Birmingham and Solihull Integrated Care System: pilot assessment report

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Birmingham and Solihull Integrated Care System
NHS Birmingham and Solihull Integrated Care Board
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Introduction and overview

Find out more about integrated care systems

Find out more about how we assess integrated care systems and the quality statements used in this assessment

CQC assessed 2 integrated care systems (ICSs) that volunteered to take part in our pilot programme. We will continue to develop the assessment process based on learning from these pilots.

Our ICS assessment team included specialist advisors and executive reviewers to contribute professional expertise. The team tested how we work with partners and stakeholders, gather evidence and work efficiently to adapt pre-existing processes to find an effective approach for assessing systems.

Using 17 quality statements from the new assessment framework as the basis for assessment, the team looked at how leadership works, how systems are integrated, progress towards reducing inequalities, and how quality and safety is managed across local services.

Birmingham and Solihull ICS engaged in this process, and we know that the system encourages its staff to see assessment as a positive opportunity to shape an emerging policy area, as seen through a series of briefings and advanced materials. We saw evidence of this throughout our assessment.

The system is working to recover from a large elective care backlog following the COVID-19 pandemic, as well as tackling significant ambulance handover delays and cancer treatment waiting times. We were also made aware in several discussions of high-profile concerns about a poor culture focusing on one provider, and the system's response to those issues.

Finance

The ICS has published information about expenditure. However, at the time of our assessment, final accounts had not been published and we have not seen them.

The integrated care board (ICB) has reported an in-year deficit for 2023/24, but there is a commitment to a break-even financial position by the end of the financial year. We heard that break-even was achieved in 2022/23.

At the time of the assessment, we were also aware of particular challenges in Birmingham City Council following the declaration of a Section 114 notice as part of its plans to meet the council's financial liabilities relating to equal pay claims, and an in-year financial gap. Concerns remained after our assessment and the local authority has published draft plans outlining £300m in budget cuts over 2 years. It is not yet clear what impact this is going to have on patients or what plans are in place to mitigate against that.

Local context

View local context from NHS Birmingham and Solihull Integrated Care Board.

Local demographics

Birmingham and Solihull Integrated Care System (ICS) is located in the West Midlands and comprises 2 places: Birmingham, and Solihull. Each place is a unitary authority and includes urban, suburban, and rural areas, with significant disparities in levels of deprivation and health inequalities across the ICS. Birmingham is the second largest city in England while Solihull includes a town centre, suburban and rural areas.

The ICS has a total population of 1,359,160 according to the ONS 2021 census. Birmingham and Solihull's populations and demography differ significantly:

- In Birmingham, the population size has increased by 6.7%, from around 1,073,000 in 2011 to 1,144,900 in 2021, which is higher than the England average.
- In Solihull, the population size has increased by 4.6%, from around 206,700 in 2011 to 216,200 in 2021, which is lower than the England average (ONS Census 2021).

Within the ICS, 40% of the population is from an ethnic minority background. In Birmingham 51% of the population is from an ethnic minority background, while this number drops to 18% in Solihull (ONS Census 2021).

Life expectancy at birth is considerably better in Solihull than Birmingham. In Solihull, the average life expectancy is better than the national average for both women (83.9 years) and men (79.6 years) while the average life expectancy in Birmingham is worse than the national average for both women (80.8 years) and men (75.9 years) (Local Authority Health Profiles -Data -OHID).

Notably, when compared with all other integrated care systems, more people in both Birmingham and Solihull reported that their general (age standardised) health was very bad or bad (ONS Census 2021; General Health).

Around 40% of households in Birmingham are not deprived in any dimension, which is below the average across all ICSs. In Solihull, a little over 50% of households are not deprived in any dimension, which is above average. The dimensions of deprivation used to classify households are indicators based on education, employment, health, and housing, which can have an impact on healthcare outcomes (ONS Census 2021; Household Deprivation).

