ABM University Health Board	
Date of Meeting: 01.02.18 **Name of Meeting: Q&S Committee** **Agenda item:4.1**	
Subject	*Quality & Safety Priorities: A New Quality Strategy*
Prepared by	Faye Killick, Therapies and Health Sciences Business Manager Alyson Charnock, Corporate Matron, Quality and Safety
Approved by	Christine Morrell, Director of Therapies and Health Sciences, Cathy Dowling, Interim Deputy Director of Nursing and Patient Experience
Presented by	Christine Morrell, Director of Therapies and Health Sciences Hamish Laing, Executive Medical Director Sandra Husbands, Director of Public Health Angela Hopkins, Interim Director of Nursing & Patient Experience

1.0 Situation

The Health Board is currently refreshing its Quality Strategy for 2018 – 2023.

The Strategy will reflect our organisational values and will be founded on the principles of prudent and value based healthcare, with a strong focus on Quality Improvement, engaging on every level with all our staff and services. Our Quality Assurance focus will further embed our culture of transparency and continuous improvement and will build on the Health Boards commitment to meet current quality standards, measured by our Quality indicators. Collaboration and benchmarking will form the basis of an integrated Health Board approach working towards seamless quality outcomes.

2.0 Background

As ABMU Health Board's executive leads for quality, our first and main priority is to deliver health services that embody the principles of Prudent Healthcare and are consistently of the highest standard.

We have taken significant steps to strengthen the Health Board's quality assurance, patient feedback and quality improvement arrangements.

A Quality and Safety Priorities Workshop was held on 1st December to review our current approach, our quality priorities and to start to consider how we may design an ABMU quality management system. This workshop was led by Christine Morrell, Hamish Laing and Linda Reid, facilitated by Alan Willson, Swansea Centre for Improvement and Innovation, Swansea University and attended by 40 ABMU senior manager and clinicians. A Quality Strategy report has been prepared and circulated to all attendees seeking further comments. (see Appendix 1).

The clinically focussed directors of the executive team commissioned this review of the Quality Strategy so that the next round of priority setting will use tested methods and build on ABMU's strengths and reflect our values.

Quality Priorities

In 2016, the Quality and Safety Committee agreed that the existing 7 Quality Priorities would remain and these rolled over into the 2017/2018 period. The ten priorities for 2017/18 are set out below, the priorities that are included in the Performance Dashboard are highlighted in green:

No	Priority	Description
1	PREMs and PROMs	Improving the way we collect and use Patient Reported Experience Measures (PREMs) and Patient Reported Outcomes Measures (PROMs)
2	Stroke Improvement	Improving our stroke services by reconfiguring the patient pathway
3	Spot the Sick Patient (NEWS)	Improving the way we identify and manage a patient whose condition deteriorates by spreading across all hospitals and wards the 'Spot the Sick Patient' initiative.
4	DNACPR Policy (NEWS)	Improving End of Life care by implementing the all-Wales Do Not Attempt Cardiopulmonary Resuscitation Policy (**Fully Implemented)**
5	e-Prescribing	Reducing medication errors by implementing electronic prescribing and administration of medicines, **Included in Pharmacy and Medicines Management Report to Quality & Safety Committee**
6	The Big Fight	Spreading the 'Big Fight' campaign which targets antibiotic resistance and the incidence of *clostridium difficile* infections in primary care. **Reported within the Infection Prevention and Control Committee.**
7	Suicide prevention	Improving risk assessment and support mechanisms to prevent those who are known to our mental health services from attempting or contemplating suicide. **Reported within the Mental Health and Learning Disabilities Quality and Safety Committee**
8	Falls	Improving the prevention of falls in hospital and community settings

No	Priority	Description
9	Pressure Ulcers	Reducing avoidable harm by reducing the incidence of pressure ulcers across the Health Board but particularly in community settings
10	e-TOC	Sharing information accurately and in a timely fashion between clinical teams, particularly on discharge from hospital by compliance with our standard for an electronic discharge summary being sent.

