NHS
North East and
North Cumbria

North East and North Cumbria
Integrated Care Board

Quality Strategy

V2

Contents

Introduction (DP/LD)

Our ICB vision

In our strategy, Better health and wellbeing for all, our vision for North East and North Cumbria is better, fairer, health and wellbeing for everyone. This is an inclusive vision, capturing the need to improve health and broader wellbeing for everyone across the North East and North Cumbria.

Our aim is to be 'the best at getting better.' We have already created the Learning and Improvement Collaborative to mobilise people from across the region.

Our intent is to build the learning system as a culture, a community and a collection of assets that support learning at every opportunity. We will do this by working with people and partner organisations, across the ICS.

Our goals are:

- To achieve longer, healthier lives for everyone;
- Fairer health outcomes for all;
- Best start in life for our children and young people;
- Improving health and care services.

Within our strategy, we identify that Health inequalities arise because of variations in the conditions in which we are born, grow, live, work and age, meaning that we do not all have the same opportunities to be healthy. One key measure of health inequalities are inequalities in life expectancy, the difference in how long groups of people live on average. Mortality rates from the Covid-19 pandemic have been considerably higher in the more deprived areas, deepening health inequalities. By April 2022, the cumulative death rates since the start of the pandemic in people aged under 75, were 3.5 times higher in the most deprived areas compared to the least deprived across the North East and North Cumbria. Nationally, the pandemic had a disproportionate impact on people from some ethnic minority groups, in terms of higher mortality rates.

Not only can health inequalities affect people's health throughout their lives, but there is also growing evidence that health inequalities, social determinants of health and people with protected characteristics may be disproportionately affected by poorer outcomes, harm, and premature deaths.

Examples of increased patient harms include: -

- Themes from the Learning Disabilities Mortality Review programme (LeDeR) shows that people with a learning disability experience more respiratory problems and there is an under recognition of early deterioration of the person's condition and recognition of sepsis.
- People from the most socioeconomically deprived groups were nearly twice (80%) as likely to die from sepsis within 30 days, than those in the least deprived socioeconomic groups.
- CQC identified in their state of care report 2022/23 there was ongoing ethnic inequalities across a number of areas, including maternal and neonatal health care and mental health care. For example, rates of detention for people from the Black or Black British group were over four times those of people from the White group.

By viewing health inequalities through the lens of patient safety, this gives us a unique opportunity to take meaningful action to reduce the risks of harm and improve the quality-of-care people receive across our system.

Patients and citizens will remain at the heart of all that we do both as an ICB and as an ICS. We are committed to being ambitious and courageous and will strive for excellence to improve the quality of services.

Where it started, the national context.

When developing our quality strategy we considered national drivers, relevant publications and documents, to help inform our Quality strategy. These include: -

- **The NHS Long Term Plan** (2019) sets out a 10-year programme that aims to improve health and care for local people of all ages, so that they can get the right care, in the right place, at the right time.
- In 2022, the **National Quality Board (NQB) published a shared commitment to quality**, is guidance on a shared view of quality across health and care systems, which provides the foundation for system working around quality, championing the need to ensure that quality is a shared goal that requires us all to commit and act. Quality care is understood in the guidance according to the NQB Shared Commitment's definition, as care that is safe, effective, provides a personalised experience, is well-led and sustainably resourced. The NQB is also clear that quality care must be equitable, focused on reducing inequalities and addressing wider determinants.
- NHS England's **Patient safety strategy** (2019) explains that patient safety is about maximising the things that go right and minimising the things that go wrong. It is integral to the NHS definition of quality in healthcare, alongside effectiveness and patient experience. They define a safety culture as an environment that is supported by continuous learning and improvement of safety risks, supportive, psychologically safe teamwork and enabling and empowering speaking up by all.
- The World Health Organisation (WHO) produced a **global safety action plan 2021-2030 Towards eliminating avoidable harm in health care.** The plan provides a framework for action through seven strategic objectives, to enable strategic and coordinated approaches to patient safety.
- Following on from the patient safety strategy, NHS England produced a **Just culture guide**. Within this they use Professor Sir Norman Williams definition which is stated as, 'A just culture considers wider systemic issues when things go wrong, enabling professionals and those operating the system to learn without fear of retribution.'
- The Care Quality Commission's **A new strategy for the changing world of health and social care** (2021), strengthens the commitment to deliver CQC's purpose: to ensure health and care services provide people with safe, effective, compassionate, high-quality care and to encourage those services to improve. The strategy has four themes which focuses on what's important to people and communities when accessing services, smarter regulation, safety through learning by regulating for stronger safety cultures across health and care, and accelerating improvement to help improve the quality of care.
- **The Health and Care Act 2022** was introduced as a legislative framework to formalise the establishment of ICB's and detailed their specific responsibilities and duties. Within the act, ICB's have a duty to continually improve the quality of

