Avon and Wiltshire Mental Health Partnership Trust (AWP)

Interim review of progress towards organisational change report

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Narrative Summary

1. The review team consisted of two of the authors (Dr Stephen Colgan and Sue Sutherland) of two previous reports (dated January and June 2012) concerning governance and management arrangements at AWP. We visited the Trust on the 30th April and 1st May 2013 at the request of the newly appointed Chief Executive Iain Tulley and a representative of the commissioners, Anthony Farnsworth, to undertake an interim review into progress against key changes that were recommended in our earlier reports.

2. The review was conducted by undertaking semi structured interviews with 16 key staff including:

- Chairman
- 1x Non- Executive Director
- Chief Executive
- Medical Director
- Nurse Director
- Finance Director
- Director of Operations
- Interim Director of Business Development
- Swindon localities team Clinical Director, Acting Managing Director, Lead Nurse and previous localities manager
- Swindon crisis team leader and a Band 6 nurse
- 2x Clinical Directors
- Deputy Director Contract Commissioning – Commissioning Support Unit

Three of the above staff were had been interviewed by us previously; the remaining 11 were unknown to us.Teninterviewees were recently appointed to posts within the new Executive, Board and Clinical Directorate structures.

2.2 We reviewed a range of documentation including:

- Chief Executives Review of Executive, Board and Clinical Directorate Structures – A Formal Consultation
- Integrated Quality Improvement Plan
- Quality and performance dashboard March 2013
- Trust Board Assurance committees, quality assurance framework and assurance mapping May 2013
- Details of key quality indicators for 2013/14

2.3 We also had the opportunity to see a demonstration of the Quality Information System, collecting up to date performance information across a range of services.

2.4. Our detailed findings are referenced to the relevant recommendations in our previous reports and are included in the table attached at Appendix A. These are also summarised below, with additions relating to the Trusts key drivers.

3. Quality

3.1 There has been a significant change in organisational culture since our last visit with all clinicians reporting a genuine focus on the quality of services rather than the relentless drive to achieve targets. Both clinicians and managers appeared re-energised to tackle problems and provide high quality services.

3.2 The current year's contract for service includes only those targets that are genuinely linked to measuring and improving qualityand are well understood by staff who see them as clinically relevant.

3.3 The Trust is about to publish an integrated quality improvement plan which brings together and simplifies recommendations from various reviews and will provide a much clearer focus for staff on those issues to be managed and delivered.

3.4 The Trust Board is implementing a revised quality assurance framework in which a soon to be established multi professional clinical academy and clinical cabinet will engage clinicians in the whole quality improvement structure and processes. These initiatives will be led by senior clinicians with front line clinical credibility.

3.5 The Trust has implemented an extremely impressive team based Information Quality System which is populated by clinical teams and which focusses on the 'must do' quality activity. This has been accompanied by a genuine willingness to hear the 'bad news', and not persecute the messenger.

3.6 It was not the purpose of this review to test out detailed quality outcomes but we did note that the Trust had made a significant improvement in the proportion of patients subject to the Care Programme Approach (CPA).

4. Clinical Engagement

4.1 There has been tremendous progress with senior doctors engaged in leadership roles and decision making throughout the organisation. This is particularly impressive given the significant level of disaffection which we encountered when undertaking our previous reviews. The catalyst for this has been the emerging change in culture, the changed management structure, the redefinition of the role of the medical director to allow a much greater focus on quality which has been received well by clinical colleagues and the realisation that clinicians can make a real difference to the delivery of high quality care. We were impressed by the enthusiasm, commitment and quality of these new leaders.

5. Localisation

5.1 The new management structure aims to decentralise leadership to give real autonomy to the localitiesand to support and enable their work bysmaller supportive central functions. This coupled with a new culture of openness and inclusivity has changed the Trust from the centralist top down controlling bureaucracy which we witnessed early in 2012 to an organisation that is now openly focussed on the delivery of the best possible care at the front line using devolved management arrangements.

5.2The Trust has understood the importance of local relationships with GP's and social services in the delivery of care, which has been further emphasised by the emergence of the Clinical Commissioning Groups (CCG). The Trust has replaced the previous management structure with a locality based model that will address many of the concerns that we expressed previously about the delivery of seamless care. Whilst it was evident that CCG's were confident in the new arrangements, it is still very early days and the Trust should focus on really understanding through appropriate channels of communication the detailed needs of their many and varied stakeholders and acknowledge and deal with them accordingly.

5.3The Trust Board has recently commissioned a workforce review. As a consequence of the findings,which, amongst other things, identified a greater proportion of staff in back office functionsthan comparator Trusts, has agreed to disinvest in centralised Headquarters' functions and reinvest in staff in localities.

