Chief Executive of IHI) suggests this is a missed opportunity. While there are many sources of training available, those trusts with established links to local universities may wish to explore the possibility of further links with business schools that have expertise in improvement methodologies.

Some trusts have chosen to engage with an external strategic partner, such as IHI or VMI. However, at this stage of the development of improvement approaches in England, an external partner is no longer essential, as many experienced trusts can offer training to other trusts at significantly lower costs.

Step 6: Sustaining momentum

Improvement is a marathon not a sprint. Embedding improvement across an organisation on a large scale entails just about everyone changing what they do from day to day, which takes a long time. Organisations can find it hard to sustain momentum when, for example, a key executive leaves, the organisation merges with another, or it has to focus all its resources on responding to a poor regulatory report.

Some top tips for sustaining momentum are:

- remember that the purpose of the work is to improve services for your customers: that is, people who use services, their families and carers; involving them at strategic and leadership levels across the organisation keeps this focus in mind (see Chapter 1)
- demonstrate and celebrate success at appropriate moments, so everyone feels they are part of something important and their contribution is recognised
- have change agents and leaders explain and reiterate why change is needed for improvement
- translate strategic goals into action
- always put ‘principles before personalities’: do the job at hand regardless of politics (AA, 1939)
- learn from when things do not go so well, a powerful driver of future improvement
- make sure the systems for measuring and analysing quality data are fit for purpose and continuously driving improvement activity.

Step 7: Measuring for improvement

Many who have embedded an improvement culture across an organisation have needed to change the way they use measurement and data (see Chapter 3). For example, they have had to streamline and focus key performance data used across the organisation on measures of people who use services and carer experience and outcomes. As described earlier, measures linked to improvement activity need to be reviewed at trust board level to help embed the improvement activity.

Trusts are likely to face significant training needs in the use of data as many clinical staff are not accustomed to using measurement for improvement and it is unlikely to have been part of their training. Visualisation of the data often helps, as does an initial focus on a small number of measures that are clearly related to people who use services’ care and experience, and captured intuitively by clinical staff. In addition, measuring for improvement focuses more on understanding variation rather than the point data used to provide assurance. Improvement measures tend to look more at trends, using run charts or statistical process control charts, than the red-amber-green rating tools more commonly used across the NHS. This difference is widely understood and is acknowledged in the national NHS strategy for leadership and improvement (NHS Improvement 2016).

Within an improvement culture, measures should aim to inform changes in real time rather than illuminate retrospectively what has happened over the past month or quarter. For example, teams should review smaller amounts of data on a daily or weekly basis, and make small-scale changes frequently to achieve improvements, using plan-do-study-act cycles (a key Lean tool).
Step 8: Scaling up and spreading ideas

Organisations need to ensure that improvement methodologies are used consistently to scale up improved working methods and spread good practice (See Table 2).

Table 2: Scaling up and spreading ideas

<table>
<thead>
<tr>
<th>Scale up</th>
<th>Spread</th>
</tr>
</thead>
<tbody>
<tr>
<td>...is the process by which new working methods are tested by a number of different teams to increase the degree of belief that they will work in multiple settings, while offering an additional opportunity to overcome new issues that may arise in a process.</td>
<td>...is when best practice is disseminated consistently and reliably across appropriate areas and in healthcare, involves the implementation of recognised interventions in the appropriate setting.</td>
</tr>
</tbody>
</table>

Among the actions that trusts can take to promote scale-up and spread are:

- involving a range of people in both implementation and dissemination of ideas, including clinical and managerial leaders
- viewing staff and stakeholders as active change agents, not passive recipients
- emphasising how initiatives address priorities
- targeting messages differently for difference audiences
- providing support and training to help staff and stakeholders understand and implement change

- planning dissemination strategies from the outset, and dedicating time and funds to dissemination
- making use of a wide range of dissemination channels such as social media, opinion leaders and existing professional networks
- evaluating the success of the improvement approaches, and also the extent of uptake and dissemination within teams and the organisation. Changes that are measured tend to get more emphasis, helping to make them priorities.

Quality control

In trusts implementing trust-wide quality improvement strategies with a chosen methodology, eventually new ways of working that systematically deliver continuous improvements in quality will become integrated into their everyday ways of working. In other words, improvement activity becomes a sustained norm. Quality control ensures better ways of working are sustained.

Each methodology comes with its own view of how quality should be controlled, but they share these common themes on managing this process:

- Controlling quality relies on standardised approaches to continuously improving quality in specific processes and systems being designed into those processes or systems. Each approach will include defined steps that consistently deliver defined requirements, clearly documented in standard policies and procedures or work practices.
- Training for staff in these standardised approaches should describe how quality in that process is understood and measured, including how relevant outcomes and goals are measured. Training should never be static, as processes will evolve and improve day by day.
- Quality control should be devolved to the staff and stakeholders involved in each process, in contrast to the traditional hierarchical system of quality control still in place in many NHS trusts.

These themes are described by several authors, including Taninecz (2013) and Murli (2013). Both describe ways to combat the often observed ‘plateau’ effect, where initial enthusiasm for improvement is not sustained in the long term, resulting in a return to ‘fire-fighting’. The way to avoid this plateau is to give leaders their own ‘standard work’. This emphasises their role in building problem-solving and innovation capacity among their workforce and coaching individuals in delivering quality. To do this, management leaders must be present every day on the ‘gemba’ (or shop floor). This entails a significant change for the many trusts that today include only clinical staff in daily ‘huddles’ or multidisciplinary teams discussing the care of individual people who use services, rather than all the staff who play a part in the performance of the system or service as a whole.

Having leaders at all levels who model appropriate behaviour, eager to learn rather than blame, will over time shape a devolved quality improvement and control culture across the NHS. In contrast, being removed from the ‘gemba’, both physically and in terms of understanding what is going on there day by day, leaves leaders and managers unable to embed an improvement philosophy and practice. Their decisions, based on second or third-hand information, will necessarily be poorly informed and they will find it increasingly difficult to relate the performance of the ‘gemba’ to the trust’s strategic objectives overall.

Summary

Organisations embarking on an improvement journey need to choose an improvement approach or methodology and stick to it. Relevant metrics and evaluation methods are built into each approach. All the approaches share a common provenance: what matters is that the chosen approach fits the organisation.
References

Alcoholics Anonymous (1946) Twelve points to assure our future. The Grapevine.


www.virginiamasoninstitute.org/ (accessed December 2017)


Useful resources:

King’s Fund (2017) Quality improvement in mental health www.kingsfund.org.uk/publications/quality-improvement-mental-health

Case study 36 - Improvement approaches

**Becoming a quality improvement focused organisation**

Lancashire Care NHS Foundation Trust

**What was the aim?**

To make quality the trust’s leading strategic priority: “we will be a national leader in quality improvement, “always being the best that we can be”.

**What was the solution?**

The trust used the 4D ‘appreciative enquiry’ approach to develop a vision for the organisation. 4D is based on:

- discovery – identifying and appreciating what works
- dream – imagining what might be
- design – developing systems and structures, and leveraging the best of what was and what might be
- destiny – implementing or delivering the proposed design.

The trust involved more than 1,000 people, including people who use services and staff, to set the direction of its single quality-led strategy. It also worked with the Advancing Quality Alliance (AQuA) and the Health Foundation’s quality improvement fellow, Dr Peter Chamberlain, to pioneer the ‘Building Blocks Framework’. This identifies key areas for an organisation wishing to take a systematic approach to QI.

**What were the learning points?**

The most important factors in developing and implementing the strategy were:

- executive and board support
- QI expertise
- QI leaders’ infectious enthusiasm
- working at team level to influence up, and at board level to cascade down
- creating opportunities to showcase QI
- engaging with people who can help – eg national programme leads, AQuA
- taking a systematic approach to QI
- co-designing QI projects with people who use services, their families, carers and staff.

**Want to know more?**

Dee Roach, Director of Nursing and Quality,
Dee.roach@lancashirecare.nhs.uk

---

Case study 37 - Improvement approaches

**Developing a supportive observation recording tool for a forensic mental health service**

Mersey Care NHS Foundation Trust

**What was the problem?**

People who use services’ experience of intensive observation is not always positive: the practice is highly restrictive, not well understood and little empirical evidence exists to guide medical and nursing staff. The trust wanted to develop best practice in supportive observation (SO) and reduce its use. In its high secure service, eight out of the 56 people who use services subject to constant observation accounted for 66% of SO hours during 12 months. It became apparent from scrutinising paper records of observations that nurses used them as proof of observation, not to capture clinically significant information that could be used in decision-making and help reduce use of observation.

**What was the solution?**

A literature review failed to provide guidance on useful information to capture in observation records, so the trust used the Delphi method to question experts and clinical staff nationally. This produced 51 items that experts agreed were diagnostic, observational and capable of being recorded in just one or two observations. These were grouped into themes that could be used in decision-making and help reduce use of observation. The trust involved more than 1,000 people, including people who use services and staff, to design or deliver the tool.

**What were the learning points?**

- Staff need to be fully informed, engaged and given a clear rationale for changing a historic practice.
- Teams should use information obtained by observing staff to inform discussions and improve clinical decision-making.

**Next steps**

If the use of hand-held devices succeeds, the trust will implement them across its secure division.

**Want to know more?**

Alison Baker, Senior Clinical Nurse,
Alison.baker@merseycare.nhs.uk

---

Want to know more?

Dee Roach, Director of Nursing and Quality,
Dee.roach@lancashirecare.nhs.uk
Case study 38 - Improvement approaches

Reducing self-harm on inpatient wards

Mersey Care NHS Foundation Trust

What was the problem?

Incidents of self-harm on inpatient wards were frequent and part of a five-year upward trend.

What was the solution?

The trust’s Partnership for Patient Protection self-harm pilot project used analytics and design thinking methodology to manage risk and improve quality. It was run in collaboration with The Risk Authority Stanford, a consulting company based at Stanford University Medical Network. The methodology comprises three phases: inspiration, forming ideas and taking action. It emphasises the role of staff, people who use services and other stakeholders, and uses rapid iterative prototyping. Semi-structured interviews were undertaken with staff and people who use services; multidisciplinary team meetings and handovers were observed, and care plans reviewed. Ward teams sense-checked the findings to identify potential areas for action, and agreed a target reduction in incidents of 20% within a year.

Teams then generated interventions, assessing each for feasibility and likely impact before taking forward their preferred options through a series of increasingly sophisticated prototypes. By prototyping, testing and modifying, failure and learning take place at the start rather than after investing significant time and resources. Chosen interventions included:

- training in preventing self-harm
- reflective practice to enhance understanding of self-harming behaviour and inform nursing care
- supporting psychology-led practice and alternatives to self-harm
- engaging people who use services more consistently in meaningful activities
- using people who use services-generated information effectively.

What were the results?

Interventions were launched across pilot wards during late 2016. By late 2017 self-harm incidents had reduced by 43%. Staff have embraced the change: one remarked that self-harm had “reduced dramatically on here since the project began. We keep reminding people of what it was like beforehand to keep them on board with the new way of working”.

Next steps

When the pilot phase finishes the trust will consider implementing a definitive set of interventions in all relevant wards.

Want to know more?

Tim Riding, Associate Director, Tim.riding@merseycare.nhs.uk

Case study 39 - Improvement approaches

Using Lean methodology to improve quality

Tees, Esk and Wear Valleys NHS Foundation Trust

What was the aim?

In 2007 a group of senior clinicians and leaders became convinced that using Lean methodology could benefit people who use services, staff and the community. With the chief executive’s support, they set out to embed quality improvement throughout the organisation.

What was the solution?

The trust developed a compact with staff ‘The gives and the gets’. This describes what staff can expect from the trust – for example, training opportunities and a policy of no redundancies arising from quality improvement. It also describes what the trust can expect from staff: their willingness to support and contribute to quality improvement, especially testing new ideas.

A kaizen promotion office delivers training, supports strategically important quality improvement work and quality assures its delivery. The training includes learning about plan-do-study-act cycles, Lean’s key principles and tools, and measuring for improvement.

The trust expects leaders at all levels to be involved in and lead quality improvement. The board supports quality improvement by asking about it when visiting teams, through the trust’s ‘Making a difference’ awards and by showcasing successes in the trust newsletter.

Want to know more?

Ruth Briel, Senior Clinical Director, ruth.briel@nhs.net
Street triage
Northumberland, Tyne and Wear NHS Foundation Trust

What was the problem?
People detained under Section 136 of the Mental Health Act should be taken to a ‘place of safety’ for a psychiatric assessment. Use of this power is increasing but often inappropriately, to get people seen and assessed more quickly. They may be taken to a police station, which can prove a prolonged and distressing experience. The trust wanted to fulfil its commitment to the Crisis Care Concordat, 7 a principle of which is that health services, social care and the police should work together to manage people in a mental health crisis.

What was the solution?
A street triage team responds to calls alongside the police, assessing a person’s mental state by face-to-face contact and advising whether detention under the Mental Health Act is necessary. If not, the team provides access to community-based mental health and other services. If the person needs to be detained in a place of safety, the team ensures staff are aware of their health needs. It also advises and supports criminal justice staff, checking whether someone is known to mental health services and signposting other services. The team completes follow-up work to promote mental wellbeing and encourage access to appropriate services and support.

The street triage service is focused on the start of the criminal justice pathway, emphasising prompt response to incidents. It promotes acceptance of those who may have offended, or are likely to offend or reoffend, to enable them to live a more productive, positive and fulfilling life.

What were the results?
The number of police detentions under the Mental Health Act more than halved, improving outcomes for individuals and potentially saving large trusts £1 million a year. A study 8 of the trust’s street triage service found the annual rate of S136 detentions fell 56%. Data from Sunderland indicated a 78% fall and a significant reduction in adult admissions originating from S136 detentions. Short-term detentions (sections 4 and 136) fell by 72%; medium-term to long-term detentions (sections 2 and 3) fell by 21%.

Want to know more?
Claire Andre, Clinical Police Liaison Lead, claire.andre@ntw.nhs.uk
1 www.crisiscareconcordat.org.uk 4 www.bmjopen.bmj.com

Case Study 41 - Improvement approaches
Quality improvement accelerator for care planning
North East London NHS Foundation Trust

What was the problem?
Care planning has historically been an area where there have been inconsistencies across teams and in the involvement of people who use services as highlighted in the 2016 CQC inspection.

What was the solution?
NELFT established a quality improvement programme and decided that running an accelerated collaborative, focused on care planning would be the best approach to achieving sustained change. They set up 6 fortnightly learning sets where identified leads from each team learned QI methodology and applied it to developing a PDSA cycle to test with their team. Virtual QI clinics were run between learning sets to offer additional support.

They also used the themes from the CQC recommendations to develop the measurement tool. They fell under the following headings:
- consent and capacity
- social situation
- collaborative
- risk assessment
- recovery focused

Teams completed the baseline audit and then carried out their PDSA cycles to implement and measure change.

What were the challenges?
Engagement and time was the biggest issue raised by staff involved in the collaborative and the QI team have been flagging any challenges centrally and providing support.

What were the results?
Of the teams who have completed a baseline and re-audit NELFT have seen their compliance rate increase from 56% to 76%.

Consent and capacity saw the biggest improvement from 56% to 86%.

Risk assessment was the area NELFT felt was highest priority – they have seen improvement of 19% in this area. Staff have reported benefits to team work, job satisfaction and a more positive view of working at NELFT. A formal evaluation of the facilitator’s cohort showed that 100% felt more positive about working at NELFT, 70% a lot more positive.

What were the learning points?
Some teams felt time to complete all the tasks in their PDSAs was a challenge, however the results show that where teams do fully engage, this approach is successful. As well as collating the results for the QIAC cohorts as a whole, each individual team is now also inputting their data onto our QI system so that they ‘own’ the data and will be able to see progress via run charts.

Next steps and sustainability
NELFT have run five cohorts of the QIAC to continue rolling out the improvements across teams. They are now looking at how they can use the accelerated collaborative approach to tackle other areas of improvement across the Trust.

Want to know more?
Laura Stuart-Neil, Lead for Quality Improvement laura.stuart-neil@nelft.nhs.uk
Red and green bed days – optimising people who use services flow

Cheshire and Wirral Partnership NHS Foundation Trust

What was the aim?
The trust wanted to optimise people who use services flow by identifying time wasted during a person who uses services journey and reducing avoidable internal and external delays.

What was the solution?
Piloting a daily multi-disciplinary ward round to rapidly assess the progress of each person who uses services and identify any internal or external barriers or delays to their care, treatment or discharge. People who use services experiencing such delays were classified as ‘red’, other people who use services were ‘green’. Action was taken to tackle the issues delaying those in the red category progress and to escalate issues where necessary.

The trust piloted the ‘red and green bed days’ process in a single ward over three months. The full multi-disciplinary assessment team included a consultant, registrar and advanced nurse practitioner as well as nursing, pharmacy, occupational therapy and home treatment staff. Quality improvement methodology was used throughout the project to improve the trust’s ability to identify and reduce barriers to people who use services flow.

What were the challenges?
- Working in a new way at the same time as dealing with ever-increasing pressures on people who use services beds.
- Using a spreadsheet as the main project tool rather than a more interactive solution. Fortunately, this challenge was encountered during the pilot and better solutions have been identified for spreading the innovation to other wards.

What were the results?
The pilot ward reduced its proportion of those in a red category from 56% at the start of the pilot to 33% at week six. The week six level has since been sustained. The average length of stay was reduced from 20 days at week five of the pilot to 9.6 days at week nine. Again, the week nine average has since been sustained.

What were the learning points?
- The need to develop a standard operating procedure to help spread the innovation to other wards.
- The importance of buy-in and input from the full multi-disciplinary team at the daily ward rounds.
- The importance of using appropriate statistical processes where data is volatile. For example, length of stay was calculated using a mean moving range. This enabled special cause variation to be identified.

Next steps
Data will continue to be gathered and analysed to validate the impact of the project on length of stay over a longer period and to identify whether this continues to be sustained. In phase 2 of the project, which began in January 2018, the innovation is being rolled out on another ward. Further next steps include scoping the use of interactive white boards, identifying lead practitioners at ward level, and using an app to simplify data input.

Want to know more?
Lauren Connah, Service Improvement Manager, lauren.connah@cwp.nhs.uk

To see the other case studies in this series, visit the NHS Improvement website at: www.improvement.nhs.uk
“Underpinning a culture of safety are good leadership at all levels, strong governance within the service and a culture of openness and transparency”

Care Quality Commission (2017)
Chapter 7

Safety, clinical audit and clinical governance during major change

Safety is a powerful driver of improvement in any healthcare organisation.

Any change is risky and it is necessary to keep services safe while implementing change.

Good governance and audit are essential and the interface with culture cannot be underestimated.

Current situation

The main duty of all NHS service providers is to provide high quality care. Safety of people who use services is one of the main elements of quality, alongside clinical effectiveness and the experience of the people who use care. Specifically, service providers are required to avoid causing:

“... unintended or unexpected harm to people during the provision of healthcare. Patients should be treated in a safe environment and protected from avoidable harm” (NHS Improvement 2017).

Safety of people who use services is currently a pressing national concern. The level of ambition is high: the Secretary of State for Health aspires to provide effective and safe care.

Clinical audit forms the backbone of clinical governance systems in most health service providers today. The main tasks of clinical audit procedures are to establish whether services are being reliably delivered to the required quality standard and, if not, to help improve them. Successful clinical audits collect the relevant data, analyse and understand it, and use it to inform improvement. So they are similar in principle to the structured approaches to quality improvement in Chapter 6, notably the Juran quality management model.

However, there are differences. For instance, clinical audits are often carried out by specialised teams rather than those providing services day to day who are involved in structured improvement approaches. And improvement approaches go beyond making sure services comply with set standards. They build the capability of everyone in an organisation to understand precisely how the way they do their work collectively affects quality, so together they can take actions to improve quality with no upper limit. From this perspective, improvement approaches can be viewed as complementing clinical audit procedures, and in some trusts the two are beginning to merge.

That said, introducing a systematic, devolved approach to improvement can place pressure on existing governance systems and disrupt lines of accountability. In response, trusts need to adapt their audit and quality control processes in a planned fashion over the course of a trust-wide programme to create capacity for improvement.

