GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester

Quality Improvement Framework

Taking charge in Greater Manchester

Greater Manchester Health and Social Care Partnership

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1. Introduction

Improving the quality of care and support that service users experience in Greater Manchester (GM) is at the heart of all our objectives and plans. It drives the transformation of existing services, the development of new services and the collaborative working of partnerships. In plans we need to make sure we measure and monitor quality of care, ensuring we maintain the current quality of care as we implement actions that will improve it.

This paper introduces an innovative and unique GM framework for quality improvement that guides a consistent approach to quality improvement in GM, locality, organisation, and service plans. This is the first time that a Quality Improvement Framework has been produced that incorporates both health and social care in this way. This report pulls together historical perspectives into a logical framework for quality improvement founded on leading international practice.

Whilst there is no single best approach to quality improvement there are similar attributes that are common to all:

- Leadership and clear direction
- Engagement of service teams
- Participation of service users
- Access to quality improvement resources
- Quality improvement skills development
- Use of an improvement process
- Continual efforts to improve
- Measure and evaluate the impact of a change

The participation of patients, service users, carers and the public in quality improvement is essential and therefore when the phrase 'service user' is used, it emcompasses them all.

2. Background

Quality improvement is prominent in the GM plan. A guiding principle of Taking Charge is to deliver the best quality, outcome based services within the resource available whilst reducing variation of outcomes and service standards within and between organisations. The will to improve quality (and reduce variation) using evidence to inform standardisation has been reflected in the strategies and plans approved by the Greater Manchester Health and Care Board (previously Strategic Partnership Board).

Numerous quality improvement policies and practices have been introduced in health and social care over the past twenty years. Many of these have been the result of a national response to serious adverse events. This has been reflected in a variety of approaches taken by national organisations leading quality improvement. As teams have addressed service priorities and responded to the numerous national quality initiatives, competing beliefs have emerged about how to improve quality of care. These beliefs are often firmly held based on long experience in each setting. We need to build on these foundations to develop an enduring GM approach to quality improvement that has both consistency of purpose and a compelling theoretical and evidential base.

The National Quality Board (NQB) was re-established with a new clinical and professional focused leadership and membership. The NQB comprises the Care Quality Commission (CQC), NHS England, NHS Improvement, Public Health England, National Institute for Health and Care Excellence (NICE) and Health Education England in a partnership model. The new NQB has far greater congruence with developments in GM as it is incorporating a wider set of organisations and considering all of health and social care. The NQB published its model, Shared Commitment to Quality, in December 2016. The CQC has been leading the development of and consulting on an aligned national Adult Social Care Quality Strategy and this is due for publication imminently.

The NQB's Shared Commitment to Quality and its forthcoming Adult Social Care Quality Strategy are valuable foundations for quality improvement activity in GM.

Figure 1: NQB's single, shared view of quality model

The NQB model of multi-agency partnership to guide quality improvement is similar to the approach established in GM in 2016. The Greater Manchester Quality Board is somewhat broader in membership as it also reflects commissioners and providers across the whole health and social care system.

The NQB broadens the scope of the CQC model (caring, safe, responsive, effective, and well-led) emphasising the importance of patient-centred care provided using resources responsibly and efficiently, with fair access to all, according to need (Figure 1).

The NQB's Shared Commitment to Quality describes seven steps to improve quality (Figure 2). These are already reflected in existing GM arrangements.

- Set a clear direction and priorities
- Bring clarity to quality
- Measure and publish quality
- Recognise and reward quality
- Maintain and safeguard quality
- Build capability, improving leadership and culture
- Stay ahead by developing research and innovation

Figure 2: NQB's seven steps to improving quality

3. What is quality?

There is no single accepted definition of quality in health and social care but there is acknowledgement that it has different dimensions:

Safe

Safe: Avoiding harm from care that is intended to help people.

