5

What makes a top hospital?

EXTERNAL INFLUENCE

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THE top hospitals 12 PROGRAMME

Contents

Editorial advisory group

CHKS has worked with healthcare organisations across the UK to inform and support improvement for almost 25 years. This is the last of five reports that highlight examples of best practice from the UK's top-performing hospitals, which we will share throughout the NHS. We would like to thank the expert panel that has advised us on these reports:

- **Helen Bevan**, Chief of Service Transformation, NHS Institute for Innovation and Improvement
- **Stephen Ramsden**, Director, Transforming Health
- **Ian Dalton**, Chief operating officer, National Commissioning Board
- **Simon Pleydell**, Chief Executive, South Tees Hospitals NHS Foundation Trust
- **Chris Ham,** Chief Executive, The King's Fund

Foreword

CHKS has judged the *HSJ* Acute Organisation of the Year since its inception. In addition, CHKS celebrates success with its annual Top Hospitals programme. As a result we have seen many examples of excellence in the delivery of healthcare by acute sector organisations. The idea behind this series of five reports is simply to share these examples of success in the hope that other organisations can take something from each of them.

While there are many examples in the literature of high-performing healthcare providers, they are often drawn from international comparisons. These reports reflect excellence in healthcare that has been recognised within the past few years. Our aim is to share the energy and enthusiasm for providing high-quality care that we have found in the NHS in the UK.

The reports are based on the collective view of the judges of the 2010 *HSJ* Acute Organisation of the Year award, who produced an overview of what they had seen across the successful trusts (see panel below). No single trust was excellent across the board but, together, they provided a set of themes from which we can share insight. These themes have supplied the focus for each of the five reports. While there may be little of surprise about the themes, it is important to recognise that they are based on current observation, so this series is not a definitive guide to good management.

Much of the focus and energy for NHS leadership has understandably concentrated on making improvements in those trusts where performance is below average. This often means the best organisations are left to get on and move forward as they see fit.

Being left to make your own way can lead to isolation. It is often difficult to find out what is going on in other high-performing organisations. This series is designed to help people get a better understanding of what is happening in other trusts, by sharing case studies that highlight what organisations have already achieved.

What makes a top hospital: the observed themes

Quality and change
- Cost reduction through quality improvement
- Disciplined execution of change at scale
- Using data for improvement, not judgement

Safety
- "Getting to zero" – zero tolerance of harm
- Deliberate focus on reducing mortality and on other safety measures

Leadership
- Strong, stable leadership with continuity of chief executive
- Distributed leadership model that empowers clinical leaders and shifts power to patients and their families
- Investment in development
- The totality of the approach

Organisational culture
- Profound sense of mission and direction
- A mobilised workforce with a passion to get things right for patients
- Defining and promoting values and living them every day

External influence
- Seeing the hospital as part of the wider community
- Corporate social responsibility
- Risk sharing with commissioners
- Learning from other healthcare providers and other industry sectors
- Comparison not just with peers but worldwide

Executive summary

Our experience has shown that external influence is undoubtedly one of the factors that distinguishes top hospitals in the UK from others in the sector. While its benefits may not be immediate, there are significant paybacks in the longer term for those trusts that invest time and energy in this activity.

We have found five areas in which leading hospital trusts have focused their efforts. First, they have adopted the view that they are part of the wider community; in other words, their activities are not considered in isolation from what is going on locally. As hospital trusts face a future where vertical integration is likely to become more commonplace, the need to understand what goes on outside the front doors, and be part of it, will increase.

Second is corporate and social responsibility. CSR in the private sector can bring competitive advantage and, with a set of different drivers, it can also bring long-term benefits for acute trusts. Two chief executives we contacted believe that their employment initiatives have contributed to the growing loyalty of their workforce and to the high percentage of staff who would recommend their trust's services to family and friends.

Risk sharing with commissioners is the third area of focus. There is general agreement that this requires significant courage, at a time when acute trusts are under increasing financial pressure. Opening your books to offer transparency to commissioners may at first seem counterintuitive – but it is the path that has been chosen by the UK's top hospitals.

Fourth is a willingness to learn from other healthcare providers and other industry sectors. By using existing learning networks, it is possible to benefit from the experience of others; equally, though, trusts should be aware of initiatives in other industries that have succeeded in improving productivity and could be applied in the health sector.

The last point on the list is comparison, not just with peers but worldwide. This can be best encapsulated in the phrase "understanding what good looks like". Trusts need to compare themselves to others, rather than operating in splendid isolation, and to broaden this comparison beyond regional to national or even international level. Many trusts have adapted what they have seen working elsewhere with good results.

Those acute sector organisations that commit to these areas of external influence are adding the final ingredient in the making of a top hospital. Taking external influence seriously requires dedication and courage – especially when system changes are afoot and financial pressures are at their greatest.

Introduction

External influence is often not seen as a core element of the business of running an acute trust. It covers activities such as corporate and social responsibility, which some view as little more than tick-box exercises. However, take a trip to one of the top-performing trusts in the UK and you will discover that external influence is far from non-core – it is something that is embedded in the organisation at the highest level.

