NHS Providers

Creating an enabling environment to improve equitably

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IMPROVEMENT

Provider collaboratives: improving equitably

Agenda

Welcome and introduction
Facilitated by chair: Jenny Reindorp – Interim director of funded programmes, NHS Providers

Presentation one:
Prof Graham Martin, director of research at The Healthcare Improvement Studies Institute

Presentation two:
Alice Forsythe, executive partner, transformation services at The Virginia Mason Institute

Presentation three:
Ailsa Brotherton, executive director of improvement, research and innovation (Lancashire Teaching Hospitals NHS Foundation Trust) and improvement director, national improvement board, and a Q member

Interactive Q&A
Facilitated by chair

Summary and close

Housekeeping

- Please note, this event is being recorded
- Please keep your camera on wherever possible
- If you lose connection, please re-join using the link in your joining instructions or email Improvement@nhsproviders.org
- Please ensure your microphone is muted during presentations to minimise background noise
- Please feel free to use the chat box for any questions or comments
- If you would like to ask a question audibly, please use the raise hand function during the Q&A section and we will bring you in
- Any unanswered questions will be taken away and answered after the event
- You will receive a link to an evaluation form at the end of the day, please take the time to complete it, we really do appreciate your feedback.

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Presentation one:

- **Prof Graham Martin - director of research at The Healthcare Improvement Studies Institute**

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Provider collaboratives: improving equitably

THIS.Institute The Healthcare Improvement Studies Institute

Made possible by The Health Foundation

What can provider collaboratives learn from existing models of collaboration?

Graham Martin

Director of Research, THIS Institute

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Overview

1. The theory behind collaboration
2. Varieties of collaborative approach
3. Do they work?
4. Implications for provider collaboratives

The theory behind collaboration

Collaboration in context

- "A network of people who come together to co-operate around a common interest, with a shared goal of improving care and mutual learning"[1]
- Network-based collaboration also posited as a 'third way' approach to public service governance
  - Hierarchies (bureaucratic command and control)
  - Markets (competition spurs innovation and efficiency)
  - Networks[2] (collaboration allows knowledge sharing and creativity)
- Collaboration has some advantages over the other two forms, at least in theory
- But it also has some weaknesses

Image: Hannah Busing, 'Untitled'. Reproduced under the Unsplash licence.

Collaboration in theory: strengths and weaknesses

- Collaborations can be **responsive and dynamic**: they are not stifled by the need for top-down approval
- Collaborations can allow **knowledge sharing**: people are more inclined to trust one another rather than see each other as competitors
- Collaborations can be **creative**: working together can result in greater innovative capacity than working in silos
- Collaborations are fragile: they may be **squeezed out** by the pressures of other governance forms
- Collaborations can **take time to develop**: they are reliant on trust, which is hard to build and easily broken
- Collaborations are vulnerable to unco-operative forms of behaviour: **incentivising people to behave collaboratively isn't easy**

Varieties of collaborative approach

Two well known approaches

- Collaboration isn't limited to formal models and approaches
- However, a couple of popular approaches illustrate some of the key 'design choices'

1. Quality improvement collaboratives
2. Communities of practice

Quality improvement collaboratives

- Various longstanding collaboratives in the United States[1]
- Common goals around
  - reducing unwarranted variation
  - sharing good practice
  - improving population health
- Use of data is key to their approach
  - credibility (e.g. routinely collected, risk-adjusted)
  - accessibility (e.g. comparisons, rankings)
  - clear 'terms of use' (for improvement only)
- Long-lived, with evidence of improvement

Image: Vermont Oxford Network.

Communities of practice

- Looser collaborations (at least as originally conceived)
- Practitioners with common expertise forming a community to share knowledge
- A particular focus on “non-canonical practices”[3]
- Originally seen as self-forming, but there is a growing focus on the ‘cultivation’ of communities of practice

Do they work?

The evidence base

- Evidence is somewhat equivocal for collaboratives and communities of practice[4,5]
- Multifaceted ‘black box’ interventions introduced alongside other things in complex systems
- Long-lasting collaboratives have offered convincing evidence of their impact
- People tend to value communities of practice but evidence of their impact on outcomes is scarce
- ‘The way that you do it’ may be crucial – and good practice guidance abounds[6]

Image: Elena Mozhvilo, ‘Untitled’. Reproduced under the Unsplash licence.

Implications for provider collaboratives

Some key implications

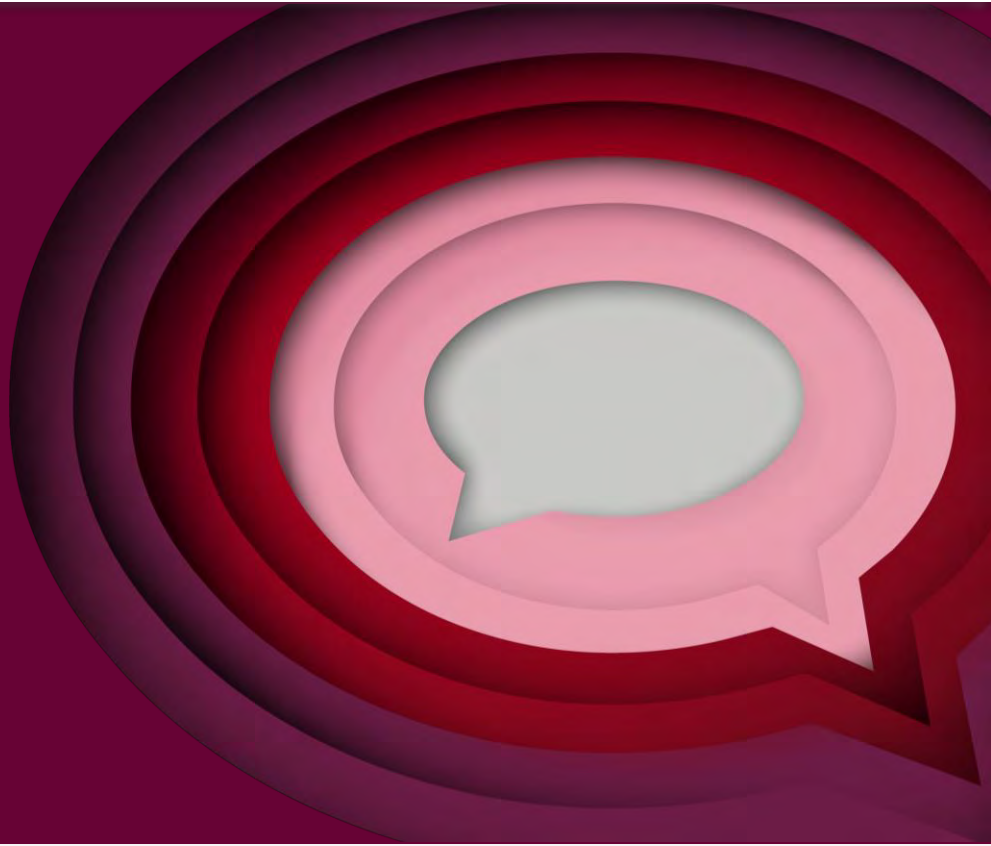
- Collaboration can mean a wide variety of approaches: what is best in reducing unwarranted variation may not be best for sparking creativity
- Collaboration can be hindered by the 'shadow of hierarchy' (or competition): to what extent is performance management helpful?
- Equally, 'under-management' may not serve the purposes of collaboration well: what are the goals? How to encourage collaborative behaviour?[7]
- Collaboration is unlikely to change practice in a sustainable way quickly: it needs time to become (understood as) a routine way of working

