Care Quality Commission

Birmingham City Council assessment

How we assess local authorities

Assessment start date: 11 May 2023

Assessment published: 17 November 2023

Assessing how local authorities meet their duties under Part 1 of the Care Act (2014) is a new responsibility for CQC. We have been piloting our approach to these new assessments in 5 local authorities who volunteered to participate. Our assessment of Birmingham City Council was part of the pilots. We will be incorporating any learning from the pilots and evaluation into our formal assessment approach.

About Birmingham City Council

Demographics

Birmingham City Council (BCC) is the largest local authority in the country by population with over 1.1 million people living in the city. It is an ethnically diverse city with 51.4% of its population identifying as ethnic minorities, making Birmingham one of the first 'super-diverse' cities in the UK. Birmingham is one of the youngest cities in Europe and nearly half the population is under 30 years old. Over the last decade, the population of the city has increased by 6.7%, which is higher than the overall increase for England (6.6%). While Birmingham is considered one of the youngest Cities in Europe, the older population is growing rapidly too. There has been an increase of 8.9% in people aged 65 and over, and an increase of 7.1% in people aged 15 to 64.

Birmingham City Council comprises 101 councillors. The Labour Party currently has most councillors and runs the local authority. The current number of councillors in each of the political parties are as follows: Conservative 22 councillors, Green 2 councillors, Labour 65 councillors, Liberal Democrat 12 councillors.

Birmingham's health and social care organisations use a locality model to deliver services across the city. Birmingham has 5 localities each made up of 2 constituencies. These are:

- Central: Hall Green and Selly Oak constituencies
- East: Hodge Hill and Yardley constituencies
- North: Erdington and Sutton Coldfield constituencies
- South: Edgbaston and Northfield constituencies
- West: Ladywood and Perry Barr constituencies.

Birmingham experiences elevated levels of deprivation, with 43% of the population living in the 10% most deprived localities in England, and 51% of children (under 16) living in the 10% most deprived areas. Using the rank of average scores measure, Birmingham is ranked the 7th most deprived local authority in England. The city is also the most deprived authority in the West Midlands Metropolitan area and is ranked the third most deprived English core city.

Financial facts

- The local authority estimated that in 2021/22, its total budget would be £1,847,287,000. Its actual spend for that year was £1,893,860,000, which was £46,573,000 more than estimated. Note that for 2022/23, Birmingham did not submit its actual spend in time for publication.
- The local authority estimated that it would spend £350,828,000 of its total budget on adult social care in 2021/22. Its actual spend was £331,951,000, which is £18,877,000 less than estimated. Note that for 2022/23, Birmingham did not submit its actual spend in time for publication.
- In 2021/2022, 18% of the budget was spent on adult social care.
- The local authority has raised the full adult social care precept for 2022/23 and 2023/24. Please note that the amount raised through adult social care precept from local authority to local authority.
- Approximately 15,275 people were accessing long-term adult social care support, and approximately 4,025 people were accessing short-term adult social care support in 2022/23. Local authorities spend money on a range of adult social care services, including supporting individuals. No two care packages are the same and vary significantly in their intensity, duration, and cost.

This data is reproduced at the request of the Department of Health and Social Care. It has not been factored into our assessment and is presented for information purposes only.

Overall summary

Local authority indicative rating

Good: Evidence shows a good standard

Summary of strengths, areas for development and next steps

The local authority had strong, effective leadership. This was driving a shift in practice away from a resource-led needs-based model, to a proactive investment in community facilities – groups, buildings, and places (sometimes known as assets) and a strengths-based assessment model. This means assessing people by starting with what they can do and what resources and networks they already have available to them, to support them to achieve their desired outcomes. This was designed to help people be resilient and more engaged with their local networks and communities. The aim being that they stayed healthier, remained independent for longer, and reduced dependence on formal services.

Staff, leaders, and partners were all passionate about supporting the people of Birmingham to achieve the outcomes that were important to them. The local authority had launched an evidence-based culture change programme called Owning and Driving Performance. The intention was to create a culture based on accountability and keeping records that showed a clear rationale for all the decisions made (known as defensible decision making). This focused on delivering improved outcomes for people and was well embedded with staff.

There was a clear and effective focus on partnership working across the whole health and social care system in Birmingham, with a shared respect and commitment to co-production, particularly with people and local groups. Joint commissioning happened often. Formal integration at an operational level was not as advanced, but was developing fast. The integrated Early Intervention Community Team had been established for some time and was working well.

When assessments and reviews took place, we heard of good, person-centred and strengths-based practice where professionals built good working relationships with the people they were assessing and, as appropriate, those who were important to them.

Delayed discharges from the acute hospital sector were rare, and there were multiple effective pathways, which were tailored to meet people's specific needs and circumstances.

Most people in Birmingham had access to a varied market of organisations who provide social care services (known as providers), and there was enough supply of both homecare (domiciliary) and residential care to meet demand.

There was robust management and oversight of delivery across all adult social care, with coherent strategies, action plans and a framework of governance. Where issues were identified, plans were implemented, and the improvement journey monitored for its effectiveness, including any unintended consequences. Where appropriate, revisions to plans were implemented.

