The Road to Improvement

A history of WWL striving for success
HSJ Provider Trust of the Year 2014
Introduction

The WWL Way

“The stories in this book show that making change work and stick in a complex; safety-critical organisation like an NHS hospital trust isn’t easy. It takes data, resources, and tools - and most importantly of all, sustained commitment across the whole organisation over a long time”.

Andy Cowper
If you’re looking for a book about a perfect NHS organisation, you won’t find it here. The fairy tales section of a bookshop might be a better place to search.

If you’re after a book about an awful NHS organisation, you’ll be likewise disappointed. Although there are some bad services in the NHS, and no small amount of bad news, this book is a welcome opportunity to share the story of how Wrightington, Wigan and Leigh NHS Foundation Trust (WWL) realised and admitted that it had some significant problems, and successfully and sustainably addressed them, making positive and durable changes in patient safety and staff morale on the way.

This isn’t a story of heroic individuals, either. The bookshop’s fiction or biography sections may help (and are sometimes interchangeable). Instead, it is a story about culture and change.

One big lesson from WWL’s journey is that change is possible if you are very determined, very open and very clear and consistent about what you want to achieve.

Above all, the stories in this book show that making change work and stick in a complex; safety-critical organisation like an NHS hospital trust isn’t easy. It takes data, resources, tools - and most importantly of all, sustained commitment across the whole organisation over a long time. This absolutely isn’t the story of a quick fix. (The self-help section of the bookshop can probably spin you a line or two on quick fixes, if you’re that way inclined.)

Much has been written about the demand pressures facing the NHS from an ageing, growing and widening population, and midway through a decade of the slowest sustained growth in funding in the NHS’s history. These issues face all NHS provider organisations: so does the ongoing turbulence following the 2012 disorganisation of NHS management structures and systems.

Resources and the realpolitik of NHS systems are both important factors, but they’re not the main story here.

A constant theme of everyone involved across these pages is that WWL’s improvement journey is not finished. “We’re not there yet” is almost a mantra. This isn’t an attempt at false humility. The trust’s staff is rightly proud of their team’s achievements, but clear-eyed that their task is not merely to sustain them, but to build on them.

This book emerged from conversations with the staff of WWL, and would not have been possible without their generous participation. It has been hugely helpful to draw on chief clinical information officer Dr Martin Farrier’s frank and funny book ‘The Road For Wigan’s Peers’, which is soon to be published.

The stories in these pages remind us that that there is nothing that’s wrong in the NHS that can’t be fixed by what’s right in the NHS. Consistency of purpose, effective systems, emphasis on safety and staff engagement can achieve big things, even in turbulent times.

The foundation of all WWL’s improvements is their values (encapsulated in the ‘WWL Wheel’ explained in chapter three). These are literally written up on the walls around the various sites. The consistency of purpose, without which change tends not to stick, is rooted in those values.
Two essential, much-used words used when writing about the NHS are culture and trust. (The latter gets a high hit rate as the name of a provider organisational form.) It’s appropriate: culture and trust are deeply linked. The NHS has a status as a national icon unique among any healthcare system. It is consistently cited in opinion polls as a source of national pride. It had a starring role in the 2012 London Olympics opening ceremony: it’s difficult to think of another nation which would do that about its health system. The NHS is a big part of the story that contemporary Britain tells itself about itself.

The NHS is also political, due to its funding from general income taxation and its universal coverage. It is highly newsworthy when things go wrong. This political/media spotlight pressurises NHS organisations to deliver the ‘right’ answer to system leaders and ministers (whether on quality and safety, regulation or finance). It thus tends to breed a box-ticking, fear-driven, system-gaming compliance culture, which generally erodes trust and staff morale.

That toxic culture is notably absent at WWL. While WWL’s improvements in patient safety are impressive, their improvements in culture and staff engagement deserve equal attention. Before and after my visits to WWL, I had ample, unchaperoned opportunities to see how staff interacted with patients and with one another. They were consistently helpful, polite and respectful. There was trust.

The phrase ‘culture eats strategy for breakfast’ is reportedly written up on the wall at Ford Motors in the USA (http://www.wsj.com/articles/SB113797951796853248), and is often quoted about the NHS. Although the dieticians of culture are worryingly silent on its choices for lunch and dinner, it’s a line which makes a vital point.

The NHS is trying to redesign how it delivers care in the face of rising demographic demand and without significant extra resources. That is a momentous task.

Organisations that get their culture right are likely to stand a better chance of success. WWL have made huge progress in this, and want to share their story. They hope you will enjoy it, find it useful, and use it. So do I.

Andy Cowper – HSJ Opinion Editor
Chapter One

A short biography of Wrightington, Wigan and Leigh NHS Foundation Trust.

“You can’t transplant culture in the NHS; you have to grow it over time…. But WWL’s story is about why people take improvement and culture seriously.”

Andrew Foster
The community that each NHS organisation serves is a key part of their context. Like many areas in the North of England, the towns of Ashton, Wigan and Leigh were transformed by the industrial revolution – thriving with the heavy industries of coal and cotton in Manchester and Lancashire. The mills and mines have been closed for a long time, and the local population has been navigating the post-industrial social and economic landscape with many of the legacy of health effects that you’d expect.

According to the 2016 Health Observatory (http://fingertipsreports.phe.org.uk/health-profiles/2016/e08000010.pdf), the health of people in Wigan is generally worse than the England average, including rates of smoking, binge drinking adults, rates of cardio vascular disease, incidences of cancer and life expectancy. However, some indicators are similar to the national average, such as physically active adults, and others are better than average, including crime, sexually transmitted diseases and road traffic injuries.

There are internal health inequalities within the Borough, deprivation, gender, age and geography all influencing health. For example, men in the least deprived areas live around 11.5 years longer than those in the most deprived areas, and for women the difference is 10 years.

Over the last ten years there have been decreases in death rates from all causes and in early deaths from heart disease and stroke, and cancer. However, the rates remain above the England averages and the gaps between Wigan and England death rates from all causes have widened over the decade.

The health of children and young people is generally worse than the England average, including breast feeding initiation and smoking in pregnancy. However, the percentage of children who are physically active is better than average.

The 2011 census data (https://www.wigan.gov.uk/Council/Data-Statistics/Census2011.aspx) found the growing population included more older people: “the percentage of the population aged 65 and over was the highest seen in any census at 16.2 per cent. 1 in 6 Wigan residents are now over the age of 65. The number of 85+ year olds increased from 4,326 to 5,400 in 2011, an increase of over 24 per cent.” Ageing is a key index of likely need for healthcare.

Deprivation and disability are two other key indices of healthcare need the Wigan Joint Strategic Needs Assessment 2011 (JSNA) (https://www.wigan.gov.uk/Docs/PDF/Council/Strategies-Plans-and-Policies/HealthAndSocialCare/JSNA/JSNA-PopulationProfile.pdf) finds that ‘those living in the most deprived communities live on average 8.6 years less long than those in the least deprived / more affluent localities; women live on average 6.2 years less long … the combination of coronary heart disease and digestive diseases make the greatest contribution to lower life expectancy”.

It’s also a largely white-skinned area, with some eastern European migration in recent years: the JSNA notes that “Wigan remains a predominantly ethnically homogenous borough, with only around 4% of residents of a black or minority ethnic (BME) background”. 
Wigan also has pockets of extreme deprivation: nine of its local ‘super-output’ areas (a term of population statistical jargon) are among the poorest 3% of areas in England. Richard Mundon, WWL’s director of strategy and planning, notes that “Wigan has a population of 320,000 and it is the largest borough of Greater Manchester, although I’m not too sure that many local people think of themselves as such!”

“The traditionally, this is a mining and mill town, and the cotton mills are a big part of the local history. There was a big mining disaster in Golborne 40 years ago (http://news.bbc.co.uk/onthisday/hi/dates/stories/march/18/newsid_4226000/4226271.stm), which is still talked about.

“This area used to have generations of whole families working in the local heavy industries. The health legacies from that remain: we have big respiratory disease issues and high rates of lung cancer (although the cause is smoking much more than industry)”.

The region’s areas of high deprivation are not unique, Mundon clarifies, “but the scale of differential between our affluent and deprived areas is quite large. The area is predominantly deprived, with industrial heritage, and disease prevalence such as you’d expect to find with that sort of community.”

Community and economy

“This is a proud area, and I think most people see themselves as part of Lancashire. There’s little community tension, and sometime you get the sense of being sucked into the huge alien-next-door of Manchester, The Big City! Wigan is more suburban than a large city like Manchester.”

The local economy is a mix of light industry and rural, with farming relatively unaffected by change. Emerging from the town centre, you’re soon in very rural areas. Mundon notes that “the biggest local industry is the Heinz factory, but WWL is the biggest employer in the borough, with 4,500 staff”.

The local authority is the second-biggest employer, but many jobs have gone due to the local government funding cuts.

The three main local MPs are Labour: Yvonne Fovargue for Makerfield, Lisa Nandy for Wigan and Joanne Platt for Leigh. A fourth constituency, Bolton West, also includes a small part of the Borough; this has been a marginal seat for a number of years, won in 2015 and 2017 by the Conservative Chris Green.

When considering culture; from George Formby to The Verve, via Wigan Casino, this town has Northern Soul. We are home to the World Pie Eating Championships and Uncle Joe’s Mint balls. The town is synonymous with Wigan Warriors who are the most successful English Rugby League club – that most northern of all sports. In 2013 the town really began to #Believe when Wigan was the first town to be crowned both Rugby League Challenge Cup winners, and football’s FA Cup Winners.

WWL’s sites and services

WWL was created in 2001 with the merger of Wrightington NHS Trust and Wigan & Leigh Health Services NHS Trust. WWL gained ‘Foundation Trust’ status in 2008. We are the provider of acute hospital services to the people of the Wigan
Borough and surrounding area. We offer district general hospital services for the local population of over 320,000 and specialist orthopaedic services to a much wider regional, national and international catchment area.

WWL has three main hospital sites, a separate out-patient centre and a share in a LIFT building which contains secondary care ophthalmology services.


This is the main A&E site, and associated specialist services related to acute care are located here. The new Cancer Care Centre, run in association with the Christie NHS FT, opened in early 2015. Richard Mundon feels this has been “great news for local people, as previously the chemotherapy was at the Christie’s Manchester site: quite a travel away. We still send patients for specialist treatments there, but the new centre has made us able to deliver most care more locally”.

Leigh Infirmary has surgical theatres, but is increasingly developed as a more community-based diagnostic and treatment centre. The Hanover Building is a one-stop provider of urology, gastroenterology and women’s services. Mundon explains this “really impressive converted building was rebuilt around state-of-the-art endoscopy facilities. The redesign made the building work around the scopes’ cleaning and decontamination: it was designed with different lifts, all bespoke, and it’s the envy of many”.

The Leigh site is something of a health ‘campuses, shared with North West Boroughs Mental Health and Bridgewater Community FTs. There’s a brand new Leigh health centre co-located there: a GP-led Local Improvement Finance Trust-financed building and the trust is hoping to co-locate most of its outpatients there”.

Wrightington has international fame as an orthopaedic specialist hospital, and the cradle of joint replacement surgery and technology. It was the venue for the world’s first modern hip replacement in 1962, by Sir John Charnley (http://news.bbc.co.uk/1/hi/health/4906010.stm; http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1888784/; https://en.wikipedia.org/wiki/John_Charnley), who practiced at the hospital for the last and most famous stage of his career. As well as being the father of modern joint replacement, Charnley developed laminar flow operating theatres, air filtration systems and exhaust-vented, negative pressure surgical operating suits, all to reduce infection rates in surgery.

Wrightington recently opened a new phase of redevelopment which features a four-table ‘barn' operating theatre, with open-plan design to enable more efficient and streamlined use of the services and facilities. Wrightington is a centre of excellence, Mundon adds, “with off-the-scale high-quality and scale-able outcomes, and very low revision rates for surgery”.

The fourth site is the Thomas Linacre Centre in Wigan: the ex-grammar school. This provides almost exclusively outpatient
services for WWL, and has a 93% utilisation rate: this is considered very high.

These are some basic facts about WWL, to help put its journey into context. But as Chief Executive Andrew Foster observes (and subsequent chapters will detail), the changes weren’t about technical elements alone. “Wrightington has one of the most efficient and high quality orthopaedic services in England. Our health economy could save several million pounds a year if all the providers in Greater Manchester operated as efficiently as Wrightington does.

“But that success was not about the novel kit, or the fancy patient pathway. It was born from a culture of wanting to do and be the best. A culture of continuous improvement.

“You can’t transplant culture in the NHS; you have to grow it over time. Clearly, you can learn from best practice, eliminate error, reduce variation. But WWL’s story is about why people take improvement and culture seriously, and so put in extra discretionary effort. That is the secret of the success that we’ve had, and we want to tell the story of that journey and process and the tools we’ve developed. Because they could help others.”

Main Learning
1. WWL is an average-sized NHS trust in a typically deprived Northern formerly industrial suburban area.
2. WWL’s main clinical claim to fame is as the birthplace of modern joint replacement. Wrightington Hospital still does more joint replacements than any other hospital in England.
3. Because of its specialisation and volumes, Wrightington achieves higher efficiency and better quality outcomes.
4. In today’s NHS, WWL’s main claim to fame is for having created a healthy organisational culture. This story will show that higher staff morale results not just in better staff survey results, but in better quality, better performance and better patient satisfaction.
Chapter Two

WWL’s unfinished improvement journey: three burning platforms and the value of candour

“Duty of candour, for me, is about understanding what has gone wrong and using the learning to try to prevent it from happening again”.

Mary Fleming
WWL’s unofficial mantra seems to be ‘we’re not there yet’. Despite having won various national awards, its management team have an almost superstitious aversion to over-claiming on their successes.

Candour about challenges is the basis of the WWL way. Their organisational culture is to admit and address problems, rather than to deny them: this is not always the case in the NHS. Chief Executive Andrew Foster uses the social media microblogging platform Twitter (https://twitter.com/andrewkfoster) to log monthly incidents of hospital caused avoidable patient harm such as infections, serious falls, pressure ulcers and ‘Never’ events. Whether the news is good or bad, the data is tweeted to the public and the world.