The 2016/2017 Annual Quality Statement (AQS) includes two sections on the Quality Priorities, one which indicates performance over the 2016/2017 period and one which indicates progress the Health Board hopes to achieve against the Quality Priorities.

3.0 Assessment

This year (2018) the AQS will need to be received by the Health Board by the revised deadline of the 1st June to include figures from the May dashboard. The AQS will contain an update on performance against the existing priorities and how they will change for the 2018/2019 reporting period.

The Quality Priorities tracker which has previously been reported to the Quality and Safety Committee details the progress made against the targets for each priority where updates are available. The main issue with this way of reporting was that some measures were only able to be updated on a three monthly basis, therefore were not available for each bi-monthly update, and some of the Quality Priorities were static in movement, such as the DNACPR Policy, which once implemented this did not change. To avoid duplication, and to ensure clarity of objectives and plans against the Dashboard and the Health Board's 10 Quality & Safety Priorities, any updates relating to indicators that were included in both the Quality Dashboard and the Quality Priorities were only presented in the Quality Dashboard update.

The Strategy will have a focus on the health & social care responsibilities of our Health Board, working with partners to discover and apply timely and effective ways of working to support our whole population. We will improve outcomes and citizen experience by reducing variation to improve health and the delivery of safe services.

It was proposed and agreed that the Health Board should align its quality priorities for 2018-2019 to our current areas of challenge, which are our strategic priorities and will focus on our five key priority programmes of:

1. Unscheduled Care
2. Planned Care
3. Stroke
4. Cancer and
5. Healthcare associated infections

The performance and quality indicators will be clearly defined and will inform a culture of Quality Assurance. Patient reported outcome measures (PROMS) and Patient reported experience measures (PREMS) will be included in the development of these quality assurance indicators where possible.

The intention is to further strengthen and refine our Quality Management System including our assurance processes around the domains of the Healthcare Standards and to continue the development of our Ward to Board Assurance Dashboard and Framework. The dashboard has now been developed to align to the Nurse Staffing Act and thus far includes two clinical indicators, pressure ulcers and falls, and a project plan will be developed to further develop this work to include further indicators.

A strategic consideration as part of the revised Quality Strategy will be the initiation of a Health Board Quality Hub. This would centralise the Health Boards' quality management approach, lead the Strategic approach to quality and provide the capacity to support the delivery of key Quality outcomes at the pace that is required in this demanding climate.

4.0 Recommendations

The Quality and Safety Committee are asked to:

1. Note the position of development of the Quality & Safety Priorities (2018 – 2023)
2. Support an engagement exercise to publicise and seek views from ABMU workforce and stakeholders
3. Note the need for development of a quality management system.
4. Agree way forward.

Appendix 1:

Swansea University
Prifysgol Abertawe

ARCH

Quality & Safety Priorities: A New Quality Strategy

Friday 1st December 2017, 9:30 - 12:45

St Pauls Centre, Gerald St, Port Talbot, SA12 6DQ

Aims:

- review Abertawe Bro Morgannwg University Health Board's approach to its health and healthcare quality strategy and priorities
- design a quality management system for the health board
- map the delivery of current priorities by such a system

Attended by:

40 senior managers and clinicians from ABMU (please see appendix 1)

Led by:
Christine Morrell, Director of Therapies and Health Science
Hamish Laing, Medical Director
Linda Reid, Head of Innovation and Organisational Development

Event facilitated and report prepared by:
Alan Willson, Swansea Centre for Improvement and Innovation, Swansea University

Logistics by:
Faye Killick, Director of Therapies and Health Science Support Manager

1. Reviewing the current approach

1.1 Quality & Safety in ABMU – The Strategy, the priorities and systematic approach. Christine Morrell (please also see PowerPoint at Appendix 2).

This workshop was commissioned by members of the ABMU executive team to allow a review of the systems for the management and improvement of quality across the health board. The review must involve all layers of the management team responsible for its delivery: hence this workshop.