ICS assessment themes

Our ICS assessments considered the core purpose of integrated care systems, as referenced in NHS England's design framework and the requirements of the legislation. They focus on 3 themes:

- Leadership
- Integration
- Quality and safety

Theme 1: Leadership

Direction of travel

There is positive progression with development of effective and coherent system leadership to achieve the aims of the ICS. We found leaders who were capable and compassionate, with a focus on a shared vision, inclusion, sustainability, improvement and tackling inequalities. We found:

- early stages of implementation of new initiatives
- continual focus on identifying population needs through data collection and knowledge of partners
- a lack of evidence to demonstrate that the system is listening to the many voices of people who are seldom heard
- feedback that not all partners felt involved and consulted by the ICS, which may risk progression in this area.

Summary of strengths

- System leaders and partners are committed to a clear vision to develop Birmingham and Solihull ICS partnerships strategies. There is a focus on addressing health inequalities underpinned by a constructive and inclusive culture, where trusting partner relationships and integrated ways of working are developing.
- There are clear 'road maps' for the system to achieve the aims and objectives of the ICS and good structures around risk, oversight and assurance. Governance arrangements support holding the system to account.

- The engagement strategy focused on hearing people's voices and we saw pockets of meaningful engagement, particularly in areas of high deprivation.
- Equality, diversity, inclusion, and health inequalities are linked across the ICS work, including in the workforce. This supported a commitment to the anti-racist pledge and demonstrated innovative approaches to recruitment and retention.

Areas for development and next steps

- There is scope to improve the responsibilities, governance and forward view around 'localities'.
- There are further opportunities to align strategies and plans into clear priorities and deliverables to ensure all activity is scalable and aligned with system objectives.
- There is scope to improve the culture and staff experiences within the ICS and other organisations by continuing to develop the Freedom to Speak Up structures and sharing learning.
- The engagement strategy needs to continue to progress by including listening to the voice of children, young people, and their families.
- There is scope to improve how data is used to identify system priorities for high impact interventions.

Summary findings for quality statements under the Leadership theme

This theme includes these quality statements:

- Shared direction and culture
- Capable, compassionate and inclusive leaders

- Freedom to speak up
- Governance, management and sustainability
- Partnerships and communities
- Learning, improvement and innovation
- Environmental sustainability – sustainable development
- Workforce equality, diversity and inclusion

Quality statement: Shared direction and culture

ICS leaders and partners strive for a shared vision to understand and meet the needs of the population in a person-centred way.

Prioritising the direction of the system

The system's overall vision was developed in conjunction with all system partners before establishing the ICB, including extensive engagement activity that was supported by an NHS England-funded external facilitator. The process was open and transparent. Not all senior leaders within the system were in post at the time of the development of the vision and the priorities.

Most system partners felt involved in setting the shared vision and priorities for the system.

A small number did not feel their professional knowledge was being used to best support population needs. This included dentists, the ambulance trust and health and overview committee members (HOSC).

Good progress has been made with the Inception Framework 2022, the ICS Integrated Care Strategy 2023, and its 5-year Joint Forward Plan. The strategy sets out the vision for the future and the specific improvements intended over the next 10 years. There is a clear aim to improve life expectancy for the people of Birmingham and Solihull, and an ambition to focus on 5 key clinical areas. This demonstrates an understanding of the population's needs, system challenges and a collaborative approach to create strong platforms to enable people to live well for longer in good health.

While the ICS's vision and the 10-Year Strategy are clear, there are multiple strategies in the ICS and partner organisations that are not aligned, which blurs their interpretation. This makes it difficult for some partners and frontline staff to understand their role in the ICS. System and provider strategies should be aligned to clarify the system vision and enhance successful partnership working.

The ICS's strategic plan and transitional operating framework supports the ICS Integrated Care Strategy and puts transformation at the heart of improving outcomes for people. Part of the reform is setting out integrated neighbourhood teams at the heart of the community.

Equality, diversity, and inclusion (EDI) is threaded throughout the ICS strategies, with some emphasis on disparities of health inequalities and on reaching those whose voices are seldom heard. The 10-Year Strategy is strong on health inequalities, but its mapping to the practicalities of health services and social care service delivery is less so.

The ICS Health Inequalities Strategy (HI) for 2022-27 includes key areas of concern and sets out building blocks and ways of working for what the system wants to achieve in relation to health inequalities, people with protected equality characteristics and those living in deprived areas. Some good work has taken place with community representatives to support this area of work.