National initiatives for the safety of people who use services

NHS Improvement provides national leadership for the safety of people who use services across the NHS. From this organisation’s perspective, the safety of people who use services is ensured by an NHS:

- that openly and transparently identifies and acts on risks to people who use services
- that demonstrates a just culture
- where the whole system works to reduce incidents that threaten the safety of people who use services and individuals are not inappropriately blamed
- where there is openness with people who use services, carers and families when things go wrong
- where staff, people who use services, carers and families are empowered to identify where change is needed and are supported to act
- that recognises where co-ordinated and systemic action is needed to keep people who use services safe.

Specific national initiatives promoting the safety of people who use services include:

Sign up to Safety (2014)

Launched by the Secretary of State, the Sign up to Safety campaign was devised to “bring organisations together behind a common purpose” (NHS England 2017). It involves more than 500 organisations from the NHS and other sectors.

Duty of candour (2014)

This duty gives health providers a legal responsibility to “inform and apologise to the patient if there have been mistakes in their care that have led to significant harm” (NHS Litigation Authority, now NHS Resolution, 2017).

The Parliamentary and Health Service Ombudsman

(PHSO) makes final decisions on complaints that have not been resolved by the NHS in England and UK government departments, and some other UK public organisations. PHSO is independent of Government and the NHS. PHSO looks into complaints where an individual believes there has been injustice or hardship because an organisation has not acted properly or fairly, or has provided a poor service and not put things right. People normally have to complain to the organisation first so it has a chance to put things right. If an individual believes there is still a dispute about the complaint after an organisation has responded, they can ask PHSO to look into the complaint. PHSO share findings from its casework with Parliament to help it hold organisations that provide public services to account, and it shares these findings more widely to help others drive improvements in public services.

The findings and recommendations from PHSO investigation reports provide an opportunity for NHS trusts to become learning organisations, by drawing the lessons where things have gone wrong, as well as working towards building trust with people who use services, such as Maintaining momentum: driving improvements in mental health care (2018).

www.ombudsman.org.uk
Freedom to speak up: whistleblowing policy for the NHS (2016)

Produced for the NHS by NHS Improvement on the recommendation of Sir Robert Francis QC, this policy supports the NHS to develop a more open culture that enables staff to raise concerns or issues relating to the care of people who use services, quality or safety. The areas covered include:

- unsafe care of those who use services
- unsafe working conditions
- inadequate induction or training for staff
- lack of, or poor, response to a reported safety incident relating to people who use services
- suspicions of fraud (which can also be reported to NHS Improvement’s local counter-fraud team)
- a bullying culture (across a team or organisation rather than individual instances of bullying)

Carter Review (2016)

Lord Carter was asked to review productivity and performance in English acute hospitals by Secretary of State Jeremy Hunt, as part of his aim to make the NHS the safest and most efficient healthcare system in the world. The review found examples of trusts that “had clearly got a stronger grip on the management of their resources than their peers”. A number of these were able to achieve “both high quality CQC ratings and [high efficiency] scores, indicating that high quality care and efficient care are not mutually exclusive” (Carter 2016, page 57). Lord Carter’s review also looked at healthcare systems abroad, including the US, Germany, Australia, Italy and France, where hospitals have a greater focus on efficiency because they have established the clear link between efficiency and care of people who use services (Department of Health 2016).

Governance in healthcare organisations

The boards of provider organisations are responsible for all aspects of leadership, direction and control of their organisations. They are expected to carry out this responsibility effectively, and demonstrate they have done so through measurable outcomes that build the confidence of people who use services, public and stakeholder confidence that their trusts are providing high quality, sustainable care.

Trusts operate in increasingly challenging environments, as recognised in the national framework for action on improvement and leadership development in NHS-funded services (NILD 2016). The challenges they face require their leaders to change how they equip and encourage people at all levels to continuously improve local health and care systems and gain pride and joy from their work.

Robust governance processes should give the leaders of organisations, those who work in and those who regulate them confidence about future capability to maintain and continuously improve the services the organisations provide. Effective governance systems give early visibility of risks that may compromise individual care, wider services or sustainable systems as well as insight into how to manage such risks.

Robust governance and effective, compassionate leadership are important drivers of improvement in quality of care. CQC has found effective leadership and clear, embedded governance systems to be key drivers of improved ratings (CQC 2017). By the same token, weak governance can have a detrimental effect on care quality (Francis 2013) and is among the main contributors to inadequate CQC ratings (CQC 2017).

Providers that have clear systems and governance enable learning and improvement from safety incidents. They encourage staff to raise concerns. They also allow staff to initiate innovation. Governance structures that enable local decision-making in this way form one of the main building blocks of an overall culture of continuous improvement (NILD 2016).

In-depth and regular reviews of leadership and governance are good practice across all industries (NHS Improvement 2017).

Current thinking

On clinical governance

The Department of Health and Social Care (previously Department of Health) describes clinical governance as:

“The system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish”


After the Department of Health and Social Care first used this definition in its 1999 circular, Clinical governance: quality in the new NHS, much work was done to specify the elements of a clinical governance system that could both assure quality and improve it. The results, known as the seven pillars of clinical governance, are:

- people who use services, carer and public involvement
- clinical effectiveness
- clinical audit
- risk management
- training and personal/professional development
- use of information
- staffing and staff management.

On clinical audit as a tool of governance

Clinical audits have two aims: to interrogate services to identify where they are meeting, exceeding or may have fallen below required standards; and to enable services to plan and manage improvement. They therefore include cycles of re-audit to check that planned improvements are taking place. To achieve those two aims, clinical audits and re-audits need to collect data that measure what truly matters to the delivery of high quality care and the effectiveness of care pathways.

“To ensure that there is capacity for safety improvement, audit data should be carefully interpreted, and preferably triangulated and analysed alongside other relevant data.”

David Wood, Cheshire and Winal Partnership NHS Foundation Trust

Clinical audits should give confidence to all a trust’s stakeholders that it has ways to monitor the care of people who use services and make a positive difference by flagging shortfalls in care delivery that may compromise safety of people who use services. Clinical audit also enables comparison with national standards, which are set on the basis of what is good for care for people who use services. Audits allow such comparisons to be made openly and transparently, as well as providing information to the public.

Routine audit information may need to be augmented by additional audits concerning particular issues. For example, enquires into Serious Incidents usually include an audit of relevant care and service parameters and other factors so that lessons can be learned from the incident and disseminated for wider improvement. Ideally, such audits should reveal any areas of vulnerability that may compromise required standards of safety. Strengthening these areas should reduce risks to safety and the chance of a similar Serious Incident recurring. Such one-off audits following Serious Incidents require a deeper level of interrogation and scrutiny than is needed for regular, routine audits.
The pros and cons of clinical audit

As a tool for measuring care quality, clinical auditing is a sound methodology but has limitations (Berk 2003). For instance, an audit may show delays in clinical responses and long waiting times for people needing to use services and this data may give rise to concern that harm will come to those unable to access timely care. However, audits do not test the statistical significance of correlations. And while there may be a correlation between poor outcomes and long waiting times, the latter may not be the only factor behind poor outcomes that needs addressing. On the other hand, it is often necessary and sensible to set standards of care on the basis that certain practices are self-evidently poor, without statistically robust evidence. It is reasonable to proceed on this basis to improve clinical care (although it may be difficult to win some arguments in this way).

Much of the literature suggests that audits tend to prioritise measures indicating high risk, high volume or high cost problems, which in turn focus attention on specific points of care processes. But focusing on compliance with a narrow set of standards and targets and specific points in care processes risks losing the broader understanding of how processes work from end to end that is the starting point of continuous improvement. In addition, as Taylor and Jones (2006) note, “few audit systems have been developed to characterize the complex outcomes of individuals in residential mental health care settings.” (page 229), and this criticism may well be justifiably levelled at other services too.

Moreover, anecdotal evidence indicates that care teams often perceive audit to be ‘owned’ outside the team; that it is being done “to” them, and that they are being audited, often against trust-wide standards that do not reflect the particular, local problems facing the care team. Used in isolation, audits can lower staff morale by spotlighting failures without giving staff the tools to succeed. In addition, by aiming no higher than compliance with a set standard, clinical audits can limit the potential for improvement.

Convergence between clinical audit and improvement approaches

The two aims of clinical audits – to identify where services are meeting, exceeding or may have fallen below required standards, and to enable services to plan and manage improvement – are similar in principle to the aims of the improvement methodologies described in Chapter 6, in particular the Juran model of quality improvement or Juran trilogy. This is a widely recognised approach for sustainably assuring, maintaining and improving quality, used by organisations in many sectors and increasingly in healthcare. According to the model, an organisation needs three processes to manage quality: quality planning, quality control, and quality improvement.

Successful improvements in service quality depend on identifying metrics that provide a true and meaningful overview of the way a service currently operates and designing into the improved service the routine collection of data that accurately reflects how well and safely it is working. The metrics routinely collected need to be readily understandable and meaningful to the staff who use them daily to deliver the best care possible, by identifying stress points from the data, taking effective action and improving safe practice.

The Healthcare Quality Improvement Partnership (HQIP) is the national body responsible for the National Clinical Audit and Patient Outcomes Programme in England. HQIP reflects the better understanding now among some care providers of the relationship between clinical audit and service improvement. It notes that some hospitals now structurally align their service improvement and clinical audit functions (HQIP 2016). Professor Don Berwick has also recommended that people in healthcare organisations should be trained in improvement methodology (Berwick 2013).

“Safety is a continually emerging property, and the battle for safety is never ‘won’; rather, it is always in progress.”

Don Berwick, Emeritus and Senior Fellow, Institute for Healthcare Improvement

Maintaining safety through audit and quality control processes while creating capacity for improvement

Maintaining core service delivery while building the capacity for continually improving services can be a major challenge for any organisation, and especially where resources are scare.

Standard audit processes need to be kept to assure continued quality control alongside planning for continuous improvement. But, as noted above, work to build continuous improvement capacity starts with collecting accurate and robust baseline data showing how current pathways and processes work and measuring change against this baseline. To collect meaningful data, understanding the true value and effectiveness of each element in a pathway as well as their interdependences is critical. Gaining this understanding involves extra work and resources.

For instance, it is important to fully understand the skills of staff and how they are deployed, when and where. This entails precise data collection and analysis, often well beyond what is routinely collected in trusts. This work has resource implications. To illustrate, if workshops are used to gain this understanding, they will take up the time of skilled staff whose first priority is to continue to deliver their core function of directly providing services. So it takes careful planning to ensure care continues to be offered without compromising safety at the same time as trusts build their improvement capacity.

‘First do no harm’ is the imperative guiding all health services. Different organisations use different approaches to understand the full impact on people who use services of their service delivery. But the main plank for all is clinical governance, which is in constant need of strengthening.

Health services taking a systematic approach to improvement on a large scale can find maintaining safety and good governance throughout the process a particular challenge. Both must be carefully planned for services to pass through the transition safely and effectively and reach a new improved service. Both must be carefully planned for services to pass through the transition safely and effectively and reach a new improved service. Both must be carefully planned for services to pass through the transition safely and effectively and reach a new improved service. Both must be carefully planned for services to pass through the transition safely and effectively and reach a new improved service. Both must be carefully planned for services to pass through the transition safely and effectively and reach a new improved service. Both must be carefully planned for services to pass through the transition safely and effectively and reach a new improved service. Both must be carefully planned for services to pass through the transition safely and effectively and reach a new improved service. Both must be carefully planned for services to pass through the transition safely and effectively and reach a new improved service. Both must be carefully planned for services to pass through the transition safely and effectively and reach a new improved service. Both must be carefully planned for services to pass through the transition safely and effectively and reach a new improved service. Both must be carefully planned for services to pass through the transition safely and effectively and reach a new improved service. Both must be carefully planned for services to pass through the transition safely and effectively and reach a new improved service. Both must be carefully planned for services to pass through the transition safely and effectively and reach a new improved service. Both must be carefully planned for services to pass through the transition safely and effectively and reach a new improved service.
NHS Improvement’s Patient Safety Team

The Patient Safety Team in NHS Improvement provides national leadership for safety of people who use services across all healthcare sectors and performs two key statutory duties:

- collecting information about what goes wrong in healthcare, in part by operating the National Reporting and Learning System (NRLS) and
- using that information to provide advice and guidance “for the purposes of maintaining and improving the safety of the services provided by the health service”

The NRLS receives over two million incident reports a year, principally by uploading information that frontline staff have already reported to their local risk management systems (usually Datix or Ulysses). While most incident reports concern patient safety challenges that are well recognised, such as preventing self-harm, falls and medication error, the added value of collecting these nationally is that this enables identification of new or under-recognised patient safety issues that may not be obvious at local level. If these are identified, the team works with frontline staff, people who use services, professional bodies and partner organisations to decide if action is needed. You can find more information on this here: [www.improvement.nhs.uk/resources/patient-safety-review-and-response-reports/](http://www.improvement.nhs.uk/resources/patient-safety-review-and-response-reports/)

One of the key outputs is Patient Safety Alerts. These are sent to all relevant organisations and require them to take specific actions by a set deadline in order to protect people who use services. Alerts are developed with people who use services and clinicians to ensure they recommend actions to address problems in a practical way, but they fundamentally rely on good quality clinical governance systems to ensure the required actions are implemented effectively and sustainably. More information is available here: [www.improvement.nhs.uk/resources/patient-safety-alerts/](http://www.improvement.nhs.uk/resources/patient-safety-alerts/)


Alongside the core functions of understanding patient safety, and providing advice and guidance on safety improvement, the national Patient Safety Team also works to support increased capacity and capability for patient safety improvement work across the NHS. The Patient Safety Collaboratives Programme delivered through the 15 Academic Health Science Networks, was established to support organisations to work together on their safety challenges, including in Mental Health care. More information is available here: [www.improvement.nhs.uk/resources/patient-safety-collaboratives/](http://www.improvement.nhs.uk/resources/patient-safety-collaboratives/)

The team also support the development and implementation of patient safety policy. This includes setting out when and how organisations need to undertake full investigations of incidents, through the Serious Incident framework. This also covers work to prevent and respond to Never Events. Allied to these, the team is also supporting the healthcare system to improve how it responds to and learns from the care provided to people who die. More information on the Learning from Deaths programme is available here: [www.improvement.nhs.uk/resources/learning-deaths-nhs/](http://www.improvement.nhs.uk/resources/learning-deaths-nhs/)

Summary

This chapter shows that a structured approach to improvement supported by an open and just culture can make safer ways of working part of an organisation’s DNA. It recognises that organisations also need robust and transparent governance to keep services safe during major change.
References


NHS Litigation Authority (2017) www.resolution.nhs.uk/ [accessed December 2017]


Case study 43 - Safety, audit and continuous monitoring

Using the DASA tool to assess the risk of violence among psychiatric inpatients

Mersey Care NHS Foundation Trust

What was the problem?
Aggression and violence are common occurrences in inpatient settings for people with mental health problems, and resolving aggressive incidents a key task for staff. The trust wanted to help staff predict the likelihood of aggressive incidents so they could try to prevent them.

What was the solution?
Training staff in the psychiatric intensive care unit to use DASA-IV (Dynamic Appraisal of Situation Aggression – inpatient version), a structured risk assessment tool. It consists of a seven-item scale against which inpatients are rated daily. Those who score highly may require increased attention over the next 24 hours to reduce the potential for a serious violent incident. Research shows DASA predicts incidents of violence better than senior clinicians.

DASA scores are included in daily nursing handovers, enabling staff to plan interventions and strategies for the day and offer inpatients support when their scores are high. Staff can identify patterns and themes around behaviour and risk, which allows more effective planning and support. DASA is now used on five high secure wards, on medium and low secure wards and in general acute psychiatric wards. Recently staff have used it on an older person’s ward and psychiatric intensive care unit.

What were the challenges?
Implementing a new risk assessment tool when staff are already extremely busy is difficult: nurses’ attitudes, time and money for training were issues to resolve. The tool had to be easy to use and produce tangible results. Two clinicians developed a bespoke training module for nurses that was trialled on wards and modified to make implementation easier. Training, which lasts about an hour, takes place during handover periods, when two shifts are on site. The trust swapped paper for an electronic version of DASA to make inputting and collecting data easier. Ensuring nursing discussions included DASA was a significant challenge, overcome by embedding DASA scores in handover notes. Staff in general acute psychiatric services had limited time to complete the documentation, but after discussions about DASA’s value they have begun to use it.

What were the results?
During the trial phase on three high dependency wards at Ashworth Hospital, overall incidents fell by 7%, use of restraints fell 44% and staff sickness rates also fell (see Figure 24). These reductions have been sustained since. Twelve wards in the trust now use DASA.

What were the learning points?
- Because staff are short of time, any tool must be capable of quick implementation and significantly improve care quality.
- Nurses need support during implementation; having a named person to contact, such as a project manager, can help.
- Risk assessment tools that are quick to score and represent data visually are far easier to implement.
- Having a dedicated team that drives safety, and senior clinicians keen to reduce violence and risk, are key.

Next steps
The trust plans to develop an electronic application for every ward that uses DASA, taking account of the different electronic records of people who use services used in the trust. Wards will then be able to represent data and trends graphically, making it easier for staff to understand the impact of interventions.

Want to know more?
Mark Thorpe, Perfect Care Programme Lead, Mark.thorpe@merseycare.nhs.uk
Dr Panchu Xavier, Consultant Psychiatrist, Panchu.xavier@merseycare.nhs.uk

Figure 24: Staff sickness absence rates before and after implementing DASA
Case study 44 - Safety, audit and continuous monitoring

Implementing a safety management system

Cheshire and Wirral Partnership NHS Foundation Trust

What was the aim?
The trust’s incidents, complaints and inquests feedback suggested it was assuring care processes rather than the reliability of its clinical pathways. It wanted to shift its culture from one of compliance to continuous quality improvement.

What was the solution?
Introducing a safety management system, which continuously analyses team, service and organisational quality and risk data. The improvement team-level safety of those who use services is central to this. They are based on the Health Foundation’s model described in The measurement and monitoring of safety, which evaluates the safety of people who use services across five dimensions. These reviews largely replace the traditional local clinical audit programme.

What were the challenges?
- Working in a new way and changing the culture from compliance to continuous improvement.
- Introducing new ideas and tools such as a safety culture questionnaire.

What were the results?
More than 30 reviews have been completed. Staff value the process more than clinical audit. Corporate teams can better support clinical teams through ‘enabling plans’, which have replaced traditional RAG-rated action plans.

What were the learning points?
Staff value the emphasis on best practice and areas requiring improvement, which has helped with engagement.

Next steps
The trust’s healthcare quality improvement team is developing the role of ‘patient safety leaders’ as quality improvement champions in each team that has been reviewed.

Want to know more?
Helen Fishwick, Healthcare Quality Improvement Manager, helen.fishwick@cwp.nhs.uk
Case study 45 - Safety, audit and continuous monitoring

Using a speech and language therapy team to enable good communication standards

Cheshire and Wirral Partnership NHS Foundation Trust

What was the aim?

Most people with learning difficulties have some speech, language and communication difficulties. The trust wanted to ensure it met the Royal College of Speech and Language Therapists’ five standards for communicating with people who have learning disabilities and/or autism when they are inpatients at a specialist hospital or in a residential setting:

- There is good information that tells you how best to communicate with someone.
- People are helped to be involved in making decisions about their care and support.
- Others are good at supporting someone with their communication.
- People have lots of chances to communicate.

People are helped to understand and communicate about their health.

What was the solution?

Speech and language therapists conducted audits of communication practice at two of the trust’s units to recommend improvements.

What were the results?

The audits showed high levels of compliance with the five standards, but highlighted the need to continuously oversee their implementation. This will be one of the main roles of a new speech and language therapist post for inpatient units in east Cheshire.

