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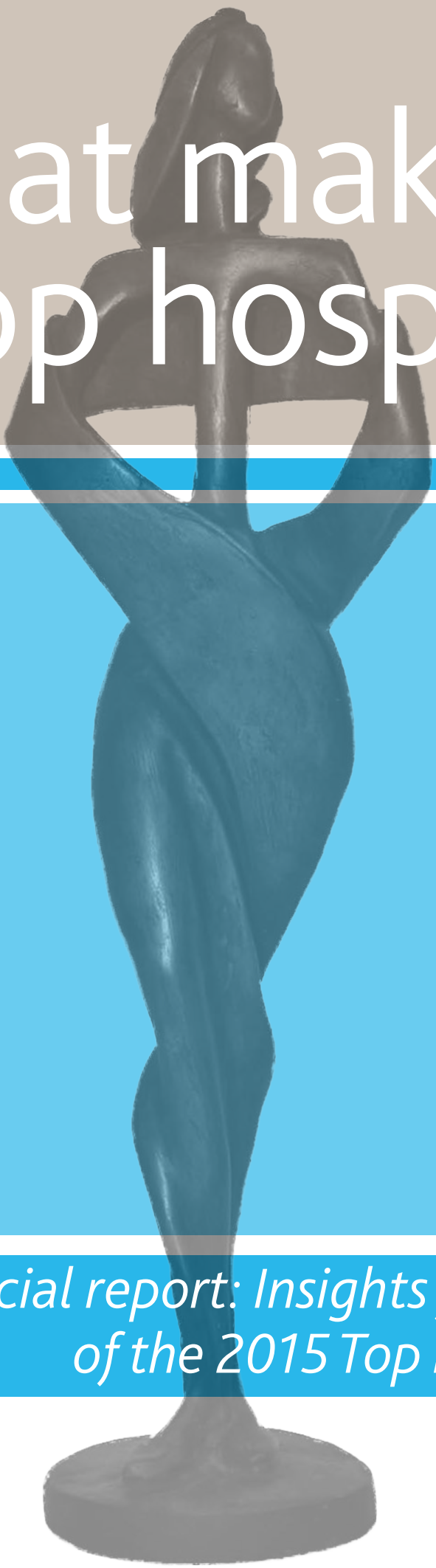
What makes a top hospital?

January 2016



Special report: Insights from the winners of the 2015 Top Hospitals Awards

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About CHKS

CHKS, part of Capita Health Partners, is a provider of healthcare intelligence and quality improvement services to the NHS and the independent healthcare sector. It has worked with healthcare organisations across the UK to inform and support improvement for more than 25 years. This report focuses on selected winners in the 2015 CHKS Top Hospitals Awards, aiming to share their successful initiatives throughout the NHS.

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FOREWORD

CHKS celebrates and shares success across the health service with its annual Top Hospitals Awards. As a result we have come across many examples of excellence in the delivery of healthcare within acute sector organisations. The idea behind this series of reports is simply to share these examples of success in the hope that other organisations can take something from each of them.

CHKS has used more than 25 years of experience in the analysis of hospital data to decide the indicators on which each of the Top Hospitals awards is judged. Awards are made on the basis of an analysis of publicly available datasets and every NHS acute trust is included.

This report focuses on selected winners of the Top Hospital Awards 2015 in order to explain how they have become the leaders in their field and share their ideas. Our aim is to share best practice and we believe there are lessons to be learned from all our award winners.

EXECUTIVE SUMMARY

Since the Francis Inquiry's final report in 2013, the Keogh review and the Berwick report, we have seen a culture shift within the NHS. Gone are the days of target-driven care that focuses solely on finance and targets, rather than on the patient.

The *Five Year Forward View* describes aspirations for a health service that meets local need and one where examples of success are shared from community to community. Reflecting this shift, we felt the winners of the Top Hospitals Awards 2015 had something to contribute. They lead the way in their field across the UK and the CHKS awards saw each recognised with a national accolade for excellence in a specific area.

A common theme that emerges among all our winners, whether they were chosen for data quality or for excellence in accident and emergency care, is a focus on putting the patient at the centre of care. Winners also value their staff and use their experiences of daily work on the frontline to shape the future of patient experience, quality of care and safety. In addition, patients, families, carers and staff are encouraged to work together to redesign services to take into account how the patient wants to be treated.

Four of our awards are for excellence in data quality. As a company with more than 25 years' experience in healthcare improvement, we know the way data are managed and used has a significant impact on the running of a hospital trust. Inaccurate data can result in damage to public trust and perception, and also have a negative effect on finances. Leading trusts are bringing clinicians and coders together to ensure everyone understands the importance of clarity and accuracy of information. This is not just a back-office function – it is the backbone of a successful trust.

This report shares the award winners' experiences and ideas and highlights the associated examples of best practice, which can go a long way towards promoting excellent, patient-centred care across the UK.

PATIENT SAFETY

Each year, around one million medical incidents are brought to the attention of the National Patient Safety Agency, and one in 10 patients suffers harm as a result of treatment.[1] In every organisation there is the possibility of inadvertent harm, no matter what processes are in place.

To ensure the bestquality and safety possible in patient care, a series of recommendations was put in place following the 2013 independent Berwick review into patient safety in the NHS. A key outcome of the review was the recommendation that the NHS should "become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end".[2]

For this to happen there needed to be a widespread culture change. Both the Francis[3] and Berwick reports pointed to a need for systemic change and for the quality of patient care to come before all other considerations in the leadership and conduct of the NHS; patient safety should be the key dimension of quality and the pursuit of continually improving patient safety should permeate every action and level in the NHS.