Quality statement: Capable, compassionate and inclusive leaders

There is an inclusive and positive culture of continuous learning and improvement as system leaders had undertaken self-reflection to review their progress since the inception of the ICB. They have made considerable effort and progress to set a culture for the development of leadership expectations. These set the foundations for integrated working to support improved, professionally engaged partnerships that reduce health inequalities and improve the lives of people who use services and wider communities.

The system is trying to progress a culture of high expectations around **capable, compassionate and inclusive leadership**. We observed senior leaders maintaining good relationships, being collaborative, accessible, and engaging during their system quality group meetings. We saw empathy and compassion and there is recognition of system and performance challenges, but also praise where improvements had been made.

Senior leaders emphasise the importance of creating a compassionate culture and executives across health and social care worked to develop the Compassionate Charter to support collaborative working and behaviours.

A set of values (TEAM - transformative, equality, accountable, mindful) were created in collaboration with NHS partners and care parties in the statutory sector aiming to align organisational values. In working relationships, there is a desire to speed up resolutions and enhance inclusivity of strategic service development. A minority of system partners raised concerns about inclusivity and perceptions of top-down leadership and decision-making, but progress has been made and most partners spoke optimistically about future ways of working. There is evidence of successful and emerging relationships across the system that benefit people who use services.

Senior system leaders intend to deepen community involvement and overcome recognised challenges to engaging with some of their community due to cultural, linguistic, and ethnic barriers. The ICP Board attendees included 6 community representatives to support this work.

Fit and proper person regulation

Leaders understand the current and new requirements for the Fit and proper person regulations (FPPR). The ICB has updated its policy to reflect the new requirements for FPPR, and new recruits were being taken through this process at the time of our assessment. A sample of records showed that most requirements were met, however not all records had evidence of interview process or proof of stated qualifications.

Quality statement: Freedom to speak up

The ICB has fostered a positive culture and has clear escalation routes for raising concerns. The Freedom to Speak Up Guardian (FTSUG) is experienced and passionate about their role with protected time for this work. Executive leaders engaged with the Freedom to Speak Up Guardian and are committed to seeing improvements.

Roles and processes

A compassionate leadership approach has been adopted to focus on improving relationships with staff and supporting the growth of a positive culture, trusting relationships and a platform to speak up safely.

There is a good sense of direction and The ICB's Freedom To Speak Up policy will be developed once the National Guardian's Office (NGO) provides guidance and has engaged with the system Freedom To Speak Up Guardian.

The ICB follows the National Guardian's processes and submits data to support transparency in freedom to speak up events. Analysis of data demonstrates themes and trends, and protected equality characteristics are collected to understand where developments and future actions are needed.

Both leaders and staff within the ICB and ICS have a shared understanding of speaking up. They are able to describe what speaking up is and the methods within their own organisations. However, a minority of leaders and staff felt they would be uncomfortable raising concerns in their own organisations.

Freedom to speak up training

The ICB intends to roll out mandatory training once the new Freedom to Speak Up policy and framework has been finalised and the Freedom to Speak Up Guardian has consulted with staff to consider how to do this.

Quality statement: Governance, management and sustainability

System leaders have established clear responsibilities, systems of accountability and governance arrangements. Leaders are committed in delivering good quality, sustainable care, treatment, and support. The maturity of these arrangements is evolving and in development.

Governance systems

The Chief Executives group across Birmingham and Solihull, including representation from all NHS, local authority and primary care organisations, meets every week. The group was created following several system leadership changes to help the new group to recognise the system perspective and work together constructively.

Recognising the level of challenge to delivery within the system, the ICB led the establishment of a System Oversight Group (SOG) chaired by the Chief Delivery Officer. The SOG's role is to drive improvement and delivery through performance and transformation to achieve the ICS's commitments. It also shares insight and intelligence and identifies opportunities for improvement. This forum is credited with the co-ordination that has delivered improvements in long waits for elective treatment.

