

Board of Directors (in Public)

Item 3.8

Subject: NHS IMPACT Provider Self-Assessment
Date of Meeting: 29th November 2023
Presented by: Karan Wheatcroft, Director of Risk & Improvement
Purpose of Report: For Noting

BAF Reference	Impact on BAF
BAF 1 and BAF 2	Assurance on Trust Improvement culture and approach as assessed against NHS IMPACT criteria.

Level of assurance (please tick one) <i>To be used when the content of the report provides evidence of assurance</i>					
x	Acceptable assurance Controls are suitably designed, with evidence of them being consistently applied and effective in practice	<input type="checkbox"/>	Partial assurance Controls are still maturing – evidence shows that further action is required to improve their effectiveness	<input type="checkbox"/>	Low assurance Evidence indicates poor effectiveness of controls

1. Executive Summary

This paper provides a provisional self-assessment against the NHS IMPACT Criteria for discussion. The outcomes from the self-assessment provide relatively positive 'scores' reflecting the culture of improvement across the Trust. It is recognised there is still more to do in terms of a proactive approach to ensuring continuous improvement, and a cohesive view of this across the Trust.

The paper also includes the actions currently being undertaken and work still to do at LHCH and also in the wider ICS context. The Trust is actively engaged with the regional improvement networks to support progression against the IMPACT framework.

The Board of Directors is asked to review and note the self-assessment.

2. Background

NHS Impact has been launched to support NHS organisations and integrated care systems to have the skills and techniques to deliver continuous improvement.

At Amanda Pritchard's leadership event on 19th April 2023, ICB and provider CEOs, and Regional Directors requested that an NHS IMPACT Self-Assessment tool be made available. This is designed to help systems, providers and partners understand where they are on their journey to embed NHS IMPACT. It will allow organisations and systems to identify their strengths and opportunities for development when applying an organisation/system wide approach to improvement.

3. NHS IMPACT criteria

The NHS IMPACT Self-Assessment is set against the five components of NHS Impact which underpin a systematic approach to continuous improvement:

- Building a shared purpose and vision
- Investing in people and culture
- Developing leadership behaviours
- Building improvement capability and capacity
- Embedding improvement into management systems and processes

When these five components are consistently used, systems and organisations create the right conditions for continuous improvement and high performance. The NHS IMPACT Assessment Criteria enables us to assess ourselves along a continuum from Starting; Developing; Progressing; Spreading; Improving & Sustaining against each of the five components of NHS Impact.

4. LHCH Self-Assessment

It should be noted that in some areas the criteria aren't always explicitly linked from each level so we have taken a pragmatic approach to determining our level whilst still recognising there will be actions needed.

The following is a summary of our provisional self-assessment for discussion. (The full Assessment Criteria and our provisional 'scoring' can be seen in Appendix B).

Standard	LHCH Level	Comments
Building a Shared Purpose & Vision		
1. Board and Executives setting the vision and shared purpose	Improving & Sustaining Our vision and shared purpose is well embedded and often referred to by the Board and other leaders, who are able to bring it to life and make the link between their team's priorities and improvement plans and the agreed organisational goals. Most of our staff can describe our vision and shared purpose in their own words and what they can do in their role to contribute.	Strengths: Staff survey: feedback; improvement programmes linked to objectives; well-led discussions with triumvirates; values well embedded Opportunities: Improvement umbrella view; connection to this; evidence of vision communication
2. Improvement work aligned to organisational priorities	Spreading Our organisational purpose, vision, values and strategic priorities are visible and understood by leaders, managers and most staff. Our organisational goals have been agreed and measurement systems have been established and are being used across most areas.	Strengths: Improvement work aligned to strategic & divisional priorities Opportunities: For it to be translated & understood; profile of improvement work
3. Co-design and collaborate – celebrate and share successes	Spreading We have an agreed plan for delivery at organisational level which is cascaded through line managers down to team level, based on an established engagement and co-development process and a common approach to improvement. Celebration and learning events are used to recognise and share improvements.	Strengths: We celebrate achievements/improvements Opportunities: Common approach? Systematically track improvement to team level
4. Lived experience driving this work	Progressing Patients, carers, staff and the public are actively engaged in co-designing organisational purpose, vision, values and setting strategic priorities for improvement.	Strengths: Family & patient listening events; quality & safety priorities; follow-up telephone calls; strategy development Opportunities: Use Patient Safety Partners for more
Investing in People & Culture		
5. Pay attention to the culture of	Improving & Sustaining We have a reputation for having established a culture	Strengths: We have a good culture for