6. Transparency

6.1 The importance of transparency was evidenced by the Trust's action to publish our first report 'Review of Governance and Management Arrangements – January 2012' internally to senior managers and others. Given that the report was critical of the Board and Board level directors this was both a courageous and symbolic act and indicative of a new Chairman who believes in openness and inclusivity.

6.2 More recently the Trust has consulted openly and widely on a number of change projects and has fed back on the decisions they have reached - 'this is what we are going to do and why' - which has been very well received throughout the organisation.

6.3 In designing and implementing the team based Quality Information and performance reporting system the Trust have ensured that the results are widely available for scrutiny, thereby enabling teams to review their own performance and benchmark it against others.

7. Conclusion

7.1 At Trust and locality level we observed the organisation to be completely different and unrecognisable from our previous visits in a very positive way. The recent restructure was consulted on and completed quickly and effectively, has broad support and is seen to enable improvements in care quality not least by simplifying care pathways and offering opportunities for improved stakeholder engagement. It has also clarified to external stake holders as to who is the responsible person, the 'go to person', when issues arise.

7.2 There was universal support for the new Chief Executive and newly appointed Chairman and recognition that they had very quickly changed the culture from 'punitive to supportive'. We evidenced the culture to be open, honest, transparent,and supportive and focussed on the delivery of high quality care. The other key players that were seen by others as instrumental in delivering the change process are the Medical Director and Director of Nursing.

7.3 The people we interviewed were open, energetic, committed and excited about the future. There was evidence of a mutually supportive executive team who were extremely focussed on the quality of care but who understood the importance of setting the framework and then enabling and positively supporting others to deliver. We were also particularly impressed with the change to the Swindon Crisis Team, who following our previous visit had implemented a number of initiatives, driven by a very able manager, achieving transformational results.

7.4 Clinical engagement is very evident through clinical directors and lead clinicians who feel involved in decision making and who value their significant newly gained autonomy to act.

7.5 There was an absolute acceptance that whilst there will be challenges aheadthe directors intend to maintain open, honest and trusting relationships through the organisation and performance manage in a constructive and supportive manner to enable the optimum delivery of services going forward.

Appendix A

Avon and Wiltshire Mental Health Partnership Trust

Interim review of progress towards organisational change report

May 2013

Independent report (Jan and Aug 2012) recommendations	Interim review evidence	Conclusion and Recommendations
1a The Board should refocus and change the Trust's culture from a top down centralist bureaucracy to a culture of clinical primacy, inclusivity, engagement and high quality performance ownership. Jan 2012 1b The Board of AWP needs to change the Trust culture from one that is ~~a~~ target driven, top down, centralist, bureaucratic and dictating to one which is open and inclusive, where the patient and quality of service is at the heart of its business and all staff and partners are engaged in the design and delivery of high quality care. Nov 2012	In November 2012, the Board appointed an experienced Chief Executive with the necessary leadership skills and behavioural attributes to lead the organisation in an open and inclusive manner going forward. In December 2012 the Chief Executive reviewed, consulted on and has subsequently replaced Executive, Board and Management structures. The Executive structure includes the appointment of a new Medical Director and Directors of Operations, HR and Business Development. The Director of Nursing (previously the Director of Nursing, Compliance, Assurance and Standards)now holds a joint responsibility forstrategic clinical and professional leadership with the Medical Director in	The Board have clearly made excellent progress in appointing a new Chief Executive and he has very quickly established an energetic and committed team of Executive Directors who were all enthusiastic and supportive of the changed structures and who demonstrated a real commitment to working in an open and supportive manner. Without exception everyone commented that there had been a positive culture change at Trust and locality level but realism that it will take longer to embed fully.

	recognition of the fact that improving the quality of care requires a multi professional approach. The new devolved management structure is largely based on 7 locality units each led and managed by a clinician of which 6 are doctors and who are each supported by a managing director and a head of performance and practice. The 2013 Contract for Service includes nationally mandated targets and a small number of CQUIN targets all of which are seen to be relevant to the quality of care. The Trust has a new Integrated Quality Improvement Plan based on 7 key indicators and designed and implemented a Trust wide electronic Quality Improvement data system which captures relevant data at team level and which is then open for scrutiny and use by all. The Trust Board took the decision to reduce the financial surplus target by £400k to reinvest directly in quality improvement and in addition will seek to reallocate up to £4m from back office functions to front line clinical services in a further commitment to support the delivery of high quality care.	The Board needs to accept that achieving a comprehensive change of culture and associated improvements in service delivery that are embedded in all localities and at all levels may not be evident for 12 months or more. This means that the Board must: • sustain momentum for its change programme • continue to role model the required behaviours • have confidence in its devolved model of decision making and trust and support locality leaders by giving them the autonomy to act and holding them to account sparingly. The non-executive directors must: • have confidence in the leaders they have appointed and concentrate on challenging and scrutinising processes and outcomes without getting involved in the detail. The Board should decide how and when it intends to test out whether change is fully embedded.