Foster explains why: “Wherever you find human error you need to look for system failure. Errors happen in healthcare because it’s delivered by humans. If we’re going to improve matters the worst thing is to try to find who to blame.

“But we need to be brutally honest with ourselves about why failure and error occur. What’s the root cause? Is it design issues (sometimes called human factors), or is something technically not working right. You must report incidents and investigate them seriously and scientifically, and relentlessly pursue errors. And you can’t do that without the right culture.”

Andrew Foster’s journey to becoming WWL’s Chief Executive in 2007 included a long period as the Department of Health (DH) Director-General of Workforce 2001-6. This board-level Whitehall experience means he knows what it’s like inside the central command-and-control bunker, where ministers sit looking out.

In Foster’s view, the changes made by the team at WWL addressed three distinct, but linked, burning platforms for change. The first two of these were in the field of quality and safety; the third was about staff engagement.

Foster recounts, “in the first phase of my time here, 2007-11, our most pressing need was to become a Foundation Trust (FT), so we had to have a five-year strategy and all the underpinnings. Our Board agreed in 2007 that quality had to be at the heart of our business strategy. In the NHS today, post-Mid-Staffs, Morecambe Bay and the Francis Inquiry, that doesn’t sound odd - but in 2007, it was far from mainstream thinking.

“When I got the job here, I didn’t think I was coming in to an organisation that was at all bad. But it soon emerged that we had serious infection control problems. We had thought we were average on measures of quality, but when the DH’s infection control support team looked at our data, they found that our Clostridium Difficile and MRSA infection rates were much worse than average. In that year, 2006-07, our figures were 373 C Diff and 39 MRSA infections. We thought that was average: they said not.
“So, we began something that looked a bit social movement-ish within the Trust to tackle infection control. One thing that was pretty memorable was our ‘no ties; bare below the elbows’ dress policy. The BMA memorably attacked it as being based on no evidence, saying that as doctors, they wanted the delineation of white coats and ties as a signifier of their status. These were pompous arguments, but helpful in that they got all staff in the organisation talking about infection control issues.

“So, we got advice and help from the DH’s infection control team and others, and that led to our achieving and sustaining a quick and dramatic drop in avoidable infections.

The second burning platform for change, Foster continues, arrived in the form of the Trust’s HSMR (Hospital Standardised Mortality Ratio) figures. Mortality rates in the NHS are measured by assessing the number of people expected to die based on their admitting condition and
dividing that by the number of people who actually die. If the figure is over 100, an organisation would appear to have either a problem of excess mortality, or of patient coding - or of both.

Foster explains, “We started looking at HSMR figures during 2007, and they were not good. This wasn’t a total surprise: it’d been a hard winter, and we pretty much knew we’d be above average for mortality rates. Still, it was a shock that our average for the whole of 2007-08 was 127, the same as Mid-Staffs’ numbers, and for December 2007, WWL’s figure was 150. That meant that it appeared in that one month, that 50% more patients died than would be expected.

“In overall terms, it appeared that hundreds more of our patients died after hospital care than would be expected. Along with the medical director and other senior medics, I called an emergency meeting in the education centre. It emerged fairly quickly that the big problems were not that we had poor clinicians, but that we had no patient safety system. So, we borrowed, developed and implemented safer systems. Within just six months, our mortality figures had begun to come down sharply.

The result, Foster continues, “Was a spectacular change. Our HSMR went down from 127 to 98 the following year: just better than average. And it continued to come down. That quick win, evidenced by hard data began to build credibility and enthusiasm for our improvement and quality focus. “Pretty soon, some of the doctors said who’d originally said that the idea we had a problem with mortality was ridiculous, started claiming credit for the improvement, which is fine with me”.

Foster suggests that these three burning platforms gave WWL the opportunity to implement the Institute for Health Improvement’s ‘100,000 lives’ techniques (explained in Chapter Four). “The beauty of these techniques and systems is that in both mortality and infection control, we got really quick results: in infection control terms, rates dropped in two years from 373 C Diff to 74, and 39 MRSA to 7.

“So, we had those two clinical areas as our initial burning platforms for change, but it was also about building improvement capacity and capability (discussed further in Chapter Four)”.

The whole WWL leadership team constantly stress that the introduction of a patient safety culture isn’t an event that stops: it’s something continuous. So, a series of phases followed after that, where WWL ‘safety’-ed up units and services, and sustained these reductions in mortality figures over the following years
Comparison of Hospital Deaths by Year & Month

Number Deaths in Hospital by Financial Year

- 2007/08
- 2008/09
- 2009/10
- 2010/11
- 2011/12
- 2012/13
- 2013/14
- 2014/15
- 2015/16

Key:
- 2007/08 all specialties (excluding still births)
- 2008/09 all specialties (excluding still births)
- 2009/10 all specialties (excluding still births)
The third burning platform was that of staff morale and engagement. WWL’s 2011 staff survey showed a decline in morale and extensive dissatisfaction, as Foster admits. “This was disappointing, particularly as the former national NHS HR director! I was supposed to do staff engagement, and for 2011 we were clearly below average.

“The next day, we got a letter about a staff engagement programme called ‘Listening into Action’ with endorsement from Sir Bruce Keogh, NHS England Medical Director. We decided to join and we also started working with Unipart, who have a big emphasis on staff engagement as crucial to the way they go about achieving improvement (http://www.unipartconsulting.com/sectors/healthcare)

The results after WWL’s 2012 work on staff engagement were pretty spectacular. Before the ‘Listening into Action’ work started, the Trust ran an internal staff survey with questions such as ‘do you feel valued by your organisation? Can you easily sort out small problems? Do you feel appreciated?’ That internal survey was repeated at the end of the year, and the positive responses to all questions shot up from an average of 36% before the programme to 65% afterwards.

Most importantly, Foster recalls, “we didn’t stop there. We said it’s not just going to be one year of staff engagement: we’re going to make it the core of our culture. And we brought in some very clever organisational development people to develop this into the most sophisticated version of staff engagement in the NHS of which we know. It was translated into a system and an operating plan, now called Go Engage”.

The Go Engage nine enablers of engagement, and how it works, are discussed fully in Chapter Five. But Foster is emphatic that this isn’t soft fluffy stuff: “the results of this are practical and tangible – we have improvements in reduced staff sickness rates and lower patient mortality.

“Our organisational development department developed a questionnaire based on metrics which lets people self-assess, and in aggregate builds a picture of staff engagement across the whole organisation, and lets us plot progress over time and across individual departments. It lets teams on wards compare themselves with colleagues”.

Director of Operations Mary Fleming emphasises that WWL’s emphasis on openness and candour is not conceived in narrow terms: “Duty of candour, for me, is about understanding what has gone wrong and using the learning to try to prevent it happening again. If we’ve made a mistake then we should be honest and upfront, apologise for what has happened and explain what we will do to put it right.
“A few years ago, an increasing number of medical outliers on surgical wards resulted in lots of patients having their surgery cancelled on the day of their admission. I considered this to be an unsafe and unfair practice, having to cancel procedures on the day of surgery was such a poor patient experience. It was equally distressing for the individual who had to sit down with the patients and tell them their operations were cancelled”.

Consequently, Fleming introduced a policy whereby any patient having their surgery cancelled on the day due to operational issues, such as no bed, would be given an apology and explanation by a senior manager who would also agree a further plan for admission. Fleming also brought the voice of these patients to the Board: “back then, the board mainly focused on the safety of patients attending A&E and who then required admitting to a bed. Fleming recalls one day when there were pressures in A&E, a board Director asked ‘will you be cancelling routine elective?’ I realised at this point we had a problem, The Board knew how many patients breached 4 hours in A&E, they knew how many infections there had been in the hospital, they also knew which patients diagnosed with stroke hadn’t been admitted to a Stroke Ward but patients listed for procedures seen as clinically ‘routine’ and cancelled on the day of their procedure were invisible.

To make this point, Fleming presented the Board with a list of patients whose surgery had been cancelled on the day over
the previous 4 weeks, the information presented was anonymised but carried a brief synopsis of each patient for example: ‘Peter is 78, he has 4 carers and wakes at night crying with pain’. ‘Katherine owns a local business and had to turn down work for the following four weeks, the period of recovery following her surgery’. ‘Susan’s mother drove over 100 miles to look after her disabled Granddaughter while Susan was in hospital’. She asked the board to tell her which of the patients they felt was ‘routine’ planned surgery. The general consensus was none of the patients cancelled could be classed as ‘routine’ given their individual circumstances, yet every person on the list had been cancelled on the day of surgery due to low clinical priority.

From taking the voice of the patient to the WWL boardroom, the team made changes that reduced on the day cancellations by 50% in six weeks. Fleming reflects that “we had a duty of candour to these patients, not only to apologise for what had gone wrong, but also to put it right by bringing ‘hidden’ patients to the board’s attention: making them visible and understanding the impact of the decisions we take”.

Fleming is, as most senior NHS managers are, keenly aware of the legal angle and litigation associated with duty of candour. “Clinical staff do talk about litigation, complaints, mortality data being published on public websites etc., and this no doubt has an impact on them. They are the ones who stand up in coroner’s courts when things go wrong or unexpectedly. “But, I have always believed we should be open and honest when things go wrong. Equally, when mistakes haven’t been made we should still say ‘I’m sorry’ if someone feels they’ve been injured or harmed, that is their reality.”

In Fleming’s view, saying and indeed being sorry isn’t about admitting guilt but having the capacity to empathise.

**Main Learning**

1. WWL’s journey to changing culture started with three ‘burning platforms’ for change: infection rates, hospital mortality and staff morale.
2. In each case, the Trust used evidence-based interventions plus metrics to achieve improvement.
3. Initial resistance and scepticism among some staff was eventually overcome by the significant and rapid improvement that emerged in each area.
4. Having achieved success in three specific areas, WWL’s next challenge was to create culture and systems that spread much wider and deeper in the organisation.
Chapter Three

Culture and values-based leadership

“Culture is what will deliver safe healthcare”

Mary Fleming

“Having clear, agreed values set helps us navigate constant policy turbulence”

Richard Mundon
It’s striking to note that, despite the NHS’s high place in public regard (it is consistently cited in opinion polling of British people as a key source of national pride, https://www.ipsos.com/sites/default/files/migrations/en-uk/files/Assets/Docs/News/Blogs/nhs-maintaining-pride-health-slides.pdf), the formal statement of NHS values is a recent matter.

When the NHS was launched by the then-minister of health Aneurin Bevan on July 5, 1948, it was based on three core principles:
• that it meet the needs of everyone
• that it be free at the point of delivery
• that it be based on clinical need, not ability to pay

It’s very noticeable that these three points are operating principles: they are not, as such, values.

It’s equally striking that if we consider the high-profile NHS care quality failures of recent years – most obviously Mid-Staffordshire, but also Southern Health and Morecambe Bay’s rogue maternity services – all of them would be able to claim to have met the three NHS founding principles.

The explicit focus on values is relatively recent. The seven principles and NHS values set out in the NHS constitution (https://www.gov.uk/government/publications/the-nhs-constitution-for-england) were published as recently as 2012. It covers values such as working together, respect, dignity and compassion. Implicitly, the right values have always been innate to the best organisations and systems – but they have rarely formally codified.

WWL wouldn’t dream of claiming to have invented values-based leadership in the NHS, but what is quite striking when you visit the Trust is that they have written their values up on the wall, in the ‘WWL Wheel’, first developed in 2010.

The ‘Wheel’ needs little explanation. It does a simple thing, simply: it states that patients are at the centre of everything WWL does, which is guided by the principles of being safe, caring and effective.
The WWL staff handbook states “you are joining an organisation that aspires to excellence in all of its activities, and that means

- Highest quality and safety of care
- Maximum efficiency and minimum waste
- Deep involvement of staff in planning and delivering services
- Meeting all our objectives and living within our financial means

The Trust’s mission is ‘to provide the best quality healthcare for all our patients’ and its vision is ‘to be in the top 10% for everything we do’.”

WWL Director of Strategy Richard Mundon observes that “my job is strategy and the complexity is significant. It seems as if every few hours, the direction of travel changes, whether that’s Greater Manchester devolution, collaboration with other Trusts, the Healthier Together legacy, new national standards, Sustainability and Transformation Plans … having a clear, agreed values set helps us navigate constant policy turbulence.”

“Our values, which the Wheel captures, go to what’s important to us as individuals. If we follow them consistently, at least we know we’re going to do the right thing for patients. Our team is led by a group of people who want to do this and have bought into it: it’s playing to our strengths and people are genuinely engaged in the process”.

Mundon is quick to point out that “there was some nervousness when we took this approach: some people had a sense that if we just had these three values (safe, caring and effective), we might be jinxing ourselves”. In practice, WWL’s leaders are clear that the values have been a key part of WWL becoming more successful and winning national recognition

Mundon explains their reasoning: “over the last 4-5 years, this organisation has flown and shone by doing the right thing, and by following high values. The awards and recognition are nice, but they’re a by-product. That’s our story: follow good values, and engage staff. We don’t do everything right; we definitely get things wrong, but we get far more right, and we’re getting things right more and more”.

Chief Executive Andrew Foster notes that the values-based approach requires continuity and consistency by all the WWL leadership team: “this work doesn’t happen by itself. Values-based approaches won’t evolve without a real effort to create the impetus. That takes a leadership team that believes deeply in the common principles and values. Once it’s been seeded, it can grow and become a real, common set of values - but you need a specific set of actions to plant the seed in the first place”.