Image: Damian Walmsley, '20220131-Snakes and ladders'. Reproduced under a CC BY-NC 2.0 licence

Some considerations for you

- **What is driving your collaborative?**
  - Is it performance-focused? Is there space and time for bigger thinking?
- **What are the 'background conditions'?**
  - Do the trusts see each other as competitors? How about the teams involved?
- **What kinds of problems is your collaborative seeking to address?**
  - Is this a matter of sharing good practice? Or are you trying to address 'wicked issues' in creative ways? If so, who else needs to be involved?
- **How will you know you are doing better?**
  - What are your data? Does everyone believe them? Is everyone pulling in the same direction?
- **What have you invested in your collaborative?**
  - Are you making collaboration easy? Do people have time to build trust? Is this a long-term initiative?

Thank you for listening.



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References

1. **Martin G, Dixon-Woods M. Collaboration-based approaches. Elements of Improving Quality and Safety in Healthcare. 2022. https://dx.doi.org/10.1017/9781009236867**
2. Powell WW. Neither market nor hierarchy: network forms of organization. Research in Organizational Behavior. 1990;12:295–336.
3. Brown JS, Duguid P. Organizational learning and communities-of-practice: toward a unified view of working, learning, and innovation. Organization Science. 1991;2(1):40–57.
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7. Carter P, Ozieranski P, McNicol S, Power M, Dixon-Woods M. How collaborative are quality improvement collaboratives: a qualitative study in stroke care. Implementation Science. 20141;9(1):32.

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Presentation two:

- Alice Forsythe, executive partner, transformation services at The Virginia Mason Institute

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Provider collaboratives: improving equitably

Embedding Equity into an Improvement Culture

Alice Forsythe, Executive Partner, VMI

NHS Providers Collaborative
18th October 2023

Virginia Mason Institute

Areas of Focus

Make the Implicit Explicit

Foster a Systems Approach

Provide Leaders & Teams with User-Friendly Tools

Virginia Mason Institute™

Make the Implicit Explicit

Organisational Values with Stated Behaviours

Compassion	• We take the time to listen intentionally to understand others' needs. • We approach every interaction with kindness for patients and each other. • We strive to make every person feel respected, important and heard.
Integrity	• We act ethically and do the right thing. • We are honest and accountable for our mistakes. • We honor our commitments and follow through on what we say we will do.
Excellence	• We consistently perform our best work every day. • We set high standards for ourselves and each other. • We are constantly seeking opportunities to improve.
Collaboration	• We work together toward our shared purpose. • We communicate with each other clearly and kindly. • We encourage and lean on each other's strengths.
Inclusion	• We celebrate our differences. • We value each person's voice and each person's worth. • We invite new ideas and perspectives.