services, but also the duty to promote the involvement of patients, the duty to promote innovation and research, and the duty to promote integration.

- Specifically, **the act** obliges the ICB to secure continuous improvements in the quality of services and outcomes that are achieved from the provision of services with outcomes that show: -
    - The effectiveness of the services.
    - the safety of services.
    - The quality of the experience undergone by patients.
- Within **The NHS People plan: We are the NHS (2020)** – action for us all, it focuses on how in the NHS, we all must continue to look after each other and foster a culture of inclusion and belonging, as well as action to grow our workforce, train our people, and work together differently to deliver patient care.
- The NHS Leadership academy produced **Our Leadership way – The Heart, Head, and Hands of Leadership** compassionate, curious, and collaborative. Complementing the NHS People Promise, Our Leadership Way formalises the approach NHS leaders should take to develop this even further. It requires every leader, at whatever level across the NHS, to recognise, reflect and bring to life every day, six core principles. One way to conceive this is to think about the Heart, Head and Hands of leadership; the things we must consciously think about, the things we and others feel and the things we should do. In short, we should lead with compassion, curiosity, and collaboration.
- In 2022, NHS England published the **Patient Safety Incident Response Framework** (PSIRF) which sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents, for the purpose of learning and improving patient safety.
- NHS England's **Quality and Outcomes Framework** sets out the expectations for quality in general practice (GPs). It includes provision for quality improvement in line with the shared commitment to quality.
- Similarly, within NHS trusts the **Commissioning for Quality and Innovation (CQUIN) framework** supports improvement in the quality of services and the creation of new and improved patterns of care.

What people say high quality care means to them.

In order to understand what was important to our communities across our system, we listened to our citizens, service users and colleagues; this is what they said high quality meant to them and therefore what it means to us.

What our citizens told us: -

- Being there for when people really need it. Personalised care making everyone feel that they matter. Really focusing on the person.
- Person centred, equitable, consistent.
- Quality service providers that deliver the best support possible.
- Seamless combined service between health and social care that focuses absolutely on the individual and carer needs.
- Easy to access and available to all; a 'tell your story once' approach; health & social care professionals communicating with each other and with the patient; listening to what the patient wants and, when possible, giving a personalised service.
- Services working together so that individuals don't have to continually repeat their stories, systems that work together so information can be shared. Wrap around holistic care for those that need it.
- Access to health and social care in a timely manner. Any services offered done so in the best interest of the person(s) concerned and not determined by budgets or who pays, or the way we have always done it.
- Easy to access and easy to understand what services are available, where they are and what the opening times are.

What providers and stakeholders told us: -

- Delivering the best quality at the level we would expect for our family.
- Having measures in place to assure ourselves that we are delivering and to identify quickly when things are going wrong.
- Needs are being met in the best way and the service users experience is the best it can be.
- Best possible patient outcomes, being listened to and the person's voice being heard.
- Local resources for local people.
- Transparent systems with clear pathways with seamless transitions for service users and staff.
- Clearly defined culture that builds trust in the system.