Examples of how the trust ensured consistency in applying the standards include:

- Making sure any new information about a person using the service’s communication is shared in their paper file and electronic care record. This is shared in the ‘communication book’ in the nurse base and verbally, so staff know the information is available.
- Using alternative methods of communication, such as staff on observations having access to a British Sign Language book of signs; signs on walls and other visual resources. Staff also use photographs to help people who use services understand what will happen next – for example, at appointments.
- Client-specific training days, attended by the multidisciplinary team (including the speech and language therapist), part of which involves going through the person using the service’s communication needs and how to support them. Families are also invited to the training day to offer their perspective.
- People who use services are encouraged to comment on topics such as food, the environment and activities at meetings about their care. A ‘participation development officer’ carries out ‘patient stories’ to get people’s feedback about the service. Where people who use services are unable to do this verbally, they are observed on the unit to capture their story if it is in their best interests to take part.

Next steps

Providing communication training for staff emerged as a key theme in the audit. The trust is discussing how to improve this as part of training needs analyses.

Want to know more?

Natalie Hewitt, Advanced Speech and Language Therapist, Natalie.hewitt@cwp.nhs.uk
Leanne Veale, Specialist Speech and Language Therapist, Leanne.veale@cwp.nhs.uk
“Digital health is a fast paced arena, and we must ensure parties work together to drive improvements... This is a really exciting time to be working on digital transformation and more so in the NHS.”

Dr Simon Eccles, Chief Clinical Information Officer, NHS England and NHS Improvement
Chapter 8

Digitalisation

There are many opportunities where digital technology can support improvement and release valuable time for frontline staff to deliver high quality services.

Digitalisation should be integrated into the organisational strategy.

View the cost of IT supporting improvement as an investment in improvement capacity, not an overhead.

Current situation

The NHS has not yet deployed at scale many digital technologies widely used in other service industries to improve access, customer experience, service quality and efficiency. This offers mental health trusts and local health and care systems an opportunity for rapid digital catch-up. Digital technologies are becoming increasingly integral to improving mental health services. So it makes sense for mental health trusts to develop their digital and their continuous improvement strategies in tandem.

This chapter highlights digital improvement opportunities and challenges that are particularly relevant to mental healthcare. It draws on the experience of trusts identified by the government’s Global Digital Exemplars (GDEs) initiative as leading the field in digital development for mental health services.

The 2014 NHS Five Year Forward View sees exploiting the information revolution as one of the keys to closing emerging gaps in population health, care quality and efficiency in England. However, the revolution has been progressing too slowly to meet specific IT-supported goals in time.

The government has decided to accelerate the development and spread of digital information technologies across the NHS by concentrating limited development resources on a small group of digitally advanced trusts, the GDEs. Their tasks are rapidly to adapt and deploy digital innovations, and to enable other trusts to become ‘fast followers’ by creating clear blueprints for each innovation, including a structured method for its replication. The GDEs’ role includes learning from others – both nationally and internationally – to speed up innovation.

Developing digital and improvement strategies in tandem

Reflecting on their experience of developing digital and improvement strategies and trying to integrate the two, leaders from the mental health GDEs and members of this group distilled the following priorities for trust boards taking the integrated strategy route:

- Appoint the right leaders at the right level. Leadership is critical. Mental health trusts’ executive teams need chief information officers and chief clinical information officers to make sure improvement and IT go hand in hand.
- Invest in the basics. To be ready for the future, trusts should review their traditional on-premises and closed systems in the light of more secure and lower cost options. Trusts need to be prepared to embrace cloud-based services. They should look at IT as an investment rather than an overhead.
- Identify the improvement opportunities that depend on digital delivery. Most mental health trusts now have some kind of electronic patient records (EPRs), but this is just the start of their digital journey. Can the EPRs be enhanced? What other digitally supported improvements can they make: for instance, using information to support measurement for improvement, mobilising the workforce or redesigning services? To illustrate, it is now usual to get a text message reminder of an appointment, or just after leaving a service you have been using to ask for your customer feedback. Healthcare has been slow to adopt such familiar digital technologies that reduce no-shows and deliver huge amounts of real-time customer feedback.

Four areas of digital improvement opportunity

There are now many real opportunities to close digital gaps between mental health services and other service industries. The mental health GDEs highlight four in particular.

1) Developing next generation electronic patient records

Mental health trusts in general have already implemented EPRs to a mature level. While current EPR systems provide an excellent foundation, they can be enhanced to support the kind of modern analytics used in other industries to tailor services to customers and improve efficiency. Benefits include improving direct care, enabling preventive care and better commissioning, and creating a ‘consent-rich’ research environment.

Improving direct care

Health professionals are still spending time entering data on records by hand. Voice recognition and recording software has developed significantly in recent years and now allow staff to voice record in treatment rooms, giving them more time to spend with people who use services.

Automatically coding data recorded on EPRs – using, for example, artificial intelligence technology rather than human coders – supports clinical decisions tailored to people who use services’ needs, partly by allowing health professionals to match EPR data rapidly to other electronically stored information.

Enabling preventive care and better commissioning

When digitally recorded data on people who use services are aggregated and analysed, patterns in people who use services’ behaviour emerge. Such patterns can help identify when people who use services may experience mental health crises. They may be able to pinpoint common causal factors, making it possible to take preventive action. Similarly, aggregating anonymised EPR data in linked datasets gives insights into trends in people who use services’ needs across a local area, making commissioning and service provision more targeted and effective.

Creating a consent-rich research environment

So far, understandable anxieties about data privacy have slowed progress in sharing EPR data across organisations, despite the potential benefits in care quality, effectiveness and efficiency that this offers. Other industries – notably financial services and social media – have overcome this problem by asking their users to choose online the levels of privacy they prefer. Some GDEs envisage NHS services being able to do the same at a local level. Giving people who use services online control of their privacy preferences and storing these on EPRs will have the added benefit of speeding up research by clarifying consent. Researchers will easily be able to find people who use services relevant to their research interest who have already given consent to be contacted about taking part in studies.
2) Interacting with people who use services through digital channels

Other industries and some NHS trusts routinely interact with their customers through a range of web-based digital channels not widely used in mental health services, such as e-mail, text messaging, Skype and interactive websites. All have a host of potential uses, including remote working by clinicians, video consultations, tele-monitoring, e-prescribing, supporting self-care and advanced customer relationship management. Some GDEs are developing therapies for distribution through digital channels: for instance, apps to help reduce self-harm and suicide and online cognitive behavioural therapy. Many of these interactions and apps could improve care quality. At scale, all are likely to save people who use services’ and health professionals’ time and reduce system costs.

Suicide and online cognitive behavioural therapy. Many of these interactions and apps could improve care quality.

Using digital channels widely used elsewhere requires NHS trusts to be able to interact electronically with people who use services. In the first quarter of 2017, 89% of adults in the UK had used the internet in the previous three months and almost all (99%) of adults aged 16 to 34 were internet users (Office for National Statistics 2017). Communicating with these people online will free professional time to spend on the minority who are not yet digitally connected, most of them over 65.

Box 2: NHS Apps Library

The NHS Apps Library is where people who use services can find tools to help them manage and improve their general health and wellbeing.

- Mental health – apps on how to manage stress and anxiety and relaxation techniques plus chat rooms for help and advice.
- Health and fitness – apps with exercise plans, food advice and recipes, plus an alcohol and diabetes tracker.
- Cancer and dementia – apps to help with long-term health conditions and support groups’ contact details.
- Learning disabilities – apps which help people with disabilities communicate better, plus support and guidance apps. apps.beta.nhs.uk

3) Building on modern platforms

Advanced digital solutions, particularly service-facing digital services, need to be built on modern, reliable and secure platforms.

The NHS’s past approach has involved specifying, procuring and developing large systems that can take many years to implement, are often out of date when they go live and become difficult and costly to develop and maintain. These developments are often capital-funded. This approach no longer fits with the delivery of modern digital solutions. The most successful digital innovators now use agile development approaches, with many organisations adopting a ‘cloud first’ approach. These ways of working allow new developments to be trialled rapidly at low initial cost and then rapidly scaled and deployed in a sustainable and affordable manner.

Sticking with old, bespoke software means NHS organisations miss out on the stronger, regularly updated protection built into modern software. This was one reason NHS organisations were vulnerable to the ‘WannaCry’ ransomware attack in May 2017.

A significant barrier to implementing these new technologies is the shift to revenue-based charging they entail while, as noted above, NHS funding for new developments is often expected to be funded via capital. NHS organisations need to understand the benefits brought by rapidly deploying new technologies that are revenue-based and identify the potential revenue savings these developments can unlock. For example, one trust is currently paying out £2.5 million a year on travel expenses. How much could it save by conducting appointments over Skype or Facetime – technologies already used by many people who use services? In short, organisations need to view the cost of IT supporting improvement as an investment to enable continual improvement rather than an overhead.

4) Directly supporting improvement

The great majority of the digital opportunities above are integral to improving service quality and efficiency at the same time and therefore improving value for people who use services. For instance:

- Making greater use of remote communications technologies allows trusts to mobilise more of their workforce. This can improve efficiency and reduce building use. It can also allow more innovative and collaborative service delivery, eg co-working with police, courts etc. Consultant psychiatrists are an expensive resource and their time is often wasted driving to appointments that could be held online.
- Several GDEs are developing digital ward services.
- Switching to digital channels to communicate with people who use services would save the NHS most of the estimated £78 million a year it currently spends on second-class stamps.

In addition, improvement methodologies (see Chapter 6) depend on continual quality monitoring and analysis of quality data. Both aspects of a trust’s improvement programme need to be supported by digital systems and IT staff.

6 https://apps.beta.nhs.uk/
Valued care in mental health: Improving for excellence > Digitalisation

Challenges to rapid digital improvement and ways to meet them

As well as sharing their digital improvement opportunities, the GDEs have also shared delivery challenges they encountered and ideas for overcoming them.

Collaboration between organisations. Many of the opportunities, especially in analytics (data linking, predictive analytics, etc) have limited scope within a single organisation. There are much greater gains to be made through collaboration with other trusts, care services, CCGs, police forces and the like at a local health system level. The degree and ease of collaboration between organisations vary greatly around the country. Moreover, there is still a ‘digital divide’ between different parts of NHS. There are few examples of care providers working together on digital opportunities.

Mental health and acute GDEs in the same sustainability and transformation partnership (STP) could collaborate on shared people pathways, interoperability and data sharing, in line with people who use services’ privacy preferences.

System interoperability. More data sharing requires systems as well as people to work together. The number of legacy systems in the NHS makes interoperability a challenge, but other industries have had to overcome this too. Suppliers need more vision to see the benefits of unlocking health data through open standards. Expect to see open suppliers increasingly dominating healthcare IT.

Urgency. GDEs have little sense that the digital revolution envisaged in the 2014 NHS Five Year Forward View is about to take off, more that it is taxiing towards the runway.

Summary

This chapter identifies opportunities for using digital technology for improvement. Integrating digital as part of your overall strategy to improve services makes sense.

Taking this route will include a shift in NHS digital investment practice, from commissioning large, bespoke, capital-intensive systems to developing more agile, ‘cloud first’, revenue-based digital solutions.

References


Case study 46 - Digitalisation

Incorporating technology into specialist rehabilitation services

Lancashire Care NHS Foundation Trust

What was the aim?

Using mobile devices in occupational therapy improves a person’s ability to engage in daily living activities and promotes independence. The trust therefore wanted to give people who use services a reason to engage with technology, to prevent social exclusion. Once engaged, it wanted to encourage them to take more responsibility for their rehabilitation plans.

What was the solution?

Developing a ‘rehabilitation app’ to engage the person in goal planning as part of their rehabilitation. People who use services were involved at each stage, from a survey of their current engagement with technology to trying the app and commenting on it as it progressed.

The app is simple and user friendly, and comprises six sections:

- Contact details
- My appointments
- My goals
- My achievements
- My plan
- My reminders.

The plan is divided into a further 15 categories, and goals can be written in each with details of the support required to achieve them.

What were the challenges?

- Some people who use services and staff may lack confidence with technology.
- People who use services are not always motivated to engage with the app.

What were the results?

After testing the app, the trust found:

- using technology improves people’s confidence and skills
- the app encouraged people to take responsibility for their goals and overall rehabilitation
- it can be used in groups or one to one.

Next steps and sustainability

The trust intends to:

- offer training to all staff
- support people who use services if they lack confidence and skills
- develop Twitter accounts to promote services and share good practice
- make tablet use part of everyday practice
- review the app and get feedback from people who use services
- explore the app’s inclusion in the new electronic care records system.

Want to know more?

Patsy Probert, Associate Director for Allied Health Professionals, Patsy.probert@lancashirecare.nhs.uk
Case study 47 - Digitalisation

Using technology to improve physical health observations on mental health inpatient wards

Lancashire Care NHS Foundation Trust

What was the problem?

The trust used a paper-based system in inpatient units to monitor aspects of physical health such as blood pressure, pulse and temperature. Completed observation charts were scanned into the digital archiving system, which was separate from the electronic patient record (EPR) and difficult to retrieve and review. This arrangement relied on nurses remembering to do the observations at the required intervals, with no formal way of ensuring they did so.

What was the solution?

‘Nervecentre’ software enables nurses to make bedside assessments on a handheld mobile device. The data is accessible alongside the EPR on desktop devices. Nervecentre automatically alerts nurses that observations are due for particular people who use services. Data is easily retrievable and can be accessed at a glance. Longitudinal data can be represented graphically at the touch of a button, enabling staff to see trends over time and pick up any deterioration more quickly. Since December 2015, more than 15 mental health wards across Lancashire have implemented the software, with plans for the rest to do so soon.

What were the challenges?

Releasing nurses and support workers from wards to attend face-to-face training sessions in various locations proved difficult. Therefore the trust’s health informatics trainers were present on wards during implementation, supplemented by online training packages.

What were the results?

- Better informed clinical decision-making as complete and accurate data is always available.
- Improved ability to pick up physical health deterioration early.
- Other staff, such as doctors, are better able to access recorded data instantly and from other locations, due to real-time updates.
- No more duplication of data entry.
- Better adherence to policies on physical health monitoring because of automatic e-alerts to staff.
- Time taken to extract performance data for reporting was significantly cut: reports that took days to compile manually can be accessed within minutes.

These benefits saved £454,000 worth of clinical time that staff can give to direct care. Staff have now embraced the technology and look forward to future developments of the system.

Next steps and sustainability

The trust hopes to expand the system’s functionality to include mental health observations.

Want to know more?

Dr Ayesha Rahim, Chief Clinical Information Officer, ayesha.rahim@lancashirecare.nhs.uk
Using telehealth to manage care plans for people with dementia

Lancashire Care NHS Foundation Trust

What was the aim?
To improve care plans for people with mild dementia and enable them to manage their condition.

What was the solution?
The trust hosts the Lancashire and Cumbria Innovation Alliance (LCIA), one of seven NHS England ‘test beds’ piloting the use of technology to help people who use services to stay well and monitor their conditions at home. The health and wellbeing clinical support solution was co-designed with people living with dementia and their carers.

The package includes a variety of daily health and wellbeing surveys, educational videos, motivational messages and a ‘house of memories’. It is based on Philips’ ‘Motiva’ interactive telehealth platform, which helps chronically ill people who use services manage their long-term conditions. It can be tailored to their illness and acuity level, and makes planning tools available to care providers. People who use services can check their own vital signs using Bluetooth equipment and manually enter readings from pulse oximeters and thermometers. A tablet or set-top box collects these readings and sends them to the person using the service’s clinical team. The system automatically schedules bespoke messages, how-to or educational videos and surveys for people who use services, carers and families to complete, using risk-profiling algorithms to alert clinicians when responses indicate an intervention is required.

What were the challenges?
Philips Motiva was designed without engaging anyone living with dementia, carers or clinicians, and failed to meet its target group’s needs. Feedback indicated the educational videos made some people feel unnecessarily anxious about their condition, while the wording and frequency of some of the health and wellbeing surveys needed adjusting to make them less repetitive. The company providing the teleconferencing technology ceased trading and another company acquired the system, raising significant challenges about information governance.

What were the results?
The LCIA test bed has been live since December 2016: 500 people who use services aged over 55 have used a range of technologies to improve their skills for managing their long-term condition and reduce their dependence on services. The programme worked with three cohorts of people diagnosed with heart failure or dementia – breaking new ground with the last. People who use services remained on prescribed technology for six months and Lancaster University Centre for Ageing Research evaluated their experiences.

What were the learning points?
• To ensure the system is appropriate and practical, design it from the start with the expertise and engagement of all those who will use and be directly affected by it.
• Active listening, perseverance and collaboration are key when developing a product with innovators, people living with dementia, and health professionals.
• People who use services and carers benefit from accurate, timely support information tailored to their community.

Next steps and sustainability
Plans to redesign memory assessment services in Lancashire and Cumbria offer an opportunity to introduce a telehealth approach as part of the pathway.

Health technology companies have an opportunity to work with clinical staff, people who use services, carers and families to develop a product that could become available on the NHS procurement framework.

Want to know more?
Janet Davies, LCIA Test Bed Programme Manager, janet.davies2@lancashirecare.nhs.uk
“Innovation – the word is ripe with the prospect of a better future. The most exciting part of innovation in healthcare is not the invention or discovery, it is that crucial part reaching many hundreds or even millions of people to benefit their mental and physical health.”

Tara Donnelly, Chief Executive, Health Innovation Network
Chapter 9

Innovation

Innovation is inherently risky but maintaining the present state may not be an option for providers. Like digitalisation, innovation requires investment to realise the benefits.

There is a great opportunity to learn from other sectors, public and private, and share good practice from outside the NHS.

Current situation

For the purposes of this resource, innovations are defined as new products, processes or services that offer a ‘step-change’ improvement in how a provider of mental health services fulfils its mission. An innovation could be invented within a provider, in collaboration with public and/or private sector partners, or elsewhere in the healthcare or other sectors.

Continuous improvement depends on innovation, and mental health service providers on an improvement journey are introducing innovations at every level of their organisations. The kind of innovations they make range from small-scale process changes in a ward or clinic, to online apps supporting specific user groups, to large-scale service redesigns, involving other health and care services. A number of established national initiatives, notably academic health science networks, are on hand to help trusts innovate faster and more effectively. Large-scale, structural networks, are on hand to help trusts innovate initiatives, notably academic health science networks, which aim to streamline co-ordination between local organisations involved in mental health service providers. Like digitalisation, innovation requires investment to realise the benefits. Innovations from other trusts are a rich source of ideas for peers. Some organisations have developed systems for regularly ‘harvesting’ ideas from both internal and external sources, evaluating them, and then taking the ideas with high potential through development to piloting and rollout. One challenge for organisations is keeping such innovation management systems lean. Another is managing explicitly the inherent risks of innovation, including the risk that a pilot innovation that benefits one part of a care pathway may have negative effects elsewhere in the pathway or the rest of the organisation when it is rolled out at scale.

Innovation is hard work. It takes courage, persistence and preparedness, since people introducing radical change must both overcome resistance and inertia and anticipate risks. Thomas Edison was right – genius is 1% inspiration and 99% perspiration. So innovation takes time and effort, but it is a critical engine of continuous improvement.

Current thinking

A complex organisation builds its capacity to innovate because this is one of the main organisational assets that will maintain its edge over time (Kay 1983).

Building the capacity to innovate can be difficult in practice, not only because it challenges the status quo. It also requires particular skills. These include the ability to understand priority needs for change facing an organisation, to ‘scan the horizon’ internally and externally to make connections and spot innovations that could realistically meet those needs, and to develop and implement them, eventually operationalising new ways of doing things (Tidd and Bessant 2013).

According to Harvard academic Clayton Christensen (1997), even successful organisations with good management can fail if they miss disruptive changes to their environment. This happens when the leadership focuses on maintaining success through small, incremental improvements based on existing processes. Christensen’s point was that if successful companies listen only to their best customers and put all their effort into funding for technology and resources that predict future needs, they do not see the whole picture. The future can contain radical shifts or changes to which the organisation is not ready to respond.

By looking only at outcomes (eg targets), organisations become susceptible to disruption from innovations to processes. Subsequently they will resist delivery models that are radically different from the standard ways of doing things (Christensen et al 2015). In short, organisations must innovate to adapt.

Existing healthcare improvement tools and techniques, once embedded, tend to yield incremental improvements in services through continual small adjustments. Significant, rapid jumps in quality are more likely to stem from more radical forms of innovation.