Virginia Mason Institute

Virginia Mason Institute™

Respect *for* People

THE VIRGINIA MASON EXPERIENCE: PATIENTS & FAMILIES, TEAM MEMBERS, COMMUNITY

Our Foundational Behaviors

1 | Be a team player

2 | Listen to understand

3 | Share information

4 | Keep your promises

5 | Speak up

6 | Connect with others

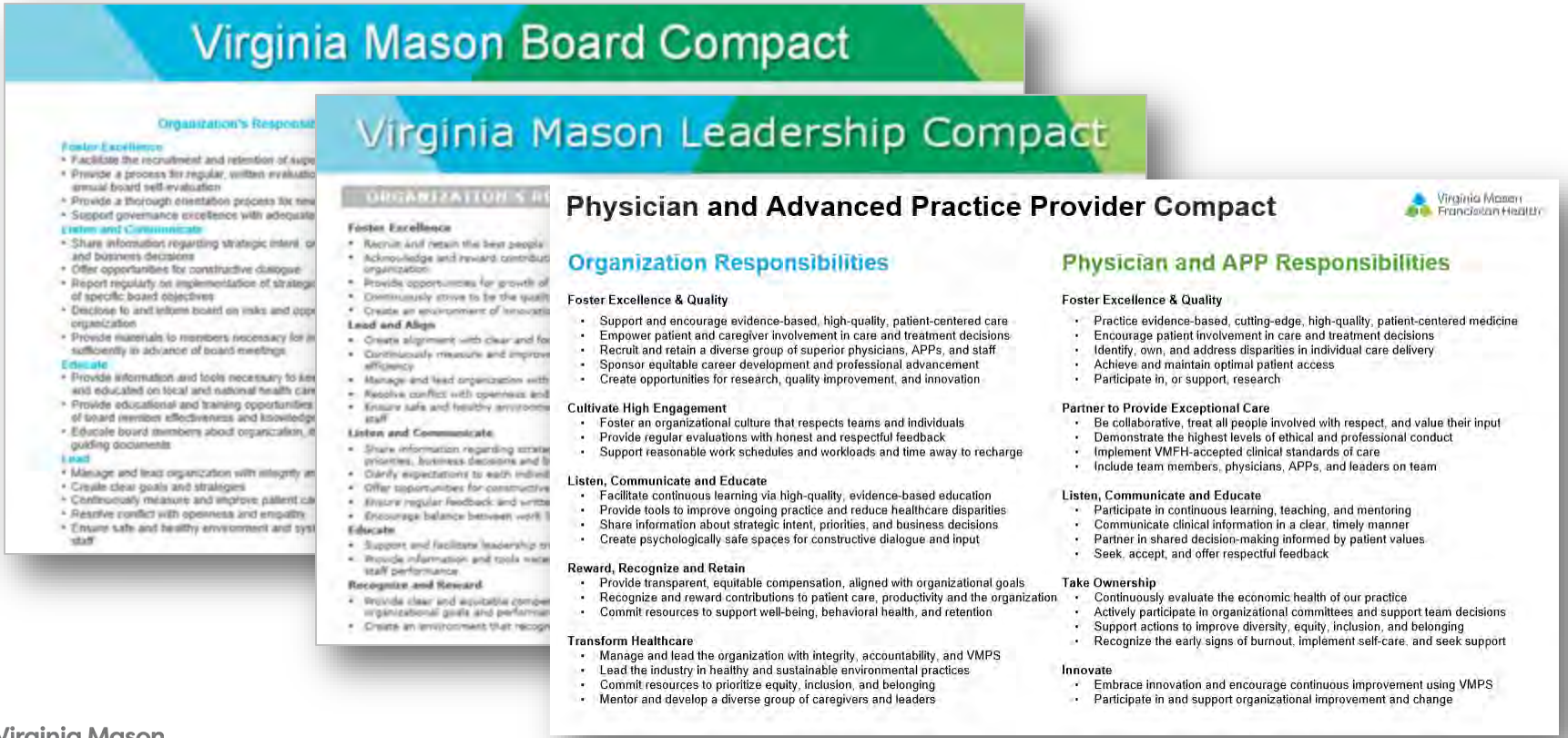
7 | Walk in their shoes

8 | Be encouraging

9 | Express gratitude

10 | Grow and develop

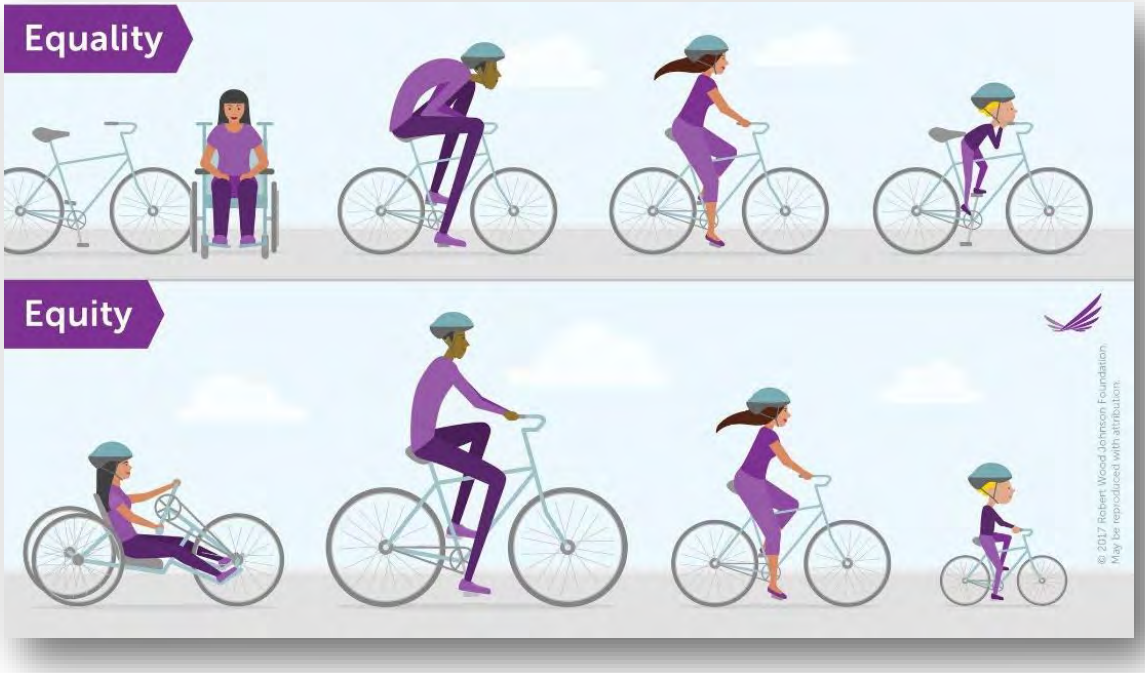
Compacts for Shared Agreements



Promoting Health Equity

Everyone has a fair and just opportunity to be as healthy as possible.

Resources are customized to individual and group needs.



Sources: Center on Social Disparities in Health at University of California, San Francisco and the Robert Wood Johnson Foundation

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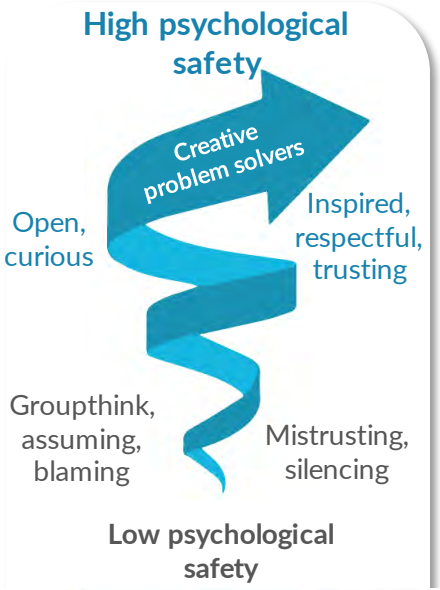
Fostering Psychological Safety and Equity



Inequity Waste Wheel

Violet inequities may be experienced by people without power and privilege
Blue inequities may be displayed by people with power and privilege, often unintentionally

