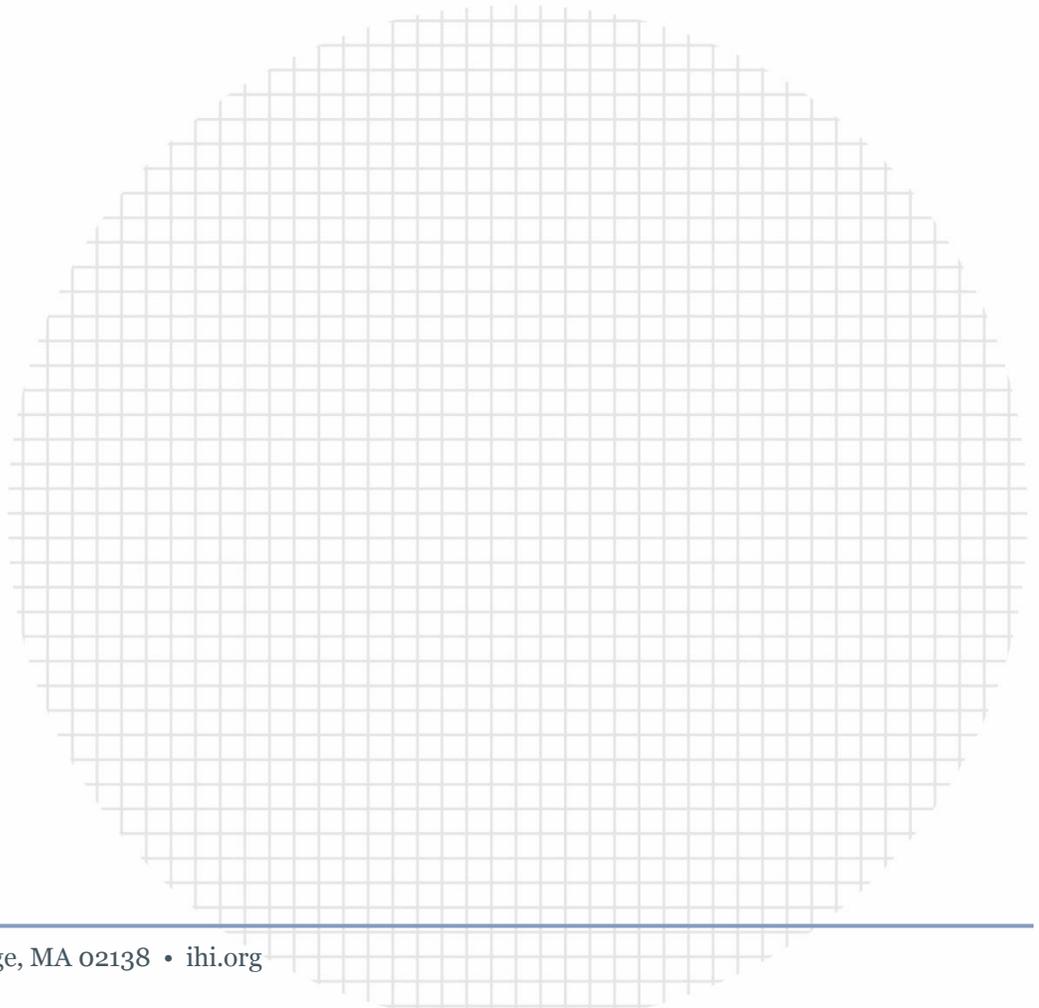




# Building a Culture of Improvement

at East London NHS Foundation Trust



AN IHI RESOURCE

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**How to Cite This Document:** *Building a Culture of Improvement at East London NHS Foundation Trust*. Cambridge, Massachusetts: Institute for Healthcare Improvement; November 2016. (Available at [ihi.org](http://ihi.org))

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## Introduction

East London NHS Foundation Trust (ELFT) in the UK, established in 2000, provides mental health and community services to a diverse and largely low-income population. The East London population is approximately 750,000, and the Trust has recently expanded its services into Bedfordshire and Luton, which includes an additional 630,000 people. Approximately 65,000 individuals come into contact with ELFT's services each year at more than 100 community and inpatient sites. The Trust is committed to offering the highest quality care to all patients.