The next 5-year phase will simplify the process of setting and communicating priorities by focussing quality work on the current areas of corporate priority. For 2018/9, these are:

- Stroke
- Cancer
- Healthcare Acquired Infections
- Unscheduled Care
- Planned Care

The task for the quality strategy will be to ensure that we work to deliver the best possible care experience and outcomes for our population across each of these areas. In so doing, we want to build systems of quality management and assurance that are health board-wide and which will enhance all aspects of the health board's services. ABMU has many strengths on which to build but there is still some way to go to achieve that aim. The task is both urgent and long term. Hence, while the workshop will inform the direction of travel, it is vital that it also results in immediate actions to start the process of change.

1.2 The need for change – Workshop

Delegates listed aspects of the current systems for managing quality that need to be kept and those that need to change. The summary below is supported by 180 comments logged on Post-It notes. No attempt was made in the workshop to reconcile apparently opposite contributions. Therefore, this is an expression of individuals' personal experience and views.

<u>Need to keep</u>

Main themes and examples

Enthusiasm/energy/commitment of staff *"excellent colleagues", "hardworking people", "willingness to collaborate"*

Training/skills *"IA training", "online resources", "IQT", "improvement team", "Q community", "training programmes"*

Culture "*values", "aspirational", "building to do more", "strong value base",*

"organisational commitment", "willingness to improve", "teamwork at groundfloor", "engaged medical workforce at unit level", "joined up thinking between DUs", "joint discussion between sectors"

Achievement *"lots of improvement at ground floor/front door", "pockets of good practice", more compliments than complaints", "acute response teams maturing", "when we work together we do it well", "improvement in MDT is working", "sytems leadership examples"*

Organisational priority *"we have a quality strategy", "commitment to training", "…hence today", "commitment to improve patient flow", "clear priorities and direction at high level", "organisational commitment to QI"*

Structure *"clear governance and quality leads in each area", "accountability for QPS and PE at triumvirate level", "clear hierarchy of meetings", "good governance within units"*

Learning and sharing *"celebrate success", "staff with good ideas", "learning being identified more than before", "sharing learning via assurance and learning group", "communication channels", "great learning opportunities through deanery and university"*

Outcome focus *"evidence that improvements are being made and harm is reduced – keep the focus", "PROMs and PREMs becoming more prominent", "some good work on PREMs", "beginning to focus on outcomes and value based HC"*

Accountability/transparency *"we do some national audits", "gather lots of data", "celebrate service models that benchmark nationally", "feed lots of info into the centre", "good at participating in national audits so we know how we are doing"*

Miscellaneous *"aligning quality to Tier 1 (but risks access being dominant)", "supportive work to reduce sickness", "workforce management in balance with employee and employer expectations"*

<u>Need to change</u>

Main themes and examples

Data *"collection & analysis needs radical improvement e.g. emergency department 'Symphony'", "access to data & management", "duplication of reporting", "lots of data but not used well and sometimes wrong data", "execs do not understand data analysis and poor practice is tolerated", "measures not meaningful for front line staff", "must have bottom up intelligence systems – at present only provided to exec team"*

Culture *"lack of empowerment", "fear of blame", improvement not embedded", "culture is inconsistent", "focus on failure not success", "name and shame approach at HB level", "too many priorities don't give culture a chance", "language of*

performance and finance stronger than quality", "HB values need to be lived by all levels"

Training and learning *"too much e-learning", "need to focus on human factors for clinical teams", "staff need more knowledge", "need to invest in change initiatives", "more training and support for change", "lack of learning across units", "don't share or integrate learning e.g. from incidents", "no infrastructure to embed learning"*

Engagement of all sectors, of staff and of patients *"connect clinicians with QI projects", "struggle to put patients at the centre", "not enough patient engagement",*
"still top down", "don't engage with junior staff", "not enough community engagement", "need more patient conversations – particularly arranging end of life care", "need to improve ownership at frontline of and for improvement"

Organisational priority *"need a board-wide clinical cabinet", "time needed by clinicians for improvement and audit", "DUs struggle to interpret what is required to meet priorities", "unclear priorities from board to floor", "not good at communicating a small number of priorities to front line staff", "very performance driven – missing the point", "focus too much on performance numbers – not quality of care", "quality secondary to targets"*