We saw evidence of place-based structures in both Birmingham and Solihull. The system has implemented a governance structure to pilot integrators at a Place level, reflecting its ambitions for services to be delivered in the community as close to patients' homes as possible. Although governance structures at place level still required further development, they had some success in rolling out the Fairer Futures Fund – an initiative designed to fund activities that will contribute to improving outcomes and tackling inequality.

There is an emerging good culture of risk-sharing within the system. This can be seen among senior leaders, particularly when addressing challenges of performance and quality, finance and workforce. For example, the system and Birmingham City Council have supportive and mature discussions about implications of a recent Section 114 declaration, to try to limit the impact on patients.

Performance delivery and recovery

The ICS outcomes framework tracks progress against the 10-Year Strategy, in alignment with the national ICS outcomes framework and health and wellbeing strategy metrics.

The SOG has 2 areas of focus: part A (performance, system pressure and actions) and part B (transformation, initiatives, and overall delivery). The System Quality Group is the strategic multi-stakeholder forum where emerging and current insight, risk, intelligence and improvement is managed with an oversight of quality concerns.

Urgent and emergency care has been a national challenge. Birmingham and Solihull ICS has recognised this and developed recovery plans in line with national guidance. For example, there have been significant improvements in urgent and emergency care, moving from tier 1 support (the highest level) to tier 3 at the time of our assessment.

The ICS is not always made aware of health inequalities in maternity safety incidents (SIs). System leaders acknowledged that other than monitoring of maternity SIs, they are not made aware of health inequalities in other patient safety incidents and further review of this is required. In the interim, an outcomes framework is in place, which identified ethnicity, gender, deprivation, and other available characteristics.

The system has processes with both overview and scrutiny and health and wellbeing boards, and met regularly with the HOSC to provide updates and attend scrutiny committees. However, HOSC felt its role and position in the system was not well understood by the ICS and partners. Health and wellbeing boards focus on reduction of health inequalities through commissioning decisions, delivering the Joint Strategic Needs Assessment for Birmingham, promoting greater service integration, participating in the annual assessment process to support Integrated Care Boards authorisation and identifying opportunities for effective joint commissioning arrangements and pooled budget arrangements.

Quality statement: Partnerships and communities

System leaders and partners understand their duties to collaborate and work in partnerships to enable services to work seamlessly for people. They are working towards implementing and delivering system-wide objectives at local levels, including reducing health inequalities, with some positive examples of collaborative working. System partners see the benefits of bringing people together to identify and resolve issues and perform more effectively.

System-wide objectives and processes

There is **leadership commitment** to work in partnership with the population, providers, the voluntary community and social enterprise, and a clear strategy for it. Transition to working as a system had not been easy for everyone. System partners spoke positively of the shift in approach to integration and collaborative working as a community.

The ICS strategic plan and transitional operating framework supports the ICS strategy and puts transformation at the heart of improving outcomes for people. The ICB set out a clear strategy around devolution of the tactical commissioning and contracting of services to 3 provider collaboratives. This will create single operating models in mental health, community (currently in pilot) and acute (due to begin 2024) sectors in Birmingham and Solihull. Some of the aims of the collaboratives are to provide systemwide focus on delivery, quality and safety of services, health prevention, and improvement in people's access and experience in outcomes.

These collaboratives are intended to help the system to improve how it manages demand and supply across sectors, but they still faced challenges and only one was operational at the time of our assessment. Partners talked positively of the shift in approach to integration and collaborative working as a community. We heard of 'green shoots' and being at a 'happy point of joined-up working', with recognition of the need to translate this into operational working for all system partners.

A small number of concerns were raised regarding methods of sharing primary care information. An operating model to address the fragmentation of primary care services is being considered to ensure one voice, address access challenges and improve services through a GP Provider Support Unit. A senior leader told us there is a primary care risk and quality group, and that primary care also fed into the System Quality Group and then the Quality Committee as needed.

Working collaboratively

The Integrated Care Partnership Board connects the local authority, adult social care, wider partners and voluntary services. Relationships are maturing and system leaders felt they are on course for delivery with a shared culture and collaborative working. Most system partners felt confident to make decisions and felt supported by ICB leaders.