In the past few years, ELFT has significantly reduced incidents of inpatient violence, medication errors, waiting times for treatment in the community, and improved staff engagement, among other achievements. In recognition of its successes, the UK's *Health Service Journal* named ELFT "Trust of the Year" at the 2015 Patient Safety Awards, and the Trust also won the Staff Engagement Award at the 2015 *Health Service Journal* Awards. Most recently, in 2016, ELFT was rated as "Outstanding" overall by inspectors from the UK Care Quality Commission, becoming one of the first providers of mental health services in the National Health Service (NHS) to earn the top rating.

How did ELFT reach this point? Leaders and staff made a concerted effort to entrench a culture of continuous improvement in the organization, and they integrated quality improvement (QI) methodology and thinking into every level of work. This report tells the story of how they went about doing so.

## Origins of Implementing Quality Improvement

The initial impetus for changing ELFT's approach was one very difficult summer, when three patients died in the Trust's care.

"In 2010," recalls Professor Jonathan Warren, Director of Nursing and Deputy Chief Executive, "we're doing OK; nothing tremendous about us, nothing terrible about us. We meet all our targets, we're financially viable, and people leave us well alone."

But then a patient murdered another patient on a ward. There was also a suicide, and a death by "natural causes," which Professor Warren believed was preventable.

In the NHS system, the quality assurance program monitors metrics such as levels of *C. difficile* and MRSA, and whether people are waiting more than 28 days for appointments. If you meet those targets, you get green marks on the dashboard; if you're within 5 percent, the marks are yellow; if you're more than five percent off, the marks are red. "As long as all your targets are green, then you're doing all right," says Warren — at least, that was the message conveyed by the system. And ELFT's targets were nearly all green. But, shaken by the patient fatalities, he and other leaders at ELFT began to wonder if there wasn't a better way to think about quality.

Professor Warren and Fred Inman, Director of Operations, devoted an entire summer to talking to ELFT staff and service users. They went around to teams and asked three simple questions: What's going well? What isn't going well? What can we do to help?

One conversation in particular stuck with Warren. During the time the World Cup was taking place in South Africa, he was asking patients those same questions. One patient said something that would really make a difference to him was “if you can get that telly working.” Warren noted that the television was turned on. “But it only plays on BBC1,” the patient replied. “I want to watch the World Cup.”

It turned out to be a “sorry tale,” Warren recalls, of bureaucracy and frustration. One staff member bought a new television at a local store, one that broadcast more channels, only to be told he couldn’t be reimbursed because no relevant policy was in place. Warren and his colleagues decided to do everything they could to remove needless barriers such as this one. They wanted their staff to be able to do their jobs, and to do their best for their patients, without worrying about those kinds of headaches.

Over the next few years, ELFT leaders continued that sort of informal work: conversation with staff and service users, and small changes in thinking and practice. They also began to contemplate engaging in a more formal, large-scale QI program. Then, in 2011, Dr. Kevin Cleary became the Medical Director, and soon thereafter asked Dr. Amar Shah to serve as Associate Medical Director. Both had expertise in QI and were eager to apply its principles at ELFT.

In 2012, they set up four prototype sites within the Trust to test QI methods, allowing the staff complete freedom to choose topics for QI projects. In fact, some executives were initially resistant to several of the chosen topics – for example, to reduce inpatient violence on the wards – because they feared the projects would fail. But these QI projects ended up being among the most fruitful efforts.

“When people came to me, I didn’t want them to [work on reducing violence] really,” said Dr. Cleary. “I thought, it’s too difficult, it’s too hard, and it’s not going to work. And they proved me wrong.”