Whether it is through relationships with the local community, corporate social responsibility, risk sharing with commissioners or having an understanding of what good looks like through regional, national and international comparison – these top performers know and appreciate the value of external influence.

In this report we talk to those who have committed energy, enthusiasm and resource to ensuring their trust fulfils a wider system role and benefits from it. They understand that the payback is not instantaneous but can take years to materialise.

It's fitting that the final report in this series looks at external influence because it is perhaps the most important distinguishing feature of a top hospital. Helen Bevan, chief of service transformation at the NHS Institute for Innovation and Improvement, says it is the one thing that sets the best trusts apart. "There is such a stark contrast between the places and the leaders that see their organisations as part of the wider system and those that don't," she says.

The case studies in this report and from the others in the series are now available online at http://tophospitals.chks.co.uk. If, having read any of the case studies, you would like to leave a comment or add your own examples, you can do so on the CHKS blog, at http://chksinsight.wordpress.com/

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> **Helen Bevan, NHS Institute for Innovation and Improvement**

Seeing the hospital as part of the wider community

According to the judging panel of the *HSJ* acute organisation of the year award and the insight gained from the CHKS national Top Hospitals programme awards, there is a clear distinction between hospital trusts that see themselves as part of the wider community and those that don't.

Helen Bevan, chief of service transformation at the NHS Institute for Innovation and Improvement, says the contrast is clear. "As someone who has been on the *HSJ*'s judging panel for a number of years, one of the things that really sets the top hospitals apart is the extent to which the organisations see themselves as part of the community," she says.

Bevan acknowledges that when times get tough, and in particular when the NHS is being asked to make unprecedented efficiency savings, the temptation to 'pull up the drawbridge' is high. The decision to concentrate on internal improvement at the expense of dealing with the outside world is not hard to understand but, she says: "Even though internal improvement work is often done in isolation, being engaged in the wider community is such a critical issue, especially because over the next few years we are going to see more organisations becoming joined up and this is not just about joined-up structures – it's about the mindset."

Nigel Edwards, senior fellow at the King's Fund, agrees that isolationism is not an appropriate strategy for an organisation that is seeking to be a top performer. He says this is a choice faced by every acute provider: "You either have an inward focus, and that is about defining the problems you face in terms of faults in the system, or you take an outward-looking position.

"Sometimes being insular and having an internal focus can produce good performance in the short term but it is not a long-term strategy and not a wise one either. I have seen trusts that have developed a siege mentality but this inevitably means you fail to understand what good looks like."

Edwards also agrees with Bevan that the current direction of travel in the NHS means trusts can no longer see themselves as standalone parts of the system. Vertical integration, he asserts, will see trusts being involved in a wide range of activities, from primary care service to mental health, which inevitably will require engagement with the wider community. "You can't do this if you are not part of the community and are not visible," he says.

Sue James, chief executive of Derby Hospitals NHS Foundation Trust, interprets this visibility in a holistic way. "Our role is to help people be as healthy as they can be and although the role of the acute provider is about specialist care, that doesn't mean we shouldn't be involved in other parts of the system," she says.

"Hospitals should not be considered as 'cathedrals' in the health system. The whole issue of community cohesion is important – some communities feel disengaged and the hospital is one place where everyone mixes together, so it is part of our responsibility to find hard-to-reach communities and work with them."

Bevan raises the issue of leadership style and says this has an important role to play in how well an organisation engages with the wider community. She describes a style that is focused on

compliance and compares this with a distributed leadership approach, which is instead focused on commitment.

"I spend a lot of time visiting organisations in the NHS, seeing what good practice means, and I see such a difference between top hospitals and the rest of the pack. When it comes to external influence there is a need to redefine NHS leadership and move to this more distributed style, which means working both within the organisation and outside. We have in the past got very caught up around compliance and this has made an impact on our leadership model," she says.

Edwards also talks about leaders, saying the ability of an organisation to connect with the community is linked with how well its leaders themselves engage with the outside world. "There are chief executives that I know of but have never met throughout all my time in the NHS," he reveals. "In fact, no one seems to have met them. Yet there are others who I will always bump into because they are interested in finding out what is going on in the world around them. This plays into how well they connect with their local community."

He points out that this can be a function of the culture of an organisation and how insular it is. An insular organisation, he suggests, may appoint a chief executive who appears to fit the mould whereas what may be needed is one that breaks it. The King's Fund 2012 report, *A Review of Leadership in the NHS*,[1] to be launched at its second annual NHS Leadership and Management Summit later this month, looks at how leaders can drive improvement by doing more to engage not only staff and patients but organisations across the health and social care system. The King's Fund picks up on the distributed leadership theme, saying it is necessary to move away from the concept of the 'superhero' chief executive toward leadership that is demonstrated at all levels and across organisational boundaries.

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Corporate and social responsibility

Corporate and social responsibility (CSR) is a common area of focus in the private sector and is becoming an increasingly important consideration for NHS boards. It is one of the components of external influence that top-performing hospitals have already mastered and they have committed time, energy and resources to doing so.