improvement	consistent with improvement, and we can evidence that with data (e.g. NHS staff survey). Teams and departments work collaboratively across organisational boundaries to deliver improvement which benefits people using services and unpaid carers. We recognise leaders, managers and staff who are role models for the kind of behaviour and culture we want to create.	improvement; reputation for culture etc; Improvement training – leadership & preceptorship Opportunities: We could proactively do more – induction etc
6. What matters to staff, people using services and unpaid carers	Progressing Most of our services and functions have a good understanding of what matters most to staff, people using services and unpaid carers (e.g. through two-way engagement) and this informs their local improvement priorities and activity. Our staff have a voice at Board level to provide feedback on how it feels to work here (e.g. through staff stories, informal interactions, staff networks). Leaders and managers help to translate the needs of patient and carers into improvement priorities or goals.	Strengths: Two-way engagement Opportunities: staff stories not used as much as they could be; knee-jerk rather improvement approaches; where does the improvement come from? CI culture – wider involvement
7. Enabling staff through a coaching style of leadership	Progressing A coaching style of leadership is well established with training available for leaders and managers who request it. Leaders and managers are widely engaged in improvement and regularly sponsor improvement activities (e.g. to help unblock issues). Senior leaders participate in improvement, celebration and learning events on a regular basis. Staff generally feel supported and empowered.	Strengths: QI Training – specific to teams; use a coaching approach; leaders & managers engaged Opportunities: systematic coaching/training (HR sessions) executive training; sustainable improvement
8. Enabling staff to make improvements	Progressing The majority of staff are actively involved in improvement activity and feel able to suggest ideas for improvement and to make changes in their own area.	Strengths: staff do improvement (maybe they don't know they do) Opportunities: Empower teams; consistent approach
Developing Leadership Behaviours		
9. Leadership and management development strategy	Improving & Sustaining Our Board focus on constancy of purpose through multi-year journey and executive hiring and development, including succession planning. Our Board are visibly linked to future planning at a system level.	Strengths: Board are sighted on all Opportunities: Not all staff have training
10. Leadership and management values and behaviours	Spreading Leadership values and behaviours are agreed, role modelled and supportively challenged when not lived up to.	Strengths: Challenge is there; OD work; FTSU Opportunities: pockets where not applied
11. Leadership and management acting in partnership	Spreading Our leadership team has shared longer term goals with network partners or commissioners as well as collaborative involvement over wider health economy.	Strengths: External work – cardiac board, cardiology collaborative with LUHFT, JSC, Liverpool Clinical Services Review Opportunities: multi-year journey with improvement – system not near it
12. Board development to empower collective improvement leadership	Improving & Sustaining Our leaders and managers – Chief Executive Officer through to front line demonstrate their commitment to change by acting as champions of the improvement and management method, by removing barriers and by maintaining a visible presence in areas where direct care / operational work is done.	Strengths: Leaders & managers are visible; in ops/clinical areas; champion improvement Opportunities: methodology; empowering all staff

13. Go and see visits	<p>Progressing</p> <p>Our Executives regularly 'walk the floor'/'go & see'; they incorporate the tools and methods into their meetings, strategic planning and daily management.</p>	<p>Strengths: Do go out into areas; use SPC in SOF</p> <p>Opportunities: Go See's for leaders – could have more of an improvement focus</p>
Building Improvement Capacity & Capability		
14. Improvement capacity and capability building strategy	<p>Developing</p> <p>Our improvement methodology has been agreed and the Board has undergone its own development to build literacy around improvement. Staff have access to induction on joining, improvement training and a small group of staff support capability building.</p>	<p>Strengths: Offer is there & training is available</p> <p>Opportunities: Reach & coverage in training; bespoke; balance between training & hands-on</p>
15. Clear improvement methodology training and support	<p>Developing</p> <p>There are pockets of capability built by motivated staff with an interest in improvement. We have a training needs analysis which is underway to understand staff development & training needs for NHS IMPACT components, alongside a dosing formula and skills escalator to support capability building ambitions.</p>	<p>Strengths: Pockets of capability & resources available</p> <p>Opportunities: common improvement language; consistently applied; longer term commitment to training & development</p>
16. Improvements measured with data and feedback	<p>Improving & Sustaining</p> <p>Sustained improvement over time for all system measures. We understand what is driving performance, (whether positive or negative), and problem solve effectively. Our goals around longer term sustainability are reviewed regularly at organisational level.</p>	<p>Strengths: SPC is used & performance is understood</p> <p>Opportunities: Use of measurement for improvement methods</p>
17. Co-production	<p>Developing</p> <p>People with lived experience are infrequently co-producing improvement. Learning is captured when doing improvements, but this is rarely shared across departments.</p>	<p>Strengths: Patient events; safety priorities</p> <p>Opportunities: Direct involvement in improvement</p>
18. Staff attend daily huddles	<p>Improving & Sustaining</p> <p>There is a cascade of huddles for all teams from Executive to frontline teams (clinical, operational, corporate) which hold regular continuous improvement huddles using a standardised format and process.</p>	<p>Strengths: Corporate Safety Huddle everyday</p> <p>Opportunities: Link to Improvement; don't attend local huddles</p>
Embedding Improvement into Management Systems & Processes		
19. Aligned goals	<p>Spreading</p> <p>Our organisational and departmental goals are systematically aligned to our overall vision; and we are working to align goals across our system. Our organisational goals are developed using a consistent management system, based on two-way engagement leading to strong ownership of the goals and greater transparency between areas.</p>	<p>Strengths: Organisation goals are linked</p> <p>Opportunities: system not mature enough to be aligned</p>
20. Planning and understanding status	<p>Progressing</p> <p>Our business planning and performance management processes give the Board and most line managers good visibility of status and progress against our goals. There is good visibility of what we are working on across the organisation. We have an agreed approach for selecting and prioritising improvement work. Staff and assets from enabling services (e.g. Human Resources, Finance, Comms, Informatics) are also aligned to our improvement priorities.</p>	<p>Strengths: Some alignment from enabling services e.g. Admin Pathway</p> <p>Opportunities: Allocation of staff – always the same people; not shared across the system in an agile way</p>