The resulting Patient Safety Collaborative Board, set up by the government, has focused on involving patients and their families directly with improving services. It aims to share best practice, build skills and capabilities and establish a culture of learning.[4]

While many trusts are creating change and improvement, there remain fundamental concerns about safety in hospital. Around one in 10 hospitals across the country is rated 'inadequate' for safety by the CQC.[5] Factors here include a failure to investigate and learn from incidents to prevent them happening again, and concern over staffing numbers and skills as well as the standard of training and support they are offered.

So how does a hospital begin to turn around its patient-safety record? Good organisations know exactly what is happening and where, through both intelligence monitoring and feedback from patients and staff. Accurate data are essential to achieve this – both specialist data and general administrative data are deemed extremely useful. However, research shows that the clearest picture of patient safety will be achieved by combining these data with patient experience and feedback. The information collected should include incidents reported, patient-safety indicators derived from administrative data, complaints, health and safety incidents, inquests, claims, clinical audits, routine data, observations, and informal conversations with staff, patients, families and carers. Research has also found that high-performing organisations regularly review a variety of sources of safety measures, combining data with observation and conversation.[6]

Feedback suggests safety can often be subjective, depending on what is wrong with patients and whether they fully understand what is happening to them. Good practice is to ask patients if they definitely understand what they are being told rather than just asking if they have any questions. Instead of asking "What is the matter?" they should be asked, "What matters to you?" In the NHS, particularly in a busy acute trust, no two days are the same and no two patients are alike, so organisations must be prepared and able to adapt to rapidly changing situations.

It is vital to ensure that the issue of safety is a focus from the ground up. It should be a part of everyday life for clinicians and staff, who must be involved in improving service design, but who must also be confident to report when things go wrong. Staff have to be the focal point of patient safety. They can make it happen; they see what happens day in day out and they can see where improvements need to be made and where standards are slipping. It is essential that leaders listen to what staff have to say and involve them in deciding on improvements. But it is also important that their wellbeing is taken into account. It is widely recognised that having a happy workforce equates to better patient care. This in turn means having the right number of staff in the right place with the right training is crucial to providing high-quality, safe care.

It is not just staff who need to be confident in reporting. Trust leaders must drive home the message that reporting of serious incidents needs to become the norm. A high-reporting trust does not necessarily mean a low-performing one; evidence shows high-reporting trusts are more likely to have a stronger safety culture.[7] Trusts are encouraged to be open about when incidents happen so that they can learn from them instead of creating a blame culture. Anxiety around reporting, for fear of taking or apportioning blame, can lead to hiding and low reporting of incidents – a far more risky path to take and one that does not contribute to patient safety.

> "We measure the things we do well, as well as those that are not done so well. We work alongside teams to gather relevant, current data, and develop staff to use this information to deliver real benefits and learning. If people make a mistake we want them to feel empowered to admit this without fear of recrimination, and safe in the knowledge that it will be a learning experience.
>
> **Olive Macleod, director of nursing and user experience, Northern Health and Social Care Trust**

CASE STUDY 1

Patient safety award: Working with hearts and minds at Northern Health and Social Care Trust

The Northern Health and Social Care Trust was established in April 2007 and is one of the five health and social care trusts in Northern Ireland. Serving a population of approximately 465,000 people, it provides a wide range of hospital services, community care and social services. The trust currently employs more than 11,000 staff, who work across a range of disciplines and professions including nurses, social workers, doctors, allied health professionals and many other technical and support staff.

Olive MacLeod took up the post of director of nursing and user experience in August 2011 and has responsibility for nurses, midwives, allied health professionals and corporate support services. Patient safety has always been the central focus of her work and since taking up post she has worked to build a culture of openness, transparency and debate. She plans to drive forward further and sustained improvements in quality and safety for all service users. Her vision is one of a forward-looking organisation that is working for, and in partnership with, its community to respond to the challenges it faces.

The overall aim of the trust is to improve the health of the population through providing excellent services that make best use of available resources. Olive says: "We seek to support clinical staff to design services that are fit for purpose, and staff working in the trust have a vital contribution to make.

"Care must be timely, safe and efficient and our frontline staff best understand the needs of patients. The trust's person-centred ethos aims to put patients at the centre of everything we do and to ensure they are treated quickly and effectively. The trust also understands that patients must be provided with information in a format they can understand, enabling them to make informed decisions and judgements that encourage and promote as much control over their care as possible."

The trust is continuously looking at how real-time improvement can be measured in order to assist teams in the delivery of safe patient care and improve performance. Olive says: "We measure the things we do well, as well as the things that are not done so well. We work alongside teams to gather relevant, current data, and develop staff to use this information to drive actions that deliver real benefits and learning. If people make a mistake we want them to feel empowered to admit this without fear of recrimination, and safe in the knowledge that it will be a learning experience."

Olive believes the emphasis on safety is maintained through conversations with staff about core values and by harnessing their dedication and commitment. To this end focus groups and forums have been established in order to ensure staff at all levels have their voice heard. She says: "Such an approach enables me to establish how change is unfolding and if the change is an improvement."

The trust holds safety meetings each morning with ward sisters, allied health professionals, corporate support services, chaplains and management staff, at which the past 24 hours is reviewed. The team works together to solve any identified issues. Feedback from staff suggests that they feel more connected and together can try to think about ways of working smarter.

Ensuring that the right people, are in the right place, at the right time, with the right skills is another important aspect of patient safety. Olive says: "It is crucial that staff are appropriately trained, are in the right roles and have real-time data at their fingertips'.