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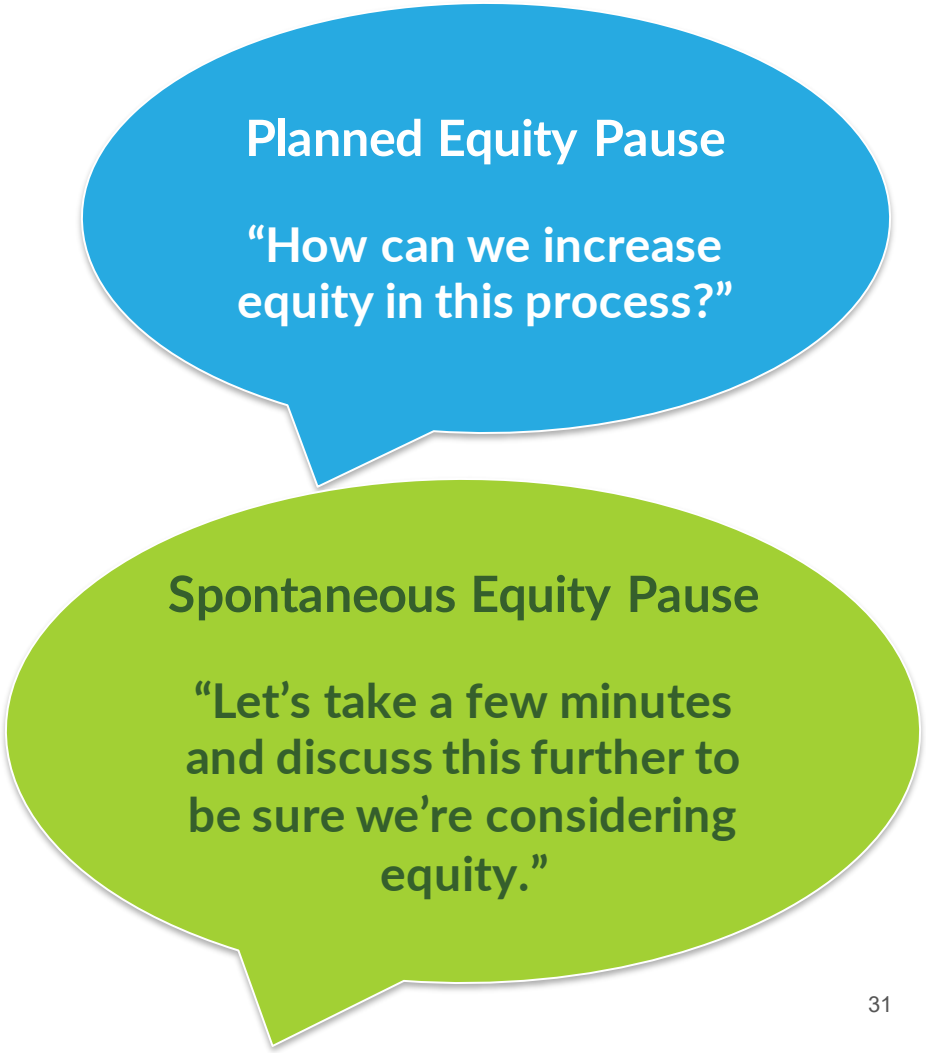
Provide Leaders and Teams with User-Friendly Tools

Equity Pause

- Remind ourselves of our shared goals/practices
- Identify what we might do better to support health equity, inclusion, diversity, belonging, psychological safety, and more
- Reflect and share our learning related to equity



Equity Huddle Cards

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Self-Directed Learning

- ❑ Identify cadence for team discussion
- ❑ Select and review materials by topic
- ❑ Identify two takeaways
- ❑ Determine how you will apply this learning
- ❑ Share and discuss
- ❑ Reflect

Foster a Systems Approach

A Systems Approach

Virginia Mason Management System

Respect for People

Safe and Respectful Environment

Patients as Partners
- Patient/family partners
- Experience Based Design
- Co-design & Co-production

Engage Individuals and Teams
- Organisational compacts
- Personal growth & recognition
- Leader competencies

Improving the Flows of Health Care

Continuous Improvement

Increase Reliability and Effectiveness

Quality Leader
- Q = A * (O+S) / W

Q: Quality
A: Appropriateness
O: Outcomes
S: Service
W: Waste

- Patient Safety Alert & Response System

Accelerate the Impact
- Speed and agility
- Innovation
- Plan-Do-Study-Act (continuously evaluate and improve)

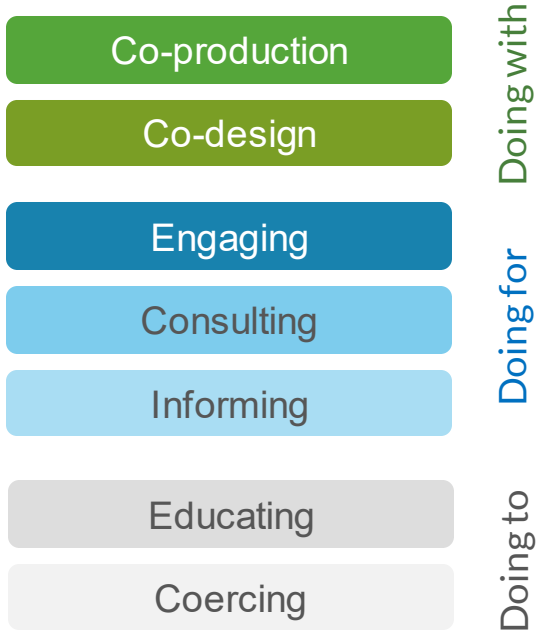
BUILD A STRONG FOUNDATION

World Class Management
Strategic Management, Cross Functional Management, Daily Management

VMPS® Principles, Tools and Methods
5S, Standard Work, Visual Control, PDSA, Innovation, Just in Time, Mistake Proof, Leveled Production

Patients as Partners means more than engagement

- VMI and The PSC are supporting mental health trusts across England
- Co-production at the heart of the programme
- It's not easy, takes time, but the results last and generate impact
- True co-production removes power imbalance and can be used to tackle the toughest issues



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Progressing to Action

- What is one tool or technique that you learned about today that you would like to begin using when you return to your organisation?
- What is the first step you could take to implement that tool or technique?

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Questions & Answers

Thank you.

