

Greater Manchester Health and Care Board

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Date: 9 November 2018

Subject: Safety Report

Report of: Dr Richard Preece, Executive Lead for Quality and Medical Director,
GMHSC Partnership

SUMMARY OF REPORT:

Patients and service users expect care to be safe. Health and care workers expect to provide care safely. Continual vigilance is essential to make sure the outcomes of care experienced by service users and patients are as good as expected.

Greater Manchester expects a health and care system that perform well on safety. This means:

-) being clear safety is a top priority;
-) having a clear, accurate and current picture; and,
-) having a supportive and learning culture.

This report describes the specific model of safety that has been in use across the Greater Manchester health and care system and future steps to develop this.

KEY MESSAGES:

A comprehensive approach to improving patient safety should take account of both the positive contributory factors that build a safety culture as well as measuring the impact on service users. Too often approaches to safety focus predominantly on what has happened, and particularly on adverse events, but it is not sufficient to only measure impact. A systematic approach to patient safety must also measure efforts to improve.

Greater Manchester has been using a specific forward-looking model of safety for several years. This report formally brings that model to the Health and Care

Board. The model has been used at numerous events since first being launched in Greater Manchester in 2015. It has been discussed at two Quality Board meetings where all localities are represented.

This report describes the model of patient and service user safety and places it in the context of the fractal GM Quality Improvement Framework. It describes how we will continue to work together, led by the Quality Board, to improve and measure safety across the Greater Manchester health and care system.

PURPOSE OF REPORT:

The report is to refresh the Greater Manchester approach to health and care safety and to formally present it to the Health and Care Board.

RECOMMENDATIONS:

The Greater Manchester Health & Care Board is asked to:

-) Support the established model of health and care safety.
-) Support the development of the model by the Quality Board in consultation with localities, Primary Care Advisory Group, Provider Federation Board, Joint Commissioning Board, and other stakeholders groups.
-) Note safety is a main agenda item on the first ever GM Clinical Leaders Summit.

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1.0 GREATER MANCHESTER QUALITY IMPROVEMENT FRAMEWORK

- 1.1. The Greater Manchester Quality Improvement Framework (QIF) was adopted in 2017. The framework focuses on the key components of health and care quality improvement that should be reflected at the whole system level, at unit level, and every level between across all health and care. The GM QIF is a fractal approach based on the similarities of good practice. (Appendix 1).
- 1.2. At the heart of the GM Quality Improvement Framework is the premise that doing the right things creates the opportunity for success. Equally, not attending to the founding components is likely to mean improvement efforts don't succeed. The attributes that are common to all approaches to quality improvement include:
 -) 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
- 1.3. These attributes acknowledge both the importance of the behaviours and skills invested in improvement activity and the importance of measuring their impact. These are equally applicable to efforts to improve patient safety. A comprehensive approach to improving patient safety should take account of both the positive contributory factors that build a safety culture as well as measuring the impact on service users.
- 1.4. Too often approaches to safety focus predominantly on what has happened, and particularly on adverse events, but it is not sufficient to only measure impact. Measures of successful outcomes and measures of harm describe the past and are a poor indicator of what will happen in the future. A systematic approach to patient safety must also measure efforts to improve.

1.5. A forward-looking approach to safety for GM health and care for Greater Manchester must:

-) Reflect the approach taken in the GM QIF
-) Take full account of the culture that will make care safer in the future
-) Transparently report and learn from adverse events
-) Build on evidence that care is becoming safer
-) Be built on the research evidence of leading practice

2.0 THE NATIONAL APPROACH TO SAFETY

2.1. To date there has been no nationally accepted approach to safety in health and care. NHS Improvement has taken a lead for healthcare but this has focused on NHS Trusts and specific activities (rather than a systematic approach to the whole of health and care). A national NHS approach to safety, informed by our preparatory work in Greater Manchester, is now being developed as part of the Long Term Plan.