The trust has a seven-day work plan that is now being rolled out to all clinical teams. It has seen improvements for patients with mental health needs, through the introduction of a Rapid Assessment Interface Discharge (RAID) system. This initiative has been put in place to better meet the needs of patients who present to the emergency department with mental health problems. Prior to the introduction of the RAID team, patients had to wait to be seen by a doctor and then the crisis response team. Olive says: "We have a very high satisfaction rate from both patients and staff, as patients can quickly be assessed and a safety plan agreed with their involvement."

Strong leadership is vital to building and maintaining the momentum in relation to patient safety. Olive says: "Staff need to feel that they can speak with managers at all levels of the organisation." The trust encourages staff to bring forward creative and innovative ideas to improve services." ●

DATA QUALITY

High-quality data are fundamental to providing high-quality, patient-focused care. As well as supporting delivery of care, it is also vital to commissioning, payment, audit and research.

To provide such support, data need to be fit for purpose. Poor data can undermine a system, provide the wrong information and ultimately be detrimental to a trust in a number of ways, from financial implications to loss of confidence among the public and stakeholders.

Professor Sir Bruce Keogh highlighted the need for trust boards and leaders to use data to drive quality improvement and to provide a full picture of a hospital's performance to the public as well as to the board.[8] Data should be used to highlight areas of concern as well as to support the way the hospital is portrayed by the board.

Good data are essential to enable trusts to innovate and transform care, providing feedback to show whether change has been successful. Data can also provide assurances for trusts that they are providing safe, quality care and highlight where improvement is needed.[5] Good-quality data must also be available to show patients and stakeholders how a trust is performing. This creates transparency and can highlight externally when things are working well, but at the same time helps service users understand how performance is linked to their experience of care.

Despite this, collecting data that are accurate and consistent across the country is a challenge for the NHS. An audit of the coding accuracy in 50 trusts showed that comorbidities were consistently under-reported, despite being an area of concern for commissioners.[9] Clinicians were not making a distinction between relevant and non-relevant when recording comorbidities. The quality of source documentation was also flagged up. Paper casework notes that are in poor condition disrupt coders by making it more difficult to extract the information. For the sake of hitting a deadline, discharge summaries are often relied on but these can lack information or detail, resulting in errors in recording comorbidities and definitive diagnoses.

The auditors also pointed to coding departments under pressure, with unfilled vacancies as well as inexperienced staff leading to a reduction in the quality of coding. As well as affecting patient care, this can also impact on payments to trusts. The quality of coding is inevitably linked to the level of payments that are dependent on it.

To create the most accurate data, leading trusts support their coders and know their value. They raise their status to a fundamental part of the running of the hospital, rather than a back-office function, and also give clinicians and consultants the responsibility of making sure they are providing information and notes of the required quality to the coders. Hospitals that have clinicians working with coders to ensure accuracy produce high-quality data.

Director of Operations Claire Tripp demonstrates how Papworth Hospital NHS Foundation Trust laid strong foundations for data quality and went on to become the winner of the Data quality (specialist) award at the CHKS Top Hospitals Awards 2015. At Papworth each of its service lines has a lead clinician attached to it, providing clinical focus for the coding.

She says: "Coding is run through our business support team. They are a very cohesive team and work with good leadership. We see our coders as very important and integral to the process. It is essential that the coding is right, and then everything else just falls into place.

"It's important that the clinicians have a clear understanding of what data quality is about. Interpreting the notes correctly ensures that we get good, reliable data to work with. We have worked with the clinical

CASE STUDY 2

Data quality award (specialist): Coders are as much a part of the team as consultants at Papworth Hospital NHS Foundation Trust

At Papworth Hospital NHS Foundation Trust, the coding team is viewed as essential to the smooth running of the hospital. Accurate and consistent reporting of data is vital. All co-morbidities logged in the notes translate into coding data that informs tariff. Accurate, legible medical notes will inform accurate coding.

Claire Tripp, director of operations at the trust, says: "The accuracy of data informs reports that can, for example, retrospectively analyse length of stay data against a particular patient group. This allows focused future planning and influences the way we run hospital services."

Within the hospital there are four main areas: cardiology, cardiothoracic surgery, respiratory medicine and transplantation. These areas are split into service lines and each of these has a lead clinician providing a clinical focus to the coding, this contributes to the success of the data quality.

This level of leadership and the presence of clinicians who understand the link between data and tariffs are vital to creating a culture where high-quality data are the norm.

Tripp says: "Coders have to be impartial. As tariff updates are released, clinicians are briefed on the changes in order to reduce the impact on the trust finances by reinforcing the need for comprehensive medical notes, which the coders will interpret and code accordingly."

Within the trust, education around coding is continuous. The trust has invested in its coders. They have support from the audit department, which ensures objectivity. Tripp believes that coders need to be valued and are as much team players as the consultants.

She says: "You can't run a good hospital without good data and coding. It is a trust responsibility that has been enhanced by a strong working relationship between coders and clinicians."

leads so that the link between the contents of the notes and the assigned code or Health Resource Group (HRG) is optimised for their service. This information dictates the income (tariff) for that service."

There can be a risk that clinicians who feel data are wrong may not engage with them, but Sir Bruce Keogh's report asserted that data quality could be improved by clinician engagement. His ambition was to see boards and leaders of provider and commissioning organisations confidently and competently using data and other intelligence for forensic pursuit of higher standards.

Organisations with high-quality data ensure clinicians are leading the way in driving change to ensure data are accurate and valid. Notes must be comprehensive, up to date and not open to interpretation which, if incorrect, can lead to the wrong coding.