Our overarching strategic themes

Strategic cross-cutting theme: Culture and Climate

“The most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end” (Berwick Review into patient safety, 2013).

"So, in order to create cultures of high quality, continually improving and compassionate care we must understand the existing culture and put in place measures to achieve a culture that truly represents and reinforces those values of high quality (safe, clinically effective, patient centred) care, continual improvement and compassion.” (Professor Michael West the Kings Fund).

Our vision for culture across North East and North Cumbria

It has long been recognised that the culture of organisations or the system shapes the values and behaviours of everyone in it, the quality of care it provides and its overall performance, meaning that ultimately culture matters if we want to consistently deliver safe high-quality care and continually improve. Despite many reports being written on the importance of safety cultures within the NHS, there is still much more to do to ensure that safety and high-quality care are consistently delivered to reduce the risks of avoidable harm.

CQC defines a closed culture as 'a poor culture that can lead to harm, including human rights breaches such as abuse', in these services, people are more likely to be at risk of deliberate or unintentional harm. Unfortunately, there have been many national examples where people have experienced and suffered harm because of a closed culture, including Whorlton Hall within our own system. We will strive to identify, reduce, and eliminate the risk of closed cultures within our system, by continuing to improve quality assurance of services and increase staff knowledge and skills to identify when a closed culture may occur.

The Reading the Signals report (2022) into East Kent's University Hospitals NHS Foundation trust's maternity and neonatal services, identified four areas for action, three of which included key aspects of culture that support positive safety cultures. These four actions are: -

- The NHS could be much better at identifying poorly performing units;
- At giving care with compassion and kindness;
- At teamworking with a common purpose;
- At responding to challenge with honesty.

The report highlights that none of these are easy or necessarily straightforward, because longstanding issues become deeply embedded and difficult to change. But unless these difficult areas are tackled, we will surely see the same failures arise somewhere else, sooner rather than later, and the report must be a catalyst for tackling these embedded, deep-rooted problems. As part of the culture and climate across the ICS, we are committed to tackling these issues, so we can "read the signals", identify areas that we need to focus on, that enables us to continually develop and improve the quality of services.

Several key themes have been identified in relation to health inequalities and patient safety. The themes include communication between clinicians and patients/carers; patient involvement in their own safety; accessibility of healthcare; cultural competency of the workforce and system; transitions of care; geographical variation and data quality.

Therefore, across the ICS we will foster a proactive and positive culture of safety that is based on openness and honesty, in which concerns about safety are listened to, safety events are investigated, and lessons are learned to continually identify improvement and embed good practices. To do this, safety and high-quality care needs to be a priority for all regardless of role, seniority or organisation, everyone needs to play their part and collaborate across the system for improvement. This is our call to action.

We will do this by adopting the values and behaviours of the following principles: -

Professional curiosity

We will adopt a culture of professional curiosity within the system from staff in frontline services through to members of the board; this will enable staff to have a holistic view and understanding of what is happening, use this information to fully assess potential risks, while maintaining an objective, professional and supportive approach to improvement.

Just culture

In line with the principles of a just culture, we want to create a culture of fairness, openness and learning within our system. This will make colleagues feel confident to speak up when things go wrong, rather than fearing blame and allows valuable lessons to be learnt, which helps to prevent the same mistakes being repeated.

Freedom to speak up.

The Freedom to Speak Up initiative was started as a means to create an environment that enables and empowers staff to raise concerns they might have or observe in their area of work and to notify the relevant body or authority with the knowledge that action will be taken as a result. We recognise it is important for people to speak up about concerns so that organisations and the system can keep improving services for all patients and the working environment for staff.