Structure *"lack of integration with hospital/community/LA", "pathways not set up right between community and hospital", "need to improve collaboration across teams with patients rather than staff at centre", silos of working", "complaints not joined up", "too much focus on secondary care", "perception of what can be done in community – lack of trust?", "align improvement and OD teams*

Outcome focus *"too much waffle in reports – not enough information", "reactive focus –HB and WG", "outcome focus – needs more of this approach", "current improvement priorities are enablers not outcomes", "not enough focus on prevention"*

Accountability/transparency *"we don't do very much benchmarking"*

Miscellaneous *"focus on staffing levels and ways to boost retention", "DATIX more important than quality improvement", "trying to resolve co-morbidities", "improve admission avoidance pathways"*

- Keep link to organisational values, WG health care standards and themes but make links simpler
- Carry on with priorities that have not been achieved and, for all priorities, show evidence for why they are important
- Keep measures of success but move up from appendix
- More on prevention and whole pathway/less secondary care focus
- More emphasis on citizens, patients and outcomes which matter to them

- Needs scientific underpinning and system of assurance/reporting
- Needs more about the improvement approach and how it will be taken forward over strategic period

2. Quality Management Systems

2.1 What is a quality management system? Alan Willson (please also see PowerPoint at Appendix 3).

Organisations need to develop and be clear about their system for managing quality. The need for a systematic approach to quality management is recognised by a recent Bevan Commission discussion paper and previously by Joseph Juran (1951). His system envisages three elements: a quality plan, quality control and quality improvement. To be effective, quality improvement requires the right organisational context if it is to be continuous and provide cumulative benefit to the organisation and its customers (Dixon-Woods and Martin 2016).

A number of publications and support tools are available to guide those discussions (e.g. Vincent and Amalberti 2014, Fulop and Robert 2015, Banfield 2012). In particular, Vincent and Amalberti's approach recognises the need for a range of approaches reflecting the different levels of operational risk within health services. Their proposals also capitalise on a range of resources which exist within most health organisations.

Almost without exception, approaches to mobilise quality management in healthcare are based on quality improvement principles and tools which were set out by WE Deming and which are summarised in by the National Advisory Group (2013), Langley (2009) and which are consistent with ABMU's core values. A quality management system requires that these approaches are applied consistently for small and large tasks.

Being explicit about the nature of this system within ABMU will support the clarification of roles and responsibilities and the planning of its maturation across the strategic period. It can also ensure that the work to achieve strategic priorities is designed so that it builds a reusable infrastructure.

2.2 How would a quality management system support the delivery of well-known quality challenges? – Workshop

Six groups each considered one quality or safety issue to consider how improvement should be supported within a quality management system and what work was most appropriately done at health board, unit and team levels. The safety issues were:

- Antibiotic prescribing (want less)
- Incidence of pressure ulcers (want none)
- Completion of discharge summaries (want more/all)
- Inpatient falls (want less)
- Wrong site/patient surgery (want none)
- Caring for an inpatient with dementia (want better)

The results are summarised in Table 1 below.