Examples:

- Good infection control minimises care acquired infections like MRSA and CDiff
- Systems are in place to identify and report safeguarding concerns

Timely

Timely: Reducing waits and sometimes harmful delays.

Examples:

- Action is taken quickly where early intervention improves the outcome (e.g. lung cancer and stroke)
- Support is delivered reliably where it is linked to other events (e.g. helping service users get ready for school)

Effective

Effective: Providing services based on evidence and which produce a clear benefit.

Examples:

- Young people are immunised against HPV, Meningitis, and other infectious diseases
- Regular checks are made to promote the wellbeing of groups at higher risk such as looked after children and people with a learning disability

Efficient

Efficient: Avoiding waste.

Examples:

- Medicines are personalised so patients get the benefit without side effects
- Community services work collaboratively to share care plans and reduce multiple visits

Person-centred

Person-centred: Establishing a partnership between practitioners and service users to ensure care respects service users needs and preferences.

Examples:

- Providers seek and act on feedback from service users
- Service users are supported to make decisions about their own care and support

Equitable

Equitable: Providing care that does not vary in quality because of a service users' characteristics.

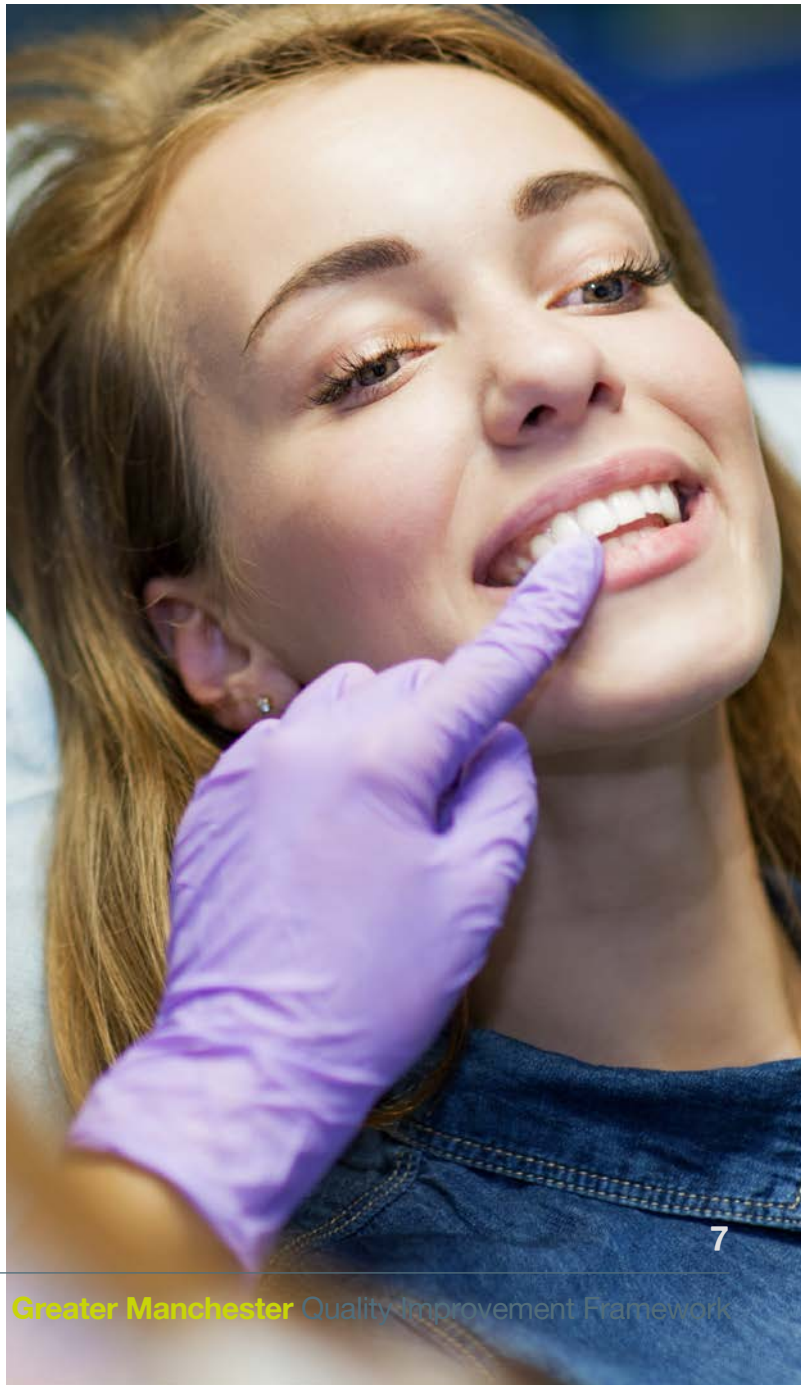
Examples:

- Service users have a consistent offer of service and support in all localities
- Dementia diagnosis rates and support are the same in all communities

Quality improvement is the continual actions to improve outcomes for service users and to develop the workforce that supports them using systematic methods. The two key elements are 'continual' and 'systematic'.

There are many accepted care improvement methods, such as Lean, PDSA (Plan, Do, Study, Act), and Six Sigma. The choice of a preferred method for an improvement activity is less important than choosing one that takes a systematic approach.

In some services quality assurance has been founded on an assurance process that combines checks of contractual commitments and levers with periodic audit. This assurance process is most effective where there is a learning culture and continual improvement. The promotion of learning and improving quality of care is at the heart of GM's transformation plans (e.g. the learning hubs included in the Primary Care Reform plan and the workforce development activity included in the Adult Social Care Transformation Programme).



4. QI Model

“healthcare is a system-of-systems. Perturbing one element of the system without considering its impact on the other elements of the system may result in a breakdown.”

Pronovost PJ et al
World Innovation Summit for Health; 2015

Although there are many views on the best quality improvement approaches, there is a broad consensus on the benefits of a systems approach. This is especially important in learning from adverse events where it is important that the immediate factors that led to the event are addressed but also the underlying factors that will prevent further occurrences.

The QI approach for GM must offer a unifying framework that builds a coherent picture that increasingly draws together the excellent work that has been done to date and that will be done in the future. This must foster a learning culture in all care settings.

Organisations have had to respond to the regular national adjustments to priority and policy and, in doing so, similarities in approaches have emerged. These local similarities lend themselves to a GM model derived from leading international practice and research. A quality improvement model can be adopted that is founded on these similar organisational approaches.

Structures of self-similar patterns – fractals – are common. The whole object has the same shape as its parts.

A fractal model has been adopted successfully to align quality improvement activities in renowned systems, such as Baltimore (John Hopkins) and Michigan. The fractal model offers a hierarchical, organisational structure for quality and safety. Its foundation is based on the integration of smaller units that are similar in structure (people), process (use of similar tools), and approach (using a common framework to address issues).

In a GM fractal Quality Improvement (QI) Framework there is accountability at each level of the system and organisation to improve quality and encourage innovation but sufficient flexibility within the self-similar approach to allow the best cultural fit within services and to encourage local ownership of the preferred improvement methodology.

1. Define a unifying purpose
2. Establish a fractal organisational structure
3. Develop a common framework for understanding quality and safety
4. Develop tools for communication and reporting
5. Create a system of shared leadership responsibility

Figure 3: Elements of a QI framework (Mathews et al 2016)

There are five key characteristics of a fractal QI Framework (Figure 3).

- The unifying purpose is defined in the improvement/business plans of teams and organisations
- The existing arrangements provide the basis of a fractal QI infrastructure – further work is needed to encourage structured quality improvement where this is less well developed.
- The Quality Board has a pivotal role in building a shared understanding of similar approaches within a fractal framework.
- The GM performance dashboard provides the foundation for reporting measures of quality of care - further work will be required to ensure there is agreement on clear and transparent measures.
- Shared leadership responsibility has become an important characteristic of health and social care – further work is needed to strengthen this mutual accountability for quality improvement where this is less well developed.