High-performing trusts also ensure that the board is central to communicating the importance of accurate data and supports the need to invest in coding teams as well as training all staff – from clinicians, to nurses and administration staff – about how to provide the best data possible.

A number of factors contribute to inadequate data, including lack of standards and guidance, poor training, a lack of awareness of the impact of substandard data, local system updates and changes, and reorganisation or reconfiguration of services. To improve patient care, providers of data need to improve understanding, training and knowledge of issues relating to data quality.[10]

In line with this, Keogh's review team found there was a shortage of key skills in data analysis and interpretation available to trust boards and management teams. In some cases, there was no consistency in the metrics and information being used to monitor quality on an ongoing basis. Review teams found that in some areas, data were just being used to reinforce or back up a certain viewpoint, rather than in an enquiring way that could highlight potential improvements. ●

CASE STUDY 3

Data quality award: Improving collaboration and documentation to improve data quality at Nottingham University Hospitals NHS Trust

At Nottingham University Hospitals NHS Trust a major drive to improve data and engage staff began after a clinician queried the quality of data in the department. The 'Better for You Crack Coding' project involved engaging the whole of the hospital to drive home the importance of good data.

Andrea Race is assistant director of information and performance at the hospital. She says that wherever data-gathering processes were examined, it was found that some staff did not understand the importance of the information they were recording. The information did not accurately reflect the health of the patient and the care they received throughout their care pathway.

Key to the success of the project was ensuring their clinicians were on board. Race says: "Once they understand the impact of data they are invaluable and really help to drive changes needed in their specialties."

Strong leadership was a vital component of the project. Stephen Fowlie, the trust's medical director, was involved in communicating with staff, sending trust briefings and emails to consultant colleagues. Many well-attended workshops were held, along with specialty meetings. There were also PowerPoint presentations, leaflets and examples of improved documentation to support raising the profile of the project.

The trust found that a one-size-fits-all approach was not appropriate and instead supported individual teams to find solutions. Race says: "We found documentation issues arose when clinicians didn't realise they were writing something that coders were not allowed to interpret. On the other hand, there could also be coding errors which were then fed back to the coding teams. This no-blame approach was a great opportunity to go through the records and get them right by improving together."

This wasn't a small project. It took about a year and one of the biggest challenges in such a large organisation with many specialties was to engage everyone. Far from being a tick-box exercise, the intention was to create continuous and sustainable improvement. Clinical champions and lead coders were appointed for each directorate, and regular teaching sessions continue to be held for junior and trainee doctors. Sessions can also be requested for other staff. Many staff were surprised to hear that the data are used for so many areas, from commissioning to mortality benchmarking.

Race says of the initial workshops and the wider awareness sharing: "It's always encouraging that once people understand the importance of how they influence our clinical data, they are happy to get involved and support the process. Feedback is invariably positive and we really appreciate the collaborative working we do to keep improving our data." ●

EXCELLENCE IN ACCIDENT AND EMERGENCY CARE

The performance of emergency departments is always a hot topic, not just in the media but also for hospital leaders, patients, commissioners and anyone who uses the service.

The A&E department is the front door of any acute trust and is often the first point of care for many patients who may think they have no alternative, whether they need emergency care or not. It is often the first place to experience bottlenecks and is dependent on effective patient flow through the rest of the hospital.

Emergency department waiting times are a key performance statistic and hitting the national four-hour waiting time target has become a measure of a good trust. However, the figures for 2014/15 show these standards steadily slipping. Performance against the target (for 95 per cent of patients to be treated within four hours) was poor. Waiting times in the fourth quarter of 2014 reached their highest point for a decade. And the figures for 2015/16 show little sign of things getting better. For the first time in a decade there was a breach in the first quarter, and despite a slight improvement in July, by August the target was breached again.[11]

There is no doubt that departments are under increasing pressure. Hospital Episode Statistics show that in 2014/15 there were more than 23 million attendances recorded at major A&E departments, single-specialty A&E departments, walk-in centres and minor-injury units in England. Evidence also suggests that more people are being admitted from A&E into hospital beds, which is having an impact on overall waiting times. In the first quarter of 2015/16 the number of patients waiting in A&E for more than four hours after a decision to admit them had risen by some 71,000 compared with 48,000 in the first quarter of 2014/15.[11]

Despite these figures, there are many examples of good practice taking place within the NHS to enable targets to be met. Leading trusts have taken a hard look at the whole hospital to see which areas need to be improved. It is widely accepted that the right strategy needs to be in place at the front door, to assess whether patients need to be in the emergency department or whether it would be better for them to be treated in the community or elsewhere in the hospital. It is also essential that every member of staff understands the importance of patient flow and what role they can play to help prevent crowding and relieve the pressure on the emergency department.

The director of the emergency care intensive support team at NHS Interim Management and Support, Russell Emeny, says: "Getting patients better quickly and safely requires the systematic implementation of known good practice, a consistent approach by all clinicians, collaboration within and between organisations and great leadership along the pathway."[12]

Trusts with excellent emergency departments have driven home the message that the whole system plays a part in the success and management of the department. This involves strong links with the community and a clear focus on patient experience. Urgent care boards are a good example of this: GPs, hospital staff and social care teams all come together to find the best solution, to work together without apportioning blame.

To increase patient flow there has been a focus on speedy discharge, having specialist doctors available at the front door to ensure patients are seen by the right person as soon as possible, creating short-stay wards and specialist frail elderly care teams. Daily ward rounds as early as possible in the day also mean patients can be discharged sooner where appropriate.