Table 1: A quality management system to deliver well-known priorities

Issue ⇨	Antibiotics	Pressure ulcers	Discharge summaries	Inpatient falls	Wrong site	Dementia care
Theory	Model good practice, public education	Monitor and understand incidence, prevention, increase team resilience	What is impact on patient, handover responsibility	Avoid patient deterioration in beds, educate patients carers, realistic aims (not eliminate falls)	Patient empowerment, documentation, WHO checklist, eliminate hierarchy, teamwork, report near miss	Avoid admission, act like a sector, time to deliver care
Risk level	High reliability	Ultra safe	Ultra safe	Ultra adaptable	Ultra safe	High reliability
Government activity	Education, training HCPs, national guidelines	Inter agency working, public awareness, national standards	Fund software	Encourage reporting but also balancing measures e.g. acuity and mobility, actively promote movement rather than number targets	National policy - checklist	Regeneration of whole system (not operational involvement), hold to account across all sectors and incentivise right behaviours
Health board activity	Local guidelines, share data/good practice, e-prescribing	Inter agency working, reporting and assurance, resources and equipment, target high risk groups	Support focus on function not document, themes limiting completion responded to, hand over parity – team:team, professional:professional, orgn:orgn	Educate at all levels, manage risk, more joint roles, give permission	Support on-going QI project/programme	Work with social care, be more risk averse, develop trust, use expertise on the ground, encourage culture of assess to discharge
Unit activity	Share data, joint working, raise profile, standardise patient info	Work with agencies, awareness and identification training, understand incidence	Systematise through patient journey, exception reporting	Enable teams, flex budgets, provide resource/space/time, support teams in PDSAs	Ward & theatre ID process, facilitate challenge in teams	Work as integrated HB – don't silo as 6 DUs
Team activity	Peer review, time to review/train/educate, recognise/share success	Ownership of care, MDT approach, avoid multiple assessment, prevention plans	Understand safety issue, value information not process, business as usual/common-sense	MDT approach to care, use improvement method, courage and space to act, move from cwtch culture of patients to cwtch culture of staff	MDT teamwork, sufficient theatre time/staff, remove pressure	Build culture of improvement and coproduction with stakeholders and partners

In summary, the activities associated with each level were:

Government: Policy, education, guidelines, infrastructure, public awareness/accountability
Health board: Joint working, strategic shift, structural change, creating the climate for improvement

Units: Exception reporting, joining up systems and teams across patient journeys, data sharing, removing blocks, systematising change
Teams: Training, reviewing, improving and supporting

3. Delivering our quality priorities through a quality management system

The same groups were asked to consider the 5 current priority areas for improvement. Using driver diagrams which have been created to drive the current performance targets, they were asked to comment on how these could be adapted to support the quality agenda. outcome of this discussion has been reported separately to the subject leads. They were then asked how improvement should be delivered. The groups discussed several potential improvement targets – 2 examples are given in Table 2.

Table 2: Delivery of our quality priorities through a quality management system

Aspect	Single pathway – attendance/admission	Unnecessary 2019
Theory	Driver diagram is clear and proactive on variation outcome	Engage, join up care, care, reduce focus
Government activity	Policy, learn from shadow running, holding to account	Public education, legislate re alcohol/obesity, avoid targets being perverse driver, define multisector roles
Health board work	Understand impact, common prioritisation, balance with other HBs, 3rd sector	Joined up cluster/network, approach,
Unit activity	Define impact, share learning, support teams	More joint working, specialist advice for GPs, signposts to healthy resources
Team	Define impact, implications, plan and ENGAGE	Increase other pathways, dialogue, education

4. Summary and actions. Hamish Laing and Alan Willson

This section combines the response to the workshop given by Hamish Lang at the end of the plenary session with some suggestions from the report's author about how the work needs to be taken forward. As the conclusion to the report, it is important that all such actions are considered by the executive team and all those who are responsible for the delivery of quality of services across ABMU.

Summary

- The clinically focussed directors of the executive team commissioned this review so that the next round of priority setting and delivery of targets will be more effective than hitherto, using tested methods and building on ABMU's strengths
- Participants today have shown real commitment to delivering change. It is vital that their enthusiasm is met with rapid action and real change; also, that those people not in the room are involved in and contributing to this discussion
- The recent recruitment to the Q community is an opportunity to capitalise on the energy and expertise of the workforce
- ABMU needs to build a system that supports and encourages improvement across all its teams and services not just those which are current priorities
- There is more work to do in order to convert the current performance based driver diagrams into full change packages which support teams to make purposeful improvements.