Taking a fractal view has several advantages:

- it helps resolve the tension between different improvement methodologies;
- it enables each part of the system to define its own unique size and shape and include any element that can influence the quality of care experienced by its service users from processes and technology to leadership behaviour and culture; and
- it highlights new areas for development that may have received less attention up to now.

5. Communities of Practice (Clinical Networks)

Important enablers of the fractal QI model are communities of practice to harness the skills, professionalism and enthusiasm of front line workers. Interventions that feel imposed are often resisted and not sustained. Improvement happens when they own it. Communities rely (primarily) on the volition of their members.

These communities transcend organisational, disciplinary and professional boundaries and ensure inclusion of all relevant stakeholders. A community has a vertical core of leadership responsible for leading, organising and mobilising activities and horizontal relationships linking members that make the community an effective enabler of quality improvement.

- Formed of **interdependent** groups and individuals
- **Cross service and organisational boundaries**
- **United by a common purpose**
- Consist of members **responsible for achieving** the aims
- Combine **vertical leadership and horizontal relationship structures**
- use primarily **informal mechanisms** to achieve change

Figure 4: Key features of a community of practice (Aveling et al 2012)

Two key principles guide these communities of practice:

- Clear and transparent data: They must be informed by agreed clear and transparent reporting of data that is as rigorous for quality as it is for operational and financial performance.
- Leadership accountability: They must have mutually supportive leaders whom hold each other to account to provide time and resources (for quality improvement).

These two principles are established characteristics of our governance arrangements in GM. Furthermore, we have many existing communities of practice. These range from single issue communities within a single provider (e.g. hospital infection control committee), to single issue communities drawn from many providers (e.g. pressure ulcer care), to broader issues communities including the GM Clinical Networks, Operational Delivery Networks and Alliances.

6. Service user participation

When the phrase `service user' is used within this Framework it encompasses patients, service users, carers and the public.

> "First, put the patient at the centre – at the absolute centre of your system of care."
>
> **Don Berwick**
> **NHS 60th birthday speech, 2008**

Service users are at the heart of quality improvement.

> "Patients and their carers should be present, powerful and involved at all levels."
>
> **Don Berwick**
> **Improving the Safety of patients in England, 2013**

By listening to people who use and care about our services, we understand their diverse health needs better and focus on and respond to what matters to them. By prioritising the needs of those who experience the poorest health outcomes, we have more power to improve access to services, reduce health inequalities in our communities and make better use of our resources.

GM is committed to listening to and learning from the experiences of service users and ensuring their full participation in design, redesign, assessment and governance. Representatives of service users are members of many leadership groups, including the elected representatives in GM and the Quality Board for health and social care.

Participation in quality improvement is not limited to attendance at meetings and involvement in project teams. There are many mechanisms to involve service users. They are engaged through feedback, compliments and comments, through social media, voluntary organisations, elected representatives, consultations, meetings and through Healthwatch which is represented on the Quality Board. Successful quality improvement is founded on actively listening to service users and promptly and effectively acting in response.

7. Working with other agencies

Services in GM must respond effectively to national organisations that establish standards, guidance and regulations for health and social care.

The CQC and NICE both provide guidance to support improvement in all parts of the health and social care system. They are directly represented by members of the Quality Board but the influence of CQC and NICE pervades the system through their guidance and standards.

The quality of care service users experience is inextricably linked to the capability and values of the caring workforce. Standards for the health and care workforce are established by agencies concerned with development (such as Skills for Care and Health Education England) and others concerned with professional standards (such as the Health and Care Professionals Council and the Nursing and Midwifery Council).

NHS Improvement is helping build the capacity and capability for improvement across the NHS.