ELFT leaders also organized a series of visits for their executives to observe other organizations that had implemented QI. Site visits included Scotland, Salford Royal NHS Foundation Trust, Tees Esk & Wear Valleys NHS Foundation Trust, and Qulturum in Sweden. In addition, three executive directors and about a dozen clinicians attended the 2013 International Forum on Quality and Safety in Healthcare, a large annual conference hosted by the *British Medical Journal* (BMJ) and the Institute for Healthcare Improvement (IHI).

Throughout this time, ELFT leaders continued to talk with their board of directors, with the staff, and with their senior physicians about moving forward with formal QI training. Persuading the board took some work. According to Dr. Shah, there is limited evidence to support the business case for QI in mental health and community services, and it was new and unfamiliar, so from the board’s perspective, it seemed to present some degree of risk.

For the most part, the staff were quite receptive, although a few doctors were wary of any program that told them how to do their work, or suspicious that it was just another way of trying to cut costs. Paul Binfield is ELFT’s head of “people participation,” which means that he and his staff of 14 support and advocate for service users and carers to hold the Trust accountable. According to Binfield, in the NHS, “Every couple of years, the government will come up with a new way of doing something, and everyone knows it will drift away. I think the initial big barrier was to really get across to our staff... [that QI] is going to be the way that we will work. It’s not just a fad or a phase.”

The leaders invested an entire year in engaging staff, to give people an opportunity to learn, hear stories about QI from elsewhere, and allow them time to adjust to the new direction the organization was taking.

## A Commitment to Train Staff in QI

By 2014, the Trust had made a long-term commitment to QI and began working closely with IHI. (In 2015, they became an IHI Strategic Partner.) ELFT established an organizational mission to provide the highest quality mental health and community care in England by 2020.

They developed two stretch aims to help them toward the mission. One was to reduce harm by 30 percent each year, prioritizing inpatient violence and pressure ulcers, because these were the most frequently reported incidents across the Trust. The other aim was to provide the right care at the right place at the right time. The thinking behind these two aims was to enable all staff to align their improvement projects to these. They also wanted to cover quality broadly, rather than restrict improvement activities to safety and efficiency.

In support of these aims, the Trust purchased an organizational subscription to the IHI Open School, providing access for all staff to online courses in QI, patient safety, and leadership. The Trust also began offering IHI's Improvement Science in Action (ISIA) course to staff, an intensive six-month program designed for people actively involved in health care improvement projects. With a unique hands-on approach, this course provides a firm grounding in improvement concepts and methods. After an initial three-day, face-to-face meeting, teams participate in web-based sessions and two further all-day learning sessions, which provide opportunities to extend their learning and gain feedback from faculty and colleagues as they apply their new skills.

IHI delivered the three-day workshop at the start of the Improvement Science in Action course at the Trust. In the first offering of the course, anyone on the staff at ELFT was encouraged to register and attend. Each staff member who attended would have an improvement project in mind. A team would be formed for the project, and one or two members of the project team would attend the training, then lead the project and share the learning with other team members.

Over the last two years, the process has become slightly more strategic and directed. First, everyone in a management position is expected to undergo QI training. Second, the leaders in each part of ELFT assess their improvement capability, and then determine who among their staff needs training. There are now clearer strategic priorities within each part of the organization, to which QI projects are aligned.

The Trust has also now developed more learning options, such as an in-house classroom-based training called Pocket QI, which teaches the basics of QI in two half-days for staff who either can't commit to the six-month course or want the essential skills of QI in order to get involved more immediately. In one year, more than 300 staff have completed Pocket QI.

ELFT implemented a new Improvement Coach program with IHI in 2015, through which the Trust initially developed 29 QI coaches. These coaches have full-time clinical or administrative roles, but are freed up for one day a week to coach a portfolio of QI teams. ELFT now has 45 QI coaches in total. Over the last three years the Trust has also been building internal expertise through IHI's Improvement Advisor Professional Development Program, and currently has six graduated Improvement Advisors, with more in the pipeline.