The local authority was committed to learning, which included having a positive focus on joint research with academic and other partners to better understand and meet people's needs in evidence-based ways.

Some people, carers and providers told us that it could be difficult to get access to the first line of information and support, social workers and commissioners at the local authority. The local authority has taken steps to address this, but further work is needed to ensure the impact of these measures. We were also told there could be delays for people to be assessed or reviewed, and some social work teams had waiting lists or were overstretched, especially the mental health and transitions teams. The local authority told us this was due to recruitment difficulties. This included general recruitment challenges, but also some more specific to specialist teams that dealt with more complex matters.

Birmingham is a city where people from ethnic minority groups are the majority of the population, and there was still a high degree of inequity of outcomes and experience. We were told that the local authority was aware of this and its commitment to change this through the equality, diversity and inclusion strategy, 'Everyone's Battle, Everyone's Business', was a golden thread through everything it did.

There were some gaps in bed-based respite care, care for people with complex needs, and culturally appropriate provision to meet the bespoke needs of some people.

The local authority had a backlog of investigations into enquiries, which it has determined meet the threshold for investigation under Section 42 of the Care Act. There had also been qualitative issues with work undertaken, a lack of evidence of professional curiosity and of defensible decision making. The local authority acknowledged that its safeguarding practice needed to improve and was able to demonstrate that a plan was in place to address identified shortfalls in practice.

The local authority also had a backlog of applications for Deprivation of Liberty Safeguards (DoLS) waiting to be authorised. The local authority has risk-assessed these and they were prioritised based on this assessment.

There was a list of 217 young people waiting for an assessment of their needs at the point of transition to adult services, of which 114 had been waiting for more than 90 days. The local authority is aware of this and has a plan to address the waiting lists.

There were pockets of inconsistencies in the way in which the local authority fulfils its duties, both across teams and types of provision. These limited the effectiveness of the strong partnerships, governance, and efforts to improve, which are in place.

Summary of people's experiences

People told us that the work done to help them live healthier, more connected lives, was positive, successful, and made a long-term difference. National data relating to supporting people to be healthier showed fewer positive results, with issues around people not finding it easy to find information about support. This was reflected in the feedback from people we heard from, who said it could take a long time to contact the frontline information and support team, and that they found it hard to navigate the web-based information service.

We heard mixed feedback about people's experience of accessing and having an assessment, or a care review. Those who had a good experience valued the approach of the individual worker, and felt listened to. Others, particularly unpaid carers, had to wait a long time, were not always able to have a face-to-face assessment when this was their preference, and did not always feel that their needs or the views of the cared for person were valued.

Many people recognised that the local authority sought the views of people with lived experience, to identify needs and to co-produce strategies and services to meet those needs. This was appreciated by those who took part. However, we also received feedback that local authority consultation exercises were not always accessible to everybody who might want to contribute.

People told us it was not always easy to get the type of care that they wanted, for example bed-based respite, and those on Direct Payments had difficulties recruiting and retaining staff. (Direct payments is a means of local authorities giving individual people funds to directly purchase services to meet their assessed care needs.)

At the point of transition between services, most people received the help they needed. People were more likely to be offered rehabilitation and reablement after a hospital stay, they stayed in hospital for shorter periods and were more able to remain at home for longer afterwards. We heard positive stories about the experiences of young people with preparing for adulthood service.

Theme 1: How the local authority works with people

This theme includes these quality statements:

- Assessing needs

- Supporting people to live healthier lives
- Equity in experience and outcomes

We may not always review all quality statements during every assessment.

Assessing needs

Indicative score:

2 - Evidence shows some shortfalls

What people expect:

“I have care and support that is co-ordinated, and everyone works well together and with me.

“I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals.”

The local authority commitment:

“We maximise the effectiveness of people’s care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.”

Key findings for this quality statement

The 3 conversations, strengths-based approach to assessing need was well embedded in the community-based teams. This is a model where the assessor has 3 separate conversations with a person: firstly to explore their needs and identify their sources of support; secondly to assess risk and any crisis interventions that may be needed and establish provision; and then thirdly to discuss long-term outcomes and planning based on a client's vision of a good life.

Staff had a good understanding of it and recognised the value in starting conversations with people about their strengths and desired outcomes, describing the process as well liked and successful.

We heard mixed responses from people who used services and their unpaid carers regarding the assessment process. When people found assessments to be a positive experience, this most often related to the approach of the individual social worker and the fact they felt heard.

The local authority has delegated the delivery of carers assessments to the Carers Hub, of which Forward Carers is the lead provider. Carers, and sometimes people who used services, did not always feel their needs were recognised or that assessments were holistic and future focused. Carers noted that even since the pandemic restrictions were lifted, face-to-face assessments were not easily available when they would have preferred them.

While acknowledging that we heard some positive feedback, further work is required to ensure that this is a more consistent experience – both for people who use services, and their unpaid carers.