There are a great many potential sources of innovation, such as when external events force a radical rethink, when changes are made to regulation, from good practice in otherwise unrelated areas, from research and development or just simple necessity (the mother of invention) and even by accident (Tidd and Bessant 2013).

Every sector has its own drivers for innovation. Factors influencing innovation in healthcare include:

- the complex system of parts, professions and functions that make up the service
- a continual evolution of available technology and underlying science
- occasional changes in direction and funding from policy-makers
- changes to regulation where regulators may be averse to risk
- internal political or emotional opposition to change (Barlow 2017).

Managing the risks of innovation

NHS trusts need to promote innovation if they want to make-step changes in the quality, safety, effectiveness, efficiency or responsiveness of their services, and to make sure people who use services, carers, families and staff feel fully valued and engaged. On the other hand, implementing innovation is inherently risky. Risk may be defined as:

"the uncertainty associated with an event [that] can be quantified on the basis of empirical observations or causal knowledge (physical design)."

(Gigerenzer 2014, page 274)

Managing risk means evaluating the possible consequences of both pursuing and not pursuing a potential innovation. It counterbalances the push for innovation in any strategic transformation process. Some innovation risks are general, such as the relevance of a proposed idea to an organisation’s core mission and purpose, or the probability of fully implementing a new process. Some innovation risks more particular to healthcare settings include:
Managing the risks of innovation

NHS trusts need to promote innovation if they want to make step changes in the quality, safety, effectiveness, efficiency or responsiveness of their services, and to make sure people who use services, carers, families and staff feel fully valued and engaged. On the other hand, implementing innovation is inherently risky. Risk may be defined as:

“the uncertainty associated with an event [that] can be quantified on the basis of empirical observations or causal knowledge (physical design).”

(Gigerenzer 2014, page 274)

- Managing risk means evaluating the possible consequences of both pursuing and not pursuing a potential innovation. It counterbalances the push for innovation in any strategic transformation process. Some innovation risks are general, such as the relevance of a proposed idea to an organisation’s core mission and purpose, or the probability of fully implementing a new process. Some innovation risks more particular to healthcare settings include: resources may be wasted on ideas that go nowhere (innovations fail to be disseminated or adopted)
- testing new services alongside old ones may compromise the capacity of existing services
- cultural differences with commercial partners can lead to costly delays
- unforeseen consequences may dent a trust’s reputation.

At the individual level, perception of risk may be influenced by overconfidence in one’s own judgment, the extent of one’s aversion to loss, and a host of cognitive thinking biases (Westland 2008). At the organisational level, the importance of embracing risk in action is highlighted by the concept of groupthink, an irrational belief that the collective or group’s consensus thinking is rational because it is the consensus, thus blocking out alternative approaches or opinions.

Awareness of the various lenses used by people at all levels of the organisation is therefore a crucial part of innovation, a point reiterated by the national framework for leadership development set out in Developing people – improving care (NILD 2016). The politics of innovation and risk are often influenced by whatever levels of tolerance for uncertainty may be constraining regulators and funders. Such restraint manifests itself in a wish for change or improvement using initiatives that minimise uncertainty and control expenditures in what is a heavily regulated environment.

National initiatives supporting innovation

NHS England has launched the NHS Innovation Accelerator (2017a) to support innovation across the service. Mental health has topped the list of priorities for improvement and innovation among Healthwatch communities for the last two years (Healthwatch England 2016). The 2017 NHS England Innovator Challenge for Mental Health called for projects which:

“have been co-designed with people (including carers, where appropriate) with lived experience of mental illness, [are] accessible to a diverse population and focus on delivering the most significant benefit in terms of outcomes and cost savings.”

(NHS England 2017b)

Currently the innovative ideas for service change in mental health are focused on STPs and integrated care systems. In time there will be other ideas and imperatives. The strength of the approach suggested here is that the same consideration of context and methodology is likely to prove useful at any time.

It is also helpful to bring different partners and providers together in a shared endeavour to improve care delivery, and examples are given below. It can be a major cultural challenge to bring together those responsible for delivering physical care and those responsible for mental healthcare delivery, alongside all other partners. However, the imperative to do so is increasingly clear.

Integrated care systems

It is envisaged that better outcomes for people who use services will be delivered by sustainable organisations operating as part of successful health and care systems. An important route to achieving this is through providers working more closely to deliver care across systems.

Integrated care systems will require effective leadership and robust governance arrangements to enable this sort of joint working and achieve their objectives.

Mental health providers are in a strong position to lead this work due to their history of partnership and collaborative working.

Summary

This chapter describes some of the rewards offered by innovative practices and how the rewards from innovative practice can be great. Risks can be managed through strong robust governance.

This chapter also provides case studies where trusts have innovated to bring about change.

Academic health science networks

There are 15 academic health science networks (AHSNs) throughout England, and they were formed in 2013 to support innovation locally at pace. They have close academic ties locally, support innovation within the NHS and promote learning from other sectors.

These networks are a key part of identifying and understanding innovative suggestions. The establishment of innovation scouts has been received very positively in many areas.
References


Integrated mental health care pathway
North East London NHS Foundation Trust (NELFT)

What was the aim?
To support the national agenda promoting social inclusion and to support the principles of integrated care and care closer to home.

What was the solution?
Redesigning the mental healthcare pathway. The new pathway provides integrated mental healthcare, emphasising the provision of acute home treatment as an alternative to acute inpatient admission.

The new pathway introduces a single point of access in the community in addition to home treatment teams, who can manage people in crisis in the community instead of admitting them to hospital. Previous investment in community mental health services has ensured a genuine emphasis on treatment at home and driven up the quality of NELFT’s inpatient care, while achieving financial efficiencies.

What were the challenges?
NELFT is seeing an increase in the acuity of people who use services conditions and more people detained under the Mental Health Act. In particular, it is experiencing a surge in female admissions. The challenge for the pathway design was to manage these changing needs appropriately given the trust’s aim to support care closer to home.

What were the results?
Increased treatment at home, which has facilitated reducing the number of inpatient beds. Now 97.5% of all the trust’s mental health people who use services are treated in the community.

NELFT has purchased only five out of area mental health beds during the past 10 years. The trust went for nine years without purchasing any until a period in November 2016, when the trust temporarily closed for admissions.

What were the learning points?
The pathway would be strengthened by including Care Pathway Leads responsible for the patient journey. Making sure all teams are represented at core meetings would also maximise the benefits of the integrated approach.

Next steps and sustainability
Following very successful ‘integrated mental healthcare pathway development days’ in November 2017, NELFT’s future work will include implementing the agreed action plan to embed and further improve the pathway.

Dialogue with commissioners will continue to make sure the adult mental healthcare pathway is appropriately funded to meet demand.

Want to know more?
Wellington Makala, Deputy Director Acute and Rehabilitation Directorate Wellington.makala@nelft.nhs.uk
Case study 50 - Innovation

**Young Person’s Home Treatment Team**

North East London NHS Foundation Trust (NELFT)

**What was the aim?**

The trust wanted to offer an alternative to inpatient admissions in a move to modernise CAMHS care and make sure that any new model of care was clinically led. This move was driven partly by the temporary closure of Brookside, the trust’s Tier 4 CAMHS unit, partly by the desire for the clinical leadership team to develop a truly innovative solution for young people. NELFT aimed to offer 24 hour crisis provision, increasing scope for positive risk taking, and to treat young people in the least restrictive environment.

**What was the solution?**

The Young Person’s Home Treatment Team (YPHTT) was created. This allowed Brookside to offer Tier 4 CAMHS provision in young people’s own homes. It is the first such service to be nationally piloted by NHS England.

The YPHTT is staffed by a multidisciplinary team of professionals including doctors, nurses, occupational therapists and psychologists. It is a 24 hours, 365 days a year service and can support up to 12 people who use services at any one time.

**What were the challenges?**

Ensuring that commissioners, partners and families were part of the journey with the clinical leadership team was challenging but crucial to gain support for this new and very different service model.

**What were the results?**

Since opening in September 2016, the YPHTT has been providing a viable alternative to inpatient admission (reducing inpatient admission by approximately 60%) as well as facilitating earlier discharge for people with significant functional difficulties and a wide range of diagnoses. Initial data suggest that 244 inpatient admissions were avoided in the first year. The inpatient average length of stay has been significantly reduced since establishing the YPHTT’s service.

The transformative new service model creates a seamless transition between inpatient and community CAMHS and improves continuity of care.

Rebekah Bewsey, Modern Matron, is “very proud of the achievements of the YPHTT to date. The new model has allowed us to bring our crisis pathway to meet expectations of transformation within the NHS and NELFT”.

**What were the learning points?**

The YPHTT is very effective at keeping young people with emotional dysregulation and self-harm out of hospital. Those young people who are admitted have more acute presentations and admissions are more appropriate.

**Next steps and sustainability**

The YPHTT has received significant interest from other NHS Trusts and Brookside is currently rolling out training in the model to a number of providers. A full service review will be undertaken. Caseload capacity is increasing as the model becomes embedded.

**Want to know more?**

David Hartie, Children and Young Person’s Care Pathway Lead, david.hartie@nelft.nhs.uk

Rebekah Bewsey, Modern Matron
Rebekah.Bewsey@nelft.nhs.uk
Case study 51 - Innovation

**RAIDPlus: reducing the incidence and intensity of mental health crises**

**Birmingham and Solihull Mental Health NHS Foundation Trust**

**What was the aim?**

To develop new and innovative technologies to reduce the incidence and intensity of mental health crises, and ensure that people who are experiencing mental ill health are supported towards their recovery.

**What was the solution?**

The trust is the lead organisation for the NHS England RAIDPlus ‘test bed’, one of seven NHS and industry partnerships testing product and process innovations to improve outcomes for people who use services. RAIDPlus is developing:

- capacity and demand dashboard information (CADDI), developed with Midlands and Lancashire Commissioning Support Unit
- predictive analytics – digital tools to help predict, with a clinically useful level of accuracy, people who use services who are at the highest risk of a mental health crisis
- RAIDPlus crisis co-ordination centre, the ‘hub’ for information gathered from new RAIDPlus technologies, brought together in one central location. Specialist teams evaluate, monitor and co-ordinate care, according to a person who uses service’s needs. The centre houses a specialised mental health trainer who provides mental health and crisis care training programmes to frontline police, ambulance and community healthcare staff.

**What were the challenges?**

- RAIDPlus has huge potential for improving services, but as a complex innovation it carries substantial risks.
- Scale, complexity and novelty – it was not possible to predict with certainty the project’s cost or the time it would take.
- Value for money – having secured £2 million in funding, the project had to satisfy expectations.
- Leadership capacity – RAIDPlus needed senior clinical and management leaders; the trust had to ensure its day-to-day commitments did not suffer.
- Intellectual property – could the trust negotiate complex IP arrangements with commercial partners?
- Resistance to change – many people in many teams will need to change their way of working, and overcome a legitimate fear of trusting computers to predict crises.
- Unintended consequences – how could the trust ensure it had the capacity and know-how to deal with these?

**What were the results?**

RAIDPlus is a live innovation project and its products are either in development or undergoing testing, evaluation and/or implementation. Results will be available at a later stage.

**Want to know more?**

*Professor George Tadros, Clinical Director of Urgent Care Pathway, george.tadros@nhs.net*

Case study 52 - Innovation

**Promoting innovation and managing risk through a research and innovation department**

**Birmingham and Solihull Mental Health NHS Foundation Trust**

**What was the aim?**

The trust’s research and innovation (R&I) department developed additional functions and expertise to those traditionally found in most trusts’ research and development departments. Anyone in the organisation, including people who use services, carers and families can suggest an innovation to the R&I team and get help taking it forward from the innovation lead or facilitator. The R&I department assesses innovations for economic, political, environmental, social, technological, organisational and legal risk.

The trust’s innovation pipeline has seven stages:

- generate – a staff members asks for help generating ideas or identifying innovations from elsewhere to address a problem; the R&I team brings together people facing similar challenges so they can discuss innovation ideas in ‘think tanks’
- assess – in relation to newness, likely success and value, risk, financial implications, feasibility and evidence base
- develop – identifying funds and supporting bids, testing, advising on intellectual property issues, accessing specialist advice, ensuring project management support
- implement – ensuring senior support, helping with adoption and culture change, linking with other departments such as IT, helping build in evaluation from the start of implementation
- promote – publicising the innovation internally, regionally and nationally with support from the West Midlands Academic Health Science Network, identifying opportunities for presenting at events, entering the innovation for awards, approaching other trusts or regional partners that may be interested, helping the innovator identify means of publication.

**What were the results?**

Typically more than 60 innovations are in the pipeline at any one time. The trust was awarded the title ‘Innovative organisation of the year’ by the West Midlands Academic Health Science Network.

**Want to know more?**

*Katie Warner, Innovation Lead, Katie.warner6@nhs.net*
Case study 53 - Innovation

How locality data packs can drive improvement

Cheshire and Wirral Partnership NHS Foundation Trust

What was the aim?

To design and implement a fresh approach to continuous improvement and encourage more evidence-based decision-making, as part of the trust’s zero harm strategy.

What was the solution?

Locality data packs (LDPs), in PowerPoint format, contain key safety and quality information presented visually, with supporting analytical comment. Launched in 2015 and refined each year since, teams use LDPs to identify opportunities to deliver safe and effective care and to support continuous improvement.

Information is presented in context – in time series or against benchmarks – and highlights areas of good practice. LDPs give positive feedback as well as highlighting areas for improvement.

The trust produces a separate data pack for every team and ward every quarter – 130 packs in total, covering all the trust’s services. Community team packs have 10 pages of charts and analytical comment, plus a page for managers to record their areas of strength and areas for further improvement. Ward packs have twice as many pages. The trust’s quality committee approved the design and content. Clinical and non-clinical staff were involved in deciding the content and format.

What were the challenges?

Designing a product that clinicians and managers could interpret easily and a production process that would be sustainable given the volume of LDPs. LDPs are produced in Excel, pasted into PowerPoint, loaded onto the intranet and an e-mail sent to team managers with a link for easy access. All data included is already collected for statutory or internal reporting, so there are no extra data collection costs.

What were the results?

One team leader says: “By incorporating the LDP as a standing item on the team meeting agenda, essential issues are discussed and addressed … As a manager who has recently returned to manage the team in a time of crisis, the data pack has assisted me by highlighting areas needing immediate attention such as supervisions and appraisals. I have been able to focus on those areas and bring activity levels up to the trust’s requirement”.

CQC told the trust that staff had consistently described the value of LDPs in helping them deliver safe and effective care, supported by sound leadership.

What were the learning points?

- Design with the end user in mind with a particular focus on clarity and visuals.
- Get full backing from senior colleagues.
- Provide advice from experts who can explain complex statistical issues in a way people can understand.
- Develop ward and team managers’ skills in measurement and data interpretation.

Next steps and sustainability

The future challenge is to include more data about outcomes, and more comparator information to support more specific benchmarking.

Want to know more?

James Partington, Quality Surveillance Analyst, James.Partington@cwp.hns.uk

Beverley Tudor, Quality Surveillance Analyst, Beverley.Tudor@cwp.hns.uk
Case study 54 - Innovation

Funding innovation and improvement
Hertfordshire Partnership University NHS Foundation Trust

What was the problem?
Turning an idea for an innovation or improvement into reality sometimes needs money – which can be hard to secure.

What was the solution?
The trust launched an innovation and improvement fund in autumn 2016 to pay for testing ideas and allow ‘proof of concept’. Ideas must contribute to one of these areas:

- improved experience for the person using services, carer or staff
- improved safety
- increased value
- better partnership working.

Applications are made on a single-page A4 template, and receive a response within four weeks. A panel of staff, people who use services and carers makes the awards. Staff members are drawn from clinical, corporate and other areas across the organisation. All panel members have equal status and have volunteered for the role. An executive director is chair, but decision-making is collaborative and egalitarian. Awards do not have an upper limit: the panel can make awards up to £25,000, while the executive team considers requests above that figure, which need a formal business case. Awards are made as one-off, non-recurrent funding, and once made are transferred to the originators of the idea within 48 hours.

What were the challenges?
After awards are approved and money distributed, people can still find it difficult to bring about change. The trust is promoting quality improvement approaches to address this. Its continuous improvement team provides advice and guidance on taking ideas forward.

What were the results?
The fund had 48 applications in its first 12 months and made 21 awards; some applications were directed to alternative funding sources or were supported through service budgets. Implemented ideas include:

- a portal system in the Essex IAPT (Improving Access to Psychological Therapies) service, reducing the effort in administering waiting lists and decreasing drop-out rates
- an interactive ‘cardio wall’ on an adult inpatient unit, to increase physical health, wellbeing, inclusion and general activeness
- a healthy eating interactive display to highlight an inpatient’s typical weekly food intake and the excess weight gain from this diet, to raise awareness and reduce weight gains
- creating and trialling a ‘living well with dementia kit’ with examples of potentially helpful products that people with dementia can buy.

What were the learning points?
Offer applicants the right support to progress their idea. Finance is not always the most crucial element: connecting the right people in the organisation, or practical help – such as measurement for improvement or project planning – can be more important.

Next steps and sustainability
The trust is evaluating the fund’s first year and examining ways to spread successful ideas across the organisation. Cash-releasing efficiency savings finance the fund, and the trust believes that investing in ideas will generate future efficiencies so the fund becomes self-sustaining to some degree. The fund acts as a catalyst for creative thinking and contributes to developing an improvement culture.

Want to know more?
Eddie Short, Continuous Improvement Lead, eddie.short@hpft.nhs.uk
Case study 55 - Innovation

Developing alternatives to inpatient admission

Lancashire Care NHS Foundation Trust

What was the aim?
To develop intensive community support services as an alternative to inpatient admission for people with mental health conditions. The trust wanted to bridge the gap between support from mental health crisis teams and an inpatient stay, taking account of risk management and recovery model principles.

What was the solution?
Opening Willow House, which provides six short-stay crisis beds in a safe, non-clinical, less restrictive environment than a hospital. It focuses on timely support and takes an evidence-based, holistic recovery approach. The trust developed and runs the house in partnership with the Richmond Fellowship, to draw on third sector expertise in managing social crisis on a non-medical model. The trust’s crisis team provides specialist clinical interventions to people before, during and after their stay at the house; Richmond Fellowship staff help people learn how to manage their condition in a normal living environment. The crisis team manages access to the house, and its use is written into escalation plans.

What were the results?
Since the house opened in May 2017, 45 out of 89 referrals (50.6%) were of people who had had multiple hospital admissions. In all these cases, inpatient admission was avoided.

Want to know more?
Sue Moore, Chief Operating Officer, Sue.Moore@lancashirecare.nhs.uk

Case study 56 - Innovation

Awarding funds to innovative ideas

Mersey Care NHS Foundation Trust

What was the aim?
To stimulate innovation across the clinical divisions to solve complex issues.

What was the solution?
Creating an innovation fund by top-slicing the trust’s annual CQUIN funding. In the first year, teams were invited to bid for awards capped at £1,000 for initiatives that would enhance care of people who use services and/or safety of people who use services and staff safety. In the second year bids were invited for a handful of awards ranging from up to £2,000 to one of £25,000.

In addition, the trust holds regular events such as ‘innovation breakfasts’ to expose staff to new ways of working: one recently brought together creative small businesses from Liverpool and key staff from the clinical divisions.

What were the challenges?
The funding awards include an offer for the Centre for Perfect Care – the trust’s small in-house team of improvement and innovation experts – to help implement successful initiatives. This proved too ambitious given the sheer number of awards, and the centre found it difficult to work with all the teams.

What were the results?
In the first year more than 40 awards were made. But having fewer awards in the second year worked better: bids were of higher quality, more manageable in number and more successfully sustained.

Want to know more?
Steve Bradbury, Deputy Director of Improvement and Innovation, steve.bradbury@merseycare.nhs.uk
Case study 57 - Innovation

Improving access for urgent and non-urgent requests for help – Initial Response Service (IRS)

Northumberland, Tyne and Wear NHS Foundation Trust

What was the problem?