2.2. The national programme is being led Dr Aidan Fowler, newly appointed as NHS National Director of Patient Safety. Progress in Greater Manchester has been shared with the National Director to make sure work on patient / service user safety in GM is being aligned with emergent national systems to avoid any duplication of effort.

2.3. A new national incident management system is also being piloted between November 2018 and February 2019. A number of GM providers across social, primary and secondary care have expressed interest in joining this beta test.

2.4. NHS Improvement has been investing in 'Patient Safety Collaboratives' (PSC). It commissions Health Innovation Manchester (and the national group of Academic Health Science Networks) to lead activities to tackle three specific patient safety issues in NHS trusts:

-) Culture & Leadership
-) Deteriorating Patient Safety
-) Maternal and Neonatal Health

2.5. In Greater Manchester the maternity safety activity is fully embedded in the GM Maternity Transformation Programme and co-ordinated by a Lead

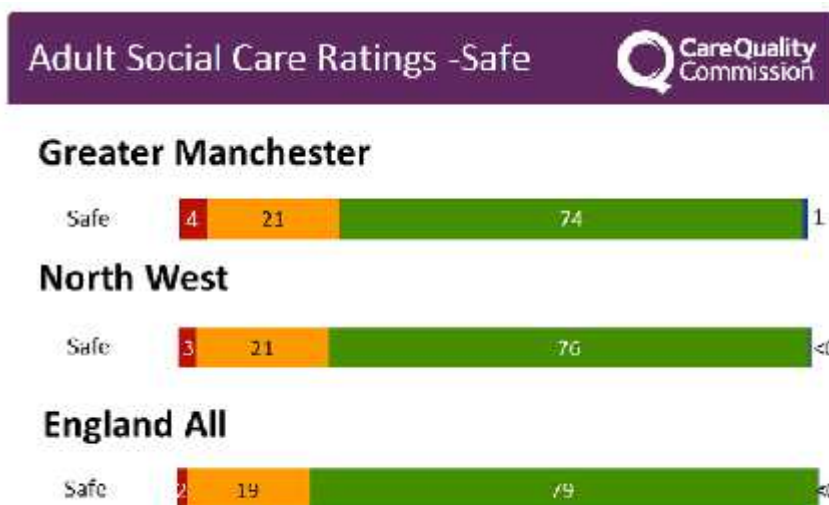
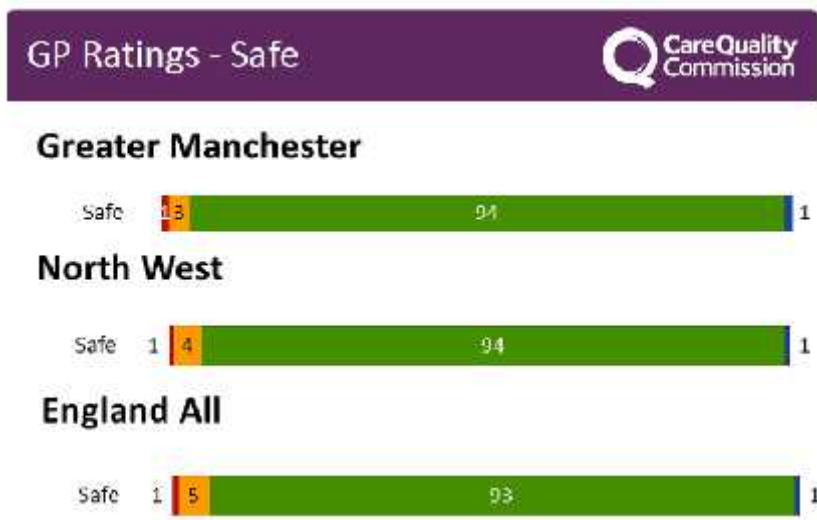
Midwife jointly appointed by the GMHSCP and Health Innovation Manchester.