This point is reiterated by director of workforce Alison Balson: “when people join this organisation, they have to be inducted in how we do things the WWL way – our values, behaviours and expectations. At induction we take our new employees for a spin round the WWL wheel, making sure there is mutual understanding about our strategy and our values.” Throughout the time staff work in WWL, we are consistent with our messages and our absolute focus on our values, with patients being at the centre of everything we do.”
The Trust had great success in winning a number of national, regional and local awards, including:

- **Health Service Journal (HSJ) Awards November 2014** – The Trust won the very prestigious ‘Provider Trust of the Year’ award.
- **Healthcare People Management Association (HPMA) Awards June 2014** – Staff Engagement was the overall winner from all category winners.
- **HSJ Awards November 2014** – The Trust’s Social Responsibility Group won in the Environmental and Social Sustainability category.
- **Healthcare Financial Management Association (HFMA) Awards November 2014** – The Trust’s Finance Department won the Accounts Team of the Year category.
- **Health Care Supply Association (HCSA) Awards December 2014** – Our Procurement Team won National Procurement and Supply Chain Team of the Year award.
- **Patient Experience Network (PEN) National Awards March 2015** – The Staff Engagement Team won in the Staff Engagement/Improving Staff Experience category for ‘The WWL Way’.
- **HSJ Value in Healthcare September 2015** – Pathology at Wigan and Salford (PAWS) won in the “Value and Improvement in Pathology Services” category
- The Finance Department has won the Financial Management Association (HfMA) Sue Rossen prize for the North West area in 2015 and 2016
- **NHS England Friends and Family Test Awards March 2016** – The Maternity ward won the FFT Champions of the Year.
- **NHS Finance Skills and Development Network December 2016** – The Business Intelligence team won the Innovation Award.

Full details of the awards successes are detailed in the annual report each year, available to download from the website [http://www.wwl.nhs.uk/about_us/annual_reports.aspx](http://www.wwl.nhs.uk/about_us/annual_reports.aspx)
Chief Clinical Information Officer Martin Farrier adds, “when we talk about the change in our organisation there are words that always arise: permission, volunteering, openness and learning from mistakes”.

Former Medical Director, Umesh Prabhu, was evangelical about the importance of having the right values modelled by leaders. This was a key focus of his engagement with staff within and beyond WWL on social media.

Umesh Prabhu quotes Andrew Foster: “Andrew always says ‘quality of care is equal to finance, but patient safety is much more important than finance’. Andrew says this publicly and repeatedly, and knowing that this is what a good leader says and believes and demonstrates: that has empowered our staff”.

Director of Operations Mary Fleming adds, “when I came to work here, WWL had no real point of major difference over other acute providers. It does now. This is probably the best organisation I’ve ever worked in. I was acting up, but wasn’t appointed in the substantive job – but I was encouraged to develop, and finally I was appointed Director of Operations: clear evidence of how this organisation values its staff. And it has a strategy for appointing values-based-leaders, and is becoming values-based-leadership organisation.

“You can feel culture and climate, and ours is fantastic; and culture is what will deliver safe healthcare. I’m pleased I got this post: I dreaded being moved on in a few years. And I have never in my life stayed in an organisation this long. What’s the difference here? The culture. It’s fantastic”.

**Main Learning**
1. The agreed WWL values, represented in the ‘WWL Wheel provide a fixed reference point for senior management team and staff alike
2. Emphasis on values was by no means mainstream NHS thinking when WWL started out on its improvement journey
3. The WWL values work is more than a programme: it is an ongoing process throughout the whole employment of staff within the trust
4. The senior management team are mindful that they must hold themselves and be held to account for living up to these values daily, to lead by example
Clostridium difficile

Performance

Chapter Four

Patient safety, drinking the IHI Kool-Aid and improvement science

“Wigan’s approach to dealing with complaints reflects WWL’s commitment to safety and transparency.”

Alison Balson
As Chief Executive Andrew Foster set out in Chapter Two, serious quality problems were the background for many of the changes WWL introduced and sustained.

Just as with values in the previous chapter, it can seem quite shocking to non-NHS lifers that patient safety and quality improvement science have not been particularly mainstream in the NHS until recently. The NHS Atlas of Variation (http://fingertips.phe.org.uk/profile/atlas-of-variation) reveals the extent of variability of access to evidence-based care recommended by the National Institute for Health and Care Excellence (NICE).

While some NHS observers find the tendency to look overseas and particularly to the USA for good practice slightly wearing, there is widespread agreement on the influence of one American, Professor Don Berwick. The Don’s slight physical stature seems to have an almost inverse relationship with his huge positive influence on improving the quality and safety of healthcare in the US and internationally.

There is no truly reliable data on the number of people who are harmed by healthcare, but the generally accepted estimate is about one in ten (http://www.who.int/features/factfiles/patient_safety/en/).

WWL Chief Executive Andrew Foster recalls “my learning about safety and health systems started when I was working at the Department of Health. Professor Don Berwick of the USA’s Institute for Healthcare Improvement (IHI), had been retained to give the then-Health Secretary Alan Milburn general advice”.

“Don worked with me on an ‘HR in the NHS’ conferences and I was really impressed by him; so, I went to one of his IHI conferences, in New Orleans. This was my first exposure to the excitement of the quality movement”.

The real eye-opener for Andrew Foster was the IHI conference in London at the start of the 100,000 lives project (http://www.ihi.org/resources/Pages/Publications/100000LivesCampaignSettingaGoalandaDeadline.aspx). “Don made an angry speech, pointing out that although he’d been working on quality improvement for 30 years, and he had seen many impressive individual improvements, there was still no systematic method of quality improvement. He was fed up with rhetorical promises and coined the slogan ‘Some is not a number, soon is not a time’.”

Working with colleagues at the Institute for Health Improvement, Professor Berwick identified the six main causes of avoidable deaths, and developed a ‘care bundle’ (package of evidence-based interventions) for each.

Berwick worked out that if 2,000 hospitals in the US signed up to implementing the six care bundles reliably and consistently, it would save 100,000 lives in 18 months. Foster recalls that “Don invited the UK to be a ‘node’ of the movement, and do our own version. The audience was overwhelmed with enthusiasm for this spectacular but highly practical vision.

“I talked to colleagues about this initiative, and we contacted NHS Chief Executive Sir Nigel Crisp and Sir Liam Donaldson, the Chief Medical Officer. We asked ‘why doesn’t the NHS sign up to this safety initiative?’ They said no, because it was not invented here (OK, they actually gave another reason, but I think that was the real issue)”. 

30 | P a g e
So, participation in the Berwick campaign didn’t happen in England at the national NHS level, but for Andrew Foster, it was inspiring. When Foster left the Department of Health Director of Workforce job in mid-2006 to go back into the service, he was clear that he wanted the patient safety and quality focus “to be my unique selling point. It was what I told the panel at my interview to become a Chief Executive, and they appointed me to do it”.

Director of Workforce Alison Balson expands on the work the Trust has done on ‘never events’ (https://improvement.nhs.uk/resources/never-events-policy-and-framework/) and encouragement of incident reporting. Still, she avoids over-claiming: “when it comes to patient safety incidents, there’s still work to do here”. Nonetheless, incident reporting has improved greatly: WWL has gone from being one of the lowest reporters of incidents to one of the highest, and so the Trust’s NHS Litigation Authority premiums have gone up (as you would expect, when more incidents are reported). Safety experts would expect to see an increase in reported incidents when reporting becomes culturally and organisationally safer.

WWL openly promote to all staff the right to raise concerns if an individual sees something wrong. Before it was nationally mandated for NHS Trusts to have a ‘Freedom to Speak Up’ Guardian (http://www.nhsemployers.org/your-workforce/retain-and-improve/raising-concerns-at-work-and-whistleblowing/freedom-to-speak-up-guardian-hub), WWL identified someone internally to take that role on, who can be independent for people to go to if they’re not comfortable through normal internal channels.

Nonetheless, Balson emphasises that WWL’s safety and reporting incidents focus “remains work in progress, and we’ve given it a re-launch recently, in which we moved away from calling it whistleblowing, and re-launched our approach to include Associate Director of Governance and Assurance Clare Alexander’s role as Freedom to Speak Up Guardian. We’re not there yet”.

Safety and quality were Chief Executive Andrew Foster’s key motivations from the time he took the WWL job. “As a Chief Executive, my immediate mission was to get Wrightington, Wigan and Leigh to become a Foundation Trust (FT – semi-independent NHS organisation with some freedoms from direct ministerial interference). WWL had applied and failed before. So, we had to do a five-year plan and we needed a strategy.

“The Board agreed back then in 2007, that quality would be at the centre of our strategy. This was not about fancy rhetoric, but hard-nosed IHI techniques”.

Foster thinks that the Trust began to build “a bit of a social movement for quality improvement, and at that time all Foundation Trusts were required to produce Quality Accounts by the regulator, Monitor. And humble Wigan was invited to be a pilot for Quality Accounts, based on growing awareness of our quality improvement work.

“Then at the 2009 NICE conference, I talked about some harm reduction work we were doing and Dr Phil Hammond wrote about it in his Medicine Balls column in Private Eye, and was complimentary. That really built our credibility, especially with doctors”.

WWL

The next phase involved producing an annual report on cases of avoidable harm. In 2011, Foster recalls the leadership team agreed that they needed some in-house quality improvement (QI) capacity, “not just to look at our known problems of infection control and mortality rates, but to look at everything else too. Our neighbour Salford has a QI department, which we simply couldn’t afford, so we nicked the idea of quality champions from Royal Devon and Exeter. We invented very little: we plagiarise others’ good work a lot and with pride – and with due credit”

WWL’s Quality Champions was a movement, based on training 2-3 cohorts a year in quality improvement science. The Trust now has over 350 Quality Champions working on 140 improvement projects: Andrew Foster reflects that this represents “a QI ‘muscle’ and system that other NHS Trusts don’t have”.

Chief Clinical Information officer Martin Farrier locates a problem in the performance data, and the senior management team work together to build capacity to deal with this and set up a Quality Champion project in areas such as acute kidney injury and sepsis.

Martin Farrier’s excellent book ‘The Road For Wigan’s Peers’ outlines some of the techniques used to make the Quality Champions projects into a social movement: “Quality Champions was many people’s idea, but Andrew (Foster)’s vision. We understood the need for training. We understood the need for recognition. What we were stumbling on was a social movement. One of the key requirements for a social movement is that the people in the movement understand how to join in and can recognise the other people in the movement”.

Farrier observes the vital importance of change being firmly rooted in data and conveyed through accessible, engaging (and real) stories: “the Institute for Healthcare Improvement (IHI) quality improvement approach has been about implementing best evidence every time. That is how we define quality”.

When WWL teach their aspiring Quality Champions about quality improvement methodology, it includes a whole section on measurement and another on understanding data. Once a month, they hold a Quality Champions Forum where teams present and discuss work. Andrew Foster chairs this session and his most common questions are ‘when can I give you a Silver Badge? Have you demonstrated a sustained improvement?’

Farrier writes, “it is data that allows us to understand our performance and compare our outcomes with either our own history or with our peers: both things being desirable. Social movements need a different sort of data. We are used to numbers and charts, but they are not engaging. They are interesting, necessary - but they don’t make us passionate. The data that is needed to bring passion is brought within stories: real examples of where problems lie. Stories are engaging.”
"Stories need to be real; they need to be challengeable; they need to be retold. It helps if we have many variations of a story. The more times we find the same story in different patients, the more powerfully the story is told. If those stories are told in real time, as they happen, they have greater validity. They are not merely constructed to win an argument. Where those stories exist, groups of people who are engaged by the story will find agreement and desire to make change”.

For their launch of Quality Champions in 2012, WWL chose an Olympic theme. Staff trained as QCs get a bronze badge. Once they achieve their project goals, this is uprated to a silver, and if they do something that gets spread elsewhere in the NHS beyond WWL, they get a gold badge. The badges are something to which staff aspire, and require evidence of achievement.

Andrew Foster reflects that WWL discovered “slightly accidentally, that the whole quality improvement process also creates massive improvement in staff motivation and satisfaction. People feel not only that they’re doing something they love, but that they love the new community feel and successful feel that Quality Champions bring across the Trust”.

Martin Farrier highlights the importance of multiple approaches to recognising quality improvement. He reflects that the power of peers can be accessed in simple ways, such as WWL’s ‘Going the Extra Mile’ awards scheme. Anyone (including patients) can nominate a member of staff for the award. “There is no filtering. WWL simply accept the nomination and send the member of staff a card telling them who nominated them and why. They get a small pin badge that says ‘I go the extra mile’.

“These are popular. They are powerful too. People in the NHS are often dissatisfied and feel that their work is under-recognised. This is a simple way of people telling each other that they are appreciated.”

Not everything is rosy in getting the wider NHS management community to take notice of quality improvement and safety, as Andrew Foster admits: “staff engagement (see Chapter Five) is easier to learn. Quality Improvement seems to be much harder to get. Every year, I go to the IHI Conference and the NHS Patient Safety Congress, and I see the same people in the Chief Executives’ stream, just six of them.

Foster suggests that most NHS Chief Executives haven’t understood the nuts and bolts of QI, or its ability to inspire staff. He suggests that his local peer, Salford Royal NHS Foundation Trust’s chief executive David Dalton, “definitely gets it, and some of what we do is like Salford’s QI work. Others see quality as being about blame and errors, not seeing the other side of motivation and satisfaction when it improves”.

WWL’s ‘Sign up to Safety’ initiative builds on the Trust’s general commitment to patient safety. Its name and aims are drawn from a new national patient safety campaign announced in March 2014 by Health Secretary Jeremy Hunt, aiming to strengthen patient safety in the NHS and make it the safest healthcare system in the world, with the ambition of halving avoidable harm in the NHS over the next three years, and saving 6,000 lives.
'Sign up to Safety’ is supported by a campaign that aims to listen to patients, carers and staff, learn from what they say when things go wrong and act to improve patient’s safety helping to ensure patients get harm free care every time, everywhere.

Workforce director Alison Balson says “this might be controversial, but I don’t really think we’re there yet on Sign up to Safety. There’s such a lot of really good stuff happening around patient safety and Sign Up to Safety is fine in principle, but I question if any staff were asked, would they know what the commitment was of Sign up to Safety” She suggests that it is a confused picture, which needs simplifying.

Balson thinks that what’s needed is “something about how we brand that area of work and communicate it. Currently, it’s presented using a driver diagram with lines everywhere, and I find it confusing. We need to pull it together in a concise way that staff could say ‘this is what Sign Up to Safety means’ ”.