NHS People Promise

We will act on the NHS people promise so that we embed a culture across the system that is compassionate, positive, and inclusive. The promises are: -

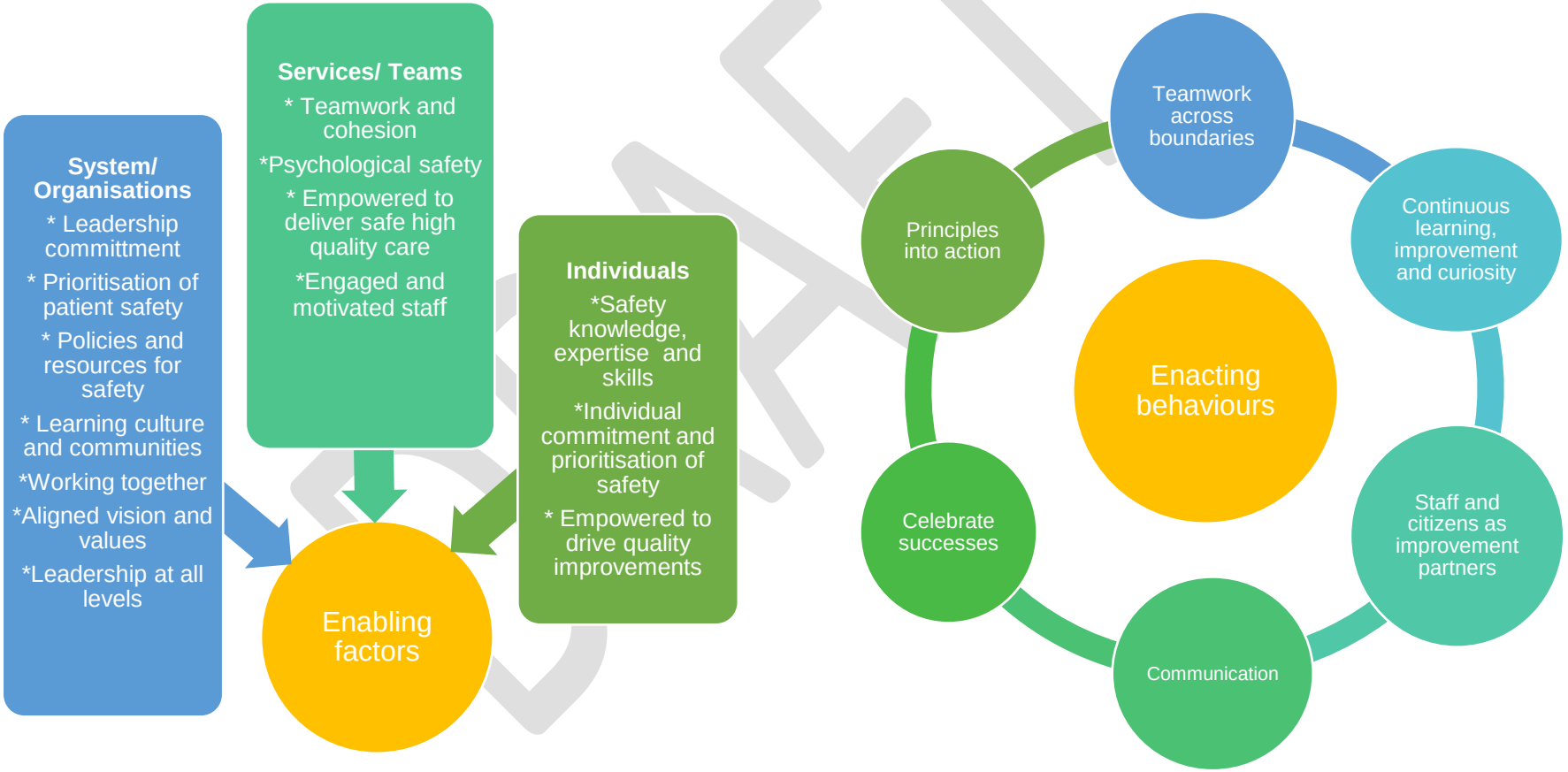
- We are compassionate and inclusive;
- We are recognised and rewarded;
- We each have a voice that counts;
- We are safe and healthy;
- We are always learning;
- We work flexibly;
- We are a team.