21. Responding to local, system and national priorities	<p style="text-align: center;">Spreading</p> <p>Our management method is well embedded in how we work in all parts of the organisation to team level. As an organisation we are using run charts and statistical process control (SPC) charts not just RAG or tables. Our technology, staff and facility decisions are aligned with our management system goals.</p>	<p>Strengths: Use SPC in SOF</p> <p>Opportunities: Are all teams using the methodology</p>
22. Integrating improvement into everything we do	<p style="text-align: center;">Progressing</p> <p>Improvement is generally well integrated with day-to-day delivery across the organisation and is increasingly the basis of how we deliver against our performance goals. Improvement activity is contributing to performance in many front-line clinical areas and supporting clinical functions.</p>	<p>Strengths: We are getting better at this e.g. PSIRF & other examples</p> <p>Opportunities: Not in all parts of organisation – umbrella again</p>

5. Action already underway

LHCH are already undertaking work that will directly contribute to NHS Impact:

- We already consistently use an improvement methodology – Institute for Healthcare Improvement (IHI) Model for Improvement, Lean, Continuous Improvement (CI/VMI)
- Internal training is available via intranet and is already an integral part of leadership development & preceptorship within LHCH
- Members of Specialist Trust QI Network & of the newly formed Liverpool QI Network (ICS representative attending) to ensure a cohesive approach
- Culture for Improvement plans in development at LHCH

There are actions still to be taken:

- Stakeholder Engagement to develop a robust action plan from the self-assessment against NHS IMPACT criteria
- Forge further links with the ICS Lead for Improvement and Improvement Directors Networks
- Develop an Improvement Strategy that responds to NHS Impact, CQC Well-Led, Staff Survey, NHS Oversight Framework
- Review intranet resources as part of the new LHCH intranet and culture for improvement plan

6. Conclusion

Agreeing a baseline self-assessment is important, so we are clear about the strengths of improvement as well as the opportunities for development.

There is a need for wider internal stakeholder engagement to agree the priorities for action as well as collaborative working across the ICS.

7. Recommendations and next steps

The Board of Directors are asked to review and note the provisional self-assessment against the NHS IMPACT criteria.

An action plan will be developed from the self-assessment and an update provided to the Board of Directors.

Appendix A – NHS IMPACT Assessment Criteria and LHCH provisional ‘scoring’