- 2.6. In addition to national improvement plans there is a nationally funded safety research programme. The NIHR (National Institute of Health Research) has established three Patients Safety Translational Research Centres (PSTRC) in England. One of these centres of excellence is at the University of Manchester. The Greater Manchester PSTRC works closely with health and care providers in Greater Manchester with a focus is on four themes:
-) Safety Informatics – developing information systems and using routine healthcare data for better understanding of patient safety.
 -) Medication Safety – exploring how the prescribing, dispensing and administration of medicines within and between health and care organisations can be improved.
 -) Safer Transitions – looking at the safer movement of patients between healthcare settings.
 -) Safety in Marginalised Groups – co-designing and testing healthcare interventions to improve the safety of marginalised patients.

3.0 THE CQC ‘SAFE’ THEME

- 3.1. The inspection reports of the Care Quality Commission (CQC) are valuable in understanding the safety of health and care. At each inspection the CQC examine all aspects of care safety and this is reported against the themes of ‘Safe’ and ‘Well-led’.
- 3.2. The CQC has reported: “At the heart of providing good care is keeping people safe. Safety also has a strong link with leadership. It is rare for [providers] to be well-led but to have substantial problems with safety.”
- 3.3. CQC has found that providers that perform well on safety:
-) genuinely put safety as a top priority;
 -) have good monitoring that gives clear, accurate and current picture; and,
 -) have a culture where staff feel empowered to speak openly about safety issues.
- 3.4. In contrast CQC has found that providers that perform the worst on safety:
-) do not keep good documentation (especially for medication);

-) do not have staffing plans in place that respond quickly to demand;
 -) do not assess and manage risks adequately; and,
 -) do not support and train staff appropriately.
- 3.5. These aspects of the best and worst performing providers in England should be reflected in a comprehensive approach to safety that includes learning from events, supporting appropriate behaviours, monitoring performance, anticipating issues, and reporting useful information.
- 3.6. The latest collated CQC ratings for 'Safe' in Greater Manchester for all GP practices, all Adult Social Care providers, and all NHS Trusts are similar to the North West and to England.



Greater Manchester



North West



England All



4.0 THE EVOLUTION OF THE APPROACH TO SAFETY IN GREATER MANCHESTER

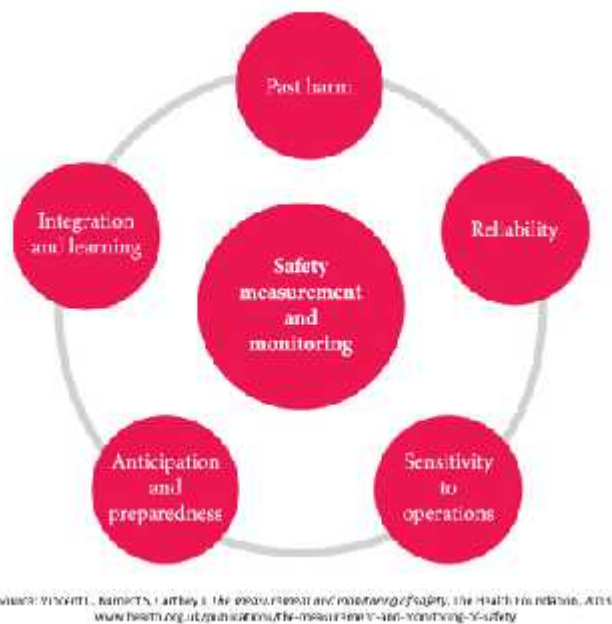
- 4.1. Although there has been widespread support for the model described by the Health Foundation in 2013. To a variable extent the Health Foundation model has been used across Greater Manchester since 2015.
- 4.2. This model was introduced to Greater Manchester at the Making Safety Visible Summit in October 2015. This Summit brought together 250 representatives from localities with presentation from Manchester, Salford, Stockport, Tameside and Wigan. A second Making Safety Visible Summit was held in May 2017 for the North East sector with locality representatives from each of Bury, Oldham and Rochdale.
- 4.3. The model has gained different degrees of traction in each of the localities over the past three years.
- 4.4. The GM Quality Board began work on a whole system approach and potential whole system metrics at its meeting in July 2018. The Board's continued through the summer and at the meeting in September with strong support for refreshing the previously established model. The model and potential metrics were reported to the Partnership Executive Board in September.