Equality, diversity, and inclusion

We value diversity in our communities and workforce; we will work towards an inclusive and fair culture by improving equality and equity for people who use services and for those who work within our system. Within our system culture we will strive to improve equality, diversity, and inclusion, and to enhance the sense of belonging for our citizens and staff to improve their experience. Everyone should have access to high quality care, and we are committed to identifying and reducing variation and health inequalities.

Creating the culture: -

We know to create the culture we strive for within North East and North Cumbria; these are the factors and behaviours that will help us to build a safer culture and drive positive health outcomes for our citizens.



Strategic theme: Patient Safety - is a priority for everyone and leaders within the system embed a culture of openness and collaboration.

Patient safety	What this means to our citizens	What this means for the system
•Safety is a priority for everyone with a clear commitment to improve safety. •We will embed processes and systems across the ICS that promotes high quality, safe and effective care. •We foster a culture of openness, transparency and learning to improve safety for people. •Care across the system is delivered in a way that minimises things going wrong and maximises things going right. •We will recognise and celebrate outstanding health and care so we can learn when things go well and when things have not gone well. •We identify risks and use these as an opportunity to put things right, learn and improve. •We will consider the impact of health inequalities on patient safety and identify actions that reduce the risks of harm.	•I feel safe and am supported to understand and manage any risks. •If something goes wrong, I will be supported in an open and honest way and will receive an apology. •I understand the service recognises when things haven't gone well and uses these to improve the service. •I am cared for by staff who have the skills and experience to support me. •I am empowered to be a partner in my care and staff understand my individual needs that promotes my safety.	•We have a culture of safety and learning where staff can raise concerns, these are investigated and learning opportunities are identfied. •There is an environment where we can share learning across organisational boundaries. •We can demonstrate improvements have been driven across the system that improves people experiences of care, reduces variation and health inequalities. •We have encompassed human factors to underpin our approach to patient safety and quality improvement. •The ICB's approach to the patient safety incident response framework across the system has been embedded. •We have established and developed our communities of practice.

Strategic theme: Clinical Effectiveness- As a system this is the way we work together which maximises the potential to improve patient outcomes and health, based on evidence-based practice, continuous improvement, and the monitoring of clinical outcomes.

Clinical Effectiveness	What this means to our citizens	What this means for the system
•Across the system people receive the right care, at the right time, in the right place. •We will adopt and share evidence based practices to the care and treatment people receive. •We will use data and intelligence to drive improvements to ensure effective high quality care. •We will measure and publish quality-measuring what matters to people, monitoring quality and safety consistently and use data to inform decision-making. •We will set clear standards for what high quality care and outcomes look like based on what matters to people and communities. •We ensure there's co-ordination of services across the system, that considers the needs and preferences of different people, including those with protected characteristics and those at most risk of a poorer experience of care.	• I have care and support that is co-ordinated, and everyone works well together and with me. • I am empowered to get the care, support and treatment that I need. • I know my care is the most effective it can be and is in line with recognised standards. • I know the services that care for me, are working together to ensure I receive high quality care. • When I move between services, there is a plan for what happens next and all the arrangements are in place.	• We have systems to use data, intelligence and knowledge to inform our decision making. • Our clinical conditions strategic plans are improving outcomes for people and reducing variation and health inequalities. • We are staying ahead by embedding research and adopting innovation to ensure progressive high quality care across the system. • We have a quality improvement methodology to support our improvement work across the system.

Strategic theme: Positive Experiences- Are shaped by what matters to people and empowers people to make informed decisions. Services across the system are delivered with compassion, dignity, and mutual respect.