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Presentation three:

- Ailsa Brotherton, executive director of improvement, research and innovation (Lancashire Teaching Hospitals NHS Foundation Trust) and improvement director, national improvement board, and a Q member

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Provider collaboratives: improving equitably

Improvement at Provider Collaborative level

Dr Ailsa Brotherton

Executive Director Improvement, Research and Innovation,
Honorary Professor, University of Central Lancashire

Lancashire and South Cumbria Provider Collaborative

NHS

Lancashire & South Cumbria Collaboration Board

Provider Collaboration Board Chair - Mike Thomas

Steve Fogg
Chair
Blackpool Teaching Hospitals NHS Foundation Trust

Shazad Sarwar
Chair
East Lancashire Hospitals NHS Trust

David Fillingham
Chairman
Lancashire & South Cumbria NHS Foundation Trust

Mike Thomas
Chair
University Hospitals of Morecambe Bay NHS Foundation Trust

Peter White
Chair
Lancashire Teaching Hospitals NHS Foundation Trust

Trish Armstrong-Child
Chief Executive
Blackpool Teaching Hospitals NHS Foundation Trust

Martin Hodgson
Chief Executive
East Lancashire Hospitals NHS Trust

Chris Oliver
Interim Chief Executive
Lancashire & South Cumbria NHS Foundation Trust

Aaron Cummins
Chief Executive
University Hospitals of Morecambe Bay NHS Foundation Trust

Faith Button
Interim Chief Executive
Lancashire Teaching Hospitals NHS Foundation Trust

WORKING TOGETHER AS ONE

Blackpool Teaching Hospitals NHS Foundation Trust ● East Lancashire Hospitals NHS Trust
Lancashire and South Cumbria NHS Foundation Trust ● Lancashire Teaching Hospitals NHS Foundation Trust
University Hospitals of Morecambe Bay NHS Foundation Trust

NHS Lancashire Care NHS Foundation Trust

NHS East Lancashire Hospitals NHS Trust

NHS Blackpool Teaching Hospitals NHS Foundation Trust

NHS University Hospitals of Morecambe Bay NHS Foundation Trust

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Healthier Lancashire & South Cumbria

Lancashire and South Cumbria Provider Collaborative

NHS

L&SC Provider Collaboration Board's Coordination Group

Each of the Trusts' professional groups links into the Coordination Group through a 'senior responsible officer' (SRO)

Governance & Legal
Angela Bosnjak-Szekeres
Director of Corporate Governance
East Lancashire Hospitals NHS Trust

Communications
Naomi Duggan
Director of Communications
Lancashire Teaching Hospitals NHS Foundation Trust

Facilities
James Maguire
Director of Estates & Facilities
Blackpool Teaching Hospitals NHS Foundation Trust & East Lancashire Hospitals NHS Trust

Mental Health
Chris Oliver
Interim Chief Executive
Lancashire & South Cumbria NHS Foundation Trust

Digital
Stephen Dobson
Chief Information Officer
Lancashire Teaching Hospitals NHS Foundation Trust

Operations
Sharon Gilligan
Chief Operating Officer
East Lancashire Hospitals NHS Trust

Strategy – Acute
Gary Doherty
Director of Strategy & Planning
Lancashire Teaching Hospitals NHS Foundation Trust

Human Resources
Kate Quinn
Executive Director of People and Culture
East Lancashire Hospitals NHS Trust

Nursing
Peter Murphy
Director of Nursing, Quality & AHPs
East Lancashire Hospitals NHS Foundation Trust

Medical
Dr Gerry Skailes
Medical Director
Lancashire Teaching Hospitals NHS Foundation Trust

Finance
Chris Adcock
Director of Finance
University Hospitals of Morecambe Bay NHS Foundation Trust

Community Services
Tony McDonald
Executive Director of Integrated Care, Partnerships and Resilience
East Lancashire Hospitals NHS Trust

Central Services Portfolio
Jonathan Wood
Chief Finance Officer
Lancashire Teaching Hospitals NHS Foundation Trust

WORKING TOGETHER AS ONE

- Blackpool Teaching Hospitals NHS Foundation Trust
- East Lancashire Hospitals NHS Trust
- Lancashire and South Cumbria NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust

Creating a Compelling Vision

Systems Approach

Systems don't just work, they have to be planned, designed and built

Kevin McGee OBE – previous CEO, Lancashire Teaching Hospitals NHS Foundation Trust & PCB

Opening Reflections: why is Improvement critical to our success?

David Flory CBE– Chair (ICS)

Model Overview

Engineering Better Care across Lancashire and South Cumbria

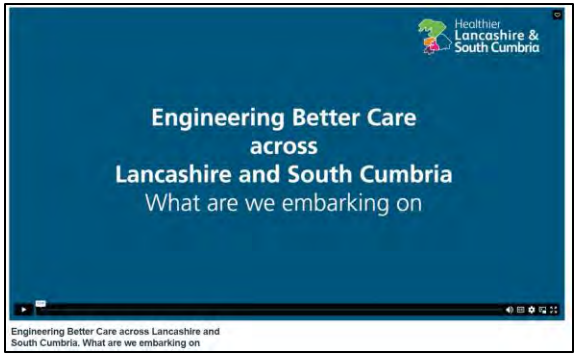
https://www.iitoolkit.com/

"We are able to make links across organisational boundaries that we never thought possible"

"EBC is helping us to empower patient and service users to have a say in the systems we design"

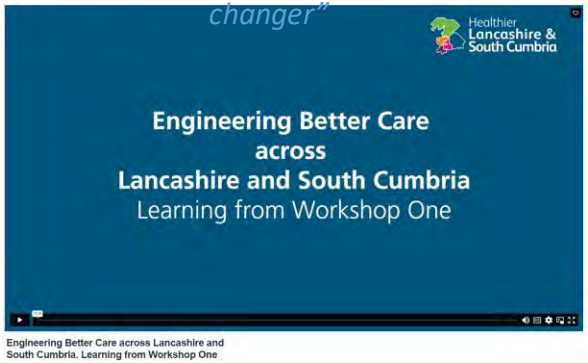



"It's helping us to improve our systems for the community"



Click to View

"Identifying all of our stakeholder partners right at the start is a game changer"



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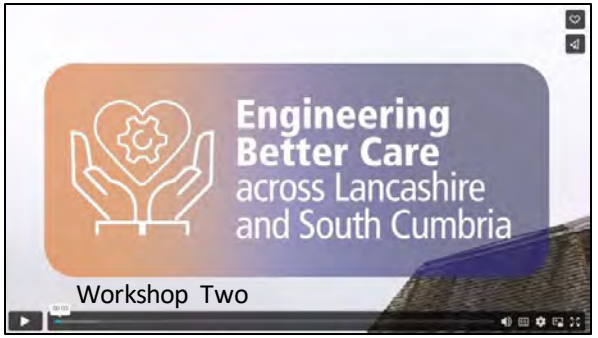
"Mitigating the risks in service delivery any evolving the way we work together"



Click to View

Our Journey so far….