Building a Shared Purpose & Vision					
What this looks like in practice: <ul style="list-style-type: none"> • Create a vision and shared purpose in an inclusive and transparent way ensuring meaningful input from all, including those with lived experience. The executive leadership of the organisation must drive this work, but it cannot be designed and created by one team. • Involve communities and people with lived experience as partners in the design of the vision and shared purpose. • Find ways to make the vision and shared purpose practical, so that they are lived everyday by its people and are underpinned by core values. • Ensure all improvement work is focused on the shared purpose and vision and question any work which does not align to these. Start by focusing on the current NHS priorities and your own organisation’s context, including the pressures it is facing. • Create a powerful, purpose-driven context and narrative for improvement work so that people are more likely to engage, based on commitment to the purpose rather than compliance with a process. • Understand the world in which frontline staff are working, their challenges, their successes, and the improvement they’d like to see to guide this vision and shared purpose, for example through methods of co-design and collaboration like crowd sourcing platforms or engagement events. • Take account of the current Care Quality Commission ‘Well-Led’ scores and where there are areas for improvement. • The shared purpose and vision should allow staff to understand the importance of their work and to see it from the patient or service user’s perspective. Celebrate and share good practice where possible 					
	Starting	Developing	Progressing	Spreading	Improving & Sustaining
1. Board and Executives setting the vision and shared purpose	We are starting to develop a shared vision aligned to our improvement methodology, although only known by a few and not lived by our Executive team. Our organisational goals are not yet aligned with the vision and purpose in a single, strategic plan.	Our Board, Executive leaders and Senior Management team can describe a shared vision and purpose that is the start of the process to align these with our organisational goals.	Our Board, Executive leaders and Senior Management team are active and visible in promoting the shared vision and translating it into a narrative that makes it meaningful and practical for staff. Measures have been agreed and defined with a small number of key metrics (e.g. Operations, Quality, Financial and People / workforce).	Our vision and shared purpose inform our journey and plans, and operational and clinical leaders and teams across our organisation know how they are contributing to, and own, our organisational goals. All employees have been communicated to and understand our shared vision in a way that means something to them.	Our vision and shared purpose is well embedded and often referred to by the Board and other leaders, who are able to bring it to life and make the link between their team’s priorities and improvement plans and the agreed organisational goals. Most of our staff can describe our vision and shared purpose in their own words and what they can do in their role to contribute.
2. Improvement	Our organisational purpose, vision, values	Our organisational purpose, vision, values	Our organisational purpose, vision, values	Our organisational purpose, vision, values	Our organisational purpose, vision, values

work aligned to organisational priorities	and strategic priorities are in development, but not yet widely communicated to staff. Organisational goals are yet to be defined in a way that enables them to be cascaded to all of our teams.	and strategic priorities are understood by some within our organisation, but generally seen as organisational goals rather than something which is directly meaningful to them.	and strategic priorities have been translated into agreed organisational goals, and measurement systems have been established. The priorities are well understood by most leaders and managers, which is helping to create organisational alignment.	and strategic priorities are visible and understood by leaders, managers and most staff. Our organisational goals have been agreed and measurement systems have been established and are being used across most areas.	and strategic priorities are role modelled and actively reinforced and communicated by leaders and managers, widely understood by most staff across our organisation and translates into improvement activity at team level.
3. Co-design and collaborate – celebrate and share successes	We are at the early stages of working out what quality or continuous improvement means in our context and how we will apply it systematically. So far engagement has been largely focused on senior leadership.	The Board has set a small number of bold aims with measurable goals for improvement, and a communications and engagement plan ensures that staff have at least heard about these goals.	Our improvement goals are developed and refined through a collaborative engagement process, which at least involves leaders and most managers and a two-way feedback process.	We have an agreed plan for delivery at organisational level which is cascaded through line managers down to team level, based on an established engagement and co-development process and a common approach to improvement. Celebration and learning events are used to recognise and share improvements.	Our leaders and managers model collaborative working as part of the organisation's continuous improvement approach. We have an agreed plan for delivery at organisational level that we can systematically track to team level. Celebrate and learning events are an established practice to recognise and share improvements widely.
4. Lived experience driving this work	There is an aspiration or stated commitment to engage people using services, unpaid carers, staff and the community in further design of our shared purpose and vision, but it is not yet fully worked through or systematic.	People using services, unpaid carers, staff and the community are involved in the design and communication of our shared purpose and vision, and may have a role in setting improvement priorities.	Patients, carers, staff and the public are actively engaged in co-designing organisational purpose, vision, values and setting strategic priorities for improvement.	Patients, carers, staff and the public are actively engaged in setting improvement priorities, including at service, pathway or team level, and in evaluating the impact of improvements from a user perspective.	Patients, carers, staff and the public have a voice which influences the strategic improvement agenda and decision making at Board level, including setting the strategic direction of the organisation and wider system.

Investing in People & Culture

What this looks like in practice:

- Set the expectation (e.g. through new joiners' welcome and induction process) that all staff should have a common understanding of improvement, that it is a priority for the organisation and that they will be supported to make improvements in their own area of work.
- Engage with people who work in healthcare roles and organisations and those with lived experience to design and implement the improvements based on what matters to them.
- Facilitate opportunities for people to visit other systems and organisations to understand different ways of operating and different organisational cultures.
- Invest in and support people to understand and own their work, enabling them to make improvements in their own area of work.
- Undertake planned and deliberate cultural readiness work prior to any improvement programme or activity, to establish and maintain a shared set of values that everyone can align to.
- Use a coaching-based approach to leadership in areas where improvement is required, encourage idea generation and run PDSA (Plan, Do, Study, Act) cycles regularly. Encourage the use of measurement to evaluate improvements and to learn.
- Have a locally agreed method to measure and assess organisational improvement culture, including drawing on NHS staff survey information, to support organisational development and learning.