5.0 THE GREATER MANCHESTER HEALTH AND CARE SAFETY MODEL

- 5.1. The Greater Manchester Health and Care Safety Model is a systematic approach to safety that focuses measure efforts to improve and to learn from

adverse events. It can be applied to any health and care setting. It comprises five dimensions:

-) Past harm: this encompasses both psychological and physical measures
-) Reliability: this encompasses measures of behaviour and systems
-) Sensitivity to operations: the information and capacity to monitor safety on an hourly or daily basis
-) Anticipation and preparedness: the ability to anticipate, and be prepared for, problems
-) Integration and learning: the ability to respond to, and improve from, safety information



5.2. Teams and providers can use the model to identify the key aspects of safety in each of the five dimensions that are most relevant to the care they provide. Each of the dimensions is valuable in all settings.

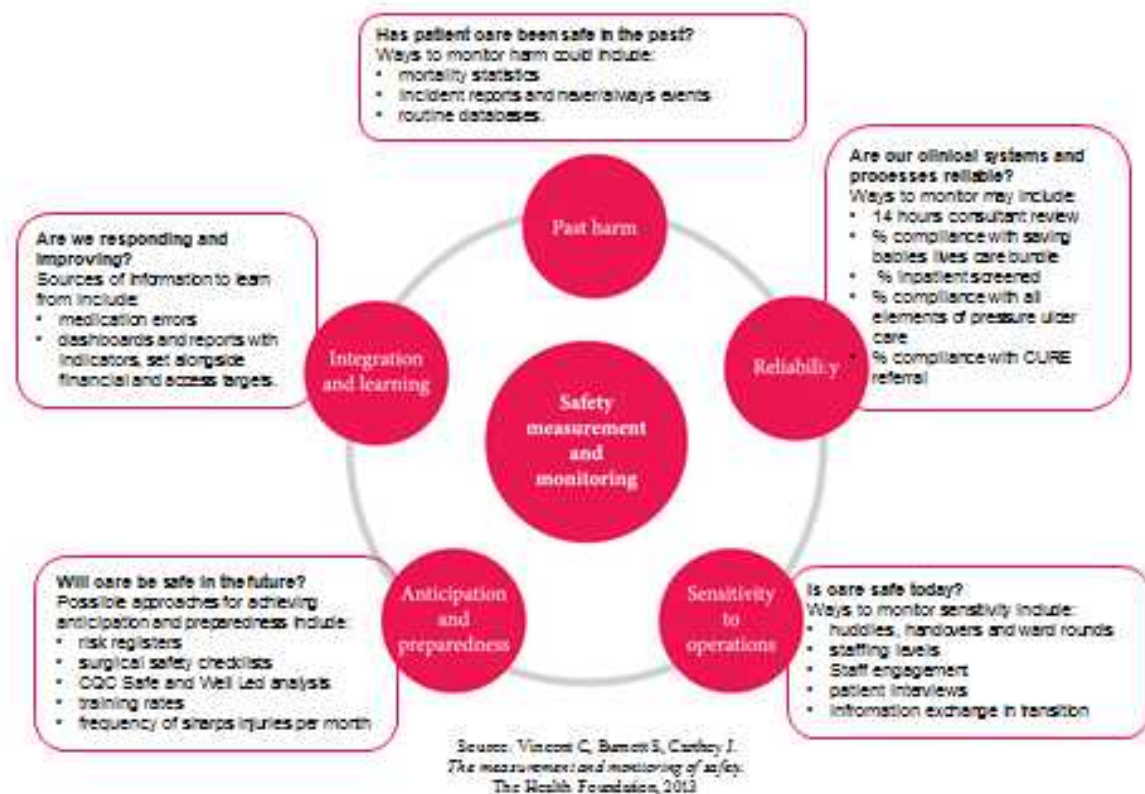
6.0 THE EMERGENT SAFETY METRICS FOR GM

6.1. With contributions from the Quality Board indicators of safety have been identified that might provide a useful overview of the GM health and care system. It is important to note the measures that are informative from the perspective of the whole GM health and care system will be different to those that are most informative to teams, providers, and localities. The

overarching model adopts the fractal approach described in the GM Quality Improvement Framework – the dimensions are similar at every level but they are then applied and measured in the most relevant way.