Despite the trust’s crisis team working 24/7, contacting it was difficult: overnight and at peak times, callers often had to wait for a clinician to call them back – many attending accident and emergency instead – although less than 35% of callers/referrals needed admission or crisis home treatment. Older people, people with a learning disability or their carers had no access to urgent advice or crisis intervention. Routine referrals took up to a week to process and were often ‘bounced’ around services, creating further delays.

What was the solution?

After analysing data on demand, performance and skills, and cross-checking it with observations of staff at work, the trust worked with people who use services, carers and stakeholders to design a new service model that covered every aspect of the person’s pathway from referral or asking for help, to discharge.

All referrals and external calls are routed to a single point for the locality with a single telephone number. Staff are trained to triage and manage requests for information, advice, help and support. The service is available 24/7, covers all ages and includes people with learning disabilities. Anyone can make a referral. The crisis team was strengthened with additional skills and expertise. If telephone contact is not enough to decide support, the team carries out rapid face-to-face triage at the individual’s home or a place of their choice, within an hour.

The trust centralised routine referral handling for all community mental health and learning disability teams to the new single point of access, and set up a multidisciplinary triage team. With the police, the trust developed a street triage service, also located with the single point of access and crisis team.

What were the results?

Over half of referrals are now made by people who need the service, their carers or families. Older adults and people with a learning disability have access to support around the clock. GPs have direct access to consultant psychiatrists, pharmacy, psychiatric nursing and social work advice in a single call; they can turn the advice into a referral request without additional paperwork.

More than 80% of calls are non-clinical – individuals asking for advice and information about services or their appointment, or wanting to contact their named nurse. Call-handling staff are trained in when to pass calls to clinicians, who triage them for urgency. In most cases they offer clinical advice and support by phone. These clinicians also make routine referrals to community teams where necessary (6% of calls). About 20% of calls passed to clinicians (4% of all calls) result in face-to-face triage or crisis assessment. Only 1% of all calls result in crisis home treatment and less than 0.5% in admission. Initial concerns that self and carer referrals would create excess demand are unfounded: referrals to crisis and community mental health teams are steady or have slightly reduced.

Want to know more?

Stewart Gee, Technical Programme Director, Trust Innovation Group stewart.gee@ntw.nhs.uk
“Mental health trusts have shared their successes as well as their learning in order for others to benefit. Here are their improvement stories…”

Clare Lyons-Collins, Project Director, Mental Health Innovation and Improvement, NHS Improvement
Chapter 10

Compendium of trust improvement stories

Hertfordshire Partnership NHS Foundation Trust

What it was like before...

What were you most concerned about?

Our improvement journey began in spring 2015 and was the step that followed our five-year transformation programme that took us into the next phase of the trust’s ‘Good to Great’ journey. Although we had effected change in every part of the organisation, delivering improved environments, service structures, IT systems and other infrastructure, we knew there was more to do – as there always will be, since change is an integral part of service delivery.

We were aware that our staff were fatigued by the previous five years of ‘big ticket’ change projects. These were largely centrally driven and supported by project management professionals and structures. We wanted to find approaches that allowed improvement initiatives of a more manageable size, which could involve staff, people who use our services, carers and families much more readily.

What was the feedback on your services from people who use services, families and carers, partners?

At the end of 2014/15, feedback was generally positive: 77% of respondents to the Friends and Family Test said they would recommend the trust, compared to 8% who said they would not recommend it.

Our CQC inspection in April 2015 highlighted the following positive feedback:

- most staff were kind, supportive and helpful
- person-centred care was working well for people who use services with highly complex needs and behaviours that might be challenging
- in the older people inpatient service, staff were very supportive to people who use services and relatives and gave them information that helped them to make choices about their care
- staff kindness and positive interaction received particular mention in some services, such as the older people inpatient wards and the inpatient long-term rehabilitation services
- people who use services knew how to make a complaint and felt confident that, if they did complain, their complaint would be taken seriously.

Some of the concerns raised during the inspection were:

- when people who use services were moved between wards and sites, their carers were not always told
- carers did not always feel well informed, listened to, or involved – for instance, by attending ward rounds
- carers expressed particular concerns about staff not responding when they reported that the person they were supporting was experiencing a deterioration in their health
- people who use services did not always have access to their care plan.

What did the staff say about the trust?

The 2014 annual NHS Staff Survey highlighted as our five top strengths:

- staff felt able to report errors, near misses or incidents
- staff felt that their role made a difference to people who use services
- staff felt secure in raising concerns about unsafe clinical practice
- staff felt motivated at work
- high numbers of staff had undertaken equality and diversity training in the last 12 months.

The same survey highlighted these top five weaknesses:

- the trust did not always take positive action on the health and wellbeing of staff
- staff were not always involved in deciding changes that affected their work
- staff did not always have adequate materials, supplies and equipment to do their work
- staff were not able to make improvements in their area of work
- staff would not always recommend the trust as a place to work.

What was the catalyst for change?

Our primary drivers were (and remain) quality and safety. Ultimately, we see developing a clear and coherent improvement approach and establishing an organisational culture focused on improvement and innovation as the right things to do for people who use our services and carers, our staff, the organisation, our commissioners and the NHS.

We believe our improvement journey will support the organisation in delivering our quality and safety ambitions. By enabling us to eliminate wasteful activities, it will help us to fulfil our financial agenda as well.
How things are now...

Do you think things are better? How do you know they are?

Yes, we believe that the organisation is stronger in both its improvement culture and its ability to maintain service delivery standards in some challenging operational contexts.

We know that our culture has shifted to focus more clearly on improvement and innovation: anecdotally the organisation ‘talks’ in these terms more frequently; we see ideas for innovation and improvement coming from across the full spectrum of staff; and we have seen an upturn in the demand for and use of evidence and data to drive service delivery and decision-making.

In areas particularly affected by staffing pressures, increased demand and acuity, and other challenging external factors, we have seen improvement thinking and techniques deployed to make steady incremental and, we believe, sustainable improvements.

It is still early in our journey, which we see as a long-term change to the organisational DNA and the way we do business. But we have already seen some really encouraging improvement delivered by the people who do the work, rather than having improvement ‘done to’ them by ‘experts’ external to the team or organisation.

In the last two years of the annual staff survey, our staff engagement and satisfaction scores have increased. Although these results are no doubt the outcome of a range of factors, we are convinced that the work we have done to build an innovation and improvement culture and a collective and collaborative approach to achieving change have played a significant part in achieving these higher scores.

What are you now most proud of?

Our story is about our journey to become an organisation that has innovation and improvement thinking at its core and to establish an organisational vision of ‘great care, great outcomes – together’. This is a vision that is, and will continue to be, achieved through continuously improving what we do and how we do it.

We are proud that our staff, people who use our services, carers and families have all contributed to developing this vision and of the co-productive ethos we nurture.

We are proud of our past history of improvement and innovation, and how this enables our future.

We are proud of a whole range of improvements – sometimes very small changes — that not only make things better for people who use our service, carers and families or our staff, but also signal that our people believe they can make a difference and are empowered to do so.

We are proud of our leadership team: our chief executive became HSJ chief executive of the year in 2017. We are proud of the results of our 2015 and 2016 national NHS staff surveys, in which we had the highest scores among England’s mental health and learning disabilities trusts for staff motivation at work two years running. We are proud of all the other awards we have been nominated for, and of the quality of the people we have within – and are attracting to – the organisation.

To us, these are all signals of progress towards achieving our ambitions. We know that this is a marathon, not a sprint, and that individual ‘successes’ need to be part of a story that shows the bar being raised by and for all.

Approach/methodology...

How did you get there? Did you use any particular Improvement methodology?

Our journey so far has been organic and exploratory. At the end of the preceding transformation programme, the organisation’s senior leaders sought a new way to ‘do change’, but we knew individuals within the organisation were also doing the same.

We started seeking out people in the organisation who were making improvements using defined approaches and techniques, and drawing them together into a coalition of enthusiasts. This coalition included people who use our services, carers and families as well as staff from across the organisation from different professions and roles up and down the hierarchy.

We spent time learning from colleagues inside the NHS who were already advanced in improvement cultures, to harness their knowledge and expertise of continuous improvement methodologies.

We defined an outline methodology based on the thinking and experiences of this initial group of internal and external colleagues, and on what we felt were the positive practices in a range of different improvement approaches, including Lean thinking. We were clear that we wanted an approach that gave people freedom to use whatever tools and techniques would help their improvement efforts, but that also provided a standard and repeatable structure that would allow a common language and broad way of doing things to develop within the organisation.

We subsequently adopted the Institute for Healthcare Improvement’s Model for Improvement as our core methodological framework,10 coupled with a set of guiding principles.

The Model for Improvement is a simple, easily understood framework that helps structure thinking and directs people towards action and measurable change through experiment and understanding. Our guiding principles provide some further direction and control regarding how we want people to do their work. For example, the principle of ‘understanding before solutions’ aims to slow the rush to make changes, and to spread fact-based decision-making.

Alongside the Model for Improvement, we allow the use of other methodologies suited to specific issues, including a core set of concepts, tools and techniques that can help us to understand our work.
We view innovation and improvement along a continuum that we describe pictorially (see Figure 25).

Figure 25: Improvement and innovation

![Figure 25](image)

We have also made a substantial commitment of about £1 million to innovation and improvement ideas that need some ‘seed funding’ to get them up and running from a specific innovation fund, established in autumn 2016, into which we direct cash released through our cash-releasing efficiency savings.

What were the most important factors in achieving the improvement?

Our story is not of one specific improvement. Rather, it is about the start of a journey towards an organisational vision of achieving ‘great care and great outcomes – together’. The improvement approach/methodology outlined above is one part of how we will achieve that vision.

Looking back from where we are today, we can see that the seeds of our future success were sown during our preceding five-year transformation programme, in particular in the work we did to establish and embed a core set of organisational values. Subsequently, we see the factors that have supported and continue to support our journey are our:

- collective leadership culture
- co-designed and collaborative improvement approach
- revised organisational mission and vision statement, simplified and accessible to everyone
- bottom-up and top-down commitment to improvement and innovation
- promotion and visible symbols of intent (our innovation and improvement website, innovation fund, etc).

Did you have any financial investment? Where did it come from?

We have not had additional external financial investment in developing this innovation and improvement approach and culture within our organisation. We have repurposed some of the funding associated with our transformation programme office to establish a small core support team.

Future work…

Do you have areas that need to improve further?

Yes, always. Fundamental to our mindset is knowing we can always do better, always improve. Additionally, we operate within an extremely challenging context that pushes us to improve what we do and how we do it, and to think differently, so we can keep delivering good services and move closer to great services. We are continuously striving to improve access to services (making it swifter, simpler and more efficient for all involved), to ease flow through our services, and to make sure we deliver value through every action.

We are working to build and formalise our improvement capability and capacity across the organisation while minimising any additional costs of improving.

What are the most important learning points?

- **Motivation.** Go where the motivation is and build from there. Find your enthusiasts and set them going. But don’t just keep preaching to the converted. You will need to build some momentum to become part of the mainstream culture rather than a cult.
- **Engagement.** Find every way you can to engage people – ‘different strokes for different folks’. But don’t waste your energy on the uninterested unless they are potential blockers.
- **Language.** This can be used to include or exclude, but you don’t want to dumb the language down too far. Don’t be afraid to use the names of improvement techniques, but do it in a way that takes people with you.

- **Senior level engagement.** This really helps to push things along and opens closed doors. You are likely to need to make a case to several senior leaders for doing things differently. Think what ‘buttons’ you need to press and how you can best press them. Using some of your own successes will help. So will using external levers.
- **Innovation versus improvement.** This is not an either/or choice. Both are part of the same improvement continuum and both can make significant impacts. It comes back to language: you may need to reframe what you mean by innovation while making clear that improvement is just as valued as doing something new. We frame improvement as incremental change that continually improves a process over time, and innovation as a step change made by finding a new way of doing what you did before.
- **Business as usual versus projects.** Our aim is to embed an improvement mindset into the organisation so that improving becomes part of how people do their work. But delivering successes through some visible projects will help to build the will for improvement and gain endorsement across the organisation.
- **Energy and resilience.** Be ready to dig in for the long haul. This isn’t a short-term initiative. This is changing long-held ways of thinking and being. People will resist.
- **Money.** You will eventually need investment to take improvement fully into the organisational mainstream. At some point you will need to pay for training, central support teams and external mentoring or partnering. Raising the necessary investment in the current climate needs some careful thinking…..and that is where we are today.
Northumberland,
Tyne and Wear
NHS Foundation Trust

What it was like before…

What were you most concerned about?

In 2011, NTW embarked on a trust-wide transformation programme. When we decided to approach quality improvement across the whole trust, our most significant concerns were about access, consistency of quality in service delivery and the balance of resourcing between inpatient and community services.

What was the feedback on your services from people who use services, families and carers, partners?

- People who use services said they were unable to access the right service and support for their needs quickly and simply. They often waited a long time for both urgent and more routine support.
- Carers and families told us they weren’t always listened to.
- People who use services and carers said they weren’t aware they were on a ‘pathway’, and that services were neither designed around the person using services nor efficient in their delivery.
- People who use our services told us they often stayed in the service for a long time, with relatively little contact from staff.

What did the staff say about the trust?

Staff generally accepted that areas of practice needed improvement. While some were sceptical, many were keen to be involved in the transformation.

Exploring existing ways of working, staff said they weren’t sure they were always following the latest evidence-based and clinical guidance. They also said they didn’t have enough time to spend with people who use services, families and carers, as levels of bureaucracy were high and administrative support limited.

What drove you to change?

Key drivers for whole-scale transformation of NTW were:

- feedback from people who use our services, families and carers, partners and other stakeholders, and their willingness to be part of the improvement journey
- delays in access to urgent mental health services for those needing crisis team care but lacking a referral, contrasting with less than 35% of people referred to urgent mental health services who in fact needed a crisis team response
- pockets of good practice and high quality service, which needed to be standardised across all areas
- a need to refocus on community services as the ‘engine room’ of the trust, and an understanding that improving their delivery would reduce the need for inpatient beds
- the understanding that quality was the absolute priority, and that cost savings as high as 20% would follow if the quality was right.
How things are now...

Do you think things are better? How do you know they are?

We know things are better because:

- We collected detailed ‘baseline’ data before embarking on the transformation journey. Understanding the ‘business’ in depth was key, not only to allow subsequent improvements to be measured, but also to aid understanding of what improvements were necessary and how they could be achieved.
- Our planning of each improvement included estimating the associated expected benefits and recording them in a trust-wide benefits realisation plan.
- Implementation of any improvement is followed by a cycle of continuous review, challenge and further improvement, which has become part of ‘business as usual’. This cycle includes evaluating realised against expected benefits.

The trust-wide benefits realisation plan provides the framework for identifying, measuring, monitoring and optimising benefits across all workstreams in this complex ‘multi-project’ transformation programme. A matrix approach allows cross-referencing of qualitative and quantitative measures. These are monitored continuously within teams and services and, at a larger scale, in fixed-point independent evaluations.

In 2013 NTW contracted Northumbria University to carry out an independent evaluation of the impact of the transformation on people who use services, carers, family members and staff. The university employed people who use services and carers to carry out semi-structured qualitative interviews, and as a learning organisation we receive and act on the results of these as they help inform future improvements.

The transformation of community services has also freed wasted clinical time, allowing clinicians to focus their skills, old and new, on supporting people who use services, carers and families. Among their new skills, digital dictation ensures NTW clinicians now spend less time manually entering notes into clinical systems. Increased numbers of administrative staff transcribe the dictated notes (see Figure 26).

Joint working makes the interface between community and inpatient services seamless. Resources have been configured to facilitate ‘step-up’ and ‘step-down’ care in the community. Staffing is managed to make sure the skills appropriate to carrying out each task at the highest level of quality are in the right place at the right time. Staffing plans are based on demand and delivery information in conjunction with ‘Skills for Health’ criteria, removing traditional focus on Agenda for Change bandings and existing hierarchies.

People who use services and carers have developed new documentation to help others prepare for appointments and reviews. Videos are also being created to help them understand what to expect throughout their contact with NTW.

What are you now most proud of?

We are most proud of involving people who use services and carers in this transformation in the truest sense: sharing their knowledge during baselining, providing challenge and support during improvement design, and working shoulder to shoulder with clinical staff to implement new ways of working.

The continued enthusiasm and commitment of staff to improvement has also helped the trust to adopt more flexible ways of working across previously ‘silo-ed’ services, and led to the devolved model of leadership now in place.

---

Figure 26: Allocation of tasks in a typical NTW clinician’s day before and after digital dictation was introduced

Before Digital Dictation

After Digital Dictation
Approach/methodology...

How did you get there? Did you use any particular Improvement methodology?

In 2007, NTW became one of six early adopters of the North East Transformation System (NETS), a regional programme led by a coalition of north east NHS organisations interested in implementing Lean thinking in healthcare. While manufacturing and some service industries have practised Lean thinking for many years, significantly improving quality and reducing costs at the same time, the healthcare sector has only relatively recently explored such possibilities.

In 2009, NTW's board of directors established the Continuous Information System (CIS) programme to take forward the Lean thinking initiative. CIS evolved into the Continuous Improvement System and Knowledge programme (CISK) in 2010, which was better aligned with the regional NETS programme.

While the CISK programme had a number of components, it mainly followed Lean thinking as described by the Toyota production system, the origin of most modern QI methodologies. Lean thinking aims to shift the thinking of everyone involved in producing something towards quality, to equip them with the knowledge and skills to challenge and improve levels of quality. It is now widely recognised that Lean thinking is as much about philosophy and people as processes and problem-solving.

From these foundations, in the course of transforming our trust over the past eight years, we have developed the NTW approach to designing and implementing a continually improving service model (see Figure 27).

Perhaps what distinguishes the NTW approach is starting with a really rigorous analysis of our existing 'business'. At the beginning of our transformation journey, we:

- explored the journey of hundreds of people who use services by cluster and locally, looking at all aspects of clinical contact and bed usage
- shadowed staff of all disciplines, looking at clinical and non-clinical activity, to understand in depth how clinical and support staff used their time, and what 'value' that brought to the person using the service, their carers and families
- mapped the skills of every member of the clinical and support teams
- mapped the resources – human, financial, equipment, - allocated to existing teams
- mapped estate against people need using geographic information systems technology
- created current state value stream maps (VSMs), which captured the flow of information and resources required to produce each service.

Having decided the only answer was to transform the whole trust, the executive leadership's priority was to maintain clinical focus throughout the transformation. The leadership team tasked senior clinical staff from across NTW to come together with people who use services, carers, stakeholders and partners, to design a new service model for the trust as a whole, based on evidence and guidance on best practice.

The resulting service model acknowledges the importance of 'purposeful' inpatient stays and the expert skills in specialist services. But it protects and invests in community-based mental health services because they are the primary source of help and support for most. The 350-page report describing the model has become the bedrock and reference point for all service improvement in NTW. It focuses on the following person-centred principles:

- you should reach us, quickly and simply
- the earlier, the better
- to get the right help and care, safely and easily
- from our flexible and skilled workforce
- in collaboration with you and your carers and partnership organisations
- so that you can gain/regain independence, as far as possible
- by making smooth and sustainable steps forward
- reaching us again, simply and quickly.

Figure 27: The NTW approach

Figure 28: NTW’s investment in services
The group then combined this service model (Figure 29) with learning from the current state VSMs to develop high-level future VSMs describing how future services should operate in line with the model’s principles.
The high level plans indicated that the trust could improve quality and cost at the same time. That prospect challenged traditional thinking in some parts of the trust. Many staff viewed quality and cost as being directly proportional – higher quality always costs more, and you can’t reduce costs without reducing quality. Many staff also needed convincing that the measurements and calculations in the current state analysis were correct. The need for change, the baseline and the new model were discussed many times from different angles before staff were sure that this was a way forward which was worth trying.

A vast amount of detail was required to operationalise the high level plans. This detail was surfaced in a series of 27 one-week long, co-produced detailed design workshops, which 362 people attended. They included GPs, local authority staff, acute trust staff, community and voluntary sector staff, CCG leads, NTW clinical, admin and IT staff, and, most importantly, people who use services, carers and families.