This internal capability enables ELFT to pursue its quality journey with increasing independence. The Trust is now on the sixth offering of the ISIA course and, by design, ELFT faculty have been teaching the course without support from IHI since the fourth offering. To date, more than 600 ELFT staff have undergone the training.

IHI continues to hold bimonthly virtual coaching calls with ELFT executives and improvement leads. These calls form part of the strategic guidance coaching as part of the Strategic Partnership support from IHI.

## Transforming the Culture

Beyond the QI training for staff throughout the organization, ELFT leaders made a conscious and dedicated effort to also transform the culture of the organization, reinforcing and facilitating the formalized training activities.

Leaders stated unequivocally that the Trust would be going in a new direction. At a monthly gathering of senior medical staff (called consultants in the UK), Dr. Cleary explained that the Trust was adopting QI as its approach, and that they would like the consultants to play a lead role in this shift. He acknowledged that not everyone may embrace this change, and said that they would help those who felt unable to be part of the new culture to move on. (Ultimately, no one has left as a result of the QI adoption.)

But, perhaps counterintuitively, this clear vision from the top coexisted with a very open, non-hierarchical approach. The leaders decreed that all staff had to adopt this approach — but the approach itself was one that empowered the frontline staff.

“You have to create the environment and the support that allows people to do this,” said Mr. Binfield, who is also a service user. “The best way is to let go of some of that control. The frontline team, they’re the best ones to solve it. Give them the skills and the support they need, rather than sending an email and saying everyone needs to do this by tomorrow.”

In the first year, the people who attended QI trainings enjoyed total discretion in choosing the focus of their projects. (The leaders later imposed some guidance in order to emphasize certain organizational priorities, but teams remain relatively free to use QI to tackle what matters most to them and their service users.)

ELFT leaders also made it clear that the main goal was not to cut costs, but to improve care — and if that required additional upfront costs in some cases, so be it. Then, ultimately, some of the projects would result in greater efficiency, which might save money as a side effect. “I think it’s important that we didn’t stress that we were out to save money,” says Dr. Cleary, “because once people think that, it distorts the message.”

One good example comes from a team working on keeping patients from gaining weight. The average patient staying on a ward will put on weight, partly due to drugs, partly as a result of being less physically active. The team — which includes a psychiatrist, mental health nurses, a dietitian, and service users — came up with a range of change ideas, such as dietician inputs and regular weigh-ins. Then the team looked at food provided by an external caterer. They determined that covering the fish with bread crumbs rather than batter would cut calories and also save money. “You would never have come up with that idea unless you had a group of people looking at it,” says Dr. Dudley Manns, Clinical Director and consultant psychiatrist. “To this day, our caterers have moved to breaded fish.”

The executives also made sure to be very visible in the effort. They undertake three Executive Walkrounds each week in pairs, listening to the views of staff – what staff are proud of, what gets in the way of them delivering great care, and how executives could help staff.

Another important step was the inauguration of quarterly quality meetings to discuss progress, attended by the CEO, all the executive directors, and the service and clinical directors. “We made it clear that we were going to focus on quality,” says Dr. Cleary, which includes an active dialogue during the meetings about improvement projects and key measures of results, and not just staring at a bunch of reports on paper.

There has been a learning curve at these quality meetings. For example, Dr. Navina Evans, the current Chief Executive and formerly Director of Operations, notes that at first some staff members felt uncomfortable in the meetings. Inevitably, some of the QI project teams were more successful at making progress toward their aims than others, and although nobody criticized or blamed the less successful teams, members of those teams still felt a little chastened when the other teams were praised.

“We then looked at what we were doing [during those meetings] that was making it feel like you’re coming before your boss to report on your project,” said Dr. Evans. They have now changed the tone and the style of the meetings to be more conversational, focusing on telling stories. They tried to think of the QI project updates in terms of learning what works well. “Every team has something that they’re doing well,” says Evans.