Staff and partners spoke of positive multi-disciplinary approaches to assessment when people were ready to be discharged from hospital. The local authority has embedded the strengths-based approach in its discharge to assess model – which is reflected in a consistent performance of over 95% of people being discharged to their own home, and over 80% of those over 65 still at home 91 days after discharge from hospital.

Some constituency teams had a backlog of assessments, but others did not. This meant there might be variation on how quickly a person had their assessment, depending on where they lived. In such cases, the team concerned stayed connected with the individuals regularly to check whether their situation had become more urgent. There was a backlog of referrals for people in transition from Children's to Adults' statutory services, which stood at 217 people. This meant there was a risk that young people may not receive a timely assessment of their needs as they moved into adulthood and may not have a plan in place for how these needs would be met. There was a plan to reduce this backlog using temporary staff by December 2023. The non-statutory Preparation for Adulthood assessment service was used to provide support while the young person awaited their assessment, and in some cases, this removed the need for the formal assessment.

The Approved Mental Health Professional (AMHP) resource was consistently under significant pressure, particularly at night and at the weekend. This had a direct impact on those staff on duty. At certain times of the night, there was only one AMHP on duty, covering the whole of the city. There are considerable travel times to some parts of the city from the office base, which affected the availability of statutory mental health assessments for people at these times.

People told us that it was sometimes difficult to request a review either at all or in a timely way, both for people who used services and carers. National data showed a higher proportion of people who need services used direct payments in Birmingham at 38.19%.

People told us about inconsistencies in getting information and advice and in recruiting personal assistants (PAs). Personal assistants are directly employed by the individual using their services. The local authority has taken steps to provide information and support in relation to the challenges of employing personal assistants. While acknowledging the positive steps that the local authority has taken, there is still more work to be done to address the difficulties we heard about.

National data indicated that the number of carers receiving direct payments directly to meet their carer support needs was above the national and regional averages of 80% and 68% respectively.

There was a range of mechanisms to respond to different assessment situations, which included making referrals for family group conferencing and to a self-neglect risk escalation conference. Staff were reminded to take mental capacity considerations into account in relation to identified needs and risks, and to consider capacity for wider impact of needs and vulnerability on wellbeing. Multi-disciplinary team meetings took place to share understanding of risk and to assist those working with people who were difficult to engage with. Where assessments were delayed, oversight and reviews took place to ensure that urgent situations were not missed.

Teams reported good management support and that their caseloads were manageable. This meant that they had enough time to do the assessments to a high standard, and if they had difficulties, they could ask for assistance.

Record keeping around assessment processes was subject to internal audits. In August 2023, these audit findings were very positive overall. We heard from senior leaders that there was now a robust programme of management oversight and support, and training to address any shortfalls in performance.

Supporting people to lead healthier lives

Indicative score:

3 - Evidence shows a good standard

What people expect:

“I can get information and advice about my health, care and support and how I can be as well as possible – physically, mentally and emotionally.”

“I am supported to plan ahead for important changes in my life that I can anticipate.”

The local authority commitment:

We support people to manage their health and wellbeing so they can maximise their independence, choice and control, live healthier lives and where possible, reduce future needs for care and support.

Key findings for this quality statement

Supporting people to live healthier lives was a key tenet of Birmingham's approach to delivering under the Care Act 2014. This had been a deliberate strategy led by the Director of Adult Social Care (ASC) since 2017. We were told that Adult Social Care had a clear vision, and that councillors and broader local authority leaders were confident in the Adult Social Care leadership team.

People told us that the work carried out to help people live healthier, more connected lives was positive, successful, and made a long-term difference. For example, young people from an advocacy group told us about the support that individuals had received to access learning opportunities. This had enabled them to gain confidence and learn new skills in relation to gaining more independence.

Staff across Adult Social Care demonstrated a good understanding and commitment to early intervention and prevention work. However, mental health social workers noted that they were not able to do as much preventative work as they would like, and the Early Intervention service eligibility criteria did not include admission avoidance or discharge planning in relation to mental health crises.

Local authority monies were distributed at a local level by a panel consisting of people and voluntary sector groups through bids to fund locally-developed provision. Voluntary sector partners across different constituencies, community groups and specialist teams were supported to access funding to meet people's bespoke needs and provide equity of support. This was built into early intervention and prevention strategies. Neighbourhood network schemes were actively asked to identify gaps and put in bids for funding to bridge them. The local authority also invested in the community through contracting with these 10 neighbourhood network schemes, each led by a voluntary sector organisation for 5 years at a time.

National data relating to supporting people to be healthier noted that people sometimes found it hard to access information about support. This was reflected by feedback we received from some providers, the voluntary sector, and from people about the time it took to get through to the Customer First team. However, the service was found to be informative and useful when accessed. Similarly, some people told us that the reliance on web-based information systems did not always suit their needs, which made it harder for them to get the help that they needed. These issues created a barrier to implementing this key priority for the local authority.

The Early Intervention and Community Teams engaged with people to facilitate discharge from hospital, or to prevent admissions. Integrated or co-located team structures and ways of working supported practice enabling independence, a 'Home First' approach and a reliance where possible on community places and services. There were multiple discharge pathways that varied based on people's needs, from bed-based to very minimal or no intervention, and that support reablement and independence. There were no reports of delayed discharges from hospital.