These workshops produced people who use services’ journeys filled with detail on approaches, methodologies and processes, all standardised at the highest levels of quality.

Knowing that “shop-floor” staff had co-designed the new ways of working helped sceptics to ‘give them a try’ in the implementation phase. Changing practice, locations, methodologies, systems and process were a challenge for some. Many didn’t realise until this point that the trust’s transformation would affect them as individuals. Responses ranged from great enthusiasm about digital technology and more admin support to reservations about team-based space allocation. Realising the innovations had been devised by peers encouraged natural ‘resisters’. So did the knowledge that actual benefits would be monitored against those planned, and continuous adjustments made to the new working patterns if need be – nothing was set in stone.

Did you have any financial investment? Where did it come from?
The trust invested money and human resources to establish the team delivering the first single point of access service. This was with the full agreement of our commissioners, who had been included in the design process. They commissioned the service once its efficacy had been established.

What were the most important factors in achieving the improvement?
Critical factors were:

• knowledgeable support and involvement from the board and chief executive
• knowledgeable support and involvement from the CCG in the first place when we implemented a completely new way of working, the single point of access
• setting the principles and values against which all improvement would be measured
• using a proven methodology
• true involvement of people who use services, families and carers alongside clinicians and support staff in all stages of work
• a clear commitment to establishing benefit realisation metrics throughout the system
• expectation that the cycle of improvement is continuous, and becomes part of ‘business as usual’.

Future work...
Do you have areas that need to improve further?
Continuing to monitor and evaluate the new ways of working is crucial, and innovative ways of thinking are encouraged within NTW. Regular monitoring, observation, shadowing and mapping of services enable staff and their leaders to identify any potential challenges within the delivery of the system. It also helps them to continuously improve the quality of care delivered to people who use services, their families and carers.

Sharing the journey that the trust has gone through with others across the country is also of great importance to ensure that we share good practice, learn from others and avoid isolation.

What are the most important learning points?
Our most important learning points are:

• culture – understand the context in each area
• leadership – involve experts by experience and partners
• plan benefits realisation clearly from the outset, based on measured baselines
• use a clear approach to enable a good understanding of the starting and end points of each process.

Increasingly, NTW has recognised that this transformation is critically aligned to integrating health and care services in each of our localities. While we work to complete the remodelling of care across our services, we continue to engage with partners in developing an integrated approach to care delivery. This includes novel approaches to service delivery based on promising new alliances.
Mersey Care NHS Foundation Trust

What it was like before...

What were you most concerned about?

Four years ago Mersey Care was a stable organisation, financially well managed, providing services of relatively good quality; we were regarded as a safe pair of hands. However, quality varied, our service and workforce models were traditional and, as a safe pair of hands, commissioners regarded the trust as old-fashioned and less innovative than its peers.

Like all other mental health trusts, Mersey Care also faced the challenge of continually improving care within a constrained financial budget, while addressing people's increasingly acute and complex needs.

A change in priorities and focus was needed to allow the trust to thrive in the future and to meet the challenges of greater competition, rising demand and expectations and the need for greater efficiency.

What was the feedback on your services from people who use services, families and carers, partners?

Mersey Care had a great track record of being values-based and working alongside people who use services and carers. However, there was a need for a clearer strategic direction and greater consistency in quality of care.

What did the staff say about the trust?

At that time, the trust operated a clinical business unit (CBU) structure, and feedback from staff was that they didn’t know what Mersey Care stood for (they identified with their service and the CBU structure but didn’t associate with Mersey Care as a whole). They were concerned about variation in quality among the CBUs/services; and they often felt isolated and lacking support because the services are dispersed across so many different sites.

What was the catalyst for change?

The need to find more effective means of doing more with less: the financial challenges faced by the NHS and by mental health in particular are very significant. We needed to find new ways of providing our services that meant we could reach more people in need, prevent and treat their illness sooner, while safely reducing cost.

The need to change our models of care to become more effective and consistent: we have national experts working in our organisation and committed teams who are passionate about the care of people who use services. We believe that between us we can develop more effective and consistent care models that are evidence-based and reflect the knowledge of our people.

The need to do all this while protecting and improving the quality of what we do: we are passionate about providing the best possible care of those who use services.
How things are now…

Do you think things are better? How do you know they are?

In 2016, Mersey Care became a foundation trust and also acquired Calderstones Partnership NHS Foundation Trust, creating our specialist learning disability division. In 2017, we became the provider of physical community services in South Sefton and from 2018, will become the provider of these services in Liverpool. Mersey Care is now a community services and mental health NHS foundation trust.

We are making good progress in many areas of perfect care and in improving quality and outcomes in our services:

Mersey Care is committed to reducing all forms of restrictive practice.

- Our initial pilot wards recorded reductions in the use of physical intervention of around 60% in the first two years. As the process has been implemented across all wards in the trust from April 2016 to August 2017, we have managed to achieve significant reductions in restraint use and assaults on staff (see Figure 31 below). Inevitably, as fewer staff are involved in physical interventions and are less exposed to assault, there are financial savings in terms of reduced replacement costs for work-related sickness absence.

- This work won the quality improvement award at the Positive Practice in Mental Health Awards 2017 and the ‘patient safety improvement category award’ at the Nursing Times Awards 2017.

Figure 31: Use of restraint and assaults on staff

Trust restraint figures from April 2016 to August 2017 (Including Whalley site for all)

Incidents of assaults on staff resulting in harm by financial year
• Mersey Care is committed to reducing the number of deaths by suicide of people in our care to zero by 2020. We are a founding member of the Zero Suicide Alliance, a collaborative of NHS trusts, businesses and individuals all committed to suicide prevention in the UK and beyond, which provides free suicide prevention training accessible to all. All staff now participate in our Mersey Care-designed suicide awareness training, which we are continuing to develop to help staff improve their clinical decision-making.

• We run the only high secure unit in England to receive a CQC rating of ‘good’ for safety, with the most efficient assessment processes in high secure services and reduced length of stay (down from 7.1 years in 2012 to 5.6 years) through focusing on recovery and care in the least restrictive setting. We have redesigned rehabilitation services in high secure services, making them more responsive to the needs and interests of people who use services and giving access to an additional 30 sessions per week on our wards to activities previously only available in centralised workshops.

• Our Street Triage (developed in partnership with Merseyside Police) improves access to mental health services as an alternative to police custody. It has impressive results: 40% fewer Section 136 detentions and £130,000 of savings in police time.

• In our local services, we have implemented a new personality disorder pathway which, in its first year, has reduced bed usage by people who use services with personality disorder by 80% and generated significant savings from repatriating out-of-area placements and reducing length of stay.

• We have made significant progress in the psychological approaches element of our transformation programme in local mental health services, including the large-scale training of nurses in psychological approaches and the appointment of 19 new psychologists, which has resulted in a 30% increase in psychological clinical activity compared with the baseline.

• Our asset-based approach to recovery is exemplified in the ‘Life Rooms’, home to our recovery college. It offers advice on staying physically well, on housing and money and access to volunteering and employment support. Over 16,000 people have accessed services or support at our Walton centre since May 2016, with 1,000 new recovery college students registered. We have since opened a second Life Rooms in Southport, with more venues planned.

• Clock View, our £25 million purpose-built inpatient unit opened in 2015, is the physical expression of our ambition for perfect care, recognising the positive impact that physical surroundings can have on recovery. It was awarded a trio of Design in Mental Health awards 2016.

• Our nationally recognised anti-stigma ‘Big Brew’ campaign, encouraging people to talk to one another in support of our zero-suicide ambition, has reached nearly 150,000 people through social media, also gaining national media coverage.

• Our physical health promotion service, ‘Dr Feelwell’, was a winner at the National Service User Awards in 2015.

• A thriving research and development programme with over 100 studies ranging from drug trials to bibliotherapy, app development to genomics.

What are you now most proud of?

We are particularly proud of our approach to co-production with people who use services and carers, having moved from a passive to active relationship with people who use services. Examples include:

• a new post of quality improvement lead with lived experience

• award-winning co-production and design:
  - Clock View Hospital
  - the Life Rooms and recovery college
  - Dr Feelwell – health promotion project

• reducing use of restraint and assaults on staff

• innovative social prescribing partnerships to support lived recovery

• suicide prevention training co-produced with people with lived experience

• working with people who use services to implement design-based solutions to reduce self-harm

• our digital innovations.

Approach/methodology…

How did you get there? Did you use any particular Improvement methodology?

The trust shifted from a clinical business unit structure (of six CBUs) to a structure of two (now three) clinical divisions to give clearer focus and more consistent, standardised care.

To embed high quality care across the clinical divisions we established our Centre for Perfect Care, bringing together our quality improvement, innovation, research and evidence services teams, and resources. This enables staff to get the basics of care right first time every time and help our people to innovate in ways that create better quality and outcomes for the people we serve while safely reducing cost.

‘Perfect care’ means:

• setting our own stretching goals for improvements in terms of big, zero-based goals in care rather than aiming to meet minimum standards set by other organisations

• getting the basics of care right first time, every time

• making improvements to the care we provide because we know it’s the right thing to do for people who use services and because we care about the care we provide

• working with staff and people who use services to design innovative solutions that greatly enhance the quality of care provided

• supporting people to try improvements, learn from their mistakes, and apply what works more rapidly in a consistent and safe manner, supported by good evidence and within an agreed framework

• helping our people to innovate in ways that create better quality and outcomes for the people we serve while reducing cost.

We have set ambitious goals in pursuit of perfect care, designed through ‘mega conversations’ with our staff:

• adopt a ‘reducing restrictive practice’ approach (avoid physical restraint, including medication-led restraint)

• zero suicide for those in our care

• optimum physical health for people who use services

• implement a just and learning culture.

We use the same improvement methodology across the organisation. This is the Institute for Health Improvement’s Model for Improvement, supplemented by teams of experts using design thinking methodology. This ensures an empathic approach to problem solving and improving quality which is standardised and easily used by clinicians in the clinical divisions. Our approach supports creative thinking and ensures we frame
the ‘real’ problem, understand the ‘now’, try innovative solutions, fail fast and learn faster, design solutions for and with all of our people.

Did you have any financial investment? Where did it come from?
The Centre for Perfect Care was created by redesigning existing resources within Mersey Care. An innovation fund was also created by top-slicing CQUIN money in relevant domains.

What were the most important factors in achieving the improvement?

Strategy
- Encourage creativity in setting ambitious targets and goals.
- Work to a strategy. Don’t just hit a control total – target something that matters to you and the organisation. Mersey Care’s strategy is summarised in Figure 32 below.
- Improve your understanding of what’s happening in the external environment.
- A vision and goals within a specific strategic timeframe are more realistic than a detailed long-term plan. Check that you are deciding what not to do as well as what to do in pursuit of your vision and goals.

Organisational culture
- Real staff engagement – Mega Conversations, Tell Joe, etc.
- Creating a clear rationale for where we want to be: ie perfect care.
- Giving staff the skills to make change across the organisation.
- Developing an approach to leadership that is consistent with the goals of the organisation.
- Build on strong financial foundations,

improve systems and processes and develop a culture for improvement.
- Quality and safety is everyone’s business and everyone knows their accountability.
- Work as a team – an open and transparent culture where everyone contributes.
- Reward and incentivise as well as hold to account.

Flexible decision-making
- Build flexibility into your decision-making so that your organisation can respond to material changes in the environment and adjust levels of investment.
- Don’t expect stability – know that uncertainty and change are the norm and that the real risks are in the assumptions.

Figure 32: Mersey Care’s strategy

Future work...

Do you have areas that need to improve further?
Our pursuit of perfect care will be greatly enhanced by the development of a ‘just and learning culture’. It is human nature to make errors, and it is widely accepted that errors cause accidents. In healthcare, errors and accidents result in suboptimal care that affects morbidity, leads to adverse outcomes and unfortunately sometimes mortality.

The trust has been developing plans for a just and learning culture. The benefits of such a culture ensure that other aspects of the quality agenda can continue to flourish, and staff are motivated to discuss mistakes and learn from them. This reduces risk in the organisation and fosters creativity. This has been informed by the significant input from the wide range of engagement events throughout the trust over recent months. We are now delivering incremental yet significant changes to fundamental aspects of organisational and procedural management to create a just and learning culture for all.

The early impact of our approach to a just and learning culture is demonstrated by the sustained fall in live staff disciplinary cases, as shown in Figure 33.

Figure 33: Number of disciplinary cases 2016 to 2017

As Mersey Care becomes a provider of community physical health services in addition to mental health services, we face new improvement challenges. In particular, we must make the most of our unprecedented opportunity to integrate services in Sefton and Liverpool and put community services at the heart of the local health system. We must ensure the safe transfer of community service staff to the trust so they can thrive.

What are the most important learning points?
Through our improvement journey, we have learned the importance of several foundations to successful improvement:
- clear strategy and ambition
- co-production with people who use services and carers
- staff engagement with quality goals
- developing a culture that enables improvement and innovation to be ‘the norm’ and part of everyone’s role in the organisation
- developing leading-edge partnerships.

As our improvement journey continues, we will learn and reflect on our progress towards perfect care.
Lancashire Care NHS Foundation Trust

What it was like before…

What were you most concerned about?
Like the NHS as a whole, the trust faced the challenge of maintaining and improving quality in the context of financial and staffing pressures. In 2015, the trust board saw the need to set a clear direction to achieve financial balance while promoting quality improvement.

What was the feedback on your services from people who use services, families and carers, partners?
People using our services and families and carers responding to the Friends and Family Test and associated questions gave positive feedback overall. However, some said they were not always involved in care in the way they would wish to be.

People who complained spoke about the ‘process’ focus of complaint management, and said the traditional ‘action plan’ approach to managing complaint findings lacked impact. Lead commissioners’ feedback on the Serious Incident process particularly mentioned reports lacking depth and noted recurring underlying themes, despite action plans following each report.

What did the staff say about the trust?
The 2014 annual staff survey highlighted the need to address some key areas of staff engagement.

What drove you to change?
The lead driver for change was quality, including safety. We needed to respond to an overall rating of ‘requires improvement’ from our 2015 CQC inspection. This was the first comprehensive inspection of the trust under the new inspection regime. We also needed to act on internal evidence from improved quality surveillance: incidents, complaints and other feedback indicated challenges in embedding and sustaining improvement work. And we needed to refresh our existing quality strategy, which came to an end in 2015.

We also recognised that health services facing challenging financial circumstances must innovate and transform to be sustainable. Keeping quality as the leading driver of change would reduce negative outcomes and their costs and keep our services competitive.

How things are now…

Do you think things are better? How do you know they are?
We believe the focus on quality as the trust’s leading strategic priority is supporting the growth of a quality improvement culture. This is demonstrated by:

• CQC reinspection results. CQC reinspected the trust in September 2016. The overall rating improved to ‘good’ with the domains of effective, caring, responsive and well led all rated as ‘good’. In particular, all core services in the domains of caring and responsive were rated as ‘good’ with only one core service rated as ‘requires improvement’ in the well-led domain. This was a full, comprehensive reinspection. As such, we believe it gives strong assurance to the improvement work we have done, although we recognise that the safe domain continues to be an area of challenge, with staffing as a priority.

• Growing quality improvement capability.
  QI capability is being strengthened from teams to the board. There are an increasing number of quality improvement projects aligned with key quality priorities, including violence reduction and care planning. For instance, we have created a centralised investigations and learning team within the safety and quality governance portfolio, focused on objective and independent investigations that fully engage people who use services, their family/carers and staff. These drive learning and improvement.

• Hearing feedback. In 2015, the customer care team and complaints management moved to sit within the improvement and experience portfolio, creating a focus on feedback with a person-centred approach, developed and tested using improvement methodology. Since then, the old ‘how to complain’ message has been changed to ‘how are we doing?’ This has encouraged people who use our service, families and carers to share their views with us. We welcome feedback as an opportunity to listen to and understand someone’s experience of care and review that experience alongside the perceptions of others involved. We increasingly use our understanding of the lived experience of people who complain to inform quality improvements.
• Quality surveillance and quality assurance supporting QI. Quality assurance at the trust is moving towards a real-time quality surveillance system including team information boards and team-level quality governance dashboards. The dashboards show key indicators such as incidents, risks, complaints, Friends and Family Test feedback, and improvement action completion in real time. The system gives teams the data and information they need to support conversations about quality and identify and create opportunities for improvement. The dashboards are aggregated at the clinical network level into trust-level surveillance reports. Known as ‘quality tiles’, these bring together quality information across domains. Good practice teams, which include an executive director, non-executive director, governor and commissioner, also regularly visit teams to hear how they are using their data to inform local improvements.

• Partnership with lead commissioners. Co-designed local CQUIN programmes have evolved from the testing and rollout of our improvement framework (see below). Its focus on ‘closing the learning loop’ follows the principles of co-designing improvements with people who use services, their families, carers and staff to support sustainable learning. The trust and commissioners have established a joint Serious Incident panel to review investigation reports and identify improvements openly and collaboratively (see more on investigations and learning below). The trust and lead commissioner for mental health services jointly submitted an HSJ Patient Safety Award application in 2016.

• Communication. Internal communications are now based on feedback from staff. Improvements include the launch of Quality Matters, a monthly informal bulletin that shares quality messages, reinforces team-to-board engagement and recognises staff achievements. The content is linked to our vision and quality plan. The Team Talk monthly bulletin for staff has been refreshed and includes live versions using Skype, so staff can hear directly from executives. We also launched a ‘Dear David’ portal, which allows staff to raise concerns directly with the trust chair, complementing the formal process for raising concerns. These measures were positively noted in the CQC reinspection of the trust in September 2016. The reinspection noted in particular the improvements in our team-to-board connection.

• Health and wellbeing. We have developed our staff health and wellbeing programme to include regular Schwartz rounds,11 recruitment of 102 health and wellbeing champions, a staff health needs assessment, working towards the Workplace Wellbeing Charter accreditation, assessing ourselves against NICE workplace health guidelines and developing our practice as a ‘mindful employer’.

11 These provide a structured forum where all staff, clinical and non-clinical, can meet regularly to discuss the emotional and social aspects of their work.
Investigations and learning. Our refreshed approach to investigations and learning has seen a sustained reduction in Serious Incidents. Recruitment to the new team was completed in 2016 using a values-based recruitment process informed by people who use our services. We ensure that people who use services and their families/carers are involved in all investigations, can inform the terms of reference, and receive final copies of all reports. We also ensure that staff involved receive copies of reports and the opportunity for a debrief. We have strengthened the feedback process for people involved in investigations and will use this to drive further improvements.

What are you now most proud of?

We are most proud of refreshing the trust vision, our quality-led strategy and our quality plan.

The quality-led strategy. During 2016/17, the trust refreshed its quality-led strategy in the context of significant changes affecting the health and social care environment, both at national and local levels. These include the requirement for the local health and care economy to develop a system-wide sustainability and transformation plan. To support delivery of our strategy, we now articulate annual shared organisational objectives. In essence, these describe our collective objectives as an organisation for the following 12 months that will help to achieve each year of our five-year strategy. This is based on the evidence from The King's Fund that a smaller number of co-ordinated, collective objectives are most effective for staff engagement and delivery.

The quality plan. Our quality plan is inclusive and co-produced with organisation-wide involvement, in line with our holistic approach. Teams across our support services, including finance, HR, medicines management, estates, performance, health informatics, transformation, communication and engagement, nursing and quality, have clarified how their work supports our clinical network and teams to achieve the core purpose stated in our vision. By articulating their contributions to clinical networks and teams in achieving the quality outcomes, support services are increasingly able to develop their business objectives and goals appreciating their impacts at the point of care. The quality plan therefore reflects shared accountability across the organisation for achieving the quality outcomes.

From a business planning perspective, operational plan objectives from across the organisation are aligned to the quality outcomes. Achievement of these outcomes is therefore closely integrated into our business planning process and assurance system.

Approach/methodology...

How did you get there? Did you use any particular improvement methodology?

Throughout 2015, The King’s Fund and Professor Michael West worked with the trust to explore the organisational culture and leadership capability. A cultural assessment tool was used alongside other diagnostic work. This led to the co-design of our people plan with staff and people who use our services.

