How-to guide: Equity-focused Quality Improvement

Quality improvement (QI) is a cornerstone of the NHS. QI is defined as "systematic, data-guided activities designed to bring about an immediate improvement in healthcare delivery in particular settings"(10).

Equity, the absence of inequalities in access, outcomes or experience, is included in many definitions of quality, such as the Institute of Medicine, but is often the most overlooked aspect of quality compared to safety, effectiveness and efficiency. QI projects are likely to have a variety of impacts on health inequalities; some do not affect inequalities, with others may inadvertently narrowing or widening them.

Figure: Potential effects of QI approaches on inequalities

NHS England's new health inequalities programme, CORE20Plus5, states that it will be "driven by QI methodologies to ensure measurable and sustained improvement" for disadvantaged groups. Currently the UK lags behind other international countries in using QI methods to address inequalities.

> A cautionary tale: QI increasing inequalities
> The National Paediatric Diabetes Audit reports the quality-of-care in paediatric diabetes unit. A 2017/18 analysis found that continuous glucose monitors improved the quality-of-care, reducing HbA1c by 2.6mmol/mol. However, this benefit was not equally distributed, with children from the least deprived areas experiencing a 5.7mmol/mol greater reduction than the most deprived areas.

How to do Equity-Focused Quality Improvement (EF-QI)

There are two main ways in which QI can address inequalities – 1) by ensuring that the distribution of benefit of QI favour disadvantaged groups and 2) by targeting specific disadvantaged groups (e.g. homeless populations, south Asian people on low incomes) or specific conditions intrinsically associated with disadvantage (e.g. addition, smoking, obesity).EF-QI projects are best undertaken at the organisational level of action. In the majority of cases this will be those organisations that deliver care (e.g. hospitals, GP

surgeries), however it could also be undertaken at a system or commissioner level.

There are five main steps to EF-QI:
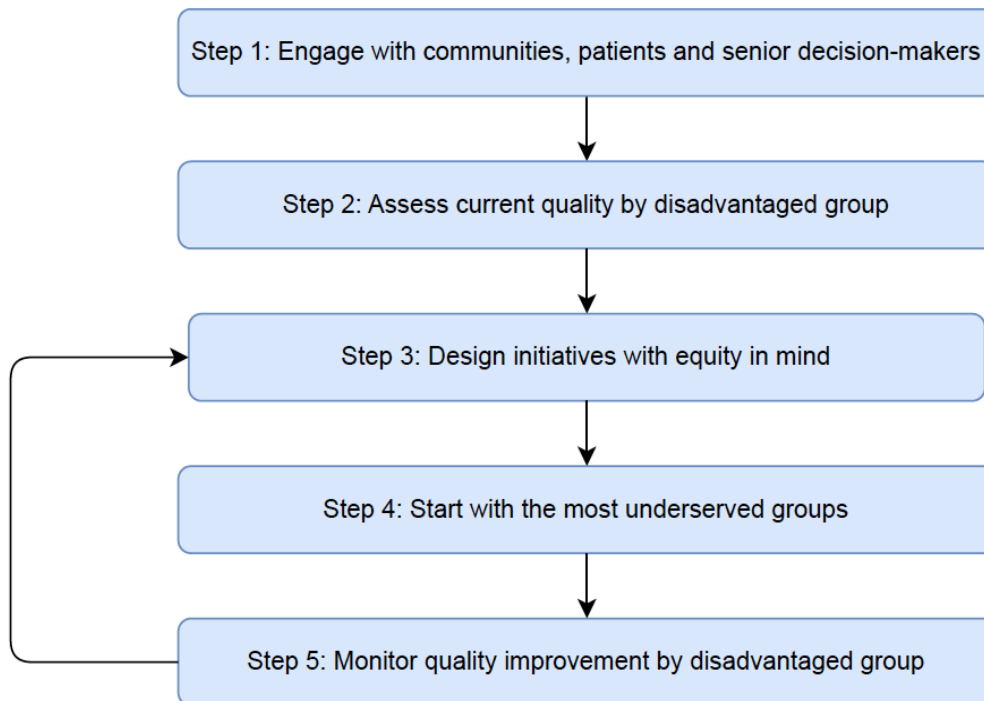
Hearing from communities and patients who face disadvantage is important both to obtain first-hand accounts of their lived experience but also to ensure that decision-making power is equally distributed. Community and patient engagement has the potential to increase inequalities if health care organisations primarily engage with communities and patients who already experience privilege in the current system.

The exact disadvantaged groups will depend on the local populations are likely to include socio-economic position and ethnicity. Local leaders may also identify specific inclusion health groups which are of interest, for example those who do not speak English or homeless populations. Identifying data gaps is an important part of this stage because it will inform data collection in the subsequent EF-QI process.

Designing QI initiative with equity in mind should include avoiding QI initiatives which place a heavy burden on patients to benefit, e.g. QI initiatives which require patients to read and understand complicated information or complete complex forms, because initiatives that require more effort from patients tend to increase inequalities. Initiatives should also seek to allocate resources proportionate to need. This may mean ensuring that more staff time is spent with those patients who have more complex social circumstances or require more flexibility.

QI initiatives which focus on reaching a pre-specified quality standard (e.g. 90% of patients reaching X quality standard), incentivise practitioners to target easier to reach patients because this will allow them to reach the quality standard in the most efficient manner.

However, this means that those who are underserved tend to miss out, further perpetuating inequalities.

Monitoring tools, such as Statistical Process Charts, plot the average improvement over time, but do not disaggregate the data to explore who benefits most (or least). As data is monitored it should be disaggregated and this in turn inform the QI initiative.

There are some practical considerations for general practices wishing to undertake EF-QI. Area-based socio-economic data is readily available based on an individual's postcode. This data will give an indication of an individual's socio-economic status but is far from satisfactory because it only reflects the socio-economic status of the neighbourhood. However, at the moment no individual measures of socio-economic status are available in health records (e.g. income, education, employment). While this data is publicly available, most general practices would need support to add this to a QI dataset. To show differences by socio-economic group (e.g. quintile) requires a reasonable number of patients, therefore disaggregating data by socio-economic group is unlikely to useful for small QI projects (e.g. fewer than 100 patients), however it does not mean that the QI project cannot be designed and implemented in an equitable manner.

Ethnicity is important but coding is patchy in some organisations. It is also worth considering the intersection of ethnicity and socio-economic status (i.e. those who are on low incomes and belong to a minority ethnic group are likely to experience even more disadvantage).

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