Alison adds that Wigan’s approach to dealing with complaints reflects the commitment to safety and transparency. WWL’s approach is to treat all complaints as potentially correct, and prioritise communication with complainants about what the internal procedures conclude. If errors have been made, a prompt apology is the priority. If no errors have been found, the Trust conveys this diplomatically, but may also apologise because the situation was not handled in a way that would have avoided the complaint arising.

The Toft Report was, she suggests, a good example of WWL’s willingness to be self-critical. Professor Brian Toft OBE is an expert in serious incident reviews. WWL had become concerned about their number of ‘never’ events, and so wanted some external scrutiny. Professor Toft came in and reviewed the Trust’s ‘never’ events; Balson notes that “he could find no clear trend of problems, and in fact, he told us that some of what we’d classified as ‘never’ events were not actually in that category”.

The image shows a group of healthcare professionals in a hospital setting, indicating a focus on patient safety and healthcare professionals.
The final Toft report was received by the Trust in March 2015. The report reviewed individual incidents so it was agreed at the time not to publish the report in full. Instead Professor Toft presented his themes and findings at the public element of Trust Board and we published the Executive Summary in our Quality Accounts.

2014/15 Quality Account can be downloaded here http://www.wwl.nhs.uk/about_us/annual_reports.aspx

Director of Nursing Pauline Law points out that an early WWL initiative was the Talk Safe campaign: “before we had Quality Champions and ‘always events’ (see Chapter Six), there was Talk Safe”. The scheme was developed by John Bamford, whose son died in hospital: he had congenital heart disease, but lived a normal life: in his mid-20s, he went in to have a quite routine operation.

Law continues, “John's son died because he was on the wrong ward; the doctors who were looking after him out of hours didn’t know his history, and didn’t believe him when he said a treatment was wrong; the nurses didn't escalate things quickly when he was deteriorating, and when they did, escalated it to the wrong person”.

Having lost his son so young, John Bamford decided that if people didn’t cut corners and followed proper process, there would be less risk in the NHS. Mr Bamford was from an engineering background, and Law notes that “his view was that we subconsciously didn’t do things: moving away from safety systems and processes, and cutting corners is not done on purpose. He set up Talk Safe at Sheffield, and brought it to us”. Talk Safe is about having safety conversations, Law adds. “You have safety conversations every time you see a colleague doing something that's unsafe, even down to a small thing like not holding onto the bannister when walking down stairs. That makes you think next time, I'll use it to prevent falls. It’s about simple things. In theatre, get the team to ‘talk me through your day’, so they remember routine things like cannula insertion”.

Another part of the WWL safety culture is the executive scrutiny committee, held weekly. The senior team bring red complaints for discussion; discuss any serious incidents; have updates from previous weeks; and discuss coroners’ cases where the Trust can learn lessons.

This group also discuss anything to do with safety and quality that needs action, using Root Cause Analysis, and allocating investigators. This committee has provoked lots of external observations: Pauline Law observes that “other people in the NHS think it’s quite extraordinary”.

“Our incident reporting has gone up dramatically, as you’d expect, due to open, honest and transparent culture so people are not frightened to report things. We do hold people to account, but in a very fair and justified way. And that really helps us”.

How do Law and colleagues find the process of getting nurses who have trained and practiced elsewhere to buy into the WWL safety culture? She replies that they recruit to the WWL values, and assume that if someone is a registered general nurse, and on the register, technically they should be
competent to do the job, so technical skill tests are not predominant.

Law and colleagues are “much more interested in their personality, and their fit with our organisation’s culture and values. So, we base all our interview questions around our ‘Wigan Way’ values. We’ll ask them ‘tell us about a time you’ve not got on with a colleague, how did you solve that, and how would you deal with it now?’ And we need to hear about their take on dignity, respect and compassion”.

WWL run a six-week nurse induction programme, which Law notes is “a fair bit longer than standard, and that's when we do test technical skills and give any training needed, but it also has a big focus on WWL values and values-based leadership that we expect of all staff, including those in lower bands”.

Main Learning
1. A focus on patient safety and quality improvement techniques has not been mainstream in the NHS until quite recently
2. Quality improvement science is a rigorous and evidence-based approach, somewhat under-used in the safety-critical healthcare world of the NHS
3. WWL has developed a range of programmes and means of recognition to support this work, including Quality Champions, Sign up to Safety, Going the Extra Mile awards and the weekly executive scrutiny committee
4. Encouraging staff to report safety and quality incidents without fear will lead to higher reporting rates; paradoxically, as an organisation focuses more honestly on safety, it will in the short term appear to become less safe. This is well-known, and should be understood at all levels, and communicated appropriately internally and externally.
Chapter Five

Turning the science of staff engagement into practice - “Go Engage: The WWL Way”

“Engagement is known to improve business unit performance, client satisfaction and safety”

Nicole Ferguson
As Chief Executive Andrew Foster made clear in Chapter Two, WWL’s various initiatives to improve how it works were driven in response to very real problems. These were what Foster describes as “three burning platforms”: infection control rates, high mortality data and poor staff engagement.

It is telling that of these three firefights, only two - infection control and high mortality figures - are ones on which national NHS regulators would (until quite recently) have been asking questions.

Yet the case for engaging with staff is clear. Evidence-based research demonstrates that engagement links positively to in-role and extra role performance (Bakker AB, 2004).

Engagement is known to improve business unit performance (Harter JK, 2002), client satisfaction (Salanova M, 2005) and safety (Nahrgang JD, 2011), (Prins JT, 2010), (Laschinger HKS, 2006). Ultimately, research into NHS data demonstrates a direct correlation between staff engagement and patient experience / outcomes (West M, 2011).

So, the case is clear, but the sophistication with which staff engagement is measured, evaluated and understood in the NHS is woefully underdeveloped. Staff engagement, however, doesn’t stand in isolation; it requires an organisational culture which unifies and empowers staff around a common goal.

At WWL, the golden thread is the shared commitment and desire “to put the patient at the centre of everything we do and wrap around this our focus on quality, through the definition of safe, effective and caring” (See Chapter 3 for WWL Wheel model).

The Trust’s values were developed by staff, for staff and these behaviours are then embedded into everything the staff team do, from the moment staff enter the organisation. Historic NHS leadership qualities based on centralised, command-and-control approaches are no longer consistent with an organisational culture that promotes collaboration, learning and discretionary effort.

WWL’s national staff opinion survey results in 2011 (received in 2012) saw the turning point for organisational culture. As Andrew Foster has noted, the Trust were in the bottom 50% of NHS Trusts and, although WWL had started on the quality improvement journey, it was clear that there was more to be done to improve the experience of staff.

WWL has always had positive and effective relationships with trade unions. Working in partnership with the staff-side, the programme of Staff Involvement Delivers (SID) had been longstanding, but hadn’t really been prioritised. The 2011 staff survey was the wake-up call for WWL to make a positive change, and it was from this point that their staff engagement journey began in earnest.

WWL worked with several partners, including Optimise (Listening into Action) and Unipart (Lean Methodology) in the first 12 months. This built on the existing infrastructure of SID, and resulted in some significant improvements over the year. The Trust improved their staff survey results, and could see some of the performance and safety improvements the research cited above suggested. Staff engagement was now clearly on the radar, and the incentives were there to be seen
The next questions to be asked were: how could the leadership team know what worked, and how would they take this work to the next level?

The appointment of Nicole Ferguson as Head of Staff Engagement in 2013 was the next catalyst for change. Ferguson used evidence-based psychology research to develop a diagnostic tool that measures staff engagement, broken down into enablers, behaviours and feelings.

This allows for trend analysis and identification of hotspots, be they by staff group or by work area. It also, for the first time, started to build a picture of staff engagement in a way that enabled WWL to use the data to target their staff engagement activities and really understand the impact of this work.

The survey is issued to a quarter of WWL staff four times a year (to avoid survey fatigue), and provides near-real-time information about the morale of the workforce. This enables the senior management team to act quickly in response to identified ‘hot spots’, rather than waiting for an annual national staff survey that doesn’t easily translate into relevant action.

Perhaps the best way to illustrate this is through some case study examples.
Recognition

WWL’s staff engagement diagnostic indicated that recognition was persistently one of our lowest scoring enablers. Many people would interpret this as a need for some large-scale recognition / reward scheme, but WWL decided to listen to what staff said. They told the leadership that the greatest satisfaction they got was from the small ‘thank you’ from their manager, colleagues, patients or their relatives.

Because of this feedback, our staff side (trade union) chair and head of staff engagement worked together to develop the Going the Extra Mile programme (described in Chapter Four). This is a quick and easy-to-use process that enables someone to express their thanks to a member of staff for ‘Going the Extra Mile’. The member of staff receives a card with a personalised message and a badge.

This may sound simple, but it has really made a difference. Almost 2000 members of staff have been recognised in this way and our diagnostic saw recognition scores significantly increase in direct correlation to the introduction of the programme.

Energy

The obvious tendency is to assume that staff engagement is positive and has a positive impact in reducing sickness absence. This is the case, and was what WWL saw as staff engagement levels improved.
However, when the data and trends are analysed more carefully, what becomes evident is that when engagement levels are so high but energy levels dip, the result was increased stress-related sickness absence due to burnout. Because of this intelligence, WWL have been able to introduce a number of supportive well-being initiatives for staff, under our Steps 4 Wellness programme. This includes mindfulness sessions; critical incident stress management; resilience training; and mental health awareness. The data was again telling the leadership what they needed to do: they simply needed to use it, and saw demonstrable results once they did so.

Local Level Culture and Engagement

Fundamentally, WWL’s culture promotes empowerment and through the Staff Engagement Pioneer Team programme, we support teams to take ownership and accountability for their own engagement.

By adding this bottom-up element to the staff engagement process, the capacity to support staff engagement increases in a similar way to the Quality Champions programme. Teams self-select for the programme and, if approved for participation, are trained in a number of core staff engagement tools. Each team is supported by the members of the staff engagement team throughout the six-month programme and are allocated an executive sponsor, whose role is primarily to help them remove / overcome any barriers they encounter.

Their experiences are then shared with the other teams in the cohort and the teams who are in the next cohort at a ‘pass it on’ event. What is perhaps most interesting is that the improvements from these bottom-up team approaches generally see improvements far in excess of Trust-wide activities. To illustrate this, the team diagnostics below show the improvements made by a ward who completed the Pioneer Team programme. Not only did this improve the experience for staff working on that ward, but patients also had a better experience; complaints dropped dramatically and positive patient feedback became the norm.

WWL have already learnt a lot from the programme, and continue on this improvement journey. This learning resulted in an assessment process prior to acceptance on the Pioneer Team programme. Members of WWL’s staff side, the Director of Workforce and the staff engagement team consider hard and soft intelligence about the team to determine whether the programme is right for them at that time. Fundamentally, no team is refused participation, but it may be delayed whilst some other work is completed (be it leadership support, system re-design or mediation, for example).
It is clear that soft intelligence from the staff engagement diagnostic and team programme can indicate areas of potential cultural concern. WWL’s staff engagement colleagues didn’t realise the power of the programme and tools in this sense until very recently. They now have an escalation process to bring these issues to the attention of the executive team, to ensure that appropriate support, ownership and accountability is in place.

No longer do WWL’s leadership need to wait for an annual staff survey to provide a baseline diagnostic about staff morale. They don’t even have an annual staff survey action plan! WWL now get this information every quarter, in a format that informs the actions they need to take to address the concerns / anxieties of staff, but also what pro-actively the Trust and its leadership can do for the well-being of staff. This has resulted in year-on-year improvements in the national staff survey.

WWL developed good tools which will help staff engagement; a survey to diagnose problems and celebrate success; a toolkit with some great engagement tools. However, those things alone don’t make staff engagement work: the right commitment, organisational culture and foundations all need to be in place. WWL’s leadership believe that happy staff results in happy patients, and back this with resources and support.
Main Learning
1. WWL developed good, evidence-based tools which will help staff engagement; a survey to diagnose problems and celebrate success; a toolkit with some great engagement tools
2. Those tools alone don’t make staff engagement work: the right commitment, organisational culture and foundations all need to be in place
3. Some of the tools such as the Staff Engagement Pioneer Team are powerful, and a gathering of soft and hard intelligence now helps the trust select and appropriately support candidate teams
4. Listening to what staff say they value helped design a recognition scheme
5. Internal quarterly surveys help the trust to track emerging issues for the workforce in near-real-time
6. WWL’s leadership believe that happy staff results in happy patients, and back this with resources and support
Chapter Six

Internal inspection, ‘always events’ and moving beyond firefighting

“Internal inspections are a way of understanding what problems are present in real time. They are best done by people who understand the work being inspected, and they are best done regularly.”

Martin Farrier
Inspection has become a massive feature of the NHS. The hugely high-profile Mid-Staffordshire care quality scandal led system designers and leaders to rely ever more strongly on quality inspection and regulation as the principal means of trying to prevent any repetition of the abusive and uncaring actions of staff.

There is serious concern across the NHS that regulation and inspection is over-complicated: one chief executive recently described their real job as ‘regulatory liaison officer’. Don Berwick mentioned this burden of complexity in his 2015 speech to the Kings Fund think-tank, calling for “a tiered system of regulation and oversight which is much more responsive to actually what’s going on on the ground” (http://www.kingsfund.org.uk/sites/files/kf/field/field_document/don-berwick-improving-the-safety-of-patients-in-england.pdf).

Berwick’s next lines are worth quoting here: “It will never not be part of your job to assert that the NHS is about quality and the patient experience. And part of your duty is to assure, as Bruce Keogh did in his brilliant report, that when warning signs ring, response happens. As my friend Lucian Leape said ‘when something happens, something happens’: that confidence the public has, that when there is an alarm it will go off, as it did not go off, it was not responded to at Mid-Staffs. It will not happen. It will require leadership right up to the top to invest in the improvement capabilities of the NHS and use the theory of improvement”.