But getting the patients to the right place is not the only factor; there has to be a focus on staff. Safe staffing levels continue to provoke debate. Staff are working in a highly pressured environment and need to feel valued as well as being given the opportunity to develop their skills. Senior clinicians need to be assured of time away from the frontline to develop clinical practice or mentor others. Staff also need to know that their voices can be heard. Leaders need to be visible and accessible to those who are working at the frontline every day.

At Derby Teaching Hospitals NHS Foundation Trust, winner of the CHKS excellence in accident and emergency care award 2015, the board has recognised the importance of staff experience. The trust has recruited staff to training programmes and appointed 14 senior doctors who were trainees in the past and were working as locums but lacking career satisfaction. The trust has also taken on more PAs so consultants can get out into the hospital where they are needed. The great work staff do is also recognised, with the introduction of Christmas awards for emergency department staff.

> "Our urgent care board has transformed the way we work. It was clear everyone needed to work together – in the hospital and the community. The board focuses on four major workstreams: keeping patients out of hospital; working in the emergency department itself; managing flow through the hospital; and discharging patients.
>
> **Sue James, chief executive, Derby Teaching Hospitals NHS Foundation Trust**

CASE STUDY 4

Excellence in accident and emergency care award: Managing patient flow at Derby Teaching Hospitals NHS Foundation Trust

Derby Teaching Hospitals NHS Foundation Trust provides both acute hospital and community-based healthcare services, serving a population of more than 600,000 people in and around southern Derbyshire.

It runs two hospitals: the Royal Derby Hospital, which incorporates the Derbyshire Children's Hospital, is a busy acute teaching hospital. London Road is the Trust's community hospital. Its community services are based in health centres and GP practices across southern Derbyshire, providing care to patients in their own homes.

The Royal Derby Hospital is the newest hospital in the East Midlands and was officially opened by the Queen in April 2010. The trust treats a million patients each year and its busy emergency department sees around 320 patients every day. According to chief executive Sue James, the winter of 2012/13 was a bad time in the emergency department. She says: "We were crashing and burning as far as targets were concerned. Consultants were worried about safety in the department and some were critical of the fact that the hospital was awash with emergency department patients."

At that time safety and patient experience was the main concern, so the trust held a summit with all the key players, including social services, GPs and doctors from the ED and emergency medicine. An urgent care board was created, which has ended up transforming the way the trust works. They were ahead of their time, with many trusts following this style of working some 12 months later.

It was clear everyone needed to work together – both in the hospital and the community - and it was not just about the emergency department. The care system was transformed by focusing on four major work streams: keeping patients out of hospital, working in the department itself, managing flow through the hospital and discharging patients. Crucially, each work stream is led by a consultant and the urgent care board is chaired by a GP.

To ensure that patient flow is continuous, the hospital developed a range of systems around daily board rounds. Everything that has happened to the patient is recorded on electronic whiteboards. Consultants and teams spend half an hour on this each morning. This is backed up by training to ensure a consistent approach.

QUALITY OF CARE

Every patient who needs hospital treatment, whether emergency or planned, will assume that they are receiving the best-possible care. But behind the scenes, achieving top-quality care relies on a complex system. Quality of care is everyone's responsibility, from frontline professionals to board leaders, commissioners, providers and regulators.[13]

To try to achieve consistency and unity of standards in this respect, Lord Darzi's 2008 strategy for the NHS set out a single definition of quality: clinical effectiveness, safety and patient experience.[14]

Not until the Francis Inquiry report five years later was it recognised that a whole culture change was needed to achieve this. At Mid Staffordshire NHS Foundation Trust, Francis found leaders had lost sight of their values, and the need to reach targets and save money had overtaken patient care. Francis urged everyone in the NHS to work towards a common goal with the aim of providing care that is safe and offers a positive experience.

It was recognised that a broad set of quality triggers were necessary to show that trusts were providing quality care. Mortality statistics were not enough – the views of staff, patients and carers were all vital to create change. However, the Keogh review found little understanding among staff at all levels of how important and simple it can be to listen to the views of patients and colleagues and engage them in service improvement.

Leading trusts now recognise they must ensure public and patient participation and co-operation between organisations, and must also foster a culture of openness and transparency to safeguard quality of care. There is also a great onus on management teams not to accept assurances about quality of care, but to actively challenge these assurances.

The use of high-quality data is also key to ensuring openness, although this cannot and must not be the only way of measuring quality of care. The publication of data for patients and service users to monitor care at their own trust is an effective means of ensuring that quality of care remains in focus.

Sharing good practice, both internally and with other trusts, is also a vital tool for providing consistency across the NHS. The provision of excellent care is also dependent on staff. A proper culture change means a change from focusing solely on staff numbers to looking at their wellbeing and the environment within which they are working. There is a strong correlation between staff satisfaction and a good patient experience. Yet the widespread use of agency staff is still an issue, while stress on NHS staff has been shown to be on the rise. There was a sharp increase in work-related illness between 2011 and 2012 and this remained at the same level in 2013. Many trusts are boosting staff numbers in response to the Francis report, but this inevitably has consequences on trust finances. An increase in staff who are not permanent employees can also lead to concerns about the quality and continuity of care.[15]

Frontline staff in particular are in prime position to spot when standards are slipping, so it is vital that they are motivated, happy in their work and know that if they do raise a concern it will be taken seriously and acted on. It is widely accepted that good trusts support staff to take responsibility for quality of care and make sure that they are aware of how to raise a concern and who to go to. Such trusts investigate quality issues and provide feedback to the member of staff who reported an issue so they can be reassured that their concerns are being explored and acted on.[16]

CASE STUDY 5

Quality of care award: Embedding a culture of responsibility and leadership at Ashford and St Peter's Hospitals NHS Foundation Trust

Ashford and St Peter's Hospitals NHS Foundation Trust has set out to meet the aspirations of the Darzi report in 2008, which focused on achieving a high quality of care to ensure patients have a positive experience.