System partners felt there is increased collaboration through the Integrated Care Partnership Board between health services, the local authority, police, and particularly voluntary services, who included the voice of the population, which had led to better oversight of challenges across the system. We saw evidence that system partners understand risks across services, and we heard examples where the ICB has facilitated and funded integrated working. For example, we heard how it funded collaborative working between the ambulance service and an NHS trust to expand acute emergency services.

There is good integration, improvement and collaboration between the ICS and its partners for some pathways of care through the mental health collaborative. As a result, people are receiving the mental health support they needed and there is a significant reduction in the length of time people are staying in hospital.

There are still significant challenges regarding transitions of care, for instance for children transitioning to adult care particularly when they still need hospice services.

There are good examples of partnerships and communities working together, building relationships, more engagement and less silo working. We were told about examples of successful work through the West Birmingham Community Health Collaborative, Flourish, and work to help unemployed and young people from Birmingham and Solihull into entry-level jobs in health and social care through the iCan programme.

Commissioners felt they worked well with system partners, and better engagement meant that information and available data could be shared at the relevant governing boards, sub-groups and working groups to improve outcomes for the population. Public health leaders have built good relationships with good quality information being shared. This enabled them to lead on the work for the ICP's 10-year strategy, which has resulted in forming a 10-year strategy with a clear focus on prevention at locality and neighbourhood level.

The ICS is working towards meeting the NICE (National Institute of Health and Care Excellence) Quality Standard on Community Engagement: improving health and wellbeing (QS148). It had carried out work against all 4 quality statements of the standard.

Quality statement: Learning, improvement and innovation

System leaders and partners are committed to a culture that brings continuous learning, innovation, and improvement across the organisation. An alliance has been created with Birmingham Health Partners, to bring together industry, charities and patients to co-design and deliver innovative solutions to urgent healthcare challenges at scale and pace. However, some system partners reported confusing and inconsistent learning and improvement structures.

Systemwide learning culture and process

The ICS Strategy, Inception Framework and Health and Wellbeing Strategy are considered as part of the Birmingham Health Partners Strategy to agree strategic direction and priorities. The ICS works with local universities to create alliances and innovation.

The ICS Inception Framework sets out expectations of enabling and fast-tracking improvements as a matter of routine, not exception. Although an important and related strategy, the 10-year Strategy does not focus on learning and improvement in the system.

The ICS introduced a system-wide escalation pathway for people with a learning disability and/or autistic people following learning from The Birmingham and Solihull Annual LeDeR report 2022/23.

System leaders and partners recognise the challenges they face in sharing learning across the system. There are early indications of a system-wide learning culture and shared efforts to innovate and improve services. Various events had taken place to reflect and learn from experiences and there is a quality improvement structure across parts of the system. We heard 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.

Some staff told us the Quality Improvement structure is confusing to understand and navigate, which led to people relying on existing relationships to escalate learning needs. Other partners and staff told us in many areas learning is not consistently shared, which left room for incidents recurring. A small number of system partners raised concerns about the effectiveness of system learning from Healthwatch reports that highlighted concerns regarding how access to GPs and NHS dentistry were affecting preventative care. It is felt these issues had not been resolved.

Partners in primary care feel they hold good local knowledge regarding health inequalities and would like to see this knowledge used more, with opportunities to lead on work to benefit localities and place planning.

Quality statement: Environmental sustainability – sustainable development

The ICS Green Board is responsible for monitoring the ICS Green agenda and the ICS has committed to a reduction trajectory. It recognises further governance around the Green Plan is required to outline specific targets and deliverables to partners and providers within localities.

Understanding of environmental sustainability and action being taken

The ICS Green Plan 2021-2026 has a heavy focus on carbon reduction. There is mention of health inequalities and the link with air pollution and health, although a lack of consideration about the need to prevent ill health more systematically through working with system partners such as the local authority. There is some reference to making Birmingham a healthier place to live, but action and the link to environmental sustainability are unclear.

The Green Board focuses significantly on estates and runs the risk of not being embedded in the wider healthcare provision, for example by not addressing health inequalities, partnership working or improving systemic social determinants of health.

The ICS sustainability lead told us the Green Plan needs refreshing to align with system plans, brining partners together and broader conversations. They also told us there is good representation from providers and they are going to individual provider boards to learn more, for example about primary care, so this could inform the green plan further.