CSR can be defined as any activity that is aimed at furthering social good but goes beyond compliance or any other activity required by law. CSR activities are wide ranging and can include using only locally sourced materials in production, supporting local communities by engaging in employment initiatives, and adopting policies that ensure the organisation is environmentally friendly.

Not everyone can agree on the exact definition and, as a consequence, measurement of the benefits can be tricky. However, CSR has been shown to improve image and reputation[2] and in the commercial world this can bring a competitive advantage.

Although competitive advantage might not be the primary incentive for some NHS trusts, there are other long-term benefits for top-performing trusts. For many of their chief executives being part of the wider community and investing in CSR does bring a tangible return. David Dalton, chief executive of Salford Royal NHS Foundation Trust, puts recent good results in the 2011 National NHS staff survey[3] down to the trust's involvement in local employment initiatives (see case study 1). When Dalton first came to work at the trust in 2001, less than 25 per cent of employees were from the Salford area – that figure has now risen to more than 50 per cent.

Diane Whittingham, who recently stepped down as chief executive of Calderdale and Huddersfield NHS Foundation Trust, is also convinced that CSR – in particular her trust's efforts to support local employment initiatives – has borne fruit (see case study 2).

CASE STUDY 1

Salford Royal NHS Foundation Trust

David Dalton, chief executive of Salford Royal NHS Foundation Trust, takes a personal interest in how the trust connects with the community. He explains there are a number of ways the trust is helping unemployed and disadvantaged people to find work, often in the trust itself.

The trust has been holding events that give disabled and long-term unemployed the opportunity to see what jobs are available in health and social care and then offer support to ensure they have a fighting chance of finding employment, within the trust or the wider community.

"Since 2005 we have seen 5,385 individuals go through this process and, as well as working with the local job centre and our partners (including Skills for Health) on pre-employment training programmes, they can volunteer to work with us, which all helps with their CV and restores self-esteem," Dalton says.

The trust is also using work placements to bring people back into employment. Dalton highlights the instance of a former patient who had undergone heart surgery and was no longer able to work as a long-distance lorry driver. After a work placement, he was taken on permanently and was the winner of a staff award in 2010.

In addition, the trust works closely with Balfour Beatty, its partner in the trust's redevelopment programme, and is involved in a National Skills Academy for Construction project. Balfour Beatty employs a dedicated person to recruit trainees and local people into construction job roles at the trust.

So what does Dalton think are the long-term benefits? "In practical terms it gives us the opportunity to find local people whose values fit with ours. The staff we have employed from the numerous schemes are loyal and clearly get a lot out of working here, according to the results of the NHS staff survey. It's not a coincidence that they also would recommend our care to their family and friends," he says. "We are also employing more local people – 57 per cent of the workforce live within 30 miles and 39 per cent within 15 miles of the site."

Dalton believes that the more the hospital is connected to the community, the stronger it will be but knows it is a slow-burning process. "If you are effecting change on this scale you are not going to get much back in five years. We are seven years into our programme and we are beginning to build something that is sustainable. In 2010 we won Employer of the Year at the Greater Manchester Employer Coalition Awards."

Supporting local and even national employment programmes might seem far removed from the day-to-day business of running an acute hospital trust but as Simon Pleydell, chief executive of South Tees Hospitals NHS Foundation Trust, points out, trusts are often the biggest employers in the region and have a responsibility to the community. "Middlesborough and the surrounding areas are deprived – with some of the worst areas of socio-economic deprivation in the country," he says. "It is a region coming to terms with major changes in terms of the demise of its traditional industrial base."

He is clearly proud of the trust's record in supporting local employment schemes. "We have been the leading light in terms of local apprenticeship schemes," he says, citing the fact that one of the trust's apprentices, now a student nurse, was named as one of the UK's top apprentices in 2011.

Pleydell takes a pragmatic approach to CSR and one that always considers the business case. He sees a clear advantage for the trust in being part of the momentum that is building behind initiatives such as the North East's Health Innovation and Education (HIEC) cluster. HIECs are collaborative partnerships between NHS organisations, academia and industry. Their aim is to transform healthcare and drive up quality to improve patient care, safety, outcomes and experience by sharing innovative research, as well as supporting high-quality health education and training to enhance and develop workforce skills.

CASE STUDY 2

Calderdale and Huddersfield NHS Foundation Trust

At Calderdale and Huddersfield NHS Foundation Trust, CSR is more than a tick-box exercise and a few well-meaning paragraphs on its website. It is dedicated to ensuring the organisation delivers care in a sustainable way. "That means everything from who we employ and what we buy, to how we complement other providers in the system and local businesses," says Diane Whittingham, who was until recently chief executive. "It is about a long-term culture shift that is embodied in the way we work."

As with Salford Royal, being a responsible employer plays a large part in this. Training and development initiatives, flexible working, staff crèches and work experience programmes are just some of the components. "We had 600 placements last year alone, covering school leavers to postgraduates, and at any one time we will have over 400 volunteers working here," says Whittingham.

The trust also carefully considers its green credentials when redeveloping the site. This covers the use of sustainable materials and waste management strategies. In 2006 it was selected as one of the first ten NHS organisations in England to sign up for the Carbon Trust's NHS Management Programme. It was chosen from 25 hospital trusts that applied nationally to engage in the programme and play their part in managing climate change.