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Continuous Improvement

Healthier Lancashire & South Cumbria

#NOF Collaborative (March 2023 – Present)

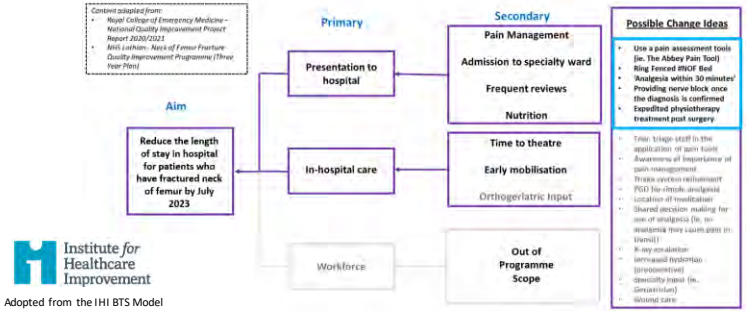
National Hip Fracture Database Performance – Pre Collaborative

Site	Acute LOS / Quartile
Blackburn	12.3 Days / Quartile 1
Preston	15.7 Days / Quartile 2
Furness	25.3 Days / Quartile 4
Lancaster	19.9 Days / Quartile 4
Blackpool	22 Days / Quartile 4

NHFD Performance – Mid Collaborative

Site	Acute LOS / Quartile
Blackburn	11.5 Days / Quartile 1 (-0.8 days)
Preston	14 Days / Quartile 2 (-1.7 days)
Furness	14.3 Days / Quartile 2 (-11 days)
Lancaster	15.1 Days / Quartile 2 (-4.8 days)
Blackpool	18.5 Days / Quartile 4 (-3.5 days)

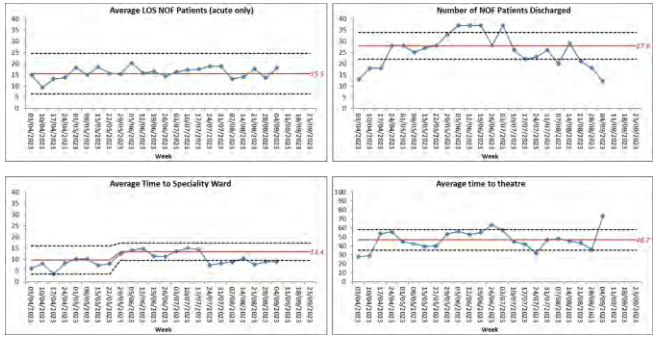
BTS Collaborative - Evidence Based Change Package



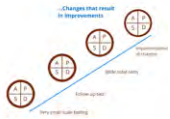
Institute for Healthcare Improvement

Adopted from the IHI BTS Model

Data Driven – Regular Data, Over Time



QI Designed – Sharing & Learning Regularly



Assessing the readiness of a system for improvement

Original research

The Model for Understanding Success in Quality (MUSIQ): building a theory of context in healthcare quality improvement

Heather C Kaplan,[1] Lloyd P Provost,[2] Craig M Froehle,[3] Peter A Margolis[4]

ABSTRACT

Background: Quality improvement (QI) efforts have become widespread in healthcare, however there is significant variability in their success. Differences in context are thought to be responsible for some of the variability seen.

Objective: To develop a conceptual model that can be used by organisations and QI researchers to understand and optimise contextual factors affecting the success of a QI project.

Methods: 10 QI experts were provided with the results of a systematic literature review and then participated in two rounds of opinion gathering to identify and define important contextual factors. The experts subsequently met in person to identify relationships among factors and to begin to build the model.

Results: The Model for Understanding Success in Quality (MUSIQ) is organised based on the level of the healthcare system and identifies 25 contextual factors likely to influence QI success. Contextual factors within microsystems and those related to the QI team are hypothesised to directly shape QI success, whereas factors within the organisation and external environment are believed to influence success indirectly.

Conclusions: The MUSIQ framework has the potential to guide the application of QI methods in healthcare and focus research. The specificity of MUSIQ and the explicit delineation of relationships among factors allows a deeper understanding of the mechanism of action by which context influences QI success. MUSIQ also provides a foundation to support further studies to test and refine the theory and advance the field of QI science.

INTRODUCTION

The use of quality improvement (QI) methods in healthcare is now widespread. Some QI initiatives have documented significant improvements in processes or patient outcomes,[1] some have shown only modest improvements,[2 3] and others have failed to show any improvement at all.[4] This variation in success has led to scepticism about the effectiveness of QI methods when applied in healthcare settings.[5] An alternative explanation for the mixed success of QI in healthcare may be the effects of context on the successful application of QI methods, not the efficacy of the methods themselves. To deal with this problem requires a shift in focus from studies examining whether QI methods work to studies aimed at understanding why, when, and where they work most effectively.[6]

Context includes characteristics of the organisational setting, the environment, the individual, and their role in the organisation or QI project.[7] Contextual factors are distinct from the technical QI process (eg, the QI methods themselves and the clinical interventions).[8] Just as the nature of the specific disease and the characteristics of individual patients matter when examining the efficacy of interventions in clinical medicine, the features of the providers and organisations involved in QI initiatives matter when assessing their effectiveness.[9] Contextual features (eg, local circumstances, resources, training, motivation, skill, etc.) of the providers participating in QI and the organisations where QI takes place must be considered when studying QI.[10]

In order to make progress in understanding the role of context in the evaluation and execution of QI efforts, explicit conceptual models, frameworks, and taxonomies are needed to focus and align research and to help practitioners learn how to manage key contextual factors that influence QI success.[9–15] A logic model that outlines the mechanism of action by which contextual

BMJ Qual Saf 2012;21:13–20. doi:10.1136/bmjqs-2011-000010

https://qualitysafety.bmj.com/content/21/1/13.long

The Model for Understanding Success in Quality (MUSIQ)

Continuous Improvement

The Model for Understanding Success in Quality (MUSIQ)

66 Contextual factors identified in the MUSIQ framework include the following:

Environment
- Competition
- Managed Care Penetration
- Medicare/Medicaid Influence
- Regulation
- TQM Adoption by Others
- Accreditation
- P4P

Organization
- Size
- QI Leadership
- Culture
- Ownership
- Teaching Status
- QI Maturity
- System Affiliation
- Location
- Physician Involvement
- Customer Focus
- Financial Health
- Organizational Structure
- Service Mix
- Physician Arrangements
- Volume
- Implementation Approach
- Motivation to Implement QI
- Innovativeness
- Process Management

Microsystem
- Motivation to Change
- Champion
- Physician Leadership
- Culture/Climate
- Capability for Change

QI Team
- Physician Involvement on Team
- Group Process
- Team Leadership
- Team QI Skills
- Group Climate
- Support
- Prior QI Experience
- Prior Experience Working Together

QI Support & Capacity
- Data Infrastructure
- Resources
- Infrastructure for QI
- QI Consultants
- QI Workforce Focus

Miscellaneous
- Strategic Importance to Organization

- Quality improvement projects often involve interdisciplinary teams working together towards a common goal.
- The MUSIQ tool is designed to help you assess aspects of your local context that may affect the success of your quality improvement project
- It gives us a method to reflect on the set-up and contextual support needed to deliver successful improvement projects.
- Provides the opportunity to make adjustments to project and organisational support systems early in the project.
- For each factor, a statement is provided for the self-assessor to score on a scale of 1-7

The Model for Understanding Success in Quality (MUSIQ)

Your **MUSIQ Score** is a valuable tool in assessing readiness for change and understanding your likelihood of success.