National data showed that significantly more people aged over 65, received reablement or rehabilitation after discharge from hospital than the national average. Birmingham was in line with the national average in terms of people over age 65 who were still at home 91 days after a hospital stay, followed by reablement or rehabilitation.

Local authority partners from the voluntary sector, including the local Birmingham Voluntary Service Council, were very supportive of the local authority's commissioning strategy regarding support for people to live healthier lives, and of the integrated team and neighbourhood network approach that focused on supporting people to maximise independence, choice, and control.

The Better Care Fund for 2023-25 had been used to set up the Early Intervention and Community Team. It was now planned to be used for expanding the integrated neighbourhood teams, as well as continuing to support timely and safe discharges from hospital and supporting people with eligible care to maintain their independence, focused on preventative actions and support for unpaid carers.

To ensure that housing decisions from the Council take account of health and wellbeing considerations, the local authority had recently published a new housing strategy that focused on 2 aspects – the quality of homes and linking to Adult Social Care, to understand issues in the health and care sectors that are housing related. The Housing department had recently become a lot more engaged with adult social care at a strategic level. They were also full members of the Adults and Childrens Safeguarding Boards and contribute in relation to any housing issues**.** Housing was a full member of the Health and Wellbeing board, which sits underneath the Integrated Care Board.

Equity in experience and outcomes

Indicative score:

3 - Evidence shows a good standard

What people expect:

"I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals"

The local authority commitment:

We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.

Key findings for this quality statement

Birmingham is an extremely diverse city with 51.4% of its population identifying as ethnic minorities. This, and the nationally recognised inequalities of experience and outcome faced by people from ethnic minority communities, is the context in which the local authority is seeking to improve equality, diversity, and inclusion.

The local authority told us that addressing these challenges is a long-term endeavour for themselves and their partners in the Integrated Care Partnership. Feedback from staff and leaders indicated that the local authority was committed to equity in experience and outcomes as a priority. The local authority used data and intelligence to consider how different protected characteristics might affect people in combination (this is known as intersectionality) to inform their approach. Commissioning was delegated to community groups to develop community assets for under-represented groups.

Neighbourhood Network schemes, each led by a single voluntary sector organisation, were specifically tasked with identifying gaps in service provision, and worked with groups and people to submit bids for services to fill these gaps. The local authority provided access to interpreters for people using other languages, including British Sign Language. They also made use of technology solutions such as video calls, to make services accessible.

There are a number of culturally specific provisions across Birmingham, but feedback from minority groups indicated that people wanting culturally appropriate care that reflected their preferences felt that the market was not developed enough to meet those needs, particularly around residential support. Local authority leaders told us this issue would be explored further to ensure people had meaningful choices as part of their ongoing work on equality, diversity, and inclusion. A positive example of this were the plans to carry out research into the reasons for the high proportion of people from Black African, Caribbean, and Black British backgrounds who used direct payments.

The local authority recognised the need to address inequalities in opportunity, experience, and outcomes that people could face. The local authority's strategy to address these is called Everyone's Battle, Everyone's Business (EBEB). Equality, diversity, and inclusion was a golden thread through the work of the Adult Social Care directorate and was further supported by having a dedicated senior manager co-ordinating work, and the Adult Social Care equality, diversity, and inclusion action plan. The local authority had a refreshed EBEB Equality Action Plan with 5 objectives: understanding the diverse community, inclusive leadership, involving and enabling diverse communities, delivering responsive services, and encouraging and building a skilled and diverse workforce which reflected the community.

The intentions of these documents fed through to other frameworks including the Integrated Quality Assurance Framework for regulated care providers. There was a robust governance framework to monitor progress of the implementation of this plan. At the time of our assessment there was no data regarding the impact of these interventions to make Birmingham a more equitable city, but the local authority, together with the Birmingham and Solihull Integrated Care System had stated their intention to measure and assess this.

There were multiple schemes to target the needs of vulnerable groups in terms of ensuring equity of experience, such as the Home for Ukraine and City of Sanctuary initiatives. The Connected Communities work had developed community facilities and groups for under-represented or dispersed communities, initially targeting 3 priority areas: LGBTQ+ communities, deaf communities, and Gypsy, Roma, and Traveller communities.

Theme 2: Providing support

This theme includes these quality statements:

- Care provision, integration and continuity
- Partnerships and communities

We may not always review all quality statements during every assessment.

Care provision, integration and continuity

Indicative score:

3 - Evidence shows a good standard

What people expect:

"I have care and support that is co-ordinated, and everyone works well together and with me."

The local authority commitment:

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.

Key findings for this quality statement

Birmingham has a large and diverse care market with proportionately fewer care home beds per 100,000 adults than the regional average. This reflects the lower admission rate to residential care, and a focus on the Home First strategy for people discharged from hospital.