In December 2015, the trust board confirmed that quality would be the trust’s leading strategic priority and that we would have a single quality-led strategy underpinned by a unique and ambitious quality plan. Shaping the future (Health Foundation 2015) describes the need for a strategy in which quality is the primary consideration for change recognising that improving the quality of care is what unites all staff working in the NHS frontline and support services.

The trust adopted IHIS Model for Improvement as the basis of our improvement framework. This is the model used by AQuA, an NHS health and care quality improvement membership organisation based in the North West that supports the delivery and development of a range of QI training options. The development of the quality-led strategy, the quality plan and the improvement framework are underpinned by improvement science and other associated methodologies: for example, total quality management, 4D appreciative inquiry and complexity science. They are fundamental to the success of the quality plan and our ongoing work to ensure a culture of continuous improvement.

The outcomes of the trust's improvement framework programmes were shared at showcase events in 2015 and 2016 and at the trust's first QI conference in 2017.

Did you have any financial investment?

Where did it come from?

The trust has invested in enabling improvement learning and expertise and engagement with national and international partners to lead a range of initiatives. The trust has committed to a number of national programmes:

- the Building Blocks Framework: AQuA and Dr Peter Chamberlain
- the Frontier Framework: NHS England and Coventry University
- Always Events: Institute for Healthcare Improvement, Picker and NHS England
- people-centred care model: Philips UK and Ireland.

A key area of investment has been in giving staff across the organisation the time and capacity to engage in improvement. Staff capability has been developed through training and learning opportunities and allowing the time to implement improvements in practice and share learning.

The trust has also invested in the quality improvement and experience team to provide supporting QI expertise and capability.

What were the most important factors in achieving the improvement?

Important factors are:

- having visible executive and board support
- developing improvement expertise within support services as well as across clinical networks and teams
- fostering and supporting infectious enthusiasm among improvement leaders
- creating opportunities to share learning and showcase improvements
- engaging with people who can help, e.g., national programme leads, AQuA
- moving from locally developed improvements to delivering quality priorities following a more systematic approach, while maintaining the enthusiasm for generating team-level improvement
- bringing together improvement and quality surveillance and quality assurance.

Future work…

Do you have any areas to improve further?

The trust is committed to continuous improvement and our quality surveillance and quality assurance work helps us identify priorities. Our plans over the next year include:

- capturing, recording and reporting improvement activity more effectively and systematically with our Life QI system
- developing a portfolio of stories from staff and people who use services to inform learning, in our ‘patient voices programme’
- continuing to build improvement capability and capacity across all teams
- truly ‘closing the learning loop’ by using improvement approaches to understand what needs to change to address complaints and Serious Incidents.
- engaging with people who can help, e.g., national programme leads, AQuA
- moving from locally developed improvements to delivering quality priorities following a more systematic approach, while maintaining the enthusiasm for generating team-level improvement
- bringing together improvement and quality surveillance and quality assurance.

Devon Partnership NHS Trust

What it was like before…

What were you most concerned about?

Our main concerns were staff attitude and morale. In 2014, the trust was in the lowest quartile of mental health trusts in the national NHS Staff Survey. Our responses to questions on whether staff would recommend DPT as a place to work and or to receive care scored very low.

What was the feedback on your services from people who use services, families and carers, partners?

This feedback was mixed. It found staff caring in the main, but waiting times were a frustration. Our services were found to be neither consistent nor easy to access across Devon. We had poor feedback on our partnerships, but problems were rooted more in relationships than ‘facts’ about services.

What did the staff say about the trust?

Staff said they liked their team and their line manager but they didn’t feel valued, and members of the senior management team were not always visible, engaged or listening. There was also a perception that we were focused on gaining and keeping NHS foundation trust status and not much else. There was a lot on negative aspects of the trust in staff feedback.

What drove you to change?

The main drivers for embarking on our improvement journey in 2014 were a poor staff survey and low morale. Given the very stark financial climate, we also needed to transform our services to bring about efficiencies and we needed to take staff with us. Quality was a critical driver as well. We needed to improve outcomes and access to our services.

How things are now…

Do you think things are better? How do you know they are?

Things have improved hugely. The staff survey in 2016 showed where we improved the most from 2015:

- not feeling pressured into coming into work when unwell
- good communication between senior management and staff
- reporting experience of harassment, bullying or abuse
- quality of appraisals
- quality of non-mandatory training and development
- fairness and effectiveness of procedures for reporting errors, near misses and incidents
- organisation and management have an interest in and action on health and wellbeing
- effective teamworking
- staff satisfaction with resourcing and support.
Our top five scores 2016 (where we compared most favourably with other mental health/learning disability trusts) were:

• support from immediate manager
• not attending work when feeling unwell because of pressure from their manager, colleagues or themselves
• effective team working
• staff satisfied with the opportunities for flexible working patterns
• staff not experiencing physical violence from people who use services, relatives or the public in the last 12 months.

What are you now most proud of?
In 2017, DPT received a CQC rating of ‘good’ for all its services, a real reflection of the improvements we have made.

Approach/methodology…
How did you get there? Did you use any particular improvement methodology?
Our improvement approach emphasises clarity of purpose, engagement of all staff, consistency in implementation and overall commitment. We have sometimes used particular improvement techniques based on Lean thinking.

Specifically, we regularly carry out or have recently undertaken:
• An annual ‘Our Journey’ roadshow to engage staff: this comprises 10 engagement events across whole of our area, including Bristol, attended by 900 to 1,000 staff each year.
• A senior staff forum three times a year: this is attended by the top 125 leaders across the trust. It strengthens shared understanding of our strategy and builds leadership effectiveness.
• A leadership development programme: in 2017, 75 senior managers participated in a diagnostic process to identify leadership development requirements against our new leadership framework. These managers now have targeted personal development plans. The trust is also revising its leadership development programme to respond to corporate themes arising from the diagnostic.
• A new leadership programme to develop team managers and ward managers
• A staff health and wellbeing programme: this concentrates on building resilience and giving psychological support to staff. Health and wellbeing have been a particular focus of our staff engagement activities.
• A project to explore how we improve the quality of our supervision and appraisal.
• A learning and development review: this examined how we can improve learning and development opportunities for staff so they support both core training and continuing professional development requirements.
• A ‘Chair’s Initiative Fund’: this encourages staff to put forward ideas for improvement that they want to test.
• Staff engagement in QI programmes, such as ‘Four Steps to Safety’.
• Regular Schwartz rounds: these provide a structured forum where all staff, clinical and non-clinical, can meet regularly to discuss the emotional and social aspects of their work.

Since the end of 2016 we have:
• improved the quality of appraisals to make sure they are meaningful for staff
• extended our staff health and wellbeing programme
• turned ideas shared at ‘Our Journey’ (see above) into improvements for people using our services and for our staff
• improved learning and development opportunities for staff.

Did you have any financial investment? Where did it come from?
We had minimal additional investment. Most of our improvement work has been done within existing resources.

What were the most important factors in achieving the improvement?
Clarity of purpose, engagement of all staff, consistency in implementation and overall commitment.

Future work…
Do you have areas that need to improve further?
Yes, lots.

What are the most important learning points?
Get on with it, and stay centred on quality.

Table 3: Staff who would recommend the trust

<table>
<thead>
<tr>
<th></th>
<th>% staff who would recommend DPT as a place to receive treatment</th>
<th>% staff who would recommend DPT as a place to work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2014/15</td>
<td>47%</td>
<td>47%</td>
</tr>
<tr>
<td>Q1 2015/16</td>
<td>56%</td>
<td>56%</td>
</tr>
<tr>
<td>Q1 2016/17</td>
<td>62%</td>
<td>62%</td>
</tr>
</tbody>
</table>
Tees, Esk and Wear Valleys NHS Foundation

What it was like before…

What were you most concerned about?
We were most concerned about our ability as a new trust to sustain services: we needed to find a way to drive up quality and drive out waste. As a newly merged organisation, we also needed to create a top team that could develop a culture built on the best of both from the previous organisations with its own strengths and identity.

What was the feedback on your services from people who use services, families and carers, partners?
We had reasonably good feedback on the national patient survey. However, we had limited ways of capturing local qualitative and quantitative feedback.

What drove you to change?
The main driver was quality. For instance, one of the original drivers for our improvement work on inpatients was the poor experience of those using services and a serious incident. However, we were clear we had to be financially viable as well. We also wanted to ensure we had close working between clinicians and managers. We achieved this in part by ensuring joint accountability and responsibility for services between operational managers and clinicians at all levels.

How are things now?
Do you think things are better? How do you know they are?
Over the past five years, we have been in the top five on both the NHS Patient Survey and the NHS Staff Survey. Our results in some of the Prescribing Observatory for Mental Health audits have increased dramatically. We have good financial performance for our type of organisation. Recruitment has improved, although it is not without challenges. We have been able to take on new services and improve them.

What are you now most proud of?
The establishment of our recovery college and our recovery-focused way of working through co-production. This has been a significant programme for us in the past three years, which has led to new opportunities for our improvement work.

Approach/methodology...

How did you get there? Did you use any particular Improvement methodology?
We started developing a clear improvement plan in 2007, shortly after the creation of TEWV as a newly merged organisation. A small number of our clinicians and our chief operating officer went to a presentation by Gary Kaplan, Chief Executive of Virginia Mason Medical Centre. He was speaking in the north east to help establish the North East Strategic Health Authority’s (SHA) transformation programme.

TEWV’s chief executive at that time asked senior clinicians if our organisation should get involved. Three out of our five clinical directors were keen, so we began to implement the TEWV quality improvement system. Our new chief executive was appointed in 2009. Senior clinicians and other leaders convinced him that if he allowed the organisation to continue with our improvement work using the Virginia Mason production system (VMPS), which is based on the Toyota production system, we could increase the quality of services while reducing waste and therefore cost. He then provided strong personal leadership, as he became convinced of the opportunities for improvement that this approach could bring. We are rigorous in our use of the VMPS and use it in three ways: to improve services; for our planning systems; and, more recently, to drive our management systems.

At the same time as we adopted an improvement methodology, we developed ‘a compact’ or shared explicit understanding of what staff could expect from the organisation and what the organisation could expect from staff. A vision for the organisation was developed with input from a wide range of staff and stakeholders, and a set of values and behaviours developed.

The VMPS and the compact aligning staff and the organisation were both essential in developing an organisational culture that could improve quality and reduce waste.

Did you have any financial investment? Where did it come from?
Initially we received some training via the SHA for executives and members of our improvement team. We have financed the establishment of that improvement team internally.
What were the most important factors in achieving the improvement?

The most important factors have been:

- board-level support and involvement especially from the trust’s chief executive
- development of a clear vision, mission, values and a behavioural compact that describes the ‘gives’ and the ‘gets’ between staff and the organisation
- development of robust governance and performance structures, e.g. ensuring pairs of managers and clinicians with clear accountability and responsibility, clear objectives for everyone, clear board and local priorities, clear reporting structures, etc
- a focus on value as seen through people who use services’ and carers’ eyes, in particular this has meant involving people who use our services and carers in our improvement events and developing a cohort of experts by experience
- external support from Virginia Mason and the SHA
- developing internal capability and funding capacity to use our improvement methodology, ensuring staff had time to be trained and to use their knowledge and skills has led to much greater staff engagement.

Future work...

Do you have areas that need to improve further?

We continue to work on improvement across our services. We have taken on new services that are not as high quality and we are working to improve them.

We are undertaking a large-scale change project with 93 of our community teams. The strands within this work are leadership, pathways, workforce redesign, use of technology, information flows and team processes.

We are working on introducing daily Lean management processes across our organisation. We have a model wards programme for inpatients.

What are the most important learning points?

- Leadership
- Co-production
- Long-term vision
- Consistency of approach
Cheshire and Wirral Partnership NHS Foundation Trust

What it was like before…

What were you most concerned about?

Unwarranted variation in quality and safety within and between pathways was an overall concern for the trust, as it is for many NHS organisations. A notable example, in 2015, was variation in the management of the challenging behaviour pathway, particularly in our reporting of prone position physical restraint compared to other trusts. The ‘story’ of continuous improvement in CWP’s management of challenging behaviour told below is just one example of many such pathway improvement stories that are unfolding as the trust’s overall ‘zero harm’ quality strategy takes effect and as the trust now starts to implement a new, long-term quality improvement strategy.

What was the feedback on your services from people who use services, families and carers, partners?

People who use services and family feedback on prone position restraint was limited because of variation in the completion of post-incident reviews. However, NHS Benchmarking Network data identified CWP as a negative outlier for the use of prone position restraint in managing challenging behaviour.

People who use services were positive about the trust overall at this time, as shown by the national NHS Patient Survey, in which people who use services gave us higher than national average scores for their experience of the trust’s services. As expected, families and carers reported mixed experiences of services directly to us: for example, through complaints and compliments. Meanwhile, the trust received consistently positive feedback about its services from those partners required to comment on them as part of the annual Quality Account process.

What did the staff say about the trust?

Staff feedback on prone position restraint was inhibited by the format of the documents for reviewing physical restraint following an incident. The old format gave limited opportunities for recording reflection and lessons learned.

Staff were positive about the trust overall at the time. The national NHS Staff Survey showed CWP staff reporting higher scores than the national average on whether they were happy with the standard of care provided by the trust.

What drove you to change?

The main drivers for improving our clinical practice in relation to the management of challenging behaviour were care quality and the safety of people who use services and staff.

How things are now…

Do you think things are better? How do you know they are?

Yes. Within three months of taking the approach described below, there was a 50% reduction in the use of prone position restraint across the trust. This reduction has not only been sustained to date but continues to improve. We know this is the current state because we have implemented collection of a minimum dataset for each ward, refreshed every quarter, to measure and monitor our quality performance. The dataset is drawn from existing data sources, such as incidents and training, but the data is triangulated to provide staff at all levels with intelligent analysis and suggestions for continuous improvement.

What are you now most proud of?

We are most proud of the way our clinical and corporate teams feel collective ownership of this continuous improvement: this is a true team effort between direct and non-direct care staff.

Approach/methodology…

How did you get there? Did you use any particular improvement methodology?

We used the Institute of Healthcare Improvement’s Model for Improvement, including a number of PDSA cycles. We started by undertaking a meta-analysis, including clinical audit, to understand in full the issues associated with the trust’s baseline practice. We then identified appropriate improvement actions and methodologies. The primary improvement methodology we used was structured reflective practice reviews. Matrons undertook reflective reviews within 72 hours of each physical restraint incident. These included staff debriefs, which use human factors principles as a quality improvement science, to seek people who use services’ views of their experience of being restrained.

Did you have any financial investment? Where did it come from?

No.

What were the most important factors in achieving the improvement?

A critical factor in achieving continuous improvement was ensuring ‘line of sight’ – ensuring transparency and providing detailed analysis of reported incidents of prone position restraint routinely at ward level, as well as monthly to the board. This encouraged oversight and scrutiny of the impact of improvements. But we attribute the sustained improvements and spread to a number of factors, not least reflective practice reviews, which drive up data quality and enable learning to be shared and implemented.

Future work…

Do you have areas that need to improve further?

Lots. On incidents involving prone position restraint, we don’t just accept the current state: we are undertaking a 90-day quality improvement cycle to identify where we can make further improvements. Our aim is to report zero such incidents as the norm. We are also exploring our quality performance on supine position restraint. Otherwise, for this year we have identified through the annual quality account process three priority areas for an improvement focus: the risks of high dose antipsychotic therapy, the effectiveness of inpatient bed management, and improving the experience of people who use services through person-centred approaches.

What are the most important learning points?

The main learning points from our experience are:

- Ensure executive director leadership of improvement.
- Enable clinicians, corporate support services and people who access services to collaborate on improvement.
- At the start of any improvement, hold a well-organised initial meeting involving all key stakeholders to agree the aim and ideas for change, ensure focus and develop a practical improvement plan.
- Use robust and complete data, which is trusted by everyone, and shows the results of interventions, pockets where work is still needed and good practice exemplars. Driver diagrams can help display this data.
Birmingham and Solihull Mental Health NHS Foundation Trust

What it was like before…

What were you most concerned about?

The formation of the trust in 2002 brought together three very different mental health trusts. Continuing to manage services based on their three localities resulted in three quite distinct cultures continuing across the new trust. This had significant effects on trust-wide staff engagement and variations in practice, which were evident in staff feedback and surveys 10 years later.

What was the feedback on your services from people who use services, families and carers, partners?

Feedback showed that, while we were a very innovative trust, we didn’t listen enough to people who use services, families and stakeholders and the trust wasn’t providing consistently high standards of care across services and localities.

What did the staff say about the trust?

Staff said the trust wasn’t sufficiently open and listening, and that it wasn’t dealing with the service and cultural variations found across the area it served. Staff wanted to see a more visible service and cultural variations found across the area it served. Staff wanted to see a more visible service and cultural variations found across the area it served. Staff wanted to see a more visible service and cultural variations found across the area it served. Staff wanted to see a more visible service and cultural variations found across the area it served. Staff wanted to see a more visible service and cultural variations found across the area it served.

What drove you to change?

The main driver for change was a need to improve quality in particular, to focus more on developing a recovery approach, and on engaging and using staff in its development. Between 2011 and 2013 there had also been a number of high profile safety concerns and homicide incidents. While no common themes were identified among them, it was important to give much greater assurance to people who use our services, carers, families and staff that these issues were being dealt with consistently across the trust.

The trust was and remains financially sound. Finance has not been a consideration in its commitment to its quality improvement agenda. However, the availability of resources and pressures on services from increased demand do at times limit our scope to focus on quality improvement initiatives. For example, all our acute admission wards operate at over 95% occupancy, so staff teams don’t get the organisational development time they need to embed all our planned quality initiatives as fast as we would like.

How things are now…

Do you think things are better? How do you know they are?

Over the five years since the start of our improvement journey we have seen: improved staff satisfaction scores and greater focus on openness and honesty throughout the organisation; improved service satisfaction scores; fewer complaints; and fewer Serious Incidents and homicides. We also do better against national benchmarks for suicide and we have a level of harm due to clinical incidents that is lower than the national average.

What are you now most proud of?

We are most proud of seeing complaints reduced and satisfaction scores improved from people who use our services, as well as a massive increase in the use of our people who use services advice and liaison service and informal mechanisms to resolve concerns and respond to enquiries.

Some of the innovations and partnerships we undertake locally and regionally are real vanguard initiatives. They ensure we remain a high profile trust, delivering new service and organisational models.

Across the organisation, there is a clear focus on making sure we learn from incidents and that we operate as a whole trust. This includes managing services on a service-line basis across our patch, so we now deliver much more consistent services across the trust.

Approach/methodology…

How did you get there? Did you use any particular improvement methodology?

The board led a clear policy and programme for staff engagement. It opened up new and innovative ways to engage and listen to staff, including a confidential ‘Dear John’ mechanism for staff to report concerns and suggestions directly to the chief executive.

Introduced four years before the Freedom to Speak Up initiative, this practice was praised by CQC and the House of Lords as innovative and successful.

Alongside this, we have focused our organisation development (OD) work on a small number of clear values, which we have now promoted to all staff consistently for five years. This work has been led by a very experienced executive team: all the executive directors and the chief executive have held director-level posts elsewhere before coming to the trust. This executive team is also a settled team, providing a consistency of approach over time. All board members carry out weekly visits, and the nursing and medical directors on the board carry out some clinical duties.

Did you have any financial investment? Where did it come from?

Yes, but all our investment in improvement was raised internally through consistently delivering each year of our financial plan. However, additional investment, if available, would be very helpful, especially if directed towards releasing our frontline teams to engage in more OD and quality improvement work. Being able to release a whole inpatient or community team for a two-day development session is a luxury we can’t afford. This limits – and will continue to limit – the speed and impact of our quality programme.

What were the most important factors in achieving the improvement?

The most important factors have been commitment and focus sustained over five years; making sure that all staff and teams are involved and engaged in this improvement; and keeping messages about quality, the importance of values, and involving people who use our services and our staff both simple and consistent.

Future work…

Do you have areas that need to improve further?

Yes. To make sure we maintain the focus on quality, we need to continue our programme and build on current successes and initiatives through new quality improvement programmes. Quality improvement is something that never ends or reaches a conclusion, as we can always improve services and we have to respond to new and changing demands.