At the time Steven Bannister, the trust's estates director, said: "A large organisation like the trust, with thousands of employees, has a major responsibility to lead on cutting carbon emissions, and the good news is that it could help us to save money by reducing our energy bills."

The results are now being seen with a carbon dioxide reduction strategy in place. There is a long list of changes, from cycle lockers and showers to trust vehicles that are now all low emission. The trust is also buying almost 50 per cent of its goods within a 50-mile radius. "We are taking CSR very seriously and we have an associate director who heads up all this work," says Whittingham.

"This is not about CSR being a nice thing to do – it makes absolute sense in terms of business. Inevitably, everything we are doing is helping to improve productivity. We have a strong and loyal staff base, with many of the people who have come in through our various schemes going on to become exemplar employees. Their commitment is substantial because we have supported them through difficult times."

Risk sharing with commissioners

One of the features we have seen in top-performing organisations is a willingness not only to 'lower the drawbridge' and engage with the local community but also to take an open-book approach to other health providers and commissioners.

The system of funding in the NHS, where commissioners determine the income of acute trusts, has encouraged many organisations to perpetuate the traditional 'them and us' approach. However, it is clear that organisations that are willing to be transparent reap the benefits. This does of course depend on the commissioner and there is anecdotal evidence that some commissioners do not encourage transparency.

Helen Bevan, of the NHS Institute for Innovation and Improvement, talks of a commitment between commissioner and provider, highlighting the example of a formal 'compact' between the two. This compact sets the ground rules for engagement and makes improvement through transparency an organisational goal. "We have had 13 years of top-down national targets and a lot of the apparatus of compliance is being dismantled. We are seeing commissioners and providers working hard to create a set of common values and shared goals," she says.

Diane Whittingham, from Calderdale and Huddersfield NHS Foundation Trust, talks of the viability of the health system and says it is impossible to have an island of success in a sea of failure. "This means we all need to take a system perspective, have strong relationships and a sensible dialogue, and know when to compromise," she says. She points to the success of a collaborative healthcare group between the trust and East Lancashire Hospitals NHS Trust, where there are opportunities for significant co-operation in areas of mutual benefit.

For Simon Pleydell, of South Tees Hospitals NHS Foundation Trust, risk sharing has been on the agenda for several years; the trust is part of a strategic management project – a genuine effort, he says, to share risk and improve the overall financial position of the commissioner NHS North Yorkshire and York, which has faced debt problems for more than a decade.

"There is no point driving the commissioner into greater debt," he says. However, Pleydell warns that transparency will get more difficult, especially as the latest NHS Operating Framework[4] will heap pressure on the acute sector, making risk sharing more problematic.

Patrick Crowley, chief executive of York Teaching Hospital NHS Foundation Trust – part of the same strategic management project – says a more transparent approach to contract negotiation and settlement has borne fruit for his trust. "Our PCT has been for many years one of the more financially challenged, which inevitably encouraged a short-term outlook and a more adversarial approach to contract management. This in turn led to a growing mistrust between partners within the system," he says.

"About three years ago the local system was again being pressured to resolve a year-end problem with little or no time to do this. However, together with the SHA, we turned the debate into one about developing a more constructive way forward. The local foundation trusts agreed to absorb much of the financial pressure providing the SHA committed to facilitating, through a considered approach to brokerage, a collective negotiation of provider contracts and a common efficiency programme based on a common purpose."

Crowley says the acute trusts took a considerable financial hit but at the same time developed a more open-book approach to contract settlement. A systems management executive was set up, consisting of the chief executives and financial teams, with the goal of a more honest process

of sharing financial pressure and a collective approach to risk management. A common set of contract clauses was drawn up, which, he says, has led to tangible benefits.

"The PCT is now in underlying financial balance, a significant improvement in a relatively short period of time, and we have a better understanding and a much greater sense of trust. This has created a solid foundation for future work with the emerging clinical commissioning groups we will be engaged in, around pathways to improve outcomes and become more efficient."

Sue James, of Derby Hospitals NHS Foundation Trust, is familiar with risk-sharing pressure. "When I arrived at the trust in January 2011, we were just coming to the end of a formal risk-sharing agreement with the primary care trust. There had been a stand-off, with the PCT saying it could afford to pay us £30 million less than the previous year." She explains they agreed a 50 per cent discount for activity over a given threshold but it quickly became apparent that activity was still increasing. "We were able to show we weren't creating activity for the sake of income and that we were delivering care even when it was against our financial interests.

"We then came up with an agreement where we would identify areas we could work on jointly to reduce activity. So for example, we are looking specifically at the frail and elderly to see what we can do to keep them out of hospital. This will involve working with GPs and encouraging them to take a preventative approach by flagging up high-risk patients," she says.

Nigel Edwards, of The King's Fund, says that, all too often, commissioners and providers find themselves in the situation game theorists describe as 'prisoner's dilemma' (see box). This is where each organisation tries to optimise its own position in the health economy but in doing so produces the worst outcome for all. Edwards says risk sharing between commissioner and providers can have advantages particularly when it comes to chronic disease areas.