Proportionately fewer registered providers in Birmingham were rated by CQC (Care Quality Commission) as good or outstanding than the West Midland and national averages. This was brought down by the proportion of homecare (domiciliary care) providers who perform less well. Birmingham's care homes had higher CQC ratings than West Midland local authority comparators. The local authority's approach to quality assurance showed that over 75% people whose support they funded were supported by a provider rated as good or outstanding. The local authority had placed contract embargoes on 2 providers in the previous 12-month period due to concerns about the quality of the care provided.

Commissioners told us they had a good understanding of the regulatory market and were confident in the way they are managing it. They had developed their own risk dashboard and had an internal intelligence team who regularly reviewed data around safeguarding, falls and complaints as well as provider credit ratings, which fed into their assessment of risk. They used this information to inform their Integrated Quality Assurance Framework which had been developed in partnership with the Integrated Care System (ICS) to ensure that people had access to high-quality and person-centred regulated adult social care. Feedback from health partners was positive about the intelligence the local authority had shared with them to inform their decision making. its

People who used services and their carers were positive about the care and support provision available to them. The local authority commits funds from their Adult Social Care budget and the Better Care fund to commission a Carers Hub for a 5-year contract. There was a lead provider, Forward Carers, of services to unpaid carers in the area, and partnership arrangements which could flex to respond to the diversity of needs presented by carers. Carers told us care services were well integrated and offered them good continuity of support. They were also well supported by Forward Carers.

In terms of the volume of need, the local authority told us the care home market was able to meet current and future demands. For people aged over 65 there was a 14% over-supply of beds in the residential market, due to a decline in demand related to the pandemic. Despite some providers exiting the market for residential care and homecare (domiciliary care), there was no significant impact on capacity in either provision. There were no known delays in meeting requests for homecare support and no areas within the local authority footprint where it was more difficult to commission care.

Although there were sufficient services for people with less complex needs who could be supported to live at home, in residential care or in supported accommodation, there was a lack of provision to meet more complex care needs. These included the needs of people with a learning disability and/or autistic people, services for people with complex needs such as a dual diagnosis, and of bed-based emergency care or respite for working age adults. We heard of younger people having no option but to be admitted to services intended for older people, because of a lack of alternatives.

The local authority told us that it had co-produced a review of day opportunities with experts by experience and service users, supported by a commissioned facilitator. Completing this work and developing a commissioning strategy for the external sector was an important priority for developing its support offer over the next year. Access to other daytime support is signposted through the Birmingham connect to support website.

Feedback from minority groups indicated that people wanted culturally appropriate care, but that they believed the market was not developed enough to meet those needs, particularly around residential support, or care that reflected their preferences.

Providers in the homecare and older adults residential care sectors told us they had good relationships with commissioners and felt engaged with them. Some providers recognised the local authority's good culture in terms of promoting people's independence. They cited good relationships and communication with the local authority and attended regular meetings with a local forum to discuss issues and promote networking. These providers also told us that the local authority's market intelligence briefings were highly informative, and that the local authority quality assurance team engaged with them in a positive way.

In contrast, some other providers, and one trade body, were less positive about commissioning at the local authority. Some spoke of unhelpful and unsupportive relationships, limited communication, one-way partnerships and feeling disconnected.

Commissioners also told us that they took their responsibility to keep the wider market sustainable seriously. For example, during the local authority's last homecare tender in 2019 it had commissioned the Institute of Social Entrepreneurs to support any decommissioned providers who were removed from its framework. People were also given the option to take a Direct Payment if they wanted to stay with their previous providers where they were no longer on the framework. Of the providers that were decommissioned at that time, 70% were still in the market at the time of our assessment.

Hospital discharge worked well, with integrated and co-ordinated resources that were effective in delivering good outcomes. There was a clear remit of discharge to assess with a series of pathways depending on need, including bespoke housing and homeless pathways. These meant that people could access temporary accommodation to enable discharge from hospital while housing solutions were explored, to prevent vulnerable people being left without appropriate support. There were no reported issues with delayed discharges.

The Early Intervention and Community Team was funded jointly between health and social care to plan, commission, and deliver appropriate care and support to people.

Staff spoke with pride of the responsiveness and skill of the in-house service provision, who usually provided a reablement service, for their ability to provide short notice or replacement care for people who were hard to engage with.

Co-production took place with health partners and others to ensure the right services were commissioned for the population. There were clear strategies for commissioning, focusing on integration, investment, and stability. They also focused on market shaping, commissioner-led support, incentivising quality, efficiency, and modernisation. The local authority placed an emphasis on robust contract management.

The local authority had a strategy to reduce reliance on commissioned adult social care services, backed by the intentional spend on supporting people to live healthier lives, which reduced, delayed, and prevented the need for formal service provision.

Partnerships and communities

Indicative score:

3 - Evidence shows a good standard

What people expect:

"I have care and support that is coordinated, and everyone works well together and with me."

The local authority commitment:

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Key findings for this quality statement

Individuals and groups told us about active engagement with the local authority, co-production and partnership working as people living in the city, or as providers of statutory, independent, or voluntary sector services across health and care. Some people we spoke with described it as a full partnership, especially people who live in the city, and who use services.

Council members and senior leaders were noticeably confident in the local authority's approach and positive about partnership working and integration with health providers. Leaders and staff within the organisation were committed to, and could show evidence of partnership working, and co-production on many levels and in many service areas. One example of this was the joint work between the social work team based in the hospital and the housing teams. One of the social work team focused on identifying people who were frequent visitors to A&E, mostly due to issues associated with homelessness. They worked jointly with the hospital staff and housing to ensure that people were supported to have emergency housing while other options were considered with them to best meet their needs. This had a positive impact for the person concerned as well as a positive impact for the provision of emergency healthcare to others.

There were processes in place, and planning paperwork and evaluation documents reflected that co-production, partnership and engagement with community stakeholders was intentional and effective.

Most people expressed high levels of satisfaction with the local authority's co-production, partnership working and engagement. Voluntary sector partners, Healthwatch, the Independent Safeguarding Adults Board chair and many providers spoke of their involvement, and evidence of co-production. The Integrated Care Partnership (ICP) chair told us they had strong relationships with the local authority and were involved in joint planning and joint strategies with a clear vision, but that some challenges remained regarding delivery. Learning, especially in relation to safeguarding practice and from research they had commissioned, was shared across the ICP.

When discussing co-production with user-led groups, we heard about the range of opportunities for people to get involved. They spoke positively about this but also said that there had occasionally been some barriers to being involved, due to difficulties in attending a meeting. There were also some concerns voiced that it was not always easy for some people to give their views if appropriate consideration had not been given to people whose first language was not English or for those who found it hard to use computer-based options. We heard from one provider of residential care services who felt that not enough was done to ensure that people with a learning disability were supported to take part in co-production.

The local authority told us about the range of ways it seeks to address barriers to engagement. These included having a mix of in-person and electronic meetings and arranging transport for people who would otherwise have difficulty participating. They also told us about making arrangements for BSL and other interpreters at in-person public meetings for people whose first language isn’t English to have an interpreter. Based on the feedback received, further work is required to ensure that these measures do enable anyone who wants to participate in engagement.

Healthwatch told us they felt their input was valued and that they worked in partnership with the local authority. In last 12 months, they noted an improvement of integration and co-production, which was attributed to the implementation of the 3 conversations and strength-based approach to assessment. They also observed a positive culture shift in the local authority, which was in keeping with other feedback we heard.

Theme 3: How the local authority ensures safety within the system

This theme includes these quality statements:

- Safe systems, pathways and transitions
- Safeguarding

We may not always review all quality statements during every assessment.

Safe systems, pathways and transitions

Indicative score:

2 - Evidence shows some shortfalls

What people expect:

“When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place. I feel safe and am supported to understand and manage any risks.”

“I feel safe and am supported to understand and manage any risks.”

The local authority commitment:

We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Key findings for this quality statement

There was a significant backlog of approximately 217 young people aged 18 and over who were on the waiting list for assessment by the Transitions service. An action plan was in place to reduce this by December 2023. A plan was also in place to reduce the waiting time post referral to ensure that young people received a safe transition when moving between Childrens and Adults social care services.

Young people in the Youth Empowerment Squad were extremely positive about the benefits of the Preparation for Adulthood and Transitions service, which aimed to ensure continuity of care during the transition from child to adult with care needs. They told us of their personal success stories, of their broadened horizons and new confidence. Bringing together the Preparation for Adulthood and the statutory Transitions service to bridge the gap mitigated some of the risk and reduced pressure on formal assessment and care services.

The Early Intervention and Community team worked smoothly to bridge the transition between acute hospital health services and community-based health and social care services.

This integrated team worked within shared pathways and communicated effectively to make the most efficient use of resources. Assessment documentation was shared so that people did not have to repeat their stories, to obtain the help and support they needed.

The single point of access ensured that people who had either been referred to, or contacted the wrong service, were referred onwards to the correct service rather than just signposted, so to the public, there was “no wrong door.”

There were frequent, regular multi-disciplinary conversations and meetings to ensure that people moved smoothly at the earliest opportunity from acute hospital services back home. This integration of health and social care at the point of discharge from hospital worked well to reduce length of stay, provided appropriate rehabilitation and reablement, and reduced likelihood of readmission to hospital.

The process to discharge homeless people to a temporary accommodation-based service where they could have a Care Act assessment provided a safe transition for those who met the eligibility criteria.

Feedback from providers was that transitions from one service to another because of changing needs, or avoiding a move where this could be safely achieved, were inconsistent, and that it could be hard to get a social worker to support with complex cases.

Safeguarding

Indicative score:

2 - Evidence shows some shortfalls

What people expect:

“I feel safe and am supported to understand and manage any risks.”

The local authority commitment:

We work with people to understand what being safe means to them and work with our partners to develop the best way to achieve this. We concentrate on improving people’s lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

Key findings for this quality statement

Birmingham was in line with national averages regarding the percentage of carers and people using services who felt safe, and regarding the percentage of people who said the services they used had made them feel safe and secure.

The Adult Social Care vision for Birmingham spoke of a focus on “making safeguarding personal” and that delivery of this strategy required partnership working as standard, as well as an effective safeguarding team with high quality intelligence about safeguarding issues.

According to the Safeguarding Adults Board, in 2021/22, 62.7% of people felt their enquiry had fully achieved what they wanted, 29.1% partially achieved and 8.2% not achieved.

Referrals to the safeguarding team had increased over time, while the average days from concern to decision making was 48 days and to complete an enquiry was 85 days. This meant there had been a build-up of work, without an equal increase in staff capacity, or throughput of referrals.

There was a high number of unallocated Section 42 enquiries that had been triaged and met the threshold for an investigation under Section 42 of the Care Act. In September 2023, almost 250 of these had been waiting between 5 and 6 months.

An earlier improvement plan to work through a large backlog of safeguarding concerns, resulted in the backlog moving from untriaged, to awaiting investigation. For a period, the plan to reduce the backlog led to staff having high caseloads and was not sustainable. It also meant that pressure to progress work risked the quality of work undertaken. We heard feedback from some staff about difficulties in raising concerns about quality or workload, but other staff found management supportive. Changes had subsequently been made to the way this work was being managed to reduce this risk.

Senior leaders told us that they were aware their safeguarding performance was on "an improvement journey" with an ongoing plan to add capacity to the safeguarding team, to address the flow of work. This included a plan in place to eliminate the backlog of Section 42 enquiries by December 2023. Evidence provided by the local authority since the assessment has shown the impact of this plan, bringing forward the expected date of eliminating the backlog of enquiries to November 2023.

The backlog, albeit reducing, presented a risk to people, which needed to be managed.

Senior leaders told us that enquiries held in the queue are reviewed regularly, closely monitored to maintain oversight of prioritisation, and to ensure that where someone was at imminent risk of harm this was allocated for investigation immediately.

The local authority had produced a suite of guidance to inform decision making in different circumstances, a robust governance framework and a corporate safeguarding network with dedicated safeguarding leads from each directorate. This met monthly to share information and support effective safeguarding of children and adults across the local authority. Senior staff were monitoring progress to improving performance and had developed a Safeguarding Improvement Next Steps plan for 2023/24.

There were now robust management processes in place to review caseload management with each team and an individual on an ongoing basis. This management incorporated both the timely completion of cases, and an oversight of the quality of both the assessment and record keeping.

Under Part 1 of the Care Act, the local authority had powers to delegate the investigation of a Section 42 Safeguarding enquiry, to determine what action should be taken and by whom. Senior leaders told us that they had oversight of such delegated investigations, but providers and other partners told us that oversight was inconsistent.

Some providers told us that they found it difficult to work with the safeguarding team, who rejected many concerns that the provider had submitted as not meeting the threshold for a safeguarding enquiry. Ongoing communication was needed so that providers were clear about the threshold for safeguarding referrals. On occasions where referrals were progressed, providers told us they were not always informed of the outcome.

The local authority received 10% more Deprivation of Liberty Safeguards (DoLS) applications than the national average per 100,000 and had processed approximately 9% more than the national average. To mitigate this risk of the backlog of applications awaiting approval, the local authority has used a prioritisation tool, which has indicated that 642 are high priority and of these, 490 had been waiting more than 90 days. This level of backlog was a risk to the rights and protections of those who were being deprived unlawfully pending the authorisation of their DoLS assessment.

The local authority had set clear targets to manage ongoing work and plans were in place to reduce the backlog by adding additional capacity and proportionate methods.

Theme 4: Leadership

This theme includes these quality statements:

- Governance, management and sustainability
- Learning, improvement and innovation

We may not always review all quality statements during every assessment.

Governance, management and sustainability

Indicative score:

3 - Evidence shows a good standard

The local authority commitment:

We have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

Key findings for this quality statement

The local authority's corporate strategy set out priorities and guided the work programme. It was clear about aims, key areas of focus, roles, and responsibilities.

The Adult Social Care vision was clearly articulated as a strategy and action plans to deliver it. The Director of Adult Social Services (DASS) and the leadership team had the sustained confidence and support of the councillors Executive Committee, and Chief Executive Officer who agreed with the vision and plans to meet the needs of the people of Birmingham over time.

There was staunch support from the council's Administration and Opposition Councillors who supported the strategy and scrutinised the Care Act duties of the Adult Social Care directorate. They had confidence in the information provided to them in briefings, and that the DASS was both aware of, and dealing with risks in their delivery of Care Act duties.

The DASS was briefed by his senior leadership team, who used the governance frameworks that had been put in place to gather performance information – including qualitative and quantitative data.

The local authority had implemented systems and processes that supported good governance and that helped them to understand and address the issues that they had in some areas. They had programmes of audit, and governance frameworks to understand and manage the development, implementation, review, and amendment of action plans necessary to deliver the vision. These included reviewing and re-organising staff resources, to integrate and deliver on a locality level.

The DASS was a visible, respected, and well-liked leader. The leadership team had been put together to focus on priorities, such as “Everyone’s Battle, Everyone’s Business.” A senior leader told us that the leadership team came from a range of professional disciplines, which added strength to their collective experience and knowledge which shaped discussions and problem solving.