Heather Caudle, now chief nurse, joined the trust in 2011 as associate director of quality and her first task was to undertake an overview of the organisation and devise a five-year strategy to ensure high-quality care. The strategy is based around four themes: leadership, structure, culture and measurement.

An analysis of the trust's data showed improvements were needed in two areas: discharge of patients to their usual place of residence, and mortality rates. The management team visited neighbouring trusts to see what best practice looked like and subsequently decided to set up a group of senior clinicians to carry out a detailed review of the data. The group's objective was to use data to drive a change in behaviour and encourage improvement.

Led by the medical director and chief nurse of patient safety (deputy medical director), the data were reviewed by specialty to see whether clinical processes could be improved. This specialty-level review led by senior clinicians was critical to changing the culture within the trust. The medical director and deputy medical director were able to work alongside other clinical directors and clinicians, creating true clinical leadership.

It was important to get all staff on board to ensure the data were accurate and to get them to understand its importance. Caudle says: "When we first started out, many staff just said the data were wrong, but we pointed out that it was their data and asked them to suggest how it could be improved. Through a lead clinical divisional director we signposted them to lead clinicians who explained what their data said, how they could improve it and how what they were doing had an impact."

It is not just senior management who have responsibility for improving and creating high-quality care. Caudle and her team have ensured it is a trust-wide responsibility. Patient feedback is crucial to improving care. Nurses use the NHS Friends and Family Test at ward level to find out where the focus needs to be. Caudle says: "Triangulating this with data, such as serious incidents, helps to focus on areas for improvement."

Also crucial to the strategy is a firmly held belief that leadership is not just for senior staff. Caudle says "Leadership is not a role, it's a function. We expect leadership to come from all members of staff. We set out leadership expectations at every level. Even at a very junior level, medical students give a presentation and each year one of their projects is chosen for rollout across the trust."

The trust is also taking part in the national "Be the change" initiative to empower all staff to identify opportunities for quality improvement. An example of this is the "15 Steps Challenge", to discover what patients think and feel about their experience when they visit an outpatient clinic.

The trust has also signed up to the "One Small Thing" campaign, whereby staff at all levels ask patients what one small change would make a difference to them. A striking example of this was the case of a young patient with learning difficulties who was nearing the end of her life. At her bedside her mother mentioned to her nurse that her daughter loved Christmas. And so in the middle of August, when Caudle visited the patient's room she found it decorated with tinsel and decorations, with Christmas music playing. She says: "This family had previously had a poor experience of care and felt they hadn't been listened too. During the time they were with us this got better and culminated in this response."

As a result of the trust's focus on high-quality care, the number of patient complaints is decreasing. When a complaint is made, it is now often followed by a letter of thanks for how it was resolved in a speedy and compassionate way.
The trust also set up a programme of work with dedicated clinical leadership to focus on sepsis. Again, this is in line with national initiatives, but was borne out of an issue discovered in the emergency department and other areas when it came to managing deteriorating patients.

The trust's CQC rating has now improved to 'good' and Caudle puts this down to the focus on quality of care. She says: "It's a demonstration of the long, hard journey we have been on and are still on, ensuring the leadership and culture is right." ●

QUALITY IMPROVEMENT AND ACCREDITATION

Quality improvement requires a resolve to learn from mistakes as well as to share best practice. Enhancing processes and standards are an integral part of the improvement journey. In order to measure improvement and ensure change for the better, organisations need a framework and guidelines for applying quality standards. Indicators of quality have to be developed, ideally monitored by an external body.

Regulation is one way to maintain standards, but is often limited to covering certain key areas. For some organisations, accreditation is a better way to engage the whole organisation. It is a useful way to benchmark standards within the whole organisation against national quality criteria. It can also identify areas of good practice as well as areas needed for improvement.

In common with CQC regulation, CHKS quality standards incorporate patient experience, the patient journey through the healthcare system and staff competency for healthcare practitioners and administrators. There are also a number of organisational themes. These include leadership, management and culture, corporate management, risk and safety and patient-focused care, as well as specialist services and service management.

> This quality standard describes markers of high-quality, cost-effective care that, when delivered collectively, should contribute to improving the effectiveness, safety and experience of care for patients using adult NHS services
>
> **Patient experience in adult NHS services. NICE quality standard (QS15), 2012**

CASE STUDY 6

Quality improvement award: Using accreditation as a framework to ensure quality improvement at Cuan Mhuire

Cuan Mhuire, winner of the CHKS quality improvement award 2015, is Ireland's largest voluntary provider of treatment and rehabilitation for people suffering from addiction. It has used the CHKS programme of accreditation successfully to ensure improvements for its residents.

Cuan Mhuire has five treatment centres across Ireland, helping residents who have a dependence on drugs, alcohol or gambling. The residents are supported through a 12/20-week, abstinence-based residential treatment and support programme, which works in partnership with their families.

At Cuan Mhuire, the policies and procedures ensure that the service contributes to residents' enjoying a good quality of life, experiencing care that is positive, person centred, safe and respectful. Quality of care is regularly monitored and reviewed to ensure continuous development and improvement.