	Starting	Developing	Progressing	Spreading	Improving & Sustaining
5. Pay attention to the culture of improvement	There is an aspiration or stated commitment at Board level to establish an improvement culture, but it is yet to be worked through even at Board and Executive level.	Our Board is committed to establishing an improvement culture and has plans to put this into practice, including Board development. The organisation has ways of measuring culture change (e.g. using a cultural survey or the NHS staff survey) and readiness for improvement	Our improvement approach considers culture as an integral aspect, including for corporate functions, recognising the value they bring to enabling organisational improvement. The majority of improvement activity starts with ways to actively engage staff and teams from clinical, operational, and corporate services in support of improvement goals and effective delivery of care. Our organisation has ways of measuring culture change and readiness for improvement at	Leaders and managers at all levels understand their part in establishing a culture consistent with improvement. We consider measures and markers of culture change alongside other ways of evaluating improvement, down to team level. We have established a culture where our staff feel confident and empowered to take part in improvement activity in their own area and talk openly and honestly to leaders and managers when	We have a reputation for having established a culture consistent with improvement, and we can evidence that with data (e.g. NHS staff survey). Teams and departments work collaboratively across organisational boundaries to deliver improvement which benefits people using services and unpaid carers. We recognise leaders, managers and staff who are role models for the kind of behaviour and culture we want to create.

			departmental or team level.	they are 'walking the floor' (e.g. during 'go & see' visits).	
6. What matters to staff, people using services and unpaid carers	Our ways of understanding what matters most to staff, people using services and unpaid carers tend to be reliant on formal mechanisms (e.g. surveys) and the link to improvement is not strong or systematic.	We understand well as an organisation what matters most to staff, people using services and unpaid carers (e.g. through two-way engagement) and this helps to shape our overall improvement priorities and our approach. Picking up on what matters most to our staff helps to bring us together around a common agenda and creates energy for improvement.	Most of our services and functions have a good understanding of what matters most to staff, people using services and unpaid carers (e.g. through two-way engagement) and this informs their local improvement priorities and activity. Our staff have a voice at Board level to provide feedback on how it feels to work here (e.g. through staff stories, informal interactions, staff networks). Leaders and managers help to translate the needs of patient and carers into improvement priorities or goals.	Most of our teams have a good understanding of what matters most to staff, people using services and unpaid carers (e.g. through two-way engagement) and this informs their local improvement priorities and activity. Most staff feel invested and excited about the opportunities they have to participate in improvement activity which matters to them. People using services have a role in the development, prioritisation and monitoring of delivery of improvement goals	Most of our staff can describe what matters most to them, people using services and unpaid carers and how this translates into their local improvement priorities and activity. There is a strong and direct connection between their improvement activity and making things better for people using services, which is energising. People with lived experience often work in close partnership with our teams on improvement activity, helping to focus on what will make the greatest difference.
7. Enabling staff through a coaching style of leadership	There is some recognition of how a coaching style of leadership helps to encourage improvement, but it is not widely applied.	There is an organisational endorsement of a coaching-style of leadership, but it is not applied systematically (e.g. through leadership training). There are some good examples of how a coaching-based approach can bring about improvement, and this is increasingly	A coaching style of leadership is well established with training available for leaders and managers who request it. Leaders and managers are widely engaged in improvement and regularly sponsor improvement activities (e.g. to help unblock issues). Senior leaders participate in improvement, celebration	Leaders and line managers are trained systematically in coaching and enabling teams to solve problems for themselves. Our Executive leaders act as coaches and teachers of the improvement method for all levels, including role modelling a coaching style.	A coaching style of leadership is embedded as the default approach throughout the organisation, and it is applied to our greatest challenges. Staff and teams thrive in this environment and take greater ownership of improvement. Our leaders and managers are recognised as effective improvement

		recognised and encouraged. Staff are often supported to make changes when doing improvement activities.	and learning events on a regular basis. Staff generally feel supported and empowered.	Managers and clinicians participate in improvement, celebration and learning events on a regular basis. Staff talk about feeling more trusted and empowered.	coaches and are often sought after to lead and support improvements beyond our own organisation.
8. Enabling staff to make improvements	Improvement activity is limited and may be centralised (e.g. led by a discrete 'improvement team' with relevant skills operating independently). Staff do not generally feel able to make improvements in their own area of work.	Some staff and teams feel able to make improvements (e.g. if they have been trained or are supported by a central team). There may be learning locally but it is generally not shared across teams and departments.	The majority of staff are actively involved in improvement activity and feel able to suggest ideas for improvement and to make changes in their own area.	The majority of teams feel empowered and trusted to carry out improvement activity in their own areas, applying a consistent approach. Our staff understand the factors driving progress (whether positive or negative), and can solve problems effectively	Staff and teams are systematically engaged in improvement activity as part of their day to day work and are proactive in sharing the learning, and in looking for ways to collaborate with people with lived experience and other teams and organisations in improvement programmes.