Another feature of WWL’s approach is the internal inspections. Former Medical Director Umesh Prabhu outlined the root cause of their self-inspection regime: “a CQC inspection three years ago found that our medicines management was appalling. We were shocked that we hadn’t spotted it, but we hadn’t. And we got a right rap on the knuckles. I was ashamed of myself. Immediately, the pharmacy director and I took action, and we turned it around in three months. But the idea of internal inspection grew from that”.

Chief Clinical Information Officer Martin Farrier describes how WWL invented this internal inspection approach in his fine book ‘The Road For Wigan’s Peers’: “Many commentators – notably W Edwards Deming (https://www.deming.org/theman/theories/fourteenpoints) – suggest that inspection approaches to ensuring quality are unhelpful. You have to build quality in. Systems must be there to ensure quality is delivered, even when nobody is looking.

Farrier finds it difficult to argue that this is wrong, but warns that healthcare is immensely complex, and systems cannot ever be perfect. “We need to continually be looking for where there are failings: failings need pointing out, and changing. The Care Quality Commission tried to deliver better, more responsive inspections. They have an impossible job to do better inspections that don’t miss problems, as they did with Mid Staffs. More inspections of more organisations! They need an army of clinicians that they don’t have, and a supply of money that they can’t have”.

Farrier suggests that an approach to inspection that revolves around waiting for the CQC to arrive is foolish. “The CQC may not find our problems, especially if we adhere to all the preparation advice and actually hide our problems. I was able to guide a health minister round this organisation before we improved and whilst the fires still burnt even if inspectors find our problems, human nature means we may well try to minimize them. Far better to find our problems and fix them,
surely?"

When Farrier was asked by Andrew Foster to help him learn from the safety and quality problems happening internally at WWL and then correct them, Farrier agreed, enlisting friends to support him. He was surprised by what followed from this.

Farrier and colleagues arranged an all-day meeting for about 30 people, to work on the safety review. All-day meetings inevitably require a high level of commitment. These 30 people were a wide-based group: patients, nurses, doctors, physiotherapists, occupational therapists, managers etc. What perplexed Farrier was that “of the 30 people invited, 45 arrived. They brought their friends”.

As a group, the participants agreed the basis of what would become WWL’s internal inspections. These internal inspections have now run for three years, and are conducted every 6 months, including external friends – our CCG, visitors from other organisations and various volunteers.

Farrier describes the WWL internal inspection process in his book: “we typically use 30 people to do an inspection over three days. We have a half-day of preparation, a day of inspection and most of a day where we feed back our findings. It is the last of those that proves the most remarkable. That is where the narrative emerges. It always does, even if I don’t know what it will be until that point.

“What is astonishing about taking a large group of staff to inspect our organisation is that they know where to look. They have a good idea where to find things. They know the systems. You can’t hide things from them. There was a problem with one of the doors in our operating theatres. It was a security issue (theatres should be secure: there are drugs and vulnerable people). The odd thing is that unless you know the theatres, you probably wouldn’t find the door. It was a back way out. You had to know what to look for”.

Each time WWL conducts an internal inspection, Farrier records, “we look in different places and at different times. We can see patterns emerging as the organisation progresses. Many of the problems that we found in the first inspection have become things to celebrate now”.

Despite the progress, WWL’s internal inspections still find problems, and Farrier thinks it “unlikely that there will be a day when we don’t find any problems. Deming was right that inspections aren’t the best way to ensure delivery of quality, but he wasn’t working in complex healthcare systems”.

He concludes that “internal inspections are a way of understanding what problems are present in real time; best done by people who understand the work being inspected, and best done regularly. They are definitely best done without building defence mechanisms against them first.

“Permission, volunteering, openness, willingness to learn from mistakes: these are the values that we were developing. They are values to which all healthcare organisations should aspire. There is no point waiting for external inspectors to come and help us. These are our values”.

Farrier also recalls that it was as a reaction to needing to submit data on ‘never events’ (https://improvement.nhs.uk/resources/never-events-policy-and-framework/) that he and WWL colleagues “jokingly felt a
desire to have ‘always events’. When our ‘always events’ emerged from a thinking space in the deputy nursing director’s office (Pauline Law is now the Nursing Director) they were a statement of what we practically will always commit to doing for every patient. And these ‘always events’ are ultimately simple things”.

The ‘real’ CQC inspection took place in December 2015 with the results published in June 2016. The CQC issued an overall ‘Good’ rating and whilst the WWL Board was particularly pleased with the ‘Outstanding’ rating for both End of Life Care and for services at the Thomas Linacre Centre, it was disappointed with the report itself and with some of the individual ratings. Despite all the rehearsals, the CQC still found 71 areas for improvement, 70 of which were completed by April 2017.

**WWL’s ‘always events’**

1. Always address patients by their preferred name
2. Always introduce yourself to patients
3. Always show patients and their families the level of respect that you would expect for yourself or your family
4. Always keep patients informed of their care in a way that they can understand and which is acceptable
5. Always ensure patients are assisted to the toilet, if requested
6. Always ensure patients have access to appropriate nutrition and fluids
7. Always challenge other members of staff who are not doing the right thing
8. Always adhere to the ‘six rights of medicine safety’: right drug, right dose, right route, right time, right patient, right documentation
9. Always ensure patients receive an expected date of discharge and appropriate explanation of what this means, on admission
10. Always ensure patients, who have died, receive dignified care and leave the ward within 2-4 hours
A side-effect of WWL’s internal inspection may have been a driver in what Director of Nursing Pauline Law outlines: “our Care Quality Commission inspection chair said, ‘we’ve never seen anything like it: the culture of your staff is friendly, warm and open. You’ve made our inspectors feel welcome in your hospital’. Their interim report called us ‘a very aspirant culture, from the bottom to the top’.

Another aspect of the WWL approach is their monthly performance reviews, as Richard Mundon explains. Most NHS organisations have monthly performance reports. WWL’s performance report deliberately places quality and safety at the centre, rather than hitting national targets and focusing solely on the financial bottom line (important as those are).

Mundon adds that “our narrative with our performance report focuses on infection controls and falls. We also always have a patient story at every Trust Board meeting; often a video talking to a patient, relative or clinician. We alternate between successes and challenges, so it’s quite sobering to hear in the words of patient, carer, and relative of things that went wrong. Hearing their voices is much more powerful than reading a paper. So we contextualise performance reports with stories”.

Previous chapters offer a broad grounding in how the WWL team works. Director of Operations Mary Fleming explained; “Previously the hospital would react quickly during times of crisis, although in reality you can determine when a crisis was due to take place, when things settled everything reverted back to functioning as it did before”.

Fleming locates this approach in a tradition that is unfortunately all too common in NHS management: “when you’ve got a crisis, staffs is encouraged to step up and go beyond the call of duty. Once the crisis is over instead of trying to sustain engagement and transformation, you just go back to silo-working. So you’d feel really encouraged in times of real pressure, seeing people engage and over-deliver and then it was back to business as usual”.

What was safety like? Fleming smiles: “There wasn’t a time patients haven’t come first – patient safety has always been paramount – but influencing change over the longer term was difficult. The Clinical Divisions worked in silos, and there was over reliance on a small number of senior people to solve problems on behalf of everyone else.

To address this, The Chief Exec was beginning to lead a new way of engaging and empowering staff by focusing on values and purpose which put staff at the centre of delivering safe, effective and compassionate care to patients. Fleming states “This was an organisation embarking on a culture change and it was tangible and I wanted to be part of it”.

I was given an opportunity to step into the role of Deputy Director of Operations for Surgery, “I worked with Jawad Husain the newly-appointed Divisional Medical Director, “we had one of most effective relationships I’ve known between operational managers and clinicians”.

Fleming and Husain’s first aim in their roles was to try and break down barriers between clinical divisions and in order to do this they headed up a clinical services redesign transformation project aimed at reducing the surgical bed base and increasing medicine’s.

It is not a quick fix, but again and again the evidence of an enabling and problem-solving culture comes out of the WWL
story. Director of Workforce Alison Balson says that when she joined the organisation, “three things stood out: a real commitment to quality; an absolute demonstration that quality is core to what we do; and the whole ‘happy staff means happy patients’ agenda.

The focus on quality also has rewards in terms of staff motivation. A key part of the WWL improvement method, drawn largely from the IHI work, is the Quality Champions programme outlined in Chapter Four.

Balson sees that as “a genuine aspiration in the organisation, where staff genuinely wants to continue to make improvements for the benefit of patients. The fact that they have an opportunity to identify something of interest to them, that they can own but be supported to do improvement in a structured programme which enables them to have a toolkit to make changes and evaluate the effectiveness of those changes – that inspires staff to want to be part of process.

“The other element is the visual recognition of having delivered change shown by the bronze, silver and gold coloured badges. That’s the way things work here: it’s like creating a social movement for change. Also, what staff like, is the way that all programmes and projects are celebrated”.

Director of Strategy Richard Mundon agrees: “our Quality Champions Committee is the best meeting of the week: staff tells us about their uplifting, great (and often simple) ideas to improve care quality”.

**Main Learning**

1. WWL developed a process of three-day internal inspections, led by staff and local partners, which are highly effective at finding problems
2. The Trust also developed a series of ‘always events’ that should always happen for patients, in response to the national focus on ‘never events’ which cause serious harm
3. Before WWL started on its journey to improve staff engagement, quality and safety, it had a ‘crisis-to-solution-to-slump-back’ rollercoaster cycle which is not unfamiliar in NHS management
4. WWL’s monthly performance reports centre on quality and safety, rather than hitting national targets and focusing solely on the financial bottom line (important as that is)
Chapter Seven

Value for money, devolved budgets and business intelligence

“I’m not going to pretend that everything is paradise and all budget holders are enthused and love and welcome budgets, but the majority do, and are almost obsessive coming up with ideas”

Rob Forster
The public spending restraint that followed the impact of the global financial crisis on the UK’s highly financial-services-dependent economy has had impacts across the public sector. The NHS has been afforded relative protection (local government, which funds some social care, has by contrast lost almost 40% of its pre-2010 funding), but financial pressures dominate agendas and discussions at every level in the Trust. The Nuffield Trust think-tank has produced this concise summary: http://nuffieldtrust.github.io/feeling-the-crunch.html

WWL has faced financial challenges like all other NHS provider organisations. However, through a clear, consistent and collaborative approach to the problem, the organisation has been able to deliver on its goal of providing value for money, based on delivery outcomes in a financially sustainable way.

In 2016/17 the Trust was able to record a year end surplus position of £14m after exceeding all its control total targets and triggering sustainability incentives. Most pleasing to Forster was “The fact that our operating position before the incentives also equated to a position above breakeven”

“There is no silver bullet, honestly it is really just hard work, day in and day out. However, employing new technology, developing an environment which encourages new ideas, and crucially facilitating a culture where problems are tackled in a devolved fashion but with central support combined together to make it possible”

The NHS financial ‘reset’ of 2016 (https://www.england.nhs.uk/2016/07/operational-performance/) means that the national system leading organisations will be watching financial performance like a pack of interventionist, system-leading hawks who fear an irate phone call from HM Treasury.

In finance, as other areas, WWL tries to innovate and involve staff more fully. Director of Strategy Richard Mundon outlines their Innovation Fund: “firstly, let’s be real: the Fund is £300,000 a year, so don’t overplay it. We started it two years ago. Access is through a ‘Dragon’s Den’ sort of format. It’s in abeyance this financial year, as the Hospital Information System (see Chapter Nine) is this year’s major innovation mechanism. But we’ll bring the Innovation Fund back next year, probably with a slightly smaller budget”.

The fund works by inviting people to put forward their innovative ideas, and the best ideas are funded, based on “investability” criteria set by the Board. It was simply about funding and testing new ideas. Successful applications need to be clear about their proposed outputs. It’s evenly available between all the Trust’s sites.

Mundon explains its congruence with WWL’s philosophy “that basically, we only get real innovation if we accept that not everything we try out is necessarily going to succeed. If we took a view of judging organisational performance that every initiative we try must be a success, we’d learn very little, and stagnate and get no progress.

This approach fits with WWL’s ideas of a ‘no blame’ culture, giving staff opportunities to try new ways of working and to put creativity into ways of working. This way, Mundon adds, “we start to build for the future. Organisations that are militantly anti-making mistakes tend not to thrive and survive. Part of
our philosophy is to make staff feel their ideas are taken seriously, and to give them chances to try new things.

“And the ‘Dragon’s Den’ format gives it a fun element - which, given the pressure and seriousness of people’s day jobs, helps us all to have elements of fun, as well as to unite as a team”.

Rob Forster, WWL’s Deputy Chief Executive and Director of Finance & Informatics, joined the Trust in 2010. His background was working for General Motors in various regions of the world and with the “Big Four” accountancy firm PWC. “I thought fundamentally, this was an organisation that was good, with a strong reputation for orthopaedics. My perspective at that time, from a financial perspective, we were struggling around break-even, swinging between a small surplus and small deficit. There were a few issues of internal division, and smoke-and-mirrors accusations between the finance cadre and rest of organisation (as it seemed).

About a year in, Forster became Director of Finance, and the Board changed slightly. The WWL change journey that was already under way, Forster recalls, “Started to pick up speed in terms of what this organisation was about, what was its DNA. We were trying, from a financial perspective, to become more transparent. That’s great: I firmly believe in challenging the view that Finance should be guarded in secrecy with only a select few trusted to understand or interpret the numbers. Hence an approach of openness and humility in treating all with the respect and dignity of the real financial position and situation even when that is at time challenging. This ran nicely alongside the organisation empowering people on the quality and safety side, moving away from being quite a top-down organisation to a staff involvement and engagement organisation”.

“And that has continued since, and one key aspect of the success, whatever department you are in, as a speech and language therapist, board member or other, are that those values on the WWL Wheel ring true”.

Forster emphasises that WWL’s leaders recognise that they have to give people opportunities to do what they can and take responsibility: give them chances. “Not everything works all the time: you need a culture where it can be OK to make mistakes (if you don’t, well, in reality people keep making them, and worse, may start to hide them).

All the while, the leadership team are making sure that everything WWL does is value-added, in the definition of value as outcomes over cost, as well as finance. So the basic question is always ‘why are we doing this? Does it help patients and / or help staff, and at what cost?’