It allows you to consider questions such as:

- Are we ready?
- What are our barriers
- What development is needed and where?
- Should we continue 'at this time'?
- Could resource be better deployed elsewhere?

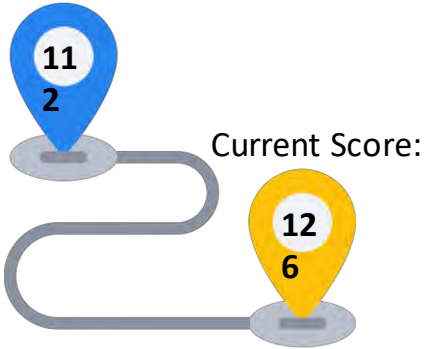
Total Score

168	Highest Possible MUSIQ Score
120-168	Project has a reasonable chance of success
80-119	Project could be successful, but possible contextual barriers
50-79	Project has serious contextual issues and is not set up for success
25-49	Project should not continue as is, deploy resource elsewhere
24	Lowest Possible MUSIQ Score

The Model for Understanding Success in Quality (MUSIQ)

Assessing system readiness for change

Starting Score:

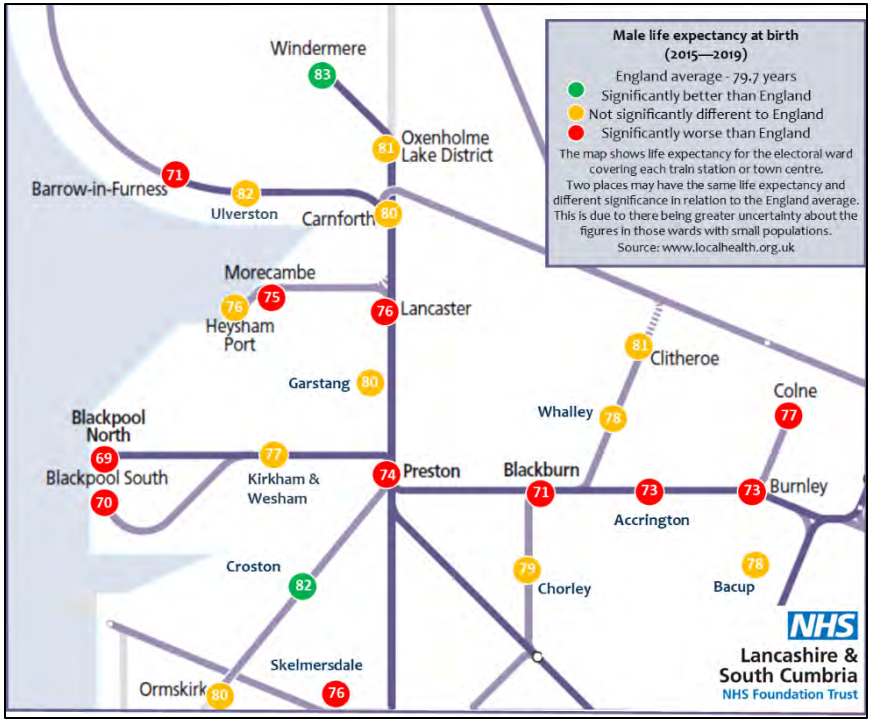


Engineering Better Care across Lancashire and South Cumbria

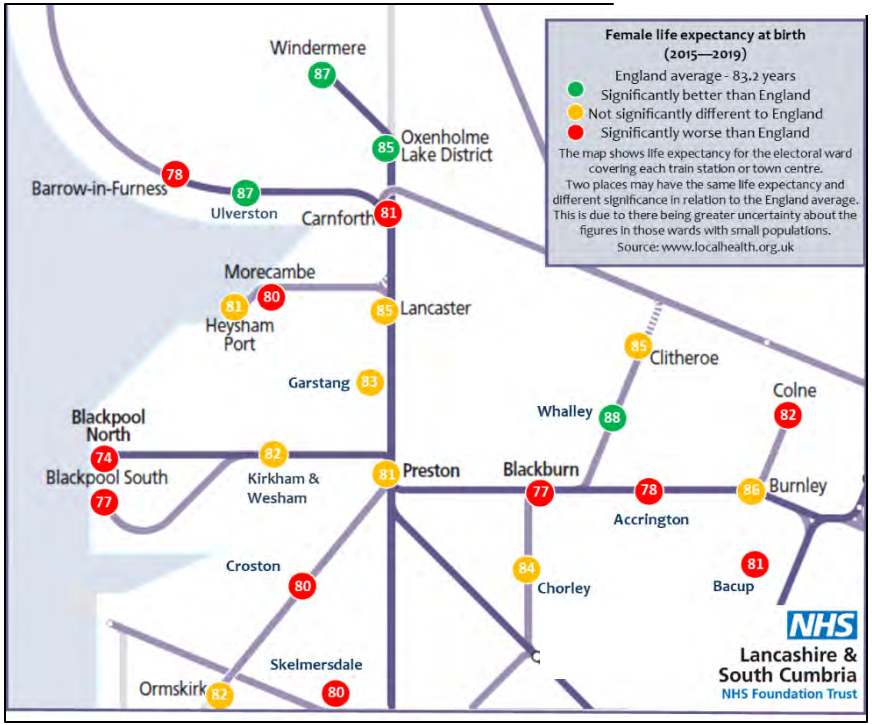
Continuous Improvement

Improvement Through an Equity Lens
Life expectancy variation across Lancashire & South Cumbria