Developing Leadership Behaviours

What this looks like in practice:

- Have a clear leadership and management development strategy in place outlining capability requirements and access to training.
- Understand current leadership styles and approaches through board development sessions identifying strengths and gaps for each individual and as a team.
- Create leadership stability and continuity of approach.
- Support leaders and managers across the system to live and breathe the values and behaviours of the organisation and hold leaders and managers to account for behaviours, not just improvement outcomes.
- Clearly agree and outline the support which is in place for people to improve their own services.
- Provide induction, training and development for everyone who has a formal leadership or management role so they have skills and experience of delivering improvements and can role model leading for improvement.
- Encourage board development to better understand how current leadership and management behaviours are demonstrating organisational values, identifying strengths and gaps.
- Engage with peer support networks to understand different approaches to the issues and leadership and management behaviours.
- Empower teams delivering on the ground to carry out and test improvement projects

	Starting	Developing	Progressing	Spreading	Improving &
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					Sustaining
9. Leadership and management development strategy	Our Board, senior leaders and line managers are not yet trained in a consistent and defined improvement approach which they are expected to apply and role model.	Our leadership team have started to develop their improvement knowledge and are gaining an understanding in how it can impact their role.	Our leadership works with managers and teams across the organisation to develop improvement skills and enable and co-ordinate improvement.	Our leadership and management teams actively enable staff to own improvement as part of their everyday work and all teams and staff have had training in improvement.	Our Board focus on constancy of purpose through multi-year journey and executive hiring and development, including succession planning. Our Board are visibly linked to future planning at a system level.
10. Leadership and management values and behaviours	Our leadership values and behaviours and our expectations of managers are not explicitly defined, or do not include reference to an improvement-based approach.	Leadership values and behaviours are agreed across our organisation.	Leadership values and behaviours are agreed, and role modelled by leaders and managers across the organisation.	Leadership values and behaviours are agreed, role modelled and supportively challenged when not lived up to.	A clear framework and expectations for leadership and management values and behaviours which are consistent with an improvement-based approach are applied throughout the organisation.
11. Leadership and management acting in partnership	Our leadership works to competing and misaligned goals lacking in clarity.	Most of our leaders work in partnership with their fellow leaders and managers.	Our leadership team have shared goals with commissioners and work effectively with systems partners.	Our leadership team has shared longer term goals with network partners or commissioners as well as collaborative involvement over wider health economy.	Our Board and system focus on constancy of purpose through multi-year journey with improvement at its core.
12. Board development to empower collective improvement leadership	Our Board discusses improvement at Board meetings, but it is not a regular occurrence.	Our Board has received some improvement training and visit to parts of the organisation at least monthly. Improvement is discussed at every Board meeting.	Our leadership works with managers and teams across the organisation to enable and co-ordinate improvement.	Our leadership and management teams actively enable staff to own improvement as part of their everyday work.	Our leaders and managers – Chief Executive Officer through to front line demonstrate their commitment to change by acting as champions of the improvement and management method, by removing barriers and by maintaining a

					visible presence in areas where direct care / operational work is done.
13. Go and see visits	Some senior leaders spend time on the 'shop floor' from time to time to engage directly with staff and teams but it is not routine or widely practiced.	Our leaders understand the importance of 'walking the floor' to 'go & see'; but we have variation in leader participation; some leaders and managers use our improvement tools .	Our Executives regularly 'walk the floor'/'go & see'; they incorporate the tools and methods into their meetings, strategic planning and daily management.	All levels of leadership and management 'walk the floor'/'go & see' as a matter of routine and the insights they gain informs decision making and problem solving to support improvement.	Leaders undertake 'walk the floor'/'go & see' visits for external bodies to visit their site and to observe different ways of working.
Building Improvement Capacity & Capability					
What this looks like in practice: <ul style="list-style-type: none"> Identify or create an improvement methodology to use across your entire organisation, ensuring a local and systemic way of practising improvement. Give all people access to induction, improvement training and support, so that everyone can run improvement projects and continuously improve their daily work. Determine how success will be measured at an early stage, use appropriate tools and frameworks, and include feedback from people working at the point of care and people with lived experience. Demonstrate the impact of co-producing improvements with people who use services as an integral part of daily work. Set an expectation that there is an organisational focus on data and all staff are empowered to make and track changes in their workplace. Create and embed a training strategy to increase improvement capability. Leaders and managers attend team's daily huddle Boards and work to unblock issues which teams are facing. 					
	Starting	Developing	Progressing	Spreading	Improving & Sustaining
14. Improvement capacity and capability building strategy	We do not have a structured training or capability building approach for improvement skills. Training is ad hoc and focused on small central teams. We have some use of external resources (e.g. Academic Health Science Networks	Our improvement methodology has been agreed and the Board has undergone its own development to build literacy around improvement. Staff have access to induction on joining, improvement training and a small group of staff support	Training is a balance of both technical skills, behavioural attributes and data analysis. Coaching support is available during and post training and time is given for staff to undertake training and development in the adopted improvement methodology. Some learning is shared across the organisation. A system exists to identify, engage and connect all those	Sustainability is addressed via 'in-house' training and development approaches including train the trainer models. Improvement capability building for 'lived experience' service user partners is underway; they are seen as contributors to improvement teams. The programme is working towards being self-sustaining through	There is a systematic approach to improvement, and induction and training are provided to every member of staff as part of learning pathways and career progression, including induction and line manager training with >80% coverage. Capability building is self-sustaining, meeting