What was Forster’s motivation to focus WWL overall on value for money and devolved financial management? “Coming from large multinational organisations, with a lot more to spend on innovation and technology, it was quite surprising that WWL used to have centrally-held budgets in the finance department, which were then selectively dished out to a few senior managers in the organisation. Then periodically, someone would get a raft of paper printout, which they either did or didn’t look at or understand, and did or didn’t agree with it if they understood it”.

Forster reflects that this made it a real step change to say a) how can we use technology better and b) what do people
need to know about budgets? The aim was to understand c) how can we get this to move away from it being just the finance director’s job ensuring that we’re in surplus at year end?

“So we worked on getting all budgets devolved to a local owner, in sizeable chunks. It’s about making people meaningfully responsible for their use of resources. We get it to them as an electronic version monthly, so they can access it when they want, drill down and understand the source data, and challenge it if need be”.

This approach has worked well, Forster concludes. “It started our journey into the world of proper business intelligence, of which we are acknowledged to be at the forefront in the NHS. Our A&E real-time waiting times app is hugely successful, and other apps are coming online, like our clinical variation tool, 18 Week RRT tool, Procurement Dashboard and a fantastic Finance Budget “Cube” giving a real time, holistic approach to budget holders’ of key data. The awards we have achieved for our approach in this area are good for the team. However, the real achievement is tangibly improving the way we manage our service in the most efficient and effective way possible. Once again returning to the concept of Value for Money.”

In the first year of this approach, WWL had about 200 budget holders. Now there are 450. The finance team can see up to division levels who own what budget at what level. Budget holders get a monthly newsletter, with the main spend areas where they’re under/over. These are, Forster adds, “not just tools our finance analysts use for communications: more importantly, WWL use them for teams to run their own finances.

“I suppose the ultimate thing we wanted was the golden thread running through finance reports to board, saying how many budgets were Red-Amber-Green risk-rated”. For a couple of years, halfway through the year, WWL ran a scheme where if a holder’s budget was at green (lowest risk), you got a sum of £50 per budget to spend as you chose on team development, as a sign of appreciation. Forster observes that it “went down really well. It’s important to acknowledge hard work, and that it’s hard to save. It says we’re all in it together”.

How did WWL address the training need created by having so many budget holders? “We developed quite an innovative training package with an external company, and it’s gone on to be used by the Healthcare Financial Managers’ Association. It involved creating a finance game about the basics of running a hospital, how much to keep in reserve and how you configure.. So there was an element of finance training, but almost covertly, hidden in a bit of fun. We took the Non-Executive Directors through it, and they seemed to like it”.

Forster also reflects that one key criteria of the challenge set to the team who created the budget devolution scheme was that you shouldn’t need to be an accountant to do this – if people felt they did, the scheme would have failed. It had to be intuitive. “Graphics, bar graphs, anything to make it easier to use, and the finance team were there if users needed support”.

Clearly, experts looked at the data at divisional level, using it as a tool consistently to examine things at a more granular level. But the individual budget holders take most of the work
away from it, Forster concludes: “finance is something all our budget holders are a part of; not just my job as finance director. I’m not going to pretend that everything is paradise and all budget holders are enthused and love and welcome budgets, but the majority do, and are almost obsessive coming up with ideas - like Chris Swann, who’s incredibly proud she consistently a green budget holder and relishes the challenge to safely meet plan whilst delivering a better service”.

Procurement strategy has been another key area for Forster and colleagues: “for a long time, procurement was almost a closet industry in the NHS; something you did, if you went out and bought a few bits, and you applied EU rules on the framework and tender, so by the standards of the world of business, it was fairly unsophisticated. The opposite of the automotive industry, which is all about stratifying your tier 1, 2 and 3 suppliers, and harnessing suppliers’ intellectual capacity as well as their financial and productive capability. Professionals in procurement accept that their suppliers are experts at what they do, and may know as much or more than you do about possible solutions and how to work in those specifics.

“It was a bit of a journey – we developed a 10-point plan (now 11) The list which includes operational initiatives such as standardisation of products, more strategic plans, including collaborative procurement, and supplier engagement programmes, re-tendering initiatives and Carter recommendation incorporation. Some of it was about being hard-nosed on upcoming contracts and renegotiating them, but it was also about getting a partnership philosophy with suppliers.

1. Achievement of £1.3m Cost Improvement Plan 15-16 target
2. Ensure recording of all costs avoided by the procurement team, demonstrating added value
3. Procurement initiatives sent to Executive weekly
4. Raising procurement profile across the organisation – presentations, customer survey etc.
5. More clearly establishing influence able spend, increasing contract and catalogue coverage
6. Achievement of next level of NHS accreditation for Standards of Procurement
7. Focus on maintenance contracts, rationalisation, efficiencies to be made
8. eDevelopment; eWaivers and Contracts Database
9. Programme of work to resist annual inflationary increases from suppliers
10. Corporate Social Responsibility, linked to sustainability policy
11. Working with other Trusts and procurement organisations to drive efficiencies that come with working jointly

“Another important piece of jigsaw in the WWL change progress came when we started a finance charity fundraising committee, FCFC, saying ‘can we give you a chance to raise money to directly affect/impact patient care?’ Over the course of its existence, we must have raised £50,000, which bought 2 incubators, redesigned a space in the Rainbow children’s ward, refurbished for special needs, with visual displays. That approach breaks down walls between finance and the rest of the hospital and says we’re one, integrated team: it’s really important”. 
Engagement with the Trust Board and stakeholders has been another area for Forster’s focus: “we redesigned board report and got feedback. Some members didn’t understand, or were maybe turned off by traditional financial statements, so we introduced visuals, with trend lines, as well the as front-page story of what directors and NEDs and trustees need to know, and the detail behind and key items.

“As the board developed and the NHS has come into more fiscal times, the skills around the board table increased anyway”.

In conclusion, Forster says “good financial management is a barometer for good management. Our Trust believes in shared responsibility, and has facilitated this approach in the area of Finance which has helped everyone play a part and take pride in the success of the Trust. The challenge doesn't get any easier, but by sharing the burden gives us the best chance of success, and ultimately creates a sustained Trust able to invest in better facilities for the best patient care which is our entire ultimate goal”

Main Learning
1. Finances are tight across the whole of the health and social care sectors, at the same time we are experiencing rising demand for services. Value for money is key in all decisions made.
2. WWL has used various innovative approaches to engage staff with budget-holding responsibilities
3. A ‘Dragon’s Den’-style innovation fund has been used to encourage staff to put forward innovative ways of working: it is accepted that not all will work
4. Procurement is key to any future strategies and must be approached in a professional and planned way.
5. There is no single solution but creating and embedding a value for money ethos gives people the tools to get involved and take responsibility for budgets which gives the best chance of success.
Chapter Eight
Social responsibility, localism and collaborative working

“The biggest area for WWL to address is partnership working with other organisations. This will be about taking all our fantastic engagement work and learning derived from it into building relationships outside this organisation …… so it’s all about systems leadership”

Mary Fleming
For Deputy Chief Executive and Director of Finance and Informatics Rob Forster, WWL’s collaborative, locally-based approach is a key part of the Trust’s community ethos. WWL introduced supplier awards in 2012: the Local Wigan Awards. These went onto be adopted regionally which WWL is rightly proud. This is part of WWL’s engagement with external subject matter experts, but also is part of the Trust’s social responsibility element, whenever possible, WWL use local suppliers. The Trust spends £4 million locally, which clearly is good for the local economy.

Forster calls the WWL procurement strategy “a synthesis of what we did locally and in partnership with the North-West procurement development office. Our supplier awards were developed in collaboration, and now it’s a big, black tie event for the whole of the NHS in north-west England”. About 400 suppliers participate in the event which is held in Blackpool.

For Forster, it’s about “recognising that the supplier community is a group of professional and valuable industries, so let’s treat people with respect’. Procurement has to be about a bit more than making unrealistic demands on stakeholder suppliers.. We engage with suppliers, we know they have to make a living and profit, so the big question is ‘how can we save money (because we must) together?"

“Maybe it’s a contract for three years instead of two, where we build in a solution so we all save and make money at the same time: a mature conversation that was not happening previously. Suppliers, big and small, have their pinch point, but also have their ideas and intellectual capital which is often overlooked. One of the most moving awards moments was about a local supplier, a couple of ladies who were making wigs for cancer patients. It was an emotional moment for them accepting the award: they’d never won anything in their lives, and it was testimony to see how much it meant. They’d started doing this as a small business, but it had given them so much satisfaction that they got motivated to go on and do more good work.

“Obviously, that’s a small business set against our other suppliers like Johnson and Johnson, who are also keen to win our awards for their big corporate professional status.

Forster notes that the national Five-Year Forward View strategy is clear that the NHS has to take this corporate social responsibility more seriously. WWL have, he adds, developed a social responsibilities group, “which some might think off-topic for a finance director, but it’s about making our approach across the Trust more holistic”.

Director of Operations Mary Fleming reflects on the risks that change in provider landscape has been caused by Greater Manchester Devolution – ‘Devo-Manc’. This followed from the local NHS efforts to redesign services under the ‘Healthier Together’ banner. Fleming states: “I’ve been involved in discussions on centralising acute surgery since I was heading the Surgical Division. There is political correctness, saying that we must do something different. I firmly believe that we can’t deliver the recommendations of the Royal College of Surgeons unless we combine our workforce.

“If I had a life/limb-threatening condition, I’d want a consultant surgeon and anaesthetist, and I’d want 24/7 cover, which I know this organisation cannot deliver - but neither can other Trusts in the area”. 
Fleming is emphatic that a very small percentage of patients (around 10% of acute admissions) will require a very high resource level, “and I believe that should be centralised, and if that delivers better outcomes for patients who should not just be surviving but surviving well, that clearly should be centralised”.

Yet she warns that by centralising, “we will force lot of patients to drive past local hospital when they would have been treated there previously, and that bothers me. I don’t think those high-risk 10% of patients will make centralised services economically viable. I think other surgery, which is safely performed in DGH, will be centralised too: The net will be widened. So if you widen the net to include higher-risk surgery, you’re talking about centralising ICUs. And 60% of ICU is medicine, not surgery. This eventually affects the clinical and financial stability of hospitals.

Fleming suggests that the biggest area for WWL still to address is partnership working with other organisations. This will, she thinks, “be about taking all our fantastic engagement work and learning, and building relationships outside this organisation, so it’s about systems leadership.

“It’s also about not being frightened of appropriate collaboration. We’ve been doing it for years for example with shared pathology services with Salford, the Christie At Wigan cancer services and cross covering of on-call rotas with other organisations. Having been involved as an equal partner, it doesn’t feel like a threat”.

Fleming is less sanguine about the region-wide efforts to reshape health and social care: “Devo-Manc and Healthier Together both feel more done to us without us getting a proper say. I also believe we need to sustain our performance: high-performance lets us flex our muscles and have a loud voice with regard to some of these structural solutions. We need to maintain performance and start building relationships outside this organisation”.

Director of Strategy Richard Mundon agrees that the Healthier Together learning was “initially, not happy lessons: it appeared to pitch hospital against hospital, so it was hyper-competitive, and seemed to suggest only two outcomes – of being a green (cold) or red (hot) hospital: there was no middle ground. This, understandably, polarised Trusts’ views across the conurbation”.

Mundon notes that when people started to talk about moving to single sector solution for various services across the footprints, conversations became much more palatable. “In the original plans, it was hard to see how there could be no A&E in Wigan; 90,000 people arrive a year, and it’s unfeasible to switch in a 3-5 year timescale to change demand in such way. But it was an opportunity to collaborate with others, retain the A&E department, but collaborate on sharing best practice and staff and recruitment models.

“And with general surgery movement, they suggested huge swathes of work being moved to other hospitals, which was equally unpalatable and did not make sense, to save lives (good thing), creating massive flux of patients and families and it risked being very destructive.

“And when they engaged on a middle way, to not necessarily move a target numbers of patients but those presenting with the highest risk, that made more sense and could get clinical buy-in”.

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For Mundon, the key lesson from Healthier Together is about flexibility rather than dogmatism, and clinical engagement - not just from a small number but properly, across all clinical leaders in all affected organisations. There's going to be a much bigger chance of success that way, rather than if a deal seems to be imposed from on high, creating winners and losers, he suggests.

“It was clearly not unreasonable to ask the Acute Trusts across Greater Manchester to reconfigure services to deliver better patient outcomes, but the way the system was 'asked' and the seemingly combative, antagonistic original approach had an unwelcome 'you guys in Acute Trust x don't know what you're doing; some of you are going to win and some lose, and this is the way it is' really didn't help.

“That imposition is never likely to work, and many large-scale changes of that nature fail. Of course organisations need some external challenge to ginger up their performance across the population they serve. Trusts can get too self-focused. Asking the question 'what is the best way of doing what we do?' will engage the vast majority of clinicians. Framing change as being about saving lives, and improving the quality of working life is much more likely to get support than seeking support for entrenched organisational positions”.

Main Learning
1. Social responsibility in areas such as procurement has been a priority for WWL for some time, and is now being nationally mandated in policy
2. Collaborative working on clinical service redesign requires genuine engagement and listening. Threats and ultimatums create an unhelpful atmosphere and sow distrust
3. Getting a good cultural fit with partner organisations in a health economy is highly important
“It’s important for me to know where the staff and doctors are up to with patients on my ward. HIS has made that easier – all the information I need.”

Victoria Lennon
The creation and installation of a new information technology system – the Hospital Information System (HIS) – has been a major project for WWL over the past 18 months. HIS is a groundbreaking clinical IT system which supports a full Electronic Patient Record (EPR) across all Services within the Trust. This new system replaced the existing predominantly administration and results based system with one that provides clinical notes, e-prescribing, referrals and basic tracking (as well as the results and clinical images that were available in the old system).

The HIS introduction successfully went live in June 2016. There were no major problems associated with this IT deployment (which is not always the case in the NHS).