- 6.2. These initial measures will continue to be refined as the most appropriate mechanisms to gather and report information are developed to describe the safety of health and care for Greater Manchester.

A framework for the measurement and monitoring of safety



7.0 TAKING SAFETY IMPROVEMENT FORWARDS

- 7.1. Greater Manchester expects a health and care system that performs well on safety. This means:

-) being clear safety is a top priority;
-) having a clear, accurate and current picture; and,
-) having a supportive and learning culture.

- 7.2. Monitoring and leading improvements to the safety of health and care is a core activity of the GM Quality Board including consistent adoption of the Greater Manchester Health and Care Safety Model.

- 7.3. Refining the measures to monitor safety and report this to the Health and Care Board will continue at the Quality Board in dialogue with stakeholders groups.
- 7.4. Safety will be one of the two main items of discussion at the first ever GM Clinical Summit on 2 November 2018. The Summit will bring together about 150 system leaders from many health and care disciplines and all sectors to discuss care improvements in Greater Manchester and agree joint actions to improve.
- 7.5. GMHSCP will continue to influence the development of the national approach to patient and service user safety and make sure it is aligned with the GM model.

8.0 RECOMMENDATIONS

- 8.1. The Greater Manchester Health & Care Board is asked to:
 -) Support the established model of health and care safety.
 -) Support the development of the model by the Quality Board in consultation with localities, Primary Care Advisory Group, Provider Federation Board, Joint Commissioning Board, and other stakeholders groups.
 -) Note safety is a main agenda item on the first ever GM Clinical Leaders Summit.

Greater Manchester

Quality Improvement Framework

Taking charge

in Greater Manchester

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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 encompasses 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.

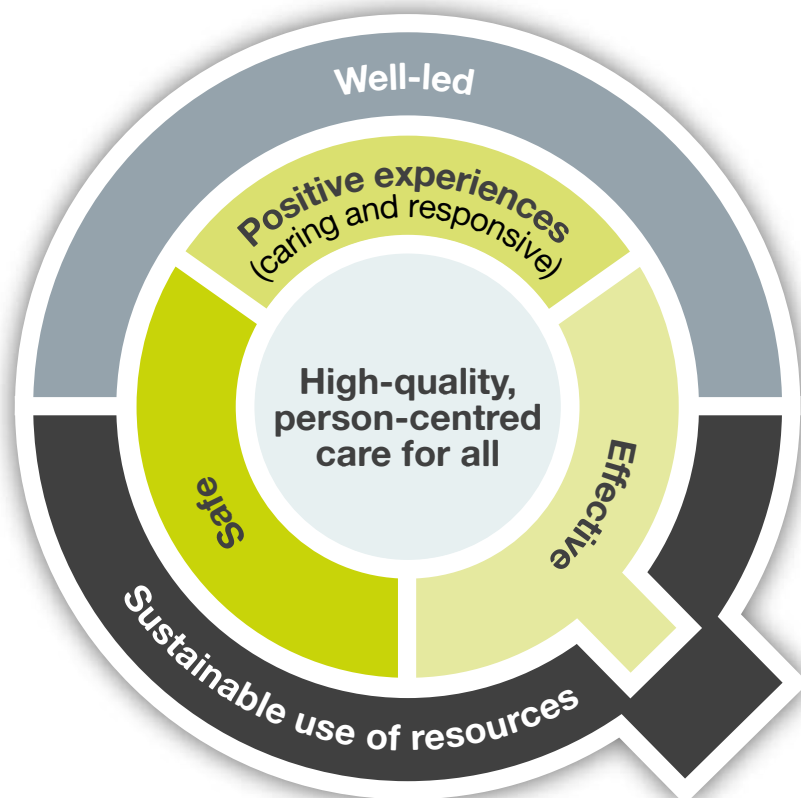


Figure 1: NQB's single, shared view of quality model

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.