	and Institute for Healthcare Improvement Open School).	capability building.	people that have existing improvement capability.	developing its own improvement coaches.	the improvement needs of the organisation. The organisation consistently shares capability, building learning with other sites, regionally and nationally.
15. Clear improvement methodology training and support	No single improvement methodology has been adopted and only limited sharing of improvement gains/learning is cascaded beyond the immediate area where improvement is underway.	There are pockets of capability built by motivated staff with an interest in improvement. We have a training needs analysis which is underway to understand staff development & training needs for NHS IMPACT components, alongside a dosing formula and skills escalator to support capability building ambitions.	Clarity exists on which improvement methodology and approach is being consistently applied. A longer term commitment exists to a training and development system for building capability at scale. Service users and carers are recognised as key stakeholders.	Training and development are undertaken by all leaders, managers and staff. Learning from all improvement activity is effectively shared across the organisation. Staff, people with lived experience and wider teams are using their skills and knowledge to deliver improvement and cascade improvement techniques to their peers.	Learning from improvement activity is driving continuous improvement. There is a common improvement language across the organisation. Knowledge and learning from improvement is highly visible, harvested, collated and shared widely as part of a scaling up and spread strategy.
16. Improvements measured with data and feedback	Our organisational approach to reviewing and tracking progress against goals has yet to be defined, at present improvement doesn't feature in whole organisational measures.	We are seeing minimal improvement in our organisational measures. We have developed some elements of our organisational approach to reviewing and tracking progress, however this is ad-hoc and stakeholders do not feel it supports them to	We are tracking improvement over time for some of our organisational measures. We have a holistic approach to achieving our goals, evidenced by data, centred on problem solving, and management that stakeholders feel is supportive.	Improvement is sustained for most organisational measures. Our goals are reviewed regularly at organisational level and our plans are adapted to ensure they meet the clearly defined goals if required.	Sustained improvement over time for all system measures. We understand what is driving performance, (whether positive or negative), and problem solve effectively. Our goals around longer term sustainability are reviewed regularly at organisational level.

		deliver.			
17. Co-production	We have small discrete teams with relevant skills operating independently from one another labelled as clinical governance, service development, clinical audit or transformation, that are working in silos reporting to various directors with no lived experience partners co-producing improvement.	People with lived experience are infrequently co-producing improvement. Learning is captured when doing improvements, but this is rarely shared across departments.	People with lived experience and wider stakeholders are strongly involved in co-designing and co-producing the capability building approach. Staff, people with lived experience and other stakeholders have access to improvement capability development.	Stakeholders including people with lived experience are both supported and challenged to ensure success. We understand the factors driving progress (whether positive or negative), and problem solve effectively together.	Stakeholders are both supported and challenged to ensure success. People with lived experience and wider stakeholders are embedded within teams and are an integral part of the capability building process.
18. Staff attend daily huddles	Any huddles are only traditional shift change clinical handovers.	There is a plan in place for team huddles to focus on continuous improvements in all clinical frontline areas with clinical and operational staff in attendance.	All clinical frontline areas have continuous improvement team huddles established. There is a plan in place to establish continuous improvement team huddles in all operational/support/corporate areas.	All operational/support/corporate areas have continuous improvement team huddles established.	There is a cascade of huddles for all teams from Executive to frontline teams (clinical, operational, corporate) which hold regular continuous improvement huddles using a standardised format and process.

Embedding Improvement into Management Systems & Processes

What this looks like in practice:

- Develop an explicit management system that aligns with the strategy, vision and purpose of the organisation at Board level and throughout all services and functions.
- Put systems in place to identify and monitor early warning signs and quality risks with clear processes of how to respond to these.
- Set up the management system as a way of standard operating that enables ongoing continuous improvement of access, quality, experience, and outcomes.
- Building a management system which enables the organisation to respond to system and national priorities more easily and with greater agility as the organisation has a consistent and coherent set of management systems and processes.