Positive Experiences	What this means to our citizens	What this means for the system
• We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. • We involve people in decisions about their care and tell them what's changed as a result. • We actively seek out and listen to information about people who are most likely to experience inequalities in experience or outcomes. • Services across the system are designed by what matters to people, that empowers them to make informed choices and is delivered with compassion, dignity and respect. • We will co-produce with people with 'lived-experience' as they are often best placed to advise on what support and services will make a positive difference to their lives.	• I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and personal goals. • I am supported to manage my health in a way that makes sense to me. • I am involved in decisions about my care. • My feedback was taken seriously and I know what changes have been made as a result. • I felt that my voice was heard and that I was listened to and understood. • I am encouraged and enabled to feedback about my care in ways that work for me and I know how it was acted on. • My individual needs and preferences are understood and these are reflected in my care, treatment and support, and takes account of my personal, cultural, social and religious needs.	• We listen to people's views and experiences and they are seen as an integral part of our quality improvement work. • We use people's experiences as a central component to quality assurance and identification of risk. • We recognise people's experience could be early warning signs of poor care. • We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity. • Our patient and public involvement strategies are embedded into our work across the system.

Strategic theme: Clinical and Multi-Professional Leadership- We will build capability for improvement by providing multi-professional leadership for quality, building learning and improvement cultures, supporting staff and people using services in co-production.

Clinical and Multi-Professional Leadership

- We will be driven by collective and compassionate leadership which champions a shared vision, values, and learning, delivered by accountable organisations and systems.
- We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of the system.
- Clinical and care professionals are involved in all aspects and every level of system decision-making.
- We have a transparent approach to identify and recruit leaders that promotes equity of opportunity, that also recognises the different kinds of leadership styles required, when working across professional and organisational boundaries.

What this means to our citizens

- When I receive care, services meet my needs and that of the wider community, and all leaders and staff support this.
- I will be involved in designing services and my feedback is heard and valued by leaders in the system.
- I am confident leaders and staff are able to identify poor care and address this quickly.
- I know that staff and leaders with the right skills and experience are making decisions about care services.

What this means for the system

- We have high-quality leadership throughout the system which is sustained through safe, effective and inclusive recruitment and succession planning.
- Our leaders are skilled and confident and can contribute effectively to quality improvement.
- We are alert to examples of poor culture that may affect the quality of people's care and have a detrimental impact on staff and our leaders address this quickly.
- We have embedded leadership strategies and development opportunities within the system.

Working together to deliver Quality – How we will do this together?

As an ICB and commissioner

- Set clear quality standards and expected outcomes when commissioning as part of quality and performance management.
- Developed the system as the 'best at getting better' with established communities of practice.
- Have clear governance frameworks for quality.
- Quality assurance gives a clear and accurate picture of safety, and there are steady improvements in safety over time.
- Develop a positive safety culture that is embedded at all levels of the system.
- Work together across the system to ensure seamless pathways between services that focus on delivery of high-quality care.
- To co-produce with communities to shape services to meet their needs.
- Share learning, best practice, and innovations across the system to influence and improve the quality of services.
- We have consistency in approaches which leads to more standardised practices in services.

For people and communities

- People in our communities know what good care looks like, what they have a right to expect, and what to do when their experience doesn't meet expectations.
- People are partners in their care and are supported in making decisions about the care they want to receive.
- People have care that is personalised, and they are treated with dignity and respect.
- People's voices are heard, listened to, and understood and feedback is used to drive improvements in quality.
- People are included in reviews and contribute to improvements in care.

For all health and care providers

- Experience a coherent system of quality assurance and performance management.
- Are accountable for the quality of care they provide, and driving quality improvements which translates into improved health outcomes.
- Care is co-ordinated across services, organisations and the system and they work collaboratively to meet people's needs.
- Support the system to continually improve and maintain quality and safety standards.
- Work as system partners and understand their role in improving health outcomes, reducing variation and health inequalities.

For all staff

- Staff are seen as partners in delivering safe high-quality care,
- Staff feel safe and confident to speak up without fear of retribution.
- Staff are supported to learn and make improvements to care at every level of the system.
- Staff are engaged and motivated to develop and drive improvement plans.
- Staff are supported to learn and develop to embed quality and safety practices in their everyday work.

What's next for our Quality Strategy? In the next 12 months: