Maturity Matrix

NETWORK TOOLKIT

	Shared purpose and focus on quality, quality and system improvement as core strategy	LIQH as a network in service to the shared purpose of quality in Leeds	Engaging patients and carers in shared decisions and co-producing services	A professional culture of teamwork, accountability and improvement	Evidence of impact for continual learning and change
5	Leeds health and social care leaders share the same ambition for the quality and system improvement and have a long term perspective, with a clear strategy sustained over time. There is evidence that leaders are giving up territory in service to a shared common goal whenever needed. Leeds has the capability to analyse patterns of care, improve care delivery and spread new practices across the Leeds. This sustained effort has lead to ground-breaking results in many areas.	The LIQH members (commissioners, programme participants, faculty) fully buy-into the strategy and plans for LIQH, and are personally committed to its future. External drivers and influences on LIQH are fully understood.	Care needs identification, service design, delivery and review all take place with the active participation of service users and carers, and at commissioning level with citizens and communities. There is active participation in health in communities, and a number of citizen led solutions are in place. Citizens play an active role in securing their own health and that of their families.	There is a professional culture in the city of improvement, peer review and accountability and teamwork across all collaborating partners. This is supported by excellent data that enables informed shared decision making between professionals, service-users and carers. There is a significant difference in the role of managers in securing performance, and professionals in securing excellence in prevention, treatment and care. All professionals regularly scrutinise their practice in terms of variation, and strive together for quality services. Performance data is transparent. Team working is mature with differences used to reach new solutions, and feedback as a core team practice. Teams are now working across the traditional boundaries of primary and secondary care, and members work as peers. There is widespread investment in staff development.	There is robust review in all quality processes in the city, and a model for evaluating the impact of quality approaches and interventions. Impact includes both qualitative and quantitative measures and is used for review and learning; and system re-design. Mechanisms for capturing and sharing impact are well established, including live and virtual events.
4	Leaders of health and social care have moved beyond the early stages of testing collaboration in health, and are organising together using a clearly articulated shared commitment to quality, with clear long and medium term goals. They are taking opportunities to realise new approaches to health care organisation. There is evidence of real sustained impact in quality projects that involve the whole system with a real benefit to service users and carers. There is evidence of leaders giving up territory in service to the longer term goals within those projects.	All members of the LIQH network are clear about the purpose of LIQH and its role in building community; generating learning and impact; and convening members. Deliverables for the community are well known and plans to achieve them are underway. The LIQH purpose is accessible to all, and used to induct new members/ participants.	Service users and carers play an active role in shared decision-making. It is the norm for all complex care needs, and is robustly practiced across the health system. Care needs identification, service design, and some delivery and review takes place with the active participation of service users and carers, and at commissioning level with citizens and communities.	There are data teams in the city focusing on providing data to support excellent professional decision making with service users and carers. This is not yet integral to all teams but is available in service to pathways. There is significant development of teams to be able to utilise data for peer review; to work together as teams across organisational boundaries; and to hold each other to account. Change take place through both innovation and improvement and through performance management, with professionals taking responsibility for their practice within teams that have had supported development.	New knowledge developed through the quality programmes in the city is well organised and made available widely. The quality approach in the city has tangible products which go beyond evaluations and include: top tips, examples, case studies, expertise, tools and templates. Examples of sharing and reusing knowledge are easily found, and people involved in quality in the city regularly provide new material.
3	The commitment to quality means that health and social care leaders have developed a shared ambition for quality in health in the city and are testing out areas where they can put this into action together. There is little evidence of widespread change in quality, but there are some promising early results from test areas.	The LIQH network has a clearly stated purpose, scope, and ways of working. Most members have a good understanding of the purpose of the network and could articulate it to others. There is an agreed plan for developing the network for the next year.	The benefits of coproduction and shared decision-making are widely understood and there are some good examples of shared-decision making and coproduced services in the city, although these tend to remain focused on marginal groups, where there has traditionally been less health professional involvement; or in mental health services. Citizens are actively involved in the identification of commissioning needs.	Teams working across organisational boundaries are emerging. These teams are supported by data to inform their decisions and are working on developing peer leadership. Within these teams, there is scrutiny of practice but it is hard to generate spread of this outside the immediate group. Performance is still mainly managed through performance management processes, rather than professional peer review and accountability.	There is a robust model of evaluating impact in LIQH programmes. As yet this has not spread more widely across the city as a model of evaluating both how Leeds is creating the conditions for quality health care and improving health; and the actual impact on services and citizens. There is material available which is kept up to date.
2	There is a shared narrative about commitment to quality, but the purpose is still not well defined in terms of expected impact for the city in the short, medium and long term. Differences between health and social care organisations are being aired by leaders and there are early steps to resolving these. There is commitment to changes within project areas and evidence is being gathered about impact.	The LIQH network scope is loosely defined. Ways of working are emerging. The community is still forming and establishing ground rules. More time is required to converge on a shared agenda for all members. Short-term plans for the network may exist, but are not widely shared.	Health professionals and leaders understand the need for and benefits of involving patients in both understanding need, designing care, and co-decision making. Citizens are involved actively in identifying needs at a commissioning level. In provision, professionals work with patients to understands variation and the patient experience, but still design packages 'for' rather than 'with' patients and carers.	Teams have the ambition for working together across boundaries and there are examples of changes in patterns of working. Change tends to be generated in parts of the system, where there is only limited knowledge of the whole pathway, or the knock on effects of any actions. There is little data available to teams to enable them to scrutinise their practice together. if things go wrong , team members blame each other or external 'other' groups (e.g. GPs blame hospital doctors or visa versa).	There is little structure for sharing and assessing the impact of quality work in the city. It is hard to distinguish 'good practice' from 'any old practice'. Threaded discussions exist, but are not summarised and often dilute their value by wandering off-topic.
1	There is no widely available shared set of goals or clear purpose for quality in health care across Leeds. There are clear differences between health and social care leaders in the city.	There is no sense of goals or plans – it's all about the here-and-now. The focus is not yet clear, exchanges often stray off-topic. Members learn about how the network works via osmosis and personal experience!	There is little understanding of the assets of patients and carers in the design and delivery of care. The health system persists in an expert model with health professionals determining both the need for care and the care pathways, with no involvement of service users.	Teams work in isolation within their organisation boundaries. The dominant mode of change is through performance management and hierarchical relationships. There is a lack of trust between teams and organisational leaders.	There is no shared model for reviewing the impact of quality programmes and no mechanism for sharing intelligence across the city. People repeatedly raise the same questions, leading to occasional frustration. There are no community artefacts or places to go for shared information resources.