- A committed Board and senior management team who own and use this approach to manage the everyday running of their organisation, including simple and visual ways of understanding performance with tracking progress.

	Starting	Developing	Progressing	Spreading	Improving & Sustaining
19. Aligned goals	Where improvement plans exist they are very locally determined and driven. Our business planning is an activity conducted at Board and senior leadership level but executives and functions goals are often not well aligned with each other.	Our department goals may involve up or downstream departments; we do not share improvement planning across departments. Our business planning is an activity conducted at board and senior leadership level to produce goals that are cascaded top-down to the rest of the organisation.	Our organisational goals are established to support our overall vision; our departmental goals align systematically with those of our organisation. Our business planning process is based on two-way engagement leading to greater local ownership of the goals.	Our organisational and departmental goals are systematically aligned to our overall vision; and we are working to align goals across our system. Our organisational goals are developed using a consistent management system, based on two-way engagement leading to strong ownership of the goals and greater transparency between areas.	Our organisational and departmental goals are systematically aligned to our overall vision and that of our system. Individual objectives are clearly linked to the strategic plan through the team, departmental and organisational goals and improvement plans.
20. Planning and understanding status	Our business planning and performance management processes do not make it easy for us to understand status or progress against our goals. We do not have visibility of what we are working on across the organisation.	Our business planning and performance management processes give the Board and senior managers reasonable visibility of status and progress against our goals. There are some routines for selecting and prioritising improvement work. Although we have some resource available there is no defined process for prioritising and allocating resource.	Our business planning and performance management processes give the Board and most line managers good visibility of status and progress against our goals. There is good visibility of what we are working on across the organisation. We have an agreed approach for selecting and prioritising improvement work. Staff and assets from enabling services (e.g. Human Resources, Finance, Comms, Informatics) are	Our business planning and performance management processes give good visibility of status and progress against our goals across all departments and teams. We have an agreed and transparent approach for selecting and prioritising improvement work which generally works well. Our supporting resources are assigned to supporting	Our business planning and performance management processes give good visibility of status and progress against our goals across all departments and teams, and is considered the 'one version of the truth' across the organisation. We have an agreed and transparent approach for selecting and prioritising improvement work which works well and can flex to meet changing needs. There

			also aligned to our improvement priorities.	delivery of improvement goals across the organisation in a way that is perceived to be fair and effective. Staff and assets from enabling services (e.g. Human Resources, Finance, Comms, Informatics) are also aligned to improvement priorities and are shared across the system in an agile way.	is complete and timely visibility of what teams are working on across our organisation. There is a co-ordinated approach to review, prioritise and co-ordinate allocation of resources to support pathway-level improvement.
21. Responding to local, system and national priorities	We do not yet have a coordinated or consistent management approach to how we respond to changing needs, address problems or deliver against our plans. Instead it is perceived as reactive or firefighting.	Across the organisation, we believe having a management method (e.g. Lean) is important to our success. Some of our leaders are using management methods daily, which is recognised to be helping.	Most leaders and managers in the organisation use our management methods to manage and run their departments, including responding to problems that may arise or to take account of changing priorities.	Our management method is well embedded in how we work in all parts of the organisation to team level. As an organisation we are using run charts and statistical process control (SPC) charts not just RAG or tables. Our technology, staff and facility decisions are aligned with our management system goals.	All teams use the management method to understand, run and improve each aspect of our organisation; we use data effectively (e.g. SPC) to understand and improve performance. Whether our work is succeeding or is challenged, we strive for continuous improvement.
22. Integrating improvement into everything we do	Improvement is seen as separate to the day to day delivery of services. Our performance management system is seen as separate from any improvement activity or methods we apply, and may be sending	Improvement is starting to be more integrated with day-to-day delivery and targeted towards particular performance priorities or risks. Improvement activity is contributing to performance in some	Improvement is generally well integrated with day-to-day delivery across the organisation and is increasingly the basis of how we deliver against our performance goals. Improvement activity is contributing to	As part of our management system, all parts of the organisation are using improvement methods, and learning occurs between areas (e.g. to understand and reduce waste). We have	The way we understand, manage and improve performance across the organisation – including how we use and report data – is consistent with our approach to improvement and based

	conflicting signals within the organisation.	front-line clinical areas.	performance in many front-line clinical areas and supporting clinical functions.	multiple examples of sustained improvement over months and years, not just month-to-month variation.	on an improvement cycle. We have many examples of sustained improvement, including reference cases recognised beyond our organisation.
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