

USING QUALITY TO DRIVE TURNAROUND

This case study explores how placing quality as a top priority of the board and therefore the organisation can contribute substantially to financial as well as quality turnaround.

This case study also links to the dilemma 'board effectiveness when things go wrong'.

Royal Wolverhampton Hospitals NHS Trust

The Royal Wolverhampton Hospitals NHS Trust provides secondary care services to the City of Wolverhampton and tertiary services to the Black Country and South Staffordshire, covering a population of 1.1 million. The Trust has a turnover of £290 million and employs 5,000 staff.

In 2004 Royal Wolverhampton Hospitals was £17million in deficit and had a cumulative debt of £37 million. In the same year, it received a damning Health Care Commission report on maternity services in the Trust. It was also ranked as the third worst hospital in the country on health care acquired infection control.

In light of this performance, two of the non-executive directors offered their resignation. However the chair and three of the non-executive directors of the Trust did not recognise their accountability for these problems and ultimately were asked to step down. A new but very experienced chief executive was appointed, and he, in turn replaced most of the executive team, also with experienced directors.

So, one key step on the way to recovery was making sure that there was the right executive and board leadership in place to move the Trust forward. It did, however, take some time for the non-executive leadership to be appointed, which meant that the initial strategy and approach was executive driven.

The new leadership identified the need to reduce the number of staff by 500, close 200 beds and four operating theatres. In order to achieve this, they identified that average length of stay needed to reduce by 1.9 days and day case utilisation needed to increase substantially. The method of achieving these changes was what differentiates this Trust. The whole organisation was engaged in improving clinical outcomes, productivity and improving safety and efficiency. This included a real focus on:

- **Staff engagement** – through an exercise called ‘Listening into Action’, in which staff feed in their ideas for service improvement, and action is taken to implement these. The message to staff, including clinicians, is about stopping harming patients and improving quality rather than about saving money.
- **C Difficile:** there was a high mortality rate. The leadership pursued driving down C Difficile rates across the organisation to close to zero. This focus has resulted in 212 lives and £8 million saved.
- **Patient safety:** including dealing with slips, trips and falls as well as having zero tolerance of ventilation acquired pneumonia and central line infections. There is a real focus on improving mortality rates. Mortality has reduced from 111 to 92. Perinatal mortality has reduced from 13.1 to 8 per 1000 births.
- **Low Health Care Acquired Infections (HCAI) in personal objectives:** The aim of zero HCAI is now reflected in the personal objectives of all senior leaders, including clinical leaders.

As well as demonstrable improvements in all aspects of quality (outcomes, safety and experience) the Trust now has a cumulative surplus of £27.2 million and is progressing through the Foundation Trust (FT) application process.

What has been the role of the board in this transformation? It has taken until 2008 for the board to be up to full complement. With an eye on FT, many of the non-executive directors bring a commercial or financial perspective. So there has been a real shift in focus and expectation to quality for many of the NEDs. Board members do recognise the need to strike a balance between financial stewardship on the one hand and quality on the other and are supportive in championing this approach and commitment to quality.