However, he too acknowledges the constraints. "If the health economy cake is expanding, then it is easy to be generous. Risk sharing gets hard when it is static or shrinking and it is possible to end up in a place where deficits are being passed between providers and commissioners. The key is to know how to collaborate to create additional value," he says.

Prisoner's dilemma – how game theory plays a part in risk sharing

Two accomplices are arrested in possession of firearms after a theft and held in isolation in separate cells. Both care much more about their personal freedom than about the welfare of the other. The arresting officer tells them they have a choice either to confess or remain silent. If a confession is made by one and the other remains silent, all charges against the one who confessed will be dropped while the testimony will be used to ensure the silent accomplice is charged and gets a maximum sentence.

They are also told that if they both confess there will be two convictions but the police will ensure they get early parole. In addition, the officer tells them that if they both remain silent they will receive token sentences on firearms possession charges.

The dilemma they face is that, whatever the other does, each is better off confessing than remaining silent. However, the outcome when both confess is worse for each than the outcome had both remained silent.

The dilemma is often used to describe what happens at organisational level, for example in a health economy. Here the dilemma predicts that where organisations pursue rational self-interest they may all end up worse off than if they were to act contrary to rational self-interest.

Learning from other healthcare providers and industry sectors

It is well accepted that organisations looking to make improvements can learn from others, not just in their own sector but elsewhere. Helen Bevan, from the NHS Institute for Innovation and Improvement, says: "We can learn from healthcare organisations that have made the leaps in service quality we aspire to." Without exception, all the acute sector organisations that are shortlisted in national awards have adopted something they have seen elsewhere in the NHS. They tend to be part of learning networks that share best practice, such as NHS Quest.

NHS Quest describes itself as the first member-convened NHS provider network for organisations that wish to focus relentlessly on improving quality and safety. It was founded in 2011 and has 14 founder members, with a programme office based in Salford. It aims to share learning as well as identify and develop initiatives that lead to improvements such as harm-free care, reducing readmissions and reducing mortality.

South Tees Hospitals NHS Foundation Trust is one of the founder members, says chief executive Simon Pleydell. "We were the first trust to have four pilot wards meeting the 95 per cent threshold for harm-free care. There is considerable effort put into organising visits between us and our partner organisations. The idea is that we are pooling our resources through learning from each other and that we are able to benchmark ourselves against the very best in the field of patient safety to drive significant improvement."

Pleydell cautions that learning visits where senior teams decamp abroad may become less and less viable and that the network approach works well. He says NHS Quest has links with the Institute for Healthcare Improvement in Boston, which adds an international element. He also highlights the trust's links with the NHS Institute for Innovation and Improvement. "We have been doing a lot of work based on the Institute's staff engagement ideas to mobilise staff and patients and build a grassroots movement for healthcare improvement."

Bevan is keen to point out that NHS acute providers can also learn from other industries. She believes that, although healthcare does have specific differences, there are industries in other sectors that can offer valuable examples.

There are well-known examples where the NHS has already learned from other industries, such as the Toyota Lean Approach and the Unipart University. Maxine Power, executive director of NHS Quest, says its members are always on the lookout for learning from other industries, and she cites her recent visit to Vernacare, the disposable system for human waste management in hospitals – which most NHS staff know as the company that makes urine bottles.

"Vernacare has a very close relationship with the NHS and is continually looking to make improvements in its manufacturing process," says Power. "Its values are very closely aligned with ours and they are exploring ways to reduce costs and improve quality.

"Their use of advanced measurement and understanding of what the optimum manufacturing process looks like, and how employees fit into this, is also extremely interesting," she adds. "The workspace is immaculate, which, given the nature of the manufacturing business they are in, is very impressive." Power says she is setting up executive-level meetings to explore learning from Vernacare.

Comparison not just with peers but worldwide

Top hospitals would not be where they are without an understanding of how their performance measures up at regional, national and even global level. But, says Nigel Edwards of The King's Fund: "An external focus on its own is not good enough; you need to know what good looks like."

Regional and national comparison has become easier, especially when it comes to indicators such as mortality and other performance measures. Edwards and Simon Pleydell agree that worldwide comparison is less straightforward since the way that data is collected and measured can differ. For example, countries in Europe may use different Healthcare Resource Group classifications and primary care systems are organised differently. "Worldwide comparison tends to be very issue-specific, such as safety, or focused around a particular model," says Edwards.

International comparison can be helpful when it comes to the role clinical leadership plays in driving improvements in performance. There are many examples of where trusts have made improvements based on work they have seen abroad and this is often pathway led.

In *Engaging Doctors in Leadership*[5], the authors say there is still further potential for learning through comparison: "The NHS has an opportunity to learn from international experience to become an exemplar in medical leadership and its development."

Several NHS organisations across the north of England have established alliances with international partners to support them in transforming services at a local level. Here, NHS North East, NHS North West and NHS Yorkshire and the Humber are part of an initiative called 'Leading Large Scale Change Through International Alliances'. This programme focuses on collecting examples of improvement from clinical teams who have established links with internationally recognised organisations, such as the Virginia Mason Medical Center, Intermountain Healthcare and Johns Hopkins Medicine, all in the US, and Jönköping County Council in Sweden.