In 2009, it started working towards gaining accreditation. Through accreditation, the process of self-assessment and external peer review set an agenda for service and team development. It has helped the organisation to see where its strengths and weaknesses lie and what needs to be improved in order to achieve the best outcome possible for its residents.

Accreditation helped the organisation on three level – with organisational improvements, staff and also residents. In terms of organisation, the CHKS accreditation programme provided a valuable tool for the organisation, helping to put in place systems for continuous improvement. It set out a framework of policies and procedures that need to be in place to help provide a consistently high-quality service.

The professional guidance helped Cuan Mhuire operate in line with best practice at all times and also enabled it to examine itself critically against an internationally recognised framework of organisational standards. The most important step for the organisation was to ensure that all policies and procedures were documented. Sister Sheila Cronin is based at the Cuan Mhuire site in Newry, which started the long and significant journey towards accreditation at the beginning of 2013. She says it was a process that brought all the staff together; they worked as a team, taking on board changes and coming up with their own ways to improve. This enables the team to ensure they are working in line with best practice at all times.

To help Cuan Mhuire gain accreditation, the team held local area meetings, looked at what accreditation meant to the staff and ultimately how they could improve outcomes for their residents. Suggestion boxes were put in place and interactive workshops were also held to ensure that

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CASE STUDY 6

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everyone knew about what was going on. Induction sessions were introduced and helped staff understand the learning processes and the impact of learning on the outcomes for residents.

For accreditation to be successful, staff had to engage. Sister Sheila says they also wanted to reassure staff that change was happening for a reason and not just for the sake of change. That year, after a lot of hard work, Cuan Mhuire achieved full CHKS accreditation.

Measurement of success was a key factor. Quality improvement audits help to improve support, treatment and outcomes for both residents and their families or carers. Systematic reviews are carried out in selected areas and evaluated against explicit criteria.

The centre also worked hard to improve waiting times and 94 per cent of residents are now accommodated within three days of making an initial contact. Risk management has also been improved and staff are now encouraged to report all incidents and near misses so lessons can be learned from them.

A number of quality markers have also been introduced to enhance the experience of residents and of their families or carers. A complaints procedure has been put in place, as have resident and family feedback and support plans. There is also continuous risk assessment in which residents' safety is a priority.

The audits also highlighted good practice. They revealed that residents were treated with respect and dignity, which is a significant factor. Many people with an addiction feel neglected and suffer with low self-esteem so it is important for them to be treated with respect. Sister Sheila says: "We needed to use the information to make change but also give praise where things were going well. It is important to give praise and keep up staff morale. It all goes to ensure good clinical governance, good management and good residents' outcomes.

"The accreditation process has helped us to drive quality and safety, and monitor the care provided to residents using our treatment and aftercare facilities."

Now accreditation has been achieved, the improvements have not stopped and Cuan Mhuire continues to build on the framework to maintain continuous development. It is currently looking at reducing readmission rates for the future by improving follow-up care once a resident has left the centre.

As a result of feedback the centre has developed a six-week non-residential relapse programme, which will provide improved follow-up support once a resident has left, and help to reduce readmission rates. This support works alongside the two-year aftercare programme for those in recovery and their families. ●

PATIENT EXPERIENCE

The process of improving patient experience is not the same for all trusts. Every organisation is different as are the staff working within each organisation. It is widely accepted that nationally agreed standards are vital as a framework for trusts to work with and to help develop patient-centred improvements.

The NHS Framework[17] brings together a number of areas that are integral to the process of improving patient experience. For many trusts this entails taking a step back and looking in detail at each of these areas, from the in-depth collating and analysis of various types of data to service redesigns involving staff, patients and their carers. The framework focuses on: respect for patient-centred values, preferences and expressed needs; co-ordination and integration of care; information, communication and education; physical comfort and emotional support; welcoming the involvement of family and friends; transition; and continuity and access to care.

In addition, the correct use of data is a crucial way of measuring and monitoring what is happening within a trust. Leading trusts should have good systems in place to co-ordinate data collection and assess their quality. Patient feedback is a focal point and most trusts have a plethora of data – from national patient surveys to complaints, interviews, focus groups, PALS and patient forums. There is little point in having such a wealth of information if it is not carefully appraised. Data are sometimes collected but not used, either because staff don't know how to do so or because they lack the relevant training.

Although specially designed data are the usual way of measuring patient experience, routine data can be just as important. For example, DNA rates, the number of times a patient is moved between wards or the numbers of staff assigned to their care can be good indicators of where improvement may be needed.[17]

In his report, Sir Bruce Keogh called for trusts actively to seek out feedback to ensure an improved patient experience. Different types of data, including patient feedback, can be used to build a picture of what is happening to patients while in the care of a trust. This should not be confused with the much broader definition of patient satisfaction, where surveys often lack the detail needed to improve patient experience.

To provide good patient experience a co-ordinated strategy is needed across all trust activity, not just for data collection. Leading organisations will have a director in place with responsibility for this. There needs to be clear reporting arrangements and an action-planning process to highlight changes and improvement, all backed up by strong leadership.[18] Patient experience requires investment so the research and data can be properly understood and linked to an improvement strategy that means something to both patients and clinicians.

The critical list for improving patient experience, devised by the former NHS Institute for Innovation and Improvement,[19] recognises that there cannot be a one-size-fits-all approach. However, in terms of strategy, leading trusts must put patient experience on a level footing with clinical quality, patient safety and financial goals. Staff experiences and patients' stories are vital to help trusts understand how to improve services and use patients as partners to help design improvements. Every board should receive regular and meaningful reports, including incidents where patient experience has been poor and improvements made. Staff must be trained to enable them to collect data and understand why doing so is vital to help embed good patient experience into the culture of the hospital.

