Taking charge of health and social care
Dr Richard Preece
GM Landscape

- 2.8 million people
- 10 localities
- 8 hospital providers
- 3 mental health services
- 560 care/nursing homes
- 400 domiciliary care agencies
- 450 dental services
- 500 general practice
- 300 community optometry
- 700 community pharmacy
- 275000 heath and care workers
- >500 voluntary organisations
Devolution principles

- Still part of the national health and care system
- Collaborative decisions in the interest of GM residents
- Subsidiarity - decisions made at the most appropriate level
- Transparent decisions underpinned by sharing of information
- Shared outcomes to drive changes to organisational form

“all decisions about Greater Manchester taken with Greater Manchester”
System leadership

Almost no studies of distributed leadership across organisations*

- crucial role of leadership in ensuring safe, high quality care
- clearly and explicitly ... a role for distributed leadership
- but ... could mean confusion about who was in charge
- hierarchically based leadership was needed to complement distributed leadership, not least to provide ... managerial clout

- Delegated responsibility to distributed (mutual) accountability

“With challenges that naturally fall in the zone of complexity … it is not surprising if the system does not act like a machine”

- Biological metaphors to guide thinking
- Create conditions .. system can evolve
- Simple rules and minimum specifications
- Space for natural creativity to emerge
Creating a fractal-based quality management infrastructure

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Abstract

Purpose – The purpose of this paper is to describe how a fractal-based quality management infrastructure could benefit medical improvement (MI) and patient safety efforts in health care.

Design/methodology/approach – The premise for this infrastructure stems from the fractal with health care professionals and organizations. The authors used the fractal structure system in a health system context, a networked collaboration, and several concrete initiatives to improve quality of care. It is apparent to coordination theory and this infrastructure is responsible to coordination theory and mapping of national and local health organizations to identify and analyze national and local health organizations to identify and analyze national and local health organizations that might fit.

Findings – The fractal structure facilitates a health system strategy to improve care, patient compliance on national care measures, and health national care events across the USA, Spain, and England to reduce national care measure and system performance targets.

Practical implications – The fractal structure approach organizes workers around common goals, links all hospital areas and, supports peer learning and accountability, provides solutions to local problems, and efficiently uses available resources.

Social implications – The fractal structure helps health care organizations meet their social and ethical obligations as leading organizations to provide the highest possible quality of care and safety to patients using their services.

Originality/value – The concept of fractal structure in health care management and patient safety management and support organizational learning is new to health care. This paper clearly describes how to create a fractal infrastructure that can scale up or down in a department, hospital, health system, state, or country.

Keywords: Management, Quality improvement, Safety and safety, Safety, Safety care, Safety management
Paper type: Viewpoint

Today’s clinicians are asked to address more and more patient safety issues without needing additional resources for these tasks. They have limited hospital safety and quality by shifting in some time and adding tasks, meetings, checks and re-checks, cross-checking, and other efforts that are above and beyond their regular duties. Clinicians deeply care about patients, and those who work to improve quality and safety. Still, they are crying “foul” as new demands press them to enhance hospital safety and quality. Many still they simply cannot add another initiative or program, at least not reliably or sustainably, without more support from their employer (Sklar et al., 2012). Further, although many in health care realize the need to engage patients in decision making, there are few mechanisms available to meaningfully engage patient preferences and ideas.
Shared understanding of quality improvement

No single best approach
Similar attributes common to all

• Leadership and clear direction
• Engagement of service teams
• Full participation of service users
• Access to quality improvement resources
• Use of an improvement process
• Continual efforts to improve
• Measure and evaluate the impact
A common framework

1. Unifying purpose
2. Fractal organisational structure
3. Common understanding
4. Tools for comms and reporting
5. Shared leadership responsibility

Matthews et al 2016
Communities of practice

- Interdependent groups/individuals
- Cross service boundaries
- United by a common purpose
- Vertical leadership
- Horizontal relationships

Aveling et al 2012
McChrystal et al 2014
Spend on admissions relating to fractures where a fall occurred per 1,000 age/sex weighted population - 2015/16

% difference compared to lowest 5 similar CCGs and quantified potential improvement opportunity

Greater Manchester
## Hip fracture database: Outcomes data

<table>
<thead>
<tr>
<th>Location</th>
<th>Surgery on day or day after (%)</th>
<th>Acute LOS (days)</th>
<th>Return home (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salford</td>
<td>72</td>
<td>15.7</td>
<td>90</td>
</tr>
<tr>
<td>Manchester Royal Inf</td>
<td>53</td>
<td>18.7</td>
<td>86</td>
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<tr>
<td>North Manchester</td>
<td>23</td>
<td>18.7</td>
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</tbody>
</table>
Summary

Improving

– Unifying purpose
– Similar structures
– Shared understanding
– Common reporting
– Mutual accountability
For further detail go to:  
[www.gmhsc.org.uk](http://www.gmhsc.org.uk)  
[@GM_HSC](http://www.gmhsc.org.uk)