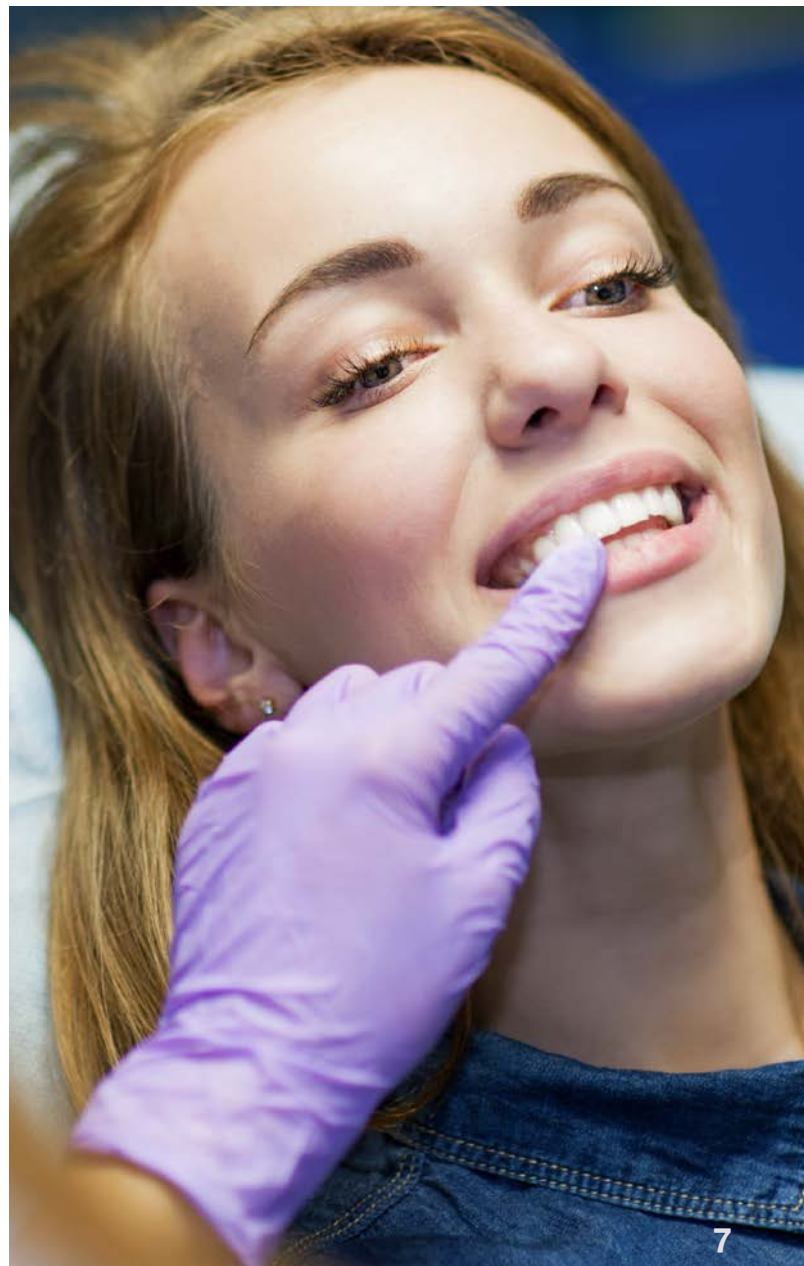
Examples:

- 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.



Get involved

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

Email: gm.hscinfo@nhs.net

Tweet: [@GM_HSC](https://twitter.com/GM_HSC)

Call: 0161 625 7791 (during office hours)

Address: 4th Floor, 3 Piccadilly Place, Manchester, M1 3BN