Helen Bevan is supportive of this work and says: "To say that it is not possible to make comparisons because of data inconsistency is missing the point. The great thing about doing worldwide comparison and learning from others is really about the mindset and adopting a whole new perspective on the way we operate."

> The NHS has an opportunity to learn from international experience to become an exemplar in medical leadership and its development.
>
> **Ham C, Dickinson H. Enhancing Engagement in Medical Leadership**

Worldwide comparison and learning from others

Patient Status at a Glance Boards

South Tees Hospitals NHS Foundation Trust has applied learning from Virginia Mason Medical Center in Seattle to develop Patient Status at a Glance (PSAG) Boards. This was done across surgery in consultation with multidisciplinary teams. The board is updated every morning, ensuring the provision of accurate information to bed managers. PSAG boards are being rolled out across the whole of the acute trust.

Developing a safety culture

Aintree University Hospitals NHS Foundation Trust developed a partnership with Johns Hopkins Medicine in Baltimore to help it build a culture of safety within the trust. As a result of the three-year partnership programme, the trust has seen significant engagement at all levels in preventing patient harm. Several initiatives have been modified and incorporated into the trust's processes; for example, it now has patient safety officers on every ward with a full day dedicated to improving safety. Weekly meetings are held and chaired by the medical director where all incidents of harm are reviewed, with a specific focus on near misses. The trust has also introduced Comprehensive Unit-Based Safety Programmes, where multidisciplinary clinical teams – from porter to consultant – meet to ask two key questions: 'How might our next patient be harmed?' and 'What can we do as a team to prevent it?'

Reducing readmissions

Calderdale and Huddersfield NHS Foundation Trust has been working worked in collaboration with a US membership organisation called the Clinical Advisory Board on its readmission agenda. The learning has helped it to bring together partners across local health and social care organisations to review local issues and get everyone to the same level of understanding about risks to patients, costs to the local health economy and preventive actions they could take. Through this association, the trust has established a multidisciplinary virtual ward that targets patients who are at risk of readmission.

Conclusion

A commitment to external influence, and in particular the areas of focus we have highlighted in this report, not only sets leading acute sector organisations apart from others, it produces significant benefits.

These benefits are not immediate – as David Dalton, chief executive of Salford Royal NHS Foundation Trust points out, they can take several years to materialise. The example of involvement in employment programmes is a potent one; helping individuals when they are at their lowest ebb and supporting them back into work can bring repayment through staff loyalty. Dalton is adamant that the trust's good performance in the 2011 NHS staff survey is down to the relationship it has with its staff. This commitment to local people has helped the trust to win awards and it is now firmly embedded in the local community.

Such local engagement is only part of the external influence package. 'Lowering the drawbridge' to engage with commissioners on an open and transparent level is another important factor. Some trust chief executives will find this harder than others depending on their existing relationship with commissioners but the effort is clearly worthwhile.

Finding out what other providers are doing and being open to new ideas is also part of the external influence package. This does not have to be restricted to the healthcare sector because there are learning points from other industries. There are well-worn paths to car manufacturing giants such as Toyota but often learning is possible on the doorstep, as NHS Quest executive director Maxine Power has discovered with her visits to urine bottle manufacturer Vernacare.

Finally, we have found that continuous comparison is vital to help trusts understand what good looks like. As Nigel Edwards of The Kings Fund says: "It's all very well seeing what good looks like but you then need a culture to encourage the implementation of what you have seen."

None of the top-performing UK trusts have all these areas covered although most do one or two of them well. As we have discovered in previous reports in this series, culture and leadership play an important role in how well a trust performs. Those two elements are inextricably linked with external influence – Edwards' observation that chief executives who foster relationships beyond the trust help to drive external influence is pertinent, and this is an important pointer for the future of NHS leadership development programmes.

> If you are effecting change on this scale you are not going to get much back in five years. We are seven years into our programme and we are beginning to build something that is sustainable.
>
> **David Dalton, Salford Royal NHS Foundation Trust**

CHKS Top Hospitals programme 2012

The CHKS Top Hospitals programme celebrates the best in UK healthcare. There are several awards: some that are open to all UK hospital trusts and some that are for hospitals and other organisations that are working with CHKS.

All UK NHS hospital trusts are entered automatically for the open awards, which are judged using nationally available datasets that include every NHS acute trust.

There are three award categories:

- Quality of care: recognising excellence in providing high-quality care to patients that is appropriate to their diagnosis
- Patient safety: recognising outstanding performance in providing a safe hospital environment for patients
- Data quality: recognising excellence in clinical coding, which plays an essential role in improving the quality of care provided to patients.

CHKS has also announced the winner of its quality improvement award. This international award recognises significant improvements in patient care and patient experience, as well as staff welfare, safety and morale. The CHKS quality improvement award 2012 was open to all healthcare organisations accredited by CHKS in 2011.