- Accident and Emergency was able to maintain its 95% 4 hour target;
- routine elective surgery was able to continue without any cancellations; and
- outpatient clinics continued all without reduced levels of activity.

HIS has been well received by staff and generated some very encouraging feedback; Victoria Lennon, Ward Manager for the Surgical Admissions Unit is clearly a champion for the scheme; “As an in-charge, it’s important for me to know where the staff and doctors are up to with patients on my ward. HIS has made that easier. I just have to go to my patient list and find all the information I need – all the bits and bobs, straightaway”.

Although problems have emerged, they were recognised and managed quickly. The whole organisation was involved with the system implementation, and solutions were often found by users and shared with other users.

IT implementations in the NHS are traditionally a time of very high risk of problems, so what was ‘The WWL Way’ approach to IT implementation?

As will be clear by this point, WWL’s whole philosophy is about engagement of all staff – HIS was very much about creating a new way of digitising workflows and patient-related activity in our hospitals in a way that is safer and more productive, but recorded on patients’ records.

So the leadership team and IT colleagues looked at implementation and reducing risk. Crucially, they completed ‘future design’ sessions with as many stakeholders as possible, so that design of the system was consistent with the operational flow of the hospital well in advance of implementation.

As well as these approaches, the Trust organised regular communication meetings with staff groups who would benefit from the system, to explain how it could help staff work more effectively. These meetings were also used to help explain what issues were being resolved before the system was introduced. Lots of nurses and doctors, operational managers and pharmacists, discussed a range of ideas about how it could work, and a significant amount of ‘user-led’ process redesign took place in those meetings.

WWL’s IT team worked very closely with AllScripts (the software manufacturers) on the development of the ‘core’ IT solution, with input for all users concerning issues such as ‘how we want prescribing to work in the new model’, and ‘these are things that nurses find difficult; can we have prompts with information to help this?’
The work of those future design groups layered up and changed the product from the ‘core’ offering; adding more value and benefit to the manufacturers’ original intention.

Unsurprisingly, WWL used the staff engagement philosophy to design and assist in our staff becoming more familiar with the HIS outputs. As a result this was not and did not feel like the Trust imposing a new system: that ‘Big-Bang-Big-Surprise’ IT implementation approach is where big risks arise, particularly those of Day 1 non-recognition by staff of how the new technology works. WWL planned carefully to avoid that at all costs.

Even if some colleagues’ work wasn’t directly affected by the HIS, the WWL leadership still took the opportunity to enthuse those people with the art of the possible with new technology, and help them to think about how this HIS could enable greater things in future, and so lay foundations for post-implementation development.

Perhaps contrary to a first impression, technology can be a great divider: there is a fairly large element of the WWL workforce who really like technology, especially clinicians, who mostly love technology and technical advances. Engaging those people is very easy.

However, engaging staff can also be problematic for some members of workforce, who’ve been doing the same thing in the same way for many years, and it’s easy for them to be challenged with a new implementation. WWL’s leadership and IT colleagues started this work with recognition that IT can be a great thing, but if we don’t involve the staff, it could also be a threat.

Chief Clinical Information Officer Martin Farrier observed in his book ‘The Road for Wigan’s Peers’ that “one of the crucial enablers to growth is IT. IT in the NHS hasn’t had a good start. Last decade’s National Programme for IT (NPfIT) was a spectacular failure. The classic lessons of IT implementation were ignored that IT systems grow from their users, that they are agile, and that they need continual updating and rewriting. The internet wasn’t one person’s design: it was many people’s.”

“Despite Apple’s dominance in popular IT, it is their continuous development that keeps the brand dominant. The device is nothing without the apps and there is a huge social progression of app development with many apps being free of charge to the end user. Healthcare IT system development must be the same.”

“The developers however are not IT gurus, but ordinary doctors and nurses. They are intelligent and able people, and given the ability to guide the development of their systems they turn out to be remarkably capable and enthusiastic”.

On the WWL initiatives, Farrier notes, “there is a wide understanding that the work we have done on patient safety can be immediately translated into an IT system. Checklists become straightforward, as do pathways and the system can also provide decision support when it is needed. Furthermore, drug management becomes safer and easier to monitor. “The same processes that led us through our struggles with raised mortality are going to lead us through developing our IT system. Many people input into the solution, with common values, and this leadership approach shown by many people will resolve our wicked problems.”
Director of Operations Mary Fleming suggests that technology, and the real-time A&E waiting times app is “a huge part of why we are one of the better performing A&E in the region in terms of achieving the 4 hour waiting targets.”

“With the real-time A&E app, we can make patients visible to the whole staff team. The live app makes us bring patients into every part of the workplace. Everyone can see what’s going on: it allows us to be very proactive. The A&E app lets us predict what happens throughout the day, so we can flex our resources to meet demand. 95% is the bare minimum we expect ourselves to achieve; likewise 18 weeks. We aspire to do better”.

Main Learning
1. Implementing a new IT systems links to WWL’s organisational culture and philosophy in the same way as other major changes.
2. Involving large numbers of users in the HIS implementation from the beginning allows for ownership to develop, and for the users to anticipate the coming change.
3. A sense of ownership of this new IT system by large numbers of people is possible, but it must be clear to them that they are influential in how the system looks and works.
4. Visions of the future are built on the foundations of the past. The successful implementation of this IT system built on the desire for quality improvement that was already built in WWL. The system was an enabler for further improvement. Clinicians began to demand its introduction, rather than fear it.
Chapter Ten

Recent history and next steps

“Our opportunity with place-based collaboration in Wigan can help us and force us to establish new models, which we are testing out as we go along”

Richard Mundon
The job of NHS managers is not a straightforward one. Healthcare organisations are complex, safety-critical and often large. The work they do is of high media and political interest. And it’s very hard to control how sick your patients will be. Then there are the facts that the UK population is living longer (a good thing, but one which takes in higher healthcare costs) and getting fatter (an unambiguously bad thing, as the risks to health of obesity are considerable).

The vacancy rate for chief executives is high. These are tough jobs, and although well paid, the pressure and stress are high. And as this book has shown, making positive change takes time, commitment and a stable leadership team.

Consequently, there are many vacancies, and not-inconsiderable friendly pressure from system leaders for successful chief executives to go and help out in troubled organisations. This is what Andrew Foster agreed to do, when he was seconded to Heart of England NHS Foundation Trust, Birmingham in 2015 as a part-time, interim Chief Executive. Rob Forster, deputy Chief Executive, took Andrew’s place during his four-days-a-week absence.

Foster reflects that his time as interim Chief Executive in Birmingham “may have been a problem for some more than others. They needn’t have worried, though. Our quality improvement work and values and openness all continued and grew while I was away. Some staff might be slightly more personally dependent on me than others. And I was only there for eight months, anyway.”

Director of Strategy Richard Mundon suggests that Foster is being unduly modest: “Andrew’s not just charismatic; he is talismanic to this organisation – that’s due to his personal qualities. So yes, I was wary we would lose momentum, and might not be able to sustain progress. The reality of what happened was that we not only sustained momentum, but kicked on and improved further. Our staff survey results improved during that period, and have improved again since.

“To me, that tells you something about WWL’s general culture: that it’s not reliant on a single individual. If he’d disappeared on secondment very early on during the changes we’ve made here, it might have been a very different story, but after years of reaping the success of our efforts and knowing it had worked, and that we had time to disseminate culture, Andrew’s stepping away for eight months didn’t have an enormous impact. WWL was still a transparent, patient-centred, open organisation, with a Board focused on quality and safety”.

Mundon offers a caveat, recalling that some relationships with some stakeholders dipped, “so perhaps we were not quite as good at the relationship with the Clinical Commissioning Group (CCG: the local GP-led NHS planning and budget-holding organisation), but the cause and effect were unclear”.

He notes, however, that on every objective measure, WWL continued to improve when Andrew Foster was at Birmingham: “it actually turned into quite a seamless change from Andrew leading WWL to Rob leading WWL, as part of an upwards trend of performance and culture”.

Director of Nursing Pauline Law adds, “Rob Forster, as you would expect, shares the same values as Andrew and the Trust Board, therefore our work was being sustained and indeed progressed during this time. We missed Andrew as well, though, and hoped he would return.”
“Rob’s personal style was different. We all have our own. Andrew Foster likes being involved in the hospital on a day-to-day basis. You’ll always see the A&E live app screen up in his office. I think it’s unusual for a CEO to be so actively involved. He is very much under the skin of WWL. Staff trusts him to do the right thing. Andrew is very fair and meticulously detailed and organised - meetings start and finish on the dot”.

Rob Forster feels that his time in charge “really showed what being a values-based organisation is about. The hard work that we had put in means that it wasn’t exactly the same as under Andrew, but the overwhelming values and culture didn’t change; safety, quality and putting patients first and at the heart of everything we do. And if I apply that framework to any decision, I could come up with consistent answers”.

For Rob Forster, his transition period into the top job was relatively straightforward, and he recalls that the leadership team were not in reality calling on Andrew’s notional one day a week at WWL. It was apparent to all parties that Heart of England was a big job and Andrew didn’t need to also be working one day at WWL.

Forster points out that “the ship kept sailing; staff engagement remained good – we kept the emphasis on good communications, letting the organisation know what was going on”.

Equally, Forster is candid that during this period, things were turbulent across the NHS in the North-West as a whole: anxiety about Healthier Together, Devo-Manc and how Vanguards would work. He adds, “Interestingly, our staff engagement continued to be good, which is not particularly about me, but about the openness of our approach, and saying so when we don’t have all the answers. We told people ‘we don’t know where Devo-Manc will end up but it will be the big show in town and we are part of it at the big tables and we’ll keep you informed’.”

What does Forster think Andrew Foster learned from his period in charge at Heart of England? “I think it probably reaffirmed Andrew’s view that ‘culture eats strategy for breakfast’. I’d say he positively appreciated the uniqueness of our culture here: Whether some of this comes from the Borough we are in – a traditional working class mining and textile area, on the outskirts of Greater Manchester and quite separate from the city centre; there is a great sense of community, of belonging of looking out for each other.

Forster also suggests that at Heart of England, “Andrew recognised what a broken culture could do. Probably a salutary lesson was that you can do some good stuff, but if the finances get away from you, the impact of that can take away most of what you did. At the end of the day, hospitals, like businesses, need to be sustainable. I think one thing Andrew got in Birmingham was an increased appreciation for the financial discipline we have here”.

For Director of Strategy and Planning Richard Mundon, the main focuses of attention over the next few years will mean addressing a lot of challenges driven by two main things: financial sustainability, and workforce. “On NHS finances, we know that, under current government policies, if we keep doing things as we do them now, the NHS will soon be utterly unaffordable. We know this. So we must find ways to change existing relationships and services. That is the key driver of our present and future behaviour.
Mundon is explicit that “we have to move away from competition, certainly locally. Competition has become very culturally ingrained in all NHS organisations since the 1990s and 2000s internal market reforms, and to get through this next period, we are going to have to behave much more collaboratively and as a health and care system. Where traditionally, organisations may think of themselves as winners or losers if they retain or close services, now we have to think of ourselves as contributors.

“We are in the business of helping patients to get their healthcare needs met safely and without bankrupting the government. And the services we provide will have to change as part of that. So we can't keep provision as it is now in every provider. Change is certain; it's the only way moving forward”.

Mundon agrees with the sense of national plans that some services traditionally run in acute settings will have to be delivered in non-acute ones. As the health system’s aim is increasingly to try to ‘switch demand off’, WWL’s leaders are increasingly looking at ambulatory care and to try to handle patients closer to home in the community, and wherever it’s safe, divert all that don’t need expensive hospital care.

Mundon observes that “some people go to A&E who just don’t need to. There is also an argument that a hospital stay under one day may be unnecessary in some circumstances”.

He sees the workforce issues associated with the changing of services as something similar: if Trusts such as WWL face a shortage of professions, such as middle grades in A&E or care of the elderly consultants, then they can’t try to provide those services in the same way as in the past, because there simply aren’t the trained staff available.

So the provision of services inevitably has to be remodelled, Mundon argues: ‘given the long-term growth of the 'oldest old' in the population, we have to consider whether we need a different working model. This looks like more being done in the community, more nursing practitioners, and more healthcare assistants.

“Our opportunity with place-based collaboration in Wigan can help us and force us to establish new models, which we are testing out as we go along. Driven by the Greater Manchester devolution reforms, we’re suggesting that there should be a requirement to collaborate on Trusts' operating licences. Where collaborative decisions are made, we have to stick to them, which changes the dynamic somewhat.

“We have to get to a point where instead of management teams getting hit around the head for not delivering on finances, they get the rough treatment if they don’t work with their partner organisations locally or across a bigger geographical footprint”.

Andrew Foster adds, “We're not there yet’ is part of the WWL mantra – even though things have demonstrably improved, we still have things go horribly wrong occasionally, we still have a significant level of patient complainants, and our standardised mortality ratio is just under 100. We need it to be around 83 to get into the top 10% of Trusts”.

Foster is frank that WWL still have a significant number of ‘Never’ Events: “this could be due to a good reporting culture, or it could be down to flawed systems with stressed staff, or it
could be plain human error. Our process tries to identify the cause.

“Pretty much all staff in the NHS went into their careers motivated by strong values and wanting to do something for society. Maybe people are partially motivated by money, but much less so than in the private sector. So there’s a set of powerful and excellent values waiting to be tapped. On the other hand, people who work in NHS for any period of time develop cynicism, and we have to work with that.

“And you do get a small number of staff who directly obstruct change, and a few who can say nothing good about WWL. We waste very little time on these recidivists: we simply let them be contrasted to our enthusiasts. In my first four years at WWL, we had a couple of directors who didn’t buy into these values, and often what the board and I were saying got undermined by what these two actually did. Both left, were replaced, and the effect was to slingshot WWL forwards”.

Foster observes that some NHS managers say that doctors are difficult to get on with, but adds that where managers do work well with their clinical colleagues, the organisation gets a massive dividend. He cites Chief Clinical Information officer and ‘Road For Wigan’s Peers’ author Martin Farrier as an example of “being converted from being a cynic to one of the most wonderfully enthusiastic in the organisation. We now have a community of leaders working together and being enthusiastic about WWL, which drowns out the small remaining number of cynics”.