But for all these changes to take place and be effective, there needs to be strong leadership. To have senior leaders constantly driving the initiative is critical

to its success. Leaders must be able to challenge the system and challenge the status quo. They must develop a culture of learning in which ideas are tested and a clear picture is built up of what works and what doesn't. To be engaged in patient experience, leaders should observe and shadow patients to help them see the experience from their perspective. Leaders must also tap into the enthusiasm of their staff, recognise when change and improvement has been made and publicly recognise the accomplishments of individuals and team members. Including patients and their families and carers in celebrations helps to give staff a reminder of why they are doing what they do.[20]

CASE STUDY 7

Patient experience award: Five-star chart points to the best patient experience at St Helens and Knowsley Teaching Hospitals NHS Trust

St Helens and Knowsley Hospitals Teaching Hospitals NHS Trust takes patient experience very seriously and has developed a five-point star chart system to help it provide a five-star service. This chart underpins all its strategic planning and the objectives that are set for staff. This in turn helps it achieve the best patient care.

The chart's five points are: care, communication, systems, pathways and safety. These are explained in the following way:

- Care should follow best practice, provide excellent patient experience and be of high quality.
- Communication should be timely, courteous and inclusive.
- Systems need to be efficient, reliable and patient centred.
- Pathways need to be planned, personalised and embedded.
- Safety has to provide good outcomes for patients, set high standards and create a learning culture.

The chart is used to help the trust demonstrate how staff can contribute to creating a five-star experience each year. Chief executive Ann Marr says: "Every year for 10 years we have set our corporate objectives around this approach. As a result, this year we were able to show CQC inspectors a 10-year perspective on these five points. We could demonstrate our progress towards delivering five-star care and patient experience."

The trust has ensured any statutory targets are included in the chart rather than being the main focus. Ann says: "The emphasis is that targets have to be met but they are secondary to achieving our major vision of a five-star service for patients."

Being accessible to patients and listening to their concerns is a major factor in the trust's success. Patients have direct access to Ann, either by email or phone. Once she has received a complaint or concern it is investigated straightaway and every communication is answered.

'Patient Power' meetings are also held at least once a month, at which patients can provide feedback. These meetings can be for all patients, or in some cases for specific patients, for example those on cancer or paediatric pathways.

Crucial to the trust's success has been the appointment of a patient-experience lead, Clare Aspinall. She is responsible for introducing and co-ordinating new initiatives. Ann says: "Lots of people know Claire and people inside the trust listen to her. She knows that we will always be supportive of her efforts."

The trust understands that collecting data and feedback is just the starting point and that what you do with them is just as important. Ann says: "We treasure our feedback and always act on it. You need to say what you are going to do and make sure you do it."

This is a leadership strategy that Ann also uses with her staff. The trust also has high-scoring staff surveys, particularly in the area of patient safety. She believes that treating all staff with the same level of respect, whatever their level of seniority, demonstrates that all are equally valued. The key to this is always sticking to what you say you'll do, and remaining consistent and authentic whatever the challenges.

It is also vital that all staff, not just frontline staff, are aware that they are also responsible for providing the best patient experience. Throughout the hospital there are photos of staff with a caption underneath stating: "I provide five-star care by…..". The photograph may be of a porter who makes patients feel calm on the way to theatre, or a booking clerk who recognises a patient may have multiple appointments and does their best to make everything run as smoothly and conveniently as possible.

Ann says: "If you have a picture of a surgeon saying 'I provide five-star care by achieving the best outcome for my patient' next to that of a porter saying 'I help a patient feel relaxed on the way to theatre', that sends a really powerful message that everyone has a part to play."

CONCLUSION

The NHS is always under close scrutiny – by the media, patient representatives and the government. But the pressure for change and improvement has never been more evident than in recent years following the publication of the Francis report and the Keogh review. It was clear that major change was needed in many trusts to ensure that safe, high-quality and effective care is given, with good clinical decisions that give patients the best outcome and also the best experience.

This kind of change takes time, resources and the motivation to change the mindset of the whole organisation. It also requires leadership teams to take a step back, assess their organisation and see it through fresh eyes, admitting when there are areas with fundamental problems that need to be addressed. It may be uncomfortable to acknowledge but those who have done so are seeing big changes and improvements for both staff and patients.

Our hospitals have shown that it is vital to get everyone on board, whether it is to improve data quality, patient experience or quality of care. They have taken that hard look at the services they are offering and learned what they can do to improve. In many cases, it has been found that it is not the job of any one person to make a difference. The smooth running of a hospital is down to everyone. More often than not, there is a recognition that frontline staff are best placed to help redesign services, and that the views of patients and their families or carers are crucial to getting it right. In other cases, it is about recognising the worth of staff and what they do; the vital work of coders is an example.

The use of data has never been more important and in our winning trusts, clinicians and coders are working together. The value of data is at the forefront of everyone's mind as part of their everyday work and this is reaping huge benefits for patients and the trusts.

The one thing that all our winning trusts have shown, regardless of category, is that, to be successful, the whole trust needs to work together. Sharing ideas and best practice can help to ensure continuity and quality of care across the NHS and reduce variation in care; best practice must be shared externally so all organisations can learn from one another.

> The organisation needs a clear vision (together with values and standards) for patient experience – known and understood by everyone in the organisation – including staff and patients.
>
> Patient experience: the importance of organisational culture. NHS Institute for Innovation and Improvement

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