Jason Harries, managing director of CHKS, says: "The government has made it clear that every hospital is accountable to its patients, their families and carers as well as the local community to provide a safe environment where effective care can be delivered.

"Our national awards recognise the important part that data quality, safety and quality of care play in this respect."

Top Hospitals latest analysis

New research finds no link between conversion and day-case rates

In the 2012 Top Hospitals programme awards CHKS has included newly defined indicators based on the British Association of Day Surgery (BADS) directory of day surgery.

Further analysis of these indicators reveals substantial variation across hospital trusts in England. However, the analysis has also helped to dispel the commonly held view that the inexorable drive for greater efficiency and higher day case rates has resulted in inappropriate referrals for day surgery (for example, for patients with complicating pre-existing conditions).

The argument is that these patients are often kept in hospital overnight, if only for observation. This would imply that trusts with higher day surgery rates would have more day case conversions.

However, CHKS analysis has found no link and that the conversion rates are no higher in trusts with the highest day case rates. Indeed, the reverse is true: conversion rates are actually better (lower) at sites with better (higher) day case performance. CHKS consultants believe this is a result of a concerted focus on providing good quality care pathways by clinicians and management.

Data quality award

The awards recognise the importance of clinical coding and data quality, and the essential role they play in ensuring appropriate patient care and financial reimbursement from commissioners. We have presented three data quality awards recognising the best performers across the UK, based on a number of indicators. This year's indicators are depth of coding (not case mix adjusted), the percentage of coded episodes with signs and symptoms as a primary diagnosis, and the percentage of uncoded episodes.

Shortlisted organisations 2012

Data quality award (England)

- Frimley Park Hospital NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- Northumbria Healthcare NHS Foundation Trust

Data quality award (Northern Ireland, Scotland, Wales)

- Betsi Cadwaladr University Health Board
- Cardiff & Vale University Health Board
- South Eastern Health and Social Care Trust

Data quality award (specialist trust)

- Clatterbridge Cancer Centre NHS Foundation Trust
- Liverpool Heart And Chest Hospital NHS Foundation Trust
- Papworth Hospital NHS Foundation Trust

Winners

Data quality (England)

Lancashire Teaching Hospitals NHS Foundation Trust

Data quality (Northern Ireland, Scotland, Wales)

Betsi Cadwaladr University Health Board

Data quality (specialist trust)

Liverpool Heart and Chest NHS Foundation Trust

Patient safety award

A national award for outstanding performance in providing a safe hospital environment for patients, it is based on more than 20 criteria, including rates of hospital-acquired infections and mortality. The indicators for 2012 include:

- Emergency readmission rate within 28 days of discharge following hip fracture (65 years and over)
- Summary Hospital-level Mortality Index (SHMI)
- Risk-adjusted mortality index
- Readmission rate within seven days of delivery
- Infection rate following Caesarean section
- Rate of deaths in hospital within 30 days of non-elective surgery
- Rate of deaths in hospital within 30 days of elective surgery
- Rate of deaths in hospital within 30 days of emergency admission for hip fracture (fractured neck of femur; 65 years and over)
- Rate of deaths in hospital within 30 days of emergency admission with a heart attack (myocardial infarction; aged 35 to 74)
- Rate of deaths in hospital within 30 days of emergency admission for a stroke
- Rate of deaths in low-mortality HRGs (HRG3.5)
- Rate of decubitus ulcer (for patients with length of stay over four days)
- Postoperative wound infection
- Complications of anaesthesia
- Foreign body left in during procedure
- Postoperative pulmonary embolism or deep vein thrombosis
- Postoperative sepsis
- Rate of accidental puncture or laceration during surgery
- Birth trauma (injury to neonate).

Shortlisted organisations 2012

- Airedale NHS Foundation Trust
- Chelsea and Westminster Hospital NHS Foundation Trust
- Guy's and St Thomas' NHS Foundation Trust
- Barts Health NHS Trust
- South Eastern Health and Social Care Trust

Winner

Patient safety

Airedale NHS Foundation Trust

Quality of care award

Awarded nationally for excellence in high-quality care to patients appropriate to their diagnosis, the quality of care award is based on a number of criteria, including the length of time patients stay in hospital, the rate of emergency readmission and whether the care pathway proceeded as originally intended. The indicators for 2012 include:

- Day case conversion to inpatient rate (vs national rates, case mix adjusted in line with BADS)
- Patient-reported outcomes score (across four procedures)
- Rate of emergency readmission to hospital
- Percentage of elective admissions where planned procedure not carried out (not patient decision)
- Summary Hospital-level Mortality Index (SHMI)
- Risk-adjusted length of stay
- Risk-adjusted mortality index
- Percentage of patients over 65 years with fractured neck of femur with pre-operative length of stay less than or equal to two days
- Cancer patients seen within two weeks (all suspected cancers)
- Discharge to usual place of residence within 56 days of emergency admission for patients with stroke
- Discharge to usual place of residence within 28 days of emergency admission for patients with a hip fracture (fractured neck of femur; aged 65 and over)
- Admitted patients' waiting time from point of referral to treatment.