8. Culture and leadership

In GM quality of care and the safety of patients are highly valued. Leaders and communities of practice recognise the importance of system connectivity and relationships and work together to engage our workforce and our service users to design services and bring about improvements in care. Leaders set the example by promoting a culture of improvement, learning and support.

This can be achieved by understanding staff experiences and their motivations.

Education, incorporating insights from continuous reflective learning, leads to informed decision-making and system resilience. The science and practice of quality improvement is part of continuing education for the GM health and social care workforce.

9. Measuring and monitoring the quality of care

Measures are valuable indicators of quality and one critical source of intelligence. There needs to be agreement on measures which are clear and transparent and their value is enhanced when they are combined with soft intelligence from service users, the workforce and other colleagues.

Providers are responsible for delivering care that meets the quality expectations of service users. Commissioners are responsible for monitoring this. The Greater Manchester Health and Social Care Partnership is focused on quality assurance through confirming and supporting the effectiveness of local quality governance systems, monitoring and developing a balanced portfolio of quality metrics, and reviewing quality of care performance in the periodic assurance reviews with localities.

The health and social care workforce are mutually accountable for working together to identify opportunities to improve care and collaborating to make those improvements. Learning and improvement are professional expectations.

Quality metrics already form one of the main sections of the performance dashboard/ report. It is likely there will be some refinement of metrics over coming months. The feasibility of a synthesised summary measure of variation is being explored to bring together the six dimensions of quality (safe, timely, effective, efficient, person-centred and equitable).

In relation to the measurement and monitoring of safety indicators, guiding principles are described below.

Safety measurement and monitoring must be customised to local settings.
Clarity of purpose is needed when developing safety measures.
Collaboration between regulators and the regulated is critical.
A more holistic approach to measuring, monitoring and implementation interventions for all potential types of harm is needed.
More anticipation and proactive approaches to safety in addition to the reactive measures is needed.

Figure 5: The Measurement and Monitoring of Safety, Professor Vincent, 2013

It is important measures of quality are both visible and easy to understand. However, the simplicity of aggregated data can disguise variations, particularly within large organisations and across localities. The metrics used to monitor quality of care must be supplemented by intelligent, fine-grained analysis by leaders across the system.

10. Refining (financial) incentives to improve quality

Actions to improve the quality of care often reduce costs, not least from targeting resources efficiently to maximise outcomes and minimise adverse effects. Nevertheless, an important consideration must be direct financial incentives to deliver improvements to care (and associated financial disincentives where improvements are not implemented).

There are incentives in the existing commissioning arrangements across all health and social care. In health care, for example, these include the NHS 'Quality Premium' and 'Best Practice Tariffs' (BPTs are national tariffs that have been specifically structured and priced to incentivise and adequately reimburse care that is of high-quality and cost effective with the aim of reducing unexplained variation in clinical quality and universalise best practice). Recently the NHS has also introduced a variant of BPTs to directly incentivise innovation and technology

11. Research and Innovation

Research and innovation are the mechanisms by which the quality of care can be transformed. This is particularly the case for two of the six dimensions of quality, safe and effective, but also true of other dimensions, including timely and efficient. Research evidence informs leading practice and informs guidance (notably from NICE).

Fostering research and innovation is an integral part of excellence in quality improvement. This has been acknowledged in recently approved plans. For example, a specific section on research was included in the GM Cancer Strategy, promoting research is highlight of the Memorandum of Understanding with the pharma industry, and, following the approval of its outline business plan, Health Innovation Manchester has become an important facilitator of quality improvement in the future. These developments build on existing work, including the research led by quality improvement support providers in GM.

Research and innovation is already recognised as one of GM's strengths and actions are underway to further strengthen this. However, there is more that can be done to optimise our research and innovation capability as partners within GM and as a coherent system beyond GM.

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Get involved

You can visit our website at **www.gmhsc.org.uk** or get in touch with us directly:

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