The ICB recognises further work is required during 2023/24 to deliver Net Zero (carbon reduction), with greater engagement with local authorities and NHS England expected.

Quality statement: Workforce equality, diversity and inclusion

The ICS values diversity in its workforce and is committed to an inclusive and fair culture. Senior leaders across the system recognise that workforce culture requires focus, demonstrated by the high-profile culture concerns raised during late 2022 and throughout 2023. A series of planned 'big conversation' events with staff have been arranged to gain an insight into staff views including inclusion and diversity.

Policies, procedures and practices

The ICS wants to promote a fair and open culture. It has some clear pledges, such as 'We support making Birmingham the first Anti-Racist city in the UK'. This work continues to be supported by the Birmingham Race Impact Group, which focuses on resourcing the next generation of activists by pulling together Birmingham's best practice on fighting racism. However, it is unclear how this initiative would be rolled out to the rest of the system and include Solihull.

Birmingham and Solihull ICB's Interim Equality Strategy 2022-2023 outlines its approach to equality, diversity and inclusion, focusing on addressing inequalities within the workforce. It is developed through analysing staff demographics, experiences, and staff feedback sessions, including the 2022 staff survey results. It includes a quality improvement approach, with ongoing analysis of data, to identify under-representation within the workforce of people with protected equality characteristics.

Accountability frameworks and Feedback from staff

The ICS uses data from the workforce oversight framework and the workforce dashboard to monitor staffing, report on risk and inform the actions needed. This includes a variety of measures such as staff survey results, sickness absence, people in leadership roles who are from ethnic minority groups, gender and protected equality characteristics. The ICS is planning to develop more metrics, including some Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) information, to be clearer and provide better triangulation, oversight and assurance.

There is some variation in the views of staff regarding discrimination in practice and meeting national targets for workforce disability, but leaders and partners are aiming to improve an inclusive and fair culture by improving equality and equity for people who work for the organisation.

ICS data on senior leaders who have a disability showed that 2 out of 7 NHS trusts are meeting national targets for having senior managers who are disabled. Three trusts are not meeting the national target and there is no data for 2 trusts.

There is some variation in whether staff in the area believed they are discriminated against, with 2 of the large partners within the ICS being in the lowest quartile in the NHS Staff Survey for this measure. The survey also shows that the ICS is ranked among the lowest in the country in relation to staff who feel their organisation acts fairly regarding career progression, promotion regardless of their ethnic background, gender, religion, sexual orientation, disability, or age.

Providers within the area are mostly meeting the national target of having 12% of senior managers from an ethnic minority background, but as an area with a high level of diversity, this alone may not meet the test of whether the workforce reflected the population.

Theme 2: Integration

Direction of travel

There is a positive direction of travel for the development of an integrated governance structure. This is beginning to support the system approach model with an early focus on re-shaping commissioning to create place-based partnerships, improving alignment and tackling health inequalities. Risks to progression include needing to align organisational priorities and enhancing approaches to population health.

Summary of strengths

- There are many examples of teams working well together and improving people's outcomes.
- There is a focus on developing collaborative relationships to improve wider population health and reduce health and social inequalities.
- The shared care record supports service integration and information sharing.

Areas for development and next steps

- There is scope to align organisational strategies and priorities to ensure these do not limit integration, particularly at place level. This will support using population health management approaches more effectively to provide joined-up care to reduce health inequalities.
- There is significant challenge around transitions of care, both between sectors and particularly for children transitioning to adult care.
- There are continuing challenges and risks within special educational needs provision (SEND). There are pressures in the system, due to insufficient capacity for diagnosis and provision of services in areas such as occupational therapy and speech and language.

- Collaboratives, which will help to integrate within sectors, are still in early stages and only one, for mental health, has formed.

Summary findings for the quality statements under the Integration theme

This theme includes these quality statements:

- Safe systems, pathways and transitions
- Care provision, integration and continuity
- How staff, teams and services work together

Quality statement: Safe systems, pathways and transitions

The ICS has a system approach model for safe, reliable and effective improvement, in early evolution and embedding. Wherein many areas this is working well, demonstrating positive outcomes for people, system maturity is evolving, and medium and longer-term ambitions are yet to be realised.

System approach alignment and collaboration

Collaborative working relationships have evolved since the ICBs inception. Social care and health care are well-integrated, and they are equal partners in areas such as safeguarding, primary care, and mental health, with initiatives to improve 'flow' through the system and ensure care pathways are designed to meet the diverse needs of the local population.

Services have been organised and integrated to ensure the safety of people and communities across their care journeys. In primary care, GP practices have come together to form primary care networks to deliver safe systems of care and clear transitions as people moved between primary and acute hospital services.

We were told about the development of a General Practice Provider Support Unit, bringing together multiple support functions into a single structure to offer support defined by, and for, general practice with the aim to improve transition infrastructure and collaboration. A steering group had been developed by members with the ambition to see progress from their transition model by March 2024.

An area of focus for the mental health collaborative is a system-wide approach to support the flow of patients out of acute hospital care for those experiencing poor mental health who do not require acute treatment. This approach has seen significant improvement in the reduced length of hospital stay for people and has ensured people receive the appropriate mental health support needed.

There were concerns about how the work would be delivered, the timeframes and capacity within the system for the acute care and community care collaboratives, which were to commence in the coming months. These were recorded on the ICS risk register and monitored through system quality meetings and place committees.

There is alignment, collaboration and an inclusive approach to tackling waiting lists. These include the use of mutual aid, using extra capacity in areas such as orthopaedic elective and dental procedures. Waiting lists and trajectories are monitored at weekly system oversight groups. Within the System Elective Hub, there is a clear focus on admissions pathways and addressing waiting list challenges.

Design and safety

There is commitment from system leaders to work in partnership with people and we saw many examples. Some services had been co-designed with people who used them, but where there was co-design, some parents and representatives from voluntary groups told us they could have been involved earlier to fully collaborate.

Using feedback from people's lived experience, the ICS had identified the need to improve the provision of care for older people. As a result, a care facility has been built in the north of Solihull and other new supported living arrangements are developed for people needing support to live independently in the community.

While there is an increase in integration within the system, we also found a lack of joined-up care pathways for people using hospice services who are moving from children and young people's services into adulthood.

Some groups, for example a service for people who are homeless, didn't feel that their organisation or the people who used their services are engaged with as an equal partner to tackle inequalities.

Quality statement: Care provision, integration and continuity

The ambition of the system is to design care pathways to meet the diverse needs of the local population, and there are some joined-up pathways through partnerships and alliances. Services included several pathways including urgent community response and virtual wards.

Leaders in the system acknowledge that the ICS is in the early stages of using population health management approaches to provide joined-up care and reduce health inequalities. The ICS is taking time to embed these processes and assess the impact on an ongoing basis.

The system is developing integrated neighbourhood teams (INTs) to improve collaboration at a local level. This is being piloted in 2 neighbourhoods in the system where leaders felt there is the greatest need and benefit.

Care for autistic people and people with a learning disability is an area of focus for system leaders and partners, with the chief nurse taking a lead on this. Partners are aware of the need for improvements and identified 20 key priorities. System leaders told us about work to ensure suitable, safe accommodation for people with a learning disability. Through collaboration between partners across the system and close working with the local authority and housing colleagues, a property had been purchased and is currently being renovated to provide crisis care support and prevent admissions to an acute hospital.

Quality statement: How staff, teams and services work together

There is commitment to ensuring people only told their story to health and care providers once by using data, information and technology effectively. This commitment is yet to be fully realised, embedded or holistically evaluated.

Approaches to provide joined-up care and reduce health inequalities

To track progress against the 10-year strategy, the ICS used a dashboard that aligns with the national ICS outcomes framework and measures for its health and wellbeing strategy.

There is a system-wide focus on teams working together, to ensure that people received the right care, in the right place at the right time.

There was a focus on collaborative working to support people in areas of prevention and early intervention. Health and wellbeing community hubs included housing, health and police services and the domestic abuse charities. There was a diversion and development plan to support vulnerable women at risk of going to prison, to holistically support them around not re-offending and to lead healthier lives. We heard about the police crime commissioner's priorities and plans to support these are being discussed by the ICB.