2. The Chairman should review both the executive and non-executive skills on the Trust Board to ensure that there is the requisite leadership skills and ability to lead the change in culture, with an appropriate emphasis on the challenge and scrutiny of clinical quality and safety of care.	On his appointment the Chairman reviewed the skills, knowledge and behavioural attributes required of the whole Board to deliver the necessary leadership going forward. This led to an overall reduction in the size of the Board and the appointment of a new Chief Executive, a new Medical Director, Directors of Operations and Human Resources. The non-executive component of the Board was enhanced by the appointment of an associate director with a significant clinical and managerial career in the NHS. All new leadership appointees were required to demonstrate an ability to communicate with openness and transparency. The Chairman and the Chief Executive are so committed to the importance of the behavioural attributes that they require in new leadership post holders that they have failed to recruit on some occasions. Executive and Clinical Directors have personal development plans, including coaching, in place.	One of the most important roles of a Board is to appoint the Chief Executive. Iain Tulley's appointment has been fundamental to the very real change that is evident and which has been warmly welcomed by all those we interviewed. The failure to recruit to both Board and locality leadership posts on some occasions has sent a very positive message to the organisation that the Board is serious about the change in culture. One clinical director told us that it was a failure to appoint that made them realise that the change was 'real' and they then applied for the CD post in a subsequent round. It is early days in the use and engagement of clinicians in front line leadership positions but a very positive step forward. The Board must enable their success by: • being patient • providing support and encouragement • celebrating success by 'naming and championing' • holding them to account via Quality Improvement system outcomes • continually reviewing their development needs to ensure that they are fully supported to deal with future challenges.

3. The performance management culture and framework in AWP needs to be changed as a matter of urgency from one that is punitive and threatening to an approach that is honest, constructive and supportive and celebrates success.	The previous performance management arrangements have been suspended and the localities currently held to account on quality and finance via the Quality Information system. The Executive team intend to hold quarterly performance management meetings with localities. Both the Executives and the Clinical Directors are committed to using a style that is supportive, constructive and celebrates and shares success. Previous 'safety' walkabouts by Board members have been re-energised and are now focussed on quality. They engage local staff by listening to their concerns and are seen as supportive rather than punitive visits.	Performance management is now focussed on a significantly decreased number of targets that are directly relevant to patient care and quoted as 'feels like staff are managing their own performance' and (targets)' are a part of what we do, not the be all and end all' This is a very significant improvement on the 'draconian' performance management we reported on previously and encourages grass roots performance ownership. The Trust's leaders must ensure that this positive, supportive and encouraging style of performance management is embedded throughout the organisation and that it is not possible during challenging or deteriorating performance for any individual or team to return to a non-constructive and punitive approach.

4.AWP and its commissioners need to work together urgently with social care to agree a revised set of clinically evidenced KPIs, withdrawing KPIs that have little or no clinical validity, and consider how financial penalties can be structured to motivate and improve service rather than be used as a threat with counter intuitive consequences.	The 2013/14 Contract for Service includes only the mandated nationally required targets and a small number of CEQUINS targets that are supported by the clinicians. In addition the Trust has published a revised Integrated Quality Improvement plan of which there are just 7 indicators: • CQC outcomes • CQUIN targets • Clinical records standards • Supervision and • Staff absence • Budget control • Service user/carer feedback. The plan is supported by a newly implemented Quality Information system which was consulted upon and which requires the input of data by locality based staff but which is open for scrutiny by all staff.	This is a very significant achievement by both the Trust and the commissioners and has been pivotal to supporting a change in culture, improving staff morale and enabling a real and proper focus on the real drivers for quality. As one front line member of staff said ' targets are a part of what we do now, not the be all and end all, and they are seen as linked to care and are relevant to me as a care worker'. The timing of the restructure meant that it was only possible to involve clinicians in the periphery of contract negotiations this year. We recommend that clinicians are more actively involved in future contract negotiations moving forward. Whilst it was evident that CCG's were confident in the new arrangements, it is still very early days. We recommend that the Trust should focus on really understanding through appropriate channels of communication the detailed needs of their many and varied stakeholders and acknowledge and deal with them accordingly. The QI system is in its early stages but appears to have been warmly received and has greatly simplified the number and range of quality performance indicators that were previously in place.