Dr. Bob Lloyd, an IHI Vice President who has taught many of the ELFT improvement trainings, found the establishment of a “quality room” at the corporate headquarters particularly telling. The Trust hired a professional artist who drew cartoons and pictures on the walls, renderings of the PDSA (Plan-Do-Study-Act) cycle and the Model for Improvement, and a drawing of Dr. Lloyd teaching. The quality staff meet in this room, and people are invited to go there to take breaks, relax, and reflect on quality. There is a screen to watch videos related to quality. Overall, it sends a strong message that quality is a priority to the organization.

## A Portfolio of QI Projects

ELFT now has about 200 QI projects underway. These projects focus on a wide variety of topics: improving access to services in the community, improving medication safety, helping service users feel more confident after discharge from inpatient care, improving the recruitment time for new staff, and preparing service users for employment, among others. Staff are highly committed to their projects, test continuously how they can more meaningfully involve their patients, service users or customers in their projects, and the senior leaders pay close attention to the progress of projects.

Two of the most successful QI projects to date have focused on reducing violence and noise on the ward.

### Violence Reduction

According to Mr. Binfield, “It’s always been expected that you’d have a certain number of violent incidents on a ward, and there’s not much we can do about it.” Indeed, as mentioned above, some of the executives tried to persuade the staff not to tackle violence as their QI project because they thought failure was likely.

But the staff were determined. Globe Ward, one of four acute admissions wards in the borough of Tower Hamlets, had a high level of violence, experiencing more than 40 incidents of physical violence per year. This ward was therefore selected as the initial test site for work to reduce violence.

Globe Ward developed a specific aim to reduce violent incidents by 30 percent by the end of 2012. The ward set up a small project team that included nurses, allied health professionals, doctors, and administrators. To generate change ideas to reduce violence, the staff held a large facilitated workshop, including staff of all levels, service users, and the police liaison officer.

The team identified some key changes to test:

- Two change ideas to predict and manage violence:
  - The Brøset Violence Checklist, a simple risk assessment tool to predict the likelihood of violent behavior in the next 24 hours by assessing behavior such as boisterousness and verbal threats; and
  - Safety Huddles, which are brief stand-up meetings, during which as many staff as possible come together to discuss safety issues and then the team immediately identifies and allocates any actions to mitigate risks.
- The team displayed “safety crosses” in the public area of the ward — a simple wall calendar that staff mark in color to show red days (when an incident of physical violence occurred) or green days (when no incident took place). This makes the state of safety on the ward very transparent and also manually records incidents, which was valuable because there had been under-recording via the electronic system.
- The team began having a safety discussion during ward community meetings, in which patients and staff are invited to talk about any emotions they experience related to violent incidents.

Implementing these changes, and refining them through iterative PDSA cycles, Globe Ward surpassed its aim, reducing violence by 85 percent — from four incidents per month during the baseline period of January through April 2012 to 0.5 per month by October 2012.

This success led to the Tower Hamlets Violence Reduction Collaborative in January 2014, in which all four acute admissions wards and two psychiatric intensive care units in Tower Hamlets participated. The aim of the Collaborative was to reduce violence by 40 percent by the end of 2015.

There was a 40 percent reduction in physical violence across all six wards, falling from 12.1 incidents per 1,000 occupied bed days in 2014 to 7.2 in 2015. These results have been sustained for more than 12 months, since mid-February 2015. Moreover, the overall estimated costs related to violence reduced from £949,045 in 2014-2015 to £767,749 in 2015-2016, reflecting an estimated cost savings of £181,296.

When the violence began to decline, a virtuous circle was set in motion. The staff satisfaction went up. “It’s a more pleasant place,” said Mr. Binfield. “You can feel the difference when you go on the ward.” And, in turn, lowering the overall stress level on the ward probably further decreases the chances of violence. According to Professor Warren, “It’s been fantastic, world-leading work.”

## Noise Reduction

Wards at times, especially for older people, can be noisy, which can disturb people and make them agitated.