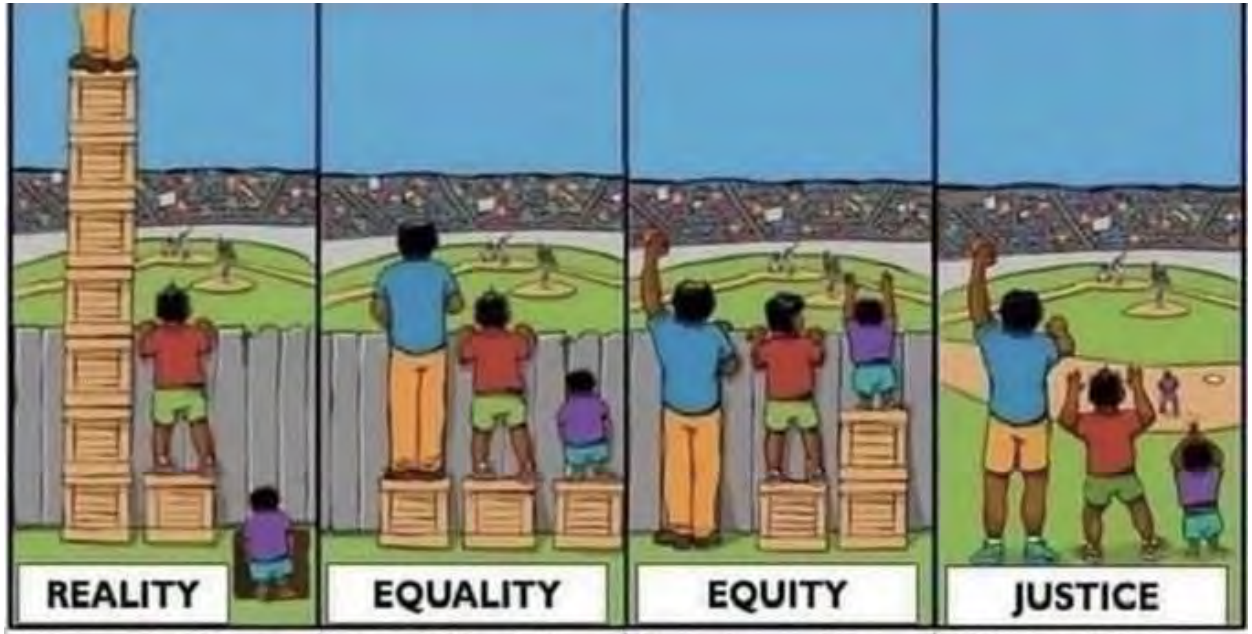
Males



Females



Acknowledgement: Thank you to Andrew Bennett, Director of Population Health NHS Lancashire and South Cumbria Integrated Care Board for permission to use this slide



REALITY	EQUALITY	EQUITY	JUSTICE
One gets more than is needed, while the other gets less than is needed. Thus, a huge disparity is created.	The assumption is that everyone benefits from the same supports. This is considered to be equal treatment.	Everyone gets the support they need, which produces equity.	All 3 can see the game without supports or accommodations because the cause(s) of the inequity was addressed. The systemic barrier has been removed.

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National NHS priorities for health inequalities

5 key strategic priorities

- Restore NHS Services inclusively
- Mitigate against digital exclusion
- Ensure datasets are timely and complete
- Accelerate preventative programmes
- Strengthen leadership and accountability

Clinical Priority areas

Driving down inequity for our 20% most disadvantaged and PLUS communities

Including:-
- Equity of access
- Excellence in experience
- Improved equity of outcomes

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Our approach….

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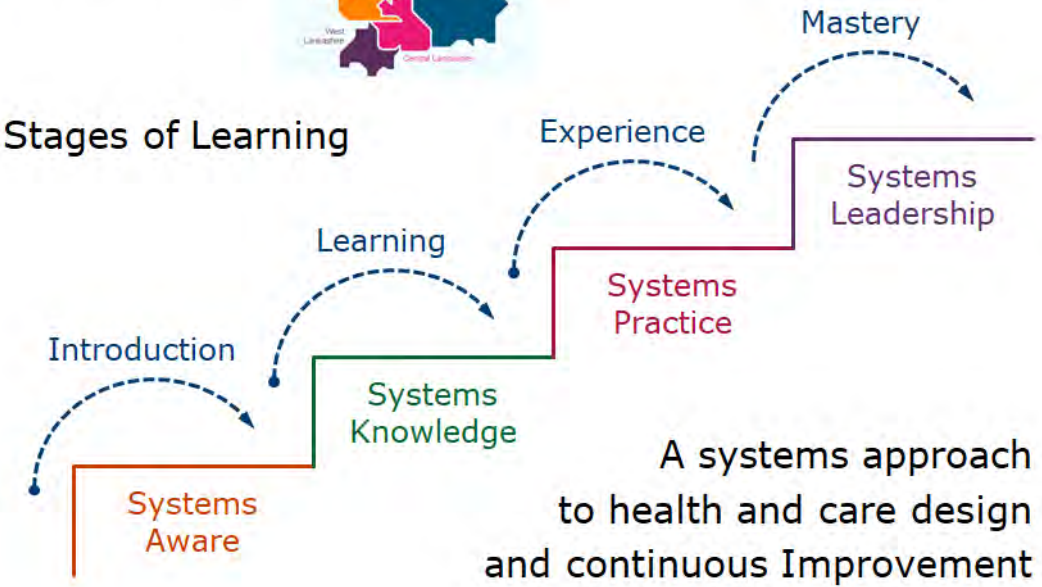
Leadership

UNIVERSITY OF CAMBRIDGE



Acknowledgement: Thank you to Professor John Clarkson for permission to use this slide

NHS Lancashire Care NHS Foundation Trust | NHS East Lancashire Hospitals NHS Trust | NHS Blackpool Teaching Hospitals NHS Foundation Trust | NHS University Hospitals of Morecambe Bay NHS Foundation Trust | NHS Lancashire Teaching Hospitals NHS Foundation Trust | Healthier Lancashire & South Cumbria

Evaluation

Tell us what you think

Scan here to access our evaluation or use the link in the chat

Upcoming events

Book now/save the date:

Tuesday 5 December | 1.30pm – 3.00pm

Improving waiting lists equitably: The importance of a partnership approach

NHS Providers

Thank you for attending

In partnership with

Q is led by the Health Foundation and supported by partners across the UK and Ireland

IMPROVEMENT

Provider collaboratives: improving equitably