5. AWP should aim to increase the proportion of time patient-facing staff are able to spend with patients by reducing the burden of data collection and input and in addition consider introducing mobile hand held technology so that data can be collected and input in conjunction with patients and carers.	The reduction in the number of targets has decreased the amount of data collected. Mobile technology is being introduced with 200 laptop/tablets etc. in place and a further 1000 due for distribution. Staff are still not entirely content with the patient information system (RIO) and it is not surprising that there is still a view that staff still spend too much time on data entry. This is being actively considered by executive directors, the clinical systems group and locality teams with a variety of solutions being considered.	The introduction of mobile technology for front line and other staff is a significant achievement and will enable the input of data, such as care plans, in conjunction with patients and carers and in 'real time' further improving quality of care whilst reducing staff time. The data entry requirements of the new Quality Information system are not considered to be onerous and have been offset by a reduction in other data and the benefits of being able to review and benchmark performance. We recommend that the Trust keeps under review the burden of data collection on front line staff.
6. AWP would benefit from the appointment of a skilled and experienced social care leader at director level in the organisation who might also act in a lead professional role.	The Chief Executive has plans in place to appoint a Head of Social Work, reporting to the Director of Nursing, located in Wiltshire but supported by all 5 other Local Authorities. In addition there is good progress on Section 75 agreements.	This is another example of swift and pertinent action that will improve partnership relationships in the long term.
7.The Trust must improve the, consultation, dialogue and speed of organisational change in order to ensure that the burden of implementation does not detract from a focus	Since December 2012 the Trust has consulted on and implemented: • a revised management structure • a Quality Information system	Very significant and fundamental change has been delivered extremely quickly, competently and with overwhelming support.

on the day to day delivery of safe clinical care and staff support.	• the introduction of mobile technology	All of the changes have been welcomed positively by staff.

8. The Board must design, consult on and implement a comprehensive clinical engagement strategy.	The Board have appointed a new Medical Director and 6 out of 7 Clinical Directors are doctors. The Medical Director has published a revised structure and process which includes proposals for a multi professional clinical cabinet and clinical academy to engage clinicians in the development and management of quality assurance. The academy is not yet formed but its Head has recently been appointed. There is a formal network of lead clinicians in localities and in addition we heard about the informal development of networks that come together to solve particular problems.	All of the doctors we interviewed told us that there was now comprehensive clinical engagement and that the clinicians felt empowered and involved. There was great sense of excitement and opportunity and that there was an enthusiasm to make the Trust a success. Recommendation –see Point 2, Page 9
9. In developing a clinical engagement strategy the Trust must include the need to engage its own clinical staff to work with commissioners to both reduce and simplify the number of KPIs / performance targets, using a clinical evidence base for contracting that focusses on delivering real quality including patient safety. These measures need to be simple, understandable and intuitively relevant to the task in hand so as to bring broad clinical credibility and engagement to the management processes	The Clinical Directors have recently been appointed so were not able to be involved in the current year contracting round but the locality structure encourages close relationships with commissioning groups and they will be fully involved from now on. The Board invites Clinical Directors to participate in Board meetings. The Chief Executive is championing and leading by example a 'back to the floor' initiative to enable 'back office' staff to work	The doctors interviewed told us that 'targets are no longer a weapon' that they were happy that previous unnecessary targets had been dropped and they were very enthusiastic about the new Quality Improvement framework and the Quality Improvement system. The 'back to the floor' initiative is a commendable way to refocus all staff on the reality and importance of front line care and

	shifts in the clinical service..	should be encouraged and embraced.

10. The Audit Committee and the Board should scrutinise all the risks recorded in all the organisation's risk registers and make judgements about the number of risks, their grading and whether the mitigations are robust.	The Board has had oversight and is satisfied with risk management processes. The Audit Committee has reviewed all risks and has satisfied itself about risk grading's and mitigating action. Going forward risk registers are now locality based and are reviewed by the Quality and Standards committee.	It is reassuring that the Board have now seen all of the risks previously listed and have revised governance processes in place to provide assurance going forward.
11. The Trust needs to have a more rigorous plan for incident reporting if lessons are to be learned in a timely and productive fashion. Ideally the new incident reporting system should be integrated with the RIO clinical record system. Integration issues need to be addressed prior to implementation.	The incident reporting system is now completely electronic and the data entry backlogs that we noted previously have gone. All incident reports are seen within 24 hours by the Medical Director to enable any urgent response. Serious untoward incidents are subject to route cause analysis. The Medical and Nurse Director have consulted widely on a revised quality assurance framework process that will ensure that key critical systems, such as incident reporting are fully embedded in robust governance arrangements that maximise quality improvement.	This is a huge improvement on our previous visit and provides assurance that the incident reporting system is more robust.