Another QI project, which grew out of the violence-reduction QI work, aimed to reduce the level of intrusive background noise on an older adult mental health ward. The team's theory was that reduced background noise would lead to reduced agitation, and thereby to decreased incidents of violence. Thus, the team identified two primary measures for their QI project: decibel levels on the ward, and agitation as manifested in incidents of violence.

The ward formed a team of frontline staff, led by nursing staff, and invited carers of people with dementia on the ward to join. They used a noise meter app to monitor background noise levels on the ward and established a baseline measure. They also surveyed staff and carers to identify areas for improvement. Change ideas included the continued use of the noise meter on the ward to monitor noise levels, posters to remind staff about noise levels, a visual indication of current noise levels (the Yacker Tracker), relaxing background music, and environmental modifications such as putting rubber and foam pads under chair legs.

Using PDSA cycles, the improvement team tested many of these ideas over the course of nine months in 2015. Specifically, the aim was to reduce noise levels from above 60 decibels to below 50 decibels. They succeeded in decreasing noise levels on the ward to 53 decibels on average.

Many of the interventions were low-stakes with little risk of unintended consequences, which made them easy to test. The staff have now incorporated the changes into routine practice and are advising other wards on similar QI projects.

These improvements have a direct impact on patient experience and, like the improvements to reduce violence on the ward, also make the Trust a nicer place to work. "You can hopefully just relax and chill out a bit," said Mr. Binfield.

## Broader Organizational Changes

Stemming from the activities of the specific QI projects, and the explicit efforts to change the organization's culture to infuse improvement into daily work, there has been a broader transformation that seeps into every part of the Trust.

One key change has occurred at the leadership level. According to Professor Warren, "Over the last four or five years we've moved from, 'If only the nurses were as good as I was when I was their age, then everything would be OK'... We've made that leap to say we think our staff are fantastic. If they are not thriving, then it is us [leaders] who are not creating that milieu in which they can thrive. That then leads to different conversations with our staff. It allows you to listen with fascination to your staff, and respond with empathy."

The change in attitude also affects the way the executives interact with one another. If an executive is not exhibiting the new standard of behavior, one of the others will take him or her aside and talk about it. "We've become rather good at policing each other around that [expected behavior], having honest conversations," Warren notes.

And at least partly as a result of this change in leadership behavior, the attitude of the staff has also changed. Warren says that clinicians “have much more trust that we want them to focus on quality. I think they believe that they can make changes in their environment and we will support them.”

Jennifer French, a music therapist and now a QI coach, agrees. “People have said, look, if you’ve got a good idea, put a plan together and give it a go. They feel that they’ve been given permission to do what they do best.” She adds, “Some of these [ideas] result in more efficient processes, but you never have a feeling that it’s a cost-cutting exercise.”

Even the service users are more engaged. There’s a new level of communication and transparency. For example, on the wards, if a service user is restrained, an immediate debrief is required. Occasionally a service user will approach the staff and say, “Hey, you forgot to do this [debrief].”

As a result of this confluence of factors — the support from leadership, and the results of the improvement projects that make it a more pleasant place to work — staff engagement and satisfaction have soared at ELFT. In many domains it’s the best in the country.

Improvement thinking and methodology have also begun to permeate every level of the organization. The staff have begun to use tools such as affinity diagrams, process mapping, and force field analysis in settings outside the projects, such as team meetings. “One of the real benefits was the applicability of the tools,” says Ms. French.

And the thinking is not even limited to the work setting. According to Dr. Evans, “It’s constantly in my mind. I’ve started to apply it to how quickly I can get from bed to the gym in the morning.”

Ultimately, the work has resulted in a staff that’s enthusiastic, energized, and proud. Ms. French says, “I’ve not seen anything like that in my working life. I’m always bowled over by the can-do attitude. The sense that there are resources and support for staff... I do think that what’s going on in ELFT is really special. And I’m delighted to be a part of it.”