The DASS had introduced the organisational culture change programme called “Owning and Driving Performance.” Staff we spoke with understood and embraced this culture and told us about how they applied it in their everyday work to empower productivity and creativity. They also spoke of increased accountability for their performance and the opportunity and encouragement to reach out for support if they needed it. Staff were very positive about working in Birmingham, and the majority felt very supported to develop innovative, creative solutions to deliver person-centred outcomes.

Team managers told us that they were empowered to improve services, using demographics and performance information to develop services and provide a holistic approach. Staff also told us that they felt safe to seek support, or to raise concerns to keep the service, and their practice safe.

Some of the issues that affected sustainable delivery of duties under the Care Act related to challenges with recruitment. Efforts had been made to address this within the local authority, but it remained a significant, widely felt problem.

We heard from both the public and provider stakeholders that some people had experienced an inconsistent service from the local authority, which depended on the individual they dealt with.

Birmingham is the largest unitary local authority in England, and therefore the number of complaints to the Ombudsman should be considered per head of population. Birmingham had 37 applications (in relation to adult social care), but this was only 3.2% per 100,000 residents, which was in keeping with other core city local authorities. Similarly, applications upheld by the Local Government and Social Care Ombudsman (LGSCO) in the 12 months to May 2023 relating to Adult Social care were comparable with the rates of other core cities, and proportionately few in number. These were in relation to assessment and care planning and 2 safeguarding complaints.

In the 12 months to May 2023, the local authority received 663 complaints directly about adult social care, and the majority were either partially or completely upheld. Of these, 45% were about service quality, 23% about service quality failure, approximately 16% about communication and almost 8% about staff conduct. These were all directly or indirectly in the local authority's span of control.

The local authority was aware of this and in September 2022 it had implemented a new process for senior adult social care staff to review complaint responses to ensure quality and consistency, and to learn from complaints.

Learning, improvement and innovation

Indicative score:

3 - Evidence shows a good standard

The local authority commitment:

We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

Key findings for this quality statement

The local authority embraced the idea of being a learning, improving and innovative local authority. It had actively engaged with and instigated research with universities, other local authorities, and partners in other countries such as the Birmingham-Leipzig Urban Diplomacy Exchange, to help to better understand the needs of their local communities, and how to meet them. They had looked to get a stronger user voice into research. The local authority had commissioned ethnographic research to better understand the needs of people from ethnic minority groups living in Birmingham and was commissioning research to hear from a wider range of people including the voices of seldom heard groups.

When new practices such as the 3 conversations, strengths-based approach, and family group conferencing were introduced, this was done in partnership with one of the universities in Birmingham to understand the impact on staff, the organisation and people who live in the city.

Partner organisations found that the local authority was strong on learning and development and embedding this into practice. We heard that the local authority and third sector partners developed their relationships and worked together effectively. They took on board the views of people, which was evident in the local authority strategies. Leadership and commissioning practice was consistent. Although circumstances and community needs changed frequently, investment and communication, and valuing the strengths of providers was consistent. People felt support was in place and it had a positive impact and supported good relationships. This approach was enhanced during the COVID-19 pandemic and has been carried forward.

The Care Homes Infection Prevention Control Service had been operational since December 2020 and was an innovative model, shortlisted for the Nursing Times Awards in 2022. We heard many examples from staff demonstrating a commitment to deliver for the people of Birmingham, being creative and working in partnership to keep people safe and as independent as possible. Innovation happened on a small scale as well as at system level. The local authority encouraged that creativity and innovation. Staff told us that the lack of easy, service-led fixes to individual needs led to lateral, creative thinking, which resulted in more person-centred outcomes. An example of this was the use of an app to allow a young person to become more independent, but with support as and when needed.

We heard that the local authority had used learning from the NHS England Vanguard pilots testing new models of integrated care in neighbourhoods to shape the approach to locality working. It had trialed a partnership of integrated provision across formal care and health services and a diverse range of community facilities in Birmingham across 5 locality pilot sites, which it intended to roll out across the city in Autumn 2023.

The Adult Social Care directorate used multiple methods to secure feedback and seek learning. Quarterly feedback from Healthwatch was used to identify themes and trends, which were fed back to teams and providers. The learning from Safeguarding Adult Reviews had led to increased training for staff teams and improved guidance.

Case file audits were carried out by the Principal Social Worker in peer reviews and supervision sessions with managers. Feedback from people was collated through audits and questionnaires, which were sent out to people using the services and their families. The Principal Social Worker produced an annual report reflecting on the previous year, including any achievements and lessons learnt.

To learn from complaints, the local authority had set up a Learning from Complaints Operational Group. This met monthly to review learning from 2 complaints and a compliment. A new Learning from Complaints Assurance Group had also been recently established to provide review and challenge of their improvement activity. For example, in response to concerns relating to communication, a communications forum has been set up to work on a library of template letters for frontline staff to use. In addition, a document setting out expectations in relation to communication has been produced and shared with staff.

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