What are the most important learning points?

It’s all about staff engagement and your people.
Valued care in mental health: Improving for excellence > Compendium of trust improvement stories | 268

East London NHS Foundation Trust

What it was like before...

What were you most concerned about?

Violence: the cost of violence to staff, people who use services and the organisation was – and remains – considerable. Violence contributes to absence through sickness and injury, the use of restrictive practices, decreased morale and higher staff turnover.

Actual physical violence (as opposed to threats or attempted violence) continues to be the most frequently reported type of incident in the trust. There are on average 137 reported incidents per month. So it remains a priority for this organisation to address. Only a very small minority of these incidents occur in community settings. The rest are distributed between general adult admission wards, mental healthcare of older people, inpatient CAMHS and forensic services.

Before 2010, we did not single out violence as an issue requiring attention in our trust. As in most NHS trusts, reporting of violent incidents was variable and did not accurately reflect the quality of care or the experience of staff and people who use services on the wards. As a signal of both, it was weak.

A homicide on one of the adult inpatient wards in 2010 became a tragic turning point for us. This incident and its aftermath set the trust on a path to fundamentally rethinking its way of operating. In the two years following this terrible event, we have consistently reported and analysed data on violence.

What was the feedback on your services from people who use services, families and carers, partners?

Feedback from the inpatient wards told a very mixed story. When people who use our services were surveyed, scores for general engagement with staff and involvement in their own care hovered around an average of 3 to 3.5 out of 5, with considerable variation within and between hospitals in the trust.

The national NHS mental health inpatient survey scores for 2012 indicated that we were then below the national average for people using services feeling safe, spending time with nurses and being treated with dignity and respect. It was not all bad news, though: we also had higher scores than the national average in many areas.

What did the staff say about the trust?

Our overall scores from the NHS Staff Survey for staff experiencing violence at work were formerly high, above the national average. However, these were, and still are, balanced by good scores for staff feeling that they can make a difference, contribute to improvements and communicate with senior managers, and for overall staff engagement.

What drove you to change?

The main drivers were:

- Quality: the review into the homicide highlighted significant problems with clinical leadership on the wards and the standard of practice in nursing.
- Safety: again, the homicide drove a fundamental rethink of the trust’s approach to safety.

How things are now...

Do you think things are better?

We now have a much improved inpatient service: following its full inspection in 2015, CQC rated our adult wards as outstanding.

We are now much more confident in the leadership on the wards and the manner in which people who use services are cared for.

The concentration on reducing violence has helped to crystallise aspects of healthy team behaviour that keep clinical care, communication, inclusion, respect and decision-making constant and focused.

What are you now most proud of?

The scale and extent of our reductions in violence. The reduction in violence initially achieved on Globe Ward in Tower Hamlets (Figure 35) was scaled up across all the wards in Tower Hamlets (Figure 36), and has now been scaled up across the adult inpatient wards in City, Hackney and Newham boroughs. Each service uses a collaborative approach to learning together and maximising the benefits of what we now call the safety culture bundle. This is a collection of four related components that focus team attention and behaviour, as highlighted above.

For further details, refer to the paper, ‘Reducing physical violence and developing a safety culture across wards in East London’ (Taylor-Watt et al 2017).
Figure 36: Reduction in violence across all wards in Tower Hamlets

Figure 37: Data for City and Hackney mental health wards on numbers of incidents of physical violence each week
How did you get there? Did you use any particular Improvement methodology?

With the board’s support, in 2014 we partnered with the Institute for Healthcare Improvement (IHI) in the United States. We have used IHI’s Model for Improvement to develop our changes and learn how our system works and behaves over time. We introduced a variety of training options and developed leadership and support structures for improvement in each locality, resulting in 235 successful improvement projects.

We have also focused on priority areas, such as reducing violence (as described above), reducing community-acquired pressure ulcers and improving access to services. There have been substantial improvements in all three areas.

Over 1,600 staff have received training in improvement science – from a basic introduction to the most advanced training in the method and its application in healthcare.

We established a dedicated central improvement team, whose improvement advisors work with each directorate. This team is supported by higher level expertise and senior leadership, both within and outside the team.

Did you have any financial investment? Where did it come from?

The trust decided to invest in both the relationship with IHI and the central improvement team. The greatest investment though is in releasing the time for staff across all areas of the organisation to work on improving something within their service, as part of their daily work. The return from these investments is realised at multiple levels: primarily from the improvement in outcomes and experience for people using our services, from the improvement in staff engagement and experience at work, from increased efficiency within many teams, from costs avoided in a number of projects and from costs removed from the system completely in a small number of projects.

What were the most important factors in achieving the improvement?

The most significant factor has been engaging and empowering our staff to lead improvements. By tackling what matters to them and providing a method, support and a systematic approach to learning, we have seen staff take considerable and justifiable pride in their work.

Consistency of leadership and making improvement part of the normal business of the organisation have been central. Engaging our key leaders and local stakeholders has kept the focus on improvement being a part of day-to-day operations, not a passing phase.
Conclusion

The purpose of this document is to provide health organisations (primarily mental health organisations) with information and practical advice to help to improve care with the people that use services.

People who use services are best equipped to describe what good looks like. Involving them, their carers and their families should be the priority or starting point for any improvement journey.

Each of the nine chapters, has described why the subject is important, provided a high level review of the literature and evidence on how the topics have been addressed in the form of case studies. The chapters conclude with suggestions so that the reader will take these forward on their improvement journey.

An important message is that any quality improvement methodology must be applied with commitment, rigour and skill. It must also be acknowledged that application of a methodology alone will not result in improved care. A core message is that without true engagement and leadership in a positive culture, improvement will not be effective or sustainable. Investment in innovation and improvement in every sense is necessary if better and safer care is to be provided in challenging times.

We believe that many of the solutions to improving mental healthcare in England lie within the system. We believe that there is a world class model for mental health service delivery in England, the problem is that different bits of it are in different organisations. This resource provides examples of good practice which if brought together would deliver to this standard right across the whole delivery system.

Sharing good practice, learning from each other and building relationships has enabled the production of Valued care in mental health: Improving for excellence. We hope those who use this resource will be helped to turn their ambitions into reality.
Appendix

Group improvement stories – thematic analysis report

We invited all partners to provide a narrative about their journey, to share not only what they are proud of and what they are doing well, but lessons they have learned.

Method

Participant responses

Birmingham and Solihull Mental Health NHS Foundation Trust
Cheshire and Wirral Partnership NHS Foundation Trust
Devon Partnership NHS Foundation Trust
East London NHS Foundation Trust
Hertfordshire Partnership NHS Foundation Trust
Lancashire Care NHS Foundation Trust
Mersey Care NHS Foundation Trust
Northumberland, Tyne and Wear NHS Foundation Trust
Tees, Esk and Wear Valleys NHS Foundation Trust

Procedure

We asked each partner to answer the questions below to capture the background to their work.

What it was like before…

1. What were you most concerned about?
2. What was the feedback on your services from people who use services, families and carers, partners?
3. What did the staff say about the trust?

How things are now…

4. What was the catalyst for change?
   • Money
   • Quality
   • Safety
   • Other

5. Do you think things are better? How do you know they are?
6. What are you now most proud of?

Approach/methodology…

7. How did you get there? Did you use any particular improvement methodology?
8. Did you have any financial investment? Where did it come from?
9. What were the most important factors in achieving the improvement?

Future work…

10. Do you have areas that need to improve further?
11. What are the most important learning points?

Analysis

We analysed responses using inductive thematic analysis. First, responses to each question were read carefully to identify meaningful units of text relevant to the question. Second, units of text dealing with the same content were grouped together into sub-themes. Third, these sub-themes were then grouped into a small number of key overarching themes. This procedure was repeated for each of the 11 questions.

Results

The results appear in the tables that follow.

Conclusion

What it was like before…

Question 1 – What were you most concerned about?

Themes identified

<table>
<thead>
<tr>
<th>Efficiency</th>
<th>Culture</th>
<th>Staff engagement/confidence</th>
<th>Quality of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving quality while reducing cost</td>
<td>Aligning staff and organisation expectations</td>
<td>Lack of staff engagement</td>
<td>Reducing violence</td>
</tr>
<tr>
<td>Improving efficiency</td>
<td>Change of philosophy</td>
<td>Staff attitude and morale</td>
<td>Noise reduction</td>
</tr>
<tr>
<td>Maximising investment in community services</td>
<td>Embedding improvement</td>
<td>Staff fatigue</td>
<td>Out-of-area placements</td>
</tr>
<tr>
<td>Balancing resources</td>
<td>Change in priorities and focus</td>
<td>Stabilising the workforce by reducing vacancies</td>
<td>Reducing waiting lists for psychological therapies</td>
</tr>
<tr>
<td></td>
<td>Variability in culture of reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Developing leadership</td>
<td>Culture of reporting did not reflect quality of care</td>
<td></td>
</tr>
</tbody>
</table>

Note: Key themes are in Bold.
**Question 2 – What was the feedback on your services from people who use services, families and carers, partners?**

Themes identified

<table>
<thead>
<tr>
<th>Staff were supportive</th>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>People who use services felt that staff were involved in their care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of communication between staff and carers about people who use services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People in service a long time</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Person-centred care for people who use services with complex needs</th>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>People who use services confident in making complaints</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff didn’t listen enough to people who use services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People who use services not treated with respect</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Good engagement with staff</th>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great track-record of being values-based</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People who use services not having access to care plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need more effective, evidence-based interventions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff supportive at inpatient services</th>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Families and friends would recommend</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People who use services have limited contact with staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serious Incidents</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Families were given information that helped them to make choices</th>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care pathways not always clear for the journey of people using services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People who use services not feeling safe</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Unable to quickly and simply access the right service</th>
<th>People who use services feel service was too process-driven</th>
</tr>
</thead>
</table>

**Note.** Key themes are in Bold.

**Question 3 – What did the staff say about the trust?**

Themes identified

<table>
<thead>
<tr>
<th>Staff felt engaged and motivated at work</th>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felt supported by manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opportunity to provide feedback was limited</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff positive about the trust overall</th>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felt could communicate with senior managers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Didn’t know what the organisation stood for</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Satisfied with their quality of work</th>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective teamworking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt not involved in decisions that affect their work</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Felt that roles make a difference to people who use services</th>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>No physical violence from people who use services, their relatives or public</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt that there was too much variation in quality of services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>There were opportunities for flexible working</th>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>No pressure to attend work feeling unwell</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not enough space</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enthusiasm about improvement</th>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felt secure in raising concerns about unsafe practices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do not have the adequate materials, supplies and equipment to do work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt isolated</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Would not recommend trust as place of work</th>
<th>Felt health and wellbeing not prioritised by trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Tension between senior staff</td>
</tr>
</tbody>
</table>

**Note.** Key themes are in Bold.
What it was like before…

Question 4 – What was the catalyst for change?

Themes identified

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Six out of nine indicated Safety as a catalyst for change</td>
<td>Eight out of nine indicated Quality as a catalyst for change</td>
<td>Three out of nine indicated Money as a catalyst for change</td>
<td>Three out of nine indicated that there were other catalysts for change</td>
</tr>
<tr>
<td>Safety</td>
<td>Quality</td>
<td>Money</td>
<td>Other</td>
</tr>
<tr>
<td>Safety as a catalyst for change</td>
<td>Quality as a catalyst for change</td>
<td>Money as a catalyst for change</td>
<td>Other catalysts for change</td>
</tr>
</tbody>
</table>

Note. Respondents indicated their responses by ticking as many of the four boxes as required. Those who ticked ‘Other’ were asked to specify.

How things are now…

Question 5 – Do you think things are better? How do you know they are?

Themes identified

<table>
<thead>
<tr>
<th>Improved performance</th>
<th>Positive shift in culture</th>
<th>Investment in services</th>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement in CQC rating</td>
<td>Increased access and engagement for people who use services with the trust</td>
<td>New and innovative pathways and approaches</td>
<td>New partnerships with commissioners</td>
</tr>
<tr>
<td>Improvement in financial performance</td>
<td>Shift in culture to improvement and innovation</td>
<td>Investment and improvement in inpatient infrastructure</td>
<td>Improvement delivered from experts by experience</td>
</tr>
<tr>
<td>Reduction in use of restraint and Serious Incidents</td>
<td>Openness and honesty through the organisation</td>
<td>Increase in number of medical research studies</td>
<td>Accreditation and awards</td>
</tr>
<tr>
<td>Decrease in out-of-area placement</td>
<td>Reality checks with staff</td>
<td>Investment in new services</td>
<td></td>
</tr>
<tr>
<td>Comparison of trend data</td>
<td>Improvement in healthy team behaviour</td>
<td>Improved support for staff</td>
<td></td>
</tr>
<tr>
<td>Improvement in overall quality and outcomes</td>
<td>Deterioration in performance flagged for further investigation</td>
<td>Improved recruitment</td>
<td></td>
</tr>
<tr>
<td>Improved staff satisfaction scores</td>
<td>Improved team-to-board communication</td>
<td>Development of new metrics</td>
<td></td>
</tr>
<tr>
<td>Improved satisfaction scores from people who use services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduction in waiting times of specialist tertiary treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduced complaints</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fewer section detentions</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. Key themes are in Bold.
How things are now…

Question 6 – What are you now most proud of?

Themes identified

<table>
<thead>
<tr>
<th>Collaborative approach</th>
<th>Improved outcomes</th>
<th>Philosophy</th>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-production approach</td>
<td>Improved staff survey and satisfaction scores from those who use services</td>
<td>Clear vision</td>
<td>Staff empowerment and engagement</td>
</tr>
<tr>
<td>Integration of people who use services, family and carer into design and implementation of services</td>
<td>Reduced complaints</td>
<td>Quality-led strategy and plan</td>
<td>Awards and accreditation</td>
</tr>
<tr>
<td>Collaborative team approach to safety and improvement</td>
<td>Reduced use of restraint and innovation</td>
<td>Adoption of more flexible working</td>
<td></td>
</tr>
<tr>
<td>Innovation and partnership work, locally and regionally</td>
<td>Reduction of violence</td>
<td>Clear focus on learning from experience</td>
<td>Enthusiasm and commitment from staff to improvement</td>
</tr>
<tr>
<td></td>
<td>Increase in concern resolutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduction in medication errors</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improvement in waiting times</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. Key themes are in Bold.

Approach/methodology…

Question 7 – How did you get there? Did you use any particular improvement methodology?

Themes identified

<table>
<thead>
<tr>
<th>Specific improvement methodologies</th>
<th>Investment in staff</th>
<th>Investment in improvement structures</th>
<th>Culture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lean thinking</td>
<td>Supporting staff involvement in improvement activity</td>
<td>Establish improvement structures/approach</td>
<td>Continuous improvement in care</td>
</tr>
<tr>
<td>Structured reflective practice reviews</td>
<td>Coaching support and leadership training</td>
<td>Consolidation of clinical business unit structures</td>
<td>Focus on priority areas</td>
</tr>
<tr>
<td>Institute for Health Improvement’s Model for Improvement</td>
<td>Increasing visibility of senior managers and clinical staff</td>
<td>Establishment of innovative pathways of care</td>
<td>Focus on priority areas</td>
</tr>
<tr>
<td>Virginia Mason production system</td>
<td>Training staff in improvement science</td>
<td></td>
<td>Learning from experience</td>
</tr>
<tr>
<td>Design thinking methodology</td>
<td>Supporting staff to innovate by improving quality whilst reducing cost</td>
<td></td>
<td>Setting goals for improvements rather than aiming for minimum standards</td>
</tr>
<tr>
<td>Fact-based decision-making</td>
<td>Harnessing internal knowledge and expertise from improvement-driven enthusiasts</td>
<td></td>
<td>The improvement mindset</td>
</tr>
<tr>
<td>Improvement framework</td>
<td>Policy and programme for staff engagement</td>
<td></td>
<td>Dynamic executive team</td>
</tr>
</tbody>
</table>

Note. Key themes are in Bold.
**Approach/methodology…**

**Question 8 – Did you have any financial investment? Where did it come from?**

Themes identified

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioners</td>
<td>None</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Repurpose of existing resources</td>
</tr>
<tr>
<td>Internal</td>
<td>Savings made from schemes</td>
</tr>
</tbody>
</table>

Note. Key themes are in Bold.

**Approach/methodology…**

**Question 9 – What were the most important factors in achieving the improvement?**

Themes identified

<table>
<thead>
<tr>
<th>Improvement philosophy</th>
<th>Investment in improvement structures/methodology</th>
<th>Investment in people</th>
<th>External factors</th>
<th>Other important factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishing improvement philosophy, principles and values</td>
<td>Foundations, systems, processes</td>
<td>Visible executive-level support</td>
<td>Understanding of the external environment</td>
<td>Incentives</td>
</tr>
<tr>
<td>Collaborative commitment to continuous improvement</td>
<td>Use of a proven improvement methodology</td>
<td>Staff training and engagement</td>
<td>Investment in external relationships</td>
<td>Quality and safety</td>
</tr>
<tr>
<td>Clear vision for improvement</td>
<td>Clear commitment to metrics</td>
<td>Developing and supporting improvement expertise</td>
<td>Multi-agency networking</td>
<td>Focused strategic timeframe</td>
</tr>
<tr>
<td>Enabling shared learning</td>
<td>Systematic approach to improvement</td>
<td>Collective leadership culture</td>
<td></td>
<td>Flexible decision-making</td>
</tr>
<tr>
<td>Expect uncertainty and change</td>
<td>Development of robust governance and performance structures</td>
<td>Teamworking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Innovation</td>
<td>Robust communication and reporting systems</td>
<td>Collaboration of people who use services, carers, and trust staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Integration of quality assurance, quality surveillance and improvement</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. Key themes are in Bold.
### Future work

**Question 10 – Do you have areas that need to improve further?**

Themes identified

<table>
<thead>
<tr>
<th>Organisational/culture</th>
<th>A person’s journey of care</th>
<th>Improvement</th>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational and learning culture</td>
<td>Inpatient services</td>
<td>More effective monitoring of improvement</td>
<td>All areas</td>
</tr>
<tr>
<td>Leadership</td>
<td>Bed management</td>
<td>Continue to build improvement capacity</td>
<td>Shared learning from experience</td>
</tr>
<tr>
<td>Mindset of perpetual improvement</td>
<td>Efficiency and flow of services</td>
<td>Improvement of services</td>
<td></td>
</tr>
<tr>
<td>Change management</td>
<td>Improving experiences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Build on the co-production approach</td>
<td>Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consistency across all services within organisation</td>
<td>Variation in practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimisation of costs of improvement</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. Key themes are in Bold.

**Question 11 – What are the most important learning points?**

Themes identified

<table>
<thead>
<tr>
<th>Investment in people</th>
<th>Methodology</th>
<th>Culture/philosophy</th>
<th>Partnerships/collaborations</th>
<th>Other important learning points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appreciative leadership</td>
<td>Improvement mindset</td>
<td>Culture of openness, integrity and learning</td>
<td>Collaborative approach and engagement between people who use services and staff</td>
<td>Quality</td>
</tr>
<tr>
<td>Executive-level engagement</td>
<td>Technological approach</td>
<td>Clear strategy</td>
<td>Developing partnerships</td>
<td>Context</td>
</tr>
<tr>
<td>Staff engagement</td>
<td>Consistency of approach</td>
<td>Ambition</td>
<td>Co-production</td>
<td>Language</td>
</tr>
<tr>
<td>Identifying and developing the enthusiasts</td>
<td>Increase efficiency, while reducing cost</td>
<td>Innovation</td>
<td>Development of relationships with the providers and the community</td>
<td>Experts by experience</td>
</tr>
<tr>
<td>Continuous training and professional development</td>
<td>Benefits realisation</td>
<td>Resilience</td>
<td>External support</td>
<td>Robust data</td>
</tr>
<tr>
<td>Continuous training and professional development</td>
<td>Benefits realisation</td>
<td>Resilience</td>
<td>External support</td>
<td>Robust data</td>
</tr>
</tbody>
</table>

Note. Key themes are in Bold.