Leaders representing emergency services told us they are made aware of the risks and challenges of health and societal inequalities for people living in Birmingham and Solihull, and that they are committed to resolving these as a system.

Effective use of data, information and technology

System partners felt there is increased collaboration across different sectors including: health, local authority, police, and particularly the voluntary and community sectors. There are more shared cared records across partners, including health and social care, local councils, prison, and emergency services to support integrated services.

The ICS and partners recognise the need to use data, metrics and clinical indicators to support equity in access. There is a structure to develop this further, but this is in early stages.

The system has begun using available data and information to address health inequalities and is developing programmes around access to care that may benefit multiple sectors. However, system-wide challenges meant improving access to care has not always been achieved in certain sectors. For example, experience of carers in making a GP appointment is generally worse than national and regional averages.

Shared care records were being used, but not across the whole system. There were challenges as not all organisations had connected electronic records. Information showed active and ongoing enrolling services including GP surgeries, nursing homes and hospices to the shared care record. We saw that usage information showed an increase in total access (service user/employee) from January to September 2023. At the time of our assessment, 209 services were actively using the shared care record.

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.

Secretary of State's priority area: Children and young people

The assessment had a focus on the Secretary of State's priority area for children and young people.

The ICS is still facing significant issues regarding equity of outcomes. The system's infant mortality rate is a stark example of this. Birmingham and Solihull ICS is one of the worst performing systems in the country for infant mortality. This is a long-standing challenge acknowledged by system leaders. The Children and Young People programme recognised that:

- Nearly half of Birmingham's children lived in the 10% most deprived areas in the country, with 8,000 living in the 1% most deprived areas.
- Almost 3 in 10 (29.8%) households with children in Birmingham are living in lone parent households, against an England and Wales average of 25%.
- Ladywood had the third highest level of child poverty in the UK with 47% of children living in poverty after housing costs.

- The ICS's Health Inequalities Strategy 2023 identified children and young people as a key area of focus. The Children and Young People Birmingham 5-year Plan and the Solihull All Age Prevention Strategy 2023-28 set out the strategic actions that system partners should take together to make Birmingham and Solihull a great place to grow up. Health and Wellbeing Boards in Birmingham and Solihull oversaw the Joint Strategic Needs Assessments. These set out the key challenges for each place, using 'data deep dives' and locality profiles to identify more specific opportunities for action. Shared priorities included:
    - infant mortality
    - childhood immunisation
    - school readiness
    - carer support
    - better data and analysis to increase understanding.

The ICS is also selected to join the Children and Young People Health Equity Collaborative with Barnardo's and the Institute of Health Equity. This aimed to improve the health of children and young people in the area and ensure they had a say on how services are run in their communities.

Providers within the system continued to face challenges in providing assessments, care and support for children with special educational needs and disabilities (SEND), including learning disabilities and autism. Waiting lists for neurodevelopmental assessments remain an issue, which is exacerbated by workforce pressures and growing referral rates. This is a key area of focus in the system's children and young people's strategy and there is also a SEND strategy and strategic group.

System partners had worked together to ensure safer outcomes for children. In 2023, Ofsted rated Birmingham City Council safeguarding provision as good. Solihull Metropolitan Council safeguarding had been rated as inadequate in October 2022. ICS leaders and the ICB are committed to improving safeguarding and both local authorities had been working on improvement action plans. The Independent Scrutineer and Chair of the MASH Steering Group had carried out a review of the multi-agency safeguarding hub (MASH) in Solihull, identified the improvements and made recommendations for continued improvement. Both local authorities had a MASH update visit in August 2023 and received positive feedback.

The ICS is working towards meeting the Transition and Transfer of Care: Looked After Children and Young People Nice Standards (QS31). It had a dedicated children in care (CiC) team, which is for all children in the care of Birmingham and Solihull local authorities. The service reviewed and supported children placed in the geography of the ICS from other authorities. All children in care and young people from Birmingham and Solihull who are living out of the area within the previous 18 months had a comprehensive review of their needs to make sure they are receiving the support they needed.