Some NHS managers seem to find the notions of staff engagement and openness and transparency uncomfortable. How does Foster suggest they go about developing these areas?

“They should study the subject rather than feel discomfort. James Reason is a safety guru who talks about the need for a healthy organisational culture when things go wrong. He draws a distinction between factors such as an innocent mistake, system failure and negligent carelessness”. Reason has developed a ‘decision-making tree’ to decide what to do when something has gone wrong. He calls this approach a ‘Just Culture’.


This approach gets staff to describe the incident, and be clear if they were innocent or a contributor, and if so how they were culpable. At one extreme you would find negligence, resulting in a disciplinary procedure; for most instances though it will be the system that is at fault, not the individual. Here, Foster concludes, it will be more effective to offer learning support or even congratulations if someone did their job right. “The methodology says transparency can be hard, but it’s about having a fair and just culture, and learning from other safety-critical industries like the nuclear or airline industries’ reporting cultures.

“We make a point that if anyone reports a problem, we praise them to the skies. Three years ago, we had an incident with some nurses who asked to speak to myself and Umesh (Medical Director), because they felt a consultant was not prescribing correctly with the risk of harm to patients. An independent review confirmed that their concerns were right. We had to recall 240 patients and explain that they might have been prescribed the wrong drugs. And we took the
opportunity to praise those nurses to the skies for raising their concern”.

How would Foster persuade managers and clinicians in NHS organisations with a more ‘bunker’ mentality the WWL approach might work? His reply is simple: “I’d show them the evidence. Look at the evidence comparing us to other NHS organisations, and you’ll see the correlation between performance, quality, and patient satisfaction and staff satisfaction: we have established a clear track record”.

For Foster, the causality from organisational culture and organisational results is evident. “That’s the core. Some organisations have pretty much given up on A&E performance seeing it as just too hard. They and their staff develop a marked lack of motivation. I was shocked how much negativity I found when I went to Birmingham and the contrast with WWL was palpable.

“Another important aspect for us is the emergence of Black and Minority Ethnic (BaME) leadership. Before Umesh, we had six senior directors in the organisation, all of whom were white males. And I wasn’t focused on it as an issue, I just inherited and accepted the senior management team, most of whom were pretty good. Umesh’s appointment set an example, and liberated a lot of really excellent BME leaders. Now, five of our six clinical leaders are BME: Sanjay Arya, Jawad Husain, Anil Gambhir, Nirmal Kumar and Umesh himself. Something in Umesh’s arrival seems to have given permission for BME staff to get into leadership. The appointment of Sanjay Arya as successor to Umesh continues the trend though like all these appointments, it was made purely on merit”.

Foster concludes with two stories about WWL staff innovation:

“A bright guy called Mark Singleton, joined our information team, and he’s turned it into the best business intelligence function you could wish for. He has developed a way of listening to clinical and other staff to present information to them in a way that meets their needs innovatively and effectively. He’s got into the business of designing apps, and most famously, our A&E waiting times app is one which I have in my office and tells me not just what is happening now but what to expect for the rest of the day. And that is just one of dozens he and his team have developed. Just brilliant.

“He decided to do this off his own bat, it’s been a great management tool internally and it’s something we can sell externally. Staff has great ideas, if you listen to them”.

“The second example is Denis. He has been a porter here for many years, and I got to know him from my ‘back to the floor’
work. Everyone knows our porters, by name: they’re the real communications hub of this organisation. One day I bumped into Denis and he had an odd expression which was a mixture of smirking and anxiety. I asked him what was going on and he said ‘I can’t tell you what’s up. Can’t say, it’s a secret’. I persevered, and eventually his story emerged.

“One thing that Denis hates as a porter is wheeling around the mortuary trolley. He feels it’s a very low-dignity experience for the deceased, and it attracts strange reactions from visitors, ranging from jokes about ‘stiffs’ to standing to attention.

“So Denis came up with the idea of a concealment trolley: the dead body goes into a box under what’s ostensibly an empty trolley. Such beds didn’t exist in the NHS, but Denis designed it, we have built a prototype and even put a motorised device in it to help with the slope to the mortuary. It is currently being tested.

“Soon we will have it commercially manufactured with a view to Trust-wide use and sale elsewhere. It’s a wonderful story of a porter inspired to innovation by something he hated, and how we could help him turn it into something real.

Main Learning
1. Organisational culture is not dependent on any individual and can be maintained as staff move on, provided it is deeply embedded.
2. The most certain prediction about the future is that there will be lots more change. Engaged staff are more likely to embrace change positively and enthusiastically.
3. Quality is a hugely unifying motivator, as it plays so strongly to the core values of NHS staff. It aligns clinicians and management to a common ethical purpose.
4. In many organisations, BME staff are unhappy and not given the chance to shine. In WWL, BME leadership has been a major factor in success and innovation.
5. Given the chance and a supportive culture, individuals will do the most wonderful things. If you want to solve a problem, go to the front line and ask staff for the solution.
Epilogue
And they all lived happily ever after …

“We’re still the best-performing trust in Greater Manchester”

Richard Mundon
The first draft of the text of this book was written in mid-2016. Books take a long time to draft, review and revise: that’s how these things go. And time passes as these things go, too. So this epilogue offers an opportunity to bring things right up to date.

The trust’s three sites are continuing good performance in a great many areas. At the end of 2016/17, WWL were the best-performing Trust in Greater Manchester for A&E 4-hour waits; the fourth-best Trust in the NHS for performance against the two week ‘Cancer referral to treatment’ target (as of March 2017); 6th best in the NHS for 18 week referral to treatment (RTT); 12th best in the NHS for the Friends and Family test (FFT) and 15th best in the NHS for the independent Picker institute satisfaction survey.

As well as these metrics, WWL’s partnership with Wigan Council is maturing and delivering mutual benefits. The trust’s leadership of the Greater Manchester orthopaedics work programme; which aims to improve clinical outcomes, reduce clinical variation and consolidate elective activity, is also delivering benefits. It has also led a successful Greater Manchester Pilot for Nursing Associates, and for workforce has seen its Nursing and Midwifery Council revalidation pass off with no lapses in registration identified.

WWL has also successfully reduced its spending on temporary agency staff, with increased effort on recruiting full-time employees and also had successes with overseas recruitment.

As evident throughout the leadership team’s words over the course of this book, they are also realistic about some challenges that persist or have re-emerged.

Performance against national targets

In 2016/17, WWL delivered on the national targets for 18 weeks referral to treatment (RTT), cancer waiting times and diagnostics waiting times.

Chief executive Andrew Foster reflects, “the nightmare is A&E – which is also a nightmare for every other acute provider, but even still, although we haven’t been able to hit 95% treated within 4 hours in A&E, we’re still the best-performing trust in Greater Manchester.

“Every trust in country has missed the 95% national performance standard for A&E. The national average was 92% across the NHS last year; this year, that’s fallen to 85%. A 7% drop is significant.

“We’re in line with that: our performance on A&E is down 7% from 95% in 2015 to 88% in 2016. Almost every A&E anywhere has seen a significant decline in performance. This past year’s decline has been much steeper than the previous three years, which were about 2% each year. We want to be honest: we’ve had a tough year and performance has dipped …”

“But we’re still the best-performing acute trust in Greater Manchester”, interjects director of strategy Richard Mundon.

Finance

The Trust’s financial position is holding up well. The annual accounts for 2016/16 show that the Trust ended the year in surplus – where many Trusts ended the year in deficit.

This performance triggered incentive and bonus payments via the Sustainability and Transformation Fund meaning that the Trust could report a surplus on the year of £13.5m.
Foster and Mundon emphasise the importance of a strong focus on the access to the nationally-held Sustainability and Transformation Funds (STF).

Foster is clear that “basically, we’ve been told we had to make £3.7 million surplus this year and deliver on waiting targets. And if we could do that, we’d get £7.9 million for revenue. In fact, we’ve not delivered A&E for the last two quarters, but we’ve achieved all the rest, so we’re about £7.4 million and we exceeded our year-end £3.7 million target for surplus by far.

“For every bit we exceed our surplus target, we get a £1-for-£1 bonus. So we know WWL will be eligible for a bonus for good financial performance, but we should say for honesty and balance that we struggled to meet our cost reduction targets. Our two big struggles have been on A&E and cost reduction”.

This means WWL will get some extra cash for 2017-18, Foster adds. “We plan for the next two financial years to deliver our control total and STF targets – we think it’s challenging, but manageable”.

Quality
On the quality front, the leadership team are quietly pleased with the broad range of pluses. Their CQC rating is good; their latest performance report shows them to be doing pretty well on never events, C Difficile, continuing reductions in pressure ulcers and serious falls.

The trust’s national patient survey results have improved year-on-year: on place/ environment, WWL has been listed as the cleanest trust in the NHS for three years in a row.

Characteristically, Foster is candid about the areas that are less good: mortality rates have deteriorated and the standardised mortality ration (SMR), number of deaths in hospital has risen and E Coli and MSSA infection rates are up: we believe this is connected to A&E performance, overcrowding in the hospitals and delays in diagnosis”.

For Forster, a third big issue is “coming off the boil on the national staff survey results (as outlined above), but we’re still in the top 20%. So we’ve gone from the peak to a bit below the peak.”

The WWL quarterly staff survey meant that the management saw this coming, Foster adds, “and we put things in like the new ‘Lose Weight, Feel Great’ programme, reiki, critical incident stress debriefing, mindfulness, the Route Map for Personal Development Reviews for careers and appraisal (which looks like the Tube map). Having seen this coming, we’ve got the technology in place right now to improve our results for next year”.

The performance data aside, how is it feeling? Foster frankly observes that “we’ve felt ourselves coming away from last year’s peak. And the decline is not homogenous: it depends where you are in the trust and what you do. For a number of years, we’ve legitimately pointed to our trust having some of the best results in the country. Almost everything we did worked.”

“Of course we’ve had challenges, constraints and pressures, and we can’t point to everything we do as being one of the best in the country, and so there’s a sense of disappointment at not making that top level, but it’s tempered with realism. Every organisation goes through peaks and troughs, and we’re still staying ahead of the pack overall.”

“So I’d summarise how it feels as disappointment without resignation. And it also feels like there’s a renewed determination to get back there”.
WWL is still a very high-performing organisation, Foster concludes, “especially among our local peers. We still have the sense of togetherness on values and engaging people: yes, we’ve had a bit of a dip, but now we have a renewed focus to get to where we know we can be”.

How has WWL ended the financial year in financial balance and indeed surplus? Foster attributes this to “two things – a tough start to this financial year and very bad October figures. Once we got them, we launched the ‘Changing Gear’ programme to get financial efforts redoubled. It worked, too. In orthopaedics, the result increased income over £300,000 a month”.

Some of the improvement, he adds, was about getting efforts into financial savings. Other bits are more technical: WWL had a windfall from a land sale, which helped. There was also a successful insurance claim, as well as one-off bonuses - and simple overall renewed effort.

Some challenges remain
Not all of the news is good, or as the WWL team would like it to be. In particular, the latest national staff survey data finds some declines in the trust’s performance as assessed by its staff.

Some of the changes in this survey data are so small as to be within a margin of error. Some falls in satisfaction are noticeably bigger, and will worry the trust’s leadership. For ‘I would recommend my organisation as a place to work’, WWL scored 72% in 2016 (down 6% from 78% in 2015; the 2016 NHS national average was 62%).

The percentage of WWL staff reporting good communication between senior management and staff in the national survey was 40% in 2016 (a big drop from 51% in 2015).

However, there were improvements and good things. On ‘experiencing discrimination at work’, only 5% of WWL staff reported this in 2016 - compared to a national average of 11%. There was also improvement on ‘my organisation acts on concerns raised by patients / service users’, with WWL scoring 80% in the 2016 survey (having been rated 79% in the 2015 iteration).

Working in Partnership
In collaboration with its partners, WWL continues to play an active part in delivering the Wigan Borough Locality Plan to address the local challenges faced by increasing demographic demand and constrained resources, whilst at the same time delivering care closer to home. The Wigan Integrated Care Organisation, Healthier Wigan Partnership, provides an opportunity for further collaboration between provider organisations to reduce demand and to deliver more joined up public services based upon place of residence.

In April 2017, WWL formed a new board subcommittee which doubles as both a WWL Strategy Committee focusing on transformation schemes closely linked to external partners, as well as acting as the Secondary Care Transformation Board of the Wigan Health and Wellbeing Board. External members of the committee include Wigan Council, Wigan Borough CCG, Healthy Wigan Partnership, GP representative and other NHS providers such as North West Boroughs Healthcare NHS FT and Bridgewater Community Healthcare NHS FT.
WWL, together with Bolton NHS FT and Salford Royal NHS FT are working together as the North West Sector to implement the Healthier Together initiative, which will see a single sector service for general surgery and subsequent changes in the clinical model as high risk surgery moves to the hub site at Salford. The sector is also collaborating on a number of other possible service changes which either mitigate the costs of centralisation, improve outcomes or address individual organisational resilience issues. Theme 3 of the broader transformation programme resulting from Greater Manchester Devolution provides an overarching framework for further change to standardise acute and specialist services and this will impact on what will be delivered locally. As part of this programme, WWL has been appointed as the lead provider for MSK/orthopaedics across GM.

**Main Learning**
1. Relative to comparable neighbouring and national NHS provider organisations, WWL remains high-performing in many areas, and has achieved a good financial surplus. As for all providers, the 4-hour A&E target remains un-met.
2. WWL has plans and strategies in place to get itself back into the top decile for performance.
3. There have been declines in the national staff survey data: some significant and some less so.
4. WWL’s internal quarterly staff monitoring survey picked this up and put things in place to improve morale.
5. Addressing these issues successfully is a challenge that energises the management team.
Wrightington, Wigan and Leigh NHS Foundation Trust

Royal Albert Edward Infirmary

Wigan Lane, Wigan. WN1 2NN

www.wwl.nhs.uk