Shortlisted organisations 2012

- Airedale NHS Foundation Trust
- Cambridge University Hospitals NHS Foundation Trust
- Dorset County Hospital NHS Foundation Trust
- The Whittington Hospital NHS Trust
- West Suffolk NHS Foundation Trust

Winner

Quality of care

West Suffolk NHS Foundation Trust

Quality improvement award

Our only international award recognises significant improvements in patient care and patient experience, as well as staff welfare, safety and morale. The CHKS quality improvement award 2012 was open to all healthcare organisations accredited by CHKS in 2011. All submissions are evaluated by the CHKS Accreditation Awards Panel

Shortlisted organisations 2012

- Beacon Centre, Taunton and Somerset NHS Foundation Trust
- Centro Hospitalar do Porto, Geral de Santo António, Portugal
- Clane General Hospital, Ireland
- Hospital de Magalhães Lemos, Portugal
- Vhi Swiftcare Clinics, Ireland
- White Oaks Rehabilitation Centre, Ireland

Joint winners

Quality improvement

Beacon Centre, Taunton and Somerset NHS Foundation Trust

Centro Hospitalar do Porto, Geral de Santo António, Portugal

> Our awards programme provides reassurance to hospital boards, staff and patients that their trust is amongst the highest performers when it comes to data quality, safety and quality of care.
>
> **Jason Harries, CHKS**

40 Top Hospitals award

The 40 Top Hospital Award is not open to all UK hospital trusts but is awarded to the 40 top-performing CHKS client trusts. It is based on the evaluation of 23 indicators of clinical effectiveness, health outcomes, efficiency, patient experience and quality of care.

Revised annually to take into account newly available performance information, this year's indicators include:

- Reported *Clostridium difficile* rate for patients aged 65 and over
- Day case rate (relative weighted performance across BADS directory)
- Day case conversion to inpatient rate (compared with national rates, case mix adjusted as per BADS)
- Depth of coding (not case mix adjusted)
- Percentage of coded episodes with signs and symptoms as a primary diagnosis
- Percentage of uncoded episodes
- Inpatient survey (overall care question)
- Percentage of outpatient first appointments not attended (specialty adjusted)
- Patient-reported outcomes score (across four procedures, per EQ-5D)
- Rate of emergency readmission to hospital (more than 16 days and less than 28 days)
- Emergency readmission within 28 days of discharge following hip fracture (for patients aged over 65)
- Percentage of elective admissions where planned procedure not carried out (not patient decision)
- Reference Cost Index (RCI)
- Summary Hospital-level Mortality Index (SHMI)
- Staff survey (overall job satisfaction question)
- Risk-adjusted length of stay
- Risk-adjusted mortality index
- Rate of emergency readmission to hospital following myocardial infarction within 28 days
- Rate of emergency readmission to hospital within 14 days for COPD
- Percentage of elective inpatients admitted on day of procedure
- Patient misadventure rate (ICD-based)
- Percentage of patients over 65 years with fractured neck of femur with pre-operative length of stay less than or equal to two days
- Unnecessary admissions via A&E.

40 Top Hospitals 2012

Bedford Hospital NHS Trust
Burton Hospitals NHS Foundation Trust
Calderdale and Huddersfield NHS Foundation Trust
City Hospitals Sunderland NHS Foundation Trust
Countess of Chester Hospital NHS Foundation Trust
County Durham and Darlington NHS Foundation Trust
Dartford and Gravesham NHS Trust
East and North Hertfordshire NHS Trust
East Cheshire NHS Trust
East Kent Hospitals University NHS Foundation Trust
Frimley Park Hospital NHS Foundation Trust
Hampshire Hospitals NHS Foundation Trust
Heatherwood and Wexham Park Hospitals NHS Foundation Trust
Imperial College Healthcare NHS Trust
Kingston Hospital NHS Trust
Lewisham Healthcare NHS Trust
Medway NHS Foundation Trust
Mid Cheshire Hospitals NHS Foundation Trust
Mid Essex Hospital Services NHS Trust
Northampton General Hospital NHS Trust
Northumbria Healthcare NHS Foundation Trust
Royal Berkshire Hospital NHS Foundation Trust
Royal Bolton Hospital NHS Foundation Trust
Royal Surrey County Hospital NHS Foundation Trust
Scarborough and North East Yorkshire Healthcare NHS Trust
South Eastern Health and Social Care Trust
South Tees Hospitals NHS Foundation Trust
South Tyneside NHS Foundation Trust
South Warwickshire NHS Foundation Trust
Southern Health and Social Care Trust
The Newcastle Upon Tyne Hospitals NHS Foundation Trust
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
The Rotherham NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
University Hospitals Bristol NHS Foundation Trust
West Hertfordshire Hospitals NHS Trust
Western Sussex Hospitals NHS Trust
Weston Area Health NHS Trust
Wye Valley NHS Trust
York Teaching Hospital NHS Foundation Trust

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THE top hospitals 12 PROGRAMME

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This makes us the provider of choice with the broadest range of services and highest level of expertise and knowledge. With 70% of acute healthcare providers in the UK choosing CHKS to support them on their improvement journey, we have the skills and know-how to help you boost quality, cost and delivery performance in your organisation.

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