Suggested actions

- A paper will need to be presented at the next meeting of the ABMU Quality and Safety Committee setting out this approach and next steps
- An engagement exercise needs to be planned to publicise and seek views from the ABMU workforce and stakeholders to further inform the building of a robust quality management system
- The building of a quality management system could be planned over a 5 year period with achievable yearly milestones. It should combine with rather than be separate from the health board's approach to performance and delivery. Its aim should be to support patient focussed improvement by those who work directly with and for people and patients. It needs to clarify the roles of the organisational tiers and ensure that all decisions and knowledge about care and treatment are as close to the patient as possible
- The quality management system should be designed in such a way that it sets engagement with patients and staff at its heart
- The five chosen priority areas need to be worked up into effective improvement packages based on best practice in improvement science. This can be done notwithstanding the fact that the "perfect" quality management system is still under construction. There are models available from IHI which will be familiar to those undergoing Improvement Advisor Training and which are like programmes which ABMU has been recently involved in. There is current successful experience of internal change programmes for example in unscheduled care and outpatient services within other Welsh health boards.
- The networking of improvement enthusiasts for mutual learning and support must be actively supported. The Q community will help but is unlikely to be enough to meet local needs.

Appendix 1. Attendance

Name	Title
Christine Morrell	Director of Therapies and Health Science
Alison Clarke*	Assistant Director of Therapies and Health Science
Cathy Dowling	Deputy Director of Nursing & Patient Experience
Hamish Laing	Executive Medical Director
Pushpinder Mangat	Deputy Medical Director and Cons ITU & Anaesthesia
Sandra Husbands	Director of Public Health
Nicola Williams	Nurse Director Morriston Hospital
Debbie Bennion	Unit Nurse Director POW
Christine Williams	Assistant Director of Nursing
Tanya Spriggs	Interim Unit Nurse Director
Lesley Jenkins	Unit Nurse Director. NPT
Alastair Roeves	Medical Director for Primary Care & Community Services
Mark Ramsey	Interim Unit Medical Director- Morriston
Hilary Dover	Director Primary and Community Services
Jamie Marchant	Service Director POWH
Linda Reid	Head of Innovation & OD
Jan Thomas	Assistant Chief Operating Officer
Malcolm Thomas	Associate Director - Recovery and Sustainability
Delyth Davies	Head of Nursing Infection Prevention Control
Faye Killick	Therapies and Health Sciences Business Manager
Rose Jones	Business Manager. Nursing Divison
Alyson Charnock	Corporate Matron Quality and Safety
Hazel Lloyd	Head of Risk & Legal Services
Phil Coles*	Consultant Anaesthetist
Emma Smith*	Service Improvement Information Manager, Information
Jock Andrew	Head of Patient Experience
Clare Dieppe*	Consultant. A&E
Brendan Healy	Consultant in Microbiology and Infectious Diseases
Andrew Macnab*	Associate Unit Medical Director Emergency Care an. A&E, Morriston
Andrea Bradley	Matron – A&E Morriston
Khan Prince*	Service Improvement Manager
Lesley OShaunessy	Operational Services Manager
Maggie Berry	
Fiona Hughes	
Rhodri Edwards	Singleton Unscheduled Care & Stroke
Chris Hudson	Singleton Unscheduled Care & Stroke
Rhian Finn	Singleton Unscheduled Care & Stroke

*Workshop facilitators

Appendix 2. Quality & Safety in ABMU – The Strategy, the priorities and systematic approach. Christine Morrell

Quality & Safety Priorities: A New Quality Strategy

Welcome

Today is About...

Giving time to

1. Reviewing together our current approach to health and healthcare strategy and priorities
2. Start designing an ABMU quality management system
3. Test mapping the delivery of current priorities by such a system
4. End with Actions

Quality Strategy Aim- Changing For The Better

We will respect people's rights in all that we do and plan our services and their care with them. Wherever and by whom it is provided care will be safe and compassionate, meeting agreed national standards, providing excellent outcomes and an experience that is as good as it can be

Health and Care Standards

Quality Priorities 2018-19

- Stroke
- Cancer
- Healthcare Acquired Infections
- Unscheduled Care
- Planned Care

Quality Priorities 2016-17

1. PREMS and PROMS
2. Stroke Improvement
3. Spot the Sick Patient
4. DNACPR
5. E-Prescribing
6. The Big Fight
7. Suicide Prevention
8. Falls
9. Pressure Ulcers
10. eTOC

Changing the Culture

The patient must be at the centre of all that we do

A top-down performance system will not produce the change in culture that is necessary

Every Board should start by recognising that:

every system is perfectly designed to deliver what it delivers

Pursuing a High Reliability Culture

1. Leadership Visibility

2. Reluctance to Simplify + measurement

3. Deference to Expertise

4. Accountability
   - Reward
   - Address bad behaviours

5. Deep Staff Engagement
   Share the Learning

6. Teamwork

Quality Delivery Plan for Wales

- Clear organisational values and goals
- Visible leadership at all levels
- Strong employee engagement and satisfaction
- A relentless focus on improvement
- Robust systems for reporting and learning
- Openness in all that they do

Not just words...

- Higher performing organisation characteristics
  - Vision
  - Quality improvement culture
  - System dedicated to collaboration, transparency and improving outcomes
  - Explicitly prioritising QI
  - Balancing short term priorities with long term investment
  - Using data for QI not only assurance
  - Engaging staff and patients in QI
  - Encouraging a culture of continuous improvement

  Within a transparent and collaborative system
- Our Quality Strategy needs to be our design tool

Not just words...

- We want to provide the best possible outcomes for our patients, their relatives and carers and the public
- Doing that but still a long way to go
- Also our Board and our structures are accountable for the quality of care we provide

Observations

The Positives

- Link to organisational values
- Focus on WG Health & Care Standards
- Areas of exemplars in quality health care- pockets of excellence
- Robust Quality Assurance Mechanisms
- Strong emphasis on learning from and improving patient experience

Areas for improvement

- Deliver on our quality priorities
- Strengthening organisational approach
- Emphasis on citizens, patient and outcomes and what matters to them
- More on prevention and whole pathway/less on secondary care focus
- Less of a focus on finance and external performance targets
- Robust system of assurance and reporting at all levels
- Agreed QI approach

Appendix 3. What is a quality management system? Alan Willson

What is a quality management system?

Alan Willson

1 December 2017

Quality management systems

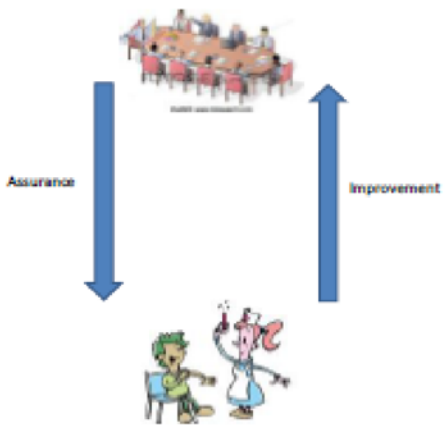
How do we plan, control and improve the quality of our services? (after Juran)

How do we provide assurance?

"Every system is perfectly designed to get the results it gets" Paul Batalden

always **improving** so that we are at our best for every patient and for each other.

Safe, positive, seek out learning and continually develop	• Be vigilant about safety and risk, never turn a blind eye • Look for opportunities to learn, enthusiastically share ideas and actively seek solutions and ways to improve	• Be negative, cut corners, cover up mistakes, ignore evidence, accept poor standards • Be obstructive or resistant to change, use negative body language like eye-rolling or sighing
Professional, responsible and hold each other to account	• Be accountable for your own behaviour, and hold others to account, keep promises • Be positive, a team leader and respectful/kind to others	• Leave notes and documentation incomplete • Accept second best, pass the buck, avoid responsibility and take to be chased by others • Complain about work colleagues
Efficient and timely	• Actively find ways to reduce delays and waste, join up services for others • Plan ahead, be prompt, organised and responsive, value others' time	• Ask others to take on too much, set unrealistic expectations and pass on stress • Avoid change 'because we've always done it this way' • Keep people waiting unnecessarily



Assurance

- "Particular challenges for Q&S Committees….reliant on assurance flows"

Wales Audit Office 2016

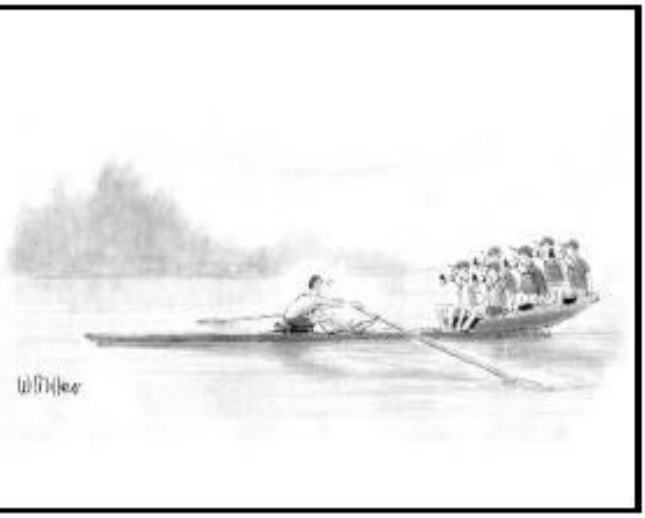
- "Serial production of lengthy reports..little impact..demoralises..not evidence based"

Ham, Berwick and Dixon (Kings Fund) 2016

Improvement

- Preoccupation with failure?
- Reluctance to simplify interpretations?
- Sensitivity to operations?
- Commitment to resilience?
- Deference to expertise?

After Karl Weick 2001



Some solutions/approaches

The Model for Improvement

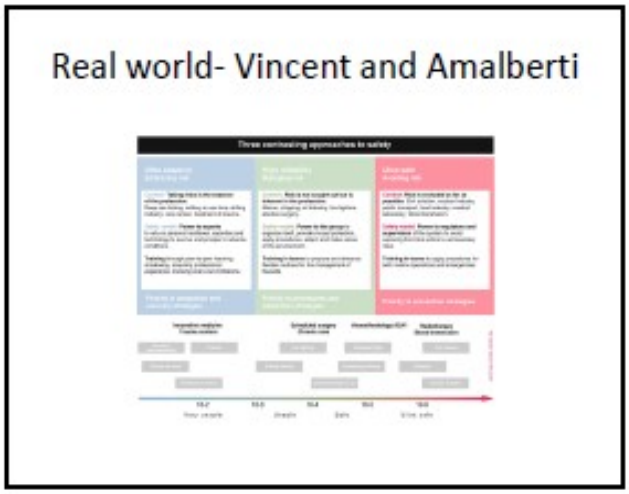
Developed by Associates in Process Improvement in 1996

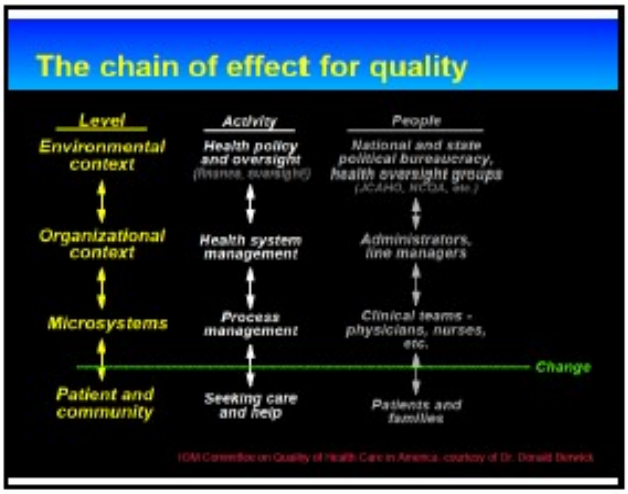
Does quality improvement improve quality?

- Act like sector
- Stop looking for magic bullets – focus on organisational strengthening
- Build capacity for designing and testing solutions and plan for replication/scaling from start
- Think programmes and resources not projects

Dixon-Woods and Martin 2016

Real world- Vincent and Amalberti





QMS – who does what?

	Improvement	Assurance	Context/rules
Government		Performance and outcome measures Holding to account	Public accountability
Health Board	Vision and direction QI hub	Public accountability and transparency	Minimise top-down initiatives HRO custodian
Unit	Coordinating urgent or multi-team improvement	Exception reporting	Consistent use of QI principles
Team	Repeated PDSAs based on system knowledge	Process management	Ownership and involvement by all involved in the work Patient and carer participation

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