Theme 3: Quality and safety

Direction of travel

There is a positive direction of travel with evidence of shared responsibility of risks and system-wide oversight and escalation routes to focus on quality and safety issues. The ICS is moving towards improving outcomes in population health and healthcare, though these are not yet shared and implemented across the system. While population health is a long-term priority, there are competing short, medium-and longer-term priorities that require resources and ongoing system-wide commitment.

Summary of strengths

- The System Quality Group (SQG) is system focused and provides suitable oversight and assurance of system-level issues and concerns. Place-based quality and safety reporting and escalation arrangements are established and included health and local authority partners.
- There is a commitment to promoting a learning culture and a shared perspective of risk and quality across the system.
- Multi Agency Safeguarding procedures and relationships are strong across the system.
- Early partner collaboration has begun in an attempt to address the wider determinants of health and health outcomes.

Areas for development and next steps

- System-wide improvements are needed to address access and outcomes for disadvantaged population groups and there is a need for continued investment and development in the ability to use and access data, metrics and clinical indicators to support equity in access to services.
- A systemised learning culture is not fully established and learning is not always shared at operational level or between partners. Further work is needed to improve learning and oversight.
- The ICS is still facing significant issues regarding equity of outcomes and there is significant work still to do in this area by making use of developed roadmaps and trajectories of the provider collaboratives and the Outcomes Frameworks to start to address these inequalities.

Summary findings for the quality statements under the Quality and safety theme

This theme includes these quality statements:

- Supporting people to live healthier lives
- Learning culture
- Safe and effective staffing
- Safeguarding
- Equity in access
- Equity in experience and outcomes

Quality statement: Supporting people to live healthier lives

The ICS has made commitments to prevention and supporting people to live healthier lives. However, plans and collaboratives to underpin these commitments are still in development or being embedded.

Collaboration with different partners and stakeholders including public health prevention

Birmingham and Solihull consistently ranks as being the most deprived health and care system in England. Although the ICS has created structures that aim to improve population health outcomes, these are not yet threaded throughout all the relevant strategies.

The ambitious population health approach to tackle health inequalities set out in the 10-year strategy was a realistic partnership strategy to improve population healthy life expectancy. Although the strategy contained metrics for long-term and medium-term trajectory, these did not clearly align to the 5 clinical conditions. It was less clear how objectives within the strategy would be prioritised and progressed where there was a focus on children and young people and how this had been co-produced with the population.

While population health is a long-term priority, there are competing short, medium and longer-term priorities that need resources and ongoing system-wide commitment. System leaders and partners told us mindset changes were needed to align the 10-year Integrated Health and Care Strategy and achieve a long-term shift to prevention and care earlier in people's care pathway.

Birmingham and Solihull have separate place-based prevention strategies. The Solihull prevention strategy uses multiple case studies that show how the council brought together voluntary and community sector providers to co-ordinate and provide community services, such as 'Happy Mamas' – a peer support group for new mums. This is an example of how the system was beginning to work towards achieving behaviour change at community level in line with NICE standards (PH6, principle 5).

The ICS demonstrates some initial progress in improving outcomes in population health and healthcare. This was reflected in examples of innovative projects to improve in this area.

Birmingham and Solihull ICS was performing below the national average for uptake of 2 measles, mumps, and rubella (MMR) immunisations for 5-year-olds. Tackling infant mortality is an area of focus in the ICS's children and young people's strategy and the 10-year strategy, and it has recognised the challenges around immunisation uptake. The ICS was working to improve this and support GPs who were aiming to improve the uptake through engagement with key community members. Figures for quarter 4 of 2022/23 showed uptake at 77.3%. While significantly below the national target of 95%, this represented an improvement for the system.

The system is developing integrated neighbourhood teams (INTs) to improve collaboration at a local level, with key aims around prevention, avoiding crisis and holistic experience to suit the needs of local people.

Mental health services remain a challenge that affects a range of sectors. While positive collaboration has started, further understanding of each sector's experiences and challenges were required to ensure the right initiatives were in place. For example, there are discrepancies between the sectors surrounding the use and demand of police powers to remove a person from a public place when they appear to be experiencing a mental health crisis to a place of safety (Section 136 of the Mental Health Act 1983).

Addressing the wider determinants of health

Birmingham and Solihull's place-based prevention strategies are presented and monitored in different formats for ease of accessibility for those with protected equality characteristics. Both are guided by available data and aimed to improve care for people of all ages. Equality, diversity, and Inclusion (EDI) is threaded throughout the ICS strategies with some emphasis on disparities of health inequalities and reaching people whose voices are seldom heard.

System partners told us that plans to address health inequalities and measure progress are still in their infancy, although we had seen a number of goals articulated through the 10-year strategy and the outcomes framework in the 5-year Joint Forward Plan. Systems and processes to analyse data are not yet embedded across the system and providers often did not have the ability to access data to help tackle inequity in access.

Partners within the system are beginning to collaborate to address shared priorities. For example, the latest data showed 25% adults who were receiving substance misuse treatment engaged in community-based treatment following release from prison from inpatient services, which is below the England average (37%). The ICS is working with the police to improve care for those with drug overdoses.

Partners are also working to improve health outcomes to address the wider determinants of health. In one example, service providers, community engagement partners and representatives from the ICS worked together to improve health outcomes for people from African and Caribbean communities.

Quality statement: Learning culture

Senior leaders and partners have a shared perspective of risk and quality and are committed to promoting a proactive learning culture. There are mixed views on how senior leaders may interpret and respond to safety concerns when raised. Standardisation and consistency of sharing learning across the system is yet to be developed to continually identify and embed good practices.

System leaders and partners are committed to promoting a positive culture in which safety-based incidents are listened to, investigated, and reported thoroughly, with lessons learned to continually identify and embed good practice. They are aware of the challenges they faced in sharing learning across the system. We heard of various round table events and peer-to-peer learning to reflect on experiences, and that sharing learning on quality is a key role for the System Quality Group jointly chaired by the ICB's Chief Nursing and Medical Officers.

The System Oversight Group offered an architecture to consider performance issues, where system leaders and partners are working together to tackle system challenges. This committee is then responsible for escalation to the Finance and Performance Committee, who can escalate to the ICB where required.. It is recognised that the next big challenge for the system is implementing the Patient Safety Incident Response Framework.

System leaders and partners have mixed views regarding how well learning is cascaded across the system. We heard of good learning across one partnership following a learning from death review. Whereas for others, there were challenges because of confusing terms of reporting and accountability, and dependency on taking information and learning elements to the right people in committees, sub-committees and groups.

Processes for reviews of Prevention of Future Death reports demonstrate evidence of investigation into incidents, looking at the person's pathway, key themes, working with other partners, and system leaders to enable appropriate action to be taken.

Quality statement: Safe and effective staffing

The ICS is actively promoting anti-discriminatory practice and the health and wellbeing of staff. There are plans and processes to address national and system workforce priorities, and to support staff effectively while they work together to provide safe care that meets people's individual needs.

Addressing national and system workforce priorities

There's an acknowledgment of a number of significant challenges on the workforce. At an organisation level, this can be seen through a number of CQC inspection reports that identify concerns regarding staffing levels and in the continued use of temporary staff to ensure safe staffing levels. There are reported challenges within local authority partners, staffing pressures in primary care, with the number of GP practice nurses per 10,000 people below national average by July 2023. It is estimated that a growth rate of 37% is needed by 2037 to meet the systems demands and respond to issues identified due to future retirement data.

High-profile cultural concerns have emerged throughout the year and the overview of staff survey results across the system have suggested some consistent experiences and cultures between organisations that are potentially leading to negative experiences for staff and attributing to some of the issues with recruitment and retention within organisations and the NHS. System leaders have taken ownership of cultural concerns, making a concerted effort to address them. Leaders are open that although some improvements had been made, it is likely to take a longer time to truly fix the culture of organisations and the system.

ICS leaders and partners in the system have worked to plan and develop leadership values and behaviours. They see opportunities to work more closely to recruit and retain staff across the whole system.

The ICS has committed to an improved system-wide approach to workforce and the numbers of staff substantively employed across the NHS in Birmingham and Solihull.

A Workforce Delivery Plan is being developed and work is ongoing to align this to the commitments within the Joint Forward Plan. This will be focused on workstreams within 'the 4R's': Reconnect, Recruit, Retain and Train, Resilience – reducing reliance on contingent actions and reform.

In recognition of the importance of longer-term workforce planning, a Director of Strategy from Health Education England had been seconded to Birmingham and Solihull ICB to help the ICS and system partners identify the workforce needed to deliver their collective ambitions over the next 5 to 10 years.

Capability and capacity

ICS leaders are implementing processes that aim to have the right capability and capacity across an integrated pathway to meet local and individual needs. There remains an over-reliance on costly bank and agency staffing and although the number of substantive staff in the system had grown, there had not yet been a commensurate fall in temporary staffing costs.

Some system leaders are concerned about the pay overspend for bank and agency staff and the financial implications for the ICS if it is able to fully recruit to the vacancy rate. Clinical leaders expressed the importance of having ongoing conversations with the finance team around staffing levels in clinical areas, acknowledging staff shortages within the system despite an increase in substantive recruitment and growth in the use of bank and agency staff. Senior leaders told us they recognise that greater workforce controls are needed across the system and greater market management of rates for bank and agency staff.

Oversight of and influence over the recruitment, deployment and development

The ICB funded an international recruitment bureau that allowed individuals to move across organisations within the system without penalties. It encouraged joint working between organisations and helped the workforce to reflect the community it served. Within a 2-year period, 323 international nurses had been recruited, with an aim to recruit 573 by March 2024, as well as recruiting allied health professionals and midwives.

System leaders told us that although there is an increase in non-clinical NHS infrastructure staff since April 2022, they are uncertain why this isn't the case for clinical staff. System partners within the local authority acknowledged the work of the ICS on workforce challenges within the NHS. They felt that social care faced different workforce challenges and had tried to engage with the ICS about them.

Although more action is needed to develop how the ICS recruited and retained staff who wanted to stay in the area, it used innovative methods to increase the substantive workforce. For example, it supported the Education Collaborative, which collaborated with local universities and NHS trusts to offer inclusive nursing programmes and align working practices, documentation, and escalation routes.

Quality statement: Safeguarding

There are clear lines of accountability within the ICS, across the system and with local safeguarding partnerships. There is an understanding of what being safe and protected from harm should look like, and system partners work together strategically to achieve this. Professionals are committed in protecting and safeguarding adults, children and young people and they are aware of the ability to escalate safeguarding concerns system-wide.

Meeting safeguarding responsibilities

Local and system-wide arrangements for the oversight and governance of safeguarding arrangements include:

- health safeguarding boards
- quality and safety meetings
- individual local authority safeguarding boards.

These provide an annual report to the ICS board.

The safeguarding partnerships in Birmingham and Solihull have enabled strong relationships, common purpose and clarity of collaboration among system leaders and across sectors, including emergency services, probation and community groups. This is expanding to include education.

Digital sharing of information is improving, as reflected in shared care records for a multi-agency risk assessment conference. However, we are also told this is a challenge for the system and concerns had been raised about integration of digital services for safeguarding.

The system is facing challenges around domestic abuse/violence. Presentations and admissions into hospital for injuries to children and domestic abuse incidents per 10,000 people were higher than the national average between April 2021 and March 2022. However, one NHS trust has lost all its independent domestic violence advisors (IDVAs) and another IDVA is for women only. This role is key to address the safety of victims at high risk of harm from intimate partners, ex-partners, or family members to secure their safety and the safety of their children.

Representatives from an organisation supporting people who have been subject to domestic violence and domestic abuse described differences in how domestic abuse teams are set out in Birmingham and Solihull and that this did not feel joined up. There was no continuity in domestic abuse commissioning. In some areas in Birmingham, domestic abuse sat in adult social care (ASC) commissioning, but for Solihull this sat in public health. The ICB provided IRIS (Identification and Referral to Improve Safety), which is a GP-based Domestic Abuse and violence (DAV) training and referral programme.

Quality statement: Equity in access

The ICS has begun developing programmes around access based on available data and information that may benefit multiple sectors. There are mixed outcomes regarding equity in access, and successes in improving access to care, treatment and support is not always replicated to address system-wide challenges.

Improving access and reducing inequalities

Throughout the system plans and strategies, there is a focus on improving access to care and treatment taking into consideration health inequalities. The ICS strategy set out plans to address unwarranted variations and disparities in access.

As part of its commitment to improving outcomes for people and tackling inequality, the ICS had set up the Fairer Futures Fund to fund activities that support this aim. Examples of activities included the Ambitions for Families Hubs, which aimed to reach out to the local population and bring services to families.

Response rates for satisfaction of people's experiences for the 2023 NHS GP Patient Survey shows Birmingham and Solihull ICS is below national averages. Principles to improve people's access to GP services have been developed and tailored to the needs of the local area. We heard that more can be done to make use of information on local populations to develop neighbourhood or place-based strategies and initiatives to improve.

People with suspected cancers are waiting longer than the England average for diagnosis, but the ICS has improved 72-week waits and achieved trajectory plans for 52-week waits. Plans for improving cancer diagnosis featured in the system recovery plans.

System leaders are also exploring a system-wide approach to improve the flow out of acute hospital for people with mental health needs who did not require acute treatment. This approach reduced the length of hospital stays and had ensured people received appropriate mental health support. However, mental health remained a challenge for the Birmingham and Solihull ICS, and other collaboratives to benefit people with mental health needs are still in their infancy.

We looked at ways in which the system is prioritising equity in access to services. For example, working with representatives of the Birmingham Lewisham African Caribbean Health Inequalities Review ICS Task Force, strong links with the system-wide immunisation and vaccination inclusion team and a wide range of organisations, including charities and primary care networks.

Some residents described difficulty accessing local services. This included people with a learning disability, and those living on a local authority border in a care home or mental health hospital, who had particular difficulties in accessing dental care.

The percentage of children seen by a dentist in the past 12 months was below the England average. However, the system is performing well on the number of dental extractions needed for under-19s and the percentage of children with dental decay. The data does not include those seen by a private dentist.

Quality statement: Equity in experience and outcomes

The strategies and processes to actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes are still in their infancy. There is an awareness of the need for system leaders to adapt approaches especially for those who are under-represented or whose voices are seldom heard. The ICS also identified the need to fully harness local insight to drive change in a systematic way that would improve and enable it to show evidence of health outcomes. We saw evidence of some co-production with the local population.

Collaboratively monitoring, listening, learning, improving and reducing health inequalities

System partners told us governance structures to address health inequalities are in their infancy. Although there is some data, systems, and process to analyse data, this information is not yet used effectively across the system. It is unclear how the system would monitor health inequalities (HI) on patient incidents before implementation. The Health Equity assessment or assessment tool had not yet been completed. Health inequality is a theme throughout the health and wellbeing strategy, but the system did not have specific equity in access or health equity plans.

Across the ICS, people's experiences of the health and care system differ significantly. People working in roles across the system recognised this variation, which is a primary focus of improvement work. Although implementation is in the early stages, there are multiple plans and strategies aimed at improving access to care and treatment, with a focus on tackling health inequalities.

The engagement strategy focuses on hearing people's voices and we saw pockets of meaningful engagement, particularly in areas of high deprivation. Over 100 people representing community and voluntary groups provided feedback on the strategy, but there is concern that engagement should have happened earlier in the process of service design.

Commissioning and system support to foster a culture of innovation

We heard about the emerging community engagement framework, which seeks to better join up engagement across the system and develop longer-term, trusted relationships in the system's communities whose voices are seldom heard.

Across the system, the ICS noticed an increase in the number of care home residents attending an urgent and emergency department. In response, as part of its operational plans for 2023-24, the ICS had committed to improving its system-wide response to people in adult residential care. The Urgent Community Response (UCR) team is expanding its capacity and remit to support the urgent emergency response and to help keep people in the community. At the time of our assessment, this is being rolled out in Birmingham, with plans to have a single point